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Feature Article

Feasibility and acceptability of a volunteer-mediated diversional therapy program for older patients with cognitive impairment

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ABSTRACT

Understanding the perceptions of stakeholders is critical for determining acceptability and feasibility of volunteer-mediated programs. This study evaluated the feasibility and acceptability for staff, volunteers, patients and their carers, of a volunteer diversional therapy program for patients with cognitive impairment undergoing inpatient rehabilitation. Post-program structured interviews were conducted with the volunteers ($n = 10$), patients ($n = 30$) and their carers ($n = 3$); and nursing staff ($n = 6$) participated in a focus group. Thematic analysis identified five themes (values, attitudes, knowledge, purpose, support) in two dimensions (personal, team culture). Overall, patients, carers, staff and volunteers were satisfied with the volunteer program and perceived benefits for quality of care. Recommendations for improvements to the program related to staff engagement with the program and the volunteers' education and training. The volunteer diversional therapy pilot program for patients with cognitive impairment on a sub-acute ward was acceptable and feasible for patients, carers, staff and volunteers.

Introduction

Volunteers regularly offer their assistance to health care organizations and volunteering is promoted as a way for community members to experience personal satisfaction through helping others, developing new skills, confidence and friendships, as well as being part of a team.[1] There has been a steady increase in the demand for volunteers in the health sector to counter decreasing resources and increasing depersonalization of health services.[2] With the increasing numbers and changing roles of the hospital volunteer there is a need for hospitals to be aware of the specialized skills of volunteers and to form strong partnerships with them.[2] Despite this increasing interest and growing use of volunteers in hospitals, few studies have examined the feasibility and acceptability for hospital volunteer programs.

The benefits of involving volunteers in hospitals, including their ability to interact with patients, family, staff and the community, have been well recognized.[2] Volunteers have been used as 'sitters' helping to reduce the risk of adverse events, such as falls and delirium,[3,4] and to provide one-to-one individualized care that meets the needs of patients.[5] Most of the research into volunteer programs has largely focused on health outcomes and to date, only a few studies have investigated stakeholder perceptions. Two previous studies conducted in Australia, using volunteers to monitor patients with a high risk of falling, have evaluated volunteer satisfaction with their programs.[6,7] Both studies used surveys and/or data from interviews/focus groups to understand the volunteers' perceptions of the program. Overall, the volunteers were positive about the programs, however communication between the nurses and the volunteers was identified as sometimes being problematic. Only one of the studies reported the acceptability and feasibility of the volunteer program for the nursing staff and carers.[6] In that study, most of the nursing staff agreed that the volunteer companions were useful in preventing falls and that the role should continue, however, nearly a third of the staff reported that the volunteers required too much supervision. There are few reported evaluations of hospital volunteer programs from the perspectives of all of the stakeholders.[6] The involvement of

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stakeholders, including staff, volunteers, the patients and their carers, is critical to the relevance, uptake and effectiveness of volunteer programs.[8]

The aim of this study was to evaluate the feasibility and acceptability for the patients and their families/carers, volunteers and staff, of a volunteer diversional therapy program for older patients with cognitive impairment in a sub-acute hospital ward.

Method

This study used a qualitative design, and was conducted in a 30-bed inpatient rehabilitation unit in a large regional health service in Australia for a 6 month period from March to September 2011. A volunteer steering group, including health service representatives from nursing, medical, governance and risk management, allied health and human resources, was established to address any workplace issues which arose and to oversee the program.

Participants

Volunteers

Volunteers were recruited through media releases, promotion of the program through the hospital's existing volunteer groups and registrations of interest in the program with the health service volunteer coordinator. Ten volunteers were recruited and two withdrew before the completion of the program study period. All volunteer data, including those who withdrew, were included for analysis.

