

An Exploration of Volunteers Supporting Patients with Dementia and Cognitive Impairment on Acute Hospital Wards: A Qualitative Study.

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Abstract

Background: Volunteers are widely used in hospital NHS Trusts but little is known about the service provided for the support of patients with dementia on acute hospital wards.

The incidence of dementia is increasing worldwide, with more people being admitted to acute hospital wards requiring treatment for medical conditions. Admission to the acute hospital wards can be distressing for patients with dementia, and health care professionals and family carers may experience difficulties in providing personalised care in this environment. Volunteers may be uniquely positioned to provide extra support.

Aim: To understand volunteerism in the care of people with dementia and cognitive impairment in acute hospital wards from a multi stakeholder perspective.

Methods: Qualitative in-depth, semi-structured interviews, and reflective diaries. Managers, staff, volunteers, former volunteers, patients and carers were recruited from a large NHS hospital trust in England and participated in a single interview. Volunteers kept a reflective diary following the interview. A thematic analysis was undertaken of the data.

Results: Themes included role and ways of working, motivations, and image and identity. 43 participants included managers (n=8), ward staff (n=11), volunteers (n=14), former volunteers (n=1), carers (n=7), and patients with dementia (n=2) were recuited between February 2017 and November 2017.

There were discrepancies between the views of participants who switched from an idealised account of volunteers to doubts about their role, concerns over safety, and conflict with work of paid staff. Managers and staff expressed a lack of detailed knowledge about the volunteer role.

The ward environment was seen as a challenging, busy, and noisy place in which to be a patient, visit, work, or

volunteer. Hospital voluntary services provide a variety of roles to support patients, staff, and carers. The main roles are mealtime volunteers, who provide support with food and drink, and chaplaincy volunteers, who assist with the spiritual, pastoral and social support and care of patients. Volunteers in both roles experienced challenges around their role and identity. Dementia was described by volunteers in both positive and negative terms. Some patients were avoided by volunteers. People volunteer for a variety of reasons and because of, or despite the presence of dementia.

The results show there is a need for careful risk management to maintain safety of patients, staff, and volunteers, which includes adequate training and supporting volunteers. There was difficulty reconciling the needs of the organisation and the motivations of volunteers as volunteers have different expectations of the service than management and staff. There was some concern about the costs of the service and making sure that these are optimised through clearer purpose and organisation.

Volunteers were described by all groups of participants as being of value, providing an opportunity for patients and carers to access extra help and support, a type of friend. The demographics of volunteers varied. Characteristics such as age and gender were seen to contribute to their image. However, there was uncertainty about their image, identity and role. This appeared to be influenced by volunteers' individual characteristics, relationships with paid staff, and the uniform they wore as they navigated the demands of working in a complex and busy environment. Wearing a uniform elicited a variety of responses, generating discussion about the advantages and disadvantages for their image and self-identity, with no universal agreement on whether or not it was beneficial or detrimental. Volunteers understood the importance of acting as an advocate for patients, even when they experienced challenges in doing so. Managers and the paid workforce expressed a a need for a risk averse strategy when deployingvolunteers. However, this was found to be less of a priority among volunteers, patients, and carers.

Conclusions: Current guidelines and policies do not appear to be evidence based but have developed in response to perceived need for supplemental support. National drives exist to deploy more hospital volunteers into NHS hospitals. In view of the different expectations of the service and lack of clarity around the role and identity of volunteers, there appears to be the potential to resolve identified tensions and improve the ways volunteers work by adopting a different approach to managing the service. One suggestion is an alternative approach to managing hospital voluntary services which consider leadership; communication; the needs of volunteers, patients, carers, ward teams and the wider organisation; funding; and protecting the rights of paid workers. The NURTURe model is proposed to maximise and streamline hospital voluntary services in this setting.

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‘The end of all knowledge should be service to others’

Cesar Chavez

Table of Contents

Abstract.....1

Acknowledgements.....4

List Of Abbreviations.....23

Chapter 1 Background and Introduction 24

1.1 Introduction.....24

1.2 Personal reflections and motivations for the study.....24

1.3 Volunteerism.....26

1.3.1 Definition 26

1.3.2 Demographics.....29

1.3.3 Motivations.....32

1.3.4 Volunteer management.....38

1.3.5 History.....39

1.3.6 The future of volunteering 50

1.3.7 Volunteering and healthcare 55

1.4 Dementia 60

1.4.1 Dementia statistics.....62

1.4.2 Needs of people living with dementia.....63

1.4.3 Problems in hospital.....64

1.4.4 Best Practice: Person-centred care.....69

1.4.5 The challenge of delivering person centred care in hospital 70

1.4.6 Carers 71

1.4.7 Volunteering and dementia 73

1.4.8 Volunteers in dementia care in acute hospitals 74

1.4.9 Recruitment, training, support of volunteers 76

1.4.9.1 Recruitment 76
1.4.9.2 Training 76
1.4.9.3 Support 79

1.4.10 The range and type of activities undertaken by volunteers 80

1.4.10.1 Volunteers in delirium prevention.....81
1.4.10.2 Volunteers and mealtime assistance 83
1.4.10.3 Volunteers and mobility assistance 85

1.4.11 The effectiveness and impact of volunteers in hospital wards.....87

1.5 Conclusion.....91

Chapter 2 Literature Review 93

2.1 Introduction 93

2.2 Review question 94

2.3 Search strategy 94

2.4 Databases 95

2.5 Inclusion and exclusion criteria 96

2.5.1 Inclusion criteria: 96

2.5.2 Exclusion criteria: 96

2.6 Methods 98

2.7 Quality appraisal 100

2.8 Description of included papers 102

2.8.1 Demographics of participants 107

2.8.2 Overview of results 109

2.9 Prominent themes in the literature 138

2.9.1 Introduction 138

2.10 The volunteer role, function, and role boundaries 138

2.10.1 How do volunteers experience their role? 139

2.10.2 How are volunteers seen by others?.....142

2.10.3 Role boundaries.....147

2.10.4 How do volunteers cope with ambiguity? 150

2.11 The type and nature of volunteer relationships 152

2.11.1 Relationships between volunteers 153

2.11.2 Relationships between volunteers and paid staff 154

2.11.3 Relationships between volunteers and patients and carers 161

2.11.4 Relationships volunteers have with others 162

2.12 The effect of context on the experience of volunteers.....164

2.13 Volunteer support in dementia and the care of older people 168

2.13.1 Context 168

2.13.2 Motivations....169

2.13.3 Training....169

2.13.4 Image of volunteers....169

2.13.5 The volunteer role....170

2.14 Conclusion....171

Chapter 3 Methods and Methodology....174

3.1 Introduction....174

3.2 Study aim....174

3.3 Study objectives....175

3.4 Research design....175

3.4.1 Epistemology....176

3.4.2 Methodological approach....177

3.4.3 Philosophical underpinning of the study...178

3.4.4 Patient and public involvement (PPI) in study design 181

3.5 Research methods....183

3.5.1 Interviews....183

3.5.2 Dyadic interviews....187

3.5.3 Diaries 190

3.6 Research setting, access, sampling, selection, and recruitment 193

3.6.1 Research setting 193

3.6.2 Access to participants 195

3.6.3 Sampling 197

3.7 Selection 201

3.7.1 Management 201

3.7.2 Ward based staff 201

3.7.3 Volunteers 201

3.7.4 Former volunteers 202

3.7.5 Patients 202

3.7.6 Carers 203

3.7.7 Exclusion criteria 203

3.7.8 Recruitment 204

3.8 Data collection 205

3.8.1 Interviews 205

3.8.2 Diaries 207

3.8.3 Exiting the field 209

3.9 Optimising the trustworthiness of the research 211

3.9.1 Credibility 211

3.9.2 Transferability 212

3.9.3 Dependability 212

3.9.4 Confirmability 213

3.9.5 Reflexivity and the role of the nurse researcher 214

3.10 Ethics 219

3.10.1 Ethical review process 219

3.10.2 Ethical considerations 219

3.10.3 Ethical considerations of involving patients with cognitive impairment in research. 221

3.11 Insider/outsider debate in relation to the duty of care 223

3.12 Data management 225

3.13 Data analysis 229

3.14 Conclusion 238

Chapter 4 Results: Setting the scene.....239

4.1 Introduction.....239

4.2 Section One: Setting the scene-volunteerism.239

4.2.1 Introduction 239

4.2.2 Description of the voluntary service 240

4.2.3 The hospital policy and organisational expectations 242

4.2.4 Mealtime volunteers.....248

4.2.5 Chaplaincy volunteers.....251

4.2.6 Other volunteers.....254

4.2.7 Conclusion 255

4.3 Section Two: Setting the scene-the environment 256

4.3.1 Introduction 256

4.3.2 The hospital and wards.....256

4.3.3 The perspectives of managers and ward staff of the environment.....259

4.3.4 The perspectives of volunteers of the environment.....262

4.3.5 The perspectives of patients with dementia, and carers, of the environment 267

4.3.6 Conclusion 273

4.4 Section Three: Setting the scene-dementia....274

4.4.1 Introduction 274

4.4.2 An overview of patients with dementia and acute conditions.....274

4.4.3 The perspectives of managers of volunteering in dementia care.....275

4.4.4 The perspectives of ward staff on dementia 279

4.4.5 The perspectives of volunteers on dementia 284

4.4.6 The perspectives of patients with dementia, and carers.....295

4.4.7 Conclusion 299

Chapter 5 Results: Volunteerism-role and ways of working. 302

5.1 Introduction.....302

5.2 Managers.....302

5.2.1 The volunteer role and position in the team 303

5.2.2 Relationships and ways of working 306

5.2.3 Developing the role and ways of working .312

5.3 Ward staff 319

5.3.1 The volunteer role and position in the team 319

5.3.2 Relationships and ways of working 324

5.3.3 Developing the role and ways of working .328

5.4 Volunteers 335

5.4.1 The volunteer role and ways of working ...335

5.4.2 Relationships and ways of working 340

5.4.3 Navigating the role 348

5.5 Patients with dementia, and carers.....357

5.6 Conclusion.....361

Chapter 6 Results: A focus on volunteerism. motivations, image and identity.....364

6.1 Introduction.....364

6.2 Section One. Motivational factors 364

6.2.1 Introduction 364

6.2.2 Volunteer statistics 365

6.3 The perspectives of managers.....368

6.4 Motivations of ward staff for the voluntary service 371

6.5 Motivations of volunteers 375

6.5.1 Barriers to continuing, and reasons for leaving the role 381

6.5.2 The impact of dementia on the motivations of volunteers 385

6.5.3 Attitudes and responses to the voluntary service of patients with dementia, and carers.....390

6.5.4 Conclusion 392

6.6 Section Two. Image and identity.....394

6.6.1 Introduction 394

6.7 The perspectives of managers on the image and identity of volunteers 395

6.8 The perspectives of ward staff on the image and identity of volunteers 400

6.9 The perspectives of volunteers on their image, social identity and self-identity.....405

6.10 The perspectives of patients and carers on the image and identity of volunteers.....410

6.10.1 The influence of the volunteer uniform on image, identity, and self-identity 416

6.10.2 Managers.....416

6.10.3 Ward staff 416

6.10.4 Volunteers.....417

6.10.5 Patients with dementia, and carers.....421

6.10.6 Conclusion 422

Chapter 7 Outcome of the analysis: The case for a new management model 425

7.1 Introduction.....425

7.2 Background to the development of the NURTURe model 425

7.2.1 The NURTURe model of volunteer management.....434

7.3 Practical application of the NURTURe model .442

7.4 Conclusion.....444

Chapter 8 Discussion and conclusion 445

8.1 Introduction 445

8.2 Summary of findings 445

8.3 Discussion of results 449

8.3.1 Diverse viewpoints 449

8.4 Expectations of the voluntary service 452

8.4.1 Expectations over risk management 454

8.4.2 Expectations over training 456

8.4.3 Expectations around diversity, inclusivity and widening participation 458

8.4.4 Expectations around cost effectiveness ...461

8.4.5 What do volunteers expect from volunteering? 462

8.4.6 Differences in expectations 465

8.5 The setting 466

8.5.1 Challenges of supporting people with dementia 468

8.6 Lack of clarity over image, identity, and role of volunteers 470

8.6.1 Identity and uniforms.....476

8.6.2 Conclusion 478

8.7 Strengths and limitations 479

8.8 Recommendations for further research 481

8.9 Conclusion.....485

References 488

Appendix 1: Results of Critical Appraisal Skills Programme Quality Appraisal Tool (CASP, 2019b). 552

Appendix 2 Patient information 560

Appendix 3 Interview guide 561

Appendix 4: Ethics approval and public liability insurance.....564

Appendix 5: Mental capacity assessment 580

Table of Figures

Figure 1 The Octagonal Model (Yeung, 2004).....36

Figure 2 PRISMA search process and results (Moher et al, 2009).....99

Figure 3 The simple relationship between epistemology, methodology, and method (Carter and Little, 2007 p1317) 176

Figure 4 Concept model.....231

Figure 5 Data analysis example of development of early themes. 233

Figure 6 Data analysis example of development of early themes. 234

Figure 7 An example of the progression from codes to themes.....235

Figure 8 Diagrammatic representation of final thematic structure: The setting 235

Figure 9 Diagrammatic representation of final thematic structure: The volunteer role and ways of working.....236

Figure 10 Diagrammatic representation of final thematic structure: Motivations.....236

Figure 11 Diagrammatic representation of final thematic structure: Image and identity.....237

Figure 12 The NURTURe model.....437

Table of Tables

Table 1 Overview of Results 137

Table 2 Volunteer type, length of service, and reason for leaving the organisation 366

Table 3 Motivations Related to Dementia and Volunteer Type 387

List Of Abbreviations

BAME	Black, Asian and Minority Ethnic
BMI	Body Mass Index
CGA	Comprehensive Geriatric Assessment
DBS	Disclosure and Barring Service
GDPR	General Data Protection Regulations
HCOP	Healthcare of the Older Person
HELP	Hospital Elder Life Program
ISTR	International Sector for Third Sector Research
IVR	Institute for Volunteering Research
MDT	Multi Disciplinary Team
NCVO	National Council for Voluntary Organisations
NHS	National Health Service
NICE	National Institute for Health and care Excellence
ONS	Office for National Statistics
OSOP	One Sheet of Paper
PPI	Patient and Public Involvement
SIGN	Scottish Intercollegiate Guidelines Network
UK	United Kingdom
VSSN	Voluntary Sector Studies Network

Chapter 1 Background and Introduction

1.1 Introduction

This chapter introduces the study by providing a background to the proposed research beginning with personal reflections and motivations for undertaking the research. It then moves on to: define volunteerism; detail volunteer statistics; describe volunteer management models; present an overview of the history of volunteering with reference to societal and political influences in healthcare; and discuss the future of volunteerism. It concludes with an overview of dementia, with particular reference to problems faced by patients with dementia or cognitive impairment while in hospital.

1.2 Personal reflections and motivations for the study.

The research idea comes from my clinical experience of caring for older people (with multiple comorbidities, including cognitive impairment, dementia, delirium, and acute medical conditions) in my role as a Registered Nurse on Healthcare of the Older Person Acute Medical Wards.

My interest in this area developed as a result of feeling continually challenged to provide good quality care in what I considered to be a demanding and difficult specialty. My interest in volunteers continued to develop as I regularly worked alongside them while facilitating a prevention of delirium project (Young, et al. 2015). I subsequently questioned whether their role could be further developed to improve the experiences of patients (Charalambous, 2014).

However, I also became aware of the lack of evidence to support the impact of volunteerism in this context. My default position became one of supporting and defending the volunteers and the role itself when others became critical or suspicious of their contribution.

As such, I am acutely aware that I bring with me to the role of researcher, certain assumptions. This resonates with Weber (1949) who insisted that social science should be value free, yet also recognised that social scientists choose to investigate certain phenomena based on their values. Having detailed my personal reflections and motivations for the study, I will now focus on aspects of volunteerism.

1.3 Volunteerism

Volunteer schemes are widely used in NHS hospitals with the aim of providing support to patients, staff, and visitors to improve their experience. This section will offer a definition, and explore the history and related statistics of volunteerism, with a focus on dementia.

1.3.1 Definition

The terms volunteering and volunteerism will be used throughout. Volunteerism refers to the use of volunteer labour (OED Online, 2019a), whereas volunteering refers to the action itself (OED Online, 2019b). Volunteering and volunteerism is defined (Oxford, 2006; Gottlieb and Gillespie, 2008) from an international (UNV, 2011), legal (The Police Act, 1997; Social Security, 2013), practical (Kitchen et al, 2005) and healthcare perspective (Mundle, Naylor and Buck, 2012; Gottlieb and Gillespie 2008; Egerton and Mullen 2008). There does not appear to be a single, concise definition (Rochester, 2006).

While there is general agreement on the core characteristics of volunteers (Rochester, 2006; Ellis Paine et al, 2010) it is difficult to accurately conceptualise and define because of preconceptions and stereotypes around volunteering (Graham, 2004). This is also due to

the diversity and complexity of volunteerism (Kakoli and Ziemek, 2000).

There is general agreement about the essential characteristics of volunteers when striving to establish a definition (Davis Smith, 1999). Volunteering should not be undertaken primarily for financial reward, it should be undertaken without coercion, and the activity should benefit someone other than the volunteer (Davis Smith, 1999). Volunteering should be formally organised (Ellis Paine, Hill, and Rochester, 2010). Therefore, when defining volunteerism, any activity which is of an informal nature between people who are already acquainted (such as helping a neighbour in need), is excluded from the definition.

However, there are challenges in establishing a clear definition to understand volunteer identity which incorporates these criteria as there may be some lack of clarity around the reimbursement of expenses, with the potential for them being seen as a financial reward. Volunteers may undertake voluntary activity freely but feel a sense of obligation to volunteer because of the need to seek career development, or feel coerced through peer pressure and sense of social obligation. It is recognised that volunteering may also benefit the

volunteer as well as those in receipt of voluntary services (Davis Smith, 1999), without any clarity over the balance of benefits. Indeed, the understanding that volunteering benefits the volunteers themselves is further illustrated by The National Council for Voluntary Organisations (NCVO, 2015) which attempts to answer the question, 'what is the voluntary sector?' with the response,

> *'The purpose of the voluntary sector is to improve and enrich society…It exists to create social wealth rather than material wealth. The common understanding behind our categorisation of the sector is that it exists to make a difference to society rather than to make financial profits'* (NCVO, 2015).

It could be argued that these benefits include the personal benefits to volunteers when they undertake voluntary work.

Volunteers can engage in a wide range of diverse activities (Do-it, 2015). Policies from international (UNV, 2011), national (Gov.UK, 2015) and local perspectives regard volunteerism as underpinned by altruistic intentions such as collaborative practice, empowerment and reciprocal benefits, but motivations vary (Zweigenhafta et al, 1996). None of the existing definitions take into account the people who volunteer;

their motivation, and reasons why they continue; the subtleties of reciprocity involved, and the benefits they derive from volunteering. These are all important factors in volunteering (for example, students who volunteer to gain experience necessary for a medical degree application might have a very different motivation from a retired person who wishes to establish a social network).

Synthesising the common elements of volunteering in the context of dementia and acute care, I propose the following working definition:

‘a person, or group of people who freely offer time, skills and services for no financial gain, other than reimbursement of expenses; and are formally organised to provide support to patients with dementia within an acute hospital setting.

1.3.2 Demographics

In the absence of a comprehensive and universally accepted definition of volunteers, and taking into account the informal aspects of some types of volunteering, it is difficult to report exact statistics. Estimates vary, but between 13.8 and 21.6 million people are thought to formally volunteer annually in the UK (Institute for Volunteering Research, 2015).

Despite the dearth of research evidence of volunteers supporting patients with dementia in acute hospitals, the literature provides a general overview of healthcare volunteers in hospitals in England (Galea et al, 2013), health and social care in England (Mundle, Naylor, and Buck, 2012), and the adult care sector in England (Hussein and Manthorpe, 2014).

These reports show a slight peak in volunteering among those aged 20 years or younger, and a more evident peak in those 65 years and older (Hussein and Manthorpe, 2014). Young people were less likely to volunteer regularly than older people, but they were more likely to engage in irregular volunteering (Mundle, Naylor, and Buck, 2012). In 2013, volunteers were found to be younger than in the previous five years, as people sought to gain skills and work experience (Galea et al, 2013). Data from the Office for National Statistics show that between 2000 and 2015, more younger people between the ages of 16-24 years volunteered than in previous years, while those aged 25-34 years spent less time volunteering (ONS, 2017). In an national survey of volunteering and charitable giving, Low et al (2007) found no significant difference in formal volunteering between ethnic groups.

Volunteers who identified themselves as white ethnicity were found to have a higher level of participation than those from minority ethnic groups (Mundle, Naylor, and Buck, 2012; Hussein and Manthorpe, 2014; Galea et al, 2013). However this trend appears to be changing with some evidence that there is a tendency towards more people volunteering from diverse backgrounds (Galea et al, 2013).

Women were found to be more likely to engage in volunteering than men (Mundle, Naylor, and Buck, 2012). Between a third and three quarters of volunteers were female (Galea et al, 2013; Hussein and Manthorpe, 2014) The statistics on volunteers in a range of settings show that more women volunteer, and for longer periods, than men (ONS, 2017).

There are an estimated 3 million volunteers working in health and social care in England (Galea et al, 2013). Approximately 78,000 volunteers work in hospital trusts in England contributing more than 13 million hours per year (Galea et al, 2013). Volunteer numbers in each trust vary, some report as few as 35 volunteers, others as many as 1300, with an average of 471 volunteers per trust (Galea et al, 2013). Respondents highlighted the trend towards a younger and more ethnically diverse volunteer workforce,

and hospital voluntary services are considered to be a growth area (Galea et al, 2013). This is encouraged by efforts from organisations such as Helpforce (2018a) and Step-up-to-Serve (iwill.org, 2019) who aim to encourage hospital volunteering.

There is little evidence available on how levels of volunteering are changing over time (Rochester, Ellis Paine, and Howlett, 2010), with conflicting evidence about whether volunteer numbers are increasing (Galea et al, 2013), decreasing, or remaining static (Rochester, Ellis Paine, and Howlett, 2010).

In short, women spend more time volunteering than men, and there appears to be a trend towards a younger and more ethnically diverse volunteer workforce. However, the evidence around the demographics of healthcare volunteers is generally sparse and incomplete, and as far as the statistics on volunteer supporting patients with dementia in acute wards, unavailable.

1.3.3 Motivations

There is evidence as to why people volunteer in healthcare contexts (Hallett et al, 2012; Fischer and Schaffer, 1993; Pillemer, Landreau, and Suitor, 1996; Clary and Snyder, 1999; Ferreira, Proença, and Proença,

2012; Cnaan and Goldberg-Glen, 1991; Clary et al, 1998; Blanchard, 2006; Lourens and Daniels-Felix, 2017; Zweigenhafta et al, 1996; Gidron, 1978).

The evidence was drawn from an international context which included hospitals (Clary et al, 1998; Ferreira, Proença, and Proença, 2012; Blanchard, 2006; Lourens and Daniels-Felix, 2017; Zweigenhafta et al, 1996; Gidron, 1978; Hallett et al, 2012), or other healthcare settings such as nursing homes and programs for frail older people (Cnaan and Goldberg-Glen, 1991). There is some evidence of why people volunteer to support patients with dementia or older people (Cnaan and Goldberg-Glen, 1991; Pillemer, Landreau, and Suitor, 1996); other types of patients such as those admitted to mental health institutions (Gidron, 1978; Hallett et al, 2012); or a lack of detail about the types of patients included (Clary et al, 1998; Ferreira, Proença, and Proença, 2012; Blanchard, 2006; Lourens and Daniels-Felix, 2017; Zweigenhafta et al, 1996).

There appears to be a reciprocal nature of volunteerism which benefits volunteers, as well as the organisation. Firstly, what motivates people to volunteer appears to stem from a sense of altruism and concern for others (Clary et al, 1998; Clary and Snyder, 1999; Cnaan and

Goldberg-Glen, 1991; Ferreira, Proença, and Proença, 2012; Fischer and Schaffer, 1993; Lourens and Daniels-Felix, 2017; Pillemer, Landreau, and Suitor, 1996; Zweigenhafta et al, 1996). Secondly, volunteers appear to be motivated by a sense of social responsibility, social obligation or a sense of giving something back to society (Blanchard, 2006; Gidron, 1978; Hallett et al, 2012; Zweigenhafta et al, 1996), some of which was prompted by ideological values such as a moral or religious convictions (Pillemer, Landreau, and Suitor, 1996; Fischer and Schaffer, 1993; Clary et al, 1998; Clary and Snyder, 1999). Lastly, volunteers were motivated by a sense of generosity, philanthropy, and the desire to do good, and to help others (Blanchard, 2006; Cnaan and Goldberg-Glen, 1991; Hallett et al, 2012; Pillemer, Landreau, and Suitor, 1996).

The sense of volunteers being motivated by receiving something in return for their efforts included material rewards (such as learning new knowledge, information, and skills) (Clary et al, 1998; Clary and Snyder, 1999; Ferreira, Proença, and Proença, 2012; Gidron, 1978; Hallett et al, 2012; Pillemer, Landreau, and Suitor, 1996), and the opportunity for career development, or being motivated by a desire for future employment (Clary et al, 1998; Clary and Snyder, 1999; Cnaan and Goldberg-

Glen, 1991; Ferreira, Proença, and Proença, 2012; Hallett et al, 2012; Lourens and Daniels-Felix, 2017; Pillemer, Landreau, and Suitor, 1996).

Secondly, volunteers were motivated by receiving some form of personal reward such as a sense of purpose and satisfaction (Blanchard, 2006; Cnaan and Goldberg-Glen, 1991; Lourens and Daniels-Felix, 2017; Zweigenhafta et al, 1996); feeling better about themselves (Blanchard, 2006; Clary et al, 1998; Clary and Snyder, 1999); or personal development and sense of fulfilment (Pillemer, Landreau, and Suitor, 1996; Fischer and Schaffer, 1993; Gidron, 1978).

Lastly, volunteers appear to be motivated by social rewards such as an increased opportunity for social contact, forging relationships or practical use of leisure time (Blanchard, 2006; Clary et al, 1998; Clary and Snyder, 1999; Cnaan and Goldberg-Glen, 1991; Fischer and Schaffer, 1993; Gidron, 1978; Hallett et al, 2012; Gidron, 1978; Pillemer, Landreau, and Suitor, 1996); acquiring a sense of status, social recognition or praise (Fischer and Schaffer, 1993; Gidron, 1978); or a sense of belonging and protection (Ferreira, Proença, and Proença, 2012; Lourens and Daniels-Felix, 2017; Zweigenhafta et al, 1996).

Furthermore, several of the papers emphasise that volunteers were not motivated by a single reason, but multiple reasons (Blanchard, 2006; Clary et al, 1998; Clary and Snyder, 1999; Cnaan and Goldberg-Glen, 1991; Fischer and Schaffer, 1993; Hallett et al, 2012).

The octagonal model of volunteer motivations (Yeung, Zhang, and Kim, 2004) highlights the polarities involved, as motivations appear to be on a continuum, and because of the reciprocal nature of volunteerism which benefits both volunteers and the organisation in which they operate (see figure 1).

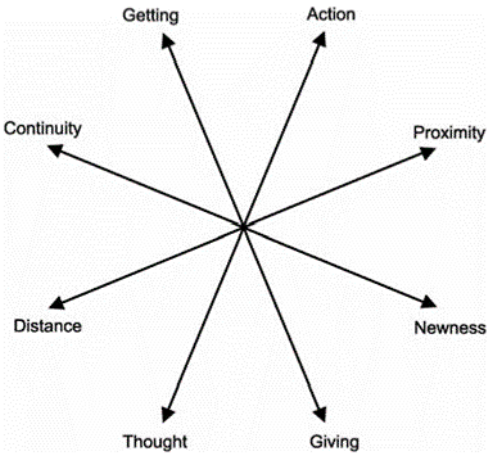


Figure 1 The Octagonal Model (Yeung, 2004)

In short, it appears that people volunteer in a range of broadly similar healthcare settings, and with patients who have mental health problems. These studies on volunteer

motivations resonate with more recent findings, namely that motivations can be complex and multifaceted with volunteers having more than one reason for volunteering; and the reciprocal nature of volunteering which means that both volunteers, and those in receipt of their support, derive some form of benefit from the process. This bears testament to the consistency of such findings across a wide period of time. Yet despite the evidence to support these common themes which motivate people to volunteer in healthcare, there was no evidence which focussed on the motivations of volunteers who provide support to people with dementia or cognitive impairment in acute hospital settings which is the area of interest for this research.

Furthermore, there is doubt as to whether or not these findings might be considered generalizable, or transferrable to this study due to the special nature of the acute hospital ward environment, and the specific and specialised needs of patients with dementia in a UK setting. Therefore, despite the evidence of the motivations of volunteers in a range of similar settings, there appears to be a lack of evidence to support a comprehensive understanding of the reasons why people volunteer to support patients with dementia and cognitive impairment in acute hospitals.

1.3.4 Volunteer management

Volunteers are managed mainly through two recognised volunteer management models: ‘home grown’ and ‘modern’ (Zimmeck, 2000). The home grown model is informal, based on shared values and ideals, equal distribution of authority, and with an emphasis on enjoyment (Zimmeck, 2000). In contrast, the modern model is formal, structured, with bureaucratic rules, policies and procedures. It operates with direct, formal control, is process based, places an emphasis on risk management and the division of specialist labour, and volunteers are subordinate to employees in this hierarchical structure (Zimmeck, 2000). The modern management model for hospital voluntary services is more suitable for large organisations (such as the NHS), as trusts strive to manage large numbers of volunteers in risk averse cultures.

There appears to be a trend for organisations to use a formal model of volunteer management more suitable to the management of paid employees (Rochester, Ellis Paine, and Howlett, 2010). A key driver for this is the need for organisations, especially public services, to demonstrate effectiveness in order to access further funding for services (Rochester, 2006).

The modern management approach has three components: standardisation, formalisation, and 'professionalization' (Zimmeck, 2000). It is characterised by: policies and procedures; job descriptions; Disclosure and Barring Service (DBS) checks; formal training; and an increased level of audit, monitoring, and surveillance (Zimmeck, 2000).

1.3.5 History

Historically, volunteering emerged as a result of philanthropy, self-help and mutual aid societies (Rochester and Zimmeck, 2012). Volunteering, existed in some form in antiquity in ancient Rome and Greece, with a focus on the notion of charity emerging as a consequence of the rise of Christianity (Buklijaš, 2008).

In the United Kingdom, institutions such as mutual aid and friendly societies provided help in schools and hospitals and were rooted strongly in religious life (Kendall and Knapp, 1993). Despite this, there has been a gradual secularisation throughout the centuries (Kendall and Knapp, 1993).

The industrial revolution of the 18th and 19th centuries saw a rapid increase in population which increased the demand on philanthropy and the state (Prochaska, 1988).

The 19th century saw a large increase in wealth as a result of the industrial revolution, and philanthropy emerged as a way of tackling the corresponding increase in social need (Rochester, 2013). The Victorian era (1837-1901) was hailed a golden age for volunteering, partly because an increase in the population, increased social need, and rising industrialisation led to the formation of people volunteering in mutual self-help groups (Davis Smith, Rochester, and Hedley, 1995). Victorian philanthropy was heavily associated with evangelical and religious intention with Sunday schools and missionary societies, among others, offering relief to the sick (Checkland, 1980).

In the 20th century, the general strike of 1926, where 1.5 to 1.75 million people collectively withdrew their labour (The National Archives, 2016a), while effective in closing transport facilities, mines, newspaper establishments, docks and power stations, (The National Archives, 2016b) prompted the government to call upon volunteers to deliver essential services (Hedley and Davis Smith, 1992). This intervention has been played out throughout the course of the 20th century, causing tensions between paid employees and volunteers (Finnegan and Brewis, 2012). The 1930s was a period of depression, unemployment and poverty with large scale marches and

Labour party involvement in public protests (The National Archives, 2016c). It could be argued that this paved the way for the social reforms of the 1940s with the introduction of a welfare state.

The two World Wars during the early part of the 20th century impacted on volunteering. The First World War (1914-1918) saw an increase in voluntary activity as people pooled both fundraising and activities, with 90,000 voluntary aid detachments mobilised to work in Britain and overseas to support medical services (British Red Cross, 2016). However, it is unclear if this work was of a voluntary nature as there is some mention of low pay, although many of those involved were reported to refuse a salary despite exacting and demanding conditions (British Red Cross, 2016). Furthermore, the level of coercion is unclear as those who volunteered as nurses were obliged to adhere to regulations when both on and off duty. These included a mandatory requirement to live in the quarters, forbidden to question the work done for patients, and be 'absolutely under the control of the matron' (British Red Cross, 2016; p. 6). Similarly, voluntary organisations emerged during the Second World War (1939-1945) to help with wartime emergencies. These included the government funded Women's Voluntary Service (Kendall and Knapp, 1996),

founded in 1938 and organising over one million women to volunteer on the home front as the nation prepared for war; they were involved in a variety of tasks including evacuating children and running air raid precautions (Royal Voluntary Service, 2018a). The largest volunteering organisation in British history, The Royal Voluntary Service, had over one million volunteers by 1943 and was granted royal honours as Her Majesty the Queen became patron (Royal Voluntary Service, 2018b).

Successive governments over the course of the twentieth century developed policies (Sheard, 1992; The Newsom Report, 1963; Ministry of Education, 1960; Hedley and Davis Smith, 1992) to encourage volunteerism in many contexts of public service to provide what was perceived to be cost free health and social care services (Home Office, 1967; Aves, 1969; Brindle, 2015; Rochester, Ellis Paine and Howlett, 2010; Shepherd, 2013; Home Office, 1990). The 1940s heralded a flurry of acts covering education, poverty, housing and health which paved the way for the introduction of the welfare state. The National Insurance Act of 1946 saw the introduction of a single system for social insurance administered through central government which reduced the need for reliance on friendly societies (Kendall and Knapp, 1996). Key developments included The Beveridge Report

(Beveridge, 1942) along with The National Health Service Act (1946) which resulted in the introduction in 1948 of a nationwide health service, universally free at the point of delivery. However, despite collaboration between government and charitable agencies (Volunteering Matters, 2015) there is evidence of historical conflict between governments, charities, and trade unions (Finnegan and Brewis, 2012). There was criticism of philanthropic intent and charity, examples including one contributor to the 1947 mass observation on voluntary work blaming it for detracting from real socialism (Mass Observation Directive, n.d.) and William Morris dismissing charity as a 'mere palliative' (Finlayson, 1994, p.157).

Following the Second World War there was a notable change and transformation in volunteering (Brewis, 2013). By the beginning of the 1960s it seemed that the golden age of the welfare state was in decline with the realisation that demand would always exceed supply, and costs and affordability would continue to be problematic (Zimmeck, 2010). This paved the way for governments to take an interest in volunteers as a cost effective solution to providing services (Home Office, 1967), and encouraged by statistics showing the steady rise in membership of national voluntary youth organisations in

the United Kingdom which rose from 2,274,777 members in 1958, to 2,514,050 in 1965-6 (Morris, 1969).

Reports in the 1960s appeared on the subject of volunteering in response to changing social conditions, including The Albemarle Report (Ministry of Education, 1960) which recommended voluntary work to be essential and to be pursued at all levels, particularly in young people between the ages of 14-20. Similarly, The Newsom Report (1963) voiced concerns over youth delinquency and recommended that children become involved in some form of community service.

Government interest in volunteering was evident in a number of reports. For instance, The Aves report (1969) recognised the limitations of resources in the Health Service and called upon the 'intelligent mobilisation of every resource' (Aves, 1969: p.16), including volunteers, to address this. The committee subsequently examined the level of volunteer involvement and opportunity for development with the intention of maximising the use of volunteers in healthcare (Rochester, 2013).

The 1970s heralded an emphasis on formalising the volunteer role as a reliable addition to existing services (Brindle, 2015). The Wolfenden committee was appointed in 1974 by The Joseph Rowntree Memorial Trust and the

Carnegie United Kingdom Trust to review the role and function of the voluntary sector (Committee on Voluntary Organisations, 1978). They expressed concerns over the potential for the overlap, or duplication of services in the voluntary sector, and called for more efficient management of voluntary organisations (Committee on Voluntary Organisations, 1978). Another example of government involvement was in the era of economic hardships in the 1970s which prompted the then Prime Minister James Callaghan, to launch the National Good Neighbour Campaign which called upon volunteers to care for elderly and disabled neighbours in an attempt to reduce the strain on public services (Rochester, Ellis Paine and Howlett, 2010). Similarly, in 1978-1979 the period of conflict between trade unions and the government, known as the Winter of Discontent (Shepherd, 2013), which resulted in uncollected refuse and unwashed hospital laundry, and the then Labour government under Callaghan called upon volunteers to provide public services. This subsequently led to fears over volunteers posing a threat to the rights of workers and was exemplified by the attempt by the Confederation of Health Service Employees trade union (COHSE), which tried to ban hospital volunteers in 1973 (Finnegan and Brewis, 2012). Nevertheless, in 1973 the then

Conservative government ignored concerns and deployed volunteers during the health disputes of the era despite the director of the volunteer centre calling on them to deploy the army rather than jeopardise the position of volunteers (Finnegan and Brewis, 2012). Subsequently, the Drain Guidelines, issued by Geoffrey Drain of the National Association of Local Government Officers (NALGO) in 1975, condemned the use of volunteers in times of industrial action (Finnegan and Brewis, 2012).

The Wolfenden Report of 1978 (Committee on Voluntary Organisations, 1978) found evidence of an emerging trend for the unionisation of voluntary organisations. While fearing for problems with control and independence, they recognised that paid employees working in voluntary organisations must be consulted over their working conditions and salaries as well as being involved in policy formation to prevent tensions between unions and voluntary organisations (Committee on Voluntary Organisations, 1978).

The role of the volunteer co-ordinator in the 1970s was recognised as being vital in the recruitment and retention of volunteers but appeared to be embryonic in its development with little attention paid to their burgeoning

workload and lack of facilities (Rocha, 1968). Volunteer co-ordinators were responsible for the recruitment and support of volunteers and provision of voluntary services for up to 500 hospital patients (The Volunteer Centre, 1980). From 1975 to 1980 The Volunteer Centre (1980) kept a register of statistics of healthcare services volunteer co-ordinators which show the total number of posts in the National Health Service declined from 322 in 1978 to 316 in 1980, although the picture is unclear with some areas increasing their number of posts and others decreasing.

The Conservative government in the 1980s continued with the theme of volunteering as a practical solution to mass unemployment and subsequent social unrest (Brindle, 2015). The then Prime Minister, Margaret Thatcher, launched the Urban Programme and Community Enterprise programme in an attempt to tackle urban decay and unemployment by involving volunteers, and released funds into the Community Enterprise programme to offer financial support by employing people to organise volunteers (Rochester, Ellis Paine and Howlett, 2010).

Both Conservative and Labour party politics in the 1990s advocated an emphasis on active citizenship (Brindle,

2015), which impacted on volunteering. In 1994 the Major government introduced the 'Make a Difference' campaign in an attempt to support volunteering (Zimmeck, 2010). A joined up co-ordinated approach was attempted with the aim of encouraging more people to volunteer, making it easier to volunteer but failing to deliver the necessary financial support to maximise its success (Zimmeck, 2010). The Efficiency Scrutiny of the 1990 Thatcher government was a way of ensuring civil servants could secure better value for money when issuing contracts, and recognised the desirability of voluntary activity because of its assumed cost effectiveness in the provision of services (Home Office, 1990). Yet concerns continued to be raised throughout the 20th century by employees and trade unions over volunteers replacing jobs when governments have called upon volunteers to replace those taking strike action (Hedley and Davis Smith, 1992).

The New Labour government moved away from the previous Labour stance on voluntary activity in 2000 when a speech by Tony Blair introduced new measures in support of volunteering, calling on supporters to remember the foundations of the Labour party having been built on such activity in the past (Blair, 2000). This was reiterated by the Chancellor of the Exchequer,

Gordon Brown, a few months later in a speech defending the party against accusations of substituting the welfare state for charity (Brown, 2000).

In short, it appears that the history of volunteerism is long standing, rooted in religion but emerging into a secularised form over time. Government involvement in volunteering, regardless of political persuasion and ideology, appears to have had an effect on shaping how it is understood to function in society. Rochester, Ellis Paine and Howlett (2010) raise concerns that this influence will introduce some form of compulsory volunteering, a practice already established in the United States of America and Canada (Rochester, Ellis Paine and Howlett, 2010). There are calls to guard against government involvement in the voluntary sector and the adoption of business practices from the private sector in an attempt to deliver a ‘cut price’ alternative to welfare provision (Haugh and Kitson, 2007, p. 991). Successive governments have taken an interest in voluntary activity, not least as a way to deliver services in times of need. As a result there have been concerns from trade unions of the impact on the rights of paid workers, which have resulted in ongoing and underlying tensions.

1.3.6 The future of volunteering

Despite the dynamic history of volunteering and the underlying tensions, there appears to be a move towards increasing volunteer numbers in hospital voluntary services.

This is exemplified by a current UK nationwide initiative, named Helpforce (Helpforce, 2018a), a community interest company which aims to facilitate the full potential of volunteers in the NHS to support staff and create more time for patient care, and plans to increase the number of volunteers working in NHS Trusts from 78,000 in 2013, to 150,000 by 2021 (Plummer, 2017). Helpforce describes the urgent need for volunteers to play a greater role in supporting NHS staff so they can focus on the clinical needs of patients. It advocates a collaborative approach to promoting the implementation of volunteers into acute hospitals and has initiated the development of new projects and volunteer roles. One example is that of 'bleep volunteers', a pool of volunteers who are contacted by staff who respond to their requests as they are needed. Tasks include collecting prescriptions or transferring patients between departments.

This initiative appears to be gathering momentum with plans for further collaboration and funding. For instance,

Helpforce has recently announced a new working partnership with the Royal Voluntary Service to help meet their aim of doubling the numbers of volunteers in the NHS by 2021 (Helpforce, 2018b); and in September 2018 NHS England announced a new £2.3 million partnership with Helpforce to promote the project across NHS Trusts, with the aim of establishing a national network to share good practice across the NHS (Churchill, 2018).

Despite the drive towards increasing the number of hospital volunteers, concerns and tensions continue to exist around the role and function of voluntary services. There is continued disquiet over the future of volunteering in that the current economic climate of austerity raises concerns over the use of volunteers as a substitute for paid employees (Naylor et al, 2013). Concerns have also been highlighted that volunteering opportunities are being missed because of the lack of organisational strategic vision and workforce planning, with recommendations that organisations focus on the quality that volunteers can bring, rather than the perceived financial cost cutting benefits (Naylor et al, 2013). The Health and Social Care Act (Department of Health, 2012) offers opportunities for volunteers to play a key role as it encourages a model of health based on collaborative working with local people and community resources. However there is also the

danger that the complex reforms of the act, such as an increased focus on economic regulation and fragmentation of services, could create the potential for volunteers to undertake the work traditionally done by paid staff and so cause further tensions (Naylor et al, 2013).

From an international perspective, global trends are predicted to impact on volunteerism in the future. These include: increased global levels of human need; growing uncertainty and disorder; HIV and AIDS creating disruption of entire communities; increased numbers of both older and younger people in many countries; the changing role of governments in tackling social problems; the influence of religion and business in world affairs; emerging technology; and changing expectations about participation (Murphy, 2004). These global tensions include the growing acceptance that volunteering benefits the volunteer as well as the recipient, resulting in the requirement for organisations to ensure volunteers encounter a positive experience, as well as an expectation that tensions will continue between paid workers and volunteers, and a need for more resources committed towards development and education as organisations compete for this type of human resource (Murphy, 2004).

Efforts are being made to address these concerns and tensions by further research, new initiatives, and predictions for the future. Firstly, hospital volunteering is being researched to increase the impact of volunteers (NESTA, 2016). Emerging organisations, such as The Voluntary Sector Studies Network (VSSN, 2016), seek to provide a better understanding of the voluntary services sector and further volunteering and policy formation through research. There is a growing realisation that volunteers do not always receive the support they need (Ellis Paine, Ockenden and Stuart, 2010). There is also limited research into experiences of volunteers in hybrid organisations, which are organisations that have characteristics of more than one sector (for example public, private or third sector) including the UK National Health Service (Billis, 2010). Some hope that future research will focus on what volunteers actually do and how collaborative working can be more effective, rather than statistics (Pearce, 1993).

Secondly, in terms of new initiatives, the development of the National Citizen Service (2015) is a joint venture delivered by charities, government, and private companies which promises to support young people to learn new skills and offers government backed certification. However, despite a broad welcome for this

new initiative, the scheme also attracts a note of caution from the voluntary sector. Davis Smith (2015) expressed concern over the possibility of enforcement of compulsory volunteering for younger people. Rather than making such involvement mandatory, there should be a focus on making it an attractive option for people (Davis Smith, 2015).

Lastly, future predictions for volunteering include an increased focus on young people volunteering and the use of social media, in particular Twitter, with the #iwill campaign (Iwill.org, 2019) aimed at encouraging young people to pledge to volunteer (Davis Smith, 2016). There is a predicted focus on including volunteers in public services: particularly hospitals; more flexibility and opportunities to volunteer for short periods as a ‘taster’; encouraging diversity within the volunteer population by opening up opportunities for disabled people to volunteer; and an increased focus on quality and impact rather than a fixation with numbers (Davis Smith, 2016). However, this comes with a caveat that increased funding challenges must not be seen as a way of delivering services at a reduced cost (Davis Smith, 2016). Other challenges include raising the profile and public perception of volunteering (Davis Smith, 2016).

Having explored the evidence around volunteer demographics, motivations, management, the history and future predictions of volunteerism, the following section focusses on volunteering and healthcare.

1.3.7 Volunteering and healthcare

Moving on from a chronological account of volunteerism, the following section will explore contemporary healthcare volunteering in relation to patient care.

A 2006 report highlighted that four out of ten older people admitted to hospital have malnutrition on arrival, and six out of ten older people are at risk of becoming malnourished in hospital (Age Concern, 2006). In light of this report, the Department of Health published core standards which aimed to address the fundamental issue of eating and drinking in hospital to involve volunteers to provide additional help and support at mealtimes. Despite the efforts to address this issue, research showed an increase in the numbers of patients entering and leaving hospital malnourished (Age UK, 2011) and reasserted the need for trained volunteers to provide support where appropriate, yet found that the implementation of mealtime volunteers remains inconsistent across the country, and within individual hospitals (Age UK, 2011).

The Royal Voluntary Service continues to be involved in a wide range of hospital support including running cafes, shops, and trolley services, providing company to hospitalised older people, and running errands on discharge (Royal Voluntary Service, 2018c), there are other large organisations offering similar services including the British Red Cross and Age UK.

The British Red Cross works alongside staff to provide support in a range of settings, including NHS hospitals. Across the UK the charity supports 80,000 people to live independently at home, by preventing unnecessary hospital admissions through A&E discharge support for 30,000 people, and facilitating discharge from hospital for 50,000 inpatients (British Red Cross, 2018). They also offer transportation support to and from hospital for 125,000 people, and provide mobility aids such as wheelchairs to 90,000 people with short term access problems (British Red Cross, 2018). This involvement appears to be particularly important in view of the winter pressures experienced by the NHS as it contributes to improving patient flow by facilitating discharge and avoiding unnecessary admissions (British Red Cross, 2018). As part of their research agenda, the organisation undertook a mixed methods study to explore the views of staff, volunteers, and beneficiaries of the service, and a

review of the literature to understand what constitutes quality volunteering (Joy, Hendry, and Nzegwu, 2011). They found that there is no ‘one size fits all’ model of management, acknowledging that managers should recognise the need for flexibility in order to respond effectively to the needs of those in receipt of the service while maximising the skills of those who provide them (Joy, Hendry, and Nzegwu, 2011). They also highlight the importance of volunteers having access to support, and the need for a clear vision which includes diversifying the workforce (Joy, Hendry, and Nzegwu, 2011).

The British Red Cross also highlighted the challenges that older people experience with mobility, managing finances, and emphasised the need for emotional and social support (Joy, Corrall, and Nzegwu, 2013). The healthcare support provided by the British Red Cross results in: reported improved wellbeing; an increased ability to manage daily activities; an increase in leisure activities; and improved coping skills. Furthermore, the wider benefits of the service include enabling safe hospital discharges and so relieving pressure on hospitals; providing support for carers; and developing advocates for service users. However, they also highlight the challenges of delivering these services in view of the increased numbers of people living with long term

conditions who require support; problems around targeting services to achieve the greatest impact; pressures experienced when trying to meet targets; and the ongoing challenges of recruiting volunteers and running a volunteer delivered service (Joy, Hendry, and Nzegwu, 2011).

A similar institution is Age UK, a large charitable organisation offering help and support to older people in the community. One example of their voluntary activity is the Cascade Training Programme which supports organisations to train volunteers and staff to work with hard to engage older people to participate in physical and social activities to promote health (Alden, Wigfield, and Kispeter, 2015). This scheme involved 75 organisations, and trained 1,382 volunteers to engage 5,368 older people in social and physical activities. Using interviews, focus groups, surveys, and documentary analysis to determine the uptake and impact of the scheme, they found that trained volunteers were able to successfully recruit older people, including those living with dementia, and there was a positive impact in increasing inclusivity and reducing social isolation by enhancing the experiences of volunteers and the older people who took part. Despite the success of the scheme, there were challenges in recruiting and retaining volunteers, possibly

because of the level of commitment and responsibility involved, and the amount of paperwork the project generated (Alden, Wigfield, and Kispeter, 2015).

Other healthcare volunteer initiatives in non-hospital settings include programs to address loneliness in older adult populations which have been found to improve social connectivity, reduce loneliness, and so promote health. Such schemes include community involvement as well as telephone based interventions (Macleod et al, 2018). It appears that there are reciprocal benefits to this type of volunteering, as there are reported benefits to those who volunteer, as well as those in receipt of these services.

Hospital volunteers are recruited to work in a variety of roles, these include ward and clinic assistance (such as befriending and visiting patients); signposting, guidance, and ‘meet and greet’; hospitality and activity support (such as drinks trolley and meal service assistance); entertainment (such as hospital library, hospital radio, and arts based programmes); and providing administrative support (such as help with patient surveys and general administration) (Galea et al, 2013).

Having explored various aspects of volunteerism, the following section will discuss dementia; set out the needs of patients with dementia, and carers while in hospital; explore what is considered to be best practice; and the challenges faced.

1.4 Dementia

Dementia is an umbrella term used to describe a number of conditions affecting the brain. It is defined by the World Health Organisation as

‘a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation’ (WHO, 2007)

In terms of establishing a diagnosis, four criteria must be met. These are firstly memory impairment, which includes an impaired ability to learn new information or recall previously learned information. Secondly, one or more of the following cognitive disturbances, aphasia (problems

with language and communication), apraxia (diminished ability to carry out motor function despite having intact motor function), agnosia (a failure to recognise objects and people despite having intact sensory function), and disturbance in executive function (which is the ability to think abstractly by planning, organising sequential activity, and multitasking). Thirdly, significant impairment and decline in social or occupational function; and lastly, that these deficits are not as a result of an episode of delirium (American Psychiatric Association, 1994).

Dementia can affect mobility, continence, eyesight, hearing, speech, decision making ability, and behavioural changes, causing disorientation and anxiety (Pace, Treloar and Scott, 2011). As such it is a disease associated with complex needs, and high rates of dependency and morbidity (NICE, 2006). There are a number of different types of dementia, the most common types are Alzheimer's disease, vascular dementia, mixed dementia, dementia with Lewy bodies, and frontotemporal dementia (NICE, 2018). The disease is generally irreversible, progressive and incurable (Pace, Treloar and Scott, 2011). The symptoms are severe enough to affect daily life and as the disease progresses, there will be increased dependency on carers.

1.4.1 Dementia statistics

Worldwide, over 47.5 million people live with dementia (WHO, 2016). There are 7.7 million new cases each year with an estimated increase in numbers to 135.5 million by 2050 (WHO, 2016). A forecast increase in the older population (ONS, 2015; House of Commons, 2013) and rising cases of dementia (Ferri, Prince, and Brayne, 2005; Knapp et al, 2007) contribute towards the urgency for greater understanding and management of the disease.

In the United Kingdom 850,000 people live with dementia, with the forecast that this number will increase to over 2 million by 2051 (Prince et al, 2014). There is an increased incidence of dementia in women in the United Kingdom over 65 years of age (Prince et al, 2014). People with dementia over 65 years of age are currently occupying up to one quarter of hospital beds at any one time (Alzheimer's Society, 2009). Furthermore, 97% of nurses reported that they work with people with dementia, and most want more training and support to help them deliver the best care possible (Alzheimer's Society, 2009). Over 40% of patients admitted to hospital with acute medical conditions can also have dementia (Sampson et al, 2009). Aside from the physical, emotional and psychological trauma of hospitalisation for people living

with dementia and their families, there is the possibility that extended hospital stays can result in increased financial pressures on the National Health Service (Alzheimer's Society, 2009). The societal and economic cost of dementia to the United Kingdom is calculated to be £26.3 billion per year (Prince et al, 2014). Those who bear the costs are the state and individuals as they include healthcare costs, publicly and privately funded social care, and the contribution made by unpaid carers to the care and support of people with dementia (Prince et al, 2014).

1.4.2 Needs of people living with dementia

People living with dementia have specialised needs arising from physical, behavioural, and communication difficulties. They may also have problems associated with memory and understanding, multiple comorbidities associated with older age, and acute medical conditions which might necessitate hospital admission. There may be a combination of any, or all of these problems, including incontinence, agitation and aggression which ward staff may find difficult to cope with (Goldberg et al, 2012). Practical issues include needing support with hygiene and dressing, continence, mobility, nutritional needs and sleeping. Added to the physical symptoms of

dementia are psychiatric and behavioural problems which include: hallucinations and delusions; aggression and unpredictable or ‘out of character’ behaviour; withdrawal; disinhibition; depression; agitation; confusion and distress (Goldberg et al, 2012; Kar, 2009). People living with dementia may have communication difficulties both related to older age and dementia, with the recognition that poor communication is widely problematic in general in healthcare (Taran, 2011). Factors which challenge good quality communication (such as understanding what someone has said and being understood by them) include: physical problems such as difficulties with hearing and eyesight; loose, missing or ill-fitting dentures which affect speech; and broken or missing hearing aids. Cognitive problems affecting communication include speech and word finding difficulties, memory problems, and disorientation to time and place.

1.4.3 Problems in hospital

People with dementia are more likely to be hospitalised, often with an acute medical condition; they are more likely to stay in hospital for longer; and once hospitalised are at risk of negative outcomes (Alzheimer’s Disease International, 2016). Two thirds of hospital beds are occupied by older people aged 65 years or older, with up

to half of them having cognitive impairment including dementia and delirium (The Royal College of Psychiatrists, 2005). Crowded and noisy hospital wards are unfamiliar environments which often lack privacy and focus on prioritising physical needs over psychological needs (Goldberg et al, 2014). Indeed, a national audit of dementia care in general hospitals in England and Wales in 2011 found a lack of coordination of hospital services for people with dementia across individual organisations with recommendations that more should be done to ensure a streamlined care pathway and action required to improve care (The Royal College of Psychiatrists, 2011). These included: comprehensive assessments and subsequent action to improve the quality of care; improved communication and opportunities for family involvement; access to specialist and support services over a 24 hour period; a systematic approach to assessing ward staffing requirements; provision of basic training in dementia awareness for all staff; dementia friendly ward design; and a review of policies to facilitate early discharge (The Royal College of Psychiatrists, 2011).

Older people with cognitive impairment have a higher risk of a number of negative outcomes in hospital: there is the potential for complications to occur; people with a

diagnosis of dementia in hospital were found to be at a higher risk of death; long lengths of stay; and complications such as falls, dehydration, reduction in nutritional status, delirium, infection, incontinence, immobility, and a decline in physical and cognitive function (Fogg et al, 2018; Glover et al, 2014). This may be because they are very old and frail and as such it could be argued this might be inevitable, or it may be due to loss of functional skills during their stay if not maintaining independence. People with dementia and cognitive impairment may experience distress in hospital because of excessive noise, harsh lighting, unfamiliar activity, number of strangers, and fast pace of routine (Department of Health, 2001). They may also experience delays in the emergency department (NHS England, 2014), and once admitted to hospital, the possibility of them being placed in residential care settings, rather than returning home (Department of Health, 2009). Indeed, a study of 250 patients aged over 70 admitted to hospital, found only 42% of those surviving a hospital admission recovered to their pre-acute illness level of function, with 27% of patients who did not return to their original place of residence on discharge (Bradshaw, Goldberg, Schneider et al, 2012).

The psychosocial needs of older people living with dementia may be unmet because of medical needs taking priority, and pressures on services to provide holistic and person-centred care (Dewing, 2001; Edvardsson, Winblad, and Sandman, 2008). Increasing numbers of highly dependent hospitalised older adults with mental health problems have implications for services as the time consuming nature of delivering care to this vulnerable group requires specialist training and expertise (Goldberg et al, 2012).

Concerns have been raised over the quality of care for people with dementia in hospitals (Tadd et al, 2011; Francis, 2013). Main areas of carer dissatisfaction with the hospital care of cognitively impaired older adults are around communication, discharge planning, and medical management (Whittamore et al, 2014). Carers have experienced poor communication, nurses' poor understanding of dementia, vulnerability, a need for advocacy, difficulties over a prolonged hospital stay, and the absence of a therapeutic relationship with clinicians (Douglas-Dunbar and Gardiner, 2007). Furthermore, 47% of carers reported that being in hospital had a significant negative effect on the health of those with dementia; and 54% of carers reported hospitalisation as having a negative effect on the symptoms of dementia

(Alzheimer's Society, 2009). The quality of care can vary between hospitals (Tadd et al, 2011); at the extreme end of the spectrum, a public inquiry into Mid-Staffordshire NHS Foundation Trust reported that vulnerable older patients, some of whom had dementia and cognitive impairment, were denied access to food and drink, left in soiled beds for long periods of time, treated with indifference, and denied privacy and dignity (Francis, 2013).

Organisational and systemic barriers, such as the effect of rigid hospital routines and the unfamiliar hospital environment to a person with memory impairment, can prevent quality care, even when staff are motivated (Tadd et al, 2011). Poorly designed wards, busy environments and largely task based care, mean that acute hospital wards are unsuited to providing optimum care for people with dementia (Tadd et al, 2011). An extended hospital stay and the increased use of antipsychotic drugs are not uncommon (Alzheimer's Society, 2009). Consequently there have been calls for organisational change in order to promote compassionate care (McPherson, Hiskey and Alderson, 2016).

In view of the complex nature of this patient group, it has been suggested that acute hospitals should adapt to

provide for their mental health needs (Glover et al, 2014), and the principles of person-centred care are adopted to enhance a sense of personhood in acute hospital settings (Clissett, Porock, Harwood et al, 2013).

1.4.4 Best Practice: Person-centred care

As dementia affects people in different ways, it is recommended that each person is seen as unique and treated as an individual (Kitwood, 2002). Main psychological needs include comfort, attachment, inclusion, occupation, and identity (Kitwood, 2002), which highlights the need for a sense of security, access to loved ones, feeling involved, and having something to do to prevent boredom and apathy.

A person-centred approach which focusses on the needs of the individual with dementia is recommended when striving to minimise feelings of fear, terror, misery, rage and chaos (Kitwood, 2002). Personhood relates to person centred care which is defined as ‘a position or social relationship that is bestowed on one human being by ‘others’, in the context of relationship and social being’ (Kitwood, 1997; p.8). Personhood focusses on a holistic approach, ensuring that those living with dementia have access to quality services to support their emotional and spiritual needs, maintain independence and feel

empowered while being treated with dignity and equity to maintain their optimum level of physical, mental, social and emotional wellbeing (NHS Education for Scotland, 2011).

Person-centred care includes facilitating occupation which supports social conversation (Howe and Goldberg, 2014), promotes night time sleep and reduces agitated behaviours, anxiety and stress (Stuckey and Noble, 2010). The opportunity for creativity and art therapy can empower older people to strengthen social networks and promote cognitive resilience (McFadden and Basting, 2010).

1.4.5 The challenge of delivering person centred care in hospital

Person-centred care is widely considered to be the best approach to supporting people with dementia. However acute hospitals which prioritise prompt diagnosis, treatment and discharge are a challenging environment in which to deliver this approach.

Hospital settings are problematic for older people because of the lack of opportunity for occupation, and subsequent boredom as the majority of patients are unoccupied (Nolan, Grant and Nolan, 1995). Staff could

engage patients in activities to provide occupation for those patients with dementia but this is difficult to achieve in practice when the majority of staff time is taken up by caring for their physical needs (Goldberg et al, 2014). Staff in acute older person care wards were found to miss the chance to engage in occupation even when the opportunity arose (Clissett, Porock, Harwood et al, 2013). Activity co-ordinators could be a way of providing occupation to patients with dementia but not all wards in hospitals have this facility. In view of this, there is the possibility that informal carers, such as family or friends, could spend time talking, reading and reminiscing with the patient about familiar topics to maintain a sense of identity (Goldberg et al, 2014).

1.4.6 Carers

The presence of informal carers in hospital to provide support to patients with dementia appears to be one way to address the problems associated with hospitalisation. Indeed, recommendations exist for families and carers of those living with dementia to be involved in their hospital care (Alzheimer's Society, 2009). The presence of carers is considered to be important when striving to maintain a sense of personhood (Kitwood, 2002) and ensure a sense of continuity.

However it cannot be assumed that all patients in hospital have such support as 9% of hospitalised older people are reported to have no identified carer (Goldberg et al, 2012). For those patients with an informal carer, coping with behavioural challenges such as agitation and irritability, faecal incontinence, and disturbed sleep contribute to high levels of carer strain and distress (Bradshaw, Goldberg, Lewis et al, 2013).

Behavioural problems have been described as more significant in contributing to carer strain than cognitive disorders or lack of self-care (Van der Lee et al, 2014) and carers of people with dementia have experienced stigma, social isolation, and challenges in engaging in leisure activities (Greenwood, Mezey and Smith, 2018). Informal caregivers of institutionalised people with dementia were reported to be the most burdened of all, they experienced social isolation and a reduced feeling of well-being as a result of caring, which was compounded by the lack of information and suitable care facilities (Nunnemann et al, 2012).

In light of this it is possible that carers may see a hospital stay as an opportunity for respite from their caring role. However, non-resident carers, such as children who live long distances away, may experience difficulties with

juggling conflicting and competing demands from their own children and work commitments (Bradshaw, Goldberg, Lewis et al 2013). This is intensified by the difficulties of restricted visiting times which still exist in some hospitals, with anecdotal accounts of families feeling frustrated at being unable to offer support out of visiting hours (Jones and Gerrard, 2014). Consequently, as there are challenges around relying on informal carers to provide support and occupation to patients with dementia while in hospital, volunteers could be one way to provide this support.

1.4.7 Volunteering and dementia

Moving on from healthcare volunteering to dementia care settings, there appear to be many opportunities for volunteer involvement (Alzheimer's Society, 2016). For example, it is possible that the types of tasks recommended in the support of hospitalised older patients with cognitive impairment in dementia care (NICE, 2006) and delirium prevention (NICE, 2010), such as support with eating and drinking and opportunities for social engagement, could be undertaken by volunteers. These evidence based guidelines call for people with dementia, and carers to be informed about voluntary support, and call for healthcare professionals to

encourage their use (NICE, 2006). There is also a recognition that not enough is being done to make a formal assessment and evaluation of volunteer activity within acute hospital Trusts (Galea et al, 2013). Despite recommendations that more volunteers are needed to facilitate psychosocial interventions, such as assisting older people with cognitive impairment in general hospitals with activities (Gladman et al, 2012), little is known about the role and impact of volunteers in this context.

1.4.8 Volunteers in dementia care in acute hospitals

Much of the literature relating to dementia and volunteering lacks detail about the number of patients included in studies who were identified as having dementia or confusion (Babine et al, 2018, Baczynska et al, 2016; Palmer and Huxtable, 2015; Preston and Burch, 2018; Roberts, 2018; Sandhaus et al, 2010; Steunenberg et al, 2016; Wright et al, 2008; Zaubler et al, 2013). A range of studies explored various aspects of volunteer engagement in the care of older patients in acute hospital wards, some of whom have dementia or cognitive impairment. A systematic review to explore the impact of volunteers supporting patients with dementia in the acute

hospital setting identified three papers which found there were perceived benefits for patients with dementia as volunteers provide a unique service (Hall et al, 2017). However, there were problems in establishing the role of volunteers with some staff reporting tensions around volunteers interfering in nursing care, and concerns around breaching confidentiality; volunteers reported feeling connected to each other, but not to the nursing team; and training and ongoing support was identified as important to maximise retention (Hall et al, 2017). The paper concluded that while the evidence suggests volunteers have the potential to support older hospitalised patients with dementia in acute hospitals, there is currently a marked lack of evidence to support the widespread implementation of volunteers in this capacity. The authors conclude that further research is required to address this gap in evidence (Hall et al, 2017).

There is a need for hospitalised patients with dementia to engage in occupation and social interaction to maintain personhood, avoid loneliness and boredom, and prevent delirium (NICE, 2010). In the absence of staff or informal carers to provide this support, there is the potential for volunteers to offer occupation, activities and pastimes, although there is also the possibility that some volunteers may find the ward environment challenging.

1.4.9 Recruitment, training, support of volunteers

The recruitment, training and support of volunteers in UK hospitals varies.

1.4.9.1 Recruitment

Some hospitals have an existing hospital voluntary service, while others recruit volunteers specifically for new projects. The methods of recruitment include advertising banners in main areas of the hospital, postcards by the cash registers in hospital cafes and restaurants, talks to local community groups and sixth form colleges (students aged 16–18) and hospital open days (Howson et al, 2018). Volunteer recruitment also includes publicity events, through existing voluntary services (Wong Shee et al, 2014), or organised by the Royal Voluntary Service who also manage volunteers and fund training programmes (McDonnell et al, 2014).

1.4.9.2 Training

There is a lack of detail within the literature on the duration and type of volunteer training, who delivers sessions, the content, and the assessment and support of

volunteers (Palmer and Huxtable, 2015; Roberts, 2018; Robison et al, 2014; Wong et al, 2008). Where specified, the duration of training ranges from half-day training sessions (Howson et al, 2018; Roberts et al, 2017) to one week (Wright et al, 2008). Some volunteers receive a series of separate sessions totalling eight hours (Wong Shee et al, 2014), an eight hour session group training program (Blair et al, 2018), or four and a half days of training (Bateman et al, 2016). There is a lack of detail around the use of training resources; when mentioned in the literature, resources include a training manual or an established training resource package (Bateman et al, 2016; Blair et al, 2018).

Some aspects of the training sessions appear to be underpinned by the principles of the Hospital Elder Life Program (HELP) model (Inouye et al, 2000), particularly around sensory impairment, eating and drinking, and mobility. There is a well-established evidence base to support the HELP model which involves volunteers as part of a multi-component, non-pharmacological approach to prevent delirium (Hshieh et al, 2018). As such, this model appears to be a useful framework to underpin all volunteering activities. The HELP model is underpinned by a person centred approach to preventing delirium and volunteers aimed to build a trusting

relationship with patients, and to attend to their personal needs (Gorski et al, 2017).

All delirium prevention activities undertaken by volunteers were designed to minimise confusion and cognitive decline, minimise and reduce psychological distress, prevent or treat sensory deprivation, avoid sleep deprivation, reduce the length of immobility, and prevent and treat dehydration and prevent malnutrition.

Where specified, training is delivered by researchers, cognition nurse clinical consultants, or diversional therapists (Wong Shee et al, 2014). There is little information on the methods of assessing volunteer competency (Howson et al, 2008; Roberts et al, 2017), but where mentioned, volunteers were assessed by pre and post education questionnaires (Bateman et al, 2016), or a competency assessment based on observations of volunteers with patients (Wong Shee et al, 2014).

Training in all cases appears to be underpinned by a person centred care approach with the aim of enhancing the emotional care, safety and wellbeing of older people, some of whom may have dementia or delirium in hospital (Bateman et al, 2016; Wong Shee et al, 2014; Blair et al, 2018). Volunteers receive training on how to understand dementia and delirium (Bateman et al, 2016; Blair et al,

2018); how to communicate with patients with dementia; and how to understand and respond to changes in behaviour (Bateman et al, 2016).

On older person hospital wards, training is focussed on working in a hospital environment. This includes hospital induction and orientation to the ward (Wong Shee et al, 2014; Blair et al, 2018; Bateman et al, 2016); confidentiality (Bateman et al, 2016; Wong Shee et al, 2014); occupational health, ward safety, infection control policies and procedures (Bateman et al, 2016; Blair et al, 2018; Wong Shee et al, 2014); and the use of personal protective equipment (Bateman et al, 2016). Some volunteers were trained how to use documentation (Bateman et al, 2016; Wong Shee et al, 2014) and general reporting procedures (Wong Shee et al, 2014). In addition to this, volunteers received training on the volunteer role itself (Bateman et al, 2016; Blair et al, 2018), as are staff who were given information about the role and boundaries of volunteers (Blair et al, 2018).

1.4.9.3 Support

Following recruitment and training, the subsequent levels of support offered to volunteers vary. In some cases staff identify suitable patients and allocate volunteers to work with them (Howson et al, 2018; McDonnell et al, 2014;

Robison et al, 2014; Roberts et al, 2017). Some hospitals use the dementia nurse specialist to direct volunteers (McDonnell et al, 2014). In the absence of a volunteer coordinator, support is provided in some areas by regular meetings with managers (Bateman et al, 2016).

1.4.10 The range and type of activities undertaken by volunteers

Where mentioned, volunteers work weekdays only (Wong Shee et al, 2014), cover two shifts each weekday between the hours of 8am-12:30pm, and 3pm- 7pm (Blair et al, 2018; Bateman et al, 2016), and work one shift per week or fortnight (Bateman et al, 2016).

With regard to tasks, there are similarities and differences in the types of volunteer activities across adult hospital wards. The activities of hospital volunteers appear to lack co-ordination despite the emergence of the HELP model which is becoming widely accepted as a way to underpin the involvement of volunteers in delirium prevention (Hshieh et al, 2018). Activities include support with sensory impairment, eating and drinking, and mobility. The hospital volunteer roles in older person care appear to be categorised into three main areas. These include delirium prevention, mealtime assistance, and mobility support which will now be discussed.

1.4.10.1 Volunteers in delirium prevention

This section will describe the specific activities of hospital volunteers in relation to delirium prevention, including tasks to support orientation, sensory impairment, sleep, nutrition and hydration, and mobility assistance.

Volunteers helped patients with sensory impairment needs mainly related to vision and hearing, and ensuring that sensory aids were available, clean, working properly and adequately worn, and providing special communication aids when needed (Caplan and Harper, 2007; Godfrey et al, 2013; Gorski et al, 2017; Inouye et al, 2006; Inouye et al, 2000; Sandhaus et al, 2010; Steunenberg et al, 2016; Zaubler et al, 2013). Volunteers were trained to fit hearing aids and replace batteries (Bateman et al, 2016). Volunteers accessed information about patients' background and personal preferences from the patient or their family (Blair et al, 2018) and completed a personal profile and deliver diversional and therapeutic activities (Bateman et al, 2016).

Volunteers engaged patients in social and therapeutic activities to provide cognitive stimulation through conversation and included activities such as reading newspapers, reminiscence and games (Caplan and Harper, 2007; Godfrey et al, 2013; Gorski et al, 2017;

Inouye et al, 2006; Inouye et al, 2000; Sandhaus et al, 2010; Steunenberg et al, 2016; Zaubler et al, 2013). Reorientation activities included playing cards, sharing crossword puzzles, humour and spirituality at the bedside, and relaxation therapy such as providing music, aromatherapy, hand massages, and nail painting (Sandhaus et al, 2010). Volunteers were involved in the use of clocks, calendars, signage, and updating orientation boards with the names of care team members and the daily schedule (Godfrey et al, 2013; Gorski et al, 2017; Inouye et al, 2000; Sandhaus et al, 2010). There was also a role for volunteers to facilitate visitors and provide support for families and carers (Godfrey et al, 2013; Gorski et al, 2017; Inouye et al, 2006; Steunenberg et al, 2016) as well as generally observing patients who are at risk of delirium (Steunenberg et al, 2016). Volunteers were also trained to observe patients for nonverbal signs of pain, particularly those patients with communication difficulties (Godfrey et al, 2013).

Secondly, despite volunteers not being available to support patients at night, they were able to engage in strategies to facilitate sleep (Inouye et al, 2006; Inouye et al, 2000). These included reducing sleep disturbance by reducing noise to a minimum during daytime rest periods. A non-pharmacologic sleep protocol at bedtime included

offering patients a warm drink, providing relaxation music, back massage, and supporting general noise reduction strategies (Godfrey et al, 2013; Gorski et al, 2017; Inouye et al, 2000; Zaubler et al, 2013), as well as giving advice on sleep hygiene (Gorski et al, 2017).

Patients were also assisted with eating and drinking and discussed in the following section.

1.4.10.2 Volunteers and mealtime assistance

Mealtime assistance is defined as enabling a person to complete the eating process (Roberts, 2018). Volunteers can improve mealtime care of adult patients in institutional setting (Green et al, 2011). Support included preparing and serving meals, feeding, monitoring and recording intake, and providing feedback to nursing staff (Bateman et al, 2016; Caplan and Harper, 2007; Godfrey et al, 2013; Gorski et al, 2017; Howson et al, 2018; Inouye et al, 2006; Inouye et al, 2000; Palmer and Huxtable, 2015; Roberts, 2018; Roberts et al, 2017; Robison et al, 2014; Sandhaus et al, 2010; Steunenberg et al, 2016; Walton et al, 2008; Wong et al, 2008; Wright et al, 2008; Zaubler et al, 2013). Volunteers monitored diet modifications (Wright et al, 2008), and were involved in developing a nutrition care plan for each patient with the nursing staff (Wright et al, 2008).

They supported patients with their food choices (Bateman et al, 2016; Wright et al, 2008); helped with repositioning; and organised patients to eat in dining areas (Wright et al, 2008). Volunteers also help patients with their dentures (Godfrey et al, 2013; Gorski et al, 2017; Wright et al, 2008); help patients with hand hygiene (Howson et al, 2008; Roberts et al, 2017; Robison et al, 2014); cleaning tables and trays (Howson et al, 2018; Roberts et al, 2017; Robison et al, 2014); setting up meals, and ensuring food is within reach (Palmer and Huxtable, 2015; Robison et al, 2014; Walton et al, 2008; Wright et al, 2008).

Volunteers assistance included opening packets (Howson et al, 2008; Palmer and Huxtable, 2015; Roberts et al, 2017; Robison et al, 2014, Walton et al, 2008; Wright et al, 2008); cutting up food (Gorski et al, 2017; Howson et al, 2008; Inouye et al, 2006; Roberts et al, 2017; Sandhaus et al, 2010; Steunenberg et al, 2016; Wright et al, 2008; Zaubler et al, 2013); promoting social interaction and conversation, and encouraging patients to eat, (Howson et al, 2008; Palmer and Huxtable, 2015; Roberts et al, 2017; Robison et al, 2014, Walton et al, 2008; Wright et al, 2008); help with cutlery (Robison et al, 2014); and offering supplements and snacks (Walton et al, 2008; Wright et al, 2008).

Volunteers also offered help with drinks (Caplan and Harper, 2007; Godfrey et al, 2013; Gorski et al, 2017; Inouye et al, 2006; Inouye et al, 2000; Robison et al, 2014; Walton et al, 2008; Wright et al, 2008; Zaubler et al, 2013), and thickened fluids for patients with dysphagia, if required (Wright et al, 2008).

In some areas they are involved in feeding patients (Howson et al, 2008; Roberts, 2018; Roberts et al, 2017; Robison et al, 2014; Walton et al, 2008; Wong et al, 2008) but despite the potential dangers, only one study specified that volunteers are prohibited from feeding patients with swallowing difficulties (Robison et al, 2014).

There was evidence to suggest that volunteers can be counterproductive at mealtimes as talking to patients when their meals arrive may prevent patients from eating (McDonnell et al, 2014).

1.4.10.3 Volunteers and mobility assistance

An emerging volunteer role is to support mobility and movement to increase activity. Ambulation is described as walking two to three times a day, and active range of movement is defined as moving each joint in the usual way if the person were physically able (Babine et al, 2018). Volunteers collaborated with nursing and physiotherapy staff to provide assistance to patients to

assist them with an active range of movements and with ambulation (Babine et al, 2018; Baczynska et al, 2016; Denomme et al, 2018). Volunteers in some studies were able to independently mobilise those patients who were judged as suitable by the physiotherapist or nurse, as well as assisting staff with those patients who needed the help of more than one person to mobilise (Baczynska et al, 2016). The frequency and duration of exercise sessions for hospitalised older patients ranged from three times daily, some being daily fifteen minute walking sessions, and some exercise classes, with one study reporting two hundred mobility encounters during a period of three months, which involved mainly walking with older patients in the hospital hallway (Baczynska et al, 2016).

Volunteers received instruction on how to safely walk with patients, encourage gentle exercises, and positioning (Bateman et al, 2016). Volunteers were trained to encourage patients to mobilise as early as possible, using walking aids if necessary, and encouraging or carrying out active range-of-motion exercises three times daily (Babine et al, 2018; Baczynska et al, 2016; Godfrey et al, 2013; Gorski et al, 2017; Inouye et al, 2006; Inouye et al, 2000; Sandhaus et al, 2010; Steunenberg et al, 2016).

1.4.11 The effectiveness and impact of volunteers in hospital wards

Several studies have attempted to evaluate effectiveness of volunteer services. The areas include volunteer impact on delirium, nutritional intake, mobility, and cost effectiveness. However, there appear to be challenges when striving to establish a causal relationship between volunteer intervention and patient outcomes.

Firstly, there were challenges in determining the impact of volunteers on delirium rates because studies used existing medical records of delirium rather than a pre and post intervention delirium screening tool (Rubin et al, 2006; Zaubler et al, 2013) and therefore possible that other factors may have influenced the results. Studies claiming volunteer involvement reduced length of stay were problematic as patients were sometimes moved to other wards which affected the study design (Bateman et al, 2016; Blair et al, 2018; Gorski et al, 2017; Hshieh et al, 2018). Furthermore, it appears that staff commonly had little understanding of delirium and how to prevent it prior to volunteer involvement which created difficulties attributing any improvements to the contributions of volunteers.

Secondly, the challenges in assessing the impact of hospital volunteers on the nutritional intake of patients are highlighted in studies, which aim to measure volunteer impact to measure the effect on dietary intake and body mass index (BMI) measurement. The difficulties around this are that nausea or anorexia might prevent frail older patients from eating and drinking and no efforts on the part of volunteers would have any effect on their likelihood of increasing their food intake (Roberts et al, 2017). It is possible that as well as feeling physically unwell, the change of environment and dislike of institutional food may contribute to adversely affecting the appetite of some patients when admitted to hospital (Wong et al, 2008). Also, it is possible that existing mealtime support may already have been adequate and fit for purpose prior to any volunteer intervention. The importance of establishing a baseline assessment of mealtime systems was highlighted in one study (Palmer and Huxtable, 2015).

Thirdly, there are difficulties establishing the impact of hospital volunteers on mobility despite studies which aim to establish causality between volunteer involvement and falls rates. However, it could be argued that as volunteers are additional people who are able to observe and support patients, it is likely that their presence might

contribute towards noticing patients at risk of falls and so alert staff to prevent accidental injury.

Finally, there is a lack of detail about volunteer support as a cost saving measure (Zaubler et al, 2013; Sandhaus et al, 2010; Rubin et al, 2006; Rubin et al, 2011) and how costs are calculated (Sandhaus et al, 2010). The challenges around cost analysis are the difficulties in drawing accurate conclusions due to the different methods used and the different factors associated with cost. It is difficult to account for possible costs which might occur as a result of interventions which prevent problems, such as delirium. The difficulties in generalisability of research from one setting to another regarding the cost benefits of volunteers are due to a variety of factors. For example, there may be a difference in what is factored into cost analyses depending on whether healthcare is publicly or privately funded. As such, studies from the USA may not be readily transferrable to a publicly funded UK health system. There are also differences in the methods used to calculate the financial impact of volunteers, and what is factored into the analysis when calculating cost benefits, such as the extent to which volunteers prevent problems associated with hospitalisation.

Even if cost effective, the initial costs of staff time and setting up interventions and new ways of working may be prohibitive and may require investment in staff time, and the management and support of volunteers (Godfrey et al, 2013). Regardless of the methods of cost analysis, managing delirium increases hospital costs (Godfrey et al, 2013) because of the likelihood of poor outcomes, increased admission into care facilities, increased likelihood of falls, and increased length of stay. Therefore, it could be argued that any measures to reduce delirium would inevitably reduce the costs and this alone might demonstrate cost effectiveness, but only if the cost of delivering the service is lower than the cost of delirium. The intervention to reduce delirium would also need to be demonstrated to be clinically effective and actually reduce incidence of delirium. It is important to highlight the likelihood that any new interventions will require the funding of additional resources (Blair et al, 2018). These include financial, physical and personnel resources to set up and maintain the intervention. Any extra costs however, may be offset by savings made by reducing falls, length of stay, and delirium, and the subsequent financial implications of them.

In short, volunteers occupy a range of roles to assist hospital patients. Limited resources, prioritising physical

needs over the psychosocial needs of people with dementia in hospital, and varying levels of carer support presents an opportunity to deploy volunteers to provide support. It appears that volunteers already offer support in a range of roles, but further evidence is needed to understand the impact, risks and benefits.

1.5 Conclusion

This chapter presents a background to volunteerism by defining volunteering, and describing a range of factors which make up healthcare volunteering. It presents background information to highlight the development of the interest in the role of volunteers in dementia and acute hospitals, particularly in view of the forecast increase in the numbers of people living with dementia requiring specialised care in hospital, and future plans to increase the numbers of volunteers. It sets out the challenges of providing support to patients with dementia in acute hospitals.

There appear to be some difficulties in determining the impact of volunteers in preventing delirium, nutritional intake, and mobility.

There is a limited amount of research on people with dementia and cognitive impairment, and challenges in

establishing an evidence base to understand the impact volunteers have on patient outcomes. The focus of the proposed study is to explore the perspectives of multiple stakeholders to understand about how volunteers support patients with dementia and cognitive impairment in acute hospital wards. This chapter provides a background to the role of volunteers, and points out the difficulties of establishing their impact on patient outcomes.

The following chapter will seek to establish evidence of the perspectives and experiences of those involved in volunteering in healthcare settings.

Chapter 2 Literature Review

2.1 Introduction

The previous chapter presented a background to volunteering, with a focus on volunteers supporting people with cognitive impairment. The proposed research seeks to understand the role of volunteers. This literature review aims to understand the role of volunteers in a range of healthcare settings by exploring multiple stakeholder perspectives.

This chapter explores the evidence, and aims to summarise and provide a critical analysis of, the existing body of research of volunteers in healthcare settings, and identify gaps in the current evidence. In order to achieve this aim, a systematic search and review of the literature was undertaken (Grant and Booth, 2009). This aims for comprehensive searching and addresses questions to produce best evidence synthesis. There will now follow a description of the search strategy, an overview of the results, and prominent themes in the literature to establish the gap in the current evidence.

2.2 Review question

The research question was developed using the SPIDER tool (Cooke, Smith, and Booth, 2012).

'What are the perspectives and experiences of stakeholders of volunteering in healthcare?'

2.3 Search strategy

Volunteer: - Volunteer experiences Volunteer workers AND	volunt* OR 3rd sector OR third sector OR non-profit sector OR non-profit organi?ations OR charit* OR civic* OR philanthrop* OR candystrip*
Healthcare AND	healthcare facilities OR health facilities OR hospice OR hospital OR care home
Qualitative research	action research OR audio recording OR cluster sample OR content analysis OR constant comparative method OR diar* OR discourse analysis OR ethnograph* OR ethnomethodolog* OR ethnolog* OR experience* OR focus group* OR field stud* OR field notes OR grounded-theor*

	OR hermeneutic* OR heuristic* OR interview* OR life experience* OR lived experience* OR narrative* OR narratives OR observation* OR participant observation OR perspective* OR phenomenol* OR purposive sample OR qualitative OR thematic analysis OR theoretical sample

2.4 Databases

The following common healthcare electronic databases were searched:

- CINAHL
- Psycinfo
- Web of Science
- Embase
- Medline
- Cochrane Library

2.5 Inclusion and exclusion criteria

2.5.1 Inclusion criteria:

- Papers published in peer reviewed journals

- Papers which use qualitative research methods, including mixed methods, which focus on the lived experience and perspectives of individual, group or organisational stakeholders involved in healthcare and medical settings, hospital, care homes, and clinics.

- Volunteers defined as a person who freely gives their time in an unpaid capacity, not staff, and not a carer or in an existing relationship with the patient

2.5.2 Exclusion criteria:

- Opinion papers, commentaries, and anecdotal or descriptive accounts

- Papers published in a language other than English

- Healthy volunteers in clinical trials

- Conference abstracts, poster presentations, and papers which lack sufficient methodological detail.

- Papers which explore the perspectives of volunteers on specific interventions

- Papers which explore perspectives of volunteer involvement in areas unrelated to the line of inquiry, such as maternity and midwifery, prison healthcare, and paediatric settings

- Volunteers who receive any form of remuneration, additional benefits or material incentives for their efforts such as bonuses, health insurance, or a percentage of the fees paid by service users to healthcare providers, and is over and above necessary expenses (usually limited to food, drink, and travel) as this fell outside the definition of volunteer

- The use of the term ‘volunteer or voluntary’ which does not include the above definition (this includes involuntary movement).

- Volunteers who are healthcare professionals but providing specialised professional healthcare services in a voluntary capacity

- Quantitative research methods.

- Studies which do not clearly differentiate volunteers from other groups such as carers or visitors

2.6 Methods

From the databases and hand searching, a total of 4846 results were retrieved. Papers were screened by reviewing titles, abstracts, then by reading the remaining papers in their entirety, and removing papers that did not meet the selection criteria at each stage. After removing papers which did not meet the inclusion/exclusion criteria (n=4735) and duplicates (n=76) 35 papers remained. Figure 2 shows the process of searching and organising the records.

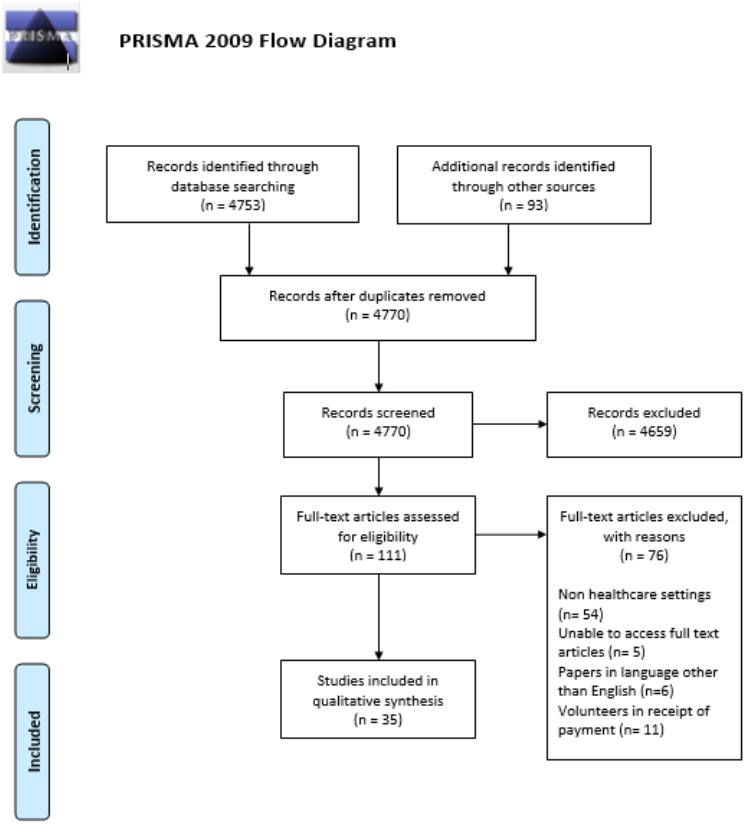


Figure 2 PRISMA search process and results (Moher et al, 2009)

The search was exploratory and iterative in nature. An initial search was undertaken at the beginning of the research process (September and October 2015) in order to inform the study. Several reviews were undertaken and the research question, search terms and inclusion and exclusion criteria changed between the initial and subsequent searches throughout the data collection period in the interests of refining the search. A systematic search undertaken at the stage of writing up during November 2018 to March 2019 is reported.

The search was a two-stage process. Firstly, titles and abstracts were screened for suitability against the inclusion and exclusion criteria. Secondly, the selected papers were read in their entirety to understand tabulated to extract the data and find themes. This included the aim of the study, context, design and methods, type and number of participants, and results. Further analysis of each paper included searching for similarities and differences, trends and patterns, and gaps in the evidence.

Once the papers had been read through several times, highlighter pens were used to facilitate the process by colour coding similarities across the corpus of literature. This process facilitated the identification of themes, with the aim of understanding the current evidence of the perspectives and experiences of stakeholders of volunteering in healthcare. The papers were also screened to determine the quality of evidence.

2.7 Quality appraisal

A quality appraisal tool (CASP, 2019a; CASP, 2019b) systematically assesses trustworthiness, relevance and results of published papers in order to understand the quality of research evidence, and to identify strengths and weaknesses (National Collaborating Centre for Methods

and Tools, 2011). The 35 selected papers were screened using the Critical Appraisal Skills Programme tool (CASP, 2019b) and found to be of good quality (see appendix 1).

All the selected papers showed a clear statement of the results, that qualitative methodology was an appropriate approach, and reported a clear statement of findings. All papers used a qualitative research design appropriate to address the aims of the research, and collected the data in a way that addressed the research issue.

All papers used a recruitment strategy appropriate to the aims of the research apart from five studies (Claxton-Oldfield & Claxton-Oldfield, 2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Elliott & Umeh, 2012; Kamaludin et al, 2013; Southby & Gamsu, 2017) which were unclear as they lacked sufficient detail on the method of recruiting participants.

There was a general lack of detail about the relationship between the researcher and participants, with only six papers providing a reflexive account on their relationship (Field-Richards & Arthur, 2012; Kilpatrick et al, 2013; Merrell, 2000; Merrell & Williams, 1999; Overgaard, 2015; Takasugi & Lee, 2012). Ten of the papers lacked detail about how ethical issues were taken into consideration (Azuero et al, 2014; Claxton-Oldfield & Claxton-Oldfield,

2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Dean & Willis, 2017; Dein & Abbas, 2005; Faulkner, 2005; Hayashi, 2016; Kamaludin et al, 2013; Merrell & Williams, 1999; Watts, 2012). Sixteen of the papers lacked sufficient detail on data analysis (Andersson & Öhlén, 2005; Berry & Planalp, 2009; Claxton-Oldfield & Claxton-Oldfield, 2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Dean & Willis,2017; Dein & Abbas, 2005; Faulkner, 2005; Hayashi 2016; Jovanovic, 2012; Lorhan et al, 2015; Morris et al, 2017; Nissim et al, 2009; Southby & Gamsu, 2017; Takasugi and Lee, 2012; Warren and Garthwaite, 2015; Watts, 2012). Nevertheless, all 35 papers were judged to make a valuable contribution to the evidence base because they accessed the perspectives of participants about their experiences of healthcare volunteering.

2.8 Description of included papers

Studies included in this literature search took a qualitative approach to explore, understand, examine, and describe volunteering in a variety of roles in healthcare settings.

Eighteen papers accessed the perspectives of volunteers only (Andersson and Öhlén, 2005; Azuero et al, 2014;

Berry & Planalp, 2009; Brighton et al, 2017; Brown, 2011a; Brown, 2011b; Claxton-Oldfield & Claxton-Oldfield, 2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Dean & Willis, 2017; Dein & Abbas, 2005; Elliott & Umeh, 2012; Field-Richards & Arthur, 2012; Jovanovic, 2012; Kamaludin et al, 2013; Takasugi and Lee, 2012; Warren and Garthwaite, 2015; Watts, 2012; White and Gilstrap, 2017). Two of the papers accessed the perspectives of staff only (Hayashi 2016; Kilpatrick et al, 2017), and one paper accessed the perspectives of patients only (Nissim et al, 2009).

The remaining papers took a multi stakeholder approach to access the views of volunteers and patients (Faulkner, 2005; Pryce et al, 2015); volunteers and staff (Akintola, 2008; Jack et al, 2011; McDonnell et al, 2014; Mckee et al, 2010; Merrell, 2000; Merrell & Williams, 1999; Morris et al, 2017; Overgaard, 2015; Southby & Gamsu, 2017); volunteers, staff and patients (Lorhan et al, 2015); volunteers, staff and carers (Preston & Burch, 2018); volunteers, patients, carers, and staff (Dodd et al, 2018).

The methods used to access the perspectives of participants about volunteers and volunteering took a range of approaches. 27 papers included interviews (Akintola, 2008; Andersson and Öhlén, 2005; Azuero et

al, 2014; Berry & Planalp, 2009; Brown 2011a; Brown 2011b; Claxton-Oldfield & Claxton-Oldfield, 2007; Dodd et al, 2018; Elliott & Umeh, 2012; Faulkner, 2005; Field-Richards & Arthur, 2012; Hayashi, 2016; Jack et al, 2011; Jovanovic, 2012; Kilpatrick et al, 2017; Lorhan et al, 2015; McDonnell et al, 2014; McKee et al, 2010; Merrell, 2000; Merrell & Williams, 1999; Nissim et al, 2009; Overgaard, 2015; Preston and Burch, 2018; Pryce et al, 2015; Southby & Gamsu, 2017; Watts, 2012; White and Gilstrap, 2017).

Twelve studies used focus groups (Brighton et al, 2017; Dean & Willis, 2017; Dein & Abbas, 2005; Jack et al, 2011; Kamaludin et al, 2013; Lorhan et al, 2015; McDonnell et al, 2014; McKee et al, 2010; Takasugi and Lee, 2012; Southby & Gamsu, 2017; Warren and Garthwaite, 2015; Watts, 2012) or informal group discussions (Claxton-Oldfield & Claxton-Oldfield, 2012).

The remaining eight studies used observations (Akintola, 2008; Dodd et al, 2018; Faulkner, 2005; McDonnell et al, 2014; Merrell, 2000; Merrell & Williams, 1999; Overgaard, 2015; Pryce et al, 2015); case studies (n=4) (Dodd et al, 2018; Morris et al, 2017; Southby & Gamsu, 2017; Watts, 2012); surveys (n=1) (Morris et al, 2017); documentary

review and analysis of medical records (n=3) (Dodd et al, 2018; Lorhan et al, 2015; Merrell, 2000).

The majority of studies were from UK contexts (n=16) (Brighton et al, 2017; Dean & Willis, 2017; Dein & Abbas, 2005; Dodd et al, 2018; Elliott & Umeh, 2012; Faulkner, 2005; Field-Richards & Arthur, 2012; Kilpatrick et al, 2017; McDonnell et al, 2014; Merrell, 2000; Morris et al, 2017; Preston & Burch, 2018; Pryce et al, 2015; Southby & Gamsu, 2017; Warren & Garthwaite, 2015; Watts, 2012). The remaining papers were from a range of international settings including USA (n=5) (Azuero et al, 2014; Berry & Planalp, 2009; Brown 2011a; Brown 2011b; White and Gilstrap, 2017); Canada (n=6) (Claxton-Oldfield & Claxton-Oldfield, 2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Jovanovic, 2012; Lorhan et al, 2015; McKee et al, 2010; Nissim et al, 2009); Japan (n=1) (Hayashi, 2016); Uganda (n=1) (Jack et al, 2011); Kenya (n=1) (Takasugi & Lee, 2012); Malaysia (n=1) (Kamaludin, et al, 2013); Australia and Denmark (n=1) (Overgaard, 2015).

The settings and specialties in which the perspectives of participants were explored were mainly hospice and end of life care (n=17) (Andersson and Öhlén, 2005; Azuero et al, 2014; Berry and Planalp, 2009; Brown, 2011a;

Brown, 2011b; Claxton-Oldfield & Claxton-Oldfield, 2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Dean & Willis, 2017; Dodd et al, 2018; Elliott & Umeh, 2012; Field-Richards & Arthur, 2012; Jack et al, 2011; Jovanovic, 2012; Mckee et al, 2010; Morris et al, 2017; Overgaard, 2015; White & Gilstrap, 2017).

Other settings included hospital general acute and mental health wards (Brighton et al, 2017; Dodd et al, 2018; Faulkner, 2005; McDonnell et al, 2014; Preston and Burch, 2018); community settings including audiology services, clinics, mental health and primary care settings (Akintola, 2008; Kilpatrick et al, 2017; Lorhan et al, 2015; Merrell, 2000; Merrell & Williams, 1999; Nissim et al, 2009; Pryce et al, 2015; Southby & Gamsu, 2017; Takasugi and Lee, 2012; Warren and Garthwaite, 2015); voluntary organisations and non-governmental organisations (Hayashi, 2016; Kamaludin et al, 2013; Kilpatrick et al, 2017).

Two studies included hospital and general practice (Faulkner, 2005), and hospitals and hospices (Dodd et al, 2018). Only two of the studies explored the perspectives of volunteers involved in the support of patients with dementia or cognitive impairment on acute orthopaedic

wards (McDonnell et al, 2014) and mental health wards (Preston and Burch, 2018).

2.8.1 Demographics of participants

There were 1024 participants across all papers. These comprised the following:

- Volunteers (n=676) in 29 papers (Andersson & Öhlén, 2005; Azuero et al, 2014; Berry & Planalp, 2009; Brighton et al, 2017; Brown, 2011a; Brown, 2011b; Claxton-Oldfield & Claxton-Oldfield, 2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Dean & Willis, 2017; Dein & Abbas, 2005; Dodd et al, 2018; Elliott & Umeh, 2012; Faulkner, 2005; Field-Richards & Arthur, 2012; Jack et al, 2011; Jovanovic, 2012; Kamaludin et al, 2013; Lorhan et al, 2015; McDonnell et al, 2014; Merrell, 2000; Merrell & Williams, 1999; Morris et al, 2017; Overgaard, 2015; Preston and Burch, 2018; Pryce et al, 2015; Takasugi and Lee, 2012; Warren and Garthwaite, 2015; Watts, 2012; White & Gilstrap, 2017)

- Staff (n=200) in 11 papers (Dodd et al, 2018; Jack et al, 2011; Kilpatrick et al, 2017; Lorhan et al, 2015; McDonnell et al, 2014; Merrell, 2000; Merrell & Williams, 1999; Morris et al, 2017)

Patients (n=57) in 5 papers (Dodd et al, 2018; Faulkner, 2005; Lorhan et al, 2015; Nissim et al, 2009; Pryce et al, 2015)

Carers (n=10) in 2 papers (Dodd et al, 2018; Preston and Burch, 2018)

- Managers (n=15) in one paper (Hayashi, 2016).

Two of the papers did not present a description of the participant demographics nor a breakdown of types of participants, but comprised of staff, volunteers, and managers (n=66) (Akintola, 2008; McKee et al, 2010).

Papers which detailed age, sex, and ethnicity showed the majority of volunteer participants to be women (n=17) (Andersson & Öhlén, 2005; Azuero et al, 2014; Berry & Planalp, 2009; Brown, 2011a; Brown, 2011b; Claxton-Oldfield & Claxton-Oldfield, 2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Dean & Willis, 2017; Dein & Abbas, 2005; Elliott & Umeh, 2012; Field-Richards & Arthur, 2012; Jovanovic, 2012; Kilpatrick et al, 2017; Merrell & Williams, 1999; Morris et al, 2017; Pryce et al, 2015; White & Gilstrap, 2017). The majority of volunteers tended to be older or retired, and aged between 30-70 (Andersson & Öhlén, 2005), 50-80 (Pryce et al, 2015), 52 (Jovanovic, 2012), 58 (Brown, 2011b), 62 (Claxton-Oldfield & Claxton-Oldfield, 2007), 64 (White & Gilstrap,

2017), 67 (Claxton-Oldfield & Claxton-Oldfield, 2012). Where mentioned, the majority were white Caucasian (Azuero et al, 2014; Berry & Planalp, 2009; Elliott & Umeh, 2012; Merrell & Williams, 1999). The gender, age, and ethnicity were therefore representative of established statistics and volunteer demographics (Rochester, Ellis Paine, and Howlett, 2010). In summary, the literature search yielded studies which spanned a range of healthcare settings, specialties, and geographical locations. Studies used a range of methods to access the perspectives of key stakeholders involved in volunteering and either having contact with, or themselves being a volunteer.

2.8.2 Overview of results

The selected papers explored the perspectives of participants and focussed on different aspects of volunteering. Several themes were identified from the included papers. These included issues around ways of working with a focus on role boundaries, particularly in the specific context in which the studies took place; motivations and what circumstance might encourage volunteers to stay, or leave their role; and how they felt about their image as volunteers and their identity.

Regardless of context, similar challenges and barriers emerged as affecting the ways volunteers worked with others, their motivations, and understanding of their role and function. Table 1 gives an overview.

Reference	Aim of study	Context, design, methods	Participants	Results
Akintola (2008)	To explore the challenges experienced by volunteer caregivers of people living with HIV/AIDS and the coping strategies employed	South Africa Semi-rural communities (n=2) Qualitative: Ethnographic Observations In depth interviews Thematic analysis	Volunteers, managers, volunteer co-ordinators, community clinic staff (n=20)	Main themes were around dealing with denial, stigma, and discrimination; waking up to reality; becoming a competent caregiver; pushing ahead with caring work; managing attitudes and behaviours; confronting poverty; developing a thick skin.

Andersson & Öhlén (2005)	To obtain an understanding of what it means to be a hospice volunteer	Sweden Hospices (n=3) Qualitative: - Interviews - Phenomenological hermeneutic method.	Hospice volunteers (n=10)	A need for volunteers to be affirmed as a caring person and received as part of the hospice team. Positive encounters with the hospice are related to personal growth. Volunteers feel rejected if their need for meaning and belonging is not satisfied.
Azuero et al (2014)	To explore the experiences of volunteers working within teams organised to support	USA End of life in the community	Volunteers (n=10)	Key social processes at work in the team approach to caring were:

	people with HIV/AIDS dying in the community	Qualitative: - Semi-structured interviews		- acquiring positive life meaning as a team volunteer - accruing lessons learned from team-based volunteering - articulating negative aspects of team based volunteerism.
Berry and Planalp (2009)	To explore ethical issues hospice volunteers confront in their work	USA Hospice Qualitative: - interviews	Hospice volunteers (n=39)	Volunteers experienced dilemmas about gifts, patient care and family concerns. There were issues related to volunteer roles and boundaries & issues surrounding suicide and hastening death. Volunteers felt that training should include the opportunity for ethical discussions after initial training

Brighton et al (2017)	To explore hospital volunteer training needs & learning preferences	England Large teaching hospital Qualitative: focus groups (n=5) inductive thematic analysis	Chaplaincy volunteers (n=8) General ward volunteers (n=17) Total (n=25)	Need for training on communication skills, grief and bereavement, spiritual diversity, common symptoms, self-care. Volunteers valued learning from peers & end of life specialists using interactive teaching methods, real case examples & role play. Volunteers valued chance to update learning at a later date. Evaluation through self-reporting or observations deemed acceptable but patient/family/staff ratings deemed practically unsuitable due to limited length of time spent with each.

Brown (2011a)	To examine the coping techniques utilised by hospice volunteers	USA Hospice Qualitative: - phenomenology - hermeneutic - semi structured interviews - questionnaire	Hospice volunteers (n=15)	Volunteers used problem focussed coping, seeking advice from members of the hospice interdisciplinary team; emotion focussed coping by talking with others and going to funerals. Meaning making through appraisals (religious beliefs, downward comparison) and physical techniques (walking/deep breathing) Talking to volunteer co-ordinator
Brown (2011b)	To explore hospice volunteers experience of stress	USA Hospice Qualitative:	Hospice volunteers (n=15)	Hospice related issues and personal issues were a concern to the volunteers. They felt most stress at the

		- Phenomenology - Semi-structured interviews		beginning of their voluntary service.
Claxton-Oldfield and Claxton-Oldfield (2007)	To examine the impact of hospice palliative care work on volunteers' lives	Canada Hospice Qualitative: - interviews	Hospice volunteers (n=23)	Volunteers commonly volunteered as a result of personal experience with the death of a family member and/or friend. Volunteers felt they had changed as a result of volunteering and their outlook on life had changed. Volunteers took action to prevent compassion fatigue or burnout. Volunteers would recommend volunteering as they felt it was rewarding. Volunteers offered suggestions for change.

Claxton-Oldfield and Claxton-Oldfield (2012)	To find out what volunteers in community and hospital based palliative care programs consider to be the most or least satisfying aspects of their work. To identify reasons why volunteers might decide to leave or continue to volunteer. To develop strategies to prevent volunteers from leaving their position	Canada Hospice Qualitative: - informal group discussions	Hospice volunteers (n=41)	Feeling appreciated by patients & families gave volunteers great satisfaction. The least satisfying aspects of the role were issues around role boundaries and role ambiguity. Volunteers continue because they feel they make a difference & meet a need. They would consider stopping volunteering if other commitments became a priority
Dean & Willis (2017)	To explore the views of UK inpatient hospice volunteers regarding initial training for role preparation	UK Hospice Qualitative:	Volunteers (n=17)	Themes included issues around role preparation, common sense and life experience, role challenges, benefits and boundaries of training, training content, &

		- focus groups x 2 - group 1 (n= 10) - group 2 (n= 7)		training delivery. Volunteers perceived initial training to be important in increasing confidence and suggested areas where additional training would be valuable. There was some disagreement about how training contributed to professionalisation and the extent of education with respect to role boundaries.
Dein & Abbas (2005)	To examine the stresses associated with hospice volunteering, ways of coping, and perception of available support	England Hospice Qualitative Focus groups (n=2) Thematic analysis	Volunteers (n=17)	There were temporary stresses involved in voluntary work but generally experienced as not stressful; there are several ways of coping with stress; volunteers generally felt well supported.

Dodd et al (2018)	To explore the perspectives of patients, family carers, volunteers, & staff on the impact of receiving a volunteer provided befriending service	UK Hospital, hospice, community end of life settings Qualitative: - case study - interviews - observations - documentary analysis	Patients (n=23) Family carers (n=3) Volunteers (n=24) Staff (n=34)	Two main forms of input were described—'being there' and 'doing for'. 'Being there' encapsulated the importance of companionship and the relational dynamic between volunteer and patient. 'Doing for' described the process of meeting social needs such as being able to leave the house with the volunteer. These had impacts on wellbeing with people describing feeling less lonely, isolated, depressed and/or anxious.
Elliott & Umeh (2012)	To examine the psychological experiences	UK Hospice	Volunteers (n=9)	Volunteers experience cognitive–affective–behavioural challenges involving themselves, patients

	of volunteers in a UK hospice	Qualitative: - unstructured interviews		and the work environment. Self-related challenges seem especially prominent.
Faulkner (2005)	To explore the volunteer role in detail	England Older person hospital wards (n=13) GP practices Qualitative: Semi-structured interviews (n=11) Observations (4 sessions) Questionnaires (n=111)	- Hospital volunteers (n=75) - Patients (n=11) - Volunteers (n=8)	Social support provided by volunteers include: emotional, informational, appraisal & instrumental support

Field-Richards & Arthur (2012)	To explore the nurse-volunteer relationship in a day hospice	UK Hospice Qualitative: - Interpretive approach - Semi structured interviews	Hospice volunteers (n=12)	The nature and dynamics of the relationship between nursing staff and volunteers within the day hospice were characterized by increasing formality and changes in the division of labour, which challenged smooth working relationships.
Hayashi (2016)	To explore the experiences of voluntary organisation managers in trying to meet the expectation that such organisations will fill the shortfall in statutory	Japan Voluntary organisations Qualitative: - Semi structured interviews	Voluntary organisations managers (n=15)	There were constraints on capacity to deliver supplementary homecare. Voluntary home care provision fails to address or resolve growing demand for older person care. Care staff are

	provision of older person care			pressurised to perform additional voluntary duties extra to their paid role
Jack et al (2011)	To evaluate the motivation for becoming a volunteer and the personal impact of being a palliative care volunteer worker in Uganda	Uganda Hospice Qualitative: - Focus groups x3 (n in each group=6-8) - Semi structured interviews	Community volunteer workers (n=32) Hospice clinical teams (n=11)	There is a cultural wish to help people as a key motivator in becoming a volunteer. Additionally, the volunteers reported having a sense of pride in their volunteering role, and this role had a positive impact on their perceived status in their local community.
Jovanovic (2012)	To examine the current state of cultural competence among volunteers in	Canada Hospice Qualitative:	Hospice volunteers (n=14)	Volunteers encountered cultural clashes when their level of competency was weak. Volunteers revealed there was a lack of adequate cultural

	hospice & palliative care in Toronto	- In depth interviews		competency training with their hospice. They felt there was a lack of ethnic, cultural, & linguistic diversity among hospice volunteers
Kamaludin et al (2013)	To examine challenges in attracting and retaining cancer care volunteers as part of the effort to develop a volunteer recruitment model.	Malaysia Cancer care non-governmental organisations Qualitative: Focus groups (n=3)	Cancer support group volunteers (n=19)	Mobility & locality appear to be significant in Malaysian context. Need for financial support & time flexibility are challenges when recruiting & retaining volunteer support
Kilpatrick et al (2017)	To explore the views of mental health voluntary sector staff on emerging peer support worker role	Northern Ireland Mental health voluntary organisations	Voluntary sector staff (n=10)	Views varied. Seen as tokenistic or valuable contribution. Concerns over professional boundaries &

		Qualitative; Semi structured interviews Thematic analysis		challenges over organisational culture.
Lorhan et al (2015)	To describe the role of volunteers in cancer patient experience in an outpatient cancer centre	Canada Cancer outpatient centre Qualitative: Focus groups Interviews Document review	Patients (n=5) Volunteers (n=6) Staff (n=7)	Volunteers enhance patient experience. Physical needs met by volunteers directing patients to paid staff. Gaps in care, screening

McDonnell et al (2014)	To evaluate the effect of a ward volunteer service on an acute orthopaedic ward with dementia patients.	England Hospital ward Qualitative: Mixed methods Interviews & follow up interviews (n=7) Focus groups (n=3) Non participant observations (n=3) Framework analysis	Staff (n=6) volunteers (n=10)	Service had a positive effect on patient experience. Patients engaged in activities & enjoyed volunteer presence. Staff valued volunteers as they saw difference to patients & their own workload.

McKee et al (2010)	To explore key community informants about the role of hospice volunteers with dying people and their families	Canada Hospice Qualitative: - Ethnography - Semi structured interviews (n=13) - Focus groups x8 (n in each group = 5-8)	Healthcare professionals and volunteers (n=46)	Volunteers inhabit a unique third culture of care that fuses elements of formal care with the informal visiting of friends and neighbours. Their role is shaped to a community context where dying is not a private medical event, but rather a whole person-in-community event,
Merrell (2000)	To focus on the relationships between volunteers & paid workers working together in 2 community well woman clinics	UK NHS well woman clinics Qualitative: Participant observation	Volunteers (n=17) Paid workers (n=9)	Volunteers experience role ambiguity in formal organisations as roles & expectations not clearly differentiated. Volunteering is contradictory as it is both work & leisure pursuit. A lack of understanding as to whether

		Interviews Review of documents		work or leisure can lead to tensions in volunteer-paid worker relationships. Organisations need to make explicit their purpose & motive for involving volunteers. Volunteers should be viewed as enriching & enhancing services rather than a cheap substitute for paid labour
Merrell & Williams (1999)	To explore the benefits & challenges of collaborative working between volunteers & paid workers in the NHS	UK Well woman clinics Qualitative: Ethnographic Participant observations	Volunteers (n=17) Paid workers (n=9)	The combined effect of volunteer and paid workers working together is greater than either group working alone. Added value of collaborative working and potential for tension and conflict.

		Focussed interviews Thematic analysis		Volunteers & paid staff working together is a positive & mutually beneficial experience. Problems include lack of feedback to volunteers about patients balanced with a need for paid staff to exercise confidentiality. Tensions exist but do not outweigh benefits of collaboration. Opportunity to share insights. Benefits to service provider as costs of running services are reduced & provide a more consumer responsive service.

				Benefits to volunteers but there needs to be a balance between what volunteers give to the service & what they receive otherwise dissatisfaction is experienced.
Morris et al (2017)	To explore good practice in volunteer involvement & identify ways of improving care through developing volunteering	England Hospice (11 sites) Qualitative: Narrative literature review Online survey of volunteer managers (n=191)	Interviews: Staff (n=72) Volunteers (n=96)	Volunteers seen as an informal and symbolic link to the local community

		Organisational case studies (n=11)		
Nissim et al (2009)	To gain insight into the experiences of patients who have interacted with volunteers & to evaluate the benefits & risks of volunteers involvement	Canada Cancer centre Qualitative: - Semi-structured interviews	Patients (n=15)	Volunteers provide enhanced support which is positively received by patients. Patients felt volunteers provided a sense of humanization and normalization, a sense of security, support for nonmedical needs, & support for unaccompanied patients. There was limited awareness of their role & a lack of a structured role definition
Overgaard (2015)	To negotiate and determine the boundaries of volunteer workers and paid staff	Australia Denmark	Volunteers, staff, managers (n=41)	Volunteers in the Danish hospice were excluded from all direct care work due to the effective monopoly of the

		Hospice Qualitative: - Non participant observations of volunteers - Unstructured interviews with volunteers, staff, management	Australia: - Staff (n=8) - Volunteers (n=14) Denmark: - Staff (n=7) - Volunteers (n=12)	professional care providers, whereas the Australian volunteers participated in the provision of care to the extent that risk could be eliminated or mitigated to an acceptable level. The findings suggest two different models of the roles of volunteers in tension with professional care providers. Both models recognise that volunteers add to the level of care delivered by the organisations and allow for a discussion that moves away from the normative discussions of 'not taking somebody's job', while also recognising that volunteers must be more than just the 'nice extra' if they are to be of any real value to the

				organisation and to care receivers.
Preston & Burch (2018).	To understand whether dementia buddies enhance person centred care on mental health wards	England Mental health hospital wards Qualitative: interviews	Staff (n=9) Volunteers (n=4) Carers (n=7)	Ability to deliver person centred care was dependant on ward culture
Pryce et al (2015)	To explore interactions between audiology patients and volunteers, to describe encounters and define the role of volunteers.	England 2 audiology volunteer schemes Qualitative: Ethnographic. Observations & interview	Audiology volunteers (n=10) Patients (n=3)	Volunteers provided support relating to local services and hearing aids, but did not engage in discussions about hearing loss. Gaps identified in audiology provision, including accessibility & information. Need for more support from audiology services to fulfil their

		study of volunteer–patient interactions.		role. Volunteer interactions with patients mimicked a clinician–patient encounter and volunteers employed strategies and behaviours used by professional audiologists.
Southby & Gamsu (2017)	To examine the lived experience of GPs & the voluntary & community sector organisations working collaboratively	England Community Qualitative: - Case study design - Interviews - Focus group - Thematic analysis	GP, practice manager, practice nurse, volunteer service managers, volunteers (n=18)	Similarities across both types of service but form & function of GP:volunteer collaborations were unique to local context. Identical factors affecting GP:volunteer collaboration are a shared understanding, time & resources, trust, strong leadership, operational systems & governance with negotiation of professional boundaries

Takasugi & lee (2012)	To ascertain motivational drivers of volunteer community healthcare workers	Kenya (rural western) Qualitative: Focus groups (n=6) Thematic analysis	Community Health Worker Volunteers (n=23)	Financial drivers include working conditions. Non-financial drivers include personal recognition, personal development,
Warren & Garthwaite (2015)	To explore the motivations & needs of community health volunteers at a healthy living resource centre	England Healthy living resource centre Qualitative: Focus groups (n=4) Thematic analysis	Community health volunteers (n=16)	Need for relevant training to avoid alienating volunteers. Communication essential to fostering positive relationships between volunteers & staff. Volunteers must be recognised & appreciated

Watts (2012)	To explore the experience of being a hospice volunteer	England Hospice Qualitative: Case study approach Focus group Semi-structured interviews Thematic analysis	Volunteers (n=8)	Motivations to volunteer are mainly for instrumental gain and altruism. Volunteers would like more training to prepare them for the role. This can be either formal training from the organisation, or peer support from other volunteers. Volunteers would like more support. Volunteers have concerns over maintaining appropriate functional & emotional boundaries.

				Volunteers need to feel valued & appreciated.
White & Gilstrap (2017)	To examine the communication challenges home hospice volunteers experience when explaining their role to organisational outsiders	USA Hospice organisation Qualitative: In depth semi structured interviews Modified constant comparison to code & analyse data	Total volunteers (n=38)	Role articulation inhibits volunteers from communicating the full scope & relevance of role experiences Volunteers use discursive strategies to alter perception of stigma, these strategies may also exaggerate insider/outsider differences, inhibit authentic role disclosure & reduce the value of service to personal benefit. Importance of external based communication training to enhance role identity &

				connection to the hospice mission

Table 1 Overview of Results

2.9 Prominent themes in the literature

2.9.1 Introduction

This section will explore the main themes from the selected papers, namely complexities around the volunteer role, their relationships, and the context in which volunteering takes place. It will seek to understand how the role, function, and role boundaries are experienced by volunteers and other key stakeholders; the type and nature of the relationships volunteers have with others in the workplace; and how volunteers experience the wider and local context within which volunteering takes place.

2.10 The volunteer role, function, and role boundaries

The first theme from the literature will explore the perspectives on the volunteer role and function, and boundaries.

2.10.1 How do volunteers experience their role?

The evidence sheds light on how volunteers experience their role, describing how they experience stress while volunteering, and finding it to be emotionally challenging (Akintola, 2008; Dein & Abbas, 2005; Watts, 2012). Hospice volunteering in particular was described as stressful as volunteers worked directly with patients and families and were dealing with death and dying to the extent it would affect their health and sleep, leaving them with the feeling of being unprepared and unable to cope (Brown, 2011b). However, they described how they became used to the things that triggered stress such as patients dying or encountering physical disfigurement over time (Dein & Abbas, 2005).

Volunteers disliked some aspects of the induction process, finding it to have a generic and uniform approach (McDonnell et al, 2014). They felt there was increasing formalisation of the volunteer role with rules, regulations, restrictions, policies, and bureaucratic recruitment procedures with a sense of volunteering becoming a semi-professional role (Field-Richards & Arthur, 2012; Watts, 2012). Volunteers felt they could be better supported with clearer rotas and a designated

contact person to manage volunteers which would make them feel more valued and supported. They disliked the bureaucratic process with delays in the disclosure and barring service (DBS) checks and large amount of paperwork impacted negatively on their experience. Subsequently some volunteers did not continue with their application due to frustrations over the process, and possibly because they were keen to retain an impartial or independent position rather than feel part of service provision (McKee et al, 2010).

Volunteers who came for work experience then left, resulted in staff struggling to access support in their absence. Staff appeared to be overstretched which left volunteers feeling that they were overlooked and forgotten and taken for granted (Warren & Garthwaite, 2015). Some volunteers felt grateful for a formalised structure of recruitment and management, others, felt it was the promise of an informal structure that had initially attracted them to volunteering in the first place. This was particularly the case in an end of life context as informality in a hospice setting was seen as important to provide quality care (Elliott & Umeh, 2012; Field-Richards & Arthur, 2012). In most cases, volunteers expressed concerns around the over-formalisation of role, wondering if it would alter their contribution as the role becomes

more task orientated rather than person centred (McKee et al, 2010).

Yet despite the increasing formalisation, there appears to be a lack of clarity around the function and boundaries of the volunteer role. This may be because some organisations lack a formal job description and written guidelines (Merrell, 2000). Examples of ambiguity include uncertainty over whether volunteers should give advice to patients (Merrell, 2000). This is complicated by some clinicians accepting that volunteers would give advice to patients, while others actively discouraged them from doing so (Merrell, 2000). Volunteers subsequently reported feeling conflict and tension because of this uncertainty over advice giving (Merrell, 2000).

The lack of clarity of the volunteer role and function is further complicated by confusion over whether volunteer activity is understood to be leisure or work, and the fact that volunteers found it difficult to articulate their role to others (McKee et al, 2010). Volunteers also felt that changes in how services were run could partly account for role ambiguity (Field-Richards & Arthur, 2012). Volunteers themselves expressed uncertainty over their role. They appear to cope with role ambiguity by developing coping strategies (Dein & Abbas, 2005) and

striving to manage their own behaviour (Akintola, 2008; Merrell, 2000). This lack of clarity appears to contribute to tensions between volunteers and the paid workforce (Merrell, 2000).

2.10.2 How are volunteers seen by others?

There appear to be differences in how volunteers are seen by others. Volunteers were viewed positively and seen as adding value to healthcare services (Kilpatrick et al, 2017; Lorhan et al, 2015; McDonnell et al, 2014; Merrell, 2000; Morris et al, 2017; Preston & Burch, 2018; Pryce et al, 2015; Warren & Garthwaite, 2015). Volunteers were seen by carers as a surveillance mechanism which serves to safeguard patients from neglectful care (Preston & Burch, 2018). In turn staff saw volunteers as a reminder to be compassionate themselves (Preston & Burch, 2018). Volunteers are generally seen as having more time than staff to listen to the concerns of patients and carers (Faulkner, 2005; Lorhan et al, 2015; McKee et al, 2010), and staff valued the contribution of volunteers, seeing them as easing patient anxiety (McDonnell et al, 2014).

The volunteer role was seen as unique, filling a need for patients to talk to someone impartial other than staff or family. Patients would tell volunteers things they would not share with family or staff, confident they would not intervene (McKee et al, 2010). Volunteers were seen as someone for patients and carers to complain to, mainly because they are often in direct contact with them for longer periods of time than are paid staff (Brighton et al, 2017; Lorhan et al, 2015).

Volunteers were seen to occupy an enhanced supportive role and their services were positively received by patients. While volunteers were seen as supportive, patients lacked an awareness of their roles and responsibilities (Nissim et al, 2009). They were also seen as bridging a gap between patients and professionals as a complementary service (Elliott & Umeh, 2012; Field-Richards & Arthur, 2012; Lorhan et al, 2015; McKee et al, 2010; Nissim et al, 2009). The volunteer role was understood to be an informal and symbolic link between hospices and the community (Morris et al, 2017). The increasing demand for services was experienced by volunteers as increasing the pressure on them which created stress and made coping with the volunteer role difficult (Akintola, 2008). Some volunteers felt their role was becoming more orientated to meeting the physical

needs of patients as gaps in services become more apparent and subsequently being filled by volunteers (Field-Richards & Arthur, 2012). While some volunteers welcomed this, others felt it was beyond their remit and introduce a potential risk (Field-Richards & Arthur, 2012)

However, while volunteers were generally viewed in a positive light, they were also viewed negatively with some staff expressing fears over volunteers causing a disruption to the everyday running of services (Kilpatrick et al, 2017).

There was also mixed opinion around how volunteers were seen by others. For example, the volunteer peer support worker role was seen as positive, with some stakeholders appreciating their value when they shared their real life experiences and saw the subsequent benefits to patients (Kilpatrick et al, 2017). As these volunteers had personal experience of mental ill health, the role was also seen as benefitting the volunteer themselves by developing their confidence and so contributing to their own recovery (Kilpatrick et al, 2017). However, some stakeholders failed to see the value of the volunteer peer support worker role, describing it as being a tokenistic gesture to including patient public

involvement in mental health services (Kilpatrick et al, 2017).

Further confusion over volunteer roles and role boundaries occurred when volunteers held another identity as well as that of a volunteer (such as a nurse) (Merrell, 2000). Volunteers who were also healthcare professionals described how patients would interact with them differently to when they were there as a member of staff; nurses seen as task driven whereas as volunteers were described as simply ‘being there’ (McKee et al, 2010).

Volunteers were valued for listening and ‘being with’ as well as ‘doing for’ and undertaking practical aspects of role (Dodd et al, 2018). Volunteers described having to balance different tasks within their role such as the practical requirements of kitchen work and the need for a more interpersonal approach in patient areas (Dean & Willis, 2017).

As well as volunteers being seen in a positive and negative light, there is evidence of how they saw themselves. They felt they occupied a distinct position different to staff and patients felt more able to talk to them, perhaps because they were seen to have a more equal relationship than the one between patients and

staff (Field-Richards & Arthur, 2012). Volunteers felt their role was seen as unique to each individual and guided by their interests and strength (Field-Richards & Arthur, 2012). In line with others, they also felt their role differed from that of professional staff as it complemented existing services (Dein & Abbas, 2005).

Volunteers felt pride in their role helping people in their community (Jack et al, 2011). The volunteer role can impact on social status in the wider community and volunteers were subsequently shown respect by others in community. In some settings, volunteers reported having an increased status as a direct result of volunteer role, gaining trust and respect from others.

In all cases, it appears that there is a need for increased clarity of the volunteer role to maximise effective deployment of voluntary services in healthcare settings. It is recommended that volunteers should be seen as a complementary service and not a substitute for cheap labour (Merrell, 2000; Kilpatrick et al, 2017). Volunteers expressed a need to feel valued, recognised and appreciated, needed to engage with meaningful work, and for volunteering to be a positive experience (Warren & Garthwaite, 2015)

2.10.3 Role boundaries

The result of role ambiguity and uncertainty appeared to cause unease among stakeholders. Lack of clarity over role boundaries had the potential to contribute towards tensions between volunteers and paid workers. One issue is that of insurance and risk management, and tensions around the organisational motives and purpose for involving volunteers as organisations express a lack of understanding of the volunteer role (Merrell, 2000). Role boundaries become more complex when paid staff in Japan were pressurised to undertake voluntary duties (Hayashi, 2016).

It appears that stakeholders experienced some ambiguity over role boundaries as volunteers were either in a position to observe patient care but were neither a healthcare professional nor a family member or friend who could legitimately raise concerns (Berry & Planalp, 2009). Volunteers were asked by patients to do tasks outside the scope of the volunteer role. This caused distress to volunteers and resulted in them having to navigate the boundaries of tasks in order to cope with the demands of the role (Berry & Planalp, 2009).

Volunteers described generally performing tasks above and beyond what was expected from the role, yet were

happy to do so. They understood the importance of operating within the role boundaries of volunteers and paid staff (Elliott & Umeh, 2012). Indeed, issues around boundaries and role ambiguity were described by volunteers as the least satisfying part of their role (Claxton-Oldfield & Claxton-Oldfield, 2012), and the negotiation of professional boundaries was identified as affecting collaborative working between volunteers and paid staff (Southby & Gamsu, 2017).

Paid staff expressed fears over blurred boundaries between themselves and volunteers with questions asked about how these boundaries can be effectively managed (Kilpatrick et al, 2017). Staff felt a loss of power, or felt threatened by the introduction of peer support worker volunteers as they feared the disruption which challenged existing systems of service delivery (Kilpatrick et al, 2017).

In some instances, the role boundaries appeared to be clear. Staff directed volunteers to patients (Lorhan et al, 2015), and volunteers suggested to staff patients they might visit. Staff were mindful of maintaining the safety of volunteers, especially when patients were agitated. Despite concerns over role boundaries, there did not appear to be an overlap in roles between volunteers and

staff and no negative effect seen on staff activities. There was no sense that volunteers disrupted nursing care as volunteers were seen to fit into existing routines. Integration was enhanced when staff saw volunteers confidence increase (McDonnell et al, 2014).

The differences in how boundaries are experienced is exemplified in a comparison study of two sites (Overgaard, 2015). Volunteers in Denmark were allocated practical tasks with strict boundaries; nurses were discouraged from volunteering in an attempt to preserve role boundaries and prevent role ambiguity; there was a strict approach to confidentiality which meant that volunteers found it difficult for them to perform their tasks (Overgaard, 2015). In contrast, the Australian context was experienced as being less strict, with volunteers taking a more hands on role. They shared tasks with paid staff which included the intensive moving and handling of patients. However, some staff resisted this level of volunteer involvement, seeing it as posing a risk. Furthermore, the author emphasises that some undisclosed incidents during the study highlighted the need for stricter definition of role boundaries (Overgaard, 2015).

2.10.4 How do volunteers cope with ambiguity?

In response to these ambiguities, volunteers described how they coped. The difficulties around understanding role boundaries were compounded by patients who expressed uncertainty over whether they were discussing their problems with volunteers or clinicians (Merrell, 2000). One example of volunteers attempting to navigate the complexities and ambiguities were of volunteers imitating the strategies and behaviours of professionals, without having the associated skills and knowledge (Pryce et al, 2015). Volunteers sought to alleviate tensions by performing tasks which they describe as contributing to their sense of belonging (Andersson & Öhlén, 2005).

The personal circumstances of volunteers were also described as having an influence on their ability to volunteer. Financial pressures were compounded by personal challenges such as childcare responsibilities and the need to undertake paid work creating a barrier to pursuing volunteering (Kamaludin et al, 2013). The emotional impact on volunteers supporting patients in end of life care was experienced as traumatic and stressful

and would prompt them to leave if they felt unsupported (Brighton et al, 2017).

Some volunteers felt their outlook on life had changed as a result of volunteering in end of life settings (Claxton-Oldfield & Claxton-Oldfield, 2007). They described how they coped with the emotional aspect of the role by attending patients' funerals and seeking meaning about what they experienced in an end of life context through their religious beliefs (Brown, 2011a). Volunteers found it helpful to exercise self-care in order to cope with impact of this context and despite the challenges, they would recommend volunteering to others (Claxton-Oldfield & Claxton-Oldfield, 2007).

There were difficulties in understanding the volunteer role and function as volunteers experience challenges when trying to articulate to others what they do (McKee et al, 2010; White & Gilstrap, 2017;).

In view of the difficulties experienced by stakeholders when striving to understand the role, function, and boundaries of the volunteer role, it seems there is a need to establish boundaries around the volunteer role. This would help to allay the fears and concerns of healthcare professionals over the role of volunteers in healthcare delivery (Merrell, 2000). There is a need for clear

guidelines to allay volunteer anxiety (Merrell, 2000) and to allay staff concerns over volunteers being seen as a substitute for cheap labour (Kilpatrick et al, 2017; Merrell, 2000).

By exploring the evidence around the volunteer role and function, and seeking to understand where the volunteer role boundaries are understood to be, there is a lack of clarity over some aspects of the role. Volunteers strive to navigate the complexities in order to continue to function as a volunteer. It appears that this lack of clarity can contribute towards tensions between volunteers and paid workers. The following section will explore the relations volunteers have with others in the workplace.

2.11 The type and nature of volunteer relationships

This section will explore the nature of the interactions between volunteers and others within the workplace by discussing the positive and negative aspects of relationships, the effect of workplace culture on volunteers, and discuss recommendations from the evidence on how to maximise working relationships.

The nature of the interactions between volunteers and paid workers can range from being brief and superficial,

to in depth (Brighton et al, 2017). When first starting in the role, volunteers initially felt they were not recognised nor welcomed by paid staff, but communication between themselves and staff improved over time (McDonnell et al, 2014).

There is evidence in the literature of the relationships volunteers have with each other, staff, patients and carers, and others.

2.11.1 Relationships between volunteers

The relationships volunteers have with each other were generally experienced as being positive. New volunteers described how they benefitted from shadowing more experienced volunteers, seeing the peer support as essential for team working (Dein & Abbas, 2005; Elliott & Umeh, 2012; Watts, 2012). They would strive to deal with their feelings about difficulties, such as supporting dying patients, by talking to each other rather than paid staff (Andersson & Öhlén, 2005). Volunteers working together in a team expressed a sense of reciprocity (Azuero et al, 2014). Volunteers felt they benefitted from being involved in the role and a sense of personal gain, a sense that they derived more from the experience than patients. Volunteers reported benefits from the shared endeavours with other volunteers, describing it as a ‘bonding

experience' as they supported one another. Some volunteers felt the need for more contact with other volunteers (Berry & Planalp, 2009).

However, as well as the positive aspects of the relationships volunteers had with each other, they also experienced challenges. These difficulties included group decision making with other volunteers about who would assume responsibility for working extra shifts, describing this as a 'diffusion of responsibility' as no one volunteer would take responsibility when working as a group (Azuero et al, 2014). However, in a hospital setting where teams work in close proximity, this may not pose a problem.

2.11.2 Relationships between volunteers and paid staff

The positive aspects of the relationships volunteers had with paid staff appeared to be based on collaborative practice, and a sense of inclusion and support (Brown, 2011b) which was seen as essential for team working (Elliott & Umeh, 2012). Volunteers were valued for their positive contribution to patients and their support allowed nurses extra time to do clinical tasks, such as administer drugs. Volunteers were valued as an additional pair of

eyes to observe and supervise patients (McDonnell et al, 2014).

Staff offered support to volunteers who were recognised as experiencing emotional difficulties (Azuero et al, 2014). Collaboration between volunteers and general practitioners in one setting was seen as yielding positive outcomes particularly improving patient wellbeing and reducing demands on health services. As a consequence of this collaborative relationship, there appeared to be a merging of two models of working cultures, namely, a community development model merged with medical model. However, there were concerns over confidentiality as a barrier to collaborative practice (Southby & Gamsu, 2017).

Volunteers and paid staff working together renders the opportunity for them to share insights, perspectives, and approaches which enhance patients health assessments (Merrell & Williams, 1999). It provides an added dimension to patient care and yields benefits for the service provider. Although the lack of feedback to volunteers has potential for tension and conflict, volunteers and patients working together is positive experience and mutually beneficial. The combined effect of collaboration is greater than the effect of either

volunteer or paid staff working alone. Tensions were not considered to be serious and did not outweigh the benefits of collaborative working. Volunteers' insights into the needs of patients were seen to enhance health assessments as they brought skills and life experience. Volunteers generally felt well supported by staff, accessing them for support but aware of their workload, and sometimes felt they were disturbing them (Dein & Abbas, 2005)

Formal support for volunteers provided by organisations included monthly mentor meetings and meetings between volunteers and nurses before the shifts started (Watts, 2012). Volunteers in one study generally felt they had good working relationships with professional staff and felt appreciated (Dein & Abbas, 2005) yet in other studies they expressed a wish to feel appreciated and valued by paid staff (Berry & Planalp, 2009; Brown, 2011b; Elliott & Umeh, 2012; Watts, 2012).

Despite evidence of the positive aspects of the relationships between volunteers and others in healthcare settings, there is also evidence of the negative aspects of these relationships.

There was a general feeling of problems around communication (Brown, 2011b; Warren & Garthwaite,

2015). Volunteers felt they were not always given enough information to safely do their tasks (Field-Richards & Arthur, 2012), finding this to be an obstacle to them offering support to patients and carrying out their role, and created tensions (Elliott & Umeh, 2012). Volunteers felt uncertain about what was expected of them and were afraid to overstep the boundaries of their role and volunteers were careful not to ask staff about patients. Volunteers were interested in patients and disappointed not to be given any information at all about them which they felt would help them to support patients more effectively (Andersson & Öhlén, 2005). Staff told volunteers they did not need to know the clinical details of patients, but this did not prevent volunteers from wondering what ailed the patients. Communication within the organisation was described as challenging as volunteers found that messages did not always get passed on (McDonnell et al, 2014). Volunteers expressed a preference for shorter and fewer meetings whenever it was necessary to communicate with each other and paid staff (McDonnell et al, 2014).

Volunteers described how they experienced a lack of support from paid staff. They felt that staff did not care about their personal preferences yet expressed acceptance of the tasks they were given (Andersson &

Öhlén, 2005).Volunteers felt unimportant as staff did not take notice of what they thought, nor sought their opinion (Andersson & Öhlén, 2005).

When first starting in the role, volunteers initially felt they were not recognised nor welcomed by paid staff, and volunteers experienced a lack of professional support (Akintola, 2008) but some found that communication between themselves and staff would improve over time (McDonnell et al, 2014).

The relationships between volunteers and nurses were found to vary as some volunteers felt positive and valued, while others suggested that issues around professional insecurity led to occasional disharmony between nurses and volunteers, who subsequently felt threatened (Field-Richards & Arthur, 2012). This was further complicated by issues around role ambiguity and differences in how some volunteers function which created tensions between relationships between volunteers and nurses (Field-Richards & Arthur, 2012).

One facet of relationships is that of workplace culture. A person-centred workplace culture was described as impacting positively on volunteers (Preston & Burch, 2018), whereas a task orientated workplace culture impacted negatively on volunteers. When volunteers did

not feel part of the team, they experienced a negative 'them and us' culture . There were underlying tensions over volunteers being seen as taking work away from paid staff. This could result in staff hindering the volunteers work. For example, staff making access to a mental health ward difficult for volunteers by failing to provide them with swipe card access. Volunteers had to ring the bell to gain entry to the ward (Preston & Burch, 2018). This appears to be partly driven by fears over a change in the philosophy underpinning practice. Existing services appeared to operate on a long standing historical medical model which presented a challenge to those who preferred a more holistic and person centred approach to recovery oriented services which place a high value on experiential knowledge offered by peer support. Therefore attitudes and organisational culture were deemed to be important and there was a possibility that staff may resent peer support worker volunteers (Kilpatrick et al, 2017).

Issues around negative workplace culture could be addressed by training and support. The need for training was seen as important (Berry & Planalp, 2009; Brighton et al, 2017; Dean & Willis, 2017; Dein & Abbas, 2005; Dodd et al, 2018; Jovanovic, 2012; Overgaard, 2015). Those volunteers who felt that their training was of limited

use described feeling discouraged, emotionally drained, and they considered leaving (Akintola, 2008). There was a feeling it could be improved (Berry & Planalp, 2009; Brighton et al, 2017; Dean & Willis, 2017; Dodd et al, 2018; Elliott & Umeh, 2012; Jovanovic, 2012; Overgaard, 2015) by emphasising the need for structured support and training to ensure this is managed effectively (Kilpatrick et al, 2017). Volunteers said they often felt unprepared for the role (Azuero et al, 2014) while also understanding that it was not possible to be prepared for every eventuality (Akintola, 2008; Dean & Willis, 2017; Watts, 2012). They reported feeling a tension between the wish to do more and a lack of time (Azuero et al, 2014) although the initial difficulties they experienced became easier over time (Brown, 2011b). Volunteers felt that they needed more training to improve their level of competence and felt the course content was not always appropriate to the role (McDonnell et al, 2014).

Training resulted in some volunteers feeling more professional while others found it to be restrictive (Dean & Willis, 2017). As well as giving volunteer information, raising staff awareness of the purpose and function of volunteers was felt to be important (Elliott & Umeh, 2012), and also patients as they lacked awareness of the role and responsibilities of volunteers (Nissim et al, 2009).

Volunteers appreciated the opportunity to access more help and support from each other. Benefits of good volunteer training was felt to be of utmost importance when seeking ways of coping with the challenges of a hospice environment (Brown, 2011a). The advantage of good support and training was that it gave volunteers a sense of being part of the team (Andersson & Öhlén, 2005). It also gave volunteers a sense of competence in their role which helped them to cope with stresses of volunteering (Akintola, 2008).

2.11.3 Relationships between volunteers and patients and carers

Volunteers said that feeling appreciated by family and patients gave them great satisfaction with relationships being the most satisfying part of their role (Claxton-Oldfield & Claxton-Oldfield, 2012). The relationships between patients and volunteers was described as having a positive effect on patients (Dodd et al, 2018)

Nevertheless, volunteers experienced challenges as they discovered there were different expectations between the needs of patients and having sufficient numbers of volunteers to meet the expectations of services as a result of these difficulties, volunteers describe negotiating the boundaries of their role in an attempt to cope (Azuero

et al, 2014). Volunteers felt insecure that they were not doing enough to help patients, and experienced initial difficulties as they get to know patients, then they feel accepted over time (Azuero et al, 2014).

Volunteers described the challenges they experienced in managing their relationships with carers. They were trusted by patients with confidential information as a result of their conversations, yet put under pressure by carers to share this information with them (Akintola, 2008). To further complicate the issue of relationships volunteers have with patients and carers, a lack of awareness of cultural needs and language barriers, were found to lead to tensions in relationships between them (Jovanovic, 2012). When patients and families made unreasonable demands on volunteers, they coped by clarifying their role to them (Akintola, 2008).

2.11.4 Relationships volunteers have with others

Volunteers described the nature of their relationships with others. Volunteers coped with the pressure of the role by talking to others such as spouses and volunteer coordinators and found these relationships to be an

important mechanisms for coping (Claxton-Oldfield & Claxton-Oldfield, 2007). However, they would continue to seek support from healthcare professionals within the multi-disciplinary team (MDT) as well as volunteer coordinators when they experienced difficulties (Brown, 2011a). This was mainly because they recognised they were unable to discuss their difficulties with family and friends because of concerns over maintaining confidentiality (Brown, 2011a).

In view of this evidence, the research suggests that maximising the working relationships between volunteers and paid workers would include volunteers to be fully integrated into the team (Kilpatrick et al, 2017). Volunteers express a need for meaningful work, and to feel appreciated and motivated by receiving the support and guidance of paid staff (Andersson & Öhlén, 2005).

It appears that the relationships volunteers have with others in healthcare settings can be experienced both negatively and positively. Workplace culture can also influence how volunteers experience volunteering. To maximise effective working relationships, it seems that there is a need for volunteers to feel supported, receive adequate and meaningful training to prepare them for the

role, and for them to undertake meaningful work to feel included, appreciated, and motivated to continue.

2.12 The effect of context on the experience of volunteers

Having explored the volunteer role, function, and boundaries, and the nature of the relationships volunteers have with others in healthcare settings, this final section will explore how healthcare contexts are experienced by volunteers.

This includes the infrastructure, clinical specialty, and availability of resources within healthcare settings. Resources can include time, access to funds, mobility constraints, and resources (Kamaludin et al, 2013; Takasugi & Lee, 2012; Warren & Garthwaite, 2015).

Problems include issues with transport as volunteers described being unable to access remote areas due to lack of transport facilities (Kamaludin et al, 2013; Takasugi & Lee, 2012). Volunteers described the lack of appropriate venues to run voluntary activities as limiting their ability to function effectively (Kamaludin et al, 2013). Lack of resources was found to be a barrier to volunteering, for example, a lack of transport to cover

large distances and insufficient support from staff (Takasugi & Lee, 2012).

Another example was restricted visiting times were found to prevent volunteers from engaging with relatives as restricted visiting hours could be at different times to the volunteer shifts (Brighton et al, 2017).

Inadequate resourcing within healthcare settings were described as causing volunteers to feel frustrated in their role, with volunteers offering accounts of needing to improve facilities in order to ensure the smooth running of services. For example, volunteers in a healthy living resource centre in England described their frustrations over inadequate cooking facilities which meant they wasted time when preparing food (Warren & Garthwaite, 2015). The international research highlighted that some volunteers experienced extreme poverty among those they supported which left them frustrated and feeling obliged to assist service users financially (Akintola, 2008). Lack of adequate funding in some areas meant that volunteers were sometimes left out of pocket as they would spend their own money to help patients who would otherwise be unable to afford to buy medicines (Kamaludin et al, 2013; Takasugi & Lee, 2012). Another example of the effect of limited resources on the

experience of volunteers was the lack of dedicated room for hairdressing and therapeutic treatments which was seen as a barrier to volunteers doing their role (Elliott & Umeh, 2012).

Access to resources were described by volunteers as having a positive impact (Warren & Garthwaite, 2015). Small gestures such as ensuring tea and coffee were made available at break times made volunteers feel valued (Warren & Garthwaite, 2015). However, limited capacity and resources (such as time to invest in collaborations, physical space for meetings and deliver interventions) were seen as barriers to planning, implementing and developing collaborations between volunteers and paid staff (Southby & Gamsu, 2017).

In most cases, volunteers expressed a wish to continue in their role but experienced the burden of inadequate resources and poor infrastructure to be a barrier to continuing.

Poor resources impacted on paid staff also which echoes the previous mention of ambiguity of role boundaries. As demand for healthcare services increases, paid staff in Japan were pressurised to deliver their services without pay in the absence of volunteers without pay as there are constraints on capacity to provide these services,

rendering them essentially volunteers (Hayashi, 2016). The appeal of volunteers are that they are assumed to provide an opportunity to reduce the costs associated with healthcare and some services were seen as not being viable without volunteers to run them (Merrell and Williams, 1999). This raises concerns over issues around exploitation as volunteers take over the role of paid staff, and vice versa.

To summarise, as well as a lack of clarity over the volunteer role and apparent tensions in the relationships volunteers have with others in the workplace, it appears that context and available resources can have an influence on the experience of volunteers, influencing how they feel about the role. Despite differences across a range of countries and healthcare specialties, volunteers experience similar issues which can feed into their decision making process of whether or not to continue.

The type of resources may differ between countries and contexts but the difficulties experienced by volunteers remain the same in terms of how these affect their motivations and intention to stay in the role. Lack of resources and an inefficient infrastructure can have a negative effect on volunteers as they experience difficulties in carrying out their volunteer role as a result.

The evidence suggests that the motivations of volunteers to continue in their role are influenced by the context in which volunteering takes place.

2.13 Volunteer support in dementia and the care of older people

Seven papers focussed on dementia or the care of older people (Brighton et al, 2017; Claxton-Oldfield and Claxton-Oldfield, 2012; Dodd et al, 2018; Faulkner, 2005; Hayashi, 2016; McDonnell et al, 2014; Preston & Burch, 2018). The main themes related to the context, motivations, training, the image of volunteers, and their role.

2.13.1 Context

In terms of the context, Hayashi (2016) highlights the pressures on care services for older people which appears to create a demand for more volunteers. It appears that ward culture (whether underpinened by task based or person centred care) has an effect on how volunteers are integrated into the ward team (Preston & Burch, 2018). There is also evidence that the level of volunteer satisfaction with the setting can influence their intention to continue in the role (Claxton-Oldfield and Claxton-Oldfield, 2012; Preston & Burch, 2018).

2.13.2 Motivations

To maximise retention, it appears that there is a need to ensure volunteers feel useful, welcomed, and supported by staff (McDonnell et al, 2014). Volunteers reported feeling satisfied knowing they were doing important work and receiving positive feedback from patients and families, and would continue if they felt they enjoyed the role and felt they were making a difference (Claxton-Oldfield and Claxton-Oldfield, 2012). There is also a need to ensure volunteers exercise self-care to prevent burnout and subsequently leave the role (Brighton et al, 2017; Claxton-Oldfield and Claxton-Oldfield, 2012).

2.13.3 Training

Where mentioned, evidence based training was seen as crucial to enable volunteers to support patients (Brighton et al, 2017; Faulkner, 2005; McDonnell et al, 2014; Preston & Burch, 2018). This was not only important to maximise retention (McDonnell et al, 2014), but also that volunteers could understand what was expected of them (Preston & Burch, 2018).

2.13.4 Image of volunteers

Volunteers were seen in both a positive and negative light (Preston & Burch, 2018). However, the evidence

suggests they were generally viewed as being a positive contribution to patient well-being (Faulkner, 2005; McDonnell et al, 2014). Staff saw volunteers as a reassuring presence and of value, as they described the effect on their workload and patient well being (McDonnell et al, 2014). They were seen as being of greater value because they were unpaid (Preston & Burch, 2018). They were also seen as complementing the contribution of paid staff (McDonnell et al, 2014), and a reminder for staff to be compassionate (Preston & Burch, 2018).

2.13.5 The volunteer role

The volunteer role in dementia or older person care included either relational or practical interactions. Volunteers engaged patients with conversation and befriending, helped with practical tasks, or both (Dodd et al, 2018; Faulkner, 2005; McDonnell et al, 2014; Preston & Burch, 2018). Some tensions over role boundaries were reported with staff reporting feeling insecure over being replaced by volunteers (Preston & Burch, 2018). Furthermore, the notion of blurred boundaries was further complicated by 'hybrid' roles which involved offering volunteers some form of payment, and paying employees

at a lower rate under the guise of volunteer type work (Hayashi, 2016).

There was evidence of a lack of clarity over the role boundaries between volunteers and paid staff (Claxton-Oldfield and Claxton-Oldfield, 2012; Hayashi, 2016), although where roles were clearly defined, no overlap was reported (McDonnell et al, 2014).

2.14 Conclusion

This section explores three main themes from the selected papers. The evidence suggests a lack of clarity over the role and function of volunteers in a range of healthcare settings. There can be underlying tensions between volunteers and paid staff as they negotiate ways of working without clear guidelines about the role description or role boundaries. The context in which healthcare volunteering takes place creates challenges and barriers to volunteers and can create difficulties for them to continue in the role.

The overarching theme across all the selected papers is that in order to address the various challenges encountered by healthcare volunteers there is a need for them to receive comprehensive training and support to undertake meaningful work in an environment which is

adequately resourced and has a positive and supportive workplace culture. There is a need for staff, patients, and carers to be made aware of the function and role boundaries of volunteers to maximise effective working, collaborative practice, and manage expectations from service users.

There were only seven papers which explored the perspectives of stakeholders on volunteers who support older people in healthcare settings, some of whom have dementia (Brighton et al, 2017; Claxton-Oldfield and Claxton-Oldfield, 2012; Dodd et al, 2018; Faulkner, 2005; Hayashi, 2016; McDonnell et al, 2014; Preston & Burch, 2018). These papers highlight issues over the setting, motivations, training, the image of volunteers, and their role.

The literature review highlights difficulties in understanding the role of volunteers in supporting patients with dementia and cognitive impairment in acute hospital wards, despite services which currently exist to deliver such a service as very few focus on this specialty.

Understanding the organisation and context in which volunteering takes place, and the characteristics which make up the service, and by understanding how volunteers deliver services, will lead to an understanding

of how to make improvements to existing services. Once there is an understanding of the current situation, strategies can be developed to improve services. Asking key stakeholders to share their perspectives can facilitate an understanding of their experiences which might identify solutions to improve services.

The literature review highlights the lack of evidence to inform an understanding of the role of volunteers in supporting patients with dementia and cognitive impairment in acute hospital wards, despite services which currently exist to deliver such a service. In view of this it is important first of all, to develop a comprehensive understanding of the role and function of volunteers in healthcare services. This is of particular importance in relation to this study in view of the dearth of evidence around the role of volunteers supporting patients with dementia and cognitive impairment in acute hospital wards. Therefore, the following chapter will set out the methodology for the proposed study to address the gap in evidence to understand the role of volunteers in supporting patients with dementia and cognitive impairment in acute hospitals.

Chapter 3 Methods and Methodology

3.1 Introduction

The previous chapters presented an introduction to the research, background to the research question, and review of the relevant literature.

The purpose of this chapter is to present and justify the chosen methods and methodology. It will begin by detailing the aims and objectives of the study, discuss the research design and justification of methods, and then describe access to participants, how they were selected, recruitment, and collection of data. The chapter will conclude with a consideration of ways to optimise the trustworthiness of the research, ethical issues, and data analysis.

3.2 Study aim

To explore the experience of volunteering in dementia care in acute hospital wards from the perspectives of multiple stakeholders.

3.3 Study objectives

- To identify organisational motivation and goals for having a volunteer service for patients with dementia and memory loss in acute hospital wards.

- To identify barriers and facilitators to volunteerism in dementia and memory loss in acute care.

- To explore ways in which volunteers work with patients with dementia and memory loss within the Multi-disciplinary Team (MDT).

- To explore, from the perspectives of patients with dementia, and carers, their experience of volunteers while on acute hospital wards.

- To explore reasons why volunteers leave, or continue, in the role of volunteer in this context.

3.4 Research design

To justify the choice of research methods, it is necessary to question assumptions about the nature of reality and establish a philosophical standpoint to address the research question. Crotty (2009) proposes four elements which underpin the research process namely methodology, theoretical perspective or philosophical standpoint, epistemology, and methods. Carter and Little

(2007) offer an understanding of the relationship between epistemology, methodology, and method as to how they work together to justify knowledge (see figure 3).

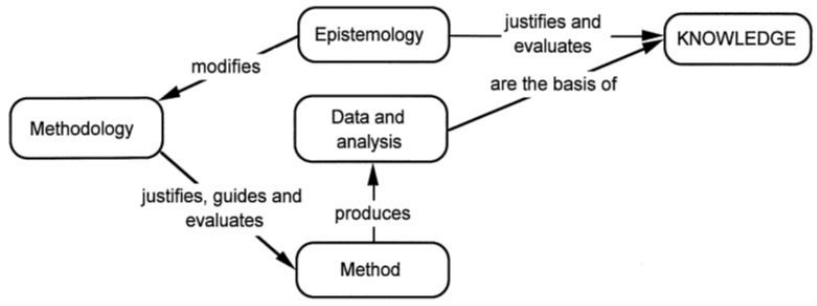


Figure 3 The simple relationship between epistemology, methodology, and method (Carter and Little, 2007 p1317)

The following section will detail the components which make up the research process, and discuss how they fit together to address the research question.

3.4.1 Epistemology

Epistemology is the “study of the nature of knowledge and justification” (Schwandt, 2001, p. 71), and is concerned with the nature of reality and how knowledge is constructed (Baillie, 2003) rather than belief or opinion. Epistemological inquiry explores the relationship between the knowledge and the knower to question how the world is understood (Denzin and Lincoln, 2000). Epistemology underpins methodology which in turn directs, evaluates,

and provides a justification for the choice of methods (Carter and Little, 2007) which are the practical aspects of research such as data collection and management (Carter and Little, 2007).

3.4.2 Methodological approach

Methodology is concerned with the approach the researcher takes when establishing what constitutes knowledge, and provides a set of rules with which to create understanding of a phenomenon (Daly, 2003).

This study takes a qualitative approach which is a type of inquiry that supports an exploration of the social world and an understanding of the social processes and relationships that occur within specific contexts (Mason, 2002). It employs flexible methods responsive to the social context in which data are gathered, and produces a rich, detailed, contextualised, and complex understanding of the focus of inquiry (Mason, 2002). The qualitative research approach aims to determine the meaning that people make from their world and the actions within it, and is an approach which values individual perspectives, and their experiences (Merriam, 2009.)

A qualitative approach is appropriate for this study because it explores a wide variety of views and

perspectives from a diverse range of stakeholders involved in volunteerism in dementia and acute hospitals. This is important because of the need to understand the social world from a range of perspectives, namely those who are involved in volunteerism in this setting.

3.4.3 Philosophical underpinning of the study

The philosophical position underpins the research process and gives context to the findings. Ways of determining a philosophical approach include identifying the purpose of the research, understanding what is meant by ‘truth’, the appropriateness of the methods, and the role of the researcher (Rubin and Rubin, 2005).

With these points in mind, the purpose of this study is to explore the experience of volunteering in dementia and acute wards to discover the understandings of those involved. To achieve this the researcher becomes key as they use an exploratory, inductive, and non-uniform approach to gathering these perspectives. The researcher is also recognised as having their own views and perspectives and as such will inevitably affect the production of knowledge as they co-construct accounts with participants through the interview process and strive to make sense of these accounts.

Traditionally, a systematic approach to discovering knowledge, or truth, has been underpinned by a positivist philosophical approach which believes that only information provided by the senses, such as objective observation, can result in scientific knowledge. Positivism values transferable, universal, observable facts (Bogen, 2014), and holds the assumption that activity and phenomena under investigation exist independently of human perceptions and understanding (Rubin and Rubin, 2005).

However, in naturalistic research, which is the study of real-world events as they occur naturally and involves the researcher being open to what they find (Patton, 2002), the researcher does not seek a single objective ‘truth’ but acknowledges that humans do not have a single shared understanding. In fact, previous experiences, understanding of social norms, gender, and class contribute to a person’s perspective on the world in which they live and subsequently influences the meaning they make of it. The aim of naturalistic research is to seek knowledge through acknowledging and valuing these different perspectives and paradigms which influence and shape understanding, and the researcher is then able to build a portrayal of the collective meaning made by participants (Rubin and Rubin, 2005). One way to

achieve this is an interpretivist approach which affirms that multiple realities are constructed to produce knowledge which is derived through an understanding of the specific context, and through the interpretation of the individual. It recognises that individuals construct meaning which is socially and culturally bound in a specific context (Berger and Luckman, 1967). Interpretivism also recognises that knowledge is socially constructed through the relationship humans have with the external world, acknowledging that individuals do not construct meaning in isolation, but as a result of shared practices and language (Schwandt, 2001). This is known as constructivism which acknowledges the researcher's involvement in the co-construction and analysis of data from the shared accounts with participants, recognising that knowledge and learning is embedded in the social world and is a result of shared and co-constructed understanding (Charmaz, 2014). It is anticipated that including a variety of stakeholders involved in volunteerism in dementia and acute hospital wards will add depth and breadth to the findings as it harnesses many perspectives from people engaged in different aspects of volunteerism.

3.4.4 Patient and public involvement (PPI) in study design

It is recommended that researchers should collaborate with service users when designing and undertaking research (Staniszewska et al, 2011). A proposal for the study was presented to the University of Nottingham's Dementia, Frail Older Persons and Palliative Care Patient and Public Involvement (PPI) group for consultation in the planning and development of the research design in February 2016. Their involvement changed the study design to include interviews with people with dementia or memory problems, and carers because they unanimously agreed that the study should include their accounts.

Despite the challenges of interviewing vulnerable people with dementia or memory impairment, there is an increased demand for their wider inclusion in research. Caldwell (2013) questions how people with intellectual disabilities can inform the production of knowledge if they are not involved in research. Recommendations from a study of 387 interviews of frail older people showed that expectations of problems of interviewing frail older people were not realised but with careful planning high response rates can be achieved (Peel and Wilson, 2008).

Throughout the study, members of the Patient and Public Involvement (PPI) group at the Institute of Mental Health, University of Nottingham, were also consulted in September 2016 and October 2017 on a variety of different designs of all the documentation aimed at patients (including patient information sheets, posters, and flyers) (see appendix 2). I subsequently received valuable feedback about the type of information people with dementia and memory impairment might need in order to decide whether or not to participate in this study. This included improving the appearance of the documents such as avoiding the use of clinical language, and using bullet points. With their permission, this information was recorded as a written account, and feedback was considered for continued development throughout the project. Particular attention was given to the presentation and layout of the documents as the feedback from the group judged the original prototype documents to be too clinical, unclear, and potentially off-putting for people with dementia or memory impairment. In addition a booklet format was rejected as the group thought it might be too fiddly to open for some older people with hand-eye co-ordination, or dexterity problems. A simple full page format was used and the content altered to incorporate feedback from the group. In

short, large print, and easy to read and understand information was used and the group preferred an easy to handle version over triple folded leaflets.

3.5 Research methods

Methods refer to the modus operandi involved in the collection and analysis of data. This section will explain and justify the reasons for the choice of methods by discussing advantages and drawbacks. The chosen methods will begin with a consideration of interviews and dyadic interviews, and move on to discuss reflective diaries.

Despite the potential difficulties of interviewing acutely ill patients with dementia, I was interested in hearing their accounts.

3.5.1 Interviews

The range of interview participants included managers, ward based staff, volunteers, former volunteers, patients with dementia or cognitive impairment, and carers. Interviews are purposeful conversations which aim to collect information about a particular topic (Leonard, 2003) by accessing the thoughts and perspectives of

participants. Interviews can be structured, semi-structured, or unstructured, where open ended questions are asked of the participant with the help of a pre-prepared interview guide (see Appendix 3).

While structured interviews are used in quantitative research to collect responses suitable for statistical analysis, a qualitative research interview can be less rigid in its approach. The purpose in this case is the co-construction of data between the interviewer and participant. Indeed, Brinkman and Kvale (2015) use the analogy of the researcher being either a miner, or traveller, when engaging in qualitative interviews with participants. This useful analogy facilitates an understanding of the epistemological stance and value of interview data. By using these metaphors we can understand that knowledge is seen as not merely mining for a nugget of buried truth, but as a journey to another place which involves exploring the landscape and telling the story upon return.

Interviews have several advantages. Mason (2002) catalogues the strengths of interviews in qualitative research as it allows access to the understandings and experiences of participants, sheds light on how social processes work, and the importance of meaning by giving

them an opportunity to share their own accounts. Interviews can be a powerful tool which allows the researcher to investigate the views of participants in greater depth (Kvale, 1996), and explore the construction and negotiation of meanings as participants consider and share their interpretation of the setting (Cohen, Manion, and Morrison, 2018). They allow for flexibility and clarification and a consideration of the nonverbal aspects of communication (Leonard, 2003). Interviews are interactive, and so afford the researcher the opportunity to modify the approach and probe the participant to pursue interesting lines of inquiry which facilitates broadening the scope of understanding (Kvale, 1996). Lastly, gestures and facial expressions can contribute to the understanding of accounts which a written account alone would not provide.

However, aside from the practical challenges of conducting interviews such as issues around cost, time, and privacy, there are methodological difficulties. These include the possibility of a recording device inhibiting the participants from opening up (Bassett et al, 2008), and difficulties around interacting throughout the duration of the interview as both participants and the researcher may have expectations and preconceived notions of each other. It is possible that there may be issues around

power dynamics, especially in view of the likelihood that participants from a range of backgrounds will be interviewed. This is of particular relevance to all groups of participants in this study because of the possibility of perceived power dynamics whereby the interviewer or interviewee may perceive the other to be in a position of more or less authority than themselves.

With this in mind, participants were invited to choose where they would prefer to be interviewed with the anticipation that the majority of managers would prefer their own office space; ward staff, carers, and volunteers might prefer a private room on the ward or the university, or patients' and carers' own home. This afforded a degree of choice and autonomy on the part of the interviewee, and served as a way to address concerns over the potential for power dynamics to influence the collection and quality of the data.

The personal characteristics of interviewers, such as age, gender, race, ethnicity, and general appearance, can influence the responses given by participants (Parahoo, 1997). There is also the possibility that participants may decide to give partial, sanitised accounts, or give socially desirable responses in order to appear virtuous and present themselves in an advantageous light (Parahoo,

1997). An example of this is a study considering the impact of the professional backgrounds of researchers which found that participant responses seemed to be related to their knowledge of the interviewer status (Richards and Emslie, 2000). Those participants who were informed of the researcher's status as a General Practitioner (GP) gave a favourable account of their experiences, whilst when the GP was introduced as a sociologist, more negative accounts of the GP consultations were given. Much is dependent on the interview skills of the researcher as they pursue a variety of techniques to elicit accounts which may often be contradictory and reveal the distinctions between 'public' and 'private' accounts (Cornwell, 1984).

Despite the potential drawback, interviews are valued as a method for listening (Miller and Glassner, 1997) and an opportunity to see the world through the perspective of the participants (Glassner and Loughlin, 1987), and therefore a suitable way to access participant's unique accounts. Because of the exploratory nature of the research, semi-structured interviews were chosen.

3.5.2 Dyadic interviews

In addition to managers, ward staff, current and former volunteers, and carers taking part in one to one semi-

structured interviews, patients with dementia and carers were interviewed as a dyad. Dyadic interviewing is a qualitative approach that recognizes the nature of interdependency in relationships between individuals (Caldwell, 2013) and consists of two participants interacting as a pair in response to open ended research questions (Morgan et al, 2013). Dyadic interviews are described as sitting somewhere between individual interviews, and focus groups (Morris, 2001). They are unique in that they consist of two individuals making up the dyad as both are connected in some way, be it through a relationship or the sharing of a common experience (Kenny, Kashy, and Cook, 2006). In this case the dyads comprise a patient with dementia who has been hospitalised, and their unpaid carer, who could be a family member or friend. The co-constructed perspective resulting from dyadic interviewing has the potential to add a richness to the data by creating a shared account (Eisikovits and Koren, 2010). Participants are also reported to find joint interviewing acceptable (Seymour, Dix and Eardley, 1995) particularly when one of the dyad is in poor health. While one to one interviews provide an opportunity for participants to share information they may otherwise have withheld in a public arena, dyadic interviews have the advantage of giving both participants

within the dyad the opportunity to stimulate ideas that may not otherwise have been recalled, and so co-construct accounts together (Morgan et al, 2013). Furthermore, dyadic interviews present an opportunity for participants to feel supported by another person with whom they have a relationship (Shakespeare, Atkinson and French, 1997). This is pertinent for this part of the study which aims to explore the perspectives of patients with dementia.

However, there are limits and critiques of dyadic interviewing. Caldwell (2013) criticises the notion of vulnerable people needing protection and support, seeing such attitudes as being negative, perpetuating the socially constructed notion of intellectual disability and contributing to the belief that people living with these problems are unable to participate in research without such support; a point of particular relevance to this study as the patient participants were hospitalised. In addition, Pratt (2002) highlights that not all people with dementia have good relations with their carers and suggest that one to one interviews with people with dementia should be considered as well as dyadic interviews. Furthermore, this method presents an ethical challenge in that each partner may reveal information they may otherwise not have chosen to disclose outside the arena of the

interview context. It is possible that each member of the dyad may be cautious of what they say in front of the other, with carers in particular, protective of the person with dementia (Cridland, Phillipson, Brennan-Horley et al, 2016).

With this critique in mind, the patients who were invited to participate in this study were older, frail, had dementia or cognitive impairment, and had been hospitalised for the treatment of an acute illness, and so the opportunity to access the support of carers was judged to be reasonable and appropriate. Taylor and Vocht (2011) in their consideration of one to one interviews and dyadic interviews, conclude that combining both approaches will lead to a richer understanding. Consequently, dyadic interviews provide a useful and advantageous alternative to accessing data from one to one interviews alone.

3.5.3 Diaries

Following the completion of the semi-structured interviews, currently active volunteers were invited to record their thoughts in a reflective diary as a way of triangulating the data and to capture detailed and personal accounts of volunteers over a period of time.

A diary is ‘a document created by the individual who has maintained a regular, personal and contemporaneous record’ (Alaszewski, 2006; p1). Diaries are used as a research tool for participants to regularly complete a first hand, detailed, and contemporaneous account with the intention of capturing experiences and events over a period of time (Symon, 1998).

Diaries feature in the design of this study because they augment the use of interviews to provide a way to explore how volunteers work with patients with dementia within the multi-disciplinary team, and explore the reasons why they continue in the role. They present an opportunity for participants to record an intimate description of daily life, providing a way of capturing data that may not be accessible via other methods (Moule and Goodman, 2009). In view of the prolonged period of time taken to record their thoughts, diaries afford a unique insight into the self-reflections of volunteers (Hinsliff-Smith and Spencer, 2016). They offer a flexible way to collect data and identify patterns of behaviour to shed light on how individuals interpret and give meaning to events with minimal intrusion (Alaszewski, 2006). Diaries have been recognised for their cathartic effects as they provide a safe and empowering method for participants to share experiences (Meth, 2003).

However, some participants may not wish to divulge personal and sensitive information (Moule and Goodman, 2009). The completion of diaries as a research tool has been criticised as being unreliable because of differences in the consistency of recordings between participants, and differences in the interpretation and meaning (Stewart, 1991). Yet, this criticism is not specific to diaries alone as a way of capturing the experiences of participants and could be directed at other methods of data collection. Diaries may also exclude those who are unable to read or write, have communication difficulties, or do not speak the language required for the study. Burns and Grove (2005) recognise that those with superior writing skills may be over represented in research using diaries, and this may impact on the findings. Where the diaries are recorded in illegible handwriting, contain misspellings and colloquial language, there is the potential for the researcher to misinterpret the data. This can be addressed by exercising caution not to alter or 'tidy up' the raw data so meaning is not lost (Nicholl, 2010). Some participants may not wish to keep a diary; they may be seen as time consuming because of the length of time required to capture sufficient data, and the need for researchers to

maintain regular contact with participants to provide support and encouragement (Corti, 2003).

Nevertheless, diaries have the potential to provide a rich source of data to explore lives, activities, and relationships, and are a cost effective method of data collection. Diaries complement interviews as a method of data collection because of the aim to access the meanings people attribute to the social world in which they interact, and the understandings they have of their experiences within it.

In summary, this section presents a consideration of the proposed methods, and provides an explanation as to why interviews, dyadic interviews, and reflective diaries were chosen as the preferred design. While acknowledging the limitations, the methods are considered suitable to answer the research question in a practical, suitable, timely, and meaningful way.

3.6 Research setting, access, sampling, selection, and recruitment

3.6.1 Research setting

The study setting is a 1,700 bed teaching hospital in England which provides services to over 2.5 million

residents. The wards specialising in the acute medical care of older adults aged 65 years and over total 8 in number and include a dementia specialist ward which provides specialist care to patients with dementia and delirium admitted to the hospital as a medical emergency. There is a high prevalence of dementia, with 50% of admitted patients over 70 found to be cognitively impaired (Goldberg et al, 2012). Volunteers are regularly allocated by the voluntary services management team to work on each of the wards.

This research setting was chosen because it fulfils the criteria for meeting the research aims and objectives. There are sufficient numbers of older person general medical acute wards, the presence of a dementia specialist ward, and an established and dynamic voluntary services department.

Initially, the aim was to access two wards with high and low levels of volunteering activity. This was to explore reasons around different levels of activity on each ward. Therefore, discussion with the voluntary services management team to determine wards with low and high levels of volunteer activity enabled two wards in the hospital to be chosen. However, the low levels of voluntary activity meant there were insufficient numbers

of volunteers available to invite to participate in the study. Therefore, being granted permission to access the remaining wards enabled further recruitment of participants.

3.6.2 Access to participants

Establishing relationships with key stakeholders is crucial to successful recruitment. Despite having formal approvals in place it is also necessary to build relationships with ward staff to smooth the transition into the field. Gatekeepers, or those individuals who are in a position in the organisation to enable or impede the researcher's access to the study site (Benton and Cormack, 2000) were identified. In order to demonstrate my credibility as a researcher and provide reassurance that data collection would be sensitively and ethically managed, good communication, an understanding of their busy workload, and an expressed intention to collaborate and be advised by them were key to furthering the recruitment process. Gatekeepers were identified as management, voluntary services management team, ward staff, clinicians, and carers.

Clinical managers were approached in the first instance to offer an introduction and provide information about the research in order to gain access. I presented the

research project to the medical team on several occasions, and planned to present at meetings held by ward managers to raise awareness. I established relationships with members of the voluntary services management team at the beginning of, and throughout the study, which proved invaluable as they were able to give information sheets to all volunteers who were leaving the organisation. Furthermore, carers were identified as gatekeepers as many were concerned about the effect on the patient if they took part in an interview; some declined the invitation to participate on the grounds that they felt it may cause patient distress and further confusion. Therefore, I planned to visit wards on a daily basis in order to establish relationships prior to recruitment.

When accessing the field, Feldman, Bell and Berger (2003) discuss the analogy of doors which they describe as a relational process, not only entering the field, but relational and continuous where the researcher must develop and maintain relationships once there. They highlight that access does not simply involve opening one door to access participants, but a series of doors which must appear interesting enough to potential participants to prompt them to open to discover what is on the other side. Similarly, Benton and Cormack (2000) warn that approaching participants can be time-consuming and

emphasise that the way potential participants are approached will have a significant impact on their decision to be interviewed. They recommend an unhurried style and giving people ample opportunity to ask questions and find out more about the study. Additionally, Fontana and Frey (2000) recommend that researchers should decide how to present themselves, spend time working on gaining trust, and establishing rapport, and understand the language and culture of the respondents.

3.6.3 Sampling

With the aim of targeting a specific, predefined population, participants were selected using purposive sampling whereby the participants are judged to be suitable (Robson, 2011) because of the likelihood they will give information-rich accounts about the subject being explored (Patton, 2002), and the inclusion/exclusion criteria was designed with this suitability in mind. Opinions vary over the number of participants needed for qualitative studies (Baker and Edwards, 2012). There are no rules for determining sample size in qualitative research (Patton, 2002). The researcher seeks adequacy of the sample rather than generalisability or representativeness (Charmaz, 2014). The justification of

sample size is also dependent on the emerging findings, as well as the approach and type of analysis, specifically an iterative process to coding and analysis and the use of themes (Charmaz, 2014). The characteristics of participants, deployment of triangulation, the quality of data, and depth of analysis become more pertinent to addressing the research question than the quantification of sample size. In qualitative research, questions around sample size can be misleading as the aim is to understand complex human issues rather than a focus on the generalisability of results (Marshall, 1996). The notion of theoretical saturation (Glaser and Strauss, 1967) whereby the researcher collects and analyses data until no new insights are obtained is unhelpful in the design stage as researchers cannot at the outset anticipate the sample size needed to achieve theoretical saturation (Bryman, 2012).

With these points in mind, and in view of the need to gather a diverse range of perspectives across a range of participant groups, a total of 66 participants were planned at the design stage. However, Sandelowski (1995) warns the researcher that deciding on a planned number of participants beforehand may hold little analytical significance. Morse (1991) recommends the method for sampling in qualitative research must be both appropriate

(in that the participants fit the research question and the purpose of the study) and adequate (in that the data is of sufficient amount, is relevant, complete, and of good quality).

To illustrate this point, during the period of data collection, more managers came forward to be interviewed than was originally planned. It was important to consider their involvement as the findings from the data already collected showed that the management of the voluntary service was of short duration and the role appeared to be an extension to existing management responsibilities. As such, these findings guided the recruitment of more managers than was originally intended. Furthermore, it became clear that some groups were more difficult to recruit than others, namely patients, carers, and former volunteers. Therefore, based on the scope and nature of this study, the quality of expected data, and study design (Morse, 2000), this guided the recruitment of participants to collect sufficient and appropriate data after the inclusion of a total of 43 participants which was judged to be an adequate number to allow for a diverse range of perspectives, and was feasible within the scope of the project. This meets the criteria stipulated by Kvale (1996) that when undertaking qualitative research interviews,

sufficient interviews should be conducted with adequate participant numbers to obtain the necessary information.

The number of participants was sufficient to ensure homogeneity in the sample because they were from a specific area and were involved in volunteerism, yet were recruited from sub groups within the area which also afforded a degree of heterogeneity (Patton, 2002) and so comprised a comprehensive range of perspectives across a diverse population. The final number of participants recruited was as follows:

- Management (n=8)
- Ward based staff (n=11)
- Volunteers (n=14)
- Former volunteers (n=1)
- Dyads (Patients and carers) (n=2)
- Individual carers (n=5)
- Total number of participants (n=43)
- Total number of interviews (n=41)

Additionally, following the interview, currently active volunteers consented to record their thoughts in a reflective diary (n=8).

3.7 Selection

Inclusion criteria were established for all groups as follows:

3.7.1 Management

- Currently working in management role in the organisation in the capacity of either a member of the trust board, voluntary services management team & hospital charity, ward manager, or matron.

3.7.2 Ward based staff

- Currently working on hospital acute medical wards specialising in the care of older adults in the capacity of permanent members of staff, agency, or locum staff

- Doctors at all grades, registered nurses, healthcare assistants, physiotherapists, occupational therapists, and ancillary staff (such as food service assistants, and domestics).

