

Angels of Hope

Professional Health Care Hospice Volunteer Orientation Manual



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WELCOME!!

Welcome! And thank you for choosing to be part of our team of dedicated hospice workers at
Professional Health Care.

Hospice work is challenging and often difficult; but it also brings abundant blessings! As you embark on your own journey into the unique world of the dying and their families, we anticipate many opportunities for your personal growth, challenge, reflection, and fulfillment. We anticipate that your perspective and your experiences with the patients will be an invaluable asset to the hospice interdisciplinary team. We anticipate that you will be blessed and that you will bless the loves of those you serve and support.

Thank you for your desire to enrich the lives of those beginning this special journey. