

# **Sheffield Hallam University**

An evaluation of the WRVS on-ward volunteer initiative at  
Sheffield Teaching Hospitals NHS Foundation Trust

## **Final Report**

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## Background

The WRVS on-ward volunteer initiative was launched within Sheffield Teaching Hospitals (STH) in November 2011. The purpose of the initiative was to improve the inpatient experience of patients with dementia by using on-ward volunteers recruited and trained by WRVS, supported by a Dementia Nurse Specialist (DNS) employed by STH. It was anticipated that around 20 volunteers would be recruited.

It was envisaged that the on-ward volunteer service (OWVS) volunteers would provide support through a number of activities including befriending, diversional therapy, companionship, reading, support with eating and drinking and supervised mobility and recreational visits within the hospital as well as supporting carers and providing respite time. The OWVS aimed to complement the care provided by STH staff. The recruitment of volunteers was to be the responsibility of the WRVS, who would also provide and fund a training programme for the volunteers and manage the OWVS within the Sheffield WRVS hub. However, STH appointed a Dementia Nurse Specialist whose role within the OWVS initiative would be to direct the volunteers to work with patients and families in the most appropriate way.

The OWVS initiative has been established in the first instance as a pilot project, for a period of 12 months based on an orthopaedic ward at STH which has a high incidence of patients with dementia who are recovering from surgery e.g. following fractured hip.

Through a partnership between STH, Sheffield Hallam University and the Translating Knowledge into Action (TK2A) theme of NIHR CLAHRC for South Yorkshire, a project was developed to evaluate the OWVS initiative from a number of different perspectives.

*N.B. At the same time as this evaluation took place, a parallel project 'Shaping our Age' (funded through Big Lottery as a partnership between the WRVS, De Montfort University and Brunel University) was taking place. This project, which adopted a participatory action research approach, focused heavily on the patient/carer perspective. In order to ensure that the focus of the evaluation reported here did not duplicate this work or overburden patients and carers, our evaluation did not include a stage which explicitly focused on capturing the patient/carer perspective, although this perspective is reported by other stakeholders. Links to the 'Shaping our Age' project are highlighted in the Discussion section on page 46.*

## **Aim**

The aim of this project was to evaluate the impact of the OWVS initiative at the Sheffield Teaching Hospitals NHS Foundation Trust.

More specifically, the objectives were:

1. To describe the care provided by the OWVS volunteers to patients and carers.
2. To describe the activities of the Dementia Nurse Specialist in relation to the OWVS volunteers.
3. To explore the perceptions of key stakeholders on the potential of the OWVS initiative to improve the inpatient experience for people with dementia and their carers.
4. To explore the perceptions of ward staff on the impact of the OWVS initiative on the delivery of care and on the experience of patients and carers.
5. To explore the perceptions of OWVS volunteers in relation to their preparation for their role and their experiences in practice.
6. To identify factors which act as barriers and facilitators to the success of the OWVS initiative.
7. To capture changes in relevant Nurse Sensitive Indicators since the introduction of the OWVS initiative.

## **Evaluation approach**

This was a mixed methods service evaluation which uses a range of different approaches to data collection. Given the resource constraints, a pragmatic approach to evaluation was adopted and the evaluation team requested the support of staff from STH and the WRVS at a number of points during the evaluation to collect information which contributed to the evaluation objectives.

The evaluation had seven stages (for timeline see Appendix 1):

*Stage 1* A qualitative consultation to explore the perceptions of key stakeholders

*Stage 2* Mapping the activities of the OWVS volunteers and the Dementia Nurse Specialist (DNS)

*Stage 3* Mapping the recruitment and turnover of OWVS volunteers

*Stage 4* A qualitative consultation to explore the perceptions of OWVS volunteers over time

*Stage 5* Observation of practice

*Stage 6* Focused conversations with ward staff

*Stage 7* Analysis of routine data

## **Stage 1. A qualitative consultation to explore the perceptions of key stakeholders**

The stakeholder consultation was designed to contribute to the following objectives:

- To describe the care provided by the OWVS volunteers to patients and carers.
- To describe the activities of the Dementia Nurse Specialist in relation to the OWVS volunteers.
- To explore the perceptions of key stakeholders on the potential of the OWVS initiative to improve the inpatient experience for people with dementia and their carers.

### **Sampling**

A purposive sample of key strategic stakeholders was selected. These were:

- Deputy Chief Nurse, STH
- Head of WRVS Yorkshire/Humber and North West Region
- WRVS Services Manager (Sheffield)
- Dementia Nurse Specialist (DNS)
- Consultant ortho-geriatrician
- Nurse Director
- Ward Manager
- (Attempts to meet with the Matron were unsuccessful)

### **Data collection**

An initial approach was made to STH staff by an email sent by the Deputy Chief Nurse providing brief information about the evaluation and enclosing a copy of the Participant Information Sheet (Appendix 2). This was then followed up with contact from a member of the evaluation team who made arrangements for the date and time of the interview. WRVS staff were approached directly by the evaluation team.

Interviews were carried out with participants at a time and venue convenient to them. These interviews took place at the start of the evaluation. Additional follow up interviews with the DNS and WRVS Service Manager were also undertaken towards the end of the evaluation in November/December 2012.

All interviews were audio recorded with the participants' permission, with the exception of one follow up interview which was done by telephone. Interview schedules are included as Appendix 3 and Appendix 4.

### **Data analysis**

Interviews were transcribed verbatim. The analysis approach drew upon the principles of Framework analysis (Ritchie and Spencer, 1994). A number of themes emerged which are presented in the following section.

## Findings

### Context

The OWVS initiative was a collaboration between the WRVS and STH which met the strategic goals of both organisations. Improving the care and experience of frail older people was an important issue for both partners. For the WRVS the initiative also formed part of a wider plan to increase the visibility of the service, develop services which cross organisational boundaries and to expand the range of activities their volunteers could become involved in:

*So we've got a big push now about visibility, presence, being known for what is it WRVS does. SS7*

*..... this allows them to offer something different and from that they can attract perhaps a different type of volunteer. SS1*

For the Trust this was one of a number of ongoing initiatives to improve the experience of patients on the fractured neck of femur pathway, who are an 'at risk' group and who may be emotionally and socially isolated when in hospital.

### Potential gains

Stakeholders clearly saw the potential for the patient experience to be improved by having someone available who could spend time sitting and talking, supporting distressed patients and allowing nursing staff to get on with meeting the specialist nursing care needs of patients:

*And again I suppose it's maybe that indirect benefit of having just that little bit extra resource in the system that frees up the other people. SS2*

*So the gap there is our nursing staff are really, really busy, I mean super busy. Actually what we haven't got is somebody with time. Okay, here's the supply, ....'s got a bunch of volunteers with lots of time SS7*

Stakeholders also saw the potential to reduce the burden on carers:

*...one of the priorities this year in the operating framework is around helping people who care to have some respite. So in a small way this may be helping and it may be something that through the evaluation we recognise we may want to make it a bigger feature of the scheme ....SS6*

Stakeholders also saw the potential for the initiative to contribute to improvements in patient outcomes e.g. falls, urinary tract infections, pressure sores and organisational outcomes such as length of stay. Stakeholders were

able to articulate a clear rationale for how the presence of the volunteers might impact upon these outcomes:

- Pressure sores – patients encouraged to engage in activities would move about more and be at less risk of developing pressure sores.
- Better nutrition – patients encouraged by volunteers to eat. Volunteers were not, however, allowed to actively assist patients with eating.
- Fewer UTI's – patients encouraged to drink more would be better hydrated, less confused. Again, volunteers were not allowed to actively assist patients with drinking.
- Fewer falls – distressed or agitated patients would have company which might prevent them from wandering and falling.

Any consequent reductions in length of stay also had the potential to result in financial benefits for the Trust from the perspective of one stakeholder:

*So if we through that intensive support that older person gets better more quickly, because they're more confident about going home, then they can be discharged two or three nights earlier..... I could quickly see well if we did that for the amount of people ... well you've saved half a million pounds immediately just like that SS7*

### **Implementation**

Implementation of the initiative took place at a time of organisational change on a newly opened ward with new staff who were not part of an established team:

*There wasn't an intent to change the staff. I think opportunistically as they recruited staff they had tried to and we did have some staff moves around that time, because some of the name of hospital wards closed. So there may have been one or two staff that previously worked on older people wards who ended up there, because we said this would be a good placement for them.....some of (the changes) ...were happy coincidence and some of them were kind of planned SS6*

The difficulties in setting the project up in such an atmosphere were noted by several of the stakeholders:

*...we have just opened .... ward and it was a new ward full of like completely new team and I was a bit hesitant that when you're opening a new ward when the nurses and support workers and the therapist and doctors haven't gelled together yet, you're introducing another body of new faces, new role, I was a bit scared that maybe things will just fall apart and everybody would have had a bad experience, SS4*

*It was new to me.....I was taking a lot on-board..... So it was a steep learning curve shall we say. The WRVS just seemed to be one of the other things that was occurring within that scheme with things within the reorganisation, that was as then being made up as we went along as to when it was happening and who was going and who was safe, and all the other things linked to it. SS3*

The DNS took up post in advance of the first volunteers arriving on the ward and there was early recognition that her appointment was appropriate and that the success of the initiative would be dependent on a 'whole team' approach:

*... was someone who appeared out of the ether, so it was a bit of a surprise for me, but a very welcome surprise too in as much as her being someone that was coming along to help with dementia care and teaching and training within care of the patients with dementia within the orthopaedic unit, SS3*

Having the DNS involved was seen to add value over and above her involvement with the volunteers - and in the early stages of the initiative, her role was already seen as having a considerable impact on the other ward staff in terms of their knowledge, confidence and skills to look after patients with dementia.

*That's right and he respects me for that knowledge of patients with dementia). In fact it's lovely, because he actually says .... there's no way name of ward are having you back he said, because I want you to stop on here, which is nice, which is lovely. SS5*

However, in spite of the role being welcomed there was a lack of clarity initially in relation to some aspects of the role. The DNS did not have a job description and lines of accountability were not clear at the start. The purpose of the DNS role in the first instance, before the volunteers began to work on the ward, was also unclear to some staff. This led to initial confusion for some staff about whether she should be included in the ward staff numbers.

### **Working on the ward**

Stakeholders who had knowledge of the volunteers felt that their training had equipped them well in terms of their knowledge of dementia. Training had included study days on general elements of hospital care including protocols and infection control, and a full day of training from a 'specialised dementia nurse trainer' from the Joseph Rowntree Foundation on the nature of dementia. As a result, some stakeholders saw the volunteers as knowing more about dementia than some of the ward staff:

*So volunteers were coming on ward knowing more about dementia than ward staff, because they actually had a proper induction day on dementia SS5*

which raised a potential problem in the eyes of one stakeholder:

*The risk with that is that if we're not careful volunteers may start directing care, because the staff that are working with them may feel they have greater knowledge, appear to have greater knowledge. SS6*

Some stakeholders held the view that in the early days volunteers didn't always feel welcome on the ward - particularly when DNS was not on duty – and that the ward staff were initially wary. However stakeholders with insight into the service at ward level felt that with time, this had improved and viewed relations between the ward staff and the volunteers as good at the time of interview, with volunteers being accepted, valued and seen as part of the ward team.

The DNS was seen as an important figure for the volunteers in terms of providing support and acting as a point of contact.

*....when they first started on here I was with them, I didn't leave them alone to flounder.... because a lot of them were only 17, 18 year old, you know, and you're thinking it's a big thing. SS5*

Volunteers were working mainly in the mornings and for stakeholders this was seen as the time when there was the greatest need. They were engaging in a variety of activities including chatting with patients, playing games, pampering and preparation for mealtimes.

### **Impact of the initiative in practice**

There was a widely held view that at the time of interviews, the volunteers were having a positive impact on patient experience e.g. relieving anxiety, providing company and diversion.

*...there was a patient who was on end of life pathway and I thought maybe should the WRVS volunteer go there, but the WRVS volunteer decided yes she will go there and she sat with the patient, was holding their hands and there were no relatives around, like they were abroad and they just couldn't be there on time, and she was there holding hands while the patient was dying and with tears in her eyes and I've got nice memories of that. SS4*

*How would a shift be different if they were on and if they were not on, if you were...? Well it'd be patients that missed out, I mean you just wouldn't do anything with them, you wouldn't do activities with them, you know, it'd be patients that suffer, staff won't because they just get on with what they did. SS5*

One of the perceived benefits of the initiative was that the care provided by the volunteers was individualised, rather than the same activity being provided for everyone and there were clear indications that the volunteers based their interventions with patients on what the patient wanted or needed on that particular day.

Staff had also received positive feedback from relatives:

*We had a lady at Christmas.....and her cousin came to see her and she thought it were marvellous what was happening, brilliant, yeah. SS5*

Stakeholders with insights into care at ward level also had a positive view of the impact that volunteers were having on the wider organisation and delivery of care by freeing up the nurses' time to do the things that only nurses could do.

### **Sustainability and spread**

Buy in at strategic level in the Trust and senior support from within the Trust was seen as important in sustaining the intervention, as was good leadership and strong commitment at ward level:

*Well you need a name of strategic stakeholder and me who've got, you know, a) the vision, but b) the kind of drive we're going to make this happen and here's when we're going to make it happen. But you also need the team on the ground who have also got that equal passion, drive and commitment to making it happen and*

*continuing to make it happen. So you need good management around, which again is a kind of barrier and a plus. SS7*

Adequate training and support for the volunteers was seen essential in order to retain volunteers.

Plans to roll the volunteer initiative out to other areas within the organisation were seen by some stakeholders as a positive move. For other stakeholders this carried an element of risk that the volunteers would be 'spread too thin' and this would result in the initiative being unsustainable.

Ensuring that volunteers feel wanted and useful on the ward and the provision of good support by the ward staff were seen as crucially important if volunteers were to be retained in the long term.

## **Follow up interviews**

Follow up interviews at the end of the evaluation period, highlighted a number of changes that had taken place over the course of the evaluation:

### **Training of volunteers**

- New volunteers were no longer getting the same training as the early volunteers. It was not seen as practical to wait to train until a new 'batch' of volunteers were ready and to employ external agencies each time. Instead, a more pragmatic approach had been adopted and volunteers now undertook an online training module on dementia awareness provided by the WRVS and were inducted to the ward by the WRVS Service Manager
- Ongoing training was provided on an 'ad hoc' basis by the WRVS Service Manager when a need was identified.
- The DNS was keen to remain involved in early training and to be involved in any follow up training events.

### **Working on the ward**

- By the end of the evaluation period, the volunteers were still working mostly in the mornings apart from one volunteer who came in on Sundays. Although the DNS would prefer the volunteers to come in the afternoon as well (ideally between 4.40 and 6.30 so they could meet some of the relatives and spend time with the patients who don't have visitors) there were not enough volunteers to do this.
- From the WRVS perspective, while it was important to ensure that volunteers worked on the ward at times when their contribution was most valuable, there was no imperative to ensure that the ward was covered at all times in the same way that retail outlets need to be staffed. It was seen as important to offer flexibility to volunteers.
- Volunteers were continuing to engage in a variety of activities. Dominoes and talking with patients were especially popular. Volunteers were also joining in with exercises classes set up by the DNS and run by physiotherapists and with the singing and dancing that ensued when a group of musicians came to the ward each month.

- The ward tables needed to be used more to enable activities to take place. Enlisting the help of the ward staff with getting the tables out was an ongoing process.
- Although it was acknowledged that the volunteers may not always work with patients with dementia, this was not seen as detrimental.
- A new way of using the volunteers was being piloted within the hospital on another ward. This involved using existing volunteers to work with specific individual patients who needed input that day, e.g. sitting with someone who was confused and agitated.
- Feedback from volunteers who had worked in this way had resulted in changes on the evaluation ward and patients who were most appropriate for the volunteers to work with were now highlighted in advance.
- The DNS had identified 'key workers' on the ward who had undertaken dementia awareness training and could advise the volunteers when the DNS wasn't on duty.
- Stakeholders had seen the confidence of the volunteers grow over time.
- By the end of the evaluation period, lines of accountability for the DNS had been clarified, although she still had no job description.
- Although the DNS helped out on the ward at busy times, she was not rostered or counted as part of the numbers.

### **Impact of the initiative in practice**

- The impact on patients was more than anticipated. Patients were seen as less withdrawn or depressed. Patients loved to talk about themselves and tell stories and the volunteers loved to listen.
- The presence of the volunteers helped patients who were agitated and the volunteers were making good use of empathy dolls with those patients who found them calming.
- From the DNS perspective, the volunteers were 'amazing' and keen and eager to help in whatever way they could. 'I can't imagine working without them'.
- The impact on carers was less than first anticipated and was indirect - through having the volunteers spend time with their relatives in their absence.
- The work of the DNS had involved much more than working with the volunteers and aimed to impact on the quality of dementia care on the ward through a variety of initiatives including education of the ward staff, provision of additional activities for patients and fundraising.

### **Sustainability and spread**

- The WRVS were developing other initiatives in Sheffield e.g. the Good Neighbours scheme and were looking ahead to linking this to the current initiative, (with different volunteers) to provide continuity for patients before and after hospital admission
- The possibility of rolling out the initiative to other hospitals in the Trust was also being explored.

## **Summary of key issues**

### **Context**

- The context for the initiative was right in terms of the organisational and strategic goals of both the Trust and the WRVS

### **Potential gains**

- The primary focus for the initiative was to improve patient experience
- Stakeholders also saw the potential to reduce the burden on carers and to contribute to improvements in patient outcomes

### **Implementation**

- Implementation took place at a time of organisational change on a newly opened ward
- Lines of accountability for the DNS were not clear at the start, although these have been clarified with time.
- While there were early difficulties with volunteers not always feeling welcome on the ward, these have improved with time.
- Volunteers who joined at the start were trained through formal study days. Volunteers now do initial training online.
- Volunteers work mainly in the mornings and there are currently insufficient numbers to cover other times.
- Volunteers engage in a variety of activities including chatting with patients, playing games, pampering and preparation for mealtimes
- The DNS is an important figure for the volunteers in terms of providing support and acting as a point of contact.
- The DNS has developed other initiatives in relation to dementia care

### **Impact of the initiative in practice**

- There was a widely held view that the volunteers are having a positive impact on patient experience e.g. relieving anxiety, providing company and diversion.
- The care provided by the volunteers is individualised and based on patient needs and preferences.
- Impact on carers is indirect.
- Stakeholders have a positive view of the impact that volunteers have on the wider organisation and delivery of care.

### **Sustainability and spread**

- Buy in at strategic level in the Trust and senior support from within the Trust was seen as important in sustaining the intervention.
- Adequate training and support for the volunteers is seen as essential in order to retain volunteers.
- Plans to roll the volunteer initiative out to other areas within the organisation was seen by some stakeholders as a positive move.
- For other stakeholders this carries an element of risk that the volunteers will be 'spread too thin' and this will result in the initiative being unsustainable.

## Stage 2. Mapping the activities of the OWVS volunteers

The objective of Stage 2 was to contribute to the following evaluation objective:

- To describe the care provided by the OWVS volunteers to patients and carers.

### Data collection

The WRVS Service Manager developed systems to monitor and capture the activities of the OWVS volunteers. This involved the use of simple proformas to be completed by the volunteers at the end of each shift to capture the number of hours spent on the ward, the number of patients seen and the types of activities the volunteers had engaged in while they were on the ward. After 6 months, it was clear to the WRVS Service Manager, that some volunteers were forgetting to complete the forms at the end of each shift and a revised proforma was introduced to collect this information.

However, it should be noted that although by the end of the evaluation period, the Service Manager was more confident that volunteers were completing the proformas correctly, she had ongoing concerns throughout the evaluation period about the completeness of the activity data.

### Data analysis

Descriptive analysis of the data supplied by the WRVS was carried out.

### Findings

The activity data is summarised in Table 1.

**Table 1. Summary of volunteer activity data supplied by WRVS**

Month	No of volunteers	Total hours	No of patient contacts	Comment
Dec-11	12	31	47	
Jan-12	11	105	129	
Feb-12	11	39	51	ward closures due to norovirus
Mar-12	12	67	57	ward closures due to norovirus
Apr-12	12	80.5	137	
May-12	9	68.5	159	
Jun-12	19	36	35	
Jul-12	13	78	82	
Aug-12	12	58	57	
Sep-12	14	84	77	
Oct-12	9	27	26	ward closures due to norovirus

<b>Nov-12</b>	10	100	67
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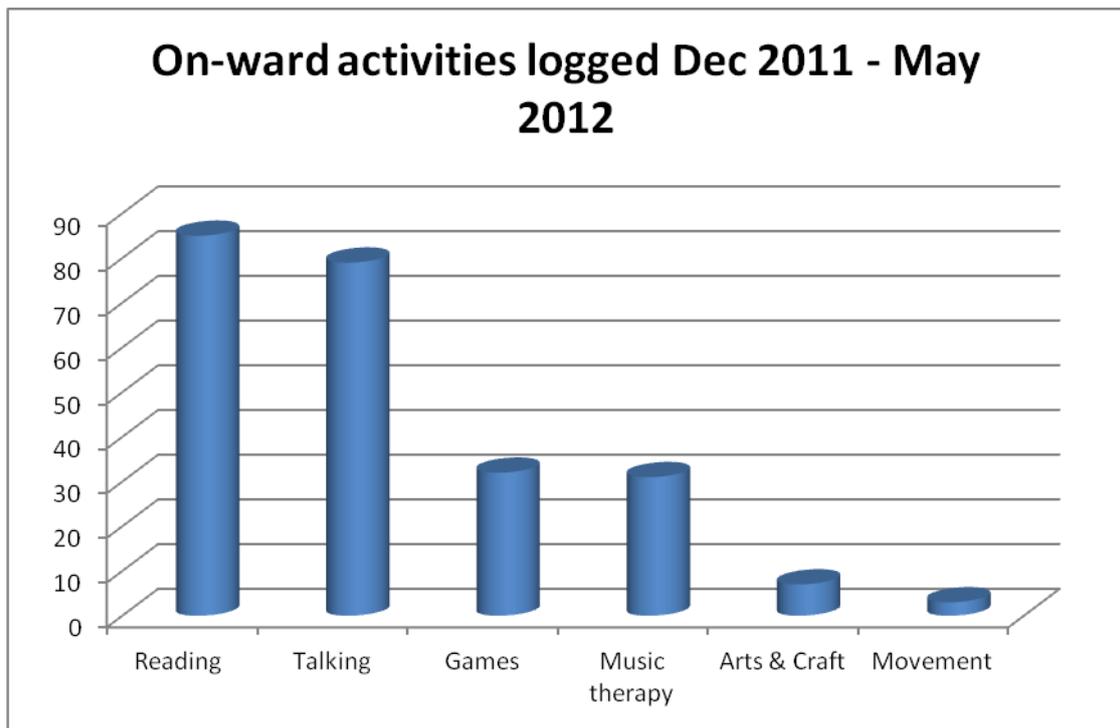
The mean number of volunteers on the ward each month was 12 (range 9 to 19).

The mean number of volunteer hours per month was 64.5 hours (range 27 to 105 hours).

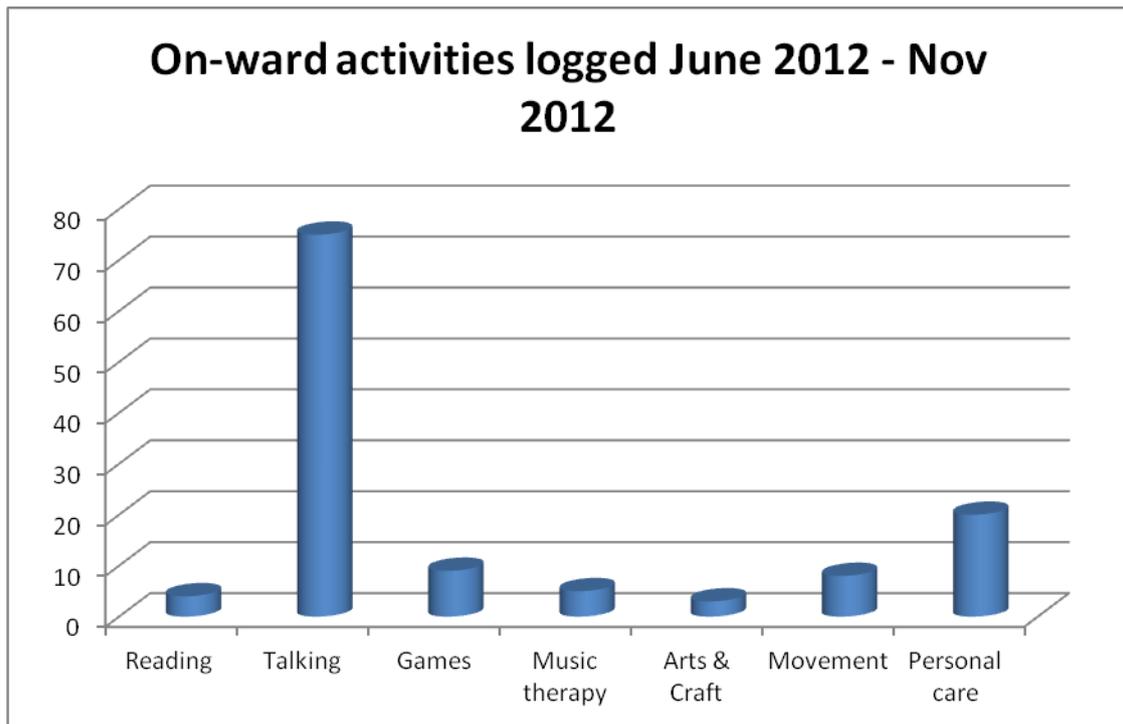
The mean number of patient contacts each month was 77 (range 26 to 159).

The nature of the activities recorded by volunteers for the first and second 6 month periods of the evaluation are summarised in Figures 1 and 2.

**Figure 1. On ward activities logged Dec 2011 to May 2012**



**Figure 2. On ward activities logged June 2012 to November 2012**



#### *Definitions of activities:*

- Talking: 1 to 1 chats, group discussions, reminiscing, etc
- Games: dominos, bingo, cards, skittles, etc
- Reading: reading to patients from the newspaper, books or encouraging them to read, looking at picture books, etc
- Music therapy: playing a CD, 'singalong' or organised visits from musicians
- Arts & craft: colouring, drawing, (for or with the patient) making things eg collages etc
- Movement: anything from organised exercise sessions to getting the patients to come to a table.
- Personal care; hand massage, hair brushing, encouraging to eat/drink, ensuring patient is warm and comfortable etc.

#### **Summary of key issues**

Due to the difficulties experienced in collecting accurate data on volunteer activities, the data presented here should be interpreted with a degree of caution. The data suggest that while the volunteers clearly engage in a variety of activities while on the ward, the most popular activity is talking with patients. The data also suggest that irrespective of the fluctuations in volunteer hours due to ward closures, there may still be considerable variation in the number of hours that the OWVS is able to provide each month.

## Stage 3. Mapping the recruitment and turnover of OWVS volunteers

### Data collection

The WRVS service manager developed systems for capturing information on the recruitment and turnover of OWVS volunteers in order to collect information on reasons for volunteering, numbers recruited and trained, turnover and reasons for leaving.