3.7.3 Volunteers

- Volunteers at all stages of their role on hospital acute medical wards specialising in the care of older adults in one designated hospital.

- Minimum of 6 months volunteering experience
- Aged from 18 years with no upper age limit.

3.7.4 Former volunteers

- Volunteers aged eighteen and over with no upper age limit, who have previously volunteered in this area but have left the organisation within the previous 24 months.

3.7.5 Patients

- Male and female
- Over 65 years with no upper age limit
- Acute admission to an acute medical hospital ward specialising in the care of older adults, with no limitations on diagnosis.

In an attempt to adopt an inclusive approach and maximise the opportunity for patients to participate in this study, identification of participants was not solely restricted to those with a diagnosis of dementia. Sampson et al (2009) highlight that only 50% of hospital patients with dementia have a diagnosis at the time of admission. Therefore, relying purely on diagnostic tools would have excluded potential participants and

harnessing their perspectives. Subsequently, memory impairment was defined as ‘memory problems including difficulty recalling time, place and person but able to hold a conversation’.

3.7.6 Carers

- Carers were defined as a family member or friend (in an unpaid position) who has regular contact with the patient participant for at least one hour a week (Bradshaw, Goldberg, Schneider et al 2012) and is the main person responsible for their care.

3.7.7 Exclusion criteria

Participants were excluded if they were:

- Patients who were acutely ill, unconscious, in extreme pain, or likely to die while in hospital.

- Patients or carers unable to read and speak conversational English.

- Carers, family or friends who were employed in a paid position.

- Anyone who was unwilling to give informed consent to participate.

3.7.8 Recruitment

Managers were approached by means of paper and email letters of invitation, and personal contact. Those who expressed an interest were asked to contact me directly by telephone, email, post, or in person.

Ward staff, volunteers, patients, and carers, were recruited via the wards. Information was displayed in ward communal areas, and ward staff were consulted as to suitability criteria of patients and carers. Potential participants were identified by ward staff who asked them if they were interested and offered an information pack. They were informed by the member of staff that I would return the following day, or they could contact me by reply slip into a designated box, telephone or email. They were able to take as long as they liked to consider the information about the study and to decide if they wanted to take part.

Former volunteers were recruited via the voluntary services management teams. Approximately 300 leavers from the Healthcare of the Older Person wards (HCOP) wards were asked if they wanted to take part as they left the organisation, and offered information packs. They were given the option of contacting me directly by telephone, email or by post using the reply slip and pre-

paid envelope, I received only four reply slips declining the invitation to take part, and one former volunteer contacted me to be interviewed.

3.8 Data collection

The key aims and objectives of the interviews and diaries are to gain access to the perspectives of participants of their experiences of volunteering to support dementia care in acute hospital wards.

3.8.1 Interviews

Information from the literature was used to identify questions and inform the interview guide. Each group of participants had a specifically designed interview guide (appendix 3) tailored to achieving the aims and objectives. Topics were introduced to facilitate prompts and probing for further information to facilitate semi-structured interviewing. All interviews were conducted in a private room. Participants were given the choice of venue, either in the university, hospital, or patient's own home, and a mutually convenient time. When inviting participants to the university I aimed to put them at ease by taking time to chat, providing drinks and making sure they chose where to sit when we entered the room. I

waited until they appeared settled before I turned on the recorder and asked their permission to take notes.

Some of the managers preferred to be interviewed in their own office. Many of the ward staff found it convenient to conduct the interview in a private room on the ward although two members of ward staff chose to be interviewed in the university. All volunteers opted to be interviewed in the university.

One of the patient participants was interviewed in her own home whereas the other patient preferred to be interviewed in their side room while an inpatient. In view of the anticipated difficulties in accessing the accounts of people with dementia or memory impairment, introductory statements and ‘warm up’ questions were used to set the scene and enhance their confidence. In addition, the terminology used to describe their condition was established beforehand by engaging in conversation prior to the interview itself and using their preferred terminology as well as value neutral language; a flexible approach was adopted; single topic questions were devised to ensure focus and minimise confusion; there was a progression from straightforward to more complex and searching questions; and visual aids were employed (Cridland, Phillipson, Brennan-Horley et al, 2016) to

maximise recall for patients and carers. These consisted of large, clear photographs of volunteers, and patients were provided with a volunteer uniform to see and feel.

3.8.2 Diaries

At the end of their interview, active volunteers were invited to keep a diary in which to record an account of their volunteering activity and thoughts around their experiences.

Instructions on diary keeping, and written information in the diary itself, included a short period of training which provided participants with guidance on how to complete it. Volunteers were asked to record their reflections for a period of one month, or for eight shifts. An open ended approach was encouraged in an attempt to capture variation in writing styles and content (Symon, 1998). Volunteers were asked to record their entries as soon as possible after their shift, and were given the option to keep the original diary at the end of the study. They were asked to include factual data, significant incidents, and personal interpretation (Denscombe, 2010).

The diary itself was a plain, lined, ring bound format which allowed participants the freedom to record their perspectives, and the opportunity to remove pages if

necessary. An unstructured format was used which enabled the participants to express their account without the constraint of a preordained framework (Hinsliff-Smith & Spencer, 2016). Once volunteers had made contact to agree to participate, clear written and verbal instructions were given. It is recognised that participant fatigue can be problematic in gathering diary data, with the possibility that diaries may be returned incomplete (Moule and Goodman, 2009). Therefore permission was requested from the diarists to meet at weekly intervals to offer support to encourage them to continue, and so minimise the likelihood of participant withdrawal (Stone, Kessler and Haythomthwatte, 1991). Diarists were also invited to make contact throughout the period of diary keeping if they experienced any problems or had any questions. Weekly meetings took place on the wards at their shift time by prior agreement, with the aim of providing volunteers with an opportunity to talk about their diaries. This proved useful in building a relationship based on trust and cooperation, and some volunteers expressed a wish to continue meeting even after all the diaries had been completed. The regular meetings were also useful at the beginning of the data collection period because it emerged that some diarists appeared to lack confidence when recording their experiences, and would describe

events during these meetings in an attempt to gain 'permission' to record them in their diaries. This was recorded in a field diary and complemented the written records received.

Of the fourteen active volunteers interviewed, six declined the offer of keeping a diary. One volunteer declined on the grounds that keeping a diary would detract from the enjoyment of her voluntary activity, claiming it would change the freedom and spontaneity of the role. Other reasons given were that volunteers were too busy, did not have time, felt that they had no further information to share, and did not like writing things down. In recognition of the potential for excluding participants on the grounds of their literacy and language speaking skills, the option for audio and electronic diaries were offered. No participants chose an audio format but some preferred to return their diaries electronically via word document or email.

3.8.3 Exiting the field

On completion of the research the goal is to exit the field with good relations with all key stakeholders and with findings which contribute to the body of knowledge (Steane, 2004). However, in practice this became less straightforward as I reflected on my own feelings in

general, and on my feelings towards some of the volunteer participants in particular. During the weekly visits it emerged that some diarists were becoming reliant on these meetings for social contact, having spare time to fill. As such it became clear that our meetings were filling their need for social contact despite the duration of diary keeping having come to an end. One volunteer in particular spoke about his social isolation and loneliness, which was the reason why he volunteered. I found myself becoming concerned about his welfare over and above the boundaries of the researcher role, which I realised had the potential to present difficulties on exiting the field. Following expert advice from the supervisory team, I managed this by carefully preparing myself, and the participant, by gradually withdrawing from the field and giving him plenty of notice that the weekly visits would come to an end. I also gave him several information sheets about further opportunities in volunteering and research, to maximise his opportunity for further social contact, and made myself available to be contacted in the future should he wish to discuss any aspects of the research.

Exiting the field was unproblematic in other respects as participants were aware that the interviews were of

relatively short duration, a once only event, and they had other commitments on their time.

Having detailed the study design, the following section will describe how the trustworthiness of the research was optimised.

3.9 Optimising the trustworthiness of the research

This study aims to provide a rich, contextualised account from a variety of stakeholders of their perspectives and experiences of volunteering in dementia care in acute hospital wards using more than one method of data collection. Guba (1981) details four criteria which show how trustworthiness can be demonstrated in qualitative research; namely, credibility, transferability, dependability, and confirmability.

3.9.1 Credibility

Credibility refers to the degree of confidence and assurance the researcher can demonstrate to show that the data have not been misrepresented and are not misleading, and the extent to which they can present an account which shows confidence in the accuracy of the research (Guba, 1981). The credibility of the findings in

this study is demonstrated by using more than one method, or triangulation, which provides an additional interpretation of meaning rather than confirmation (Flick, 1992). One to one and dyadic interviews were used alongside diaries, to collect another layer of data, aiming for the accounts to be sufficiently rich and detailed to facilitate an in-depth understanding (Denzin and Lincoln, 2000; Fine et al, 2000). Triangulation of data sources is also demonstrated by seeking out multiple perspectives from various stakeholder positions to access diverse viewpoints (Denzin, 1978; Patton, 1999).

3.9.2 Transferability

Transferability relates to how applicable the findings might be to other contexts (Guba, 1981). By providing sufficiently rich, thick, and contextualised detail, the reader is then able to determine the relevance of this study and the findings to those of other settings.

3.9.3 Dependability

Dependability relates to the consistency of findings and the extent to which the study could be repeated by another researcher without necessarily achieving the same results (Guba, 1981). This is demonstrated by providing a clear description of the research process in

sufficient detail, keeping analytical memos and meticulous documentation.

3.9.4 Confirmability

Confirmability refers to the role of the researcher in influencing the research by considering the degree of impartiality and neutrality in the findings to ensure the research is of good quality (Guba, 1981). An audit trail was established which describes each step of the data analysis stage and provides a rationale for each decision made throughout this process.

In qualitative studies, the researcher becomes an instrument of the process (Janesick, 2000), and as such their skill and insight is seen as a strength (Guba and Lincoln, 1981). Miles, Huberman, and Saldaña (2013) emphasise the danger of researchers being too close to their subject in terms of posing a threat to the trustworthiness of the research.

This was potentially problematic for me having worked as a Registered Nurse in older person acute care for a considerable length of time. To address this I participated in regular debriefing with the supervisory team, and sharing the transcripts and raw data with them (Janesick, 2000) to ensure the data analysis was discussed and

considered from more than one perspective (Creswell and Miller, 2000).

The following section will continue in this vein to describe reflexivity, and the role of the nurse researcher.

3.9.5 Reflexivity and the role of the nurse researcher

This section will discuss the impact of the role of the researcher which requires special consideration when seeking to demonstrate rigour because of the nature of the dual role. Leslie and McAllister (2002) highlight the benefits of this dual role, that of a Registered Nurse and researcher, suggesting that nurses develop skills to facilitate the research process. Also the background knowledge and socialisation of nurses is argued as being positive as nurse researchers investigate settings in which they are familiar (Bonner and Tolhurst, 2002). However the ease by which some nurses may be able to fit into this setting has also been highlighted as problematic, not least in terms of the level of involvement the nurse researcher should undertake (Borbasi, Jackson, and Wilkes, 2005) but also the emotional impact of the setting on the researcher (Pellat 2003). There may be difficulties managing the dual role of nurse and researcher (Gerrish 1997); the nurse researcher may

experience role conflict when conducting research (Baillie, 1995); this may include nurses who are socialised into the hospital culture, they fail to see the significance of the taken for granted.

It is argued that it is impossible to set aside one's own frame of reference and that this process of detachment is neither practical nor beneficial (Heidegger, 1962). Rather there is value in embracing one's position to arrive at an interpretation rooted in context, and from an openly articulated standpoint (Gearing, 2004). A more honest and effective approach is for the researcher to acknowledge and embrace their world views and encourage a personal awareness of self which brings the researcher into the process. This process, known as reflexivity, involves the researcher seeking transparency by striving to exercise critical self-awareness, self-analysis and conscious reflection; and recognises how their interactions with participants and subsequent analysis of data may affect the interpretation of information (Green and Thorogood, 2014; Polit and Beck, 2014). It gives the researcher the necessary opportunity to reflect and report on how their interactions with participants and their relation to the research itself, assumptions, interests and position have a bearing on the research (Charmaz, 2014). This approach is important

because the researcher's background is widely recognised as having an effect upon the topic of investigation, methods, findings, and how conclusions are arrived at (Malterud, 2001). The researcher is recognised as a tool of the qualitative research process (Patton, 2002), and as such the analysis and interpretation of the data is filtered through the lens of their paradigm of understanding. This is impacted upon by language, social class, gender, ethnicity, and race (Denzin and Lincoln, 2000).

Therefore, by exploring our own beliefs and understanding, developing a sense of self-awareness, articulating their standpoint, and recognising that any such knowledge produced is not right or wrong, there will be a development of understanding (Denzin and Lincoln, 2000).

Furthermore, I underwent a process of self-examination by keeping a reflexivity diary which proved invaluable in prompting my thought processes to pursue different avenues of inquiry, and to question my own perspective. I also completed courses on qualitative methods, philosophy, interview skills, further qualitative research, and attended an unconscious bias workshop in an attempt to widen my perspective and self-awareness.

Furthermore, verbatim quotes to illustrate analysis were used in the final report to demonstrate transparency (Howitt, 2013).

This is of particular relevance to this study as I am a Registered Nurse with several years of experience working with frail, older people with dementia, and volunteers in acute hospital wards, and now a novice researcher. In the pursuit of rigour, and instead of attempting to ignore my previous experiences, I chose a reflexive approach whereby I was able to articulate and acknowledge my standpoint and perspectives. The personal reflective journal (Finlay and Gough, 2003) used throughout the study used Gibbs' reflective cycle (1988) as a framework to facilitate critical self-reflection. The journal served to record personal reflections and thoughts in relation to each stage of the research journey, particularly analysis. I wrote a comprehensive account of past activities in relation to volunteers and discussed this with the supervisors throughout the study in an attempt to be as open as possible about my personal perspectives and feelings. I also withdrew from working as a clinician throughout the duration of the study in an attempt to distance myself from the nurse role and immerse myself in the role of researcher.

As I intended to interview managers, some of whom hold powerful positions within the organisation and others who are also gatekeepers in a position to allow or deny access to other groups of participants, I reflected on the potential outcome of this and how this may affect the co-construction of accounts during the interview and subsequently affect the quality of the data. On the other hand, there were some participants who may have felt that the position of researcher held a certain position of authority, not least because of the perceived surveillance nature of the role, and may have tailored their responses accordingly when presenting their accounts. Furthermore, I recognised the previous experiences I had had with volunteers through my work as a Registered Nurse, and sought ways to challenge my views in the realisation that these may introduce issues around the quality of the research. In view of this, I spent time reflecting on my previous experiences and actively looked for ways to explore possible drawbacks to volunteerism rather than focus on the positives. This included searching the literature for negative issues around volunteerism in a range of contexts and served to readjust my focus.

3.10 Ethics

This section will address the ethical considerations of the study, including the ethical review process.

3.10.1 Ethical review process

University sponsor approval was agreed on 16th November 2016 (Ref: RGS 16095) and public liability insurance obtained (see Appendix 4). A favourable ethical opinion was granted by Yorkshire & the Humber - Bradford Leeds Research Ethics Committee on 13th January 2017 [Ref: 16/YH/0498] (see Appendix 4). Health Research Authority approval was granted on 3rd February 2017 (see Appendix 4). Local site specific approval was also granted by the Hospital Trust Department of Research and Innovation on 14th February 2017 (see Appendix 4). In addition to the necessary approvals, verbal approval was sought from the matron and the managers of each ward as a matter of courtesy and to ensure the smooth running of the project.

3.10.2 Ethical considerations

Further ethical considerations included issues around confidentiality and anonymity, the positionality of the researcher, duty of care to participants, and the

management of data. The ethical considerations are relevant to all participants, with particular focus on people with cognitive impairment.

The ethical principles of autonomy, beneficence, and justice underpin the research process in order to protect and maintain the rights of the research participants (Orb, Eisenhauer and Wynaden, 2001). Ethical models provide broad frameworks which help researchers to reflect on ethical issues (Edwards and Mauthner, 2008). These include a deontological model which focusses on intention rather than consequences; the utilitarian model focusses on outcomes such as increasing knowledge; and virtue ethics which rely on the internalisation of ethical principles within the researcher (Edwards and Mauthner, 2008).

Additionally, the Declaration of Helsinki (WMA, 2008) is a statement of ethical principles used in medical research involving humans, and focusses on the rights and welfare of research participants. However, in the case of people with dementia, such rights and definitions of welfare become less clear, with many examples of people with dementia being excluded from taking part in research because of their dementia. Issues to consider include the ethics of epistemology and power dynamics; who decides

what constitutes knowledge, and how this decision is arrived at (Edwards and Holland, 2013).

The duty of care included being aware of participants showing any signs of distress at which point the interview would be suspended and the interviewee given the choice to continue. Careful consideration was given to protecting participants by maintaining their anonymity when writing up the final report; pseudonyms were given, and as there was only one former volunteer who came forward to be interviewed, they were included in the volunteer group to ensure anonymity.

3.10.3 Ethical considerations of involving patients with cognitive impairment in research.

Concerns over the legal, ethical and moral implications of involving people with cognitive and perceptual impairment in research have previously led to their exclusion (Cridland et al, 2016; Hellström et al, 2007). It is possible that their involvement could be further problematized by potential communication difficulties and behavioural issues such as aggression, agitation and restlessness (Tadd et al, 2011). Ethical concerns arise from participants lacking mental capacity to consent. Because

patients in this study had some degree of cognitive impairment, an assessment was made of their mental capacity to consent to participate in the study using the Mental Capacity Assessment (MCA, 2005), which protects the rights of people who lack capacity. It is possible that patients with dementia or memory loss may not have the mental capacity to consent so were assessed using the two-stage capacity assessment with the intention that consultee agreement would be sought for those unable to give informed consent (see appendix 5). Consultee agreement was not required in this study as the patients who were recruited were both assessed as having capacity.

Efforts were made to ensure informed consent was obtained in an ethical manner. This included participant information sheets, which were produced with a large font size to facilitate reading for those with failing eyesight, and a low readability score was determined to support their understanding of the text. All participants were given the opportunity to ask questions prior to consenting. They were given as long as they wanted to consider if they wished to participate in the study, with a minimum of 24 hours to decide. In addition to this, close attention was paid to the use of language when discussing dementia

with patients and carers, as I was aware that this might be a topic of considerable sensitivity.

3.11 Insider/outsider debate in relation to the duty of care

This study strives to explore the perspectives of participants from a variety of backgrounds, namely, managers, ward staff, current and former volunteers, patients with dementia or cognitive impairment, and carers in order to understand their views on volunteerism. Therefore a discussion of the ethics of interviewing a variety of participants must explore the positionality of the researcher. Positionality refers to the position of the researcher in relation to the local and wider context of the study, and can affect each stage of the research process from constructing a research question, designing a study, and collecting data, to the construction of knowledge, publication, and dissemination of findings (Rowe, 2014). This is worthy of consideration since I was employed by the organisation and subsequently had an understanding of hospital systems as well as relationships with colleagues. Research which involves colleagues can raise issues around power dynamics between those of

different status within the organisation (McDermid et al, 2014).

The notion of ‘insiders’ and ‘outsiders’ (Evered and Louis, 1981) in research refers to ‘insiders’ being familiar with the setting and having pre-existing knowledge and relationships with those within it, and ‘outsiders’ which refers to the researcher as a stranger (McDermid et al, 2014). The concept of insiders and outsiders can be further nuanced by the presence of certain characteristics, such as age, ethnicity, and belief systems, which may affect relationships between researchers and participants as this may influence how they feel about each other (Tinker and Armstrong, 2008). Either way, positionality can create challenges in recruiting and interviewing participants.

There are advantages and disadvantages to either position as an insider researcher will have knowledge and understanding of the organisation and how it works which can be advantageous in understanding the needs of the organisation (McDermid et al, 2014). However, it may be more advantageous if the researcher is unfamiliar with the setting and the social world as this may increase the potential for them to question events from a fresh perspective (McDermid, 2014).

It has been suggested that issues around positionality are less important as social researchers never fully adopt either stance (Ogilvie, Burgess-Pinto and Caufield, 2008). Indeed, the debate rests more on their ability to adopt an honest, open and authentic approach to accurately represent the experiences and accounts of the participants (Corbin Dwyer and Buckle, 2009); their ability to be open and practice reflexivity, establish trust and rapport with participants; and ensure confidentiality (McDermid et al, 2014). In the final analysis, an 'insider' position could have the potential to distort the composition of the sample, but in this case was advantageous in providing an opportunity to utilise existing relationships with key people in the organisation in order to facilitate recruitment and access areas.

3.12 Data management

Every effort was made to protect the identity of participants. Confidentiality and anonymity were maintained by anonymising the raw data during transcription of the interviews and diaries. A list of participants' names, identifier numbers, and pseudonyms, was kept in one securely stored master file. Each participant was assigned a unique identifier from which the anonymised data was analysed. Data were managed

in compliance with the Data Protection Act (1998) and General Data Protection Regulation (GDPR) (NHS Health Research Authority, 2018).

A transcription service was used for some of the interviews (n=34) and checked for accuracy. I transcribed the remaining interviews (n=7). This included the dyadic interviews with patients and carers in an attempt to minimise the possibility of innacurately transcribing the accounts given by people with memory problems and difficulties with communication. Diaries were photocopied and the content scanned and imported into the qualitative data management system NVIVO11 to manage the raw data and facilitate the process of data analysis. Resulting transcriptions were discussed with the supervisory team for guidance and clarification of techniques. The data from 2-3 participants were transcribed as a starting point. Early analysis of data alongside collection allowed me to question the approach, and find ways to collect further data to fill gaps that emerged through analysis (Miles, Huberman and Saldaña, 2014).

A professional and experienced transcription company was used for some of the transcribing. They are an associate of the University and have signed a confidentiality agreement prior to working on

transcription. The process involved checking all the raw data for any possible information which could reveal the person or location of the study site. When this criterion was satisfied, the audio files were divided into sections and sent to members of the transcription team. Then the sections were edited, timestamped, merged and proofread to ensure the text was consistent. I carefully checked the completed transcripts numerous times for accuracy, checking them against the interview recordings to ensure all transcriptions were consistent with the raw data, ensuring that nonverbal cues and subtle nuances of meaning were captured as accurately as possible, as well as keeping detailed notes to prompt recall of the interview.

In addition to this, caution was exercised when writing the thesis to ensure that participants would not be identifiable from their accounts. All participants were given pseudonyms when writing up the final report. In cases where the participant had a unique job title, a generic title was used when referring to them. There were challenges in concealing the identity of participants because of the risk of them being recognised through their accounts written in the form of verbatim quotes in the thesis. For instance, one study participant occupied a high profile position within the organisation and gave permission for

their job title to be used in the final report, but efforts were made to ensure they could not be identified from their verbatim quotes.

When presenting the results, quotes were recorded verbatim and punctuated to indicate pauses (…), and unintelligible, repeated, or irrelevant data […].

Aside from the issues already discussed around positionality of the researcher and inherent power dynamics of the interview process, there are additional ethical issues around interviewing people who may be perceived as being vulnerable by the nature of their position in the organisation, such as volunteers, or those who lack the mental capacity to consent, in this case patients with dementia or cognitive impairment. Should volunteers have required any further support in addition to the planned training and support, provisions were made for them to be signposted on to the voluntary services management team. I also reminded them they were under no obligation to continue in the study and could terminate their involvement if they wished (Travers, 2010) and this would not affect their legal rights or healthcare.

3.13 Data analysis

This section will describe the data analysis strategy and organisation of the data. Thematic analysis was chosen as a way of 'identifying, analysing and reporting patterns within data' (Braun and Clarke, 2006; p79). It was used to analyse the interview and diary data as it supports the identification, analysis and reporting of patterns within data (Braun and Clarke, 2006). It is an inductive and iterative process which takes a six stage process:

• Familiarisation with the data.

• Generate initial codes.

• Search for themes

• Review themes

• Define and name themes

• Produce the report.

Familiarisation of the data is achieved through 'immersion' which involved reading and re reading the transcripts and diaries and listening to the recordings. I constantly revisited the data and moved backwards and forwards across the entire corpus of data to increase my familiarity, assign codes, and identify themes. All the

transcribed data were coded and collated. The process of coding involved naming segments of data with a label which categorised, summarised, and accounted for each piece of data (Charmaz, 2014). The transcripts were initially coded manually, but as the volume of data increased, coding in NVIVO11 facilitated the construction of meaning of the large amount of data (Seale, 1999). The coding process involved getting a sense of the whole dataset by reading the transcripts carefully and making notes; then, when all the data had been examined, making a list of topics and forming these into groups. Finally, data were revisited frequently and recoded as new categories emerged (Tesch, 1990).

The reality of analysis proved to be time consuming and complicated not least because of the huge amount of data generated by not only the raw data, coding, and memo writing, but also a field diary, and a reflexive journal. Memo-writing is recommended by Charmaz (2014) as a useful starting point from which to become actively engaged with the data, helping to develop ideas, and supporting reflexivity; memo writing also helped me to make sense of the data and develop themes. I kept a methodological journal where I recorded spontaneous thoughts about the data. This allowed me to focus on the data and supported the process of comparing codes.

Two stages of coding involved defining descriptive codes to describe what was of interest in the accounts, and interpretative codes which seek to focus on interpretation of meaning (King and Horrocks, 2012). All data were coded and from this a concept model was constructed to support further analysis (see Figure 4).

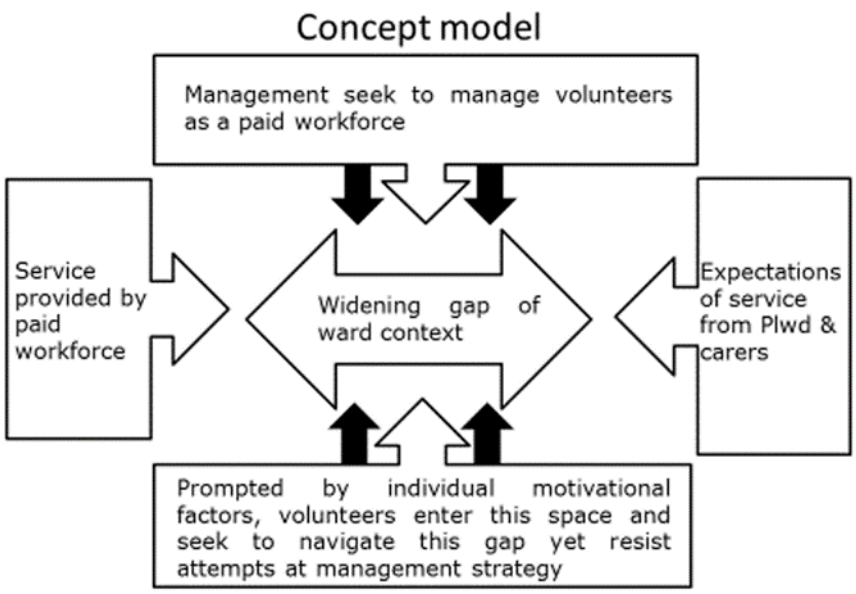


Figure 4 Concept model

The concept model was developed by focussing on the data within each participant group in turn (namely managers, volunteers, ward staff, and patients and carers). This served two purposes. Firstly it facilitated the analysis of the large corpus of data, and secondly it was used as a 'road map' to direct further in-case and cross-case analysis by scrutinising each participant group in turn and facilitated searching for similarities and

differences within them. At the same time the data were analysed to determine how they could be mapped against the objectives for each group.

Pope, Ziebland and Mays (2000) highlight one of the main challenges of qualitative research is the large amount of data it generates. With this in mind, the data from each participant was organised into groups which facilitated further analysis and afforded a sense of control over the vast amount of data. The participants were organised into four groups: managers; ward staff; volunteers and former volunteers; and patients with dementia, and carers. Each group was analysed as a whole to determine any similarities and differences with other groups, and to map the data against the research objectives. This allowed further exploration and focus on the research question and aim. From this I was able to use the OSOP, or ‘one sheet of paper’ method (Ziebland and McPherson, 2006) for each group and conclude this stage of analysis with OSOP thematised analysis for all groups. The OSOP method involves reading each section of data, noting all the different issues raised by the coded extracts, along with the participants identifier, and recording this on one large sheet of paper (Ziebland and McPherson, 2006). Once completed, there is a summary of all issues within the code which facilitates further

analysis to determine how these issues might be grouped together under broader themes. The aim is to develop an explanation of the data and account for all issues raised by participants rather than focus on the most common (Ziebland and McPherson, 2006).

As well as using NVIVO11, diagrams, tables, and mind maps were constructed to facilitate thinking and exploration of the data to group together themes. Figure 5 and figure 6 give examples of this stage of data analysis.

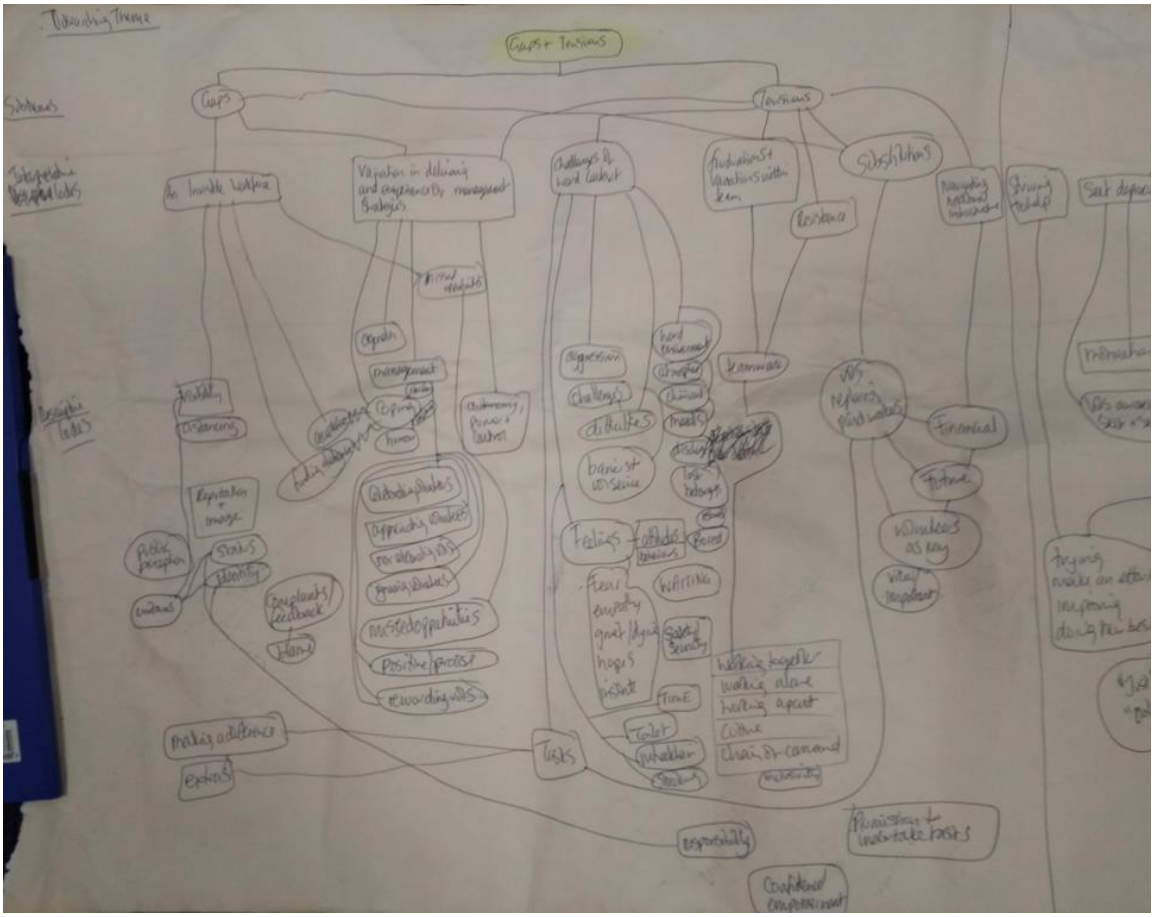


Figure 5 Data analysis example of development of early themes.

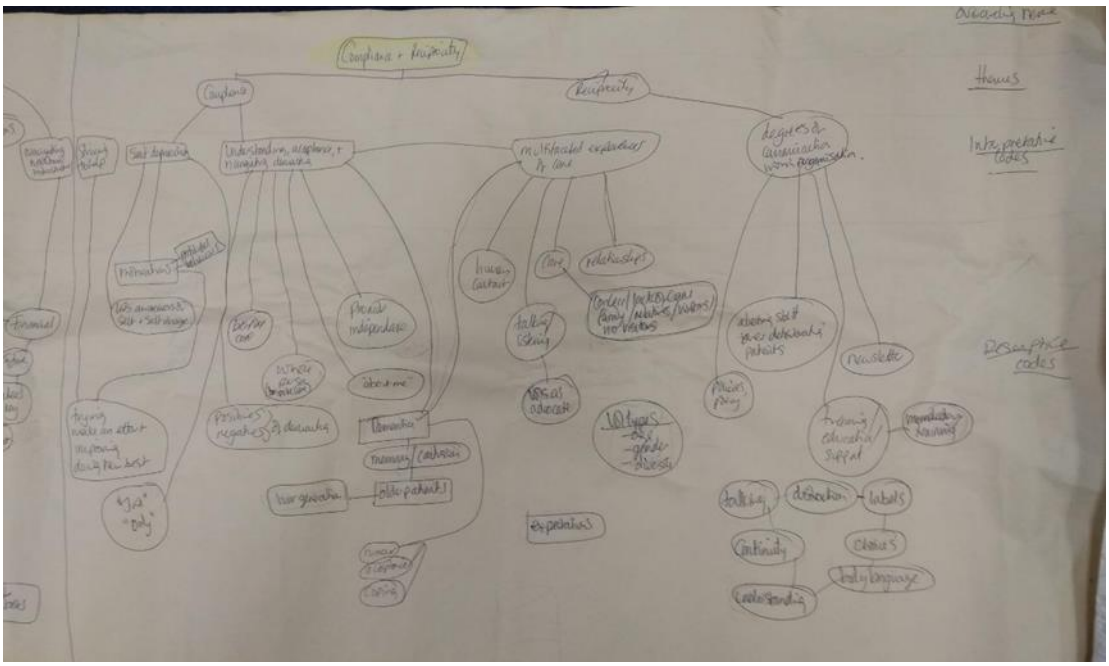


Figure 6 Data analysis example of development of early themes.

Analysis included looking at the relationships between codes and themes and categorising them into groups. The codes were then sorted into different themes which present the main ideas from the data. Data analysis began alongside the interviews and continued well into writing up the findings.

Figure 7 provides an example of the progression from codes to early themes and then onto the final themes arrived at by the process described above.

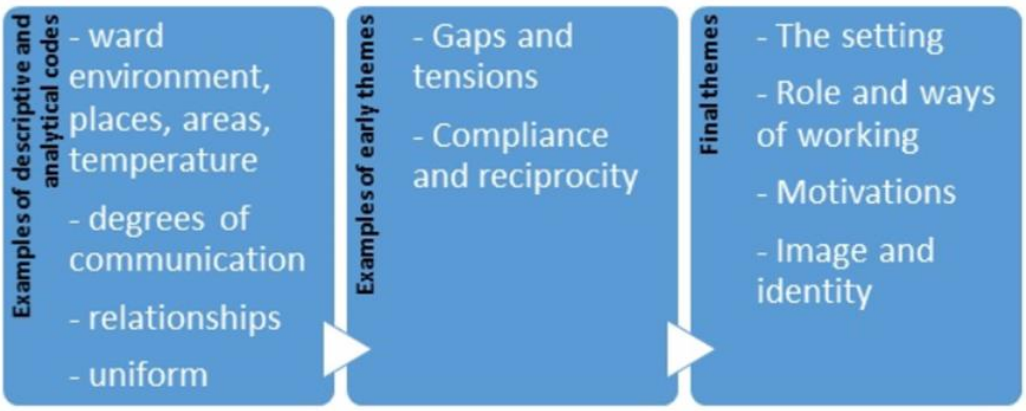


Figure 7 An example of the progression from codes to themes

Following from this conceptualisation of the themes, figures 8, 9, 10, and 11 present a diagrammatic representation of the final thematic structure.

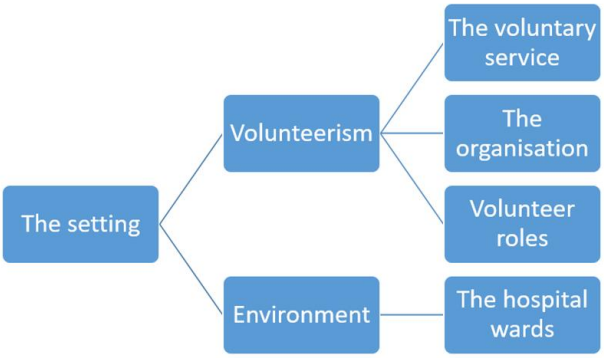


Figure 8 Diagrammatic representation of final thematic structure: The setting

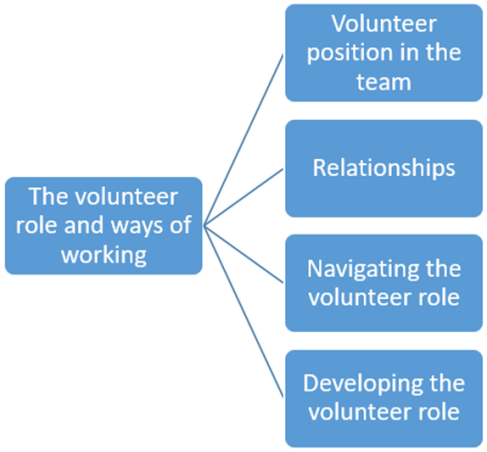


Figure 9 Diagrammatic representation of final thematic structure: The volunteer role and ways of working

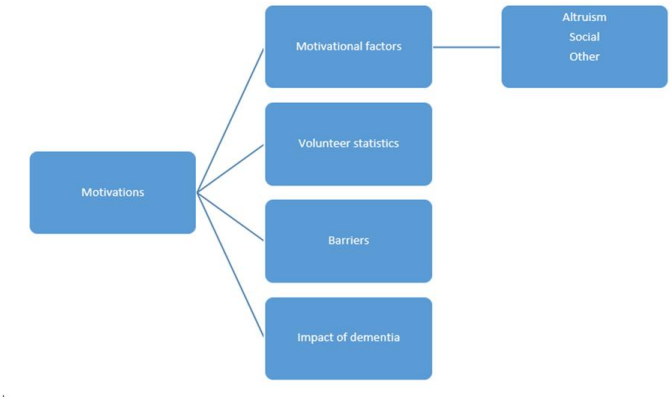


Figure 10 Diagrammatic representation of final thematic structure: Motivations

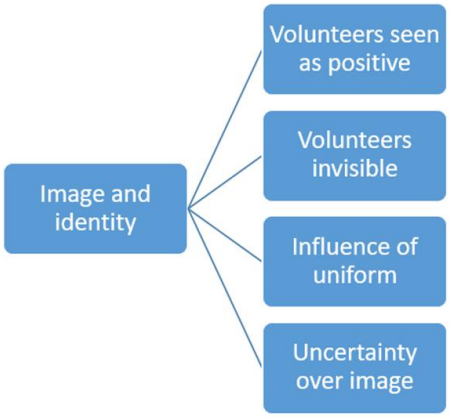


Figure 11 Diagrammatic representation of final thematic structure: Image and identity

The supervisory team were involved at each stage of the process, having access to all raw data, transcripts, and coding framework to provide expert guidance and assistance as the analytical process unfolded.

Revisiting the existing literature facilitated the analytical process as it enabled further questioning of the data in a more focussed and structured way. Through a process of condensing, synthesising and subsequently thematising all the data, a structure was formulated which encapsulated the main findings from across the entire corpus of data. This was further structured into a synthesis of the main findings from each group of participants to ensure a sense of flow and order to the report.

3.14 Conclusion

This chapter follows on from a contextualisation of the research within the literature to detail the approach involved in tackling the research question. It offers a rationale for the choice of research methodology, and emphasises the appropriateness of research design from both a theoretical and practical perspective by detailing the underpinning philosophy as well as describing the real world challenges of the approach. The following three chapters will present the results.

Chapter 4 Results: Setting the scene

4.1 Introduction

The previous chapter outlined the methods and provided a justification for the choice of methodology. The three results chapters will set the scene, and then present the results in relation to the volunteer role and ways of working, motivations, image and identity. The first results chapter is in three sections and will set the scene by presenting the findings in relation to volunteerism, the environment, and dementia.

4.2 Section One: Setting the scene- volunteerism

4.2.1 Introduction

This section will explore volunteerism and present information which describes: the voluntary service itself; the hospital policies and organizational expectations of volunteers; the different types of volunteers working in this context, and what they do.

4.2.2 Description of the voluntary service

The following information was obtained during the course of the interviews with managers. All volunteers are classed as complementary helpers and they have a defined role description in accordance with their basic training. Volunteers cannot undertake tasks that are deemed skilled, paid staff roles, and volunteers are not permitted to be involved in any clinical aspects of hospital care. The number of volunteers fluctuates as people leave and are recruited, but the figures for the study setting given by the voluntary services management team at the time of writing stands at around 1580 volunteers across the entire hospital trust, and includes 152 chaplaincy volunteers. Whilst volunteer demographics are not currently collected by the hospital, information provided by the voluntary services manager suggests that the volunteer population is a diverse group of people from a variety of ethnicities, belief systems, ages, and genders with more women than men volunteering. There are plans to collect demographic data in the future as the voluntary service becomes aligned with the Human Resources (HR) department.

Volunteers provide a variety of services and are managed in two main groups: registered volunteers and guest

volunteers. Registered volunteers have direct patient contact and include the chaplaincy volunteers, the bereavement department, patient and public involvement (PPI) groups, palliative care volunteers, ‘meet and greet’ volunteers who welcome and direct visitors to the hospital, mealtime volunteers, and ward or clinic volunteers. The guest volunteers do not have direct patient contact. They attend meetings, and work from home to provide administrative support by writing quarterly newsletters to update patients on developments. They also attend groups to proofread patient information leaflets in order to comply with the hospital trust’s commitment to the NHS England Information Standards. Also included are the research and innovation groups, and three groups involved with the League of Friends who attend for meetings only and whose main purpose is to raise funds for the benefit of patients, carers, and staff at the hospital.

All types of volunteers are managed directly by the hospital. Volunteers are asked which areas they would prefer to work in and attempts are made by management to evenly spread the allocation of volunteers across all areas. There are a variety of volunteer roles which include hospital library services, volunteer drivers, hospital radio, and voluntary fundraisers. Occasionally

the voluntary services department will advertise for ad hoc temporary roles as they become available, such as helping at extra fundraising events for the hospital. The main volunteer roles in HCOP wards are mealtime volunteers, chaplaincy volunteers, and others which include individuals or groups who offer patients with dementia the opportunity to participate in arts and crafts, music, or pet therapy.

4.2.3 The hospital policy and organisational expectations

The hospital policy states that the Chief Nurse has overall responsibility for the activities of volunteers, delegated from the hospital trust Board. The Head of PPI is responsible for supporting the voluntary services manager to ensure that the approach by the hospital trust to working with volunteers and the voluntary sector complies with good practice and national standards. At the time of data collection there were plans to transfer this role to the hospital communications team and HR department. The voluntary services team is comprised of one manager, a coordinator, and three administrators all of whom work part time. Volunteers help the team with errands such as collecting the attendance registers from the wards. These registers are a way of streamlining

communicating between the wards and the voluntary service management team as volunteers are expected to sign in and out at shift times. The registers are also frequently used by volunteers to leave messages and updates about when they will be on leave.

The Voluntary Services Manager is responsible for ensuring that recruitment complies with current legislation and Department of Health guidance (NHS England, 2017). The team are responsible for the management of volunteers and volunteer staff; the development of volunteering opportunities throughout the hospital trust; planning and recording the training of volunteers and ensuring that volunteers have an induction and annual mandatory refresher training sessions. The Voluntary Services Manager is also responsible for liaising with heads of departments to provide voluntary services, and is expected to provide reports on volunteer activity as required (for example, to the hospital trust's Learning and Education Committee each year).

There is also an expectation that volunteer group coordinators, departmental managers, clinical nurse specialists, practice development nurses, matrons, and individual staff members will take responsibility for

providing support to volunteers, work in partnership with them, and ensure they adhere to hospital policies.

The hospital only considers applications from potential candidates who live within the local area. Volunteers are aged 16 or over with no upper age limit, although must be over 18 to work in areas such as maternity, paediatrics, theatres, and any other areas deemed unsuitable for those under the age of 18. The voluntary services team work with the hospital HR department. The recruitment process involves receiving the application submitted by the potential volunteer. The voluntary services department then interviews all candidates, and successful candidate applications are sent to HR for a Disclosure and Barring Service (DBS) check, visa, and health checks. The Voluntary Services department then request references, and once this process is completed the candidates are invited for training and induction where finally the volunteers are placed in wards and departments.

Volunteers are expected to ensure their overall appearance is smart, clean, and tidy, and that they do not present themselves in a way which might undermine confidence in the organisation or its services. They must wear the uniform provided which consists of a royal blue

T-shirt with collar. The aim of the uniform is to ensure standardisation across the organisation, and to promote a continued professional image to patients and visitors. All volunteers wear a blue lanyard and identification badge, but the chaplaincy volunteers have ‘chaplaincy’ printed on theirs.

At recruitment, all volunteers undergo initial mandatory training which lasts for three hours, regardless of the role to which they have been allocated. This covers training on information governance and data protection; values and behaviours; health and safety; fire safety; infection prevention and hand hygiene; safeguarding vulnerable adults and children; and manual handling. The organisational expectations of the roles and responsibilities of volunteers are underpinned by the importance of prioritising the needs of patients. The role of patient advocate is emphasised at the training, and detailed at the introductory training sessions. The boundaries and limitations of their role are emphasised to volunteers at the training sessions. Volunteers are expected to sign a declaration of confidentiality. They must also complete a health declaration.

In addition to the initial mandatory training, volunteers are provided with written information at the point of

recruitment. This includes contact details of the voluntary services management team, as well as details of what the organisation expects from volunteers. Following an introduction to the hospital, volunteers are given information about facilities and travel information, behavioural standards and customer care guidelines. This emphasises the need for confidentiality, the expectation they will attend regularly, wear the uniform and identification card, and requires volunteers to observe organisational rules, policies, and procedures. The management team strive to keep volunteers up to date with current hospital events, and ensure that volunteers are prepared for any future changes in services by issuing a weekly newsletter (by email or by collection from designated pick up points in the hospital) with current information, and dates of forthcoming annual refresher mandatory training one hour sessions.

Volunteers are provided with meal vouchers if they work four consecutive hours or more, or two hours for volunteers who work in adverse weather conditions (such as ‘meet and greet’ tram volunteers). They are also covered under the indemnity insurance arrangements provided by the hospital trust, and receive support with travel assistance. Volunteer participants expressed appreciation in their accounts of these efforts to support

them.. Volunteers do not generally take a break as shifts are of short duration.

Individuals are asked to commit to volunteer for a minimum of two hours a week over a six month period. They are allocated to a more experienced volunteer on commencement of the role to ‘shadow’ them with the intention of learning under supervision. They are also invited to an exit interview when leaving the organisation.

Desirable personal attributes stipulated in the hospital policy are that potential volunteers can display ‘skills and abilities’ without mentioning what these might consist of. There is no mention in the hospital policy of the need to possess skills in communicating with people with dementia or memory impairment. However, efforts are made by managers to match organisational requirements with the motivations and preferences of volunteers, and to allocate volunteers in an area they would find suitable and acceptable. As such, those who have skills in dementia care and wish to use them in their role as a volunteer have the opportunity to do so. This depends on availability on the ward rotas which cover lunchtime and evening meal time slots. One volunteer is allocated per shift on each ward.

Once volunteers are successfully recruited, they are able to exercise choice over where they would like to work. The voluntary management team will strive to provide a suitable area, if available. If volunteers expressly wish to work in dementia and acute wards, the manager will allocate them to the wards with the lowest number of volunteers. They are allocated to training sessions suitable for the role they applied for which, in the case of dementia and acute hospitals, encompasses either mealtime volunteers, or chaplaincy volunteers.

4.2.4 Mealtime volunteers

The majority of volunteers are allocated to the mealtime role unless they request otherwise. The organisational expectations of mealtime volunteers are clearly defined at the mandatory training sessions held by the hospital trust. The sessions are delivered by a Registered Nurse and the hospital Food Safety and Compliance Officer and consist of a power point presentation; short video clips; two minute question challenges; discussions in pairs; visual demonstration of equipment; and concludes with a food tasting of hospital food and evaluation. Sessions are generally delivered monthly to around 25-30 new recruits. Volunteers who attend the training are given written

information which includes the training session slides, role description, food safety quiz, and evaluation forms.

The session is based on Department of Health (2014) and Age Concern (2006) reports which highlight the need for nutritional support for patients. The sessions detail ways for volunteers to support the nutritional needs of patients and cover the concept of protected mealtimes where all non-urgent clinical activity stops during mealtimes and the focus is on patients' meals. The red tray and red jug systems are highlighted as ways to identify patients whose food and fluid intake require monitoring and patients who need observation or assistance at mealtimes. The sessions also cover how to provide help, assistance, encouragement and support to patients; helping patients choose from the menu; making drinks for patients and relatives; and mealtime preparation which includes preparing simple snacks at ward level. Other areas covered are the correct use of aprons, patient preparation such as simple positioning, checking whether the patient needs to use the bathroom before mealtimes, and assistance with hand hygiene. Also included is the provision of appropriate crockery, cutlery, and drinking utensils; unwrapping food for patients with dexterity problems; being part of the team which includes giving feedback to staff; and the role of

the volunteers as an advocate to patients. Volunteers are not permitted to feed patients unless they have received further training.

The mealtime volunteers can act as advocate for patients by speaking up for them and offering reassurance, raising concerns with nursing staff and giving feedback at the end of each shift. Examples include letting the ward staff know if they have received the wrong meal; asking for extra portions or offered an alternative choice.

The training also focusses on government legislation around food safety regulations which includes cleaning and disinfection techniques, hazards, controls, personal hygiene, and top food safety tips. Some information is given at the mealtime training about how to support the nutritional needs of patients with dementia. This includes highlighting that they may be unable to ask for food and drink; may not remember how to feed themselves; may be unable to recognise food; have a decreased attention span; and may forget to eat and drink. In addition volunteers are given information on the ‘about me’ document, which is a support tool to facilitate and enable person-centred care, and is readily available to all staff.

The other duties of mealtime volunteers include assisting with housekeeping (such as stocking up, running errands,

tidying and helping to make beds;, helping with directions and providing information; answering telephones and taking messages; escorting patients; supporting patients with diversional and craft activities; and providing the opportunity for engagement and occupation for patients with dementia. The shift times for mealtime volunteers are between 11.30am-1.30pm for lunch, and 4.30-6.30pm for the evening meal.

4.2.5 Chaplaincy volunteers

In addition to mealtime volunteers, hospitals also have spiritual and pastoral care teams who are there to offer emotional or spiritual support to patients, visitors, and staff. These teams are based in hospital chaplaincy departments and specially select and train volunteers to offer a range of services. This includes transporting patients to acts of worship services, and providing support for their spiritual well-being and care through visits and conversation. The service is available to everyone regardless of their religious beliefs.

Similarly to mealtime volunteers, the hospital chaplaincy volunteers are recruited and managed by voluntary services and must comply with all the aforementioned requirements, such as mandatory attendance of initial and refresher sessions. In addition potential volunteers

must supply a reference, or recommendation from their faith community or belief group. Before the recruitment process, and in contrast to other volunteer roles, an informal interview is arranged with the chaplaincy volunteer manager to assess the suitability of potential chaplaincy volunteers. Following the recruitment process, the chaplaincy volunteers are managed by the chaplaincy management team. The chaplaincy volunteers attend a five session training course run by the chaplaincy department which covers communication techniques. This covers: how to initiate a conversation; open up the dialogue to facilitate patients to explore their feelings; close conversations; and how to communicate with people with dementia and cognitive impairment. The sessions provide the chaplaincy team with an opportunity to continue the selection process by getting to know potential volunteers. The sessions also provide an opportunity for further screening as to the suitability of potential volunteers in the role, particularly in identifying those who may wish to use their role as a volunteer to drive a religious agenda. In addition to the introductory sessions, chaplaincy volunteers are invited to a yearly training event. This includes a non-denominational rededication ceremony at which volunteers commit to continuing in their role as a chaplaincy volunteer. There is

also scope for further training at the request of volunteers, such as sessions on managing grief and loss, or listening skills. In contrast to mealtime volunteers, every 6-8 weeks chaplaincy volunteers are offered reflective practice sessions which allow them to discuss sensitive issues arising as a result of their interaction with patients. This involves volunteers starting their shift earlier to explore as a group, any issues which may have arisen over the course of their volunteering duties under the supervision of the chaplaincy manager. The aim of the sessions is to discuss issues in a supportive environment, and to explore ideas together to provide help with future encounters.

The facilities for chaplaincy volunteers differ from those provided for mealtime volunteers as they have access to a dedicated area away from the wards which is private, lockable, and in which they are able to store personal items; participate in peer socialising; and undergo debriefs with the volunteer manager should they wish to.

Because of the interpersonal nature of the role, shift times are less flexible in that volunteers are limited to a choice of only three set days per week during the hours of 10am to 12midday. This is because the chaplaincy team want to be available to provide them with support

before, during, and after their shift, and also to avoid mealtimes.

The organisational expectations of chaplaincy volunteers are that they provide the patient with: human contact; a non-judgmental listening and befriending service where patients have the opportunity to speak in a safe space and receive undivided attention; and an opportunity for people with dementia to be taken seriously. Some practical help is also given, for example if a patient has financial worries they can be given information and signposted onto other services. Chaplaincy volunteers will occasionally help patients with activities or drinks.

Chaplaincy volunteers are allocated to a ward and given a list of patients to visit. This information is obtained from the hospital intranet where chaplaincy staff receive alerts when patients who require their services are admitted, and pass this information to volunteers. As well as visiting those on the list, chaplaincy volunteers also respond to individual requests from patients and staff once arriving on the ward, and requests from ward staff to run errands.

4.2.6 Other volunteers

Aside from the mealtime and chaplaincy volunteer roles, there are a number of other tasks that can be undertaken

by volunteers on the wards. These include pet therapy and activities such as arts, crafts, and music. They are available to all wards, but the volunteer rotas show that the dementia specialist ward attracts the most volunteers in this category. Some of these roles tend to be on an ad-hoc basis organised through the voluntary services management team, although a pet therapy volunteer visits the wards once a week, has indemnity insurance, and has undertaken the necessary pet health checks.

4.2.7 Conclusion

This section contextualises the research by exploring hospital volunteerism with particular reference to the care of older people with dementia and cognitive impairment in acute wards. There appear to be comprehensive arrangements in place, supervised by the voluntary services department, to recruit, train, manage, and support volunteers in a variety of roles. The hospital has policies and procedures in place to screen and withdraw those people who are judged to be unsuitable in the volunteer role.

The following section will explore the environment in which volunteering takes place.

4.3 Section Two: Setting the scene-the environment

4.3.1 Introduction

The previous section explored hospital volunteerism. This section will explore how the environment is seen and experienced through the accounts of participants, facilitate an understanding of the social world, and set the context for further interpretation. It begins with a description of the hospital, the different types of older person acute wards, and continues with accounts of the environment from the perspectives of the different groups of participants. All the information was obtained during the interviews with managers and ward staff.

4.3.2 The hospital and wards

The site is a 1,700 bed teaching hospital in the Midlands which provides services to over 2.5 million residents. The Healthcare of the Older Person department is within the main body of the hospital and is part of the medical division with eight wards, including a dementia specialist ward, which provides specialist care to patients with dementia and delirium admitted to the hospital as an

acute medical emergency. Patients admitted to these wards are aged 65 years and over with a range of acute medical conditions. There is a high prevalence of dementia, delirium, and cognitive impairment. Internal hospital statistics show the length of stay to vary but the average length of stay over the previous twelve months was 10.6 days for all the older person acute medical wards with an average of 12.9 days length of stay in the dementia specialist ward. Visiting times are between 11am and 8pm every day; however, the hospital operates flexible visiting times for carers.

All wards are served by the MDT which consists of a range of health care professionals, students, and support services. The team aim to deliver holistic care through the means of a comprehensive geriatric assessment (CGA) which takes account of the whole person and their social circumstances, rather than just treating medical conditions. Personal details such as their preferences, routines, personality, and family background are generally recorded on the ‘about me’ document.

A system of preventing patients from falling, known as ‘cohorting’, is in place on all the wards. This involves allocating one bay specifically for patients who are assessed as at risk of falls, with a designated member of

ward staff responsible for supervising and monitoring them in this area at all times.

All wards have a volunteer rota, which allocates one volunteer to an available slot around mealtimes. There are several gaps on the volunteer rota on the general older person acute wards, with some of the wards having only one or two regular volunteers.

It appears that the dementia specialist ward is a desirable place to volunteer as there are more opportunities to work alongside paid staff, for example activity coordinators. In contrast to the general older person acute wards, all mealtimes and chaplaincy volunteer shifts on the unit are fully covered with no gaps on the rota. Volunteers on the dementia specialist ward who express a wish to take on extra shifts are offered other wards due to a lack of available shifts. Some volunteers who participated in this study, reported having had to wait for a space to become available on this ward.

Following a general description of the context, there will now follow an account of the ward environment from the perspectives of each group. This includes both the dementia specialist ward as well as the general acute older person wards. Volunteers did not always specify whether or not they were familiar with both types of

wards, and so did not always distinguish between the two contexts when giving their accounts. Volunteers gave their accounts based on the type of ward in which they worked. The groups include hospital managers, ward staff, volunteers, patients with dementia, and carers.

4.3.3 The perspectives of managers and ward staff of the environment

There is little in the data to describe how managers felt about the ward environment other than a general consensus that staff are busy, and that the specialty itself is seen as a challenging environment because of the difficulties in caring for acutely ill patients with dementia.