Patients and carers

Patients admitted to the sub-acute ward were included in the study if they had a cognitive impairment, defined as a Mini Mental State Examination (MMSE)[9] score <25 or a diagnosis of dementia, and had exhibited behavioral disturbance (e.g. agitation or wandering). Carers of eligible patients who consented to be participants were included. Informed consent was obtained from the patients or their carers for the patient's involvement in the program and for structured interviews for feedback on the program. For patients where carer consent was required due to the patient's level of cognitive impairment and/or dysphasia, consent was obtained in the presence of both the patient and carer where possible. No patients who were invited to participate in the volunteer program declined to participate or withdrew.

Staff

All staff ($n = 30$) working on the ward received written invitations to participate in the focus group. Staff members were included in the focus group if they were permanent staff who were available to attend the focus group at the scheduled time and had been exposed to the volunteer diversional therapy program. Seven staff members, including a nurse unit manager and nursing staff, consented to be participants in a focus group conducted post-intervention to explore their perceptions of the volunteer diversional therapy program.

Education

Volunteers were exposed to program-specific education provided by a researcher (AWS), the cognition nurse clinical consultant and the diversional therapist. This education included: (i) hospital induction session (4 h), which included standard general hospital orientation, confidentiality, occupational health and safety and infection control policies and procedures; (ii) diversional therapy program session (2 h), which included information on working with patients with cognitive impairment, person-centered care, program documentation and procedures; and (iii) supervised patient sessions (two mandatory 1 h sessions), including ward orientation, ward safety and reporting procedures and supervised patient session, by the researcher (AWS) and the diversional therapist. The patient sessions provided practical guidance and strategies for volunteers in the use of diversional therapy activities and communication with patients with cognitive impairment. The volunteers' competence related to working with patients with cognitive impairment and following program procedures was based on observations of the volunteer by the researcher (AWS), the health service volunteer coordinator and the diversional therapist, during both the diversional therapy program session and the supervised patient sessions.

Volunteer diversional therapy program procedures

A diversional therapy assessment, completed by the diversional therapist for each patient participant, was used to provide a personal profile of the patient participant, including recreational interests, activity choices and other support needs to assist the volunteer's understanding of the participant and enable person-centered care. The volunteers visited one or more patients on a patient list, compiled by the researcher (AWS) and/or nursing staff, based on patient availability and their willingness to participate. Therapy sessions, medical visits/interventions and visitors took priority over the volunteer visits. The volunteers worked on a one-to-one basis with patient participants. Volunteers provided orientation and diversional therapy activities, using appropriate communication for interaction with a person with memory or thinking difficulties. The volunteer documented the type(s) of activity and the response to activities for each patient participant visited on a volunteer program patient activity form.

Ethics approval for the study was obtained from the relevant university and health service Human Research Ethics Committees.

Data collection

Demographic data (age, gender) for the volunteer participants were collected from their health service volunteer records. Demographic (age, gender) and medical data (diagnosis, cognitive status, fall risk score) for patient participants were collected from their medical records. Cognitive function was measured using the Mini Mental State Examination[9] (MMSE) admission score. Scores on the MMSE range from 0 to 30, with lower scores indicating poorer cognitive function. Cognitive impairment is defined as a score <25 or an abnormal clock face drawing. The 9-item fall risk assessment tool, The Northern Health modified STRATIFY (St Thomas's Risk Assessment Tool In Falling ElderlY inpatients) (TNH-STRATIFY)[10,11] was used to assess the level of falls risk on admission. The TNH-STRATIFY has 9 items, including falls history (current admission; previous 12 months), mental state, mobility, balance, age, toileting needs, vision impairment and drug/alcohol abuse. Total scores range from 0 to 11, with a score of ≥3 indicating a high fall risk. The length of stay was measured from the time of admission to separation. All patient data collected for the study were routinely collected hospital admission information. Demographic information (age, gender) was collected from staff during the focus group. Diversional therapy activity data were collected from the volunteer program documentation. To gain qualitative feedback from the volunteers, patients and carers, structured 1:1 interviews were conducted at the time of the patient participant's discharge from the ward (patients and carers) and with the volunteers after the completion of the intervention program or when they left the program. A focus group was conducted