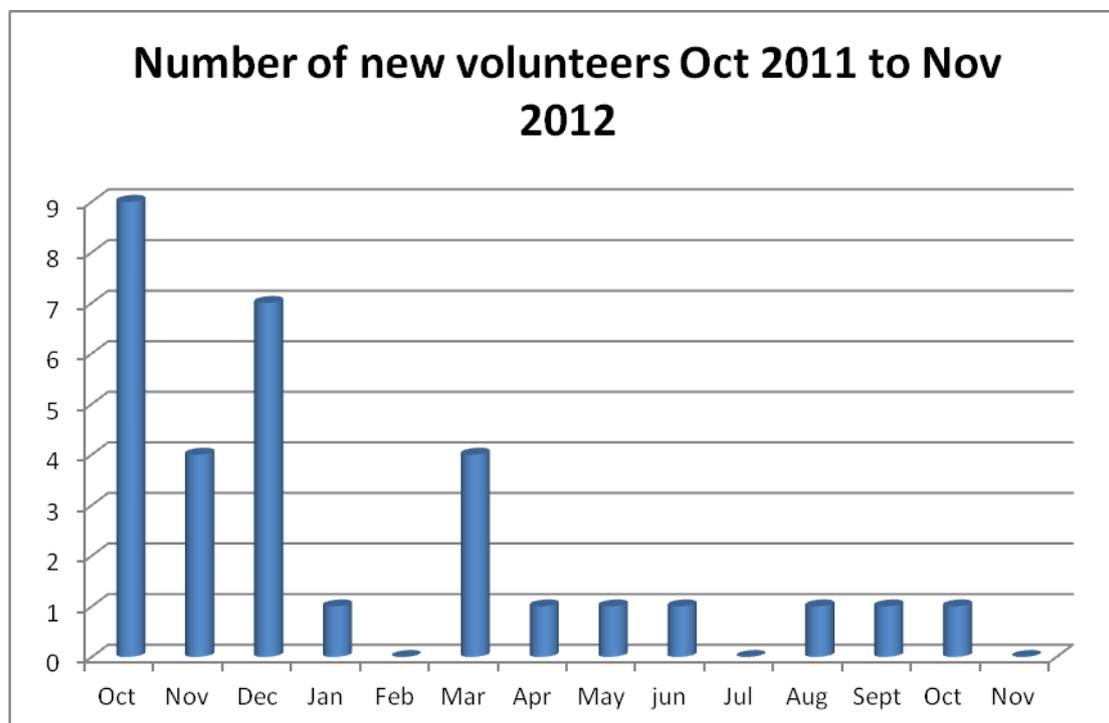
### Data analysis

Descriptive analysis of the data supplied by the WRVS was carried out.

### Findings

In total, 31 volunteers were recruited, although three never actually began work on the ward. The pattern of recruitment over time is summarised in Figure 3 and indicates that most volunteers were recruited at the start of the initiative with smaller numbers recruited on an ongoing basis since then.

Figure 3. Number of volunteers recruited Oct 2011 to Nov 2012



The main reason for volunteering was recorded by the WRVS and these varied. Seven of the nine volunteers who were recruited in October 2011

were already volunteering with the WRVS but wanted to try something else as well. Other reasons for volunteering included work experience/career development (n = 12) and wanting to try something new (n = 6).

Over the period of the evaluation, seven of the 28 volunteers who had worked on the ward left. Of those who left, the shortest period of service was 1 month and the longest was 11 months. Reasons for leaving varied and are summarised below:

**Table 2. Volunteer's reasons for leaving**

<i>Reason for leaving</i>	
<i>Maternity leave</i>	<i>1</i>
<i>New job</i>	<i>3</i>
<i>Left the country</i>	<i>1</i>
<i>Started college</i>	<i>1</i>
<i>Other committments</i>	<i>1</i>

### **Summary of key issues**

The original target of recruiting 20 volunteers to the OWVS has clearly been achieved and given that many volunteers come forward in order to gain work experience and develop their careers, the fact that four of the seven leavers left to take up employment or further education is an indication that volunteers were achieving their personal goals.

## **Stage 4. A qualitative consultation to explore the perceptions of OWVS volunteers over time**

The objective of the qualitative consultation was to contribute to the following objectives:

- To describe the care provided by the OWVS volunteers to patients and carers.
- To describe the activities of the Dementia Nurse Specialist in relation to the OWVS volunteers.
- To explore the perceptions of OWVS volunteers in relation to their preparation for their role and their experiences in practice.
- To identify factors which act as barriers and facilitators to the success of the OWVS initiative.

### **Sampling**

In order to maximise participation rates with minimal disruption to hospital activities, the Stage 4 focus groups were convened where possible to follow on from or form part of routinely scheduled meetings involving the on-ward volunteers. Three focus groups were conducted in May, early September and November 2012. A convenience sample of on-ward volunteers took part in the focus groups (n = 4, 5 and 4 respectively). Some volunteers attended more than one focus group. In total 10 volunteers took part.

### **Data collection**

An initial approach was made by a letter sent by the WRVS service manager providing brief information about the evaluation and enclosing a copy of the Participant Information Sheet (Appendix 2). Arrangements for the date and time of the discussions were made through the WRVS service manager.

The discussions were audio recorded with the participants' permission. The interview schedule is included as Appendix 5.

### **Data analysis**

The discussions were transcribed verbatim. The analysis approach drew upon the principles of Framework analysis (Ritchie and Spencer, 1994). Key findings are presented in the following section.

## **Findings**

### **The volunteers**

The volunteers had varying amounts of experience on which to base their views. Two had started in the last couple of weeks, while others had been amongst the first volunteers appointed. The volunteers were very diverse in terms of age and their reasons for undertaking the role varied from getting experience to inform possible future career choices within healthcare to

having time to spare and wanting to use it to do something worthwhile. Overall all the volunteers were very positive about their roles and clearly gained a great deal of personal satisfaction from what they were doing.

### **Preparation for the role**

The volunteers who had been among the first to be recruited had attended structured training in the form of study days prior to taking up their roles where they learned a lot about dementia and how to approach people with the condition. These were highly rated by the volunteers in terms of knowledge they gained in relation to the condition of dementia and how hospitals operate including procedures for infection control and hand washing:

*We actually learned what dementia was didn't we, because I don't know anybody else but I'd had no experience with dementia really so it was quite enlightening.*

Volunteers who had started later had not received training in the form of study days. Some had accessed online modules in dementia awareness which could be accessed at home or in libraries, while others who had started recently were not able to identify any formal training. Two volunteers who were undertaking a course in health and social care felt less apprehensive about dealing with patients who had dementia as a result of their course and other volunteers had family members who had suffered from dementia. Those volunteers who had not received formal training described meeting the WRVS service manager when they started and being allocated to work with more experienced volunteers when they first came on the ward.

In terms of ongoing training, some volunteers had attended training on the 'life story book', while others were not able to identify any ongoing training.

### **Early experiences**

From the perspective of the volunteers who had been on the ward since the start of the initiative, there was clearly a 'bedding in' period when they first started - where the volunteers needed to familiarise themselves with the ward and the staff and the ward staff also became accustomed to the presence of volunteers. There was some evidence that not all the ward staff fully understood their role at first. One volunteer described being challenged by a doctor who thought she was a visitor. These difficulties were exacerbated by the fact that at first the volunteers were not in uniform:

*It was hard with staff as well, because it was new to them. So we'd come on and at first we didn't have uniforms so they didn't know who we were or they'd think that we were visitors of patients.*

However, the volunteers were all of the opinion that these were only issues at the start and had been eased considerably when they were provided with uniforms. Relationships with ward staff were now seen as good and overall volunteers felt the ward staff appreciated their role:

*Vol: They weren't unwelcome put it that way, and we were the same, it's a strange environment. We're walking into their house, if you know what I mean, so they've got*

*to get used to seeing us walking about the ward, and we've got to respect them as well, they know the patient, not to upset or disturb them. So it's taken time to get together but they're very good.*

*Vol: They are now yeah, you felt a bit like an intruder didn't you at first, you felt a bit like...*

*Vol: You didn't want to get in the way.*

*Vol: That's right, and you felt, as I said they've got used to us now, they understand what we're doing and they seem really appreciative now, you know, aren't they, they're glad to see us.*

Some volunteers would have liked a better orientation at the start as to who was who on the ward and what the different uniforms meant. One volunteer described one occasion where they asked the receptionist about a patient, thinking she was a nurse.

Volunteers also described being apprehensive about dealing with patients when they first started on the ward:

*Interviewer: And how did you find it when you first came on?*

*Vol: I was a bit nervous at first.*

*Vol: Yeah I was, I found it a bit daunting at first, very nervous.*

*Vol: I was wondering, thinking oh what am I going to say, is it going to be awkward silences, but you get used to it and you like ask them questions.*

The 'This is Me' books were seen as a useful resource to help volunteers get to know patients when they first came on the ward;

*They've got those, 'This is Me', which is for the patient, which is very good and it's supposed to be for relatives to put details down, relations names, if they've got children, daughters, sons or whatever, where they actually come from. So that you can actually, it helps you start a conversation, so that is a good thing if the well patient's relatives actually do think, it does help everybody, it makes it easier.*

## **Working on the ward**

### *Shift patterns*

The volunteers tended to do the same shift each week and with the exception of one volunteer who came in on her own on Sundays, they preferred to work with other volunteers and came in the morning during the week. Initially the volunteers described working between 10.00 and 12.00 but the 'shift' had changed by the end of the evaluation period to 10.30 - 12.30. Some volunteers said that if they weren't able to come in on their usual day they would let the WRVS service manager know, whilst others were not aware of any requirement to do this. Some volunteers were of the view that they were free to come in on other shifts provided they let the Service Manager know after the event.

### *Activities*

Volunteers described being involved in a variety of activities with patients. Sitting and talking with patients was seen as important and volunteers highlighted how much they got to know individual patients and how much they were able to find out about them through these conversations. Volunteers also described putting music on and dancing with patients, doing artwork and playing games such as dominoes and bingo. They clearly selected activities on the basis of what the patients wanted on the day, rather than planning activities in advance:

*That's right, I mean every day you come on it's different, you never get two days the same do you, every shift you do is totally different. Some days you might get four people up and have a game of bingo, and sometimes you might just wander round chatting, or sometimes you might spend longer with one patient than other because they need your time. It all depends on the patients.*

Some volunteers described the use of empathy dolls:

*I can't believe how they calm them down, the dementia patients, they're really good them. It's amazing how they work, just unbelievable.*

Other volunteers felt free to try out other activities, once they had checked this out with the DNS:

*I once brought some stuff to make a fruit salad in but the ward was closed because of norovirus. But I am planning to do that again, that was just something that, because obviously they can't bake, we brought them readymade buns in they could decorate them*

Volunteers also described helping at mealtimes with encouraging patients to eat and sometimes spot those who had 'missed out'. Some volunteers commented that they would prefer a more 'hands on role at mealtimes i.e. to be able to feed patients. However, they were all aware that this was not currently within their remit.

In terms of recording their activities with patients, volunteers described how the systems had changed since the start of the initiative:

*We keep, we've tried various ways of filling things in at the end of day, you know, we have changed the forms once or twice. But we started off using a diary to write in the diary what we'd done, and then we got some new forms and now we've just got some more new ones where we just tick the subjects what we've done sort of thing, so we don't have to actually write down. Like when we used to come in every Friday, if you'd only chatted you'd say oh well what can we write today, chatted to so and so.*

The importance of using the ward tables for activities and mealtimes was highlighted by some volunteers who would like more help from the ward staff in organising activities involving the tables. If the volunteers wanted to do one to one activities the tables weren't needed, but if they wanted to do scrabble or bingo etc and needed the patients who were interested (who may be in different bays) gathering round a table, this was hard to organise, not just because they need to get the tables out but because they were not allowed to walk the patients to the tables themselves - they needed to ask the ward staff

to do this. By the time they had identified the patients, got the tables out and arranged for the patients to sit around a table it might be almost time for them to go. It clearly took a lot of drive and confidence to do this, especially if the volunteers were working on their own.

### *Selecting patients*

Mechanisms for deciding which patients the volunteers would spend time with when they came on the ward changed considerably over the evaluation period.

The DNS was clearly an important figure for the volunteers from the start. In the first instance she guided volunteers on what to do with the patients and who to work with and how. When she was on duty they felt more confident and she sometimes left notes in the ward book in the early days about who they should work with on a particular day. However, at the start of the evaluation period, if the DNS was not on duty, the volunteers themselves went round the ward and decided which patients they were going to spend time with and what they were going to do. There was little evidence of consultation with the ward staff about this.

Towards the end of the evaluation period, changes had taken place. The DNS had begun to indicate which patients would be most appropriate for the volunteers to spend time with on the whiteboard behind the nurses' station. This was a huge improvement as far as the volunteers were concerned:

*We've just started, the patients that need our time they've started putting WRVS at the side of the patient's name, we can come in, look on the board, write down what patients need the time and then we can just go straight to the patients that need us, whereas before we'd come on and wonder where shall we start, not actually knowing who actually needs, dementia patient that really needs your time and you might have spent your shift talking to somebody that's quite all right. So it's much easier now, it's a much better system now that, they've started doing that in the last couple of weeks and that's much easier.*

Another volunteer commented:

*You know what patients need your time sort of thing, whereas before you didn't know if they actually, there might be a patient that doesn't have any family come and see them, and you might miss them out because you're talking to someone that's chatting that do have family come in. So we prefer to spend time with someone that really needs it, where they see us more useful.*

This also linked into the issue of whether the volunteers only saw patients with dementia or saw other patients as well. One volunteer observed that without being told who had dementia you couldn't always tell, so the volunteers couldn't always select dementia patients themselves.

### *Communication with ward staff*

Volunteers felt that their communication with ward staff had improved considerably over time:

*They're more approachable now, at first I didn't know whether to, what to say but now when I come in if I'm on my own I'll just go up to someone and say is there any*

*particular patients that I can see, or they direct you to that board in there or tell you, and that's easier. But before I was a bit like, I don't know, I didn't know where to go or whether to ask. I was glad when Name of DNS was there, but now if Name of DNS's not here I know what to do, I can just ask someone. And they know who we are now ..*

The volunteers described comfortable relationships with ward staff and were able to identify instances where they had alerted ward staff to the patients' needs and act as 'another pair of eyes':

*We do inform staff if a patient's in difficulty, we'll go and fetch a staff and say this patient wants to go to the toilet*

However, there was no established system for volunteers to feed back to information about the patients they had spent time with to the ward staff at the end of each shift. Nonetheless one volunteer did describe passing on what she felt was important information relating to the patients' condition, based on what she had learned in her initial training:

*Or if you've picked something up that, the doctor might have picked it up but you think oh I'll just tell them just in case they don't know. Like one day I noticed a lady was really confused and she was hallucinating, and I told Name of DNS after because she'd told us in our training that if someone's hallucinating you need to tell us because it can be a sign of an infection, or it could be part of the dementia, so that was a good thing to tell her. And she said well I'll check on her when I go back, so it's good for that as well.*

Some volunteers commented that they would like more information about patients. 'This is me' was seen as useful:

*Well it is helpful if you know about the patient but that's where the This is Me comes in, because you can go on, read that and then you know about their life and then it gives you something to start a conversation. But not everybody has This is Me, so you just have to start from scratch*

Some volunteers also described wanting more information about the patient's condition and were unsure whether it was appropriate for them to look at the information on the white board behind the nurses' station.

### **Support in practice**

In each focus group discussion, it was clear that the DNS was an important source of support for the volunteers. Her presence on the ward clearly made a big difference throughout the evaluation period, but was seen as being particularly important at the start:

*Vol: Well we would have still done our best put it that way, we would still have put every effort in, but we're getting more knowledge from Name of DNS being about.*

*Vol: And watching her with the patients.*

*Vol: It would have been a lot harder; I would have said it would have been, we would have maybe struggled for a little while.*

The DNS was seen as a role model and the volunteers learned from watching her in practice with patients. Her presence also lifted the atmosphere on the ward:

*Interviewer: is there a difference between when Name of DNS's not on shift when you come on to do your work or when Name of DNS is on shift?*

*Vol: Yeah, she brings a bit of light.*

*Vol: Yeah she does.*

*Vol: She's ever so cheerful and happy. She just brings a different glow, something we try to do but she's just got something that is different, she's fantastic.*

The DNS was seen as a valuable source of knowledge and expertise and the volunteers felt comfortable to approach her and ask for help and guidance.

The WRVS Service Manager was also seen as an important figure by volunteers, some of whom called in at the café/shop where she was based for a chat before and after their shift:

*Vol:.... you can go to her for advice as well.*

*Vol: Yeah you can, she's very easy to talk to isn't she?*

*Vol: Yeah, so if you're worried about something or anything you can go to Name of Service Manager and Name of Service Manager would sort it out.*

*Vol: She's really easy to talk to isn't she?*

*Vol: Yeah.*

*Vol: Sometimes I email her to tell her what's happened, or you can phone her up or whatever, but I'll maybe send her an email and just say oh we've done in the ward, even though you did a book but if something good, extraordinary, you can let her know.*

Volunteers also used each other as a source of support on a day to day basis and preferred to work when there were other volunteers on duty:

*I just think it's more comfortable like that, just in case anything did go wrong, someone's in same bay as you to turn round and say I need a bit of help or, just something, I know it sounds silly but when someone's there you just feel a bit better about it.*

Throughout the focus group discussions the support provided by the more experienced volunteers to their novice colleagues was clearly seen as an important support mechanism.

*Interviewer: And is it easier to do a shift if there's more than one of you on?*

*Vol: Oh yeah definitely, it's a lot easier.*

*Interviewer: You're all nodding at that.*

*Vol: That is true, you've got a bit of company as well if you know what I mean.*

*Vol: Yeah, it's much better when you're with someone.*

*Vol: And you can have a different type of conversation when there's two of you sitting there, it can be an exchange, whoever's with us might have a different attitude to talk to that person better than you're doing at the time, and it goes round in a circle as such. We just help one another, that's what it's-*

## **Impact in practice**

### *Impact on patients and carers*

From the volunteers' perspective, patients valued their role. They were clear that their input made a big difference to patients for example by providing companionship for patients who were lonely and may not get many visitors. They described getting visible and immediate feedback from the patients they worked with.

*Vol: It gives them something to do, at the end of the day it's like oh I really enjoyed your company, can't wait to see you again and stuff like that, so it makes you feel like you've made them happy with just the talking.*

*Vol: I think it's a really rewarding thing to know that you can go in and see a patient cry and then by the end of you leaving they're laughing and really happy. And you just think I did that, just from a few hours of sitting with someone. I do, I think it's really rewarding.*

Volunteers were able to give examples of relieving patients' distress - for example one day, a patient had a stroke and the other patients in the bay were clearly distressed, so the volunteers were able to sit with them and comfort them.

The volunteers also felt that their presence at mealtimes could make a difference in terms of encouraging patients to sit round a table and to eat:

*There's some patients where when we've sat round table they'll eat and nurses will walk off and say she doesn't usually eat that much, because we're like encouraging them and then because they're seeing, when they're round the table with other patients they start eating as well sometimes. So they encourage each other, not like as much as like come on, don't you think you should eat that, because they're talking and eating they forget that they're actually doing it.*

However, it was clear to some volunteers that developing close relationships with patients could result in volunteers becoming 'too attached' which may result in them becoming upset:

*Vol: It is hard, me and Vol L once met a lady called name of patient, and she was the most beautiful little lady you have ever met, and she was going home and me and Vol L were nearly in tears, and she fell to sleep so we wrote her a letter to say bye. And she sent us a card when we came the next week, and I do just think that Vol L's right, we were sad that she was going home but we were supposed to, you're supposed to be happy, you've done your job, she's going home.*

While the volunteers had had little contact with relatives themselves, one of the medical staff had passed on how much she appreciated them and said the relatives had passed on some good feedback to her as well.

#### *Impact on staff*

The volunteers were clear that their presence had a positive impact on the ward staff in a number of ways. By sitting and talking with patients, particularly those who were agitated, they were able to free up nursing time for nursing tasks on a very busy ward. They felt they were very valuable to staff and sometimes received feedback to this effect:

*Vol: Well it gives them time to look after patients better. You know, they can spend more time with any patient that's ill. I know they're all ill but that is worse. And they don't need to look after half a dozen; we can talk to a few and keep them busy while the nurse is actually doing her proper job.*

### **Summary of key issues**

- Reasons for undertaking the role varied from getting experience to inform possible future career choices within healthcare to having time to spare and wanting to use it to do something worthwhile.
- Early recruits had attended study days in preparation for the role which were well received. Some later recruits had accessed online modules while others were not able to identify any formal training prior to starting on the ward.
- There was clearly a 'bedding in' period when the initiative first started - and some evidence that not all the ward staff fully understood the role of the volunteers, who did not always feel welcome at first. With time and the provision of uniforms these issues had been resolved.
- Overall, the volunteers felt comfortable to approach the ward staff but there were no established mechanisms for volunteers to feed back information about patients to ward staff.
- Volunteers would like more information on 'who is who' on the ward.
- Most volunteers worked in the mornings and undertook a variety of activities with patients, including talking and more structured activities and games.
- Using the tables for activities was sometimes difficult to organise.
- Some volunteers would like to be able to assist more actively at mealtimes.

- Mechanisms for selecting patients to work with had evolved over time and are now more structured and directed by the DNS and ward staff.
- The DNS was clearly an important figure for the volunteers in terms of guidance, role modelling and support.
- The WRVS service manager was also an important source of support for the volunteers.
- Overall the volunteers were very positive about their roles and get a great deal of personal satisfaction from what they are doing.
- The volunteers felt that patients and relatives appreciate their role
- They felt that the ward staff appreciated their role and that their presence helped free up the nurses to do their work.

## **Stage 5. Observation of practice**

The aims of the observations were to gain insights into the work undertaken by the volunteers and a deeper understanding of the context in which the volunteers were working. The observations enabled the evaluation team to initiate ad-hoc conversations with volunteers, patients, ward staff and WRVS volunteers to better understand their experience of the initiative.

Specifically the observations addressed the following evaluation objectives:

- To describe the care provided by the OWVS volunteers to patients and carers.
- To describe the activities of the Dementia Nurse Specialist in relation to the OWVS volunteers.
- To explore the perceptions of ward staff on the impact of the OWVS initiative on the delivery of care and on the experience of patients and carers.
- To identify factors which act as barriers and facilitators to the success of the OWVS initiative.

### **Sampling**

Two members of the evaluation team undertook the observations which were conducted across three time periods between July and December 2012. Three sets of three hour observations were planned for each time period and these were negotiated between the evaluation team, the Dementia Nurse Specialist (DNS) and the WRVS service manager.

In total eight visits were made to the ward. One was cancelled as there were no volunteers due in on the day. On two of the visits the volunteers who were expected did not arrive. Some time was spent with the DNS instead.

Six visits took place between 10.30 and 13.00hrs, the time when most volunteers were on the ward. Eighteen volunteer visits were observed (some volunteers were observed on more than one occasion) and in total 11 different volunteers were observed.

Three observations were conducted jointly by two members of the evaluation team and five were undertaken by one or other of the evaluators. (Full details of the visits are shown in Appendix 6).

### **Data collection**

Information sheets were given to the DNS to distribute amongst staff and volunteers. On each visit the evaluation team members introduced themselves to the person in charge of the ward and to any staff and patients who showed an interest. Volunteers were made aware of the observation and asked their permission for the observation to take place, no-one declined. The evaluation team members were mindful of the impact of the observations

on the volunteers and patients. On some occasions it was relevant to shadow the volunteers more closely and for example follow them into a bed bay or room, on other occasions a more distanced and discrete observation took place from outside the bed bay or room to minimise any anxiety or discomfort for the volunteers or the patients.

Both members of the evaluation team maintained independent notes. Where possible brief notes were made on the ward and then these were written up into field notes away from the ward soon after the observations.

## **Data analysis**

The two members of the evaluation team met on three occasions to discuss visits and agree on emerging themes. This involved a systematic process of sifting, charting and sorting the material into key issues and themes. Although a framework was provided to guide data analysis, the evaluation team adopted a more flexible approach to enable the development of themes emerging from the observations. A summary report was produced after time periods 1 and 2 which enabled further agreement and refinement of themes. The final report was agreed by both team members.

## **Findings**

Five key themes have emerged from the observations undertaken. These themes are reported below and are evidenced by the field notes and are referenced by Time Period (1, 2 or 3); Observation (1, 2 or 3) and Evaluation Team Member (a or b).

### **The value placed on the volunteers visits by patients**

There was strong evidence that patients benefited from talking with the volunteers. Patients appeared genuinely pleased to see the volunteers. Two patients were asked how they had found talking to the volunteers on a previous day:

*One patient said she thought the volunteers were lovely and you hear such bad reports about younger people it was lovely to meet such lovely young people. The other patient described how the male volunteer had listened to her concerns and how nice it was to have someone to talk to particularly as her family were away. Fn 1:2:a*

The observations across all time periods identified positive interactions that took place between the volunteers and the patients:

*Two patients seemed animated and seemed to enjoy the company and attention. They smiled, told the volunteers things and laughed. Fn 1:1a*

*Two volunteers spent time in one bay, engaging three of the patients in conversation around the subject of a chair that one of the patients was using. There was a lot of laughter and all the patients were involved in the conversation. Fn 1:2:b*

*All patients appeared to appreciate the conversation which helped to facilitate 'cross bay' conversations. Patients describe feeling bored and having someone to talk to helps pass the time. Fn 2:3:a (Volunteer) was called by patient in next bed who appeared to be bed bound. Conversation around the dementia doll, patient was engaged and responsive. Fn 3:2:b*

A patient had told a volunteer on a previous visit how she enjoyed gardening; the patient was delighted when on her next visit the volunteer brought in some tomatoes she had grown for the patient:

*The volunteers took a genuine interest in the patients; one volunteer had brought in tomatoes from her garden. Fn 2:1:a*

No patients were seen to refuse to see a volunteer during the observations.

### **Communication**

In the earlier observations there appeared to be some challenges in communication between the WRVS and the DNS, in that the DNS was not always sure which volunteers were due to visit on which days.

*Two new volunteers introduced by WRVS, DNS not on the ward ? if she knew they were coming. Fn 1:3:b*

*No volunteer arrived and the DNS was not sure whether anyone was due or not that day. Fn 2:2:a*

However, the observations in time period 3 demonstrated an improvement, certainly in communication on which volunteers were due on which days:

*There is now a rota in the volunteers' file which states which volunteers are due to visit on which day. Fn 3:3:a*

*Staff sign in log noted – most days of the week covered including weekends. Fn 3:2:b*

The observed improvement was supported by the DNS being able to say which days were covered with which volunteers.

Volunteers varied in their contact with the DNS and the WRVS service manager. Some volunteers seemed to have regular contact and were aware of things such as filling in the activity sheets at the end of a visit and with working with 'This is Me' with patients. Other volunteers were less aware of these things and had not seen the WRVS service manager or the DNS for some time:

*Some volunteers see the co-ordinator regularly where others see her rarely. The DNS told us that volunteers would spend time completing 'This is Me', but the volunteers today did not seem aware of that. The way that volunteers communicate with one another and with ward staff is unclear. A volunteer told me initially personal notebooks were kept, this then changed to writing in an A4 book, however when the volunteer came*

*to write in this book it appeared it was not being used and the volunteers were unsure where to record their visit. Fn 2:1:a*

At time period 3 the system for recording had changed again:

*New 'job' sheet where volunteers can record who they saw and what they did. Fn 3:2:b*

*New feedback sheets for volunteers to complete when they leave. Allows them to say how they spend their time with the patient. Fn3:3:a*

It was unclear whether all volunteers completed these, or whether they read the sheets from other volunteers.

The communication between volunteers and ward staff varied. At times there appeared to be little or no recognition of the volunteers by the staff on the ward.

*No contact noted between various disciplines and volunteers. Fn 1:1:b*

If staff needed to attend to a patient whom a volunteer was talking to there was a polite request made for the volunteer to leave.

*Staff going about their work, asking volunteers politely to step aside when they need to perform a care task with patient, no obvious valuing nor displeasure at volunteer presence. Fn 2:1:a*

However, the 'atmosphere' felt on the ward varied between visits and may have been related to staff on duty at the time or levels of activity. It seemed to have an impact on how relaxed the ward felt, how much chat and laughter there was. It was difficult to assess how the ward 'atmosphere' on the day impacted on the observations we made:

*Totally different ward – more chatter and general conversation. More interaction between the staff and volunteers – the atmosphere felt less 'tense' with the volunteers seeming to be more accepted by the staff that were working. Fn 1:2:b*

The final set of observations suggested that perhaps the volunteers were more integrated in the ward but there was still an absence of interaction initiated by staff towards volunteers during the periods we were observing.

### **Confidence of volunteers**

Volunteers appeared to come to the role of volunteering for a range of motivations. The observations identified some of these as: wanting to build experience for a CV, recovering from personal issues, building confidence, wanting to 'put something back' into health services. Similarly volunteers had a range of levels of confidence and experience.

The DNS described taking an active role by 'mothering' volunteers when they first started before encouraging them to 'fly solo'. However the DNS was not always on duty and on these occasions, the supporting role fell onto a more

experienced volunteer. In all visits we observed the support and guidance that more experienced volunteers offered to less experienced and less confident volunteers.

*Older more experienced volunteers teaching new volunteers re 'This is Me'. Fn 1:1:b*

*New volunteers led and guided by more experienced volunteer Fn 1:3:b*

*A less confident volunteer said she appreciated it when the more confident volunteer was around as it helped her to feel more confident in interacting with patients and making introductions. Fn 2:1:a*

On one occasion two new volunteers arrived on the ward when the DNS was not on duty and another volunteer inducted them to the ward:

*Led and guided by more experienced volunteer, shown 'This is Me' document, layout, questions, objectives explained (wondered if the nursing staff could do that?) Fn 1:3:b*

A consequence of some volunteers feeling less confident was sometimes two or more volunteers spent time with one patient. One observation noted four volunteers with one patient:

*2 experienced volunteers pairing with 2 new volunteers sat with one patient completing 'This is Me' form. With more direction it may have been helpful to have separated them into pairs? Fn 1:1:a*

*5 people in room, younger volunteers grouping together. ? too many for patient? Fn 1:1:b*

We were unable to assess how the patients felt about having a number of volunteers sat with them but as an observation the numbers sometime appeared excessive.

One volunteer was asked how her first day as a volunteer had been:

*She said she had really enjoyed it and enjoyed talking to the patients ... the volunteer said she felt that she had made some difference. Fn 1:1:a*

The accounts from volunteers on how volunteering has helped them were heart warming. A consequence of this was sometimes volunteers then leaving to take up another role or paid work.

Volunteer numbers were described by the DNS and by other volunteers as being too low.

### **Direction given to volunteers**

The direction given to volunteers about which patients they should talk to on the ward varied greatly between observations. When the DNS was on duty on one occasion, she was seen to take some volunteers to the bed board and

talk through which patients it would be relevant for them to see. However, this took place quickly and appeared to assume familiarity with both the bed-board and ward layout and it was difficult to assess whether the volunteers understood the suggestions.

Volunteers preferred it when the DNS was on duty as they felt they received more direction on which patients to see. When the DNS was not on duty sometimes a sister or staff nurse would be approached by a volunteer to request guidance or occasionally a staff member would approach the volunteers:

*After initially being asked to wait while she took a phone call, the sister soon returned to the volunteers and directed them to the bed board to suggest patients who could be seen. Fn 2:1:a*

*The DNS was off sick today, as soon as the volunteers had signed in a staff member approached them and suggested a particular patient who was upset that might appreciate having time spent with her. Fn 1:2:a*

On other occasions the volunteers would gravitate to someone they had already met and then perhaps move on to other patients if there was interest shown.

By time period 3 there has been a change in the way that volunteers were directed to patients:

*The DNS said there was a new system where she looks through the bed board and writes WRVS by the name of the patients she wants the volunteers to spend time with. Fn 3:1:a*

*Patient board used to identify patients noted to have WRVS in red next to names. Fn 3:2:b*

On a subsequent observation the volunteers were asked how the new system was working for them, one described:

*They had been to volunteer on another ward where the sister had identified patients on the board she wanted them to see, they suggested to the DNS who agreed to adopt the system on the ward. The volunteer felt it was much better as it saved wasting time with patients who did not need the volunteers as much as other. Fn 3:3:a*

Through the three time periods the ways in which patients were allocated to volunteers had changed and these changes were seen as improvements. What remained uncertain by the end of the observations was how the patients seen over a week was distributed:

*Questions occurred on how these volunteers knew who had time spent with them on previous days. Although it is written on the volunteer feedback sheets I did not observe the volunteers referring to these. Does it matter if the same 3 patients are seen on every visit? Fn 3:3:a*

*How do volunteers know who has been seen from one day to the next?  
Danger of same patient being seen on different days? Fn 3:3:b*

The observations also identified that it was not always patients with dementia who were allocated to the volunteers:

*The nurse on duty appeared to identify patients that were 'with it' or 'good communicators' and on this occasion volunteers were either not actively encouraged or on one occasion (because of 'aggression') dissuaded from talking to patients who were 'confused'. Fn 2:1:a*

The DNS was asked about this on a subsequent observation visit:

*She explained that the service had initially been set up for people with dementia but that sometimes volunteers might be directed to lonely older people on the ward who might be feeling a bit down and feel like a chat, she thinks that this is a legitimate use of volunteers' time. Fn 3:1:a*

The non participant observation visits exclusively observed volunteers spending time talking with patients. There were reports of games being played but these were never observed and were dependent on the tables being brought out. Some volunteers said this was more likely to happen when the DNS was on duty:

*If the DNS is on duty then there are more opportunities for the tables to be brought out and for volunteers to work with a small group of patients.  
Fn 2:1:a*

*In the past they (the patients) described volunteers playing games which they had enjoyed. Fn 2:1:a*

On one observation the DNS asked whether the tables in a bay could be brought out for the volunteers to sit with patients at:

*The support worker responded in a slightly irritated way that she was still washing patients (looks were exchanged between support workers when the DNS left). Fn 1:1:a*

We understood that a nurse was required to initiate the use of the tables in order to be able to assess which patients could safely mobilise from their beds to the tables. Our observations never included the use of the tables:

*Tables not in use – again used for storage. Fn 1:3:b*

The role of the DNS seemed significant to the volunteers and a number expressed a preference when the DNS was on duty. At the final visits a number of initiatives that the DNS had implemented were noted:

*Dementia link nurses identified by name on posters around the ward. Fn 3:2:b*

*Notice board outside ward has been added. Identified DNS and talks about the roles of volunteers on the ward. Fn 3:2:b*

The DNS had also been nominated by the consultant for her work with the volunteers and had won a Trust Award.

### **Impact on care**

It was difficult to assess the precise impact that volunteers had on the care the patients received. There were occasions the 'wellbeing' of patients appeared enhanced through the volunteers talking, laughing and listening to them. This was discussed above and some staff members also reported the wider benefits of the volunteers particularly for patients with dementia:

*A transfer nurse approached me about the volunteers and said "They're a Godsend, they are great to ask to sit with people with dementia, even just to hold their hand and offer some reassurance or otherwise they can sometimes distract someone with dementia who is wandering". Fn 3:1:a*

*The Consultant described a scenario where a young volunteer spent time with a patient with advanced dementia, the patient was seen to be responding in an animated way and the patients relatives commented later in a day what good spirits the patient was in. Fn 3:3a*

*A support worker said the volunteers were all really good; she said it was good to be able to ask a volunteer to walk around with a patient who wanders or who is anxious or calling out. It helps staff to know the patient is safe and occupied. Fn 3:3:a*

One observation noted how a rather withdrawn patient was respectfully engaged by a volunteer.

*One lady appeared asleep – the volunteer respectfully approached her and after a while the patient became animated and joined in the conversation, she smiled and her face lit up. Her 'well-being' was enhanced." Fn 2:3:a*

There was uncertainty whether volunteers were aware of sensory deficits in patients such as sight and hearing:

*One of the patients had very poor sight and may have benefited from sitting nearer to the other two? Fn 1:2:b*

The role of the volunteers at mealtimes appeared unclear. The soup arrived around 11.30 and often volunteers were in mid conversation with patients. There was no evidence of any guidance for volunteers on what they should do. Some continued talking with patients whilst their soup was left standing; some patients ate their soup and talked. One observation noted a patient 'hinting' to a volunteer that they would like to be left alone to eat but the volunteer did not pick up on this.

*The patient was heard to say 'Don't worry about me, you can go and talk to someone else if you like' Fn1:2:b*

On another occasion a patient was more able to ask a volunteer to leave.

*One patient became rather anxious and told the volunteer that she struggled to talk and eat. The volunteer respected the patient's wishes but appeared to feel a bit embarrassed, the patient later apologised which did not seem necessary but the encounter had seemed a bit uncomfortable for her. Fn 2:1:a*

Sandwiches arrived twenty minutes later and again there was no clear approach. The evaluation team questioned whether volunteers enhanced or detracted from the mealtime experience:

*Interrupted by lunch! Do the volunteers help or hinder at lunch time?  
Fn:1:2:b*

*Volunteers were still talking with patients and completing 'This is Me' whilst dinner arrived. It may have been helpful for direction to change from the emphasis on completing 'This is Me' to enhancing mealtimes for those who needed encouragement? Fn 1:1:a*

There were opportunities for information to be passed onto staff regarding patients nutritional needs but these were either not noticed or if they were it was unclear whether they were reported to staff:

*Volunteer identified a patient as someone who was not eating much, ? passed information to nursing staff. Fn 1:1:b*

*One rather thin lady said she would be better having more soup than sandwiches as it went down better, this was not picked up on or acted on by the volunteer. Fn 2:1:a*

At time period 3 there were some examples where volunteers did help prompt patients during mealtimes:

*The volunteer proactively moved to the opposite side of the bed and assisted with a drink. Stopped during lunch and encouraged patient with same. Fn 3:2:b*

*Volunteer was seen to be encouraging patient to drink her soup. Fn 3:3:a*

It was noted that the DNS had made a 'Nutrition Information Board' on the ward giving guidance and example of good practice for nutrition with people who have dementia but it is not clear whether the observations of volunteers helping patients at mealtimes was related to the work the DNS was implementing.

Volunteers were sometimes seen going off the ward to collect something a patient has asked for from the shop or assisting them in other ways:

*Volunteers fetching drinks for patient from machine outside ward. Fn  
1:2:b*

*The volunteer asked if the patient would like help to put her cardigan on (it was quite cold). Fn 3:3:a*

The observations identified uncertainty from volunteers about which staff to approach if a patient requested care:

*A patient had asked for the toilet. Volunteers looking for appropriate member of staff to ask, no animosity but volunteers seemed unsure as to who did what, initially approached the housekeepers. Fn 1:2:b*

*(Volunteer) requested help from staff when patient complained of having a 'numb bum', unsure of who to approach, initially asked occupational therapist, I had to point her in the direction of a staff nurse. Fn 3:2:b*

It seemed that some volunteers were not conversant with the different staff roles and means of identifying them.

There was no observation of staff asking volunteers for feedback about any interaction with patients. Volunteers often just left the ward when they had finished, not always letting anyone know they had left. This was reflected in the field notes:

*As our conversation ended the other volunteers joined us and said to one another 'shall we go back?' and they all left the ward. There was no reporting to the DNS that they had left and no passing over about what they had done. Fn 1:1:a*

Many volunteers write in the activity sheets but it is unclear whether these are read by staff and they do not provide detailed information. There was no evidence of any other formal or informal way that volunteers could report to staff about their visit.

## **Summary of key issues**

The observations indicated that the work of the volunteers was valued, certainly by the patients and also by some of the staff we spoke to. The benefits for patients seemed largely in terms of having company, someone to talk to and at times an increased sense of wellbeing indicated by laughter and interaction with other patients.

Ward staff were polite and respectful of the volunteers but were not observed to generally initiate interactions with them (with the exception of the DNS). The role of the DNS appeared significant to many of the volunteers and they reported that things were more organised in terms of patient allocation and getting activities underway when the DNS was on duty. The DNS had developed in her role through the time periods of observation and was implementing changes to the way that patients were allocated and was taking a more proactive role in raising awareness about people with dementia on the ward. Some of the earlier communication challenges around which volunteers were arriving on which day seem to have been resolved by the visible volunteer rotas.

The volunteers arrived with a range of levels of experience and confidence and the more experienced and confident volunteers were able to support the less confident and experienced volunteers.

There appeared to be some missed opportunities for volunteers to impact on some of the care needs of patients. Mealtimes were a good example of where volunteers' time could potentially enhance the mealtime experience for some patients. Additionally if a care need was identified such as a patient wanting the toilet or expressing discomfort then volunteers did not always know how to ensure this was reported to the staff member best able to address the need.

What has become apparent through the observational time periods is how the initiative is evolving based on learning from what is working well and what could be improved.

## **Stage 6. Focused conversations with ward staff**

The objectives of this stage of the evaluation were:

- To explore the perceptions of the ward staff on the impact of the On-Ward Volunteer Scheme (OWVS) initiative on the delivery of care and on the experience of patients and carers
- To identify factors which act as barriers and facilitators to the success of the OWVS initiative from the perspective of ward staff

### **Sampling**

The ward manager assisted the evaluation team to identify a purposive sample of six staff, which included a range of staff grades and roles.

### **Data collection**

The ward manager approached the potential participants with a letter from the evaluation team leader and a participant information sheet explaining the nature and purpose of the study (Appendix 2). Once the individuals had agreed to be contacted by the interviewers, their contact details were passed to the interviewers. Each of the staff members was contacted by one of the interviewers and interviews were arranged at a time and date suitable to both. A topic guide was developed to meet the objectives outlined in the protocol (Appendix 7). This topic guide was a document which evolved over the course of the interviews. Amendments were made after initial data analysis revealed areas to be further explored in future interviews, such as the volunteer role at mealtimes, and also after feedback from the Advisory Group meeting which identified further areas of interest to explore in the interviews. Data was recorded through note taking and a data collection tool was completed as soon as possible after the interview. Interview notes were then consolidated into categories using an Excel spreadsheet.

### **Data analysis**

The analysis approach drew upon the principles of Framework analysis (Ritchie and Spencer, 1994).

## **Findings**

### **Sample Demographics**

Five of the staff were female, one was male. Three were registered nurses of different grades and three were support staff undertaking different roles on the ward. All had direct contact with patients throughout their normal working day. There was a wide range of length of health care service, from 6 months to 40 years and a range of experience of working with patients with dementia. A number of themes emerged which are presented below.

### **First Impressions**

All of the staff interviewed had been informed of the initiative prior to it starting by senior ward staff, and they understood the role of the volunteers to include talking to patients and activities involving tables and chairs.

Senior staff and the DNS took time to explain to staff the role of the volunteers, outlining what they would and would not be doing while they were on the ward. Prior to the initiative starting, some staff members were consulted by the DNS regarding potential patient groups that might benefit from volunteer input. All six participants *“thought it was a good idea”* when it was first explained to them.

#### **Staff/Volunteer Interactions**

There was discussion about what involvement the staff had with the volunteers. The staff greeted the volunteers, some made them a drink, and they facilitated patient movement if required. The staff did not directly get involved with the volunteer activities, but may have peripheral involvement such as joining in with banter. It was indicated that this was due to time constraints for staff, who expressed a desire to be able to have the types of interaction with patients that the volunteers are having, but felt unable to do so due to a lack of time.

At the time of data collection, there was no plan as to when or how many volunteers arrive on the ward from the staffs' perspective. There did seem to be some consistency with volunteers mainly coming in the morning and leaving before afternoon visiting: weekends were not usual times for the volunteers to be on the ward. This was seen to fit well into the ward routine and was non-disruptive. If the volunteers were willing to try informing the ward in advance of when and how many are coming, the staff would be happy to try this approach, but they were unsure if this would be of any benefit.

Communication between the volunteers and staff with regards to which patients are seen by the volunteers seemed to vary. The qualified nurses seemed to have the most frequent discussions about who may benefit or enjoy the activities, but the amount of involvement support staff had in this discussion seemed to vary depending on the individual. Staff did state that they would steer the volunteers away from acutely unwell patients.

Staff expressed that they tried to prepare the environment for the volunteers as much as possible, trying to get the tables and chairs ready. Staff stated that on their arrival, the volunteers were directed to patients who might benefit from their time by the DNS, staff nurses or senior nursing staff. In return, the volunteers might suggest patients that they were familiar with from previous visits and would see everyone that they were asked to. In screening patients, the ward staff were mindful of patient needs, but also of volunteer safety, especially when asking them to see agitated patients:

*“one volunteer sat with a patient in a side ward, but at a distance, as name of patient can be quite feisty” (S1).*

Appreciative of the service the volunteers were providing, the staff stated that they tried to facilitate the volunteers' work by, for example, moving patients to the group table where the activities take place. The volunteers were said to ask for assistance as needed, for themselves or on behalf of patients, without unnecessarily interrupting ward staff.

The staff acknowledged that while they recognize the volunteers through their uniform, and were becoming familiar with some faces, they did not know the names of volunteers, nor did they know when the volunteers were going to be on the ward.

Some staff had occasionally received feedback from volunteers regarding patients after a visit, but it was highlighted that more structured volunteer feedback to staff could potentially enhance the benefits of the service.

Perhaps due to the voluntary nature of their work, the volunteers across the age ranges were described as cheerful, friendly and patient. For this reason they were very welcome on the ward:

*“it’s always nice to see them” (S2).*

#### **Benefits to the staff**

Overall the staff stated that the OWVS initiative was having a positive impact. It was clear that as the role of the volunteer was distinctly different to that of the staff, there was no overlap in roles, and therefore no negative impact on staff activities and duties. There was no sense of the volunteers disrupting ward activities or impeding nursing care: they were seen to fit in with ward routines:

*“what they do is very subtle, they blend in” (S6).*

Staff had seen the volunteers become more confident as time has passed and they had become increasingly familiar with the ward and its routines: this had enhanced this integration.

The OWVS were reported as making the ward a more cheerful environment. The activities undertaken with the patients generated laughter amongst patients, staff and the volunteers.

*“They were playing cards, a young volunteer and a dementia patient and the patient was telling the volunteer to hurry up. It was funny. Bingo can be funny, depending on the patient level of dementia, but ... it is useful interaction even if the patients don’t follow the game exactly” (S1)*

Additionally some of the activities that the volunteers started were continued by ward staff after the volunteers have left e.g. playing music.

The presence of the volunteers on the ward was also reassuring for the staff. The volunteers were seen by staff as an additional ‘pair of eyes’ in the ward area: knowing that there was someone with the patients when they were not physically there helped them focus on other duties. Also if the volunteers were including anxious or agitated patients in activities this released the staff to perform other activities as the patients were then occupied and needed a less supervision.

*“If someone is chatting to a patient then you don’t have to worry – one less thing to think about” (S6).*

While this additional supervision was clearly of benefit to the staff and patients, staff clearly had a concern about becoming over reliant on the volunteers in this capacity.

*“Don’t want to come across as if we are just using them – it’s just about pressure” (S6).*

Throughout the interviews it became evident that the OWVS is a service that was highly valued by the ward staff.

*“(They are doing a) great job hope it stays and they don’t feel it’s a wasted cause or they get fed up of coming” (S5)*

### **Impact on patients**

All of the staff interviewed mentioned a wide range of activities that were undertaken by the OWVS. Some were group activities; cards, dominoes or board games such as Scrabble, which could lead to jovial banter between patients, volunteers and staff. However the main activity mentioned was conversation. This could be as simple as a conversation between two people, or it could be guided with the use of memory aids, such as books. Patients were seen to gain social activity that they would not receive without the OWVS. This socialisation was multifaceted, between the patient and the individual volunteers, the patient and the staff and also between the individual patients in the ward.

There was discussion in the interviews that there has been an improvement in patient mood, along with reductions in patient boredom and anxiety noticed by staff since the start of the OWVS. This had been demonstrated through the OWVS interacting with restless and agitated patients, who became more relaxed and occupied during the interaction.

Volunteers were seen to be providing the patients with a choice of activities and acting as a spokesperson for the patient, for example informing staff if patients needed the toilet or wanted to go back to bed. Although some of the activities undertaken are group ones conducted in the 4 bed bay area, not all of the patients in that room may want to take part: this decision was supported by the staff and volunteers.

*“Some patients decline to sit in middle for the group activities. Not dementia it’s patient’s choice” (S5)*

Although patients with dementia could struggle to remember the details of the activities with the OWVS, such as the identity of the person who spoke with them, some of the patients could remember that there was a social interaction with another person. One staff member reported a patient saying, after a volunteer visit

*“I don’t know who they were but they were lovely” (S2).*

Other patients had provided positive feedback to the staff interviewed, expressing gratitude and pleasure over the interaction:

*“wasn’t it nice to have a chat and a laugh” (S5).*

These observations had led to the conclusion that the patients value the OWVS. However the staff noticed that the OWVS do not tend to come to the ward during visiting time: they felt that this could be an area for improvement, as not all patients have visitors and this is a potential source of isolation for them.

### **Nutrition**

At the time of data collection, the volunteers came to the ward before and during lunch time. However, there was some confusion and lack of clarity over the volunteers’ role whilst the patients are eating. Some staff noted that some of the volunteers helped patients at mealtimes, but this was not a universal activity.

*“They are there at mealtimes, sit with patients, pass drinks, it’s helpful to have them to prompt “that looks nice”. Some patients, in case you say ‘have something to eat’ it will just sit in front of them.” (S1)*

It was acknowledged that the volunteers cannot ‘feed’ patients with swallowing or other specific dietary needs, but the staff would appreciate a greater role for the volunteers at mealtimes, with the volunteers acting as a prompt for dietary and fluid intake for patients who require this assistance.

*“If WRVS were trained to assist at meal times it would help staff but would need to be selective, it would be unfair to ask them to feed sick patients. Maybe they could help with prompting patients or assisting patients with no swallowing difficulties” (S5)*

### **Impact on families/carers**

Some relatives had provided positive feedback to the staff with regard to the service provided. Others seemed to have a limited knowledge about the service, in spite of the work of the DNS and the advertising and information specifically for relatives on the ward.

### **Barriers and facilitators**

The volunteer nature of the OWVS seemed to be helping the initiative. That is to say that had additional staff members been employed to provide the service now offered by the volunteers, the same levels of success may not have been achieved. This was demonstrated in the comments made during the interviews which showed a regard for the volunteer status, especially them giving up their time.

There was some discussion about what could improve the OWVS. It was felt that better chairs would help with group activities, also a wider range of CDs may help. The main discussion around enhancing the service focused on improving communication with the volunteers, and on clarification of the volunteer role at mealtimes as there seemed to be inconsistency and

confusion around what the volunteers could and could not do at this time of day.

#### **A valuable service**

The staff described how, much as they enjoy talking to the patients, they *“like to chat, but don’t have time”*. If the opportunity for a conversation does arise then the staff are always aware that they have somewhere else to be, another job they should be getting on with. Furthermore, staff conversations with patients are likely to have an alternative agenda or purpose – perhaps to assess needs, or identify information which may be helpful in the patients’ ongoing care. The staff compare this to the volunteers, who are not in professional uniform, have lengthy periods of time set aside solely for patient interaction, and can be more social, friendly and relaxed in their conversation:

*“it’s a different level of chat” (S5).*

The staff recognise this difference, and its value in delivering the service. Across the board, the staff see that the volunteers are doing a *“great job”*. The value of the service provided by the OWVS is probably best demonstrated through the staff concerns for the continuation of the project. They are aware that this is a pilot and many of the staff commented that it would be a shame and a disappointment if the volunteers were to stop coming to the ward. Others asked about the other parts of the service evaluation, asking if this was positive, as if this would provide an indication of if the service would continue in the future.

### **Summary of key issues**

- The staff highly valued the volunteers. This is seen as a high quality service and staff were keen to see the OWVS initiative continue.
- Staff tried to assist volunteers by moving patients and tables.
- Some staff were involved in the selection of patients who were most appropriate for the volunteers to work with although this was variable.
- Receiving feedback from volunteers about patients was not routine.
- Staff felt the volunteers improved the atmosphere on the ward and their presence was reassuring for staff through the provision of additional supervision for patients.
- The service was seen as highly valued by patients. By engaging in a variety of activities with patients the volunteers were felt to improve patient mood and reduce anxiety and boredom.
- There was lack of clarity regarding the role of the volunteers at mealtimes and some staff would like to see them being more actively involved with feeding.
- While some relatives have given positive feedback, not all families were aware of the service.



## **Stage 7. Analysis of routine data**

The objective of Stage 7 was:

- To capture changes in relevant Nurse Sensitive Indicators since the introduction of the OVWS initiative.

### **Data collection**

Routine data at ward level for the 6 month period before and after the initiative was introduced were supplied on the incidence of following Nurse Sensitive Indicators (NSIs):

- falls
- pressure sores
- Serious and untoward incidents (SUIs)

More data on the nature of the SUIs over the period of the evaluation were also supplied.

### **Data analysis**

Descriptive analysis of the data supplied by STH was undertaken.

### **Findings**

Trends in the incidence of falls, pressure sores and complaints per 10,000 bed nights were summarised graphically(not presented here).

None of the SUIs reported involved or related to the presence of volunteers on the ward.

### **Summary of key issues**

Although there is some indication that there is a trend towards the rate of complaints reducing in the six month period after the OWVS was introduced, there is no clear trend for pressure sores and for falls the direction of the trend appears to be increasing. However, no firm conclusions should be drawn on the basis of this data. Due to service reconfigurations within the Trust the casemix on the ward changed over the period the data was collected and therefore the data which represents the 6 month 'before' period does not reflect a casemix which is comparable to the 'after' data. Furthermore, attributing any changes in NSIs to the introduction of a single initiative on a ward where so many other changes were taking place, including changes to the ward staff and ward manager would not be wise.

## **Discussion and conclusion**

This study set out to evaluate the impact of the OWVS initiative at Sheffield Teaching Hospitals NHS Foundation Trust. The evaluative design adopted a pragmatic approach and assessed impact through capturing the perspectives of a wide range of stakeholders within both the Trust and the WRVS including stakeholders with strategic roles, Trust and WRVS managers, clinical staff, and the volunteers themselves. This approach allowed a more complete and multi-dimensional picture of the initiative to emerge. The range of data collection strategies used, which included one to one interviews and conversations, focus group discussions and non-participant observation as well as the analysis of routine data collected by both the WRVS and the Trust was also a strength of this evaluation. The consistency of some of the issues which emerged across a range of data collection methods adds to the confidence we can have in the findings of the evaluation.

New services change and develop over time. In their early stages, they can be more effective due to initial waves of enthusiasm which wane as time goes on. Conversely they can be less effective at inception as existing systems and staff struggle to adapt to change. The collection of data over a 12 month period of time provided a picture of the development of the OWVS initiative in situ, rather than simply a snapshot in the early stages. This approach allows a clearer picture to emerge of the impact of the introduction of an innovation in practice.

However, the evaluation did have a number of limitations. The data collected in Stage 2 to map the volunteer activities was acknowledged to be incomplete and should therefore be interpreted with caution. The volunteers who participated in the Stage 4 focus groups were based on convenience samples and may not represent the views of all volunteers and the Stage 5 observation of practice was based on a small number of short visits to the ward and may not reflect the full range of practice or activities which take place. The Stage 7 analysis of routine ward level data yields little useful information given the changes in casemix on the ward as the initiative was introduced.