However, ward staff highlighted the ward environment as being an unsuitable place for people with dementia and memory impairment because of the unfamiliar environment. Speaking specifically about the older person wards,

> *"it is challenging working on a hospital ward […] there's lot of things happening- and it can be quite daunting" (Rose, Ward Staff).*

As such, there was a general understanding amongst ward staff of the importance of instilling a sense of 'normality' for patients by providing an environment which minimises medicalisation and boredom, and promotes social participation and contact with the outside world, however difficult this is to achieve in terms of managing risk, such as infection and accidental injury. Ward staff described their workload and the effect on patients and carers, describing it as being an

'alien and disempowering environment […] the ward environment is so busy it's frenetic' (Ben, Ward Staff).

This sentiment is a common theme among all interviewed staff regardless of which ward they worked on.

While voicing an appreciation for communal spaces, the availability of resources, and the investment of charitable funds to secure a "*beautiful"* (Lisa, Ward Staff) day room with activities and games on the general older person acute wards, the opportunity for patients to engage in activities was described as not being a regular occurrence. This was attributed to insufficient numbers of staff to supervise patients, and as a result such facilities were described as

'a huge waste of space and a wasted opportunity' (Lisa, Ward Staff).

While realising the difficulties in providing comprehensive personalised care and the limitations of the ward in terms of restricted space, noise and lack of privacy, there was also a recognition of the potential for improvement, particularly the opportunity for patients to safely access outside areas. The ward atmosphere itself was commented upon by several of the ward staff as they described how this would alter when there was an opportunity for patient engagement. This could include live music or visits from animals which were seen as altering the mood and ambience,

'Their eyes light up, they love music […] and obviously the therapy dog […] if they're dog lovers, you know, it sort of cheers them up, makes them smile […] sometimes they cry! They are just so happy to-to see a dog and it makes a big difference to their day! […] it just really cheers them up' (Zoe, Ward Staff).

Ward staff described their workload as busy, but most gave a positive account of their role and expressed a sense of job satisfaction. The accounts of ward staff differed from those of managers and patients in that they compared the dementia specialist ward to the general, older person acute medical wards. The main difference being extra numbers of staff, and more resources.

However, despite identifying the problems, and striving to improve and maximise the environment to ensure it benefited this group of patients, ward staff recognised the difficulties of caring for patients with cognitive impairment and challenging behaviour. The following section will explore the accounts of volunteers and their perspectives of the environment.

4.3.4 The perspectives of volunteers of the environment

Volunteers also offered an account of the environment which resonated with the accounts given by ward staff to some extent. On the whole volunteers initially began their accounts by describing the ward environment itself as generally friendly and welcoming. However as the interviews progressed, the accounts became more candid as volunteers described the ward environment as being generally unpleasant, noisy, too crowded, busy, frightening, challenging, and clinical. The side rooms were seen as being quieter than the main ward, not least because one was able to close the door. The general sentiment of noise and chaos was summarised by one volunteer who described how she felt when she first started volunteering,

'I think it's not easy to walk into a ward as a volunteer first off and try and work out where you fit into this…jungle.' (Gladys, Mealtime Volunteer).

Volunteers who described the hospital and wards saw it as encompassing a large area. Some of the older ward based volunteers described how walking the long distances down 'claustrophobic' (Shane, volunteer) corridors when running errands, aggravated existing health problems. One former volunteer who was retired and had experienced health problems, described how she would guide people to other areas in the hospital as part of her ward based role,

'sometimes you're walking miles in a day you know It's like [whispers] oh dear. I used to use my stick but it became a bit tiring. I used to wish the patients would push me in a wheelchair [laughs] and I'd just point the way! You know…oh dear' (Fay, Chaplaincy Volunteer).

She reported having to stop volunteering because of the difficulties she experienced when walking long distances. Others who endured difficulties and health problems expressed a wish to continue in the role.

The ward temperature was mentioned by a number of volunteers,

'The wards are, in my humble opinion […] far too hot, and it would make a healthy person drowsy' (Matt, Volunteer).

However, they recognised that many older people often felt cold despite the heat,

'the number of people who are sat by their beds in a nightie, and sometimes not very much else, through the winters and the heating doesn't always work that efficiently. Who are frozen! it's cold!' (Gladys, Mealtime Volunteer).

Volunteers described the ward facilities for staff and patients. Some volunteers said they were unsure of the location of staff toilets, or the existence of the staff rest rooms. Others described the inadequacies of staff facilities which were described as not having enough space nor coat pegs to store personal belongings, which meant staff and volunteers' coats were kept on the floor. The staff rooms were described as dirty and uncomfortable with dirty dishes filling the sinks. Wards had resources which some volunteers said they had looked through to find ways to occupy patients, others said they did not feel comfortable to do this. Those who had found equipment on the general older person acute wards said they were unused, or found to be inappropriate such as puzzles being too easy, or too

hard, for patients to do. Volunteers described how they used resources on the ward, often showing creativity by using what was available, such as using the drinks trolley to approach patients as a way to get to talk to them. Some volunteers described that being of a similar age to patients helped with the flow of conversation, and used simple prompts such as the view from the ward window, an unfamiliar accent, or the meal itself as a starting point for conversations. The pet therapy volunteer highlighted the importance of the dog as a resource, saying he would find it difficult to engage with patients with dementia or memory impairment without it,

'I'm lucky because I've got the dog! So I've always got somebody, or something, to talk about. If I was on a ward without the dog, I don't know what I'd be doing, to be honest' (Matt, Volunteer).

Aside from the issue of resources, the ward routine itself was judged to be monotonous and restrictive for patients, illustrated by this chaplaincy volunteer's diary account,

'I know it's not the most exciting place to have to be, with all the days basically the same, and I think I can begin to understand the patient who likened it to a prison […] I only spoke to one other patient that morning […] he hated

being in hospital, had eye trouble and described being in there as 'dying slowly'' (Leo, Chaplaincy Volunteer Diary).

Volunteers also gave an account of their views on the ward atmosphere. This was recognised as being dynamic, fluctuating, and unpredictable not least because of the effect of the moods and perceptions of patients as they strive to understand and navigate their new surroundings. The sudden differences experienced by volunteers of patients' moods are illustrated by this account of one snapshot of time captured by a mealtime volunteer in his diary entry,

'A […] nurse guided a male patient into an armchair, and as he sat down the patient kicked him, shouted abuse, and blew his nose into his hand and threw it at the nurse, good job he hadn't got his boots on. Lady in armchair gave me the biggest smile as I went by every time'
(Shane, Mealtime Volunteer Diary).

The busy atmosphere seemed to have an effect on how volunteers and ward staff communicated with each other. The atmosphere of the ward was seen as being more pleasant when patients had the opportunity to engage in interactions with animals, or participate in live music sessions as this would lead to conversations other than

those with a health related content. A pet therapy volunteer spoke about the effect of his visits,

'it brightened the mood on the ward! And that's because the staff are lifted and it gives a bit of a burst of energy […] Yeah! because it's just, they go "Oh did you see the dog? Nice to see you talking to the dog." And it gives the staff something to talk to the patients about and it engages them better!' (Matt, Volunteer).

Having explored the accounts of managers, staff, and volunteers, the following section will explore the accounts and experiences of the ward environment of patients with dementia, and carers.

4.3.5 The perspectives of patients with dementia, and carers, of the environment

Patients and carers gave an account of their experiences of the ward environment. They spoke about the challenges of being on a hospital ward and the difficulties associated with communal living, describing other patients as noisy and annoying.

The environment itself was described by patients and carers as busy, noisy, monotonous, and restrictive. One carer highlighted how the effect of patients repetitively

calling out might cause other patients to become disturbed,

'there are annoying-you do get annoyed, if you hear something 50 times, 100 times, it does sort of like wear you down a little bit […] if all the patients are around you in that same mode, sort of dementia-wise […] and the patient in this bed here is constantly shouting, it is-it does sort of like cause a disturbance, kind of thing, and then it can have a knock on effect in as much as this patient […] could get disturbed by it, or upset by it and things like that!' (Owen, Carer).

Patients and carers described their boredom and the lack of opportunity for occupation on the wards,

'there's nothing to do sat in those beds is there? There's no television, there's no radio to listen to, I mean in the olden days, she used to have a radio and headset and things, didn't you? […] and there's-there's nothing! absolutely nothing! and I mean it would drive me round the bend stuck in somewhere like this, it really would [laughs]' (Chloe, Carer).

In addition to the feeling of boredom and monotony while on the ward itself, the limited opportunity to leave or go outdoors was seen as highly problematic. Those patients and carers who spoke about the benefits of being able to

leave the ward felt there was insufficient opportunity to do so, and expressed a feeling of confinement, of areas of the ward being ‘caged up’ (Vera, Carer), and a sense of being ‘stuck’ (Joe, Carer). One carer described the effect of this on his wife,

‘my wife she's going nuts being in hospital all that while she's going cranky you know she needs to get out you know […] She likes to get about, yes. I mean as I say, what's getting her down at the moment is she's stuck in the ward, and she's just sitting there, she's bored!’ (Joe, Carer).

The staff on the general acute older person wards and dementia specialist ward were on the whole appreciated for their expertise, familiarity with and focus on the problems experienced by older people in contrast to other general wards, particularly in relation to the awareness and management of falls. For example one carer described her concerns over her mother being admitted to a general ward whenever there were no beds available on the older person acute wards. Here she describes her experience

‘The […] ward that they stuck my mum on […] ugh, in fact, one of the […] elderly patients, she’d got dementia, in the next bed to mum […] she got up out of her bed, she

hadn't got her rails up […] she got up […] I say, "Christ sakes, this woman, run, she's going to fall!" you know, if I hadn't been there and she'd have pushed the trolley, she would have fell smack on her face!' (Vera, Carer).

The efforts made by staff on the older person acute wards to ensure the environment addressed the needs of patients with dementia and acute illness, such as a personalised approach and the availability of resources, were appreciated by patients and carers. Nevertheless, ward staff were perceived as being busy and not always available to help with their immediate needs in a timely manner. In one account a carer gave a description of being unaware who to approach when he needed help,

'he […] got a bit incontinent and he needed- what you call those things? Paper bottle things? […] I asked this woman nurse who was there, "Could you get me a bottle?" She just looked at me, and said, "oh I don't work on this ward," and she walked off! […] and he was there flapping away beside me and I was stressing about it. […] I found that a bit upsetting' (Arthur, Carer).

Carers and patients with dementia described the pressures on the paid workforce. They showed an awareness of the number of acutely ill patients requiring help, and an understanding of the workload and time

pressures on staff to deliver services. This carer's description of the ward illustrates the pressures within the environment,

'Well I mean…when I come to visit I've got to bear in mind that there's six patients on that ward […] I've noticed some of the ladies on that ward can be very demanding, they're shouting ''come help me'' and all this you know, […] I mean I've been on that ward and there's been nobody there because the staff have been doing other things […] They've just either popped-not for long. I'm not saying- […] I'm not criticizing but as I say they're busy'
(Joe, Carer).

Carers spoke about their experiences when visiting the hospital as causing them to feel frustration and anxiety. They described their experiences about the difficulties in accessing help, or having to wait for help from ward staff. Consequently they felt their needs were unmet. This anxiety further compounded their underlying feelings of frustration of coping with the problems associated with dementia, delays in treatment, lack of communication, feelings of powerlessness and loss of control, and financial worries. They expressed concern over where they fit into a system which they felt did not always provide them with a personalised service. While three of

the carers gave accounts of their experiences with volunteers alleviating their frustration as they were offered help, all of them anticipated that any frustration and anxiety would have been avoided if they had had access to a volunteer.

Nevertheless, despite sometimes experiencing difficulties in accessing help immediately, patients and carers expressed an understanding about the demands on staff to deliver care in what they understood to be difficult conditions,

'With the best will in the world you can't stop the nurses from doing their job, cos they're busy enough as it is, aren't they?' (Maud, Dyad: Carer).

The sense of having people around, including volunteers, was greatly appreciated by carers and patients with dementia, and was described as contributing to their feeling of safety and security.

Therefore, the accounts of patients and carers resonated to some extent with the accounts of ward staff and volunteers in terms of how the ward environment is seen and experienced.

4.3.6 Conclusion

This section seeks to contextualise the research by exploring the accounts given by each group of participants of the ward environment. While managers only briefly mentioned the challenges of the wards, the other participants gave more detail by describing them as being a unique specialty which aims to meet the needs of older people with dementia and acute illness. The complex needs of these patients who are over 65 years of age, frail, have a range of complex multiple comorbidities and social problems, and a large proportion of whom have dementia or cognitive impairment, contribute to the understanding that the specialty is seen as busy, noisy, and a challenging area in which to receive treatment, work, visit, and volunteer.

These accounts describe the facilities and resources made available to support this group of patients, and despite a recognition that there is a room for improvement, there is also an understanding about the difficulties in doing so.

This description of the environment provides a backdrop upon which to build an understanding of the world where volunteering occurs, and sets the scene for further interpretation. However, more detail is needed about the

distinctive characteristics of dementia in this environment which will be addressed in the following section.

4.4 Section Three: Setting the scene- dementia

4.4.1 Introduction

To contextualise the research findings, the previous sections explored volunteerism and the environment in which it takes place. This section continues this contextualisation by exploring the accounts of participants to understand their perspectives on dementia, with particular reference to the involvement of volunteers.

4.4.2 An overview of patients with dementia and acute conditions

In addition to having dementia or cognitive impairment, patients on the wards may also have one or several chronic conditions, as well as acute illness necessitating a hospital admission. Furthermore, patients may require help due to problems with continence, mobility and co-ordination, communication (including impaired vision, speech, and hearing), and be at risk of falls and delirium. All participants understood that the majority of patients

had some degree of cognitive impairment, as well as being acutely ill. Patients were described in a variety of ways which included being tired, sleepy, asleep, and unrousable. Some were described as being aggressive to staff and each other, swearing, offensive, upset, agitated, demanding, and feeling miserable and unwell, while others were described as being settled and happy.

4.4.3 The perspectives of managers of volunteering in dementia care

Managers began their accounts by speaking about the positive aspects of volunteering in dementia care, and voicing their appreciation of the value of volunteers in this context. However, as their accounts unfolded they discussed how dementia care differed from other specialties and began to describe the negative image of dementia, one of being frightening and challenging.

Managers began their accounts by describing volunteers as being a solution to some of the challenges of caring for patients with dementia in an acute environment. Their descriptions were framed in a positive way, seeing volunteers as a way of valuing the person with dementia despite memory impairment and confusion, and as a way of taking them seriously and acknowledging their worth. Volunteers' knowledge and understanding of dementia

was seen as being of less importance than the warmth of genuine human one-to-one interaction. They described volunteers as making a unique contribution to patients with dementia, and how they have the ability to connect with them in a different way to staff. They expressed their gratitude and acknowledged their contribution towards enhancing patient experiences.

While managers did not have any figures detailing the cost of the voluntary service, they nevertheless described the challenges of obtaining funding for dementia services. The investment of extra charitable funding was seen as worthwhile because efforts to engage patients with dementia through arts and crafts made available by such funding was seen to improve the hospital experience for patients with dementia,

'they're actually making a difference to that patient' (Olive, Manager).

This reference to making a difference was echoed throughout the accounts without any reference to specific examples.

As their accounts unfolded, managers began to speak about the possibility that dementia care may be seen by volunteers as an unattractive and unpopular context in which to spend time, and so deter potential volunteers,

despite evidence to the contrary as there were no vacancies available on the volunteer rota on the dementia specialist ward.

The presence of patients with dementia was seen by some managers as posing a challenge as they spoke of the difficulties and demands faced by people caring for these patients. This was seen as being potentially problematic when recruiting volunteers, as illustrated by this manager's account,

'In my experience, a lot of people kind of give it a wide berth because it frightens them or it challenges them or can feel like a waste of time because you're not having a coherent conversation' (Greg, Manager).

Any previous experience volunteers had in dementia care, be it through personal or professional involvement, was seen as valuable even though this was also seen as a possible reason why people might be deterred from volunteering in this setting as they understand the challenges of being with patients with dementia.

Consequently, managers described volunteering with patients with dementia as perhaps not suitable for everyone, and they recognised the need for volunteers to exercise choice in where they worked, and the need for them to be placed in appropriate specialties,

'so yeah so I think-I think there's loads of opportunities… but the key is matching the volunteer- it's not everybody's cup of tea…' (Eva, Manager).

While expressing the view that volunteers make a difference in dementia care, there were scant details around how this was assessed or evaluated other than a general view that volunteers were beneficial to improving the patient experience. All managers offered suggestions on how to improve voluntary services in dementia care. These included adequate education and preparation for the role, and that volunteers should be encouraged and supported to feel comfortable and to only do what comes naturally when interacting with patients with dementia. This was seen as preferable to a mechanistic role which could result in them coming across as artificial in their approach. Managers also suggested integrated ways of working to deliver services tailored to the individual needs of patients with dementia. This included providing opportunities and utilising the skills and any previous experience that volunteers already have, such as caring for a relative with dementia, to allocate tasks which would have a clinical benefit for patients. This was seen as having the potential to contribute towards accelerating rehabilitation and subsequent discharge from hospital. Managers took a broad view, speaking about the benefits

of this approach to the organisation, and that the provision of coordinated and tailored services might facilitate the organisation to keep up with future changes. This suggests that this is not what is happening at present as they described the possibility of further development of dementia services, particularly the development of the chaplaincy volunteering role in dementia. However, they also recognised the potential challenges, and warned against developing the service too quickly, not least because this might dilute the quality of the service to patients with dementia by having large numbers of volunteers who require varying levels of supervision from the paid workforce.

The following section will explore the accounts of dementia from the perspectives of ward staff.

4.4.4 The perspectives of ward staff on dementia

Similarly to managers, ward staff began their accounts by expressing their gratitude for the contribution volunteers make to the care of patients with dementia, but voiced caution over the possibility for problems to arise, and the subsequent need to manage risks.

There was little in the ward staff accounts to support a positive image of dementia, although one member of the ward staff saw a dementia diagnosis as being beneficial to patients when admitted to hospital as this meant they might be more likely to receive extra services, compared to other patients with similar symptoms. Some ward staff described younger volunteers who sought ways to understand dementia in order to realise their career aspirations. Volunteers were seen having a different attitude to staff in their absence of a clinically orientated agenda, and there was a sense that they were seen as more valuable in contributing positively to their experience while in hospital.

As the accounts unfolded, ward staff spoke of the image of dementia, and that of older people in general, as being generally negative. They described the darkness, gloom, dread, fear, and loneliness of dementia. This perception of dementia as being something to be afraid of was highlighted as being a potential concern, and something that may affect the degree of involvement volunteers have in this specialty. Younger volunteers in particular were seen to experience difficulties, which they attributed to a lack of awareness, understanding, or previous experience of dementia. Ward staff described how

volunteers would avoid patients with dementia, particularly if they were aggressive.

Ward staff gave examples of how quickly and easily things could go wrong in this environment,

'You've got to be so careful […] say for example, giving somebody a drink! you know don't do it until you've asked a member of staff because then it could go horribly wrong, couldn't it? If they give somebody a drink and actually they're on thickened fluids so there's a lot of a lot of things to manage really' (Rose, Ward Staff).

As such, they expressed a need for caution, careful management and supervision. Ward staff were mindful of safety concerns and warned against volunteers working unsupervised because patients with dementia might be unaware of their capabilities, or unable to voice them to others,

'…somebody with dementia is potentially not aware of their level of function. So… if they're saying to the volunteer … you know if they're asking for toilet, for example, and they tell the volunteer that they're able to walk when actually they're not, is there a potential for the volunteer to try and help them stand up […] …the person's insight into their own level of need, may not actually match reality' (Rick, Ward Staff).

This suggests that ward staff did not always have a clear understanding of what volunteers do, and the limited nature of their activities.

There was a general understanding by ward staff that older people with dementia required specialised care, and their needs distinctly differed to those of other patients,

'I think dementia is very unfamiliar […] I-I think issues around dementia […] often lie outside the experience of many lay people, many health professionals' (Rick, Ward Staff).

Ward staff also felt there was an overall lack of understanding about the experiences and problems encountered by people living with cognitive impairment. The care of people with dementia in acute wards was described by ward staff as challenging. They shared their suspicion that they were perceived by society as a lower priority compared to other specialties. Ward staff compared dementia to other diseases, describing it as being an unfamiliar, unknown concept, and outside the experience of the general public or health care professionals. One participant reflected on this and made a comparison between the public image of both cancer and dementia,

'Palliative care really has created a social movement, hasn't it? That it's something people can you know can relate to […]… dementia is perhaps you find it depressing? […] certainly, palliative care have-have used volunteers on a huge scale compared with what with what we do' (Ben, Ward Staff).

While expressing caution about the role of volunteers in dementia, staff felt that lessons could be learned from other areas as to how voluntary services for patients with dementia could be improved. They recognised the need for a personalised and individualised service to patients with dementia, described the difficulties in achieving this, and saw volunteers as a possible solution. They offered suggestions as to how dementia care could be improved by developing voluntary services. This included the need to challenge attitudes and perceptions of dementia, and raise awareness as a way of encouraging volunteer involvement in this specialty. This approach was seen as preferable to merely training volunteers to do tasks, and included formalising the volunteer role to incorporate their activities into rehabilitation goals as a way of improving function, and so contribute to recovery. Some ward staff hoped for a more tailored approach where volunteers had an increased awareness of dementia and were allocated

tasks which fitted into the multidisciplinary team (MDT) care planning.

The following section will explore the accounts of dementia from the perspectives of volunteers.

4.4.5 The perspectives of volunteers on dementia

In line with managers and ward staff, all volunteers recognised the specialty as a unique place, requiring specific and specialist knowledge and skills. They had a myriad of opinions on dementia ranging from negative to more positive views. They expressed a lack of knowledge and uncertainty about the disease, describing their feelings about dementia, their efforts to help, and how they were affected by their experiences. Furthermore, volunteers were unsure which patients had dementia or memory problems and were wary of approaching confused and distressed patients. They expressed uncertainty over what activities they could do with patients, and were reluctant to wake patients who were asleep and hard to rouse, despite ward staff prompting them to do so. Volunteers were also unsure how to respond appropriately to patients with an altered perception of reality. They described their fears of making the situation worse, despite trying a variety of different

approaches. These included trying to establish what patients needed and repeating offers of help, offering food, blankets, drinks, hand holding, conversation, distraction, as well as using avoidance. The environment itself was recognised as being particularly problematic for patients with dementia as it was unfamiliar to them, and memory impairment meant that patients did not always know where they were. Volunteers understood that a sudden admission to hospital was frightening, confusing, and isolating for people with dementia, and described how they tried to show empathy and understanding. They described patients as being reluctant to socialise with others in unfamiliar communal areas, preferring to take comfort and deriving a sense of security from their increasingly familiar bed area, and access to personal belongings,

'It's very difficult when people are admitted to hospital, which is often sudden, confusing, frightening. They sit by their beds and they watch what's going on, and it's isolating though, they kind of often don't stray far from their beds then. There are obviously lots of people that do wander, because of the area, because of the nature of dementia, but quite a lot of people are sort of rooted by their beds' (Gladys, Mealtime Volunteer).

Volunteers did not routinely receive any information from ward staff about diagnosis or conditions, and as such were unaware of their level of cognition. It appears that their role was not to specifically support patients with dementia but there to offer general support to all patients on the ward.

Volunteers described patients with dementia as not always having the appearance they would expect of a confused person, which added to the uncertainty. They reported not always understanding what patients were saying but recognised that they were experiencing an altered state of reality, describing them as being in their own world. They spoke about how they recognised confused patients by talking to them and gradually realising that the patient might have some degree of memory impairment, although remaining unsure of the background aetiology. Nevertheless, despite reporting their uncertainty about which patients had dementia, volunteers did not feel that the condition itself made any difference to how they approached or interacted with patients, although they would avoid those who showed signs of aggression. In fact, they reported that they would be more likely to treat all patients in accordance with their individual needs as they got to know them,

‘I treat everybody on the ward the same, really… and just listen to what somebody has to say and sometimes… last week, I was with a gentleman in a side room and he said, "This office is awful!" [laughs] […]..I just sat and talked to him and we talked about his life and… but…it-I don't think it would have really mattered whether he’d got dementia or not. He was still feeling vulnerable….you know …’
(Sally, Mealtime Volunteer).

Volunteers described the challenges they faced around communicating and interacting with patients with dementia. Communication difficulties were intensified by high levels of ambient noise with other patients shouting loudly and repetitively, and so the environment itself was seen as not conducive to maintaining privacy and confidentiality. The problems associated with dementia were often compounded by problems associated with the ageing process in general, such as poor hearing, impaired speech and missing dentures, and some patients were unable to speak English. Subsequently, volunteers reported difficulties around understanding what patients were saying, resulting in both patients and volunteers raising their voices to be heard,

'lady in […] ward talked very loud to me but I couldn't understand a word she said' (Shane, Mealtime Volunteer Diary).

As such, this group of patients were seen as being more difficult to interact with than patients on other wards.

The volunteers had varying degrees of understanding about dementia. Some reported lacking the skills or knowledge of how to deal with challenging situations; volunteers reported difficulties when confronted by aggression, swearing, racism, and repetitive requests. They would subsequently develop an understanding of each patient by observing their behaviour, taking time to speak to them and their family. In contrast to the perspectives of ward staff, other volunteers described their previous experiences with dementia, such as a nursing background or having cared for a relative, and in contrast to the opinions of some ward staff, considered themselves as confident in recognising dementia.

Volunteers felt that previous experience, not only with dementia but life experience, was helpful but not essential. More training was welcomed but not seen as critical because they felt that a patient and compassionate nature was inherent in the qualities of a volunteer, and could not be taught. An individualised

approach towards people with dementia was seen as being more valuable than generic training, with many preferring informal support and an opportunity to ask questions while on the ward. Nevertheless, volunteers appreciated the support of others when coping with the challenges of dementia, and chaplaincy volunteers found the reflective practice sessions particularly useful as a way of developing strategies to deal with future challenging encounters.

However, in contrast to the challenges they faced, and the negative feelings they experienced, many of the volunteers described the positive aspects caring for patients with the condition, and saw patients with dementia as capable, able, and trustworthy. They described the positive effects of being with patients with dementia, their sense of amazement about the extraordinary lives they lived when they were younger, and the sense of satisfaction they felt when helping them. One volunteer talked about how the patients would remember their own dogs and children and he trusted them not to be aggressive when in contact with the pet therapy dog,

'they will remember the dogs they've had generally, they know what they're doing. It's like when you go on there

and you see a lady carrying around a doll! They know what they're doing, they're not going to drop it, they're not going to hit you with it, because it's their baby! and so-same with dogs…I think' (Matt, Volunteer).

Volunteers also described patients with dementia as happy, settled, and smiling,

'Talking to lady […] about her dogs, husband, family etc. All seemed ok then she asked what time the bus was coming to take her to dinner and dancing. She seemed to be in a lovely world' (Ida, Mealtime Volunteer Diary).

Despite sometimes feeling sad as a result of their interactions with patients with dementia, some volunteers enjoyed engaging with them and preferred working with them to any other groups of patients. This sentiment was mainly expressed by the older volunteers; the younger ones described their interactions as being more reserved. These volunteers would actively seek out opportunities for having fun with them and would use humour as a way of coping with difficult situations, such as being unable to understand what patients with dementia were saying to them. Despite experiencing problems with communication, one volunteer described her enjoyment in the interactions she had with patients,

'I really had no clue what she was talking about. I don't think she really understood what I was talking about, but we were communicating on some bizarre level, I mean we actually had quite a laugh because she said something that amused her and she laughed, so I laughed, then she laughed because I was laughing […] and we actually had quite a lot of fun! [laughter]' (Ella, Mealtime Volunteer).

Volunteers reported an overwhelming feeling of sympathy as they described the daily difficulties encountered by those with dementia, and their families. They expressed a sense of stoicism over what they saw as unusual behaviour and tended to accept such behaviours as part of the inevitability of the condition or ageing process.

Some, although not all, of the older volunteers tended to use a different style of language than the younger ones who took a more subtle approach and sensitive stance. It is unclear why this is the case although it was apparent that different age groups adopted a different style of speaking and describing when giving their accounts. All volunteers expressed sympathy and acknowledged the individuality of patients, yet some would describe patients with dementia as having similar behaviour patterns to each other. Most of the older volunteers tended towards

framing their impressions of dementia by using negative or what may be considered to be stigmatising language. When discussing their experiences, this sub group would use generic labels in order to explain their behaviour, such as '*troublemaker*' (Shane, mealtime volunteer diary), *'aggressive wanderer'* (Leo, chaplaincy volunteer diary), *'shouter'* (Leo, chaplaincy volunteer diary), or describing them as '*like sheep'* (Fay, chaplaincy volunteer); it is unclear where these labels might originated from. Their descriptions included feelings of sadness, gloom, dread, fear, loneliness, suffering, and futility. Some had the impression of dementia being a cruel disease, with a sense of these patients being outside the norm, distant, or absent, as illustrated by this retired volunteer's account,

'I was talking to a lady today and she really is not with it at all, but y-you wouldn't know that if you looked at her, she looked quite young and quite normal but anything, oh no she's … she's…away with the fairies' (Ida, Mealtime Volunteer).

Those who spoke of the vulnerability of patients likened them to children, describing them as helpless.

In contrast, the younger volunteers, or those defined as pre retirement age, gave an account of taking a more

positive approach to dealing with the challenges of dementia. For example, one younger mealtime volunteer described her strategy for dealing with repetitive requests from cognitively impaired patients whom she was unable to help,

'I probably try and…keeping it…clear and calm, but without being sort of quite patronising…cos it's not nice…' (Dawn, Mealtime Volunteer).

All volunteers spoke about how their interaction with patients with dementia affected them. Most recognised the short term and often transient nature of their interactions, but volunteers of all ages often described themselves as feeling vulnerable, out of depth, and at a loss when speaking to patients. They frequently expressed a sense of exasperation, feeling unsure how they should interact with patients, or what to say to those patients who made repeated attempts to leave the ward. The sense of futility and subsequent frustration felt by volunteers is illustrated by this account from an interview with a chaplaincy volunteer when giving his account of talking to patients with dementia or memory problems,

'ah….it can be frustrating. On the other hand, it can be quite easy […] it gets on a bit of a repeating loop, but the thing is then you can also back out of it. [Laughs] It's easy

to back out of […] I guess, it's inevitable in any role like this where you think, "Well, could I be-could I be doing something else with the time?"' (Leo, Chaplaincy Volunteer).

As well as describing their experiences of being with patients who had dementia as time consuming, hard work, boring, and exasperating, many also gave an account of the extent to which they were deeply affected by their involvement with patients with dementia. They described how being with them would trigger emotionally charged feelings from similar previous life experiences. Chaplaincy volunteers in particular would describe how they were likely to engage in conversations which may cause patients to become emotional and subsequently feel sad themselves; but the mealtime volunteers too would experience sadness as a result of being with patients with dementia. Interaction with patients with dementia from the so called 'war generation' was seen as being particularly emotive and illustrated by this account from a chaplaincy volunteer,

'I'm going to get emotional now [voice falters] I do think this generation [crosstalk] are very special, the war generation…so yeah […] yeah, sometimes I've had to

bite my-bite my cheek because I've been moved to tears'

(Una, Chaplaincy Volunteer).

These recollections had such a strong effect on this volunteer that it resulted in having to pause the interview until she recovered from her distress and was happy to continue.

The following section will consider the accounts of dementia from the perspectives of patients with dementia, and carers.

4.4.6 The perspectives of patients with dementia, and carers

Both patients who took part in an interview were open about having a diagnosis of dementia, yet spoke little about the condition itself. However, when they did mention it, they framed their reflections using positive terminology. They expressed an awareness of how their behaviour may affect others, and showed concern for the feelings of volunteers. One patient with dementia was mindful of her forgetfulness, and at regular intervals throughout the interview asked her daughter to remind her if she had complained about her stay while she was in hospital. She was keen to convey that she did not want to be a burden to others saying,

'I know there was somebody on hand and I say folks grumble about the food and that, I didn't! So no, no I've not complained to you at all have I?' [turns to daughter] (Dora, Dyad: Patient).

However, carers spoke less positively about dementia than the patients themselves; expressing a sense of dread and futility in engaging with family members who were severely affected by dementia, as well as feeling unsure if they were able to understand the content of conversations. They expressed sadness about their loved one having the condition, describing a sense of them being unable to understand what was being said,

'there's no point telling [patient] anything cos it's in one ear and out the other, you know what I mean? […] If it's someone with a broken leg and they've got their marbles, then […] the patient can tell you […] But if it's somebody like [patient] […] it all depends how far gone they are but, there'd be no point telling [patient], in our particular circumstances' (Arthur, Carer).

While sharing their accounts, carers would refer back to the issue of dementia and describe how they coped with the subsequent changes they saw in the patient. They would reflect on the difficulties they experienced, particularly around accepting the changes brought about

by dementia, and how the condition had contributed towards changes in their personal relationships with each other,

'trying to have a-a meaningful conversation is difficult […] I sat with her […] and we were talking […] I actually thought I was getting through to her […] my son he had a really bad time with her […] it upset him a bit. […] say I've tried to have conversations with the wife. I don't know how much she's…taking in […] but she can't remember what she had for breakfast […] I mean now look at her, you know, she's just struggling…' (Joe, Carer).

Carers felt that patients with dementia deserved good care.

'elderly people they need something. I think they've worked for this country all their life, so why not? They deserve it. They've paid their taxes. They deserve to be treated, you know, and looked after' (Vera, Carer).

They expressed a sense of hope for the future, even though they recognised the likelihood of further deterioration as a consequence of dementia. They appreciated the sympathetic approach of ward staff and volunteers, as well as the repeated attempts of volunteers to interact with patients.

'the one that was on the ward yesterday was absolutely lovely! She's gorgeous! [laughs]' (Chloe, Carer)

Carers expressed appreciation of an individualised approach to patients with dementia, as illustrated by this carer,

'there's some nice people on here […] you know if they notice a little bit of her accent sort of thing "Where are you from?" Then she will talk about [name of country] and you know it's just those kinds of things!' (Owen, Carer)

Patients and carers emphasised the importance of the opportunity for patients with dementia to exercise choice while in hospital. The two patients who were interviewed discussed their need for choice, both giving the same example in their accounts of preferring conversation and interaction over computerised formats,

'I hate the fact that nowadays they're forcing it on you […] I'm in jail! I wanna gerrout! […] …I'm sorry, if the person decides they want to have a fag…that's the patients' prerogative, because you cannot….determine their way for them…you know so its got to be…totally open ended…' (George, Dyad: Patient).

This participant expressed a sense of frustration and anger as he described how the lack of opportunity to

exercise choice exacerbated his feelings of being in what he experienced as an already restrictive environment.

4.4.7 Conclusion

This section sought to provide a contextualisation of the research by exploring the accounts given by participants in relation to dementia. Each group of participants spoke of issues around dementia and offered both negative and positive perspectives.

Managers and ward staff began their accounts by voicing an appreciation of the contribution volunteers make in dementia care. Their accounts developed into an awareness of the risks and drawbacks and how dementia may be seen as having the potential to pose difficulties. Management took a wider view of dementia and spoke more broadly, especially as to how future services could be developed. Their accounts echoed those of ward staff who also voiced concerns over dementia specialties being seen as a less attractive place to volunteer. They discussed the challenges of dementia, and voiced concerns about risk management. Volunteers and carers described the interpersonal aspects of dementia and how they were affected by this, with volunteers themselves reporting feeling uncertain about who had dementia, but accepting patients as individuals regardless of whether or

not they had the condition. Patients were less focussed on the disease itself but were mindful of the effect they may have on others while expressing a desire to exercise choice. Despite the challenges experienced, all participants valued an individualised approach and the contribution volunteers made to patients with dementia.

All participants spoke about the positive and negative aspects of dementia. Dementia itself seemed to evoke a negative image in that it was something to be afraid of, futile, challenging, or to be avoided. On the other hand, accounts were offered of patients with dementia appearing to be happy and settled. This was further complicated by the accounts of the volunteers themselves as the older volunteers would discuss dementia less positively than younger volunteers, assigning labels to describe behaviour.

Participants recognised that supporting patients with dementia might be potentially unsuitable for some volunteers. They highlighted the importance of a specialised approach, and suggested a need for careful risk management.

The description of volunteerism, the environment in which it takes place, and the participants' experiences and perspectives of dementia provides a backdrop against

which to build an understanding of the context in which volunteering happens, and sets the background for further interpretation. The following chapter will explore the themes which have been identified from the data.

Chapter 5 Results: Volunteerism- role and ways of working.

5.1 Introduction

The previous chapter provided a contextualisation of the study by presenting the findings on volunteerism, the environment, and dementia.

This chapter will explore the volunteer role, their function, ways of working, and level of interaction with the paid workforce, from the perspective of each group of participants starting with managers.

5.2 Managers

Managers took a broader perspective of the volunteer role and ways of working, discussing issues at a national, organisational, and interpersonal level. This covered issues around: the role and function of volunteers; their position in the organisation and team; the nature of their relationships with staff and how they work together; and suggested ways to develop the voluntary service. Throughout their accounts, managers focussed on safety and risk management.

Managers had varying levels of contact with volunteers and consequently varying levels of understanding about their role and how they worked. Those in more senior positions did not differentiate between the different types of volunteers and spoke in general terms about the role and function of volunteers. However, they were aware that volunteers perform a range of tasks having spoken to them at celebratory events and having seen them involved in the library and sweet trolley services, signposting visitors, talking to patients, helping with meals, and providing comfort and reassurance to patients and families.

5.2.1 The volunteer role and position in the team

Managers understood the function of volunteers to be one of contributing to the smooth running of services. This was illustrated by one manager who described the role and ways volunteers work as,

'The oil in the machine that's smoothed the working' (Greg, Manager).

They emphasised the complementary role of the voluntary service, rather than one which delivers core services. This is exemplified by a description of their

position in the organisation as an ‘add on’ to existing services, or an integrated support workforce described as filling in the gaps in services,

‘the sort of like cotton wool that fills in all those other bits’ (Ivy, Manager).

They voiced concerns over how the boundaries between paid and unpaid staff could be navigated, and warned against over reliance on volunteers, seeing this as potentially problematic,

‘we need volunteers at the moment because we wouldn't manage without it so if we're going to use volunteers we need to train them up and resource them… but you know you could argue it with the best will in the world that ideally it should be the staff that are delivering […] that, […] what we must be really careful of is not giving the volunteers something that we should be doing anyway’ (Eva, Manager).

Managers also felt there was lack of clarity around the tasks volunteers undertake, and the role itself,

‘I can’t imagine them not being there even if you said that ‘’tell me exactly what they do’’ I probably wouldn’t name everything that they could do, but you just know that if they weren’t there you'd miss them’ (Yvonne, Manager).

It appears that this uncertainty has the potential to lead to misunderstanding at ward level about the type of tasks volunteers can do, and illustrated by this manager's account when describing the level of expectation from ward staff as to the volunteer role,

'they expect you know that your volunteer can take someone to theatre on their trolley for them you know and they can take these blood samples down to the labs and things when actually you know it's a clinical matter isn't it? So yeah if anything people are more shocked that the volunteers have a limited remit' (Amos, Manager).

The concerns of managers over what volunteers do appears to stem from what they regard as being safe for them to do, but their accounts also suggest that these concerns might be based on professional boundaries and status rather than what is possible and safe to do. Managers expressed concern over how such issues should be handled, and the need to guard against volunteers replacing paid staff. They also voiced concerns over issues around patient confidentiality and safeguarding patients when allowing volunteers access to patient areas, and urged caution over allowing volunteers too much choice and freedom in their role. Furthermore, they felt that patients and families may not understand

why volunteers work on wards, their purpose, and what they can do, which might cause concerns over their involvement. So there seems to be some ambivalence in the accounts of managers as they describe the value of volunteers while expressing caveats around their role.

5.2.2 Relationships and ways of working

Managers continued to take a broader view of the volunteer role by emphasising the importance of effective recruitment, support, and the significance of good working relationships between volunteers and paid staff.

They urged caution over recruitment, favouring a stringent and rigorous selection process where volunteers are carefully screened for suitability to the role in order to safeguard patients. They were aware that delays with Disclosure and Barring Service (DBS) checks and limited training sessions, can cause frustration, and result in a higher attrition rate. They also voiced concerns over the high level of administration required to manage the service. One manager described how it was not uncommon for people to sign up to volunteer and then fail to attend. This creates work without the benefit of a volunteer deployed on wards at the end of the process. A common example is when students only need proof of attendance as part of their career plans, such as applying

for university. They register to volunteer but do not attend, and subsequently lie dormant until the necessary paperwork could be completed.

Managers were aware of the challenges and potential drawbacks to the voluntary service, and expressed caution over the volunteer role and ways of working. They felt this could be addressed by managing them in a similar way to that of the paid workforce. However, they also recognised that this model may not be straightforward to translate to the voluntary service, acknowledging that the reasons why people volunteer are often different to the reasons why paid staff work. They also emphasised the importance of meeting the needs of volunteers. This included the provision of refreshments, travel expenses, and organising annual celebratory events as a way to show appreciation. They discussed the importance of recognising and meeting the motivations of volunteers, matching their skills to suitable areas, and offering appropriate placements and support to maximise effective collaborative working.

Managers recognised that voluntary services could be criticised if volunteers undertake tasks designated for the paid workforce; they were subsequently cautious over volunteers being seen as a free service. One manager

emphasised that all volunteers, particularly in chaplaincy, should be able to contain their personal opinions and beliefs, and to self-regulate their behaviour in this sensitive environment. Another manager expressed a preference for fewer volunteers, offering a quality service rather than simply increasing numbers.

'I'd rather lose someone than have the wrong people here, to be honest […] it's just about using what resources we've got and using the skill-sets that we've got where they're best used really, rather than trying to do too much and spread it too thin that we'd do it not well' (Greg, Manager).

The volunteer demographic was mentioned by some managers as having the potential to affect how they worked. Age was one example, with chaplaincy volunteers in particular described as older people with more life experience:

'The age profile is sometimes worrying, but if someone's good at doing what they're good at doing then the age doesn't come into it […] pouring your heart out to an 18-year-old may not feel the same as pouring your heart to someone with grey hair you thinks been around a bit, and seen a bit, you know? I don't know, I don't know, maybe that's a bit prejudicial' (Greg, Manager).

Nevertheless, the diverse ages and backgrounds of volunteers were valued, with managers describing this as having a positive influence on how they worked with others.

As well as discussing individual cases, managers emphasised the importance of good interaction within teams. Managers would begin their accounts by describing the positive aspects of volunteers working as part of the team,

'the volunteer will also have a very strong relationship with the clinical team caring for the patient and may on occasions be able to share information appropriately about the patient to-to the clinical team… to help them care for the patient' (Glen, Manager).

However, while they described the constructive relationships which developed over time as volunteers became established onto a ward, they later on described the potential for difficulties. They anticipated problems in managing what they described as essentially an unpaid workforce with no contractual obligations. They highlighted the challenges of volunteers who expressed a wish to work autonomously and the dangers of volunteers establishing a power base where management might lose control, creating problems for the organisation as

volunteers worked beyond their remit. Difficulties included volunteers not being accepted by staff, or volunteers failing to deliver services in the way staff intended. They also discussed the potential for some volunteers to create problems for the organisation as they built relationships with staff, and became established. They described situations where volunteers caused conflict by refusing to work within the boundaries of their role once they become settled. This manager hesitantly described volunteers who became frustrated at the slow pace of change and subsequently overstepped the boundaries of their role,

'they get a bit blasé […] sometimes we have to say I'm sorry you can't do that because it's you know over the remit of a volunteer which then causes a little bit of… friction… we have dismissed volunteers for over […] stepping their role… and […] even at dismissal point cannot see what we're trying to tell them and why […] dare I say it they-in the end they were dismissed for verbally threatening a […] member […] of staff' (Amos, Manager).

Managers discussed the far reaching implications of this, such as the potential for reputational damage to the organisation, and time spent by paid staff to manage it. One manager described her concern over losing control

over what volunteers do and suggested ways to address such difficulties by:

'giving them the opportunity to try different things and see different things maybe like on a rotational basis […] building up someone's skills too rather than just sticking them in the same space because sometimes I think that's where empires get grown and you can't, no one can infiltrate them' (Ivy, Manager).

Factors affecting how staff and volunteers work together were discussed by managers. Firstly, they understood the pressures on ward staff, describing the challenges of allocating volunteers to wards where staff may be too busy to support them. Secondly, managers gave examples of staff avoiding volunteers, especially if they were seen as requiring additional support, or asking too many questions. They highlighted challenges around communication, describing the ward culture as influencing communication. This included a failure for information to cascade through the organisation when new volunteers start, and miscommunication or misunderstandings at ward level which they described as contributing to volunteers leaving.

Despite the potential for problems to occur, managers saw the voluntary service as currently operating

successfully, especially as it receives limited funding, but offered suggestions for ways to develop the role and the ways volunteers work.

5.2.3 Developing the role and ways of working

The volunteer service was described by managers as taking a short term approach, and operating with little senior management input. The priority of clinical needs over voluntary services, and the subsequent perceived lack of urgency to develop the service was illustrated by this manager who said,

'there's nothing massively wrong with volunteering right now, but it doesn't say this is massively really right […] and if it can continue without a huge amount of thought […] then is there something really, really, wrong with it?' (Ivy, Manager).

This was in no small part seen as due to the difficulties in managing the service with limited resources; it was seen as cost effective but nevertheless requiring an investment in time and effort. Managers held the view that there was scope for further development of the voluntary service, but it remained underfunded. Investment was seen as crucially important because of the current financial

challenges to publically funded services, illustrated by this manager who said,

'the NHS is going through the toughest financial…challenge of its entire 60 plus year history and having volunteers…ensures we can provide services we simply couldn't afford otherwise to provide… and volunteers have always been important a-arguably they're more important now than ever before because of that' (Glen, Manager).

Securing more resources was seen as beneficial in terms of developing the service and providing extra support to volunteers. For instance, when discussing ways to improve voluntary services, one manager responded by saying,

'More staff! (Laughs) yeah … yeah just-just more staff more hours… […] I personally feel that we don't give our volunteers enough time' (Amos, Manager).

Managers were mindful that failing to develop the service to its full potential would be a missed opportunity to improve services. When planning changes, managers highlighted that the needs of patients, as well as the organisation, should be balanced against the needs of volunteers,

‘We’ve got to find what works best for us as well, not just the volunteer. So it's trying to find that balance between the two because if we've just got the same volunteers doing the same thing, we're always going to have these gaps that are always going to be missed’ (Ivy, Manager).

Managers suggested ways to improve the service which included assessing the current situation, exploring funding opportunities, and collaborating at a wider, local, and individual level. An assessment of the service would include understanding the impact and efficacy of volunteers, with recommendations to establish an evidence base; reflect on current practice; establish what the entire range of volunteering opportunities are; and ensure that volunteers are deployed to areas of the hospital most in need. Furthermore, managers urged for a clear vision and plan for the future, including an understanding of why there is a variation in the number of volunteers in wards and departments within the trust.

Managers discussed the potential benefits of increased financial investment which would fund further support for volunteers. One suggestion for accessing further investment was to develop a business case to obtain charitable funding in order to pump prime the service to catalyse improvements. Other suggestions included the

provision of a designated space for volunteers to meet, and further investment in the recruitment and deployment of volunteers to facilitate more integrated ways of working with staff. This was seen to be potentially more important in an era of austerity and limited public funding, as managers anticipated more people would come forward to volunteer if they felt supported.

However, managers were also of the opinion that despite limited funding and limited availability of support staff, the position of the voluntary service was seen as a lower priority in terms of receiving funding in comparison to other services within the hospital, and accepted that the service must continue with existing resources,

'there is no more new funding […] you've got to make the best of what you've got […] which I suppose is in some ways why it's more important and more vital that if we've got the right people, in the right places doing the right things, volunteers, then we can make the most of what we've got, and that funding becomes less of an issue'
(Ivy, Manager).

All managers described the potential for improving the voluntary services, with one suggesting it could be integrated into the hospital trust business model,

'If you're going to develop a business case for this in the future, you got to be a bit bold and look at how much is spent on cohorting patients […] and actually, if you had a robust volunteering workforce, could you minimize that cost? Or could you reduce the spend?' (Olive, Manager).

Suggestions to improve the service included collaborative working with industry to offer opportunities to businesses who support employees to volunteer their time, rather than a charitable donation. They anticipated the development of new roles, one example being the falls prevention strategy, which might involve volunteers being deployed to sit with those patients at risk of falls to observe them with the aim of preventing further injury. This was seen as having the potential to help manage the costs incurred when using agency staff to do this work, and so reduce labour costs by filling gaps in the paid workforce, but would amount to volunteers doing the work of paid staff. Other strategies to develop the service included linking with other organisations to develop a national strategy to manage hospital volunteer services centrally; planning targeted recruitment campaigns to include specific groups of people, such as younger people; and planning events such as national volunteer week in order to meet the seasonal needs of the organisation. All managers were either supportive of the

fact that volunteers received training, or expressed the need for further training to equip volunteers with the information necessary to deal with changes in the organisation to streamline services,

'With the right training, even if it is that they're people who can come in and do activities but we do that in a very coordinated way, I think we need to be planning for that, so that they can respond in line with what we know will be a change in patient cohort' (Yvonne, Manager).

They suggested that further training could improve communication and so maximise the impact volunteers have on patients, however managers were also mindful of the difficulties in organising and funding this.

Managers saw a gap between volunteers leaving the recruitment phase and starting on the wards,

'Once we get to ward placements… communication between a LOT of the wards is-is poor really […] we tend to have a LOT of people coming back saying 'well they're not giving me things to do'' (Amos, Manager).

This manager described the difference between success and failure of ways of working hinged on whether or not ward staff adopted a positive and welcoming approach to volunteers, and the degree of communication between

the voluntary service management team, and ward staff. In recognition of the need to encourage more integrated ways of working, managers suggested ways the voluntary service could be developed at local level. They felt that more could be done to facilitate the integration of volunteers into the workforce by increasing awareness of what volunteers can do.

As well as suggesting changes to the services at wider and local level, managers felt that the volunteer role itself could be developed. They suggested publicising the role of volunteers in dementia and acute wards so staff and visitors become more aware of their function, responsibilities, and boundaries. Other suggestions included applying a different model widening the boundaries of the volunteer role by exploring cross-disciplinary working such as across hospitals and the community in an attempt to streamline services. Managers who were also clinicians felt that the work of volunteers could be more focused and outcome driven, and tailored to the patients' care plan,

'if […]…a dementia patient has got problems with…I don't know mobility of their arm or something, they can't get it that they've got to move their arm or something, and the physio's advice is […] do repetitive movement […] so

then your volunteer activity should be to do something to get them to use their arm. So it's targeted volunteering… with the team… would be perfect' (Eva, Manager).

Managers tempered their vision to develop the service with an understanding that change takes time, and may be difficult to implement.

Having explored the accounts of managers, the following section will discuss the views of ward staff.

5.3 Ward staff

While managers took a wider view of the volunteer role and ways of working from an organisational perspective, ward staff discussed their impact at ward level.

5.3.1 The volunteer role and position in the team

The picture was mixed across ward staff as to how well prepared volunteers were when arriving on older person acute wards. Similarly to the accounts of some managers, age was mentioned and there was a general feeling among staff that older volunteers were more capable and better prepared than younger ones because of previous life and work experiences. Ward staff described volunteers undertaking practical tasks such as

helping with mealtimes, administration, cleaning, stocking up supplies, running errands, as well as spending time with patients providing them with the opportunity for social engagement and conversation. They described the role as useful because volunteers were another person on the ward who could observe patients at risk of falls. They described how volunteers would use the 'about me' forms to prompt conversation. Others were seen as having the interpersonal skills to engage and connect with patients with dementia, without the need for the 'about me',

'There was a gentleman who we were trying…he was quite agitated […]…but one of the volunteers came along and they lived in a similar area. So when-when the volunteer sat down and started talking about places that they both knew about, that was really useful in just sort of calming the situation and you know building a-a-a relationship there in that short time' (Neil, Ward Staff).

In contrast to the accounts of managers, ward staff described volunteers working autonomously which afforded them the freedom to choose what they could do, some preferring to run errands and undertake housekeeping and administration type duties, rather than engaging in patient focussed activities.

However, some ward staff expressed uncertainty over the role of volunteers and their function within the team,

'I'm not sure what they're allowed to do and what they're not allowed to do' (Zoe, Ward Staff).

They were unsure of the boundaries and limitations of their role, who was responsible for their management and supervision, how volunteers were allocated, and where they fit into the team. The perspectives of ward staff as to where volunteers were positioned as part of the workforce seemed to vary, with volunteers seen as being on the periphery of the ward team, as an extension of the team, or there to complement and support paid staff. There was a sense of segregation with ward staff seeing volunteers as separate to the multidisciplinary team (MDT), and they were not always introduced to each other. Some staff felt that volunteers were not part of the team, which was illustrated by one member of staff who said,

'I don't think they feel like they're part of the team at all […] I don't think they feel like they fit into the team at all, at the minute- but I don't feel like they feel like they've got a defined role at all either' (Lisa, Ward Staff).

However, other ward staff felt they were integrated, and described how they embraced and defended volunteers

as part of the ward team, even going as far as to describe longstanding volunteers as part of the ward family,

'They're very much part of the team and they do help, considerably at times […] they came week in, week out, year in, year out, like anything else, you build your bond and your trust […] and they just become part of our [name of ward] family' (Lily, Ward Staff).

Nevertheless, ward staff understood that it took time to develop a working relationship and gave examples of volunteers working collaboratively. In terms of integrating volunteers into the team, their unpaid status was discussed by some ward staff. This did not sit comfortably with the small cluster who mentioned payment, as they felt it was fundamentally unfair to expect people to undertake tasks to benefit patients and for them not to be paid. This highlights a dilemma in navigating the boundaries of the volunteer role and ways of working, and their position in the organisation, because such boundaries do not appear to be clear. For instance, volunteers might fill in for paid staff who were on sick leave; manage the reception desk; and take on the duties of housekeeper. Despite ward staff expressing uncertainty over the role, they nevertheless felt it necessary that volunteers knew the boundaries of their

role in order to prevent confusion and potentially cause problems. Ward staff saw volunteers as adding to existing services, rather than replacing paid staff. They saw the potential for paid staff to be replaced by volunteers, seeing the over-reliance on volunteers and the allocation of tasks traditionally done by paid staff as possibly causing widespread resentment in both staff and volunteers. The recognition that volunteers might replace paid staff was balanced against some staff questioning why volunteers could not do more,

'Volunteers could do what I do! […] you know if you're a volunteer and you recognize that you're doing …a job that other people are getting paid to do, is that then going to cause resentment from the volunteers? […] will they think, ''well...actually I may as well come and get paid for doing it then'' […] you know it kind of makes you wonder …why aren't they doing more?' (Gwen, Ward Staff).

Consequently, ward staff urged caution over volunteers replacing paid staff as they were recognised as filling the gap between services offered by paid staff to patients with dementia by offering additional support and help.

5.3.2 Relationships and ways of working

The nature of the relationships between staff and volunteers appeared to vary. Volunteers were described by ward staff as working both independently and in collaboration with the team. At the beginning of their relationship interactions between staff and volunteers would commonly be brief, if at all. Ward staff described how they would check if volunteers were happy to do allocated tasks and would discretely observe volunteers to ensure safety when they first started working on the ward, with the intention that they did not want them to feel as if they were under surveillance. As they became familiar with each other, volunteers were described as requiring less direct supervision. Ward staff felt that volunteers would respond to their requests, and the variety of tasks they undertook alleviated their workload. While they described the positive and negative aspects of their relationships with volunteers, ward staff highlighted a need for improvement, focussing on the need for more collaboration.

When discussing the positive aspects of their relationships with volunteers, ward staff judged them to be reciprocal where each receives support from the other. They understood the importance of giving time to support

volunteers, especially when they asked staff for help. They felt there should be appropriate mentorship, support, and supervision for volunteers, especially when patients died. Good relationships were seen as largely beneficial in contributing to meeting the needs of patients with dementia, however several ward staff emphasised that volunteers were not expected to work with patients who have complex needs who might be seen as challenging and difficult to interact with. Ward staff anticipated that by helping them to feel part of the team, volunteers would experience greater job satisfaction and be more likely to stay, which would in turn help staff. Ways to achieve this were through the voluntary services system itself, and included adequate training; clear communication; having a welcoming point of contact; someone to report to on arrival and to work alongside; an update at the beginning of their shift; and guidance and direction along with a rationale.

Ward staff spoke about the pressure of their workload and how they appreciated the support of volunteers because it allowed them to focus on more urgent cases. One member of the ward staff gave an account of feeling reassured when working with volunteers,

‘Patient was distressed […] somebody could have sat with one of the other patients and perhaps done something with them, […] held their hand, or chatted to them, or … brought them a drink or something then… then yeah that would have been really helpful. That would have reduced my stress because then I would know that actually […] the other people were being… were having a service as well…’ (Rose, Ward Staff)

Indeed, three members of staff described how volunteers had alerted them to seriously ill or deteriorating patients, as illustrated by this member of staff describing a patient who,

‘-had suddenly become quite poorly […] she didn't know what it was, but she had the sense to come and say, "He's not right. There's something wrong with him. Come and have a look!" …and potentially, that saved that gentleman's life’ (Lily, Ward Staff).

Furthermore, ward staff expressed concern for the welfare of volunteers, realising the importance of them experiencing job satisfaction and variety. They appreciated the diversity of the volunteer population, seeing it as beneficial to patients. Ward staff recognised that volunteers were often undervalued and went unrecognised, and there was a need to raise staff

awareness and understanding of their role. It was felt that any lack of a connection with volunteers was a missed opportunity to maximise their support, as well as the potential to negatively affect the retention rate of volunteers. One member of the ward staff expressed frustration when volunteers left but accepted the transient nature of the role. It was also recognised that volunteers might attend for one shift only and not return if they felt ignored and unappreciated by staff, as illustrated by this account from a member of the ancillary staff,

'yeah they don't treat some of the volunteers them good, no! They let them stand there like they're nobody […] and some of them do cry and don't come back […] some of them said, "I'm not coming back." […] there was this […] volunteer and she went off crying and she said to us […] "I will never come back into this hospital." […] We never see her again' (Isla, Ward Staff).

Indeed, some ward staff described how they would avoid volunteers, not interacting with them at all,

'I have my own daily duties and commitments and really don't have a lot of involvement with volunteers. You know if I'm honest, I've tended to ignore them really' (Gwen, Ward Staff).

However, those ward staff who said they had not had much contact or interaction with volunteers said they would like the opportunity for more engagement. Ward staff expressed a desire to work with more volunteers than they currently did, describing them as having the potential to enhance the workforce and improve services. They were aware of the need to support volunteers but equally aware that this did not always happen, citing their heavy workload as the main reason why.

There was a general feeling that providing supervision and support to volunteers was not the responsibility of individual members of staff, and sharing information with them might increase their workload. They offered suggestions to develop the role and ways of working.

5.3.3 Developing the role and ways of working

The general feeling was that the volunteer system itself needed more investment in terms of structure, support, and the systematic organisation of volunteers on a larger scale to match the scale of need for disengaged or unoccupied patients with dementia, and busy staff in this environment.

Uncertainty over the volunteer role was a common theme throughout ward staff accounts. They spoke of addressing these uncertainties by being given more information about their role, function, and ways of working. Volunteers were described as willing to undertake more tasks but prohibited from overstepping the boundaries of their role. Subsequently ward staff felt that volunteers were limited in what they could do and that the role could be expanded to cover a wider range and variety of tasks and by allocating them specific patients. Some felt that volunteers were not always used appropriately, and there was potential for further development of the role. Others saw the potential for volunteers' skills to be identified to maximise the help offered to the ward to organise and lead activities. Most saw advantages to having even more volunteers, especially if they were able to come at different times of the day, rather than the set shifts already in place. Eight members of the ward staff discussed issues around diversity, emphasising the benefits of having a varied demographic of volunteers from a wide range of backgrounds. They saw this as a valuable contribution to supporting patients with dementia, who may also come from different backgrounds:

'we often find that men don't want to engage in groups as much as the ladies do […] we are quite female-weighted […] topics of discussion can be quite limited […] sports and things like that, those sorts of topics […] really would benefit I think more male, perhaps if we can get more male volunteers' (Neil, Ward Staff).

As well as expressing uncertainty and a wish for more investment and information, ward staff discussed other ways to improve voluntary services. The two main points were around increased collaboration and tailoring the ways volunteers worked with the clinical team, as well as suggesting ways to improve communication.

One suggestion was to change how volunteers work to give more purpose to their tasks. This might include increased collaboration and integrated ways of working with the team, including developing the role to align voluntary activities with the work of the multi-disciplinary team, particularly therapists. This also might include tailoring the activities of volunteers in a meaningful and purposeful way to bring them in line with discharge and rehabilitation goals with the aim of maximising patient recovery and accelerate discharges,

'kind of integrate them into our team use them to help the patient experience […] I think […] it's a good time to kind

of think about how we can get that you know …use them better […] giving them a better experience on the ward also to benefit patients better' (Lisa, Ward Staff).

As well as suggesting more integrated ways of working, ward staff felt that communication with volunteers could be improved. Some members of ward staff who were interviewed spoke about communication. One participant illustrates this by emphasising the importance of communication and working together as a team,

'We need more communication between both-everybody. You can't just be you, because it's not about you, it's about the whole entire complex that we are involved into and the patient care and how we do it and why we have to do it…yeah… […] and if we don't have a team, we don't have a workforce, isn't it? No. […] I think a lot of things need changing. And if there is people who can fix it, it would work better. […] We need it to fix. We need team. Because if we have nurses, carers, care assistant, doctors, practitioners and everybody, volunteers and everybody, we come together, we knows what can happen' (Isla, Ward Staff).

Two members of the ward staff felt that good communication would happen naturally as a result of good relationships. However, one of the ward staff felt

that volunteers did not need access to information as they were not involved in discharge planning,

'I suppose if they're not involved with discharge and… if they're not …committed to, say, a day a week on the ward …then there-there's probably no there's no need for them to sort of be involved in that side of it' (Tess, Ward Staff).

This cluster who discussed issues around communication, suggested ways it could be developed and improved. One suggestion was for further clarification over the role of volunteers, with a wish for more information, feedback, and a greater degree of interaction with volunteers and the voluntary service itself. Ward staff were uncertain about what training or induction volunteers received and who should be responsible for training them. They felt that volunteers would benefit from extra training in dementia, communication, and how to manage risks to improve their understanding of the special needs of patients with dementia. However, they also felt this could be provided informally. They described how they would occasionally offer information about dementia to volunteers, and by encouraging them to learn through experience by listening, interacting, and showing an interest in, and affection towards, people with

dementia. This was seen as a way of contributing towards increasing the confidence of volunteers, subsequently improving their understanding, motivation, and the quality of their interactions.

Another suggestion was to encourage the use of the 'about me' form. However, two members of the ward staff spoke about the effect culture can have on relationships within the team, describing hierarchical ways of working which was understood to have an effect on how volunteers worked with them. One example of this was a member of the ward staff who spoke of the need to challenge elitist attitudes around documentation, particularly when using the 'about me' form. He described the document as being kept in the nursing notes on some wards, rather than at the bedside, and therefore not as easily accessible to the team, or volunteers,

'About me should be a working document. […] a volunteer, they just come to sit and chat, they might be able to get information that we can't. So yeah, absolutely, they should be writing in the 'about me's' […] there will be people out there that believe that […] volunteers […] shouldn't be touching paperwork […] that's part of the culture that's trying to be changed […] by […] challenging attitudes' (Rick, Ward Staff).

As part of the drive to develop working relationships with volunteers, ward staff advocated a more open and collaborative approach, particularly around sharing information. However, they were aware that this did not happen routinely and cited the need to prioritise their clinical workload as the reason why,

'you've got relatively little time to do the job you meant to be there to do, sitting around and making polite conversation with volunteers doesn't get to the top of the priority list [laughs]' (Ben, Ward Staff).

Lastly, ward staff were cognisant of the challenges, not least because of the need for further investment in time needed to organise and implement change. They described the often task based nature of their work. While volunteering might appear to fit into an infrastructure based on task allocation, they recognised the need for a move away from hierarchical ways of working towards an increased focus on volunteers providing quality, social experiences for patients with dementia.

Having considered the views of managers and ward staff on the ways of working, there will now follow an exploration of the accounts from volunteers.

5.4 Volunteers

Volunteers described themselves as working both independently and in isolation from the team, as well as together with ward staff. They gave examples of team working and described the degree to which they integrated with staff, describing the boundaries encountered when negotiating relationships, and the barriers and facilitators to team working. They also spoke about communication and training and how this impacted on their role and ways of working.

5.4.1 The volunteer role and ways of working

Volunteers described how they could work independently or with others. All volunteers commonly reported difficulties when they first started on the wards. In the absence of direct supervision, they described how they developed a routine, a standard way of working, whereby they would arrive on the wards and sign the attendance register. Mealtime volunteers would put on an apron and engage patients in conversation as they began to clear bedtables in preparation for lunch. Once meals were distributed and patients helped with their food, volunteers would clear up and look for ways to fill time until the end of their shift. This would include identifying patients who

they judged to be lonely or sad, and they would attempt to engage them in conversation or activities. They would also run errands for ward staff if needed.

There appear to be differences between the chaplaincy and mealtime volunteer roles. Mealtime volunteers take on what might be considered to be a more manual role involving ‘hands on’ tasks such as light cleaning duties, wiping tables, clearing away dirty dishes, and generally doing things to help patients in a practical way. Whereas chaplaincy volunteers are there to engage in in-depth conversations along the lines of a counselling service, report in the written records, and simply be there for patients to talk to. Chaplaincy volunteers were given a list of patients to visit but would also approach patients they felt needed support, or would be asked by ward staff to see patients once on the ward. Occasionally ward staff would ask chaplaincy volunteers to make drinks for patients, or run errands, seemingly unaware of the difference in the mealtime and chaplaincy roles. Furthermore, there were differences between the facilities and level of support provided for chaplaincy and mealtime volunteers. The chaplaincy department had extra facilities including a private rest area, opportunities to attend religious retreats and social events, and a chaplain who

was available at volunteer shift times to provide additional support.

There also appeared to be a difference between the types of conversations volunteers had with patients. Chaplaincy volunteers were there to offer spiritual and pastoral support which often included issues around loss, illness, bereavement, and fears of dying. On the other hand, the content of the conversations mealtime volunteers had with patients was described as generally being around practicalities of ward life such as eating, drinking, toileting, walking, activities and occupation. This introduces the possibility that volunteer roles and the tasks they do might impact on their status, as mealtime volunteers undertake mechanical tasks and chaplaincy volunteers engage in more skilled work. How the volunteers themselves might feel about this is illustrated by one account,

'Sometimes if somebody comes onto the ward and wants to do something, I will endeavour to help their-tell them where to go, because…in effect, stand in for the receptionist if the receptionist isn't there, that sort of thing. Or on one occasion even go and fetch stuff! [Laughs]'

(Leo, Chaplaincy Volunteer).

When asked he had any involvement in mealtimes he said,

'No, no I don't. I've not been trained to, and I think well, maybe I could, but since I'm not -- that is in a sense is not my designated role, but as I say I'm off by the time lunch arrives' (Leo, Chaplaincy Volunteer).

This illustrates his humour at being involved in menial tasks and clear understanding of his role as someone who talks to patients, rather than to serve meals. On the other hand, another chaplaincy volunteer expressed her lack of concern over what she did to support patients; this was her response to being asked how she might feel about taking on the role of mealtime volunteer,

'It wouldn't bother me, I would enjoy it' (Iris, Chaplaincy Volunteer).

A further point to note about how volunteer tasks might have a connection with status, is an example of ringing the bell for mealtimes. Two volunteers described how they took it upon themselves to ring the bell to alert the ward team that the meal trolley had arrived on the ward. However, one felt reprimanded by a member of the ward staff for doing so without any understanding of why,

‘I learned today that there must be a rota for ringing the bell. Cos somebody said, "It's my turn to ring the bell!" because I'd started ringing the bell! [Laughs] It was time. And I mean I just thought I was saving somebody the bother. Ooh! Somebody reacted "It was my turn to ring that bell", I said, "Oh, there you are!" [laughs] And she rang it!

Interviewer: was she having a laugh? Or just joking?

Interviewee: I don't think she was!’

(Anne, Mealtime Volunteer).

Therefore it seems that there were differences in the volunteer roles. Chaplaincy volunteers had more intensive training and seemed to have more responsibility than mealtime volunteers as they were allocated patients, were involved in spiritual conversations, and contributed to record keeping of a potentially sensitive nature. In contrast, the mealtime volunteer role was of a more practical nature.

5.4.2 Relationships and ways of working

As well as relationships between management and ward staff, volunteers also built relationships with other volunteers and staff around the hospital as they ran errands to different departments. Some would meet other volunteers for lunch while on duty as well as meeting socially outside work.

It is unclear how volunteers were generally referred to by staff other than being assigned the term ‘volunteer’ which encapsulated all the different volunteer roles. However, those volunteers who had been in the role for longer periods spoke of their appreciation of small acts of recognition, such as staff using their first names, which helped them feel included. Two volunteers said they had social contact with staff outside of work and would exchange gifts at Christmas.

Volunteers described how ward staff shift changes meant they worked with different people each week; this was cited as one reason why it took time to build relationships. However, working together over a period of time appeared to change the relationship volunteers and staff had with each other. This seemed to be partly because of them sharing the emotional aspects of ward work

together, as illustrated by this diary entry from a mealtime volunteer when she describes the death of a patient,

'Lady […] died whilst I was on the ward. Her husband and son were with her. It was very moving when her husband left he came to find the senior nurse to thank her for all she had done for his wife. It was very touching and we were all close to tears' (Ida, Mealtime Volunteer Diary).

When working independently, volunteers described how they developed a range of coping strategies. This included approaching patients slowly, or removing potential missiles to prevent injury. It was also quite common for volunteers to routinely use avoidance in order to cope with the demands of engaging with patients with dementia or memory impairment, especially if they were faced with signs of confusion or aggression. One volunteer described how he preferred to work independently, and keep a low profile,

'I don't like sitting there and…you know I'd sooner be get out of the way. Stand around the corner out the way' (Shane, Mealtime Volunteer).

It emerged that his main reason for volunteering was to establish social contact with others, and valued interactions with ward staff.

The reasons given by volunteers as to why they exercised avoidance included a sense of futility, a lack of knowledge and sense of powerlessness, and a feeling that they had exhausted all their ideas of how they could help. Firstly, one volunteer wondered if he was helping anyone as he described feelings that his efforts to help patients with dementia were futile,

'had three reasonable conversations although one of the patients had dementia-I don't know how severe, but I noticed that after five minutes he started to repeat himself and he went round in circles for a bit. Again, I was left feeling that I hadn't done an awful lot of good, but I suppose I hadn't done any harm either […] an enjoyable chat but for the umpteenth time I wondered what I was doing there' (Leo, Chaplaincy Volunteer Diary).

Another volunteer described how he felt about his ability to help patients with dementia, feeling he did not know what to do, nor in possession of the necessary skills to help them,

'I mean I can't do much for 'em…. No…no I can't help them I don't think' (Shane, Mealtime Volunteer).

Another volunteer described how she would carry on with other duties once she felt she had exhausted all the possibilities of helping patients with dementia,

'you will sort of just like sort of start to walk away and then sort of …carry on distributing meals to the rest of the ward' (Dawn, Mealtime Volunteer).

On the other hand, some volunteers went out of their way to engage with patients, despite experiencing difficulties,

'I just think, "Oh, I could perhaps be doing a bit more." […] I just usually wander around and look for a likely patient that might want to chat [laughs] […] I don't know that much about it really but there's patients that I've spoken to that are-are in a different place and seeing something different to me…and I'm quite happy to talk to them' (Ella, Mealtime Volunteer).

As well as choosing to avoid or engage with patients, some volunteers expressed a preference for working autonomously and purposely chose tasks they could do alone, such as running errands or stocking up equipment, feeling more comfortable keeping their distance from both staff and patients. Volunteers also described how they would withdraw from staff to a certain extent as they did not want to be in their way, seen as a hindrance to the workings of the ward, or seen as inappropriately inquisitive.

There appeared to be more opportunity for mealtime volunteers to work alongside the ward team than

chaplaincy volunteers. This was mainly because of the interpersonal nature of the chaplaincy role as they engaged in one-to-one pastoral conversations at the bedside. Mealtime volunteers would work with ward staff to distribute meals and assist patients to eat and drink. This gave them an opportunity to informally chat together and get to know them. Some volunteers described staff as being friendly and helpful, while others reported feeling uncomfortable and unwanted at times.

As well as working independently, volunteers also worked alongside paid staff. Experienced volunteers would routinely be asked to supervise new volunteers, or non-clinical staff who visited the ward for further experience. Those who were asked to do this described the experience as giving them a feeling of being trusted by staff to undertake a supervisory role, and helped them to feel part of the ward team. As well as supervising new staff, volunteers described how they would try to help new members of staff regardless of their status. This account illustrates the dynamic nature of team working as a mealtime volunteer was approached by a new doctor seeking help with a clinical matter,

'one young doctor […] was doing a …cannula and …I've seen doctors before and they get you know … the

different …things from the cupboard so I knew vaguely what they get and I said the swabs are there and […] she held her tray in front of me and she says, "Have I got everything I need?" [giggles] […] she looked about 12 and she was so nervous and I said, "I am sorry love. I'm a volunteer"' (Sally, Mealtime Volunteer).

When describing their relationships with ward staff, it appears that volunteers had the most contact with nursing staff, activity coordinators, and food service assistants. They also had contact with therapists and doctors, but to a lesser extent. The majority of volunteers expressed admiration for the nursing staff and reported feeling secure and reassured by the care given to patients,

'The nurses are always there …when there's anything goes off... They're always there. They're there like that. They don't leave. You never see the ward empty of a nurse. Brilliant they are' (Shane, Mealtime Volunteer).

Despite the volunteer role being clearly defined and described at the mandatory training sessions, volunteers nevertheless expressed uncertainty over their position in the workforce. When asked how they felt as part of the team, their accounts varied from feeling completely integrated to the extent they would be invited out on

social occasions, to neither feeling part of the team, nor wanting to. There was a sense of feeling lost in the beginning, with new volunteers navigating the ward environment through a process of trial and error. Those volunteers who did not feel integrated into the team described being on the periphery, feeling that they had a role to play but not as part of the mainstream workforce as illustrated by this mealtime volunteer's diary account,

'Felt awkward/ a 'spare part' when patients were eating. Unsure of what is required of me other than to talk to the patients' (Rita, Mealtime Volunteer Diary).

The extent to which volunteers and staff communicated with each other seemed to vary. Chaplaincy volunteers would complete notes about who they had seen while visiting the ward for the chaplaincy team. Any information they received was seen as useful and was appreciated by volunteers. This is illustrated by a volunteer who described working with one of the physiotherapists,

'she used to make me a little list out before I went in in the morning of […] who was talkative, who wasn't, who was very ill, who went to church, […] and that helped me because I didn't go to people who didn't want anybody talking to them you know, so basically knew who to chat

to about what […] it was so thoughtful, really was' (Fay, Chaplaincy Volunteer).

However, some volunteers described experiencing a lack of interaction and communication from staff, and the perceived lack of an initial point of contact once arriving on the ward. A lack of structure, direction, and guidance around activities for volunteers, was also seen as a challenge to establishing integrated ways of working.

Some volunteers reported feeling invisible, unrecognised and unacknowledged by staff. Others felt valued by doctors and nurses. One volunteer gave an example of feeling valued by ward staff when the doctor said they would return after she had finished her conversation with the patient she was talking to,

'they always said if the doctors were coming round, you know we had to sort of leave that patient and move, but it's surprising the amount of doctors that actually said to me, "I'll see somebody else and I'll come back"—and I used to think, "oh bless you." You know it's just so nice' (Fay, Chaplaincy Volunteer).

Volunteers described how they built relationships with management, staff, and other volunteers over time. Both mealtime and chaplaincy volunteers described their relationships with management as being supportive, and

appreciated efforts to allocate them to their preferred placement. They also felt that there was scope for improvement by the provision of more training and information, guidance, support, and help integrating into the wards.

With respect to teamwork once on the wards, volunteers expressed an understanding it would take time for trust to develop and to form relationships with staff. Indeed, the level of integration between volunteers and ward staff appeared to increase over time as relationships developed. However, in the beginning, both mealtime and chaplaincy volunteers described feeling a sense of isolation and disengagement from staff, feeling alone and striving for ways to problem solve independently. Nevertheless, some volunteers expressed a sense of satisfaction in being able to work independently as they had learnt what was required of them over time, some preferring to work alone.

5.4.3 Navigating the role

There was a sense from the volunteers that they must carefully navigate some aspects of their role. They expressed how they would encounter unexpected situations which required careful decision making. This included self-direction, often in the absence of a member

of staff to guide them, or from whom to receive advice and support. Volunteers expressed an awareness of the organisational expectations of the role and the boundaries involved, having been fully briefed at the mandatory and induction training sessions by voluntary services, and given verbal and written information about what they are expected to do, and what they are not allowed to do before they reach the wards and begin working in the role. Yet despite the organizational expectations of the role and ways of working, volunteers described finding themselves having to decide how to respond to situations not covered by the training sessions. Lacking the knowledge of how to deal with some situations, volunteers described feeling unsure of what to do, how to do it, or if they should. Their accounts illustrated the difficulties they experienced when navigating the needs of patients, carers, and staff who requested help which may lie outside the remit of their role. They described how ward staff were busy and not always immediately available to respond to queries, and they were reluctant to create more work for them by asking for help.

In the absence of verbal information, volunteers described how they used auditory and visual cues to make meaning of what happens on wards. They would

also listen or overhear staff talking together, or observe the ward environment and how staff handle situations, using it as an opportunity to learn. For example curtains drawn around the bed area for long periods might indicate that a patient had died.

Nevertheless, despite their awareness of the boundaries of the role; partly driven by the needs of the ward, and partly because of their wish to be helpful, it emerged that volunteers would take on extra tasks outside their role boundaries. These appeared to be prompted by the needs of patients, and included assistance with light touch personal hygiene in an attempt to comfort patients. Examples given included such as wiping hands, nose and mouth, and rubbing the patient's back. Volunteers would be approached by patients, carers, or staff, and asked to undertake tasks which they were aware were outside their remit, such as pushing patients in wheelchairs to attend appointments, or taking patients to the toilet. They described feeling eager to help and having a sense of obligation to help patients and staff,

'I'm quite happy to throw myself into anything really [pause] […] Now we weren't supposed to take people outside in wheelchairs anyway, but what can you do […] you know and that was hard because that pavement in

the road […] and one man he was huge! Oh! […] I turned round and I was pulling him. I thought it might be easier and then started to go downhill and I thought, "I'm going to be squashed here!" so I had to sort of spin the chair round, he nearly fell out the chair…' (Fay, Chaplaincy Volunteer).

In the absence of a point of contact to ask for help and advice, volunteers described how they would strive to find a solution and manage situations to the best of their ability.

Despite the understanding that volunteers are a complementary service and prohibited from undertaking any clinical duties, it emerged that volunteers were asked to supervise patients at risk of falls in the absence of an available member of staff. The following example highlights the complexities of this,

'they have the cohort wards … where you can't leave the patients. And they'll just say 'oh just stand there [name] will you?' [laughs] and I say, 'What do I do then if they move?' ..'tell 'em to sit down!' [laughs] […] so I stand there… […] [points with finger] 'you dare move!' [laughs] […] I just make sure that their table is pushed in front of them. If-if they start pushing it back I just say—'ooh let's

just you know' so I move the table back to pen them in a bit more where they're sat' (Sally, Mealtime Volunteer).

In the absence of information, or feeling reluctant to ask staff for guidance, volunteers spoke about sometimes finding themselves in situations where they had to make a decision on whether or not to restrict the free movement of patients, seemingly in an attempt to maintain safety. This included encouraging patients to remain seated when they wished to move around the ward freely, or putting up bedrails without prior knowledge that the patient had been assessed. Furthermore, none of the volunteer accounts expressed awareness of the procedures in place for staff to assess patients at risk of falls. Such decisions, albeit well-meant and innocently executed with the best of intentions, raise serious issues around the mental capacity act and deprivation of liberty, the safeguarding of vulnerable adults, and acting in the best interest of the patient without sufficient knowledge or authority to do so (NICE, 2018).

Some volunteers described feeling uncomfortable when approaching staff for help, and expressed a wish for more knowledge and authority to take on a wider range of duties in order to feel helpful. Common examples given were patients who needed to use the toilet, a task which

is not part of the role of a volunteer. The following comment illustrates the dilemma faced by volunteers when asking staff to help patients with their toileting needs, which in some cases was seen as having an effect on the working relationship with paid staff:

'if the staff are busy […] you have to be a bit careful if they're desperate to go to the loo. I will sometimes go and ask the staff but sometimes you're treading on a bit of a hot potato there, but if somebody's asked me to go and do that I will go and do it [laughs] doesn't matter what expression I get!' (Enid, Chaplaincy Volunteer).

Volunteers described how they would persevere with the role of advocate despite sometimes feeling uncomfortable, and would encourage patients to ask staff for help and information. This account from a mealtime volunteer's diary of speaking to patients who needed help serves to illustrate the point,

'I suggested that they asked the nursing staff […] the older ladies – they don't want to 'be a bother' […..] I explained that all the staff were there to care and help them and they expected to be asked questions and would not mind in the least' (Ella, Mealtime Volunteer Diary).

Volunteers would overcome their reluctance to approach ward staff they saw as busy if they felt the patient was in

need of urgent attention. This account describes a patient receiving emergency treatment from the team for an acute episode of illness as a direct result of the actions of the volunteer who had alerted a member of staff to a patient who had deteriorated,

'I was talking to [name] […] she was looking but quiet. I thought she tired, ask the nurse if she can lie on the bed. When nurse […] saw, she start saying 'she going, going, going' & one minute 2-3 doctor came with some big machine, whole team survive her, I mean to say save her life. I was panic that time but in the end I was very happy to see her. Then after two week they send her home. Then [name of nurse] told me I did the right thing what I did. In my mind I was thanks God that she was ok' (Ruth, Mealtime Volunteer Diary).

This account serves to illustrate the complexities of the volunteer role and ways of working as volunteers described ways of navigating their role when faced with situations which lay outside the tasks described at the training sessions. Volunteers expressed a sense of navigating tasks and negotiating unspoken boundaries of the relationships with other members of the team. They voiced an awareness of staff being busy and, conscious of their role as helper would strive to avoid causing them

any extra work. As such, volunteers described how they quickly worked out how they could be useful to staff. This might include remaining neutral, reluctant to share opinions which might be construed by staff as being controversial. This sentiment was articulated by a volunteer when she described how she would strive to establish a neutral stance,

'It's not for me necessarily as a volunteer to…argue with or set myself up. Often I realize that people come into the ward and discuss with perhaps somebody that I'm talking with what their future should be or try and outline and I usually make myself scarce then. I'm somebody that comes in for a couple of hours or so a week and that's the other thing about volunteering here, you have to accept that it's transitory' (Gladys, Mealtime Volunteer).

A reason for this way of working was given by another chaplaincy volunteers as,

'because it's not your business to offer an opinion' (Enid, Chaplaincy Volunteer).

Furthermore, mealtime volunteers described how they navigated the different systems of communication when on the wards. These included the coloured tray scheme. If a patient was assessed as needing help with food and drink, this was written on the overhead board alongside

the patient details and they subsequently received their meal on a red tray, instead of a white one. However, on some occasions volunteers described how this system was not always used as intended, which added to their confusion and uncertainty over how they worked. This mealtime volunteer's diary entry describes how she bypassed the system when it was not being used as intended and tried to identify patients herself in an attempt to help,

'Red trays don't seem to be being used as intended any more. The nursing staff know who needs help but don't really pass that information on to me although I have asked. I now just walk around all the bays and rooms when the food has been served and observe how each patient is getting on' (Ella, Mealtime Volunteer Diary).

In summary, volunteers work both independently and in collaboration with paid staff. Volunteers often experience difficulties when they first start the role, which can leave them feeling alienated and unacknowledged. However, over time they often build social relationships with staff and other volunteers.

There are differences in some aspects of the chaplaincy and mealtime roles, such as the tasks they do and the perceived status of these tasks, the types of

conversations they have with patients, and the facilities provided for them.

Volunteers find ways to cope with the challenges they experience when interacting with patients with dementia. Some exercise avoidance, while others look for ways to engage with them.

Despite the role being clearly defined by the organisation, volunteers commonly expressed uncertainty and confusion over role boundaries.

Having explored the perspectives of managers, ward staff, and volunteers, the following section will explore the accounts of patients with dementia, and carers as to their views on the role and ways volunteers work.

5.5 Patients with dementia, and carers

It emerged that there were varying degrees of interaction with volunteers, some patients and carers experiencing regular contact with them, while others spoke more hypothetically as they had no previous contact, nor seen any volunteers on the wards. The accounts appear to be hypothetical in some sense as there was very little comment on the actual volunteer role itself, possibly because of the lack of direct contact and experience. Patients with dementia, and carers focussed on what they

felt they could gain from contact with volunteers to help them cope with the challenges of being in hospital, and having their needs met.

Patients with dementia, and carers did not differentiate between the different types of volunteers. While they expressed uncertainty over what volunteers could actually do, they were more forthcoming about what they would like them to do. They described seeing volunteers talking to patients and visitors, cleaning and tidying up, making beds, helping with meal service, clearing away meal trays, and stocking up. The volunteer role was understood to be a useful way of facilitating two way communication between staff and patients with dementia, and carers by acting as a neutral intermediary to access help, obtain information, and to prevent repeated questions being asked of paid staff. Volunteers were seen as a way of complementing the work of paid staff. They expressed an understanding of the heavy workload of nurses and saw the volunteer role as a way to support them,

'if you want a newspaper they will nip and get one… or a drink from the machine, or-or something…you know, because you can't, with the best will in the world you can't stop the nurses from doing their job, cos they're busy

enough as it is, aren't they? So I think it's a good idea I really do…' (Maud, Carer Dyad).

They likened the voluntary service to that of a kind of hospitality service which complemented the clinicians, bridging the gap to ensure the smooth running of services and ensure patients and carers felt happy and cared for,

'a bit like a-almost kind of like a maître d' aren't they? […] like in a restaurant. They're just there just to oversee it […] somebody who's not there, to particularly produce anything as such, but just to enhance the whole thing and make it easier for, perhaps, both sides' (Arthur, Carer).

While understanding the pressures on staff, patients and carers spoke of a preference for having their needs met more quickly. They anticipated the response from volunteers to be more immediate than the response from ward staff.

Carers expressed a wish to avoid projecting an image to staff of being demanding, which appeared to underpin their understanding of the role of the volunteer as a way of accessing help,

'if they can go and help a patient to sit up, or whatever, it takes them-it stops you from annoying the nurses, and can be doing something else kind of thing' (Owen, Carer).

They felt the volunteer role was of importance when faced with a situation where they were unable to access the support and help from staff. They described their perception of a gap in service provision which they considered could be filled by volunteers. They saw the role of volunteers as a way to help staff by bridging this perceived gap in services, describing them as

'somebody you can talk to without feeling you're pestering staff […] they can act as a stepping stone if needs be'

(Arthur, Carer).

In addition to this, carers felt that volunteers played a role in offering an opportunity for patients to engage in conversation, especially when staff were seen as being busy delivering clinical care. However, this was only seen as of value if it was something of the patients choosing, and only if they were willing. Their role was described as being of value in alleviating the guilt carers felt when unable to visit as they knew that they would have another person to interact with. Patients and carers appreciated the practical and emotional support given by volunteers as part of their role, and carers felt reassured by their presence. Volunteers who helped by providing comfort to patients were felt to be of particular importance, especially when carers were unable to visit,

'you know, clean glasses and things like that, because it's-it's the personal things […] but it's just-it's the little things […] you feel differently, the patient feels differently. It helps, I think, all to recovery […] it's all them personal touches that make a big difference' (Vera, Carer).

In terms of ways of working, patients and carers spoke about volunteers working both together and independently. Carers did not anticipate any problems with staff sharing information with volunteers, in fact some saw an advantage to volunteers being involved in the use of the 'about me' documentation as a way to share personal information. They felt it was acceptable for the team to share information with volunteers about the individual needs of patients as long as the information was kept secure and confidential, and no medical details were revealed.

In terms of improving the service and developing the volunteer role, patients and carers said they would appreciate the availability of more volunteers to help them with non-clinical requests.

5.6 Conclusion

In the quest to understand the volunteer role and how they work, there are issues around their position in the

organisation, what they do, and their relationships with staff.

The volunteer role was seen by participants as one way to expedite the provision of hospital services to patients with dementia in acute hospital wards since volunteers are assigned to undertake non-clinical tasks, which paid staff often find challenging to deliver. This is because of issues around funding services, the busy environment and staff workload, severely ill patients who require support, and the expectations of patients and carers to receive a personalised service.

The role of volunteers was described as a supplementary or complementary service which exists to support staff and enhance services and systems which are there to deliver care and support to patients with dementia, and carers. The role appears to be valued but there is a recognition that the service must be carefully managed to address the potential risks. Volunteers work together, as well as autonomously, and relationships between volunteers and ward staff appear to develop over time.

Participants highlighted the potential to improve the service and offered suggestions. These included firstly accessing funding and developing a long term strategy with other stakeholders. Secondly, developing the role by

increasing the level of integration, offering information and support to staff to achieve this, and by providing further training to volunteers while being mindful of the rights of the paid workforce. Lastly, other suggestions included tailoring the volunteer role in line with the efforts of clinicians to complement the treatment and rehabilitation goals for patients.

The following chapter will explore the reasons for having a voluntary service, the motivations of volunteers, and issues around image and self-identity.

Chapter 6 Results: A focus on volunteerism. motivations, image and identity

6.1 Introduction

The previous chapters provided a contextualisation of the research by describing volunteerism, the environment, and dementia; and explored the role and ways volunteers work. Volunteers were found to undertake a range of tasks which include mealtime assistance, chaplaincy support, and other roles such as pet therapy in a complex and busy environment.

This chapter will be in two sections to explore motivations, and issues around image and self-identity.

6.2 Section One. Motivational factors

6.2.1 Introduction

This section will explore the reasons for having a voluntary service for people with dementia in acute hospitals from the perspectives of each group of participants. It will explore: why participants decided to volunteer and continue in their role; understand how the context may affect motivational factors; and identify

barriers to volunteerism. It will begin with an overview of volunteer statistics.

6.2.2 Volunteer statistics

The voluntary management team routinely gather information to determine the reasons why volunteers leave the organisation, with each volunteer being offered the opportunity to provide feedback at an exit interview. Various reasons were given for leaving which included: lack of time; ill health; study or work commitments; moving area; deceased; failing to contact the organisation; or volunteers being asked to leave when demonstrating attitudes or behaviour which fell below the expectations of the organisation.

Statistics on the status of volunteers in older person acute wards who had left the service, including details of length of service, and reasons for leaving were obtained from the voluntary management department from the previous two years and shown in the following table (see table 2).

Type of volunteer	Student (n=41)
	Seeking work (n=14)
	Retired (n=2)
	Disabled/ex patient (n=2)
Length of service	1-6 months (n=17)
	7-12 months (n=22)
	13-24 months (n=14)
	25 months and over (n=6)
Reasons for leaving	Unable to spare the time (n=20)
	No further contact (n=18)
	Moved away from the area (n=8)
	Health reasons (n=4)
	Personal reasons (n=3)
	No reason given (n=2)
	Obtained paid employment (n=2)
	Asked to leave as unsuitable for role (n=1)
	Unhappy with placement (n=1)

Table 2 Volunteer type, length of service, and reason for leaving the organisation

The following information describes the characteristics of participant volunteers in this study. These were as follows: retired or semi-retired (n=11); young student (n=2); or young mature (n=2). In terms of gender, these volunteers were both male (n=3) and female (n=12). The volunteer roles included that of chaplaincy volunteers (n=6), mealtime volunteers (n=8) and pet therapy volunteer (n=1).

One manager suspected that the reasons volunteers gave for leaving the role were in fact different to the reasons given to others,

'We-we try to get feedback […]… we ask them why… [laughs] interestingly they-they may tell us one thing and then tell somebody else another… because volunteers know each other as well […] we'll have a volunteer come in and say 'ooh volunteer X left last week didn't they?' and we'll go 'oh yeah because..' and they say 'it's not what they told me' [laughs]' (Amos, Manager).

It is unclear why this is the case, especially in view of the fact that only one former volunteer came forward to be interviewed for this study, but could be explained by the accounts people give in interviews can vary according to context, audience and purpose. Nevertheless participant

volunteers were asked about aspects of the role they disliked, and offered hypothetical reasons for leaving.

Having detailed the statistics around volunteerism and their reasons for volunteering, the following section will explore the perspectives of managers on the reasons for having the service.

6.3 The perspectives of managers

Throughout their accounts, all managers began the interview by voicing their appreciation of the contribution made by volunteers to the organisation, and the positive impact on the quality of patient experience, citing this as the reason why they favoured having the service. However as the interviews unfolded, their accounts became inconsistent as they all began to discuss the disadvantages of the voluntary service. Their initial accounts were of the positive image of volunteers, describing them as ‘marvellous’ (Yvonne, Manager), and ‘lovely’ (Greg, Manager). Any previous personal, life, or work experience volunteers had was described as being helpful to the role, and particularly valuable when supporting patients with dementia. They also acknowledged the needs of volunteers, ascribing altruism as a major motivational factor. They spoke about the reciprocal effects of volunteering, highlighting the benefits

to volunteers themselves by giving examples of how a recent bereavement, religious beliefs, and career aspirations may be common motivational factors which prompt people to volunteer in this setting, and can benefit volunteers in return for their contribution by making them feel valued.

All managers emphasised the positive contribution volunteers make to the quality of services to patients, with five of the eight managers interviewed describing the difficulties of providing support to patients without the voluntary service. Volunteers were described as 'vital' (Glen, Manager), and 'invaluable' (Amy, Manager), with four managers emphasising that some services would be unavailable without them. One manager illustrated this when discussing chaplaincy visits,

'Something like 40,000 contacts a year […] we couldn't do a fraction of that without the volunteers' (Greg, Manager).

The general sentiment of all managers regarding the organisational motivations and goals for having a volunteer service for patients with dementia in acute hospitals is illustrated by this manager,

'primarily, fundamentally, it's because it's patient benefit. So all these people are doing good for patients […] that-

that's-that-that's the motivation. There's not anything beyond that' (Amy, Manager).

While all managers spoke about the importance of volunteers, their accounts soon developed into a discussion of the potential disadvantages and problems, and a need for careful management,

'You have to handle it, you've got to be careful' (Olive, Manager).

For example, managers warned against building services around the needs of volunteers, as this could eclipse the needs of the organisation or patients. They also expressed caution over volunteers taking over the work of paid staff. The possible risks associated with the service, included issues around confidentiality, with two managers questioning the evidence around the efficacy of volunteers. They also emphasised the importance of having a clear plan for voluntary services, and the need to manage the risks and benefits.

As well as the contribution to patient care, all managers described the financial advantages of having volunteers who delivered services for no payment. The inconsistencies in all their accounts continued as they initially described the extra investment in time and money as worthwhile, but then managers would move on to

discuss how volunteers had the potential to increase the workload of paid staff.

So, despite describing the voluntary service in a positive way, managers were also cautious about the effect of volunteerism. Highlighting the potential risks and drawbacks, they expressed a need for careful management of the service.

In line with the accounts of managers, ward staff discussed their reasons for having a voluntary service, describing it as contributing positively to the quality of the patient experience.

6.4 Motivations of ward staff for the voluntary service

Volunteers were particularly appreciated for their help in supporting patients with dementia who needed someone to talk to, and ward staff acknowledged the positive effect of both mealtime and chaplaincy volunteers on patients,

'he's quite good with the patient, he sit with them, he talks to them and he's really good […] she come quite early and she stay over the one hour that she always come for, cos I think she enjoy working on there with the patient and talking to them, and the gentleman […] he is really,

really, really good, really good with them' (Isla, Ward Staff).

Ward staff discussed the commitment made by all volunteers, regardless of their role, and held a generally positive image of them. They valued the additional support and help provided by volunteers and reported finding it difficult to deliver services without them. One member of the ward staff spoke about their reliance on volunteers, and another emphasised the difficulties experienced when giving out meals without volunteer support,

'That can be very helpful when we are short staffed… because we can rely on our lady […] you know it's the little things that she'll do that if she wasn't there […] she's actually helping all the patients because …she's taking that pressure off us …with the meal service' (Lily, Ward Staff).

They spoke of their appreciation of volunteers, particularly in view of the fact that they are not paid, while emphasising that this did not mean the service was substandard in any way. However, none of the ward staff who were interviewed questioned the cost of running the voluntary service, or whether these costs were justified in relation to benefits. They described it as a cost efficient

means of delivering support to patients, contributing to the reasons for having volunteers.

Ward staff elaborated on the reasons why they viewed the voluntary service positively. They saw the potential for volunteers to undertake tasks which could contribute towards the rehabilitation of patients. Yet despite ward staff starting out their interviews with a positive account of volunteers, this did not remain consistent throughout their accounts. In line with managers, they expressed caution over the service. As the interviews developed they spoke about the lengthy recruitment process being potentially off-putting to volunteers, and described volunteers working in isolation, and unacknowledged or unsupported by staff. They emphasised the need for volunteers to receive support from staff, such as further training in dementia, and how to feed patients safely. This was described as helping to keep volunteers motivated in their role and to ensure they felt valued. However, ward staff expressed uncertainty about who should be responsible for this.

Furthermore, they expressed caution over asking volunteers to undertake tasks which might be seen as replacing paid staff with an unpaid workforce. One

member of the ward staff highlighted the potential for volunteers to feel exploited by working for no payment,

'If you're a volunteer and you recognize that you're doing …a job that other people are getting paid to do, is that then going to cause resentment from the volunteers? You know will they think, well actually I may as well come and get paid for doing it then' (Gwen, Ward Staff).

There was an element of tension as volunteering was seen by most of the ward staff as a specific role requiring careful management,

'you've got to be very careful although these people are giving their time freely, which is lovely, but you-you do have to screen them rigorously […] they come to work with our most vulnerable people' (Rose, Ward Staff).

Ward staff, like managers, discussed their reasons for viewing the voluntary service as being advantageous and a positive impact on patients and staff, but also voiced concerns over the potential for risk.

While each group spoke about the reasons for having a voluntary service, those who discussed motivational factors the most were the volunteers themselves. The next section will explore the reasons why people

volunteer and focus on how dementia impacts on these reasons.

6.5 Motivations of volunteers

The volunteers described their motivations which were thematised into three main groups: altruism, social, and other. Firstly, those who were motivated by altruism described this as a wish to help others (including staff) based on their ideology, religion, or personal value system; expressing a sense of commitment; and a wish to ‘make a difference’ and to feel useful. Some defined their altruism as feeling empathy towards older patients with dementia. In addition to this, three volunteers had previous caring experience which they described as part of the reason why they volunteered in this role.

This sense of altruism was evident across the majority of volunteers. All volunteers reported that they were not motivated by material rewards; some said they preferred the unpaid nature of volunteering as it afforded them a degree of self-determination, giving them freedom of choice and flexibility not offered by paid employment and contractual obligations. When discussing payment and when asked about receiving reimbursement for travel and luncheon vouchers, one mealtime volunteer replied,

'No! […] No, I don't-I'm one of them sort I don't want owt off them, and I don't want owt off the government either. They can keep it! I don't want it! (pause) […] I'm a bit independent….' (Shane, Mealtime Volunteer).

These volunteers demonstrated pride in not being in receipt of payment, with one saying they would leave if payment were offered. Nevertheless, most of the volunteers interviewed voiced an appreciation of the contribution made by the organisation to promote their comfort, such as the provision of meal vouchers, and reimbursement of travel expenses. Some of the volunteers reported having always volunteered in some capacity throughout their lives because of their sense of altruism. This extended to a sense of commitment to their present role; expressing guilt if unable to attend because of illness. It seems their sense of altruism did not rely on the approval or validation of others. In fact, some volunteers were reluctant to tell others about their involvement, preferring to quietly continue in their role,

'I don't tell everybody I'm doing it, one of my friends at church-I didn't tell her for a year […] I don't want people to think I'm always doing this and doing that I just keep it to myself, you know' (Una, Chaplaincy Volunteer).

Volunteers described their contribution as unremarkable, but nevertheless appreciated the responses from paid staff who expressed gratitude towards them. In fact, volunteers described their meaningful relationships with staff and other volunteers as yet another reason for continuing in the role. Their appreciation of the positive feedback received from staff with whom they routinely worked was judged to be more influential in motivating them to continue than any of the organisational events held by management.

Secondly, volunteers were motivated by a desire to seek social contact as a result of volunteering. This included expressing a sense of loneliness and boredom, a need for occupation, and a wish to fill their leisure time either post retirement, or while looking for employment. Some were motivated following a bereavement and a subsequent desire to establish supportive relationships with staff and other volunteers. Some sought to derive a sense of inclusion, purpose, routine and enjoyment as a result of volunteering, and to strengthen their existing relationships with religious organisations. They appreciated the positive feedback received from staff which motivated them to continue.

These volunteers spoke about the need to fill their time and to embed some structure in their weekly routine, enabling them to meet new people and form relationships. They described volunteering as a way to achieve something valuable, appreciating the social contact and often humorous engagements with staff and patients. Nevertheless, these volunteers were reluctant to directly speak about their loneliness, couching their reflections in language which focussed on their need to help others. Exemplifying such reflections, this retired mealtime volunteer described the reasons why he decided to increase his shift to an extra day,

'Looking at four walls, and feeling down in the dumps, fed up with housework, gardening and shopping, so why not go down and take the dinners around to people who are worse off than me, 95% of the patients are nice, and the odd few grumpy ones cannot help it (we are all different) and I come out feeling ten foot tall, go home watch a bit of television and go to bed, feeling satisfied (and that's why I went on Tuesday)' (Shane, Mealtime Volunteer Diary).

Other social and personal reasons for volunteering included a sense of gratitude and feeling fortunate for being physically able to volunteer, particularly the older

generation who described their health problems. In these cases they described volunteering as being of more benefit to them, than the contribution they made to others. Volunteers described how being with acutely ill, frail older people helped them come to terms with the realisation of their own vulnerability, failing health, and increasing age,

'My legs were aching before I got here today but after starting work and going around the patients the aches are forgotten, and I realise how lucky I am not to be in one of those beds' (Shane, Mealtime Volunteer Diary).

They spoke of their encounters with people with dementia as giving them an increased sense of appreciation for being independent, a sense of purpose, a feeling they were doing something worthwhile, and a determination to continue.

Thirdly, some volunteers gave other reasons for volunteering. They highlighted the reciprocal aspects of volunteering by acknowledging the potential for career development, seeing it as being good for them, or by describing a feeling of being fortunate and an appreciation of their own good health. Some expressed a sense of guilt if they were unable to attend a shift. There were those volunteers who gave personal reasons for

volunteering which did not match the responses given by the others. These included a sense of serendipity; a liking for the hospital itself; having the financial freedom to be able to volunteer; the fact that volunteering did not cost them anything (although one other volunteer was motivated to some extent by the free lunch and paid expenses); another was motivated by the ease of the journey; two volunteers said the uniform contributed to their motivation to volunteer; another was motivated by the opportunity to use their skills; and two volunteers continued because they found the work to be interesting. Having the right dog was a motivating factor for the pet therapy volunteer as he said he would be unable to volunteer without it.

The need for personal and professional development was cited by the two younger volunteers as their main reason for volunteering. In this case they needed to gain work experience, particularly contact with patients, in order to realise their education or career aspirations. They aspired to be health professionals, and volunteering is a mandatory entry requirement of such university courses. They judged their commitment to be short term in order to achieve this goal, however they spoke of their appreciation for the opportunity for personal growth and

to gain confidence and expressed a sense of altruism and empathy towards patients with dementia.

All volunteers had multiple reasons for volunteering, apart from one who volunteered purely to gain confidence and experience in order to progress in her career. All of the volunteers appreciated flexibility, choice, and the ability to exercise autonomy over what they did.

Therefore it appears that there are complexities and nuances around the notion of altruism. Those volunteers who expressed this as the reason for volunteering, also derived some benefit from carrying out the role. Volunteers also discussed barriers to continuing in the role and reasons why they might leave.

6.5.1 Barriers to continuing, and reasons for leaving the role

Despite the various factors which motivate volunteers, and their enjoyment of the role, they expressed other feelings which challenged their decision to continue. They described what kept them going when they became dissatisfied with volunteering.

Volunteers spoke of the barriers to continuing, or gave hypothetical reasons for leaving which would result in them being unable to cope with the demands of the role.

These included a deterioration of any existing health problems; the possibility of feeling unappreciated by staff; the possibility of receiving negative feedback about their performance; receiving what they understood to be undeserved criticism from staff; family commitments, or personal and social life taking priority; and dissatisfaction with the types of duties involved in the role. One volunteer gave reasons why she might consider leaving,

'Babysitting grandchildren! [laughs] but other than that…y-you don't know do you? […] well if somebody was really unpleasant and told me I was doing a bad job then I wouldn't come! […] if it's somebody in the chaplaincy team said, "Well you're really not doing a very good job." Then no I wouldn't come…' (Enid, Chaplaincy Volunteer).

Volunteers also discussed the actual barriers and drawbacks of their role, how they endured it, and gave examples of negative aspects and challenges they experienced. For example, they discussed the unpleasant ward environment, describing offensive smells; the ward temperature (which was deemed by several of the volunteers to be too hot); feeling socially isolated from staff; absence of thanks for their contribution; feeling out of place or bored with nothing to do; a dislike of the uniform; and poor restroom facilities for staff and

volunteers. They also described the sometimes abusive attitude of patients and visitors, and the demands made upon them to deliver services outside their remit. They described their frustration over encounters with patients with cognitive impairment who exhibited aggressive behaviour, and repetitive conversations with patients with memory impairment. Some volunteers mentioned the tiring nature of the role; one described the emotional aspects and how it was necessary to engage with patients with dementia in a positive and energetic way which resulted in them feeling tired and physically drained at the end of their volunteer shift,

'it is tiring I get home and I usually get a cup of tea, sit down and fall asleep! Cos you-it's draining! Cos you've got to keep your wits about you, sometimes it's difficult to hear what they're saying and things so…[…] it is emotional yes, I think that's probably why you feel tired 'cos it's-it is draining yeah' (Una, Chaplaincy Volunteer).

Other difficulties included the length of time it took to travel to the hospital and the journey itself, especially in wintry weather. Despite the challenges they experienced, and despite feeling nervous or even scared at times, volunteers expressed a sense of endurance. This appeared to be common across all the volunteer

accounts, regardless of their length of service, or level of experience. Volunteers reported that they would continue in the role as long as they were satisfied by the experience, and that it continued to meet their expectations and motivations. This expression of endurance is illustrated by the following account,

'I suppose a bit of it is that you're not going to give up, you want to-you're [exhale] well I didn't really think of giving up, I thought oh you've just got to get on with it haven't you? And the more you do it the more […] confidence you get […] yeah, I wouldn't have given up'
(Una, Chaplaincy Volunteer).

Volunteers spoke about how they would miss the social contact and sense of belonging, satisfaction, and appreciation they felt the role provided. They expressed their intention to endure these difficulties, considering their reasons for volunteering far outweighed the potential drawbacks. They expressed a sense of endurance, and placed an increased emphasis on their original motivations for volunteering as having more of an influence on them than inconvenient or negative aspects. Therefore they persevered, highlighting that it could take many months, often up to a year, to settle into the role.

The volunteers' views of dementia and how this impacted on their motivations to volunteer was also explored in the data.

6.5.2 The impact of dementia on the motivations of volunteers

It appears that while some volunteers were prompted to volunteer because of their wish to help older people with dementia, others were motivated to volunteer despite the presence of dementia and the challenges they faced (see table 3).

It is worth noting that many of the volunteers who were interviewed spoke of the difficulty in recognising those with dementia, and said they were not routinely informed about cognitive impairment by ward staff. These volunteers spoke about their interactions and conversations with patients and their gradual realisation that patients had memory problems.

Motivations did not appear to be associated with volunteer demographic characteristics. The picture is mixed with more people motivated to volunteer because of dementia than despite it. Both students reported they volunteered because of the need to fulfil the necessary criteria of having experience in this area as an essential

prerequisite for entering a healthcare profession, and in spite of this resulting in contact with patients with dementia. The majority of retired volunteers said the opportunity to engage and interact with patients with dementia was a reason for volunteering.

Volunteer type	**Motivations related to dementia**
1. Retired	Because
2. Student	Despite
3. retired	Despite
4. retired	Because
5. young mature	Despite
6. retired	Because
7. retired	Because
8. retired	Because

9. retired	Because
10. retired	Because
11. young mature	Because
12. retired	Despite
13. student	Despite
14. retired	Because
15. retired	Because

Table 3 Motivations Related to Dementia and Volunteer Type

Those who volunteered despite the presence of patients with dementia reported feeling that any interactions were pointless, and that they felt unable to help them. Nevertheless, they hoped to gain further experience and utilise the skills they already had in order to help others. They reported a sense of failure and frustration in the contact they had with patients with dementia, finding it difficult to understand and navigate their needs. Four of the five volunteers in this cluster reported little or no previous contact with, nor understanding of dementia.

In contrast, those who volunteered because they were motivated to work with patients with dementia expressed a love of older people in general, and specifically those with dementia. Their accounts ranged from feeling empathy and deriving a sense of enjoyment and satisfaction from the interactions, to a sense of frustration and subsequent endurance. This focus was partly because of their admiration for older people. They described these patients as special because of their increased vulnerability compared to other patients, and partly because the volunteers enjoyed hearing about local history and personal life stories. They reported feeling empathy, a need to feel useful and helpful to others, and wanting to give something back to the health service for having previously been in receipt of help and support when they or their family were ill. They spoke of their satisfaction in helping others, particularly those seen as vulnerable. Volunteers gave examples of their motivation for volunteering with this group of patients and exemplified by this diary entry from a mealtime volunteer,

'Today I fetched some hand cream and toothpaste for a lady in one of the side rooms. These little actions seem to make such a difference to the patients and they are often so grateful. Being able to help in such a way really makes

me glad to be a volunteer' (Ella, Mealtime Volunteer Diary).

The feeling of making a difference to those patients with dementia was described as being one of the reasons why they volunteered in this setting. Some volunteers described how their religious beliefs underpinned altruistic feelings towards patients with dementia. Volunteers showed an awareness of the vulnerability of patients and their need for extra support. Volunteers motivated by the presence of dementia commonly had previous personal experience of the disease, expressed a sense of commitment to the role, and felt they occupied a special and privileged position. They reported that their role as a volunteer in this setting helped them come to terms with personal feelings resulting from caring for a relative with dementia. Some also volunteered in other dementia settings, not only acute hospital wards. They considered it to be unimportant that patients with dementia could not remember them, nor their interactions with them, reporting it to be more important that they were simply there for them. In addition, eleven of the fifteen volunteers who were interviewed described the older person acute wards and dementia specialist ward to be friendlier than the other wards they had worked on,

which further increased their motivation to work in this area.

Therefore, the reasons people gave for volunteering in dementia and acute hospital wards were many and varied. Some continued in the role despite the challenges and inconveniences they experienced, while others actively enjoyed supporting and interacting with patients with dementia, citing this as the reason for volunteering.

Carers and patients with dementia also discussed their reasons for wanting the voluntary service.

6.5.3 Attitudes and responses to the voluntary service of patients with dementia, and carers

In contrast to the managers, ward staff, and volunteers; patients with dementia, and carers reported no drawbacks or disadvantages to volunteer involvement, and were overwhelmingly in favour of having a voluntary service, whether or not they had previously had any contact with volunteers. They described staff as being busy and appreciated the efforts of volunteers to support staff, and to provide patients and carers with extra support. This carer described how she felt about a

volunteer she encountered when visiting her mother-in-law who was seriously ill,

'The one that was on the ward yesterday was absolutely lovely! She's gorgeous! [Laughs] […] she's lovely, yeah […] she was actually making beds yesterday but she's helping feed people last week, yes. Just generally talking to them and cheering them up. Cos that's what you need, isn't it? […] I suppose it sort of cheered us a bit. Gave us someone sensible to talk to [laughs]' (Chloe, Carer).

They described having to wait for help from ward staff and so valued the contribution volunteers made as it provided them with another way to access assistance, and have some of their non-clinical needs met promptly. One carer spoke about the challenges of providing stimulation to patients with dementia in an acute hospital ward, and described the advantages of a volunteer being present,

'they are some that just lie there and you don't see visitors, as well, so they're basically just living in their own head…and that guts me to think, you know, I look at some of them, and you just think, ''how-how can anyone just leave you here? Hours each day?'' you know it's something that it don't sit well with me. But if a volunteer was to come and chat-it brings them out of themselves as

well! […] it takes that loneliness away…yeah' (Owen, Carer).

They cited reasons for having a voluntary service as being advantageous to the volunteers themselves,

'It's really, really nice and rewarding I think […] you're in the best position…as a volunteer…yeah…' (Vera, Carer).

They described volunteering as an opportunity for volunteers to experience the benefits of participating in the care of others, and a way to access social contact on retirement.

6.5.4 Conclusion

This section explored the accounts of all participants to identify their reasons for having a voluntary service, and explored the reasons why people volunteer in dementia and acute hospitals.

The reason why managers, ward staff, patients, and carers were in favour of volunteers supporting patients with dementia in hospital was because they saw the service as contributing positively to patient care and the provision of services. However, managers and ward staff expressed caution over the potential for problems to occur around the deployment of volunteers, who were described as essentially members of the public who are

screened and trained on entering the organisation to be in close contact with vulnerable adults. Consequently, the voluntary service is viewed favourably as long as there is a strategy for risk management.

Volunteers expressed a range of motivations including: a sense of altruism; or for social, personal, and developmental reasons. These motivational factors underpinned their decision to continue in the role despite experiencing challenges which included encountering difficulties engaging with patients with dementia in an uncomfortable environment; negotiating the demands placed on them; receiving negative feedback; experiencing health problems; or lengthy travel time.

Volunteers were motivated by a sense of commitment religious conviction, altruism, endurance, a desire to be of help to staff, a love of older people, or a desire to help or be with people with dementia. Those volunteering to gain experience to gain a place on a healthcare course reported they were likely to leave once they have fulfilled the criteria for entering their chosen profession (as is generally the case with younger people). Health problems were also a factor which could result in volunteers leaving.

The following section will explore issues around the image and identity of volunteers.

6.6 Section Two. Image and identity.

6.6.1 Introduction

The previous section explored motivations for volunteering, and reasons for having a voluntary service for patients with dementia and cognitive impairment in acute hospital wards. This section will explore what each group of participants said about the image and identity of volunteers. Image is the general impression that a person conveys to others (Oxford, 2006a), and identity refers to the characteristics which determine it (Oxford, 2006b).

It includes the impression participants have of volunteers, their views about the characteristics determining their identity, and what this represents to them. It will also explore issues around self-identity. The chapter will focus on how the uniform influences the participants' understanding of volunteers, and begins with the accounts of managers.

6.7 The perspectives of managers on the image and identity of volunteers

Managers began their accounts by emphasising the personal qualities of volunteers, describing them as selfless, possessing altruistic intentions, and highly valuable in providing a vital source of expertise to hospitals. They also expressed uncertainty over the identity of volunteers, making suggestions how it could be developed.

Volunteers were described by managers as occupying a distinctive position, having unique access to areas of hospital wards generally unseen by the public. The volunteer image as part of the hospital was seen as adding value to the organisation and a way to improve hospital services. There was some inconsistency between and within their accounts of the volunteer identity as part of the organisation. Some described volunteers as not completely belonging to the organisation, but partially detached in a way paid staff are not as illustrated by this manager,

'Of course, they're never going to be clinical and they're never going to be an alternative workforce, but they are a support force' (Ivy, Manager).

However, others described volunteers as part of the organisation

'They're not different, they're part of our workforce and I think that's the view we've got to get around and thinking about' (Olive, Manager).

This statement suggests that some managers aspire for volunteers to be seen as part of the organisation, and integrated into the workforce.

All managers described volunteers as an important asset, and a way of adding value by enhancing existing support and providing services that might otherwise not be available. Examples included practical tasks such as giving out meals but also being a welcome presence for patients with dementia by spending time getting to know them, focussing on their personal history, likes and dislikes. Older volunteers in particular were seen as using their life experience to build relationships and establish a rapport. This account illustrates how managers viewed volunteers in a positive light and as a positive contribution to the organisation,

"they've got time […] wanting to listen and to share experience and also they have this foundation most usually of an extraordinary life experience, sometimes through adversity […] and that I think is a very important

part of contributing to the soul of the organization […] and there are some folk who've volunteered for […] 40 years which is absolutely staggering. I think that's a wonderful gift that they entrust to us' (Glen, Manager).