A detailed analysis of each stage of the evaluation has been given in the preceding sections of this report. What follows is a brief summary of the key issues in relation to the cumulative findings of Stages 1 to 7, followed by recommendations for the organisations to consider. Reference is also made to the 'Shaping our Age' consultation which took place between April and August 2012 and involved interviews with 32 patients and 11 carers on the ward. These interviews included opinions about hospital stay as well as opinions of the OWVS (James et al 2012).

## **Implementation of the initiative**

The introduction of the OWVS initiative was a new development, both for the Trust and for the WRVS. The OWVS was introduced to a ward which was already undergoing considerable change and reorganisation. It is therefore perhaps not surprising that the introduction of the volunteers to the ward was not without problems. At the start some ward staff did not fully understand the role of the volunteers and there was some initial wariness on both sides which resulted in volunteers not always feeling welcome on the ward. This was compounded by the fact that volunteers did not initially have a uniform. However, as the ward became used to the volunteers, who were supplied with uniforms and began to grow in confidence themselves, these early problems were largely resolved and there was clear evidence in this evaluation that the volunteers are now valued by the ward staff.

While the DNS was seen as a welcome addition to the ward team from the start, this was also a new departure. There was some initial uncertainty about the nature of her role, particularly in the period before the volunteers arrived on the ward. Lines of accountability were unclear at first and there was confusion over whether she should form part of the ward numbers. This uncertainty was not helped by the lack of a job description. Again, there is evidence that these problems resolved over time and the DNS is now highly valued as part of the ward team, although still has no job description.

## **Working on the ward**

### **Shift patterns**

Most of the volunteers work on the ward in the mornings, arriving mid-morning and leaving after lunch. Although one volunteer works at the weekend, there is little or no input from volunteers in the afternoons or evenings. While there is a consensus that mornings are a valuable time for the volunteers to be present and a consensus that there are not enough volunteers to cover other parts of the day as well, this means that volunteers have limited interaction with relatives and little opportunity to spend time with patients who do not receive visitors. At the outset, the potential for the OWVS to impact on carers and provide respite was recognised by key stakeholders and one of the concerns around hospital stay highlighted by both patients and carers in the Shaping Our Age evaluation was feeling lonely, especially when family were unable to visit (James et al 2012).

While at the start of the initiative, there was little evidence that the ward staff knew with certainty when to expect the volunteers on the ward, towards the end of the valuation period, volunteer rotas were more visible and explicit.

### **Activities**

While the volunteers engage in a range of activities with patients, the most common activity is talking with patients. This interaction is highly valued by patients, volunteers and staff alike. Volunteers also engage in more structured and organised activities including dominoes, bingo, music and pampering, which provide an additional dimension and opportunities to socialise for patients. However, these activities do not take place as

frequently and rely on the use of tables, which in turn requires staff to assist the volunteers to get the tables out and move the patients to the tables. This is sometimes problematic and can curtail the extent to which these activities can take place.

There was clear evidence that the volunteers tailor the activities they offer to individual patient preferences on the day.

### **Selection of patients**

Mechanisms for identifying the most appropriate patients for the volunteers to spend time with have evolved considerably over the period of the evaluation. Initially the DNS would guide the volunteers regarding which patients to see when she was on duty, but in her absence, routine systems were not in place to assist the volunteers with this and the volunteers were often left to decide for themselves which patients to see and what activities to engage in. There was little evidence that the ward staff were routinely involved in the selection of patients in the early stages. A consequence of this was that the volunteers had little means of identifying those patients with dementia or those patients who might benefit most from their attention. However, by the end of the evaluation period, new systems had been developed by the DNS to identify patients for the volunteers using the whiteboard and key members of ward staff had received training in dementia awareness who could provide support in the absence of the DNS.

### **Role of the DNS**

The role of the DNS was pivotal to the implementation of the initiative, particularly in the early stages. In addition to being the link between the volunteers and the ward staff, she provided support to the volunteers on a day to day basis and was seen as a role model from whom the volunteers learned how to interact with patients. Her presence on the ward gave the volunteers confidence.

In addition to her role with the volunteers, the DNS also contributed to the improvement of care for dementia patients through other initiatives including staff training, introduction of new activities such as visits by a music group and new approaches to the care of dementia patients e.g. use of empathy dolls and fundraising.

### **Role of volunteers at mealtimes**

While there was some evidence that the volunteers can play an important role at mealtimes in terms of encouraging patients to eat and drink, there was also evidence that their role at mealtimes could be more clearly defined and there was clearly potential to make better use of volunteers to improve patients' experience at mealtimes. There were also suggestions that their role could be expanded to include assisting with feeding. The Shaping our Age evaluation highlighted that problems managing at mealtimes was a concern for patients and carers when they came into hospital (James et al 2012).

## **Communication with staff**

While there were indications that the volunteers and ward staff felt comfortable with each other and volunteers felt able to ask for help or seek advice on occasions, there was little evidence of volunteers providing feedback to ward staff in relation to the patients they had spent time with and no mechanisms in place for this to happen on a regular basis.

## **Impact of the initiative**

### **Impact on patients**

There was clear evidence that the OWVS is appreciated and valued by patients. A consistent picture emerged through seeking the views of volunteers, stakeholders and staff and from direct observation of the volunteers in practice. The service clearly enhances patient experience while in hospital in a variety of ways including providing companionship, relieving boredom and providing reassurance. The opportunity to participate in a range of other activities was also valued. This reflects the findings of the Shaping Our Age evaluation which also highlighted the benefits of company and conversation provided by the volunteers. 'Shaping our Age' also identified that patients who had experienced being moved away from their beds for an activity had enjoyed this (James et al 2012).

The available data did not allow for any meaningful exploration of the impact of the OWVS on quantifiable patient outcomes, but there was no evidence that the presence of the volunteers had resulted in either complaints or SUIs.

### **Impact on carers**

Although there was some evidence that carers valued the OWVS, its impact in this respect was not strongly evidenced in this evaluation (and we did not set out to capture the perspectives of carers). The impact on families/carers was viewed as being 'indirect', rather than being achieved through direct involvement of the volunteers with relatives or carers, many of whom were thought to be unaware of the role of the volunteers on the ward.

While the use of the 'This is Me' booklet was seen as a potential way to gain useful information about patients from carers, which the volunteers could make use of, there was a lack of clarity about how it should be used by the volunteers in practice.

The Shaping our Age evaluation interviews with carers highlighted varying levels of awareness of the service amongst carers, but those carers who had direct experience of the service found it a comfort to know that the volunteers were on the ward and those who had met the volunteers appreciated their involvement and clearly liked them, finding them patient and friendly (James et al 2012).

### **Impact on staff**

There was clear evidence that the OWVS had a positive impact on the quality of working life of the ward staff and no evidence that their presence on the ward had caused problems for any of the staff or disrupted care, although the use of the tables on occasions did not go smoothly. The presence of the volunteers sometimes freed up nursing staff to focus on elements of care that were seen as exclusively as nursing duties, while volunteers spent time with patients who were agitated or distressed and the presence of the volunteers could enhance the atmosphere on the ward. The volunteers across the age ranges were seen by staff as cheerful, friendly and patient.

## **The volunteers**

The volunteers were a diverse group in terms of age and reasons for volunteering. The volunteers clearly valued their work on the wards and there were strong indications that as volunteers became more experienced on the ward, their confidence had grown and their integration with the ward team had improved over the evaluation period.

Volunteers came to the role with varying degrees of confidence and experience of patients with dementia. Coming on to the ward could be very daunting at first and volunteers clearly valued the support of the DNS and the WRVS service manager. However, the support provided by other volunteers was also crucial. Help from more experienced volunteers was highly valued by novice volunteers and the majority of volunteers preferred to work on shifts with another volunteer and could find working alone very challenging. Ensuring that volunteers feel wanted and useful on the ward and the provision of good support by the ward staff were seen as crucially important if volunteers were to be retained in the long term.

The in-depth training on dementia and on elements of hospital policy received by the first volunteers recruited evaluated very positively. Following this training volunteers were well equipped with quite specialised knowledge on the nature of dementia and the needs of patients with the condition. This has now been replaced by online training, which is not necessarily completed prior to the volunteers starting on the ward.

## **Sustainability and spread**

While the initial target to recruit 20 volunteers had been met, this was mostly achieved at the start of the initiative and ongoing recruitment, while keeping pace with volunteers who were leaving, may not be sufficient to expand the service to cover the ward at evenings and weekends or to expand the service to other areas of the Trust without a considerable increase in numbers.

## **Conclusion**

There was clear evidence that the OWVS is enhancing the experience of frail older people on the evaluation ward, which was the intended focus of the service when it was first introduced. Patients clearly value the company of the volunteers and take pleasure from a range of activities on offer. This is also an element of their care where they can exercise choice. There are few areas of care that patients are able to choose when in hospital, they have no choice

in what time they will eat for example. In the OWVS the patients can choose whether to take part or not and the activities are tailored to their preferences.

This evaluation has described a service which is also valued by ward staff. The volunteers can free up nurses' time by sitting with patients who are upset or agitated for example and can lift the atmosphere on the ward. The OWVS complements rather than duplicates the care provided by ward staff.

However, there may be an enhanced dimension arising from the fact that the service is delivered *by volunteers*. Teasdale (2007a and 2007b) studied the impact of volunteers in NHS services and found that staff appreciated volunteers giving up their own time to help out, and also noted that the volunteers made the staff's job easier. This is reflected in this evaluation - the staff have respect and regard for the volunteers in giving up their own time to help others, and they appreciate the job that the volunteers are doing and the benefits that it provides. This reflects the findings of Scott (2006) who reviewed volunteer services in a children's hospice, where volunteers were perceived to be more relaxed than staff, using their time differently to staff, but in a way that complemented staff work. Scott (2006) and Teasdale (2007a and 2007b) both describe "special qualities" that volunteers bring to the hospital setting: fresh ideas, giving, selflessness, flexibility, more time to spend with patients.

By spending time with frail older people in a busy acute setting, simply chatting, reading or playing games, the OWVS volunteers provide a service that otherwise existing staff would struggle to offer.

## **Recommendations**

### **Working on the ward**

- Consideration should be given to developing systems for volunteers to report on their interactions with patients to staff before leaving the ward
- Greater clarity is required around the role of volunteers at mealtimes. Expanding the role of the volunteers to include feeding patients should be considered. In the absence of this, clear practical guidance should be developed on how the volunteers can enhance the experience of mealtimes for patients.
- While simply talking to patients is highly valued and may reflect patient preferences on the day, practical ways of ensuring that volunteers can draw upon a broader repertoire of activities should be explored.
- The issue of how the tables should be used on the ward for activities and the role of the ward staff in assisting the volunteers when the tables are needed should be clarified.
- Information on the roles of ward staff and the meaning of different hospital uniforms should be provided to the volunteers as part of their induction.
- Consideration should be given to organising the volunteer shifts to include visiting times, evenings and weekends. However, in the absence of the DNS on some of these shifts, this should only be done if named individuals are identified to support the volunteers on these shifts.
- Newly established systems to involve nursing staff in identifying the most appropriate patients for the volunteers to see should be maintained. These systems could be developed further to ensure that volunteers are given any appropriate information about these patients by ward staff at the start of their shift.
- The role of the volunteers in both completing and making use of 'This is Me' should be clarified.

### **Volunteers**

- The supervision and mentoring needs of volunteers when the DNS is not on duty requires thought and clarification, particularly when considering the range of experience and confidence that volunteers have.
- Feedback should be sought from the volunteers to establish whether the current preparation for the role meets their needs.

- The ongoing training needs of volunteers would benefit from review in terms of some of the more subtle issues such as how to engage people with sensory impairments and how to share time effectively between patients.

## **Sustainability and spread**

- If the OWVS is to be rolled out to other areas for the care of patients with dementia under the supervision of the DNS, this will inevitably mean a dilution of her presence at ward level. Should this happen, a named member of staff on each ward should be identified to provide relevant clinical support to the volunteers and act as a go-between between the ward and the WRVS/DNS. Consideration should be given to the appropriate individual to undertake this role on a ward by ward basis.
- The DNS should be provided with a job description.
- If the OWVS is to be rolled out to other areas, consideration should be given in advance to the provision of practical equipment such as tables, CDs, games, books and empathy dolls.
- Ward staff should be prepared about the role of the volunteers before the volunteers come onto the wards. This preparation should include clarifying the staffs' role in identifying the most appropriate patients for the volunteers to see, providing volunteers with appropriate information about these patients, establishing mechanisms for the volunteers to feedback useful information to ward staff and assisting volunteers with the practicalities of sitting patients at tables when required,
- Careful considerations should be given to the number of volunteers required to support expansion of the service. Sufficient numbers are needed to ensure that volunteers can work with a colleague and work on the same ward on every shift if this is their preference.