It appears that the reasons why managers described volunteers positively is partly because they were seen as altruistic, and partly because they were seen as benefitting the organisation while not being paid. There was some discussion about the need to invest time and money into voluntary services, and an expectation of a return on that investment, as managers recognised the potential for volunteers to be a drain on resources. Nevertheless, despite all managers expressing a lack of knowledge around actual costings, volunteers were assumed to make a valuable contribution,

'the money that we put into supporting volunteers, the return on that is enormous […] significant- and it's not measured in terms of money it's measured in terms of the contribution we can make to patients and their families and staff, and that's an enormously positive return on that investment' (Glen, Manager).

As well as managers describing the positive impact of volunteers, they also described societal benefits. Managers identified the voluntary service as another

facet of public engagement, a way of giving people the opportunity to become involved with local public service, and providing opportunities for career development and wider engagement across other areas such as businesses and charities. Volunteers were also described as representing a positive and humane society:

'Just caring wise, just having someone be there who isn't paid to be there... just probably helps a lot…oh! I think it's huge value […] it's also the mark of a good society! I think. You know it just shows that people …actually have some level of humanity beyond themselves [laughs]' (Amy, Manager).

Volunteers were seen as the first point of contact for members of the public entering the hospital, and they subsequently have the potential to make a positive impact and promote the image of the organisation.

'That's sometimes the first experience that somebody's got your Trust when they walk through. The first person they meet might be a volunteer' (Yvonne, Manager).

Nevertheless, all managers spoke about the need to manage the image of volunteers, emphasising the potential for development. They described the identity of volunteers as not fully understood, and a missed opportunity to develop voluntary services. They felt the

organisation's volunteer strategy at board level was unclear. There was also a general lack of understanding about the identity of the volunteer service, and uncertainty over where good practice exists. They felt there was insufficient publicity about the service, and a need for promotion and marketing to raise the profile and image of volunteers as part of the organisation. This included raising their status in the organisation by increasing involvement, and giving them more opportunity to feedback about how services could be improved. Managers were also interested in working on the brand and image of volunteers to attract people into the role from a variety of backgrounds and ages; open up volunteering to more groups of people; and strengthen voluntary services at national level to encourage involvement and promote collaborative working,

'Get your name badge, your training and your basics, you could give them a passport for volunteering […] do it for-us first and then if it works internally, without doing it externally' (Olive, Manager).

There was a sense that more could be done with the voluntary service, but also an awareness that it was less important than the delivery of clinical treatment.

The following section will explore the perspectives of ward staff.

6.8 The perspectives of ward staff on the image and identity of volunteers

The extent to which ward staff recognised volunteers and understood their identity varied; some failed to recognise them, while others showed a comprehensive understanding of their characteristics and what they represent. The level of visibility and recognition of volunteers ranged from staff not 'seeing' them at all, to staff knowing which days they worked, and describing them as individuals rather than as generic volunteers. They also expressed an awareness of their identity increasing over time as staff and volunteers developed relationships and got to know each other. The longer they worked together, it appears that the extent to which staff recognised them increased, as exemplified by this member of staff,

'They've been coming week in, week in, year in, year out […]…they do feel part of the team […] it's just like, "Oh, [name] is here." and you don't think, "Oh, [name] the volunteer." It's just, "Oh, [name] is here. It must be Thursday […] [chuckles]. So it- it's really nice. We have

built that-that bond up with her […] she's been coming probably …five years plus? Coming a long time, a long time' (Lily, Ward Staff).

As such, some volunteers were seen by ward staff as valued individuals in their own right, referring to them by their names, rather than by the generic term of 'volunteer', whereas new volunteers were described in some cases as being less visible to them. This account from a member of the ward staff illustrates this point when she discussed the arrival of new volunteers,

'They just let them stand there like they don't exist! […] we have lots of volunteers that only come once and never come back' (Isla, Ward Staff).

Despite some of the ward staff reporting that they did not have a comprehensive understanding of who volunteers were, or what they were there to do, some staff expressed a sense that they were doing more than people were generally aware of and as such were appreciated for their time, effort, and commitment. This suggests that their accounts might be shaped by their assumptions and expectations of what ought to be the case as well as what they experienced.

Around half the ward staff interviewed showed a lack of awareness of the volunteer presence, unsure of who they were, or what they could do, and in a sense invisible:

'I've never come across any…[…] … I've never thought about them […] maybe they are being utilized but I don't know what in what way 'cos I don't recognize it …unless I work with one. But I-I do you know I-I would say that they've always been nondescript to me! I-I don't know! Or maybe that's just me being rude…' (Mabel, Ward Staff).

It was suggested by one member of staff that volunteers might be noticeable by their absence when staff needed help with tasks,

'perhaps the ward staff don't even notice that they're there […] but perhaps if they're away, off sick, or if they stop coming, or they're on holiday for any length of time, maybe it would be noticed then […] it's noticed when they don't come […] they're noticed when they're not here…' (Gwen, Ward Staff).

Ward staff expressed the view that volunteers had a positive image, and regardless of whether or not they had worked with volunteers before, all described them favourably at some point during their accounts, and as a valuable and positive addition to the organisation. Those who were familiar with volunteers voiced an appreciation

of their help and support, and valued their friendliness. Their non-clinical status was seen as a valuable addition to services, especially because of their ability to take a different approach to engaging with patients, providing them with the opportunity to socialise in a clinical environment. Those ward staff who were aware of volunteers saw them as generally helpful and enthusiastic, having a distinct identity separate from that of paid staff or family,

'Volunteers, they almost have that sort of like friend role' (Tess, Ward Staff).

Volunteers were seen as making a positive contribution, described as a diverse group of people, and valued for the different skills they could bring to help others:

'we've got a multitude of different age groups, we've got you know different cultures, […] different religions, ethnicities….so I-I think it works well having that diversity coming onto the ward' (Rick, Ward Staff).

While valued for their individual skills, age differences were highlighted by eight of the eleven ward staff interviewed. For example older volunteers were seen as having better communication skills, more life experience, and knowledge of the local area which could help patients with dementia to reminisce,

'People who've got some life experience, who've got a knowledge in the area […] it seems a bit prejudicial against younger people, but I think […] you're looking at a certain type of person' (Neil, Ward Staff).

However, others valued the presence of all volunteers, regardless of their age,

'It's mostly like young girls and boys and they are really act mature when they come […] I saw a gentleman on there, an oldish gentleman and he's quite good with the patient. He sit with them, he talks to them and he's really good. And some of the girls, the young girls them that come, they are quite good with them' (Isla, Ward Staff).

In addition to this, ward staff discussed their views about the differences in volunteer characteristics. In this example, it is unclear if these views are based on direct experience, or are assumptions and expectations of how age affects their performance,

'The older ones had more stamina and staying power when they've made a commitment where the younger people, if they don't like it, they just go' (Gwen, Ward Staff).

None of the ward staff who were interviewed voiced any kind of negativity towards volunteers. Indeed, the only

negative comment about volunteers was directed at the specialty itself, rather than volunteers, with one member of staff comparing the image of volunteering in dementia and acute care unfavourably to that of volunteering in palliative care, making a direct comparison,

'[Laughs] it's quotes 'sexier' close quotes!- it's- (pause) maybe-maybe they've run their publicity better?- that they have palliative care really has created a social movement, hasn't it?' (Ben, Ward Staff).

So, despite some of the ward staff expressing a lack of awareness or in-depth understanding of what volunteers represent, they all nevertheless described them in a positive light, seeing them as making a positive contribution to services.

On the other hand, volunteers spoke about how they felt they were seen by others, and how they saw themselves.

6.9 The perspectives of volunteers on their image, social identity and self-identity

Volunteers discussed feelings of uncertainty over their image, social identity and self-identity and described how they managed this.

They described how patients with memory impairment would express uncertainty over their image, identity, and purpose,

'A lot of the patients don't realize I'm a volunteer. Th-they think I'm a nurse […] [laughs] […] those that are a little bit more with it, it does make a difference. They realize I'm a volunteer, so they don't ask me to take them to the toilet and…things' (Ida, Mealtime Volunteer).

However, some volunteers described patients with dementia as seeing them as having a different identity to ward staff,

'I think that they think I'm…less an authority and more like one of them… because the nurses have this sort of like ….authority on a ward' (Gladys, Mealtime Volunteer).

Nevertheless, whether or not patients were seen to understand their identity, most volunteers described them as simply wanting social contact with another person regardless of who they were,

'They do seem to like and appreciate-just, I think it wouldn't matter who it was, it's just somebody there to listen, for them to tell their story, their worries… just to have a little chat' (Una, Chaplaincy Volunteer).

While discussing their views on how they felt they were seen by patients, volunteers also expressed concern over how they might be seen by their own family and friends outside the hospital. One volunteer did not tell anyone in her social circle about volunteering, and shared her reasons why,

'I just don't want to be seen as a do-gooder!' (Una, Chaplaincy Volunteer).

As well as reflecting on how others saw them, they also shared their views about their self-identity as a volunteer. This appeared to be complicated with volunteers discussing a kind of internal struggle as they balanced multiple identities. For example, six of the volunteers had caring experience in previous or currently active roles, including one who also worked as a Registered Nurse. This volunteer described how she navigated the challenges of a dual identity, especially when patients exhibited clinical needs which she would ordinarily address when nursing. This was further complicated by the fact that a Registered Nurse carries their accountability at all times, whether on duty or not (NMC, 2019). She discussed her reflections on the implications of this as it forced her to decide how she should navigate her identity as a volunteer, and concluded that her

responsibility as an advocate to patients took priority over all else. Furthermore, despite elements of uncertainty in their self-identity, acting as an advocate was described by most of the volunteers as an essential characteristic of their volunteer identity, as exemplified by this account,

'My first priority is really for the patients' (Ida, mealtime volunteer).

Volunteers reported becoming more confident and comfortable as a volunteer over time, feeling more positive about their identity as they became increasingly familiar with the team, and developing relationships with them as they became noticeable to ward staff.

As well as navigating multiple identities, volunteers described how they would adapt their performance as a way to manage how others saw them. One chaplaincy volunteer described how he would look for things to do because of his concerns over how he might be seen by others,

'[Laughs] I don't want it to appear as if I'm standing around you know' (Leo, Chaplaincy Volunteer).

Another example which provides us with an interesting angle on the performance element of all ward

participants, was one volunteer who considered how she might be seen by others when interacting with patients,

'With dementia patients as you know they'll cry out, and they'll go "Ahh! Ahh!" you know at the slightest—you'd just be looking at them and they'll decide they want to shout out at you and I don't want someone to think I am hurting somebody' (Sally, Mealtime Volunteer).

They also described feeling concerned that they may be seen as inappropriately curious or as creating problems for staff,

'I don't want to think that I'm encroaching on their jobs, so I-I back off, you know, except if they want me to do it […] I don't want them to feel that I'm… encroaching. I think there's a fine line between me doing-doing too much and just being the volunteer, you know, I think it's a very fine line and I don't want to …push it […]' (Ida, Mealtime Volunteer).

This volunteer said she would absent herself from the bay when doctors were doing a ward round, concerned that she might be seen as listening to what was being discussed. As well as discussing their thoughts around how they might be seen by staff, they also showed an awareness of the difficulties experienced by patients with dementia in understanding who people are. Several of

the volunteers described how they would manage this by introducing themselves to patients. They described how they would strive to simplify the introduction by referring to their identity in a vague or general sense,

'I always say I'm 'so and so' from the church department because I think with them having dementia they don't really know necessarily what a chaplaincy is but church, everybody knows church, and I mean a lot of them are quite…they don't know what's going on or anything so I just introduce myself, say where I'm from…' (Una, Chaplaincy Volunteer).

It is uncertain if this attempt at simplification might have added to the confusion or made their identity more clear.

Carers and patients with dementia also discussed the volunteer image and identity.

6.10 The perspectives of patients and carers on the image and identity of volunteers

Three of the carers gave an account of having seen volunteers, and expressed an understanding of who they were. However, the remaining four carers were unsure as they said they had not seen any at all while in hospital.

They cited anxiety and preoccupation with the welfare of the patient they were visiting as a possible reason why they failed to notice them. One carer described his preoccupation with the needs of his wife who had been an inpatient on three wards for a total of eight weeks. He visited at different times of the day and wondered if this was why he had not been aware of volunteers on the ward despite them having been there,

'So...as I say, obviously, you're focussed on …a patient don't you? so there's people milling around but you don't always notify specific people you know so…[…] So sh-she's spent a good bit of time…this year in hospital you know so-but I don't recall…seeing the…no…(pause)'
(Joe, Carer).

Two of the carers said they were unable to distinguish between volunteers and staff, or between the different types of volunteers. Those who were aware of the volunteer identity had seen the uniform, and said they had worked out who they were without being given any information.

Similar to the accounts of other groups of participants, the general image that carers and patients with dementia had of volunteers was a positive addition to services, particularly in view of them being unpaid. One carer

voiced his fear of patient neglect as a result of heavy staff workload. Despite not having any contact with volunteers, he described feeling reassured that volunteers worked on the ward,

'That takes that worry away really […] I mean, you hear these stories don't you of people lying there not getting a drink of water, and didn't one die of thirst […]-was it Stafford? Which was- died of thirst or something which is like horrific, isn't it? […] but yes, it's reassuring to know' (Arthur, Carer).

They expressed the view that volunteers might be an easy way for patients to access help. Speaking about patients, one carer said,

'They don't want to bother nurses and doctors, they might talk more to the volunteer' (Vera, Carer).

None of the patients nor carers described the volunteers as disadvantageous in any way. All the carers interviewed saw volunteers as representing someone who would support them and act as an advocate, even those who had no previous contact with them. This impression of volunteers with no direct experience suggests that these participants already held an overall positive image of volunteers.

Both patients who were interviewed spoke of their gratitude to volunteers for providing them with an opportunity to talk to another person outside the clinical team and their family. Their general impression of volunteers was that they did not have an agenda other than to approach them to interact socially. One patient saw healthcare staff as interacting with them because of the need to deliver clinical treatment; relatives were seen as having emotional ties, and so he felt the need to protect them. He described volunteers as,

'They are…not….th-there's no bias is there? You know th-their not sort of…stuck to the clinical element looking for things that are right and wrong and… if you like a critique side, and then family, you know sort of not gonna tell them lot because they'll only go on' (George, Patient Dyad).

Another patient expressed her gratitude of the opportunity to speak to volunteers while in hospital which subsequently alleviated any fears of future admissions,

'Yeah I enjoy a chat…yeah I enjoy listening to other people and their experiences, and their grumbles, and their praise, yeah. Now I would not be afraid of going in again […] Yes I was quite happy in hospital wasn't I?

Yeah I'd go back tomorrow if they'd take me in for a bit!'

(Dora, Patient Dyad).

Patients and carers reported feeling comfortable approaching volunteers for help in the absence of staff. They were happy to talk to volunteers about their anxieties without feeling they were causing extra worry to family or staff. Whether or not patients could identify people as volunteers did not appear to present a problem as they were simply glad of another person to talk to, regardless of their identity,

'I wouldn't mind people coming in! […]…no….I enjoy hearing about people's lives and that even though I don't know the people concerned I don't mind listening about it'

(Dora, Patient Dyad).

Concerned about their own image of being seen as a nuisance, people with dementia, and carers felt a connection with volunteers, seeing themselves as having an affinity with them and describing them as,

'One of us really, rather than…one of you [laughter]'

(Arthur, Carer).

They discussed the importance of a positive volunteer image which hinged on finding people in possession of suitable and distinguishing characteristics. These

included natural genuineness; the ability to be flexible and tailor their approach to the needs of patients with dementia; and being skilled in communication,

'You've got to be on the right wavelength, that's the important thing, you've got to be on the right wavelength for dementia patients. Sort of half humour them but not humour them! [Laughs]' (Chloe, Carer).

Carers expressed a preference for volunteers from a variety of different backgrounds, rather than with a generic identity and a uniform approach. They described how being more aware of volunteers might have improved their hospital experience. They suggested ways to promote the image and identity of volunteers and publicise their availability. Suggestions included disseminating information via leaflets, posters, verbal information, and laminated information cards attached to the bed table or overhead board.

When discussing identity and image, participants also shared their views about the uniform.

6.10.1 The influence of the volunteer uniform on image, identity, and self-identity

This section will explore how the uniform influences how each group of participants perceives them, and how it impacts on their identity and self-identity.

6.10.2 Managers

There was little discussion about uniform in the accounts of managers, but organisational expectations include the mandatory wearing of the uniform and identification badge as a way to ensure standardisation across the organisation, and of promoting a professional image with the aim of enhancing confidence in the Trust and its services.

6.10.3 Ward staff

Ward staff were aware of the uniform but as their relationships with volunteers developed they described them using names and individual characteristics, rather than by the generic term of ‘a volunteer’ and seen by staff as individuals in their own right who had come to help them. One example of this individual approach was of one volunteer who did not wear a uniform, preferring to

work in his own clothes. Nevertheless, he had volunteered for approximately five years and was well-recognised by ward staff both inside and outside the ward environment.

The participant group who discussed the uniform in more detail than any of the others were the volunteers themselves.

6.10.4 Volunteers

Volunteers described the uniform as impacting on their identity and self-image, and expressed conflicting views. Eight volunteers did not mind wearing it; five volunteers were vehemently against uniforms with one refusing to wear one; while two expressed a preference for it. In all cases, the uniform appeared to impact on their image, identity, and self-identity.

The current uniform was introduced three years before the data collection period. Before this, volunteers had the option to wear their own clothes. Those participants who could remember this time discussed the uniform, judging it as creating a sense of anonymity rather than a sense of identity. The identity card lanyard is part of the uniform and was described by one volunteer as adding to the confusion because it was the same colour as the T shirt,

'My badge describes me as a 'ward visitor volunteer spiritual and pastoral care', but the lanyard says '[name of hospital] CHAPLAINCY' in capital letters, and a far larger font size. In fact, I make a point of showing my badge to patients when I introduce myself, and I'm not sure how many can actually read it' (Leo, Chaplaincy Volunteer Diary).

One long-serving chaplaincy volunteer reflected on how the uniform impacted on her self-image, likening herself to a supermarket worker, or someone who cleans the wards and toilets. She discussed her feelings around how she felt her identity had changed since the introduction of the uniform, regarding this to be the reason why she did not get invited by ward staff to support dying patients,

'I've been called over, before the T-shirts, and asked if I would pray for them […] since the advent of the T-shirts, I've not been asked once' (Iris, Chaplaincy Volunteer).

Despite most volunteers saying they complied with the organisational rules to wear the uniform, much of the resistance against them was from long-serving volunteers who were used to wearing their own clothes while volunteering. These volunteers explained the reasons why they disliked it, considering them to be too hot and judging the style to be inappropriate, particularly two older

female volunteers who described themselves as feeling less confident as a result of wearing it. They viewed the expectation from management that they would wear the mandatory uniform as further pressure upon them to comply with organisational rules and expectations, and more in line with what is expected of paid staff than of volunteers.

Furthermore, it appears that the blue colour of the uniform had the potential to create confusion over volunteer identity, particularly among carers and patients with dementia. They described how they were mistaken for clinicians:

'Many of the patients call me Nurse – even though I wear a volunteer's polo shirt. Perhaps their eyesight is poor & I appear to be another person in blue uniform' (Sally, Mealtime Volunteer Diary).

As well as simply disliking the uniform, one volunteer was vehemently against it,

'I hate the t shirt! […] I don't mind wearing a uniform. I've worked in many a job where I had to wear a uniform but…it's just those […] I wouldn't wear it at home to do the gardening in and when I wash it, I always make sure the neighbours aren't about before I hang it out' (Iris, Chaplaincy Volunteer).

Others, however, saw the uniform as having positive advantages. The uniform was favoured by these volunteers, not only because it provided them with a sense of identity and status, but also for its practical advantages. This younger volunteer describes how she saw it as a way to project a professional image and so give her license and confidence to engage with patients:

'you need something to distinguish you 'cos if you just walked on the ward […] in your normal clothes and started […] fiddling round with people's things on their table trying to clean them or bring them their dinner then it's sort of-doesn't look quite as-professional' (Dawn, Mealtime Volunteer).

Those who expressed a preference for the uniform saw it as a useful way to raise awareness of volunteers by increasing their visibility, and might have the potential to encourage others to volunteer.

Despite participants sharing their thoughts on what they considered to be the advantages and disadvantages of the uniform, they did not appear to have any need for a uniform to establish their identity. In addition to the uniform, and despite making efforts to introduce themselves to patients with dementia, volunteers found that using a range of props was a more productive way to

establish or enhance their identity. Some props were simple, everyday activities such as wiping tables down for mealtimes which provided them with a way of interacting with patients. Other props included talking about personal belongings, or sharing a view from the window to prompt conversation. Chaplaincy volunteers would take religious items, such as a rosary or prayer book, which they described as helpful in establishing their identity among patients, by providing some symbolic meaning. In addition, the pet therapy volunteer wore a different colour uniform to the rest of the volunteers, but described the dog to be key in providing him with an identity rather than what he wore.

6.10.5 Patients with dementia, and carers

Lastly, patients with dementia, and carers discussed the volunteer uniform. One carer highlighted the possibility that uniforms could create a barrier when caring for older people,

'I think uniform can be a bit of a barrier […] things were different in the past with the medical profession they were frightened of doctors, they were frightened of nurses, they were frightened of going in hospital […] a uniform is a barrier, and I think they've got used to in the past of it's an official thing' (Vera, Carer).

Patients and carers considered individual volunteer characteristics, personal qualities, and attitudes to be more important in dementia care than the wearing of a uniform.

They also expressed uncertainty over whether the uniform contributed to establishing the identity of volunteers. One example was the blue colour of the uniform which was described as giving the impression that volunteers were in a clinical role as they blended in with the rest of the staff. Some wondered if this was the intention, and suggested that a different colour uniform might be advantageous in differentiating volunteers from ward staff.

6.10.6 Conclusion

This section explored participant accounts to discover their perspectives on the image and identity of volunteers, including how volunteers saw themselves. There was some uncertainty over the image and identity of volunteers, but they were generally seen as positive by all participants. Patients with dementia, and carers saw volunteers as an additional opportunity to access help.

The volunteer image and identity does not appear to be fully understood by all ward staff but they held the general

impression that volunteers made a positive contribution, particularly in view of the fact that they were unpaid. Managers described volunteers as part of the workforce in a support category. Relationships and time were significant factors as volunteers who had developed a connection with staff were described as more easily identifiable than new volunteers who had not developed relationships with the team, whether or not they wore the required uniform to facilitate identification.

There was some discussion about volunteer characteristics affecting performance; diversity was appreciated by staff, but it was unclear whether this was based on experience or assumptions.

Volunteers themselves expressed some uncertainty over their own identity, citing examples of patients with dementia confusing them with clinicians and ward staff. Nevertheless they recognised their identity as an advocate, and described how they considered the needs of patients to be their priority. They also described how they adapted their performance and navigated multiple identities in order to manage their image and volunteer identity. They described becoming more secure over time in their identity as they became increasingly familiar with

the role. Furthermore, participants discussed how to do more to promote the identity of volunteers.

Having presented the findings of the study, the following chapter will present an outcome of the analysis by proposing an alternative model of volunteer management, and present a description of the suggested model.

Chapter 7 Outcome of the analysis: The case for a new management model

7.1 Introduction

Following on from the results chapters which detailed the setting, aspects of volunteerism which included motivations, image and identity, and the volunteer roles and ways of working, this section will present an outcome of the analysis. It will propose an alternative model of volunteer management, and present a description of the suggested model as a way to address the challenges to volunteers and organisations in this setting.

7.2 Background to the development of the NURTURe model

The voluntary service is set up as a complementary service to enhance care (Merrell, 2000; Nissim et al, 2009; Overgaard, 2015; Lorhan et al, 2015). However, the findings of this study are consistent with previous studies that volunteers are increasingly filling gaps in services (Lorhan et al, 2015) to support staff (McDonnell et al, 2014). In the absence of further funding to support the increasing demands on services, and a lack of clarity over whether voluntary services are cost effective, it

seems sensible to maximise volunteer retention to minimise further pressure on paid staff (Hayashi, 2016) while recognising the tensions which might occur between volunteers and paid staff.

If volunteers are managed appropriately, and their needs taken into account, they might be less likely to leave. As there is a cost involved to the trust in terms of administration, training, support, and the provision of out of pocket expenses and a uniform, volunteers who leave would represent a poor return on investment.

Hill (2016) highlights that a lack of adequate management of voluntary services can inhibit its impact and emphasises a need for strategic leadership, culture change, good practice learning, financial resources and regulatory incentives. Further backing for the case for a new model of management comes from Rochester et al (2010) who raise the question of how volunteers should be managed, stress that one size does not fit all, and that there is space for more than one model (Rochester et al, 2010).

Drucker (2007) summarises the three main functions of management as being to produce economic performance, to make productive enterprise out of human and material resources, and to manage workers and work

(Drucker, 2007). Indeed, The Aves Report (Aves, 1969) highlighted the management of volunteers as essential to ensure an efficient service and that volunteers gain satisfaction from their involvement. Despite the declared distaste from volunteers of bureaucratic management, the National Survey of Volunteering (Lynn and Davis Smith, 1991) found a major disadvantage of volunteers was poor organisation. An exploratory study found that poor leadership, including the absence of support and meaningful opportunities, was one of the main reasons given by American community volunteers for leaving (Pollard, 1977).

The management model at the study site had all the components of a modern management model (Zimmeck, 2000) as the voluntary management team recruit volunteers in what appears to be a formal framework appropriate to managing paid staff and has previously been highlighted as deterring volunteer participation, particularly from marginalised groups (Davis Smith, 1996).

This increased bureaucracy is experienced by volunteers to be a generic and uniform approach (Elliott & Umeh, 2012; Field-Richards & Arthur, 2012; McDonnell et al, 2014; McKee et al, 2010), and the increasing

formalisation of the volunteer role with rules, regulations, restrictions, policies, and bureaucratic recruitment procedures giving them a sense of volunteering becoming a semi-professional role (Field-Richards & Arthur, 2012; Watts, 2012). How volunteers are managed and supported has been found to influence whether or not they stay (Kamaludin et al, 2013). With regard to their reasons for considering leaving, the perspectives of volunteers in this study around what would prompt them to leave, resonate with those of previous studies which found that while understanding the need for stringent recruitment and management procedure, they expressed a dislike for bureaucracy, with some feeling that it impacts negatively on their volunteering experience, and subsequently leave (Elliott & Umeh, 2012; Field-Richards and Arthur, 2012; McDonnell et al, 2014; McKee et al, 2010; Watts, 2012). Increased formality has previously been found to challenge smooth working relationships (Field-Richards & Arthur, 2012).

Managers, staff and volunteers described the negative side of volunteering as volunteers were sometimes overlooked, or took on duties outside their remit which sometimes necessitated dismissal. The managers in this study understood the potential for developing voluntary services, but expressed the wish to have some form of

control over volunteers. The diversity and personal nature of volunteer motivations does not appear to sit comfortably with these organisational expectations. It may be inappropriate and counterproductive for organisations to seek to manage voluntary services using a model deemed as more suitable for the employment of paid staff, as volunteers are motivated by different drivers. In view of the fact that volunteers appreciated the flexibility, choice and autonomy of their role, these contrasting motivations seem incompatible and there is a possibility this could lead to further tensions; the majority of volunteers in this study expressed the intention to leave if they were unable to exercise choice in their role. This could be problematic in view of the financial investment and time taken to recruit them.

The case for a new model of volunteer management in this setting would take into consideration the aforementioned issues around motivations, training, and leadership. In view of the expressed desire of some volunteers in this study to know more about how to support patients with dementia, volunteer education could include more dementia training which would equip them with the necessary skills to successfully engage with cognitively impaired patients. The provision of training is recognised as an important part of volunteer programmes

(Rochester, Ellis Paine, Howlett, 2010) and the value of investing in the training of volunteers has been emphasised in previous studies (Berry & Planalp, 2009; Brighton et al, 2017; Brown, 2011a; Dean & Willis, 2017; Dein & Abbas, 2005; Watts, 2012). The findings from this study, and earlier studies in healthcare settings, found that volunteers expressed a need for more information in order to feel they were maximising their contribution (Andersson & Öhlén, 2005; Brown, 2011b; Elliott and Umeh, 2012; Field-Richards and Arthur, 2012; Warren and Garthwaite, 2015).

However, this would also require funding and leadership in order to manage the necessary screening and training. An improved voluntary service could be achieved by tailoring the motivations of volunteers to the needs of patients, staff, and the wider organisation, and underpinned by good communication to achieve this purpose. Söderhamn et al (2012) in a phenomenological study of volunteering in dementia care in Norway highlight the need for mutual trust and freedom when promoting volunteering in a caring context. Good models of volunteering in dementia care include collaborative working, adequate resourcing, and a recognition of the effect of a positive organisational culture which highlights the positive impact on people with dementia, as well as

the challenges faced by volunteers who provide support in care settings who may find the experience daunting, and so need preparation and training (Hill, 2016). Organizations which provide specialised training and ongoing mentoring have been found to be more likely to implement programs for cognitively impaired residents successfully (Damianakis et al, 2007).

Previous studies suggests that for volunteer programs to demonstrate success, they may wish to consider incorporating volunteer management principles which include planning, developing, recruiting, training, recognition and appreciation when recruiting, training, supervising, evaluating, and subsequently retaining volunteers (Govekar, 2004; Shin & Kleiner, 2003). It is suggested that volunteer programs in nursing home settings should include two important components when striving to address the needs of cognitively impaired older adults; these include clear, detailed guidance to volunteers interacting with people with dementia, and a volunteer liaison worker who can collaborate between nursing-home staff, volunteers, and professionals (Holmberg, 1997).

Arguments for the formalisation of volunteer management include the strategic vision for volunteering in health and

social care, which sets out the government's long term vision for social action (Department of Health and Social Care, 2011). It recognises the contribution of volunteers, the need to embed a deeper understanding and awareness of what volunteers do, and encourage a more strategic approach would lead to improved quality and outcomes (Department of Health and Social Care, 2011). The recommendations from King's Fund report on the role of volunteers in the NHS (Ross et al, 2018) are that all NHS acute care trusts have an adequately resourced formal volunteering strategy; be proactive in extending the range of current roles by learning from other trusts; ensure good practice guidance for recruiting and managing volunteers is implemented; ensure frontline staff are empowered and trained to have supportive working relationships with volunteers; develop clear lines of communication between staff and volunteers; clarify the supplementary role of volunteers; recognise and reward the contribution of volunteers (Ross et al, 2018).

Arguments against the claim for a new model of volunteer management to maximise effective voluntary services to provide extra support to patients with dementia on acute hospital wards comes from Zimmeck (2000) herself who highlights the paradoxical relationship between theory and practice. She suggests that good theory does not

always make for good practice, and good practice often has no theory at all (Zimmeck, 2000). Furthermore, as the decision to volunteer lies solely with the volunteer themselves, they are not driven by remuneration but a range of motivations, it is possible that any suggested model of management may have little or no influence over their decision to continue and no guarantee of success. Rochester, Ellis Paine, Howlett (2010) warn against the drive towards increasing formalisation, fearing this will damage the spirit and characteristics of volunteering yet argue for the need to develop new models of volunteer management tailored to different contexts. In this setting there is undoubtedly a need to manage risk and to safeguard patients, staff, and volunteers yet the existing model is experienced by some volunteers as too bureaucratic.

This study echoes the findings of previous research (Akintola, 2008; Andersson & Öhlén, 2005; Berry and Planalp, 2009; Brown, 2011b; Elliott & Umeh, 2012; Field-Richards & Arthur, 2012; Mckee et al, 2010; Merrell, 2000; Preston & Burch, 2018; Rochester, Ellis Payne, and Howlett, 2010; Warren and Garthwaite, 2015) in that there appears to be scope for improving the ways volunteers work, particularly by the introduction of a model of management appropriate to this setting. This

could usefully focus on aspects of the voluntary service addressed in this research. Therefore, in view of the existence of two main models of managing volunteers, namely ‘modern’ and ‘home grown’ (Zimmeck, 2000) the following section will propose an alternative model to streamline the management of volunteers in this setting, based on the findings of this study and the current evidence.

7.2.1 The NURTURe model of volunteer management

The acronym NURTURe is used to name the model in reference to each section (Needs, commUnication, RighTs, fUnding, and leadeRship) (see figure 12). It comprises eight components making up a comprehensive strategy with which to maximise and streamline voluntary services, and facilitate the process of volunteers supporting patients with dementia and cognitive impairment on acute hospital wards, and other specialties. The design of the model is drawn from systems theory which has a wide range of applications across a variety of different disciplines, and has roots in natural sciences (Bertalanffy, 1950; Dekkers, 2017). It proposes that whole systems are made up of a number of separate parts. Systems theory recognises that a system

can be either open or isolated, the complexity and interdependence of relationships within it, and how the interacting and interdependent parts contribute towards the whole (Bertalanffy, 1950).

Systems theory recognises that system comprise of a set of distinct parts, which make up a complex whole. These parts might include employees, assets, products, resources, and information. Systems have inputs, throughputs, and outputs. In the case of a hospital trust, inputs might include resources such as equipment, or the work of employees or volunteers. Products or services released from the system are known as outputs. These may include patients who are discharged out of hospital, or people forming an impression of the organisation in the case of a hospital trust. The process of transformation from inputs to outputs is known as throughputs.

Feedback loops are a way to provide the organisation with information by connecting the outputs to the inputs. Negative feedback loops provide information about problems that need to be corrected. An example of this in a hospital trust might include negative patient feedback, which might result in developing staff training in that particular area.

Systems theory has been suggested as a possible way to support healthcare management (Petula, 2005). The role of management in systems theory is to manage inputs and outputs, monitor throughputs, monitor for positive or negative feedback loops and make changes to reduce or eliminate negative feedback loops by increasing organisational effectiveness or goal achievement.

The boundaries of this model are loose, being part of the wider hospital voluntary service and organisation, which means it is defined as an open system and so there can be an exchange of energy, resources, and information between the voluntary services and the wider organisation. This is important in view of the current national drivers to recruit more volunteers and may subsequently influence what happens at local level (Helpforce, 2019). The benefits of this are that good practice can be shared and so has the potential to increase efficiency.

The findings from this research feed into systems theory to conceptualise the NURTURe model. It appears that the lack of clarity around the image and identity of volunteers, and their role and ways of working could be addressed with the model.

This model offers a holistic and contextualised approach to the management of volunteers in this setting. It considers the modern and home grown models of volunteer management (Zimmeck, 2000; Rochester, Ellis Paine, and Howlett, 2010), and builds on the guidance from NHS England (2017) on how to recruit and manage NHS volunteers by incorporating the principles of inclusivity, collaboration, and a culture of partnership (Public Participation Team NHS England, 2017). The components of the suggested model align with the recommendations from King's Fund report on the role of volunteers in the NHS (Ross et al, 2018).

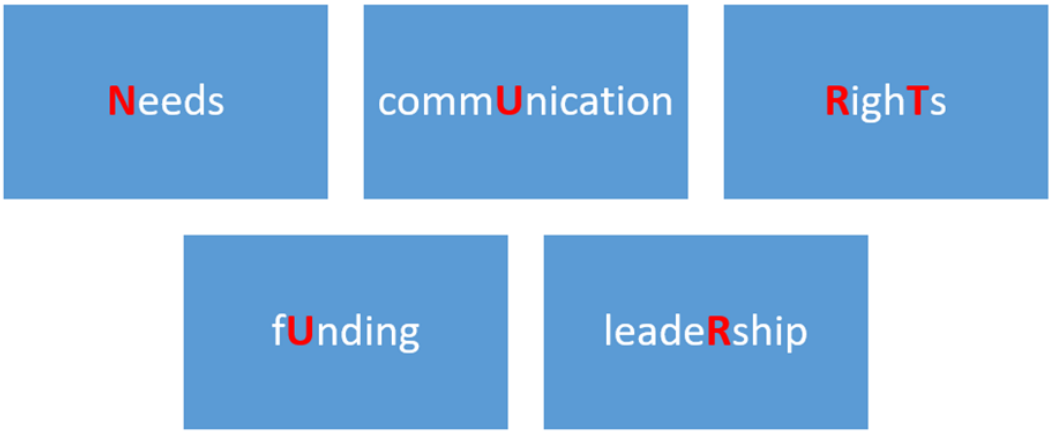


Figure 12 The NURTURe model

The NURTURe model is essentially a framework upon which to plan, develop, and organise voluntary services to maximise the level and quality of support provided to patients with dementia and cognitive impairment while on acute hospital wards.

The component parts which make up the whole systems model include:

Needs: of the wider organisation, ward teams, volunteers, patients, and carers. The logistics of how these needs are managed would be an iterative process and regularly evaluated to develop the service.

Firstly, the needs of the wider organisation, or hospital as a whole will be assessed by management to determine how best to deploy volunteers. This might include extending current roles and areas of engagement including seasonal tasks, such as those tasks associated with winter pressures, and asking volunteers to work in those areas most in need in addition to their contribution to the support of older patients with dementia on acute wards.

Secondly, the needs of ward teams can be determined at ward level between staff with the recognition that each ward will have different requirements, and decisions then made as a team to determine how this can be implemented in relation to volunteering.

Thirdly, an assessment of volunteer needs is important because of the range of individual motivations which drive each volunteer. One to one interviews at recruitment would determine what the volunteer wants from the

experience, and what opportunities the organisation can provide to achieve this (for example offering bespoke training). This can be followed up at a mutually agreed time point with the voluntary services management team to ensure the aims are met.

Lastly, the needs of patients and carers will be assessed by clinicians as part of the nursing process and comprehensive geriatric assessment process (Welsh, Gordon, and Gladman, 2014) on admission, and throughout their hospital stay. It would take into account the challenging setting. Volunteers could then be assigned complementary, non-clinical tasks tailored to each individual patient as an integral part of the care plan with the aim of enhancing patient recovery and potentially accelerate discharge.

Communication: includes establishing a universally agreed definition of volunteers and promoting the role and identity of volunteers across the whole organisation to inform all stakeholders of the nature of the voluntary service. In view of the lack of clarity of the image and identity of volunteers, and in view of the uncertainty over role boundaries, it is important that any new model is underpinned by good communication to achieve this.

Brand development affords one way of challenging and changing the image of volunteering. Despite the challenges in reaching a consensus (Rochester, Ellis Paine, and Howlett, 2010) and despite the possibility that patients with dementia, and carers may not fully comprehend the identity of volunteers due to personal barriers, there is the possibility that this could be maximised through effective communication strategies taught at staff and volunteer training sessions. For example, a universal understanding of what volunteers can and cannot do is likely to lead to a more streamlined way of working and subsequently maximise effective support for people with dementia in acute hospitals.

Rights: In view of the historical and contemporary drives to encourage more people to volunteer, it is important that the rights of paid workers are taken into account when determining what tasks volunteers can do, how the volunteer role is to be implemented, and what constitutes the boundaries of the role. Organisations must secure an assurance that the rights of paid workers will be protected to comply with union and workforce regulations which state that volunteers should only be deployed to undertake supplemental activity, they are not a cost free option to paid staff, and they should not be used to replace the work of paid staff at times of industrial action

(Unison, nd; Trade Union Council, 2009). Therefore all the components of the nurture model must be in line with employment law and trade union regulations (Unison, n.d; Trade Union Council, 2009).

Funding: In view of the difficulties establishing evidence to determine the cost effectiveness of volunteers and the costs involved in deploying them, this component of the model would consider how the service is funded, future plans for funding, and details around the costs of voluntary services. It is likely that details around costings would inform and support long term strategies for the voluntary service.

Leadership: would establish administrative management of volunteers, and include recruitment, training, ongoing support, and consideration of the workplace culture. In recognition of the apparent gap between the voluntary service management team and ward staff, one person could be designated as a facilitator to provide individualised support to volunteers at ward level. This component would also include developing new volunteer roles, such as developing the role of mobility volunteers to increase physical activity of hospital patients, a role which is not universally used across acute hospital trusts at the present time (Babine et al, 2018; Baczynska et al,

2016; Bateman et al, 2016; Denomme et al, 2018; Godfrey et al, 2013; Gorski et al, 2017; Inouye et al, 2006; Inouye et al, 2000; Sandhaus et al, 2010; Steunenberg et al, 2016).

In conclusion, hospital volunteers occupy a variety of roles to provide a range of services, one of which is to support acutely ill patients with dementia at mealtimes and through social interaction. Yet the findings of this study and current evidence suggests that there appears to be scope for improving the ways volunteers are managed in order to mitigate the risks and maximise the benefits of the service to ensure what happens in practice meets expectations. While it is also possible that any model may fail to promote effective management, it is possible that a move away from modern, formalised models of voluntary management towards a more bespoke model suitable to address the needs of stakeholders in this setting might improve ways of working, and so maximise volunteer retention.

7.3 Practical application of the NURTURe model

The practical application of the NURTURe model would be to prompt an assessment of stakeholder needs within

the organisation, to discover new ways to improve input (funding), throughput (interactions between volunteers and patients), and outputs (satisfied patients, volunteers, and staff).

All components of the model are interdependent, For example, clear communication would not only ensure that stakeholders develop an understanding of the volunteer image and identity, and role boundaries, it would also ensure raised awareness of workers' rights, and so be a major influence in the leadership strategy when managing volunteers.

Following on from the research findings, the model is currently being trialled in one hospital trust as part of a nationwide hospital Youth Volunteer Project. Now funding has been granted, the remaining components which include needs, communication, rights, and leadership, underpin the development of evidence based volunteer roles. One role is that of Fitness Friends (Charalambous, 2019) who are volunteers trained and supervised by physiotherapists to support patients with bed and chair based, lower and upper limb exercises.

7.4 Conclusion

Following on from the results chapters which detailed the setting, aspects of volunteerism (including motivations, image and identity, and the volunteer roles and ways of working), this section presents an outcome of the analysis. It proposes an alternative model of volunteer management underpinned by systems theory, and presents a description of the suggested model as a way to address the challenges to volunteers and organisations in this setting.

Having presented the findings of the study and suggested a new volunteer management model, the implications of these findings will be considered in the following discussion chapter.

Chapter 8 Discussion and conclusion

8.1 Introduction

Following on from the results, this chapter will discuss the results of the study in relation to the objectives. It will begin with a summary of the major findings. Throughout this chapter reference will be made to similar studies to explore the similarities and differences, and build on current evidence. The chapter will continue with the strengths and limitations of the study and will conclude with recommendations for further research.

8.2 Summary of findings

The aim of the study was to address gaps in the current evidence by developing a rich and in depth understanding of the experiences and perspectives of a range of stakeholders involved in voluntary activity to support people with dementia and cognitive impairment in acute hospital wards and develop a descriptive and explanatory account of the phenomenon of volunteering in this setting. The objectives were:

- To identify organisational motivation and goals for having a volunteer service which provides support to

patients with dementia and memory loss in acute hospital wards

- To identify barriers and facilitators to volunteerism in dementia and memory loss in acute care

- To explore ways in which volunteers work with patients with dementia and memory loss within the Multi-disciplinary Team (MDT).

- To explore, from the perspectives of patients with dementia and carers, their experience of volunteers while on acute hospital wards.

- To explore reasons why volunteers leave, or continue, in the role of volunteer in this context

The focus of the study was on the support provided by volunteers to patients with dementia and cognitive impairment in acute wards. However, the volunteers were not recruited specifically for this purpose as some patients do not have cognitive impairment on older person acute wards, they provided support to all patients. The study took an interpretivist approach which recognises that knowledge is socially constructed through the relationships people have with the outside world. I carried out qualitative interviews to understand the perspectives of participants from a range of stakeholder

groups from five acute older person medical wards and one dementia specialist ward in one NHS hospital over nine months, and collected data using one to one and dyadic semi structured interviews, and diaries. An inductive and iterative process to data analysis used thematic analysis to identify, analyse, and report patterns within the data. In discussing the findings participants gave conflicting accounts, and there were underlying tensions and uncertainties about the voluntary service.

Firstly, the ward was experienced as a busy, noisy, and challenging place in which to receive treatment, work, visit, and volunteer, and the presence of dementia impacted on volunteers.

Secondly, the role and ways volunteers work were valued by participants, but there was a recognition that the service must be carefully managed to address potential risks. Managers highlighted the potential for improving the service, offering suggestions such as: accessing funding; developing a collaborative and long term strategy to understand the needs of key stakeholders and streamline the service; and developing the role by increasing volunteer integration, offering information and support to staff, and further training for volunteers.

Thirdly, volunteers were motivated by altruistic, social, and other reasons. Volunteers were both motivated and deterred by the opportunity to support frail older people with dementia.

Lastly, the image and identity of volunteers was generally that they were of value, providing an opportunity for patients and carers to access extra help and support. It appears that the longer volunteers work in the role, the more familiar and recognisable they become to staff. Volunteers were seen as a type of friend to patients, a relationship different to that of a clinician or family member. The diversity of volunteer demographics, including age, was seen as contributing to how they were seen by others. Volunteers saw themselves as an advocate for patients. Wearing a uniform elicited a variety of responses, generating discussion about the influence on identity, with no universal agreement on whether or not it was beneficial or detrimental. Some volunteers had other identities which sometimes presented them with challenges when navigating their role. The following section will discuss the meaning and importance of the findings.

8.3 Discussion of results

This section will discuss the results, including the different expectations of the service, the challenges of the role, the volunteer image and identity, and conclude with the strengths and limitations of the study. Exploring the diverse viewpoints of multiple stakeholders found tensions between their expectations which will now be discussed.

8.3.1 Diverse viewpoints

The data consist of written and oral accounts from a variety of stakeholders involved in volunteering, and there were layers of interpretation and nuances in their understanding and expression of their lived experiences. The inconsistencies in accounts of many of the managers, staff, patients, and carers which varied as the interviews progressed, appeared to be shaped to some extent by stereotyped images of volunteers, rather than their actual experience of them. Many participants began with a positive account of volunteers but on further probing they began to elaborate, discussing the negative aspects of the volunteer identity, highlighting the potential risks and disadvantages. Volunteers were held in esteem

for being essential, but there was general uncertainty over what they do.

Managers and ward staff began the interviews by presenting what appeared to be a sanitised account of volunteers, describing them in a favourable light. Initially, they were described as valuable, positive and an intermediary for patients and carers to access help in the absence of staff, mainly because the financial and workload pressures on the organisation meant that staff were busy, which in turn created challenges to delivering services. Volunteers were perceived as having a connection with patients and carers in a way not experienced in the relationship between patients and clinicians or family. Volunteers were described as being crucial to plugging gaps in service provision, providing support to patients by distributing meals and offering companionship. However, as their narratives unfolded, the majority of staff and managers began to share contradictory accounts and gave examples of the negative aspects of volunteerism and possible drawbacks to the service. One example was from those members of staff who gave accounts of describing volunteers as providing an important service, yet were often unable to describe exactly what that service entailed. They often did not identify nor recognise volunteers on the ward.

The uncertainty and conflicting accounts around how staff and managers described volunteers may be an example of what Cornwell (1986) describes as ‘public’ and ‘private’ accounts. Cornwell (1986) stresses the distinction between how participants frame their ‘public’ accounts in a way they may feel will be acceptable to strangers; whereas ‘private accounts’ reveal more personal perspectives thought to be less publicly accepted. Cornwell (1986) describes how public accounts would dominate the interviews in her study which explored the relationship between people’s ideas about their health, and the social and economic factors governing them. However, once trust was established with the researcher, this was the point at which participants offered private accounts in this study.

However, some staff described how they had not previously considered volunteers and so it is also possible that the interview process gave them the opportunity to construct their own perspectives of volunteers, giving them the time and space to reflect on their own understanding of volunteers for the first time, a point previously raised by Cornwell (1986). The accounts illustrate the dominance of stereotyped images and the rhetoric around altruism. Managers and staff in this study used positive rhetoric to describe altruistic volunteers,

seeing them as vital, which dominates the modern day discourse and serves to perpetuate this image of selfless individuals. But they also described volunteers as not always seen, nor their purpose fully understood. In view of this, there is a danger that the contribution of volunteers is overstated. Having discussed the diversity of accounts, the following section will discuss the differences in the expectations of stakeholders of the voluntary service.

8.4 Expectations of the voluntary service

There appear to be differences in what is expected of the voluntary service, concerns over risk management, training, inclusivity and widening participation, cost effectiveness, and a discussion of what volunteers expect.

The expectations at national level are illustrated by the plans to shape 21st century volunteering by recruiting more volunteers into acute hospital trusts. This initiative driven by Helpforce claims that hospital volunteering creates a better experience for patients and more time for staff to do their job (Helpforce, 2019). This appears likely to continue in view of: the political and economic agenda

as seen over the course of previous decades (Blair, 2000; Brindle, 2015; Brown, 2000; Home Office, 1990; Zimmeck, 2010); the intention to increase public involvement in healthcare through the contributions of volunteers (NHS England, 2017); and the long standing tradition of hospital volunteers. The positive rhetoric used by groups such as Helpforce to describe volunteering appears to fit the stereotyped image of volunteers presented by some managers and staff in this study with little in depth discussion, analysis, or evidence of the disadvantages or drawbacks. There is a danger that including volunteers could be a tokenistic gesture towards patient and public involvement (Kilpatrick et al, 2017). It is understandable that there might be public demand for all hospital services to be delivered by accountable healthcare professionals rather than members of the public. The continued drive for volunteer involvement is likely to continue in view of volunteers being seen as a way of saving money, despite previous warnings against such an approach from central government (Haugh and Kitson, 2007). One example is the expectation from some managers and staff in this study that volunteers could be deployed to supervise patients at risk of falls, currently a nursing responsibility. There are warnings from union bodies to guard against deploying volunteers in any

capacity other than that of a complementary service, not least because of the subsequent tensions which may occur between paid staff and volunteers (Finnegan and Brewis, 2012; Shepherd, 2013). Previous studies have emphasised the need for organisations to make explicit their motives for involving volunteers (Merrell, 2000; Overgaard, 2015), but despite role descriptions being made available to organisations at local level, this study highlights the variations in what volunteers provide in terms of tasks being judged to be complementary or essential.

8.4.1 Expectations over risk management

The accounts of managers and staff changed over the course of the interviews to reveal concerns over risk management and expectations that safety should be a priority.

The aforementioned concerns about volunteers taking over the positions of paid staff highlight the need to manage potential risks of this type of public involvement. It appears that the hospital seeks to address this by using a formal management model suitable for paid staff. This is partly through a desire to formalise and standardise the system, and partly to exercise control over the volunteer workforce with the aim of maintaining patient safety and

to safeguard the reputation of the organisation. These concerns raise questions around whether the risks and challenges of involving volunteers might outweigh the benefits, and suggests that the contribution of volunteers could be overstated, particularly in view of the positive rhetoric universally used by participants in this study to describe them. This positive terminology used to describe volunteers is consistent with that used by national organisations, such as Helpforce (2019), who focus on the positive aspects of volunteers with no mention of drawbacks such as potential risks to patient safety or increasing staff workload. Undoubtedly, there are people who should not be allowed to volunteer with vulnerable patients. Indeed in the aftermath of the Jimmy Savile case, The Lampard Inquiry highlights the need for stringent management of volunteers in NHS organisations, including screening and careful recruitment procedures, in order to safeguard patients (Lampard & Marsden, 2015).

Previous studies have highlighted that poor leadership was a barrier to co-ordination and information sharing and recommends considering employing nurses as volunteer co-ordinators to maximise services in hospice volunteering (Vanderstichelen et al, 2019). Nurses as volunteer coordinators were found to have been

beneficial in dementia settings when considering how to manage risks (Bateman et al., 2016; McDonnell et al, 2014).

The use of a formal model of recruitment seems appropriate as the voluntary service involves members of the public being in close contact with vulnerable people who need safeguarding. However, a formalised management approach was viewed by some volunteers in this study as a barrier to continuing, as they valued autonomy, freedom, and choice in their role. The need for appropriate training was raised by members of staff and managers when discussing risk management.

8.4.2 Expectations over training

All volunteers at the study site were required to undertake mandatory training. This covered what managers considered to be essential information, underpinned by a need for risk management, safeguarding and infection prevention. While these topics are undoubtedly important in healthcare settings, some volunteers in this study felt the training did not fully prepare them for the role once they arrived on the ward. However, chaplaincy volunteers who participated in this study received extra communication training and ongoing support which they appreciated and described how this helped them to

engage in difficult conversations with patients with dementia.

This finding is consistent with previous studies which highlight concerns over volunteer training, particularly to avoid alienating volunteers (Warren and Garthwaite, 2015). Previous studies suggest that the experiences of volunteers in this setting are similar to the experiences of volunteers in other healthcare settings, such as hospices (Brown, 2011a; Watts, 2012), and older person hospital wards (Faulkner, 2005) where volunteers experienced challenges and expressed a need for more support and training. Hospice volunteers preferred more training in order to prepare them for the role (Watts, 2012), increase their confidence (Dean & Willis, 2017), provide opportunities for ongoing ethical discussions (Berry & Planalp, 2009), or provide formal peer support and communication training (White & Gilstrap, 2017). A lack of training has been highlighted as creating problems for hospice volunteers in previous studies who encountered cultural clashes when their levels of cultural competency was weak (Jovanovic, 2012). Relevant training has been suggested as a way to avoid alienating volunteers (Warren and Garthwaite, 2015). In hospital settings volunteers expressed a need for training in communication skills, grief and bereavement, spiritual

diversity, common symptoms, self-care and an opportunity to update their knowledge (Brighton et al, 2017).

Previous studies have shown that appropriate training improves how volunteers work (Berry and Planalp, 2009; Brighton et al, 2017; Dean and Willis, 2017; Warren and Garthwaite, 2015; Watts, 2012; White and Gilstrap, 2017). However, in the absence of formal training hospice volunteers described coping strategies which included seeking advice from staff, drawing meaning from their religious beliefs (Brown, 2011a), or taking action to prevent compassion fatigue or burnout (Claxton-Oldfield & Claxton-Oldfield, 2007).

8.4.3 Expectations around diversity, inclusivity and widening participation

Attempts have been made to change the image of volunteering to encourage more people (Hankinson and Rochester, 2005; Commission on the Future of Volunteering, 2008; Rochester, Ellis Paine and Howlett, 2010). The image of volunteering has been described as being poorly organised, only for white middle class women, expensive and time consuming, and boring; uncertainty of the benefits, has been previously highlighted as an obstacle to the participation of young

people (Niyazi, 1996). When promoting the image of volunteering for young people in particular, it is suggested that an emphasis is placed on the value in career preparation, acquiring useful skills, and instilling a sense of involvement and appreciation (Niyazi, 1996). In view of this it appears that organisational efforts to establish an identity for volunteers by providing them with a uniform do not always have the desired effect. The symbolism associated with uniforms can create further confusion, and there is a need for clearer information around the identity of volunteers.

Managers and staff in this study appreciated diversity and said they would welcome more volunteers from a variety of backgrounds, genders, ages, and ethnicities and echoes the positively framed rhetoric at national level (Helpforce, 2019). This aim of widening participation to champion inclusivity and embrace diversity of volunteers is admirable, but raises questions over how far organisations can accommodate and resource this without placing an extra burden on paid staff. Subsequently there appears to be a balance of risk versus benefits when embracing inclusivity, diversity, and widening participation. However, widening participation to include traditionally under represented sections of the population may be difficult to achieve with current

resources. There are recognized challenges to pursuing inclusivity in voluntary action (Rochester, Ellis Paine, Howlett, 2010). A report undertaken by the Institute for Volunteering Research (IVR, 2004) highlights how voluntary services are not yet fully inclusive, and questions whether organisations have the capacity to truly be inclusive by widening participation as they may not have the resources or capacity to do so. In view of this, the special needs of volunteers and the organisation would need to be assessed at the recruitment stage to assess suitability on a case by case basis, and to determine the level of support required by each person.

The dangers of the gap between the perception of volunteering and the reality of practice, has been identified as a major barrier to providing young people with the opportunity to devlop skills and experience (Rochester, Ellis Paine and Howlett, 2010; Ellis, 2004; Gaskin, 1998; Niyazi, 1996) and also influences older peoples' decision to volunteer (Rochester and Hutchinson, 2002; Davis Smith and Gay, 2005). The image of volunteering was also found to be a barrier to widening participation in Black, Asian and Minority Ethnic (BAME) communities and people with special needs, as these groups are unlikely to volunteer in an activity they cannot identify with (IVR, 2004). Lukka and Ellis Paine

(2007) highlight the historical significance of the altruistic image of volunteering which emerged from the Victorian ideology of philanthropy and illustrates the underlying power dynamics of those in middle class positions offering help to those less fortunate. This western construct of benevolence is described by Lukka and Ellis Paine (2007) as being largely at odds with the views of BAME communities because of the difference in the meaning placed on volunteering, and their understanding of what it involves over and above altruistic behaviour in society.

As well as concerns over inclusivity, there are also issues around cost associated with voluntary services.

8.4.4 Expectations around cost effectiveness

Managers and staff in this study who referred to the cost saving nature of voluntary services, acknowledged they were unable to give specific details. This is consistent with the findings of previous studies which acknowledge that volunteer turnover is costly and time consuming (Van Ingen & Wilson, 2017), yet recognise the difficulty in establishing cost effectiveness of voluntary services (Sandhaus et al, 2010). There are suggestions that setting up new interventions may actually increase costs (Blair et al, 2018; Godfrey et al, 2013).

The costs include staff time to complete the administration necessary for recruitment and ongoing support. It could be suggested that the risks to patient safety, safeguarding the reputation of the organisation, and pressure on staff to support volunteers may be too great and not worth the investment.

As well as expectations of the voluntary service, volunteers themselves have their own expectations.

8.4.5 What do volunteers expect from volunteering?

The benefits of a voluntary service to support patients appears to be important to volunteers, but not the entire reason for them volunteering. Volunteers interviewed in this study expected their experience would meet their motivations.

They described their reasons for volunteering, often expressing a need for social contact, inclusion, routine, to gain work experience, or because of their religious beliefs. Volunteers also expressed the reciprocal aspect of the role, expressing how they felt volunteering was good for them, and a reminder to appreciate good health.

These findings are consistent with current literature which proposes that volunteers are motivated by receiving something in return for their efforts (Blanchard, 2006; Clary et al, 1998; Clary and Snyder, 1999; Cnaan and Goldberg-Glen, 1991; Ferreira, Proença, and Proença, 2012; Fischer and Schaffer, 1993; Gidron, 1978; Hallett et al, 2012; Lourens and Daniels-Felix, 2017; Pillemer, Landreau, and Suitor, 1996; Zweigenhafta et al, 1996). In general, motivations to volunteer in healthcare settings were found to be mainly for material gain and altruistic reasons (Watts, 2012).

The findings around the reciprocal expectations of volunteering concur with those of previous studies which found that, on the one hand volunteers acquire a positive life meaning from volunteering (Azuero et al, 2014), and they would recommend volunteering to others as they felt it was rewarding (Claxton-Oldfield & Claxton-Oldfield, 2007). Yet on the other hand, volunteers felt rejected if their need for meaning and belonging is not satisfied (Andersson and Öhlén, 2005; Claxton-Oldfield & Claxton-Oldfield, 2012; Faulkner, 2005; Warren and Garthwaite, 2015; Watts, 2012), and would cease their volunteering if other commitments became a priority (Claxton-Oldfield & Claxton-Oldfield, 2012).

Some volunteers expressed a wish to retain some flexibility and autonomy in their role. This is also consistent with previous studies in similar settings which found that some volunteers had a distaste for bureaucratic systems of management, which they felt stifled the spontaneity of their volunteering experience (Elliot and Umeh, 2012; Field-Richards and Arthur, 2012; McDonnell et al, 2014; Mckee et al, 2010; Watts, 2012). Indeed, Handy (1983) highlights the hierarchical and controlling nature of management, particularly in voluntary services.

Volunteers appreciated positive feedback from staff in this study which made them feel valued, and motivated them to continue. This is similar to the findings of previous studies which found that volunteers express a need to feel appreciated and supported by staff, patients, and other volunteers (Andersson and Öhlén, 2005; Claxton-Oldfield & Claxton-Oldfield, 2012; Elliott and Umeh, 2013; Jack et al, 2011; McDonnell et al, 2014; Merrell, 2000; Merrell and Williams, 1999; Takasugi and Lee, 2012; Warren and Garthwaite, 2015; Watts, 2012). They expect a level of support from staff to feel appreciated or express an intention to leave. Hospice volunteers in previous studies felt rejected if their need for belonging was not met (Andersson & Öhlén, 2005). This

was consistent in the findings of previous studies which found that volunteers experience satisfaction in their role which enables them to continue (Andersson and Öhlén, 2005; Azuero et al, 2014; Claxton-Oldfield & Claxton-Oldfield, 2007; Claxton-Oldfield & Claxton-Oldfield, 2012; Jack et al, 2011; Watts, 2012).

8.4.6 Differences in expectations

This study highlights the tensions between the different expectations of stakeholders of the voluntary service, issues around risk management, training, widening participation, and cost. Overall, managers expected to have some form of control over volunteers. Managers, staff, patients, and carers expected voluntary support to benefit patients. However, volunteers expressed their own agenda which did not always match their perceived image of being altruistic and selfless. They expressed a need to feel they were making a difference, develop skills and experience, or other reasons such as social contact. The contrasting expectations and tensions appear to be exacerbated by the rhetoric of volunteering and the image of altruism and selflessness which persists across all the accounts, and highlights the differences between expectations and what happens in practice.

Volunteering in this setting is complex. It offers the attractive promise of delivering complementary hospital services to patients with dementia for little cost; supporting staff; improving the reputation of the organization; and having a positive impact on patients, carers, and staff. However, behind the rhetoric of altruism and selfless intentions of volunteers there are tensions between the perspectives of stakeholders, conflicting accounts, and underlying uncertainty. The promise of a voluntary service underpinned by altruism and selfless intent on the part of volunteers comes with a caveat as volunteers have their own agenda which is not always in line with that of the organisation, nor the expectations at national level. The discussion of results will now turn to a consideration of the setting.

8.5 The setting

Staff, managers, volunteers, and carers in this study described the ward environment as a challenging place in which to volunteer. Previous studies have highlighted the unsuitability of acute wards for older patients with dementia and cognitive impairment who require treatment for an acute illness (Tadd et al, 2011). Hospital settings are problematic for older people because of the lack of opportunity for occupation, and subsequent boredom as

the majority of patients are unoccupied (Nolan, Grant and Nolan, 1995).

There are difficulties in making substantial changes to the physical environment due to the cost involved. However, more appropriately trained people could be deployed to deliver person centred care. Previous studies have highlighted the challenges of staff (Goldberg et al, 2014), and carers (Clissett, Porock, Harwood et al, 2013; Bradshaw, Goldberg, Lewis et al 2013) when meeting the psychosocial needs of patients with dementia (Dewing, 2001; Edvardsson, Winblad, and Sandman, 2008). Volunteers were seen by managers, staff, patients, and carers in this study as a way to provide extra support. However, because some of the managers, staff, and carers who participated in this study highlighted the challenges and potential unsuitability of the setting for volunteers, this raises the question of whether it is an appropriate place to volunteer.

There were also polarised views, for example the setting itself was experienced by volunteers as either interesting or boring; and the presence of patients with dementia was described as both a barrier and positive motivator to volunteering.

8.5.1 Challenges of supporting people with dementia

The presence of patients with dementia was described by some volunteers in this study as presenting a challenge, particularly when patients could be distressed by the unfamiliar environment (Fogg et al, 2018; Glover et al, 2014). They experienced difficulty understanding what patients were saying because of patients with hearing difficulties, memory loss, and missing dentures, unable to speak English, confusion, experiencing repetitive and meaningless conversations, and encountering physical and verbal aggression. Effective communication between volunteers and patients with dementia has previously been highlighted as challenging (Kempler, 1995).

The issue of volunteers avoiding communicating or engaging with patients with dementia is consistent with the findings of other studies which found that nursing home residents with advanced dementia were often overlooked for volunteer support, even though they might potentially benefit the most from these interactions (Van Der Ploeg, et al, 2014). A structured model is suggested to ensure that volunteers are equally deployed amongst residents (Damianakis et al, 2007; Van Der Ploeg et al, 2014). In view of these challenges, the issue of some of

the volunteers in this study avoiding people with dementia could be addressed by careful allocation, management support, and education.

On the other hand, despite the challenges and potential risks of deploying volunteers, it appears that this setting may be suitable for some volunteers. While some volunteers in this study expressed frustration, they also expressed a sense of endurance about the uncomfortable environment, and a determination to stay. Some volunteers described their enjoyment when supporting older patients with dementia and said they would not volunteer with any other patients; they actively sought them out, enjoying the person-centred philosophy of care, describing them as happy, content and settled, and requiring no specialist support, regardless of dementia or the severity of confusion.

It could be argued that since around a quarter to a third of hospital beds are occupied by people with dementia or cognitive impairment (The Royal College of Psychiatrists, 2005), with 97% of nurses caring for them in hospital (Alzheimer's Society, 2009) the setting itself is not specialised but, to some extent, commonplace throughout the hospital. In view of the forecast increase in the numbers of people with dementia (Prince et al, 2014), it

seems appropriate to continue to provide voluntary support in a variety of settings, including acute wards to give people the opportunity to develop an understanding of the needs of people with dementia and gain confidence to engage with them through volunteering.

Despite the challenges of the acute hospital setting, there appears to be a need for patients to receive extra support which some volunteers are well placed to provide. In view of the limited roles of chaplaincy and mealtime volunteers, it is possible that roles could be developed to include different types of engagement in a wider range of activities. However, there are risks and challenges highlighted by managers and staff in this study, and the literature which need to be mitigated against by appropriate training, management, and support in order to maximise success. The following section will discuss issues around the image, identity, and role of volunteers.

8.6 Lack of clarity over image, identity, and role of volunteers

Apart from the challenges of the setting, this study found that the volunteer image and identity is unclear, even among the volunteers themselves. This lack of clarity has previously been highlighted, along with calls for the

volunteer movement to rediscover its identity (Hedley and Davis Smith, 1992). According to social identity theory, the process of identification occurs as a basic cognitive mechanism which humans find useful when understanding themselves and others; people can have multiple social identities which can impact on the way they experience the social world (Jenkins, 2008).

Managers, staff, patients, and carers in this study described volunteers as having the potential to complement the efforts of paid staff who deliver person centred care which values the individual and is consistent with the findings from other studies (Kitwood, 2002; Clissett et al, 2013), as well as meeting the need to promote compassionate care (McPherson, Hiskey, and Alderson, 2016). There is evidence from previous studies that the experiences of cancer patients and carers are enhanced by volunteers who are trained and managed appropriately to provide person centred support, as well as volunteers being a valuable resource for staff (Lorhan et al, 2015; Nissim et al, 2009).

The practical support provided by mealtime volunteers, and the interpersonal nature of the support provided by chaplaincy volunteers, is consistent with the findings of Dodd et al (2018) who described the role of volunteers as

‘being there’ or ‘doing for’. This echoes the ways of working for mealtime volunteers whose main role involved manual labour assisting patients with food and drink and clearing away (‘doing for’); whereas the chaplaincy volunteers’ role was more interpersonal and consisted mainly of listening and befriending (‘being there’).

As well as a lack of clarity over the image and identity of volunteers, there is a need to establish where these boundaries lie, particularly where different volunteering roles operate. Healthcare volunteers in previous studies have expressed issues around role ambiguity (Berry and Planalp, 2009; Claxton-Oldfield & Claxton-Oldfield, 2012; Dean and Willis, 2017; Hayashi, 2016; Kilpatrick et al, 2017; Merrell, 2000; Nissim et al, 2009; Overgaard, 2015; Pryce et al, 2015; Southby & Gamsu, 2017). Furthermore, hospice volunteers have previously reported difficulties when articulating their role to others (White & Gilstrap, 2017).

Volunteers were given training, but encountered a variety of situations not covered by mandatory training. Volunteers are deployed to provide supplemental or complementary support; the underpinning ideology is that should volunteers be removed, the service would

continue to function. However, staff and managers described volunteers as filling a gap in services, and subsequently described them as essential. This finding echoes previous research which found that hospice volunteers inhabit a unique position, a third culture of care, which fuses elements of formal care with the informal visiting of friends and neighbours (McKee et al, 2010). This characteristic represented neutrality and an approach which was driven by the desire to help patients; describing volunteers as ‘one of us’. The findings from this study emphasise the positive effect of volunteers in filling gaps in services, a finding which echoes previous studies where volunteers were described as a helping to bridge a gap between patients and services (Jack et al, 2011; Lorhan et al, 2015; McDonnell et al, 2014; Mckee et al, 2010; Merrell and Williams, 1999; Morris et al, 2017; Nissim et al, 2009; Overgaard, 2015; Pryce et al, 2015; Sévigny et al, 2010).

The tensions around whether the voluntary service is a complementary or essential service appears to be more complex as volunteers would occasionally fill in for essential services in the absence of staff. In an attempt to help, volunteers described taking on non-clinical tasks they knew were prohibited. This included filling in for the ward receptionist, or supervising patients at risk of falls in

the absence of nursing staff. Some volunteers expressed a fear of overstepping these boundaries as they did not wish to appear to be taking advantage of their position. These difficulties have previously been highlighted by hospice volunteers who discussed the complexities of establishing where role boundaries lie, and the difficulties in navigating them (Claxton-Oldfield, Gibbon, and Schmidt-Chamberlain, 2011).

Volunteers in this study described the stress of navigating what appeared to be unclear role boundaries, particularly in the initial stages. They employed various coping strategies, but were reluctant to bother staff who appeared busy. This is consistent with studies which highlight the stresses involved in hospice volunteering (Dein & Abbas, 2005; Elliott & Umeh, 2012).

This lack of clarity around identity and role boundaries suggests a missed opportunity in that chaplaincy and mealtime volunteers are seen as positioned somewhat outside the boundaries of the team. Suggestions made by some staff and managers were that there could be greater integration and direction for volunteers who appreciated being included.

The identity of individuals can be determined by others though a process of classification which is rarely simple

(Jenkins, 2008). Jenkins (2008) suggests that to identify a person is enough to decide how they are to be treated, an important point in the example of volunteers in this study who were described as being ignored by staff and then subsequently left the volunteer service. This is illustrated by the findings of this study as the identity of volunteers appear to be partly shaped by the predetermined image others have of them, namely that of an altruistic and selfless individual, and subsequently internalised by the volunteers and projected onto others. This fits the social constructionism approach underpinning the study as understandings are co-constructed through language and behaviour and so perpetuated (Charmaz, 2014).

A critique of the term identity is that it is expected to deliver too much by way of assigning similarities across populations (Brubaker and Cooper, 2000) and has become so meaningless as to render it almost redundant as a term to uncover the rich diversity and nuances of individuals (Jenkins, 2008). Nevertheless all types of participants spoke of their understanding of the volunteer identity which was a prominent finding in this study and as such provides a deeper understanding of how volunteers were seen and how they saw themselves, regardless of the semantics involved.

A Dutch study testing the theory of volunteer role identity predicted that people would identify more strongly with the volunteer role as a way to compensate for the absence of other productive role such as retired or unemployed people (Van Ingen and Wilson, 2017). The study found a strong association between age and volunteer role identity. Older volunteers place a high value on their role in terms of self-identity because of the extra time retired people have to volunteer and protecting them in some way from social exclusion and loneliness (Van Ingen and Wilson, 2017). Such findings could be useful in guiding the management of volunteers since turnover is costly and time-consuming (Van Ingen and Wilson, 2017).

8.6.1 Identity and uniforms

There is an expectation from the organisation that volunteers wear the uniform provided by the hospital to help establish their identity. Volunteers discussed how this impacted on their image and identity. Volunteers saw the uniform as either a barrier or a facilitator to volunteering. Some volunteers felt it created a sense of anonymity rather than identity, or a change in status. Patients and carers described uniforms as adding to the confusion over the volunteer identity, seen by some as a

barrier, a symbol of officialdom, and others described them as a reminder of institutionalization and officialdom, reinforcing perceived power dynamics between patients and clinicians. These views about volunteer uniforms raise questions over their efficacy and general purpose; pose challenges around how volunteers should be recognised by staff and patients; and serve as an example of the volunteers resisting being managed.

These polarised views resonate with the literature on how uniforms affect the identity of nurses. Hospital uniforms, particularly nurses' uniforms, have a long tradition and raise issues around gender, equality, power and identity (Shaw and Timmons, 2010). Uniforms are seen as either a mode of conveying a nonverbal statement that nurses have skills and knowledge (Spragley and Francis, 2006) or a means of enabling the wearer to carry out their role (Pearson et al, 2001). Richardson acknowledges the inherent power dynamics of institutional uniforms and the fear and barriers to communication they can present (Richardson, 1999).

In summary, volunteers were commonly described by the participants in this study as essential, but there was some confusion among staff about their image, identity, and the role boundaries despite all volunteers being given

information at the training sessions. Davis Smith (2016) highlights the challenges in raising the profile and public perception of volunteering, but having a clearer understanding of the image and identity of volunteers, and what they are there to do, it is likely that services may run more smoothly. This could be achieved by clearly communicating the purpose of volunteers throughout the entire organisation.

8.6.2 Conclusion

This study highlights the different and divergent accounts of a variety of stakeholders involved in voluntary services for patients with dementia on acute hospital wards. There are tensions and inconsistencies in and between the accounts of participants. The concept of a voluntary service appears to be commonly idealized by the participants in this study, and to some extent stylized with some recognition of the risks involved. This is illustrated by the differences in the public and private accounts of participants. There appears to be conflict between the need for the organisation to exercise control over volunteers, and the need expressed by some volunteers for autonomy and a sense of control over what they do. There is a lack of clarity over the image, identity, and role of volunteers. The challenges of acute hospital wards and

the presence of dementia raises questions over the suitability of this setting for volunteers.

By considering the diverse accounts of various stakeholders, and the available evidence, it is possible that a different model of managing volunteers may guide interventions or practices to resolve identified tensions. This would meet the needs of various stakeholders to offer an infrastructure to maximise the efficiency and effectiveness of voluntary services. The following section will discuss the strengths and limitations of the study.

8.7 Strengths and limitations

The strength of this study is that it is real world research and draws from the perspectives of a range of stakeholders. To my knowledge, it is the first study to explore the role of volunteers who support patients with dementia and cognitive impairment in acute hospitals from multi-stakeholder perspectives.

This study is well timed in view of current national drives to integrate volunteers into health and care services in England. One of these is to recruit and deploy tens of thousands of volunteers into acute hospital NHS trusts with the aim of improving the quality of healthcare services for patients, staff, volunteers, and organisations

(Helpforce, 2018a). In addition to this, other national projects include the step up to serve #iwill campaign which aims to engage more young people to volunteer (IWill.org, 2018). This increase in the numbers of people wishing to become hospital volunteers will inevitably have implications on the voluntary services infrastructure, resulting in extra administration and management.

However, there are limitations to the study. Firstly, in spite of the efforts to recruit the planned number of participants, only one former volunteer and two patients came forward to be interviewed. In an attempt to address this, currently active volunteers were asked to explore reasons why they might leave. Voluntary services were also contacted to explore why volunteers leave. As the study was advertised via gatekeepers and posters, it is not possible to determine the number of non-responders. It is possible that the views of those who chose to take part in the study were different from the views of those who chose not to. Nevertheless, the views of all those who participated were relevant.

Secondly, it is important to note that I have been involved in volunteer services over a number of years as part of my clinical role, and continue to do so in the role of youth volunteer project manager while completing this thesis.

Despite efforts to guard against bias by exercising reflexivity, it is possible that this may have subsequently introduced unconscious bias in my interpretation of the data. Only one researcher analysed the data which may have resulted in bias, however, supervisors oversaw the analysis.

Thirdly, the data were collected at a single site in a large teaching hospital and as such the views of stakeholders might differ from those in smaller or rural hospitals, hospitals in countries other than England, or those hospitals with less well established voluntary services. Having discussed the strengths and limitations of the study, the following section will discuss recommendations for further research.

8.8 Recommendations for further research

Suggestions for further research are around participants, volunteer roles, and cost analysis.

Firstly, because of the limited number of former volunteers who came forward to be interviewed (n=1), further research could explore ways to access the perspectives of this group of volunteers in order to understand their reasons for leaving. This could include

exploring their views on training and the support provided in this specialty. The absence of formal measures to assess the suitability of training at the study site, raises questions over whether the existing training is suitable. Further research could focus on evaluating the current training to determine what information volunteers and the organisation feel is required for volunteers to feel more confident in their role.

Secondly, there is emerging evidence of the role of mobility volunteers (Babine et al, 2018; Baczynska et al, 2016; Bateman et al, 2016; Denomme et al, 2018; Godfrey et al, 2013; Gorski et al, 2017; Inouye et al, 2006; Inouye et al, 2000; Sandhaus et al, 2010; Steunenberg et al, 2016) with much of the evidence coming from the non-pharmacological approach to delirium prevention (Hshieh et al, 2018). However, this role does not appear to be routinely used across all NHS trusts. One reason for this could be risk averse cultures and cautious managers who fear that volunteers assisting patients to mobilise could increase the risk of falls and associated complications. However, there does not appear to be any evidence to support this perceived danger and there are calls to consider therapy which enhances the functional capacity of hospital patients (Cortes, Delgado and Esparza, 2019). Indeed, it is

possible that the reverse may be true, as patients who are active will be more likely to maintain their level of function, which in turn may reduce their risk of falls. Furthermore, the current evidence of the role of mobility volunteers (Babine et al, 2018; Baczynska et al, 2016; Denomme et al, 2018) does not appear to focus specifically on acutely ill hospitalised patients with dementia and cognitive impairment, but on older hospitalised patients. Therefore, further research might usefully focus on the development of specialist volunteer roles in this setting to explore how best volunteers can support patients with dementia and cognitive impairment to mobilise in acute hospital wards.

Thirdly, there was a general assumption among managers and staff in this study that volunteers represent good value for the initial investment made by the trust, but this was expressed in vague terms, without any clarification nor evidence of how this cost benefit analysis was determined. This finding is consistent with the findings of other studies of volunteering in healthcare settings which aim to assess the economic impact of volunteers by undertaking a range of methods and criteria for assessing their cost effectiveness, and highlight that volunteer support is assumed to be a beneficial and cost saving measure for hospitals yet they are unable to

define this in accurate figures (Blair et al, 2018; Godfrey et al, 2013; Rubin et al, 2006; Rubin et al, 2011; Sandhaus et al, 2010; Zaubler et al, 2013). There is a lack of detail about how costs are calculated, there are differences in cost analysis methods, and a dearth of robust evidence to support the claim that volunteers represent good value for money.

Despite this lack of detail around cost effectiveness of volunteers, there appears to be a recognition of the need for investment to resource, evaluate and support NHS voluntary services. This is currently being delivered by NHS England and NHS Improvement to support the development of voluntary services through a £2.3million partnership with Helpforce to enable NHS trusts to develop voluntary services (Helpforce, 2019a). Further schemes include ‘Step up to Serve’ which aims to invest in youth social action (Pears Foundation, 2019). Further research could focus on establishing cost effectiveness before planning any further modification or expansion of the service. There is the potential for an economic evaluation of volunteerism in this context to establish exact costings, calculate cost effectiveness in a range of areas, and determine the value of initial investment versus return. This information would be beneficial when planning the funding of future voluntary services and if

found to be cost effective, might provide evidence to support future funding.

8.9 Conclusion

What emerged from the findings was a deeper understanding of the many facets of volunteerism in this setting. In general, staff and volunteers described the day to day details of the role and ways of working, while managers focussed on the role from the perspective of the needs of the organisation. Volunteers were valued as a way for patients and carers to access extra support in a busy and complex environment. While volunteers are very often stereotyped as being altruistic in nature, it emerged that there were many different reasons why they volunteered, often for more than one reason alone. There were issues around image and identity which were influenced by the uniform in different ways.

This thesis is significant because this is the first time the role of the volunteer supporting patients with dementia and cognitive impairment in acute hospitals has been explored from a multi-stakeholder perspective. This study sought to access the perspectives of a traditionally marginalised group of people, namely people with dementia and cognitive impairment. Subsequently we now have a descriptive and explanatory account of the

phenomena of volunteering in this setting. This provides insight into what volunteers do, why they volunteer, and how they work in this environment because of the focus on this specific role. It provides a deeper and clearer understanding of the complex environment of acute hospital wards in which such patients are cared for. It provides evidence of how volunteers and others see themselves in the role, how they work in this setting, what they do, and why.

It is possible that the full potential of voluntary services will not be realised as a way of enhancing, streamlining and smoothing the provision of services if there continues to be uncertainty over the identity of volunteers; their role and ways of working; or if the differences in expectations between volunteers and managers are not addressed.

This study highlights the need for a voluntary service in this setting, but local hospital guidelines and recommended practice documents to deliver voluntary services to hospital patients which currently exist at the data collection site do not appear to be evidence based. There do not appear to be voluntary services policies related specifically to patients with dementia or cognitive impairment. At present there are national drivers to deploy more volunteers into NHS hospitals, with a

general understanding that more volunteers would be beneficial to services. This appears to be underpinned by the generally held public accounts of managers and staff that volunteers are beneficial to hospital services, and perpetuated by the use of positive rhetoric with some mention of the potential problems which may occur. In view of the resistance of some volunteers to be managed, and their declared distaste for bureaucracy, it is also important for organisations to recognise the need for sensitive and appropriate management of the service to ensure safety; and by understanding the motivational drivers which prompt volunteers to begin, and continue in their role. It is important to recognise the need to balance the risks of deploying members of the public as volunteers against the intended benefits. This thesis provides evidence to support the planning and development of future services. It proposes a new management model as a way to maximise the efficiency of hospital voluntary services in the future for acutely ill patients with dementia and cognitive impairment.

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Appendix 1: Results of Critical Appraisal Skills Programme Quality Appraisal Tool (CASP, 2019b).

Reference	1. Was there a clear statement of the results? Yes/no/ Unclear	2.Is qualitative methodology appropriate? Yes/no/ Unclear	3.Was the research design appropriate to address the aims of the research? Yes/no/ Unclear	4.Was the recruitment strategy appropriate to the aims of the research? Yes/no/ Unclear	5.Was the data collected in a way that addressed the research issue? Yes/no/ Unclear	6.Has the relationship between researcher and participants been adequately considered ? Y/n/ Unclear	7.Have ethical issues been taken into consideration?Y /N/ Unclear	8.Was the data analysis sufficiently rigorous? Y/N/ Unclear	9.Is there a clear statement of findings? Y/N/ Unclear	10.How valuable is the research?
Akintola (2008)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	2/3

Andersson & Öhlén (2005)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Unclear	Yes	2/3
Azuero et al (2014)	Yes	Yes	Yes	Yes	Yes	Unclear	Unclear	Yes	Yes	3/3
Berry & Planalp (2009)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Unclear	Yes	1/3
Brighton et al (2017)	Ye s	Yes	Yes	Yes	Ye s	Unclear	Ye s	Yes	Ye s	2/3
Brown (2011a)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	3/3

Brown (2011b)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	3/3
Claxton-Oldfield and Claxton-Oldfield (2007)	Yes	Yes	Yes	Yes	Yes	Unclear	Unclear	Unclear	Yes	1/3
Claxton-Oldfield and Claxton-Oldfield (2012)	Yes	Yes	Yes	Unclear	Yes	Unclear	Unclear	Unclear	Yes	1/3
Dean & Willis (2017)	Yes	Yes	Yes	Unclear	Yes	Unclear	Unclear	Unclear	Yes	2/3

Dein & Abbas (2005)	Yes	Yes	Yes	Yes	Yes	Unclear	Unclear	Unclear	Yes	3/3
Dodd et al (2018)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	3/3
Elliott & Umeh (2012)	Yes	Yes	Yes	Unclear	Yes	Unclear	Yes	Yes	Yes	2/3
Faulkner (2005)	Yes	Yes	Yes	Yes	Yes	Unclear	Unclear	Unclear	Yes	3/3
Field-Richards & Arthur (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Ye s	2/3

Hayashi (2016)	Yes	Yes	Yes	Yes	Yes	Unclear	Unclear	Unclear	Yes	3/3
Jack et al (2011)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	2/3
Jovanovic (2012)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	No	Yes	1/3
Kamaludin et al (2013)	Yes	Yes	Yes	Unclear	Ye s	No	Unclear	Yes	Yes	2/3
Kilpatrick et al (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	2/3
Lorhan et al (2015)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Unclear	Yes	3/3

McDonnell et al (2014)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	2/3
McKee et al (2010)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	1/3
Merrell (2000)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	2/3
Merrell & Williams (1999)	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	3/3
Morris et al (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes	Unclear	Yes	1/3
Nissim et al (2009)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Unclear	Yes	3/3

Overgaard (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	3/3
Preston & Burch (2018).	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	2/3
Pryce et al (2015)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	2/3
Southby & Gamsu (2017)	Yes	Yes	Yes	Unclear	Yes	No	Yes	Unclear	Yes	3/3
Takasugi & Lee (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	3/3

Warren & Garthwaite (2015)	Yes	Yes	Yes	Yes	Yes	No	Yes	Unclear	Yes	2/3
Watts (2012)	Unclear	Yes	Yes	Yes	Yes	Unclear	Unclear	Unclear	Yes	2/3
White & Gilstrap (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	3/3

Appendix 2 Patient information

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Nottingham University Hospitals NHS

Nottingham Hospitals Charity

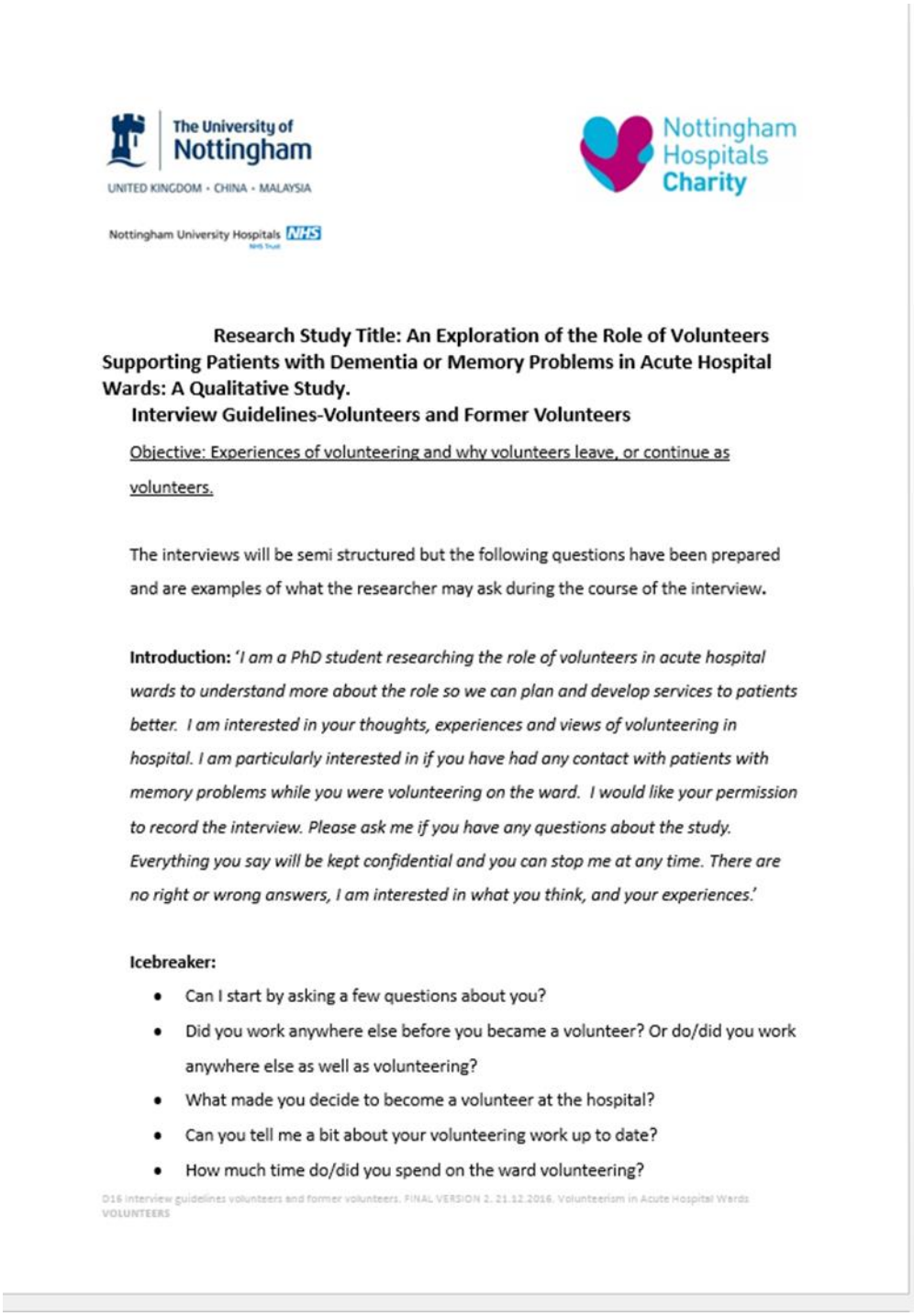
An Exploration of the Role of Volunteers Supporting Patients with Dementia or Memory Problems in Acute Hospital Wards: A Qualitative Study.

I am a PhD student at The University of Nottingham researching the role of the volunteer supporting patients with dementia or memory problems in acute hospital wards.
I would like to interview patients with dementia or cognitive impairment, their family member or friend, volunteers, and staff on the Healthcare of the Older Person wards at Queen's Medical Centre as part of this research project.
If you are interested please contact me on
Tel: [07910 936290]
Email: liz.charalambous@nottingham.ac.uk
For more information
Thank you. Liz Charalambous



B4 Access poster and leaflet. FINAL VERSION 2. 21.12.2016. Volunteerism in Acute Hospital Wards. GENERAL

Appendix 3 Interview guide



The University of Nottingham
UNITED KINGDOM • CHINA • MALAYSIA

Nottingham University Hospitals NHS

Nottingham Hospitals Charity

Research Study Title: An Exploration of the Role of Volunteers Supporting Patients with Dementia or Memory Problems in Acute Hospital Wards: A Qualitative Study.

Interview Guidelines-Volunteers and Former Volunteers

Objective: Experiences of volunteering and why volunteers leave, or continue as volunteers.

The interviews will be semi structured but the following questions have been prepared and are examples of what the researcher may ask during the course of the interview.

Introduction: *'I am a PhD student researching the role of volunteers in acute hospital wards to understand more about the role so we can plan and develop services to patients better. I am interested in your thoughts, experiences and views of volunteering in hospital. I am particularly interested in if you have had any contact with patients with memory problems while you were volunteering on the ward. I would like your permission to record the interview. Please ask me if you have any questions about the study. Everything you say will be kept confidential and you can stop me at any time. There are no right or wrong answers, I am interested in what you think, and your experiences.'*

Icebreaker:

- Can I start by asking a few questions about you?
- Did you work anywhere else before you became a volunteer? Or do/did you work anywhere else as well as volunteering?
- What made you decide to become a volunteer at the hospital?
- Can you tell me a bit about your volunteering work up to date?
- How much time do/did you spend on the ward volunteering?

D16 interview guidelines volunteers and former volunteers. FINAL VERSION 2. 21.12.2016. Volunteerism in Acute Hospital Wards VOLUNTEERS

- Which wards do/did you work on?
- How long have you been/were you a volunteer?
- Have you any other experience of volunteering?
- **For currently active volunteers:** Do you think you will continue as a volunteer in the hospital?
- **For former volunteers:** Can you tell me a bit about why you left?

Experience of volunteering:

- Can you describe a typical shift?
- What does/did your work involve when you come to the ward?
- Who manages/managed your work on the ward on a day to day basis?
- How much freedom do/did you have to decide what to do and for which patients?
- How do/did you decide what to do when you arrive/arrived on the ward?
- What sort of information do/did you receive from ward staff?
- What kinds of things do/did you find positive about volunteering?
- Do/did you find anything negative or experience any difficulties when volunteering?
- What are your thoughts on volunteering in the hospital?
- Have you spent/did you spend time volunteering with patients who have dementia?
- Can you think about a patient you recently spent time with on the ward, can you describe what you did?
- Did anything help you to do this?
- Was there anything that didn't help?
- Can you give any examples?
- Has volunteering ever caused problems for you?
- What do/did you like best about being a volunteer?
- Is/was there anything you don't like?

Experience of the ward:

- What are your thoughts about the ward environment?
- Is there anything you would like to say about the ward staff?
- Are/were you able to talk to staff?
- Do/did you work alone or together with other volunteers or ward staff?
- What is/was your training like? Do/did you have any access to dementia training?
- What support would you like/would you have liked?
- How would you describe your relationships with other people on the ward?
- Has volunteering caused conflict between you and another person?

Prompts:

- Why? How? Where? What? When? Who?
- Can you elaborate on that?
- Can you tell me about it?
- Can you give me an example?
- What do you mean by that?
- Then what happened?
- How did you feel?
- How do you feel about that?

Steering Questions:

- I'd like to understand more about how this relates to what we were talking about earlier

Concluding questions:

- Is there anything else that we haven't talked about that you feel is important about your thoughts or experience of volunteering?
- Is there anything else you would like to say?

For currently active volunteers:

- Would you be interested in keeping a diary about your volunteering experiences?

Thank you for taking the time to talk to me

Appendix 4: Ethics approval and public liability insurance

NHS
Health Research Authority
Yorkshire & The Humber - Bradford Leeds Research Ethics Committee
Jarrow Business Centre
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0207 104 8081

19 December 2016

Dr Kristian Pollock
Room C1061 C Floor
School of Health Sciences, Medical School, Queen's Medical Centre
Nottingham
NG7 2UH

Dear Dr Pollock

Study Title:	**An Exploration of the Role of Volunteers in Acute Hospital Wards: A Qualitative Study**
REC reference:	**16/YH/0498**
Protocol number:	**16095**
IRAS project ID:	**214692**

The Research Ethics Committee reviewed the above application at the meeting held on 13 December 2016. Thank you for attending to discuss the application.

Provisional opinion

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

The Committee requested the following information before confirming its final opinion:

1. The following amendments to the Participant Information Sheets were required;
    a. The use of direct quotes needed to be mentioned, and included as a clause on the Consent Form.
    b. The focus of the study needed to be made clear.
    c. It needed to be stated that participants had been selected because they had a diagnosis of dementia or other cognitive impairment.
    d. The information on the disclosure of poor practice needed to be clearer and needed to include the disclosure of past as well as recent events..

A Research Ethics Committee established by the Health Research Authority

The Committee queried whether it was necessary to include participants lacking capacity.

Dr Goldberg advised that the focus of the study was patients with dementia. A Public and Patient Involvement group had reviewed the study and thought the inclusion of patients lacking capacity was important.

The Committee suggested that the title of the study was amended to make it clear that the focus of the study was patients with dementia.

- **Recruitment arrangements and access to health information, and fair participant selection**

There were no concerns about the consultee information. The researchers were only appointing personal consultees.

Members queried whether the carer participants and consultees could be the same person.

Dr Goldberg expected that this was the case for most participants.

Was it possible that patient participants could be recruited without a carer.

Dr Goldberg advised that those with capacity could be recruited on their own, but those lacking capacity needed a carer.

The Committee noted that the researchers aimed to recruit sixteen carers and ten patients as participants, and queried the discrepancy in numbers.

Dr Goldberg explained that patient participants needed to be able to hold a conversation to be interviewed, therefore some may be excluded.

Members queried whether any patient participants were interviewed alone.

Mrs Charalombous advised that patients were interviewed in a dyad with the carer.

The Committee asked if this meant that patient participants needed a carer who had consented to take part in the study.

Dr Goldberg advised that if a patient had capacity and had given consent, then the carer participant was not interviewed unless the patient was present. Interviews were held in the participants' homes after they were discharged from hospital. They could also choose to attend hospital for the interview.

- **Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity**

2. The title of the study required amending to make it clear that the focus of the study was patients with dementia.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact Miss Katy Cassidy (REC Manager), nrescommittee.yorkandhumber-bradfordleeds@nhs.net.

When submitting a response to the Committee, the requested information should be electronically submitted from IRAS. A step-by-step guide on submitting your response to the REC provisional opinion is available on the HRA website using the following link: http://www.hra.nhs.uk/nhs-research-ethics-committee-rec-submitting-response-provisional-opinion/

Please submit revised documentation where appropriate underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. You do not have to make any changes to the REC application form unless you have been specifically requested to do so by the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 18 January 2017.

Summary of the discussion at the meeting

Student Investigator Mrs Pauline Charalombous was welcomed to the meeting alongside Academic Supervisor Dr Sarah Goldberg.

- **Social or scientific value; scientific design and conduct of the study**

The Committee queried whether the project was looking specifically at patients with dementia, or all elderly patients admitted to an acute ward. Dementia was mentioned in the IRAS form, but not in the Participant Information Sheets. If patients with dementia were the focus of the study then this needed to be made clear on the Information Sheets.

Dr Goldberg advised that the focus was volunteers working with patients who had dementia while on acute wards.

Members queried whether all of the patients on the two wards had dementia.

The researchers were comparing wards that often used volunteers and those that didn't. She expected that around seventy percent of patients on the wards would be cognitively impaired.

The Committee queried whether all patient participants had dementia.

Dr Goldberg confirmed that they excluded those that were not cognitively impaired. It was difficult to separate those with dementia and those with other cognitive impairments.

The disclosure of any adverse findings was not consistently dealt with in the Participant Information Sheets and members queried the process for managing disclosure of past events as well as recent observations of poor practice.

Mrs Charalombous explained that cognisance of past events had been a driving force behind the development of the research project. . Dr Goldberg explained that a management structure was in place for volunteers to report concerns

The Committee advised that the Information Sheets needed to be clearer on the disclosure of bad practice.

The Committee noted that other issues may be raised in correspondence.

The research team were thanked for attending and left the meeting.

Compliance with the Mental Capacity Act – the Committee agreed the following;

Relevance of the research to the impairing condition

The Committee agreed the research is connected with an impairing condition affecting persons lacking capacity or with the treatment of the condition.

Justification for including adults lacking capacity to meet the research objectives

The Committee agreed the research could not be carried out as effectively if it was confined to participants able to give consent.

Arrangements for appointing consultees

The Committee considered the arrangements set out in the application for appointing consultees under Section 32 of the Mental Capacity Act to advise on whether participants lacking capacity should take part and on what their wishes and feelings would be likely to be if they had capacity.

After discussion the Committee agreed that reasonable arrangements were in place for identifying personal consultees and for nominated consultees independent of the project where no person can be identified to act as a personal consultee.

Balance between benefit and risk, burden and intrusion

The Committee noted that while the research would not benefit participants lacking capacity it is intended to provide knowledge of the causes or the treatment or care of their impairing condition. After discussion, the Committee agreed that the risk to participants is

Document	Version	Date
Copies of advertisement materials for research participants [access poster and leaflet]	final version 2	21 December 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [2016 to whom it may concern clinical trial]		16 November 2016
Interview schedules or topic guides for participants [interview guidelines patient and carer]	final version 2	21 December 2016
Interview schedules or topic guides for participants [interview guidelines volunteers and former volunteers]	final version 2	21 December 2016
Interview schedules or topic guides for participants [interview guidelines ward based staff]	final version 2	21 December 2016
Interview schedules or topic guides for participants [interview guidelines managers]	final version 2	21 December 2016
IRAS Application Form [IRAS_Form_16112016]		16 November 2016
IRAS Checklist XML [Checklist_21122016]		21 December 2016
Letter from funder		
Letter from sponsor [16095 sponsor letter]		16 November 2016
Letters of invitation to participant [access letter for volunteer management]	final version 2	21 December 2016
Letters of invitation to participant [access letter to matron and ward manager]	final version 2	21 December 2016
Letters of invitation to participant [invitation letter for patient and carer]	final version 2	21 December 2016
Letters of invitation to participant [invitation letter for volunteer and former volunteer]	final version 2	21 December 2016
Letters of invitation to participant [invitation letter for hospital manager]	final version 2	21 December 2016
Other [statement of activities]	1	28 October 2016
Other [schedule of events]	1	28 October 2016
Other [capacity assessment form]	final version 2	21 December 2016
Other [Non-Substantial Amendment form]		31 January 2017
Other [HRA Statement of Activities]	1	03 February 2017
Other [HRA Schedule of Events]	1	03 February 2017
Participant consent form [consent form patient with capacity]	final version 2	21 December 2016
Participant consent form [consent form non patient]	final version 2	21 December 2016
Participant consent form [consultee advice form]	final version 2	21 December 2016
Participant information sheet (PIS) [PIS patient]	final version 2	21 December 2016
Participant information sheet (PIS) [PIS consultee]	final version 2	21 December 2016
Participant information sheet (PIS) [PIS carer]	final version 2	21 December 2016
Participant information sheet (PIS) [PIS volunteers interview]	final version 2	21 December 2016

HENDERSON
INSURANCE BROKERS

Henderson Insurance Brokers Limited
Trueman House
Capitol Park
Leeds
LS27 0TS

Tel 0113 393 6300
Fax 0113 393 6363

www.hibl.co.uk

20 July 2016

To Whom it May Concern

Dear Sirs,

EVIDENCE OF INSURANCE – The University of Nottingham &/or Subsidiary Companies

We are writing to confirm that we act as Insurance Brokers to the above client and that we have arranged liability insurance on their behalf as detailed below:

CLINICAL TRIALS

Legal liability in respect of accidental injury of any research subject arising out of a Clinical Trial carried out in the course of University activities.

INSURER	:	Lloyds of London Newline Underwriting Management Ltd, Syndicate 1218 Suite 5 / 4, The London Underwriting Centre, 3 Minster Court, Mincing Lane, London EC3R 7DD
POLICY NUMBER	:	WIBCLT15475
PERIOD OF INSURANCE	:	1st August 2016 – 31st July 2017
LIMIT OF INDEMNITY	:	£10,000,000 any one event and in the annual aggregate
SITUATION	:	Clinical Trials held in the United Kingdom

Subject to the policy terms, conditions, limitations, exclusions and cancellation provisions. If you should require any further information on the above please do not hesitate to contact us.

Yours faithfully,

Henderson Insurance Brokers
Tel: 0113 393 6825
Fax: 0113 393 6363

This document is issued as a matter of information only and confers no rights upon the document holder other than those provided by the policy. This document does not amend, extend or alter the coverage afforded by the policy or policies as described herein.

Notwithstanding any requirement, term or condition of any contract or other document with respect to which this document may be issued or pertain, the insurance afforded by the policy (policies) described herein is subject to all terms, conditions or exclusions of such policy (policies). Limits shown may have been reduced by paid claims.

Registered Office: Trueman House · Capitol Park · Leeds · LS27 0TS
Authorised and Regulated by the Financial Conduct Authority (FCA)
Company Registration Number - 1985767

For **NUH sponsored studies only**, the Chief Investigator is responsible for:

i. All duties as detailed in the "Clinical Trial Delegation of Sponsorship responsibilities to Chief Investigator" agreement.

ii. Contacting the sponsor for review of all amendment documentation prior to submission to the HRA and MHRA. Please note that according to HRA and MHRA regulations, all submissions of amendments need to be signed by the authorised sponsor's representative. All relevant documentation should be emailed to rdamend@nuh.nhs.uk.

iii. Sending copies of the completed Annual Progress Reports, Development Safety Update Reports, and End of Study report required by the Ethics Committee and the MHRA (if appropriate) to the sponsor researchsponsor@nuh.nhs.uk.

iv. Notifying NUH R&I of all SAEs by completing and sending the *"Serious Adverse Event reporting form"* to R&I (only via fax, e-mail or by hand), within 24hrs of becoming aware of the event. Further guidance can be found in the R&I Adverse Event SOP (SOP-RES-019).

v. Reporting any Serious Breach of the UK Clinical Trial regulations in connection with the trial or Serious Breach of the protocol, immediately after becoming aware of the breach to NUH R&I as sponsor. Further guidance can be found in the R&I Non Compliance and Serious Breach Reporting SOP (SOP-RES-017).

vi. The CI/Study Team must in accordance with "End of Study Notification and Premature Discontinuation of a Study" SOP_RES_025 must:

- Inform R&I of any closure, premature discontinuation or temporary suspension of a research study
- Complete the relevant declaration form to provide R&I with adequate information to be able to report to the Research Ethics Committee (REC) and the Medicines and Healthcare Products Regulatory Agency (MHRA) where appropriate

Confirmation of Capacity and Capability Conditions

The Principal Investigator is responsible for:

1. Compliance with all relevant laws, regulations and codes of practice applicable to the trial including but not limited to, the UK Clinical Trials Regulations, Medicines for Human Use (Clinical Trial) Regulations 2004, principles of Good Clinical Practice, the World Medical Association Declaration of Helsinki entitled 'Ethical Principles for Medical Research Involving Human Subjects' (2013 version), the Human Rights Act 1998, the Data Protection Act 1998, the Medicines Act 1968, and the NHS Research Governance Framework for Health and Social Care (version 2 April 2005). Should any of these be revised and reissued this will apply. Copies of the up-to-date regulations are available from the R&I Office or via the R&I website http://nuhrise.org.

2. Submission of study amendments to the HRA, Ethics Committee and MHRA in accordance with the IRAS guide-lines. Amendments and information with regards to changes in study status must be sent to R&I at rdamend@nuh.nhs.uk., (this includes changes to the local study team). Within 35 days from the receipt of a valid amendment submission the R&I department will inform you if the amendment cannot be implemented locally. If no objections are raised NHS permission/confirmation is valid and the amendment may be implemented.

3. Ensuring all study personnel, not employed by Nottingham University Hospitals NHS Trust hold either honorary contracts/honorary research contracts/letters of access with this Trust before access to any patients or staff; their data, tissue or organs, or any NUH facilities.

4. In accordance with the Department of Health's Plan for Growth for initiating and delivering research the first patient first visit should occur within 70 days from the "date of selection of the participating organisation".
This applies to all studies that are classed as "clinical trials "on the IRAS filter page (first 4 categories)

5. Ensuring the research team via an identified individual, collaborates with the department of R&I and the CRN:EM in reporting recruitment data using Documas and the CRN EM Study Tracker.

6. Ensuring that for GTAC approved studies the site authorisation letter issued by GTAC is received by NUH as a site prior to recruitment commencing. A copy of this letter must be forwarded to R&I.

7. Comply with requests from NUH R&I to allow monitoring of research to comply with the Research Governance Framework and other applicable regulations.

8. Record *all* types of adverse events (including Suspected Unexpected Serious Adverse Drug Reaction -SUSARS) in the patient medical records and study documentation and report to the sponsor as required by the protocol.

9. Report any Serious Breach of the UK Clinical Trial regulations in connection with the trial or Serious Breach of the protocol, immediately after becoming aware of the breach to the study sponsor.

10. Reporting any changes to the study to R&I by letter or e mail. These should not be implemented until agreed with R&I.

NUH Confirmation of Capacity and Capability Conditions, version 1 April 2016

Participant information sheet (PIS) [PIS volunteers diary]	final version 2	21 December 2016
Participant information sheet (PIS) [PIS staff and managers]	final version 2	21 December 2016
Research protocol or project proposal	3	31 January 2017
Sample diary card/patient card [volunteer front page diary]	final version 2	21 December 2016
Summary CV for Chief Investigator (CI) [Kristian Pollock short cv]		16 November 2016
Summary CV for student [CV Pauline Elizabeth Charalambous]		16 November 2016
Summary CV for supervisor (student research) [Kristian Pollock short cv]		16 November 2016

If you wish to discuss further, please do not hesitate to contact me.
Kind regards
Participating NHS organisation

Dr Maria Koufali
Deputy Director Research and Innovation
Please note that the R&I department maintains a database containing study related information, and personal information about individual investigators e.g. name, address, contact details etc. This information will be managed according to the principles established in the Data Protection Act.

Kelly Alvey
Research Project Manager

research & innovation
Nottingham Health Science Partners
Nottingham University Hospitals NHS Trust
C Floor, South Block
Queen's Medical Centre Campus
Derby Road
Nottingham NG7 2UH

E: kelly.alvey@nuh.nhs.uk
T: 0115 9249924 **Ext:** 70641
R&I Website: www.nuhrise.org

NHS Health Research Authority The way that research is ap through the HRA approval www.nuhrise.org or contac
NHS Health Research Authority The way that research is ap through the HRA approval www.nuhrise.org or contac

From: Alvey Kelly (Research & Development) [mailto:Kelly.Alvey@nuh.nhs.uk]
Sent: 14 February 2017 15:12
To: Charalambous Pauline <ntxpecha@exmail.nottingham.ac.uk>
Cc: Keyworth Ryan <bbzrk@exmail.nottingham.ac.uk>; Pollock Kristian <ntzkp@exmail.nottingham.ac.uk>
Subject: IRAS 214962 Confirmation of Capacity and Capability at Nottingham University Hospitals NHS Trust

Dear ***Liz***

RE: IRAS 214962 Confirmation of Capacity and Capability at Nottingham University Hospitals NHS Trust

R&I Ref: 16MH002

Full Study Title: An Exploration of the Role of Volunteers Supporting Patients with Dementia or Memory Problems in Acute Hospital Wards: A Qualitative Study.

Sponsoring Organisation: University of Nottingham

This email confirms that **Nottingham University Hospitals NHS Trust** has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation. We agree to start this study on **14th February 2017**, as previously discussed.

Please be aware this confirmation of capacity is provided on the understanding and provision that you will follow the conditions set out in the attached document (NUH R&I of Confirmation of Capacity and Capability Conditions, v1).

The following documents were reviewed:

NHS
Health Research Authority

Dr Kristian Pollock
Room C1061 C Floor
School of Health Sciences, Medical School, Queen's Medical Centre
Nottingham
NG7 2UH

Email: hra.approval@nhs.net

03 February 2017

Dear Dr Pollock,

Letter of HRA Approval

Study title:	**An Exploration of the Role of Volunteers Supporting Patients with Dementia or Memory Problems in Acute Hospital Wards: A Qualitative Study.**
IRAS project ID:	**214692**
Protocol number:	**16095**
REC reference:	**16/YH/0498**
Sponsor	**The University of Nottingham**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Our reference: RGS 16095
IRAS Project ID: 214692

0115 8467906
sponsor@nottingham.ac.uk

Research, Enterprise and Graduate Services
University of Nottingham
King's Meadow Campus
Lenton Lane Nottingham
NG7 2NR

Health Research Authority
Research Ethics Committee

Kristian Pollock, Chief Investigator

16 November 2016

Dear Sir or Madam,

Sponsorship Statement

Re: An Exploration of the Role of Volunteers in Acute Hospital Wards: A Qualitative Study

I can confirm that this research proposal has been discussed with the Chief Investigator and agreement to sponsor the research is in place.

An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*

Any necessary indemnity or insurance arrangements will be in place before this research starts. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**

* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Yours faithfully

Ryan Keyworth
Acting Chief Financial Officer
University of Nottingham

Yorkshire & The Humber - Bradford Leeds Research Ethics Committee

Attendance at Committee meeting on 13 December 2016

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mr Sharif Al-Ghazal	Consultant Plastic Surgeon	Yes	
Professor Diana Anderson	Professor of Biomedical Sciences	Yes	
Dr. Nigel Birch	Lay Plus Member	Yes	
Ms Anne Davies	Clinical Research Consultant	Yes	
Dr Stan Dobrzanski	Clinical Services Manager Pharmacy	Yes	
Mrs Jenny Foggin	Senior Governance & Corporate Affairs Officer	Yes	
Mr Simon Gelsthorpe	BDCFT Head of Psychological Therapies	Yes	
Dr Janet Holt	Senior Lecturer	Yes	
Dr John Keeler	Consultant Anaesthetist	No	
Dr Kirste Mellish	Research Programme Manager	No	
Mr Andrew Scally	Senior Lecturer	Yes	
Dr Christopher Skidmore	Retired University Lecturer	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Miss Katy Cassidy	REC Manager

Yours sincerely

pp



Dr Janet Holt
Chair

Email: nrescommittee.yorkandhumber-bradfordleeds@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: *Mr Ryan Keyworth, University of Nottingham*
Dr Maria Koufali, Nottingham University Hospitals NHS Trust

A Research Ethics Committee established by the Health Research Authority

IRAS Application Form [IRAS_Form_16112016]		16 November 2016
IRAS Checklist XML [Checklist_26112016]		26 November 2016
Letter from funder		
Letter from sponsor [16095 sponsor letter]		16 November 2016
Letters of invitation to participant [access letter for volunteer management]	1	28 October 2016
Letters of invitation to participant [access letter to matron and ward manager]	1	28 October 2016
Letters of invitation to participant [invitation letter for patient and carer]	1	28 October 2016
Letters of invitation to participant [invitation letter for volunteer and former volunteer]	1	28 October 2016
Letters of invitation to participant [invitation letter for hospital manager]	1	11 October 2016
Other [statement of activities]	1	28 October 2016
Other [schedule of events]	1	28 October 2016
Other [capacity assessment form]	1	28 October 2016
Participant consent form [consent form patient with capacity]	1	28 October 2016
Participant consent form [consent form non patient]	1	28 October 2016
Participant consent form [consultee advice form]	1	28 October 2016
Participant information sheet (PIS) [PIS patient]	1	28 October 2016
Participant information sheet (PIS) [PIS consultee]	1	14 November 2016
Participant information sheet (PIS) [PIS carer]	1	14 November 2016
Participant information sheet (PIS) [PIS volunteers interview]	1	14 November 2016
Participant information sheet (PIS) [PIS volunteers diary]	1	28 October 2016
Participant information sheet (PIS) [PIS staff and managers]	1	14 November 2016
Research protocol or project proposal [protocol]	1	14 November 2016
Sample diary card/patient card [volunteer front page diary]	1	14 November 2016
Summary CV for Chief Investigator (CI) [Kristian Pollock short cv]		16 November 2016
Summary CV for student [CV Pauline Elizabeth Charalambous]		16 November 2016
Summary CV for supervisor (student research) [Kristian Pollock short cv]		16 November 2016

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

16/YH/0498 **Please quote this number on all correspondence**

A Research Ethics Committee established by the Health Research Authority

likely to be negligible and the research will not significantly interfere with their freedom of action or privacy or be unduly invasive or restrictive.

The Committee decided that the research did not require Site-Specific Assessment at non-NHS sites as it involves no clinical interventions and the Committee was satisfied that the risk to participants is likely to be negligible, and the study procedures will not significantly interfere with participants' freedom of action or privacy or be unduly invasive or restrictive.

The arrangements for recruitment in an emergency setting

The Committee noted that the research would not take place in circumstances involving the provision of urgent treatment to participants lacking capacity.

Information for consultees

The Committee reviewed the information to be provided to consultees about the proposed research and their role and responsibilities as a consultee.

The Committee was satisfied that the information was adequate to enable consultees to give informed advice about the participation of persons lacking capacity.

Additional safeguards

The Committee was satisfied that reasonable arrangements would be in place to comply with the additional safeguards set out in Section 33 of the Mental Capacity Act.

Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [access poster and leaflet]	1	28 October 2016
Covering letter on headed paper [16095 sponsor letter]	1	16 November 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [2016 to whom it may concern clinical trial]		16 November 2016
Interview schedules or topic guides for participants [interview guidelines patient and carer]	1	28 October 2016
Interview schedules or topic guides for participants [interview guidelines volunteers and former volunteers]	1	28 October 2016
Interview schedules or topic guides for participants [interview guidelines ward based staff]	1	28 October 2016
Interview schedules or topic guides for participants [interview guidelines managers]	1	28 October 2016

Appendix 5: Mental capacity assessment





An Exploration of the Role of Volunteers Supporting Patients with Dementia or Memory Problems in Acute Hospital Wards: A Qualitative Study.

Patient Name:
Date of Assessment:
Assess Capacity:

Can the person (free from undue pressure)

- Understand information about the study? Yes ☐ No ☐
- Retain the information (for long enough to make a decision)? Yes ☐ No ☐
- Use it to make a decision? Yes ☐ No ☐
- Communicate the decision? Yes ☐ No ☐

If yes to all questions then the patient has capacity. If no to any questions then the patient lacks capacity

Patient has capacity: **Yes** **No** [circle response]

If yes, ask patient if they are willing to take part, and take formal consent.
Ask patient if you could talk to a family member or carer. Then contact carer for carer-participant consent.

If no, contact carer, seek consultee agreement and carer-participant consent.