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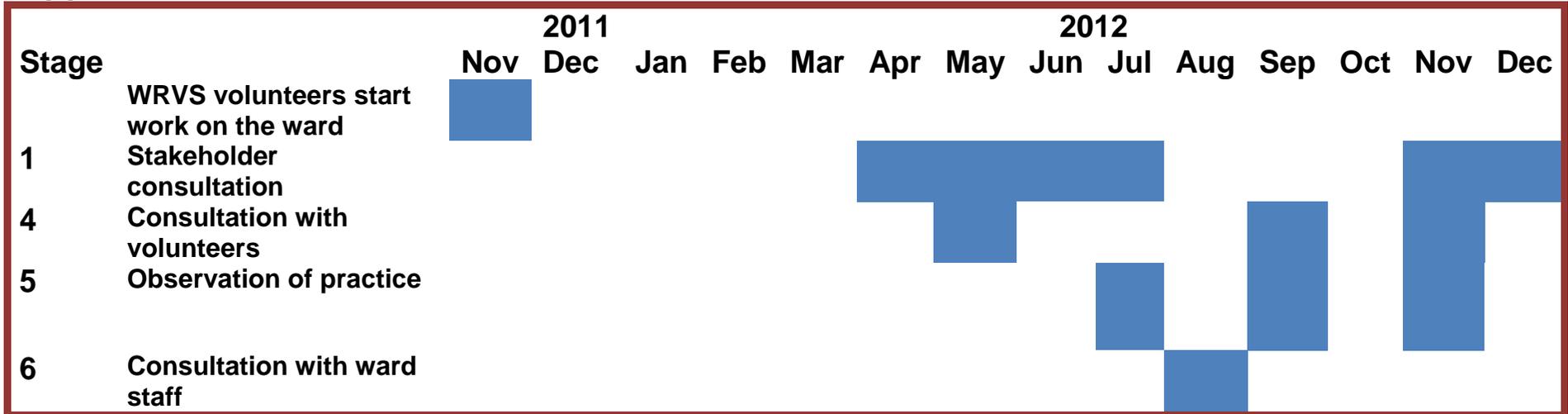
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## Appendix 1. Timeline



## Appendix 2

# **An evaluation of the WRVS on-ward volunteer initiative at Sheffield Teaching Hospitals NHS Foundation Trust**

### **What is the purpose of the evaluation?**

The WRVS on-ward volunteer initiative was launched within Sheffield Teaching Hospitals (STH) in November 2011. The purpose of the initiative is to improve the inpatient experience of patients with dementia by using on-ward volunteers recruited and trained by WRVS, supported by a Dementia Nurse Specialist (DNS) employed by STH.

The aim of this evaluation is to assess the impact of the initiative from the perspective of a range of stakeholders within the organisation and to identify factors which act as barriers and facilitators to the success of the initiative.

In order to gain a comprehensive picture, we will be seeking the views of the volunteers themselves, carers/family members, senior managers from STH and the WRVS plus a range of healthcare staff including doctors, nurses and other members of the ward team. Time will also be spent observing practice in the clinical areas where the volunteers are based.

### **What will happen to the results of the evaluation?**

A report will be sent to the Deputy Chief Nurse at STH - who commissioned this evaluation. In addition we will provide a summary of the findings for distribution within the Trust to key stakeholders including the Nurse Executive Group and to those who participated in the evaluation. We also plan to publish the findings in journals so that other people can learn from this work.

### **Who is undertaking the evaluation?**

The evaluation is being undertaken by a team from the Faculty of Health and Wellbeing at Sheffield Hallam University and STH. The team is led by Dr Ann McDonnell. The evaluation plan has been reviewed and approved by the Clinical Effectiveness Unit.

### **How do I find out more about the evaluation?**

If you would like to find out more, please contact:

Dr Ann McDonnell

Centre for Health and Social Care  
Research

Sheffield Hallam University

Montgomery House

32 Collegiate Crescent

Sheffield S10 2BP

Tel: 0114 225 2439

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**Appendix 3**  
**V1 26-03-2012**

**Semi-structured interview with key stakeholders**

**Welcome and introduction**

Overview of project – Any questions? How are you for time today?

Purpose, format and length of in-depth interview – topics to discuss, audio-recording, note-taking

Ground rules of interview – e.g. if you say any names we'll anonymise; if you need to stop/pause (e.g. if they are needed/emergency)

Emphasise any concerns re participation to let know.

Request to tape record discussion – Check OK and START recording.

**Current role**

1. Could you tell me briefly about your role within STH/ WRVS?

**Background to the OWVS initiative**

2. From your perspective, can you explain why the OWVS initiative was developed?

3. What was your involvement?

**Aim of the OWVS initiative**

4. What does your organisation (STH or WRVS) hope to gain through the introduction of this initiative?

5. What does the partner organisation (STH or WRVS) hope to gain through the introduction of this initiative?

**Impact of the OWVS initiative (what difference it makes in practice)**

6. What do you think the impact (positive or negative) of the on-ward volunteers will be (or is having)?

- on patients
- on their carers/families
- on the ward staff
- on the organisation of care

Probe: will/do the above groups like/dislike having the volunteers around?

7. How has the introduction of the on-ward volunteers affected your own role/ your own work?

**Barriers and facilitators**

8. What factors do you think will help/are helping the OWVS initiative succeed in practice?

9. What factors do you think will act/are acting as barriers to the success of the OWVS initiative in practice?

**Anything else?**

10. Are there any other issues associated with the impact of the OWVS initiative you'd like to mention that we've not covered?

**Close**  
Thanks

Ensure they have contact details/emphasise can contact if any queries/concerns

**Appendix 4**  
**V1 13-11-2012**

**Semi-structured interview follow-up interview with key stakeholder 1**

**Welcome and introduction**

Overview of project – Any questions? How are you for time today?

Purpose, format and length of in-depth interview – topics to discuss, audio-recording, note-taking

Ground rules of interview – e.g. if you say any names we'll anonymise; if you need to stop/pause (e.g. if they are needed/emergency)

Emphasise any concerns re participation to let know.

Request to tape record discussion – Check OK and START recording.

Purpose of the interview is for us to pick up on any issues we need to clarify and to explore their perspectives on the initiative now it's well established on the evaluation ward.

**Recruitment, training and retention**

Have you been able to recruit the numbers you hoped for?

How are the new volunteers being trained? In the same way as the initial vols or in a different way?

Will they receive any ongoing training?

Are you able to retain the numbers you want?

Are more or less leaving that you anticipated?

**Patterns of working on the ward**

Are the volunteers working on the shifts you thought they would? Do you cover all parts of the day or some more than others? If so, why?

Are the volunteers doing the sorts of activities you thought they would be involved in?

When the initiative first came in, it seemed to be aimed at working primarily with patients with dementia - is this what has happened in practice or have they worked with other patients too?

Do you think the vols feel well supported?

Is supporting the vols primarily your role or the role of the DNS?

**Impact of the OWVS initiative (what difference it makes in practice)**

Looking back over the time the vols have been on the ward, what do you think the impact (positive or negative) of the on-ward volunteers has been

- on patients
- on their carers/families ( as much as you thought it would be?)
- on the ward staff
- on the organisation of care

You mentioned when we first talked about the vols not always feeling welcomed at the start (especially when the CNS wasn't around). Has this changed?

### **Barriers and facilitators**

What factors do you think have helped the OWVS initiative succeed in practice?

What factors do you think have acted as barriers to the success of the OWVS initiative in practice?

How important has the DNS been?

Would the initiative have worked without her?

Anything that's worked out better than you'd anticipated?

Anything that's not worked out as well as you anticipated?

### **Lessons learned**

If you were starting the initiative from scratch again is there anything you would do differently. Why?

### **Sustainability and spread**

Do you think that the initiative will be sustained on the evaluation ward?

Are there plans to spread the initiative further?

How will this work in practice?

### **Anything else?**

Are there any other issues associated with the impact of the OWVS initiative you'd like to mention that we've not covered?

### **Close**

Thanks

Ensure they have contact details/emphasise can contact if any queries/concerns

V1 13-11-2012

## **Semi-structured interview follow-up interview with key stakeholder 2**

### **Welcome and introduction**

Overview of project – Any questions? How are you for time today?

Purpose, format and length of in-depth interview – topics to discuss, note-taking

Ground rules of interview – e.g. if you say any names we'll anonymise

Emphasise any concerns re participation to let know.

Purpose of the interview is for us to pick up on any issues we need to clarify and to explore their perspectives on the initiative now it's well established on the evaluation ward.

### **Changes since you came into post**

When we first talked you seemed a little uncertain on accountability. Has this now been resolved?

### **Patterns of working on the ward**

Are the volunteers working on the shifts you thought they would? Do you cover all parts of the day or some more than others? If so, why?

Are the volunteers doing the sorts of activities you thought they would be involved in?

When the initiative first came in, it seemed to be aimed at working primarily with patients with dementia - is this what has happened in practice or have they worked with other patients too?

Do you think they vols feel well supported?

Is supporting the vols primarily your role or the role of the WRVS service manager?

### **Impact of the OWVS initiative (what difference it makes in practice)**

Looking back over the time the vols have been on the ward, what do you think the impact (positive or negative) of the on-ward volunteers has been

- on patients
- on their carers/families ( as much as you thought it would be?)
- on the ward staff
- on the organisation of care

### **Barriers and facilitators**

What factors do you think have helped the OWVS initiative succeed in practice?

What factors do you think have acted as barriers to the success of the OWVS initiative in practice?

How important has your role been?

Would the initiative have worked without her?

Anything that's worked out better than you'd anticipated?

Anything that's not worked out as well as you anticipated?

**Lessons learned**

If you were starting the initiative from scratch again is there anything you would do differently. Why?

**Sustainability and spread**

Do you think that the initiative will be sustained on the ward?

Are there plans to spread the initiative further?

How will this work in practice?

**Anything else?**

Are there any other issues associated with the impact of the OWVS initiative you'd like to mention that we've not covered?

**Close**

Thanks

Ensure they have contact details/emphasise can contact if any queries/concerns

**Appendix 5**  
**V1 24-04-2012**

**Focus group discussion with WRVS volunteers**

**Welcome and introduction**

Overview of project – Any questions? How are you for time today?  
Purpose, format and length of in-depth interview – topics to discuss, audio-recording, note-taking  
Ground rules of interview – e.g. if you say any names we'll anonymise.  
Emphasise any concerns re participation to let know.  
Request to tape record discussion – Check OK and START recording.

**Preparation for the role**

1. How well do you think the training you received prepared you for your roles as on-ward volunteers?

**Early experiences working as on-ward volunteers**

2. What were your experiences when you first worked on the ward?

Prompts:

Did you feel welcomed by the ward staff?

Did you feel you know what your role and responsibilities were?

What was your involvement with patients?

**Support in practice**

3. Do you feel supported while you are working on the wards?

Prompts:

Who provides you with support?

Who do/would you go to if you had a problem with a patient/with your role as an on-ward volunteer?

**Impact of the OWVS**

4. Do you feel that what you do as a volunteer on the ward makes a difference?

Prompts:

Impact on patients

Impact on carers

Impact on ward staff

Impact on the organisation of care

Probe: Do the above groups like/dislike having the volunteers around?

**Barriers and facilitators**

5. What factors do you think will help/are helping the OWVS initiative succeed in practice?

6. What factors do you think will act/are acting as barriers to the success of the OWVS initiative in practice?

**Anything else?**

7. Are there any other issues associated with the OWVS initiative you'd like to mention that we've not covered?

**Close**

Thanks.

Ensure they have contact details/emphasise can contact if any queries/concerns

## Appendix 6. Details of each non-participant observation

Time Period	Date and time of visit	Number of volunteers	Evaluation Team	DNS on duty
1	1: Wednesday 11 <sup>th</sup> July 10.30 – 13.00	6	a & b	Yes
	2: Friday 13 <sup>th</sup> July 10.30 – 13.00	3	a & b	No
	3: Friday 20 <sup>th</sup> July 10.30 – 12.30	3	b	No
2	1: Monday 3 <sup>rd</sup> Sept. 10.30 – 12.30	2	a	No
	2: Thursday 6 <sup>th</sup> Sept. (visit cancelled as no volunteers expected)	0		
	3: Tuesday 11 <sup>th</sup> Sept. 10.30 – 11.30	0	a	Yes
3	1: Wednesday 14 <sup>th</sup> Nov. 10.30 – 11.30	0	a	Yes
	2: Thursday 29 <sup>th</sup> Nov. 10.30 – 12.30	2	b	No
	3: Friday 30 <sup>th</sup> Nov. 10.30 – 12.00	2	a & b	No

## **Appendix 7. Conversations with ward staff**

### **Welcome and introduction**

Overview of project – Any questions? Have they read the information sheet?  
How are you for time today?

Purpose, format and length of discussion – topics to discuss, note taking  
Ground rules of discussion – e.g. if you say names we'll anonymise, if you  
need to stop pause (e.g. if they are needed/emergency)

Emphasise any concerns re participation to let know

Check OK and START

### **Current role**

- Could you tell me briefly about your role on the ward?
- How much experience do you have with dementia patients?

### **OWVS initiative – first impressions**

- When did you first hear about the WRVS volunteers coming on to the ward?
- What did you understand their role to be?
- How were you informed about the volunteers?
- What were your first thoughts on hearing of the program?

### **Having the volunteers on the ward:**

What do you think about having the volunteers on the ward?

#### **Probes:**

- How do the volunteers identify themselves, do you know who they are?
- Are you involved with the volunteers when they come on to the ward?  
How?
- Do you know when they are coming, do you make plans that include them?
- What time of day do they come on the ward? Are there other times that might work well?
- Who decides which patients they will work with? How is this decided?
- What type of patients do they work with?
- Do they work with single patients, or in groups?

- How many patients might they see per visit, how long would they spend with a patient?
- Do they only work with dementia patients?
- What types of activities do you see them doing?
- How do you communicate with the volunteers about patients?
- How do they respond when asked to see a patient or to do something?
- Do they feedback information to you about patients or issues?

### **Impact of the OWVS initiative (what difference it makes in practice)**

Do you think the volunteers on the ward is a good idea?

#### **Probes:**

- What do you think the impact (positive or negative) of the on-ward volunteers will be (or is having)?
  - > On patients
  - > On their carers/families
  - > On the ward staff
  - > On the MDT
  - > On the organization of care – washing, feeding etc.
  - > On mealtimes
  - > On the ward environment / atmosphere
  - > When the volunteers are not on the ward

Probe: will/do the groups like/dislike having the volunteers around?

Does everyone like them?

- Has the introduction of on-ward volunteers affected your own role/your own work/your time? How?
- Has the OWVS service got better / worse since it first started? In what way?

#### **Barriers and facilitators**

- What factors do you think will help/are helping the OWVS initiative succeed in practice?
- What do you think would help to improve the OWVS?
- If another ward were setting up a similar service, what advice would you give them?

That's everything I had to ask today. Is there anything that you wanted to add that I haven't covered? Anything that you think is important that you want to mention? Thank you for your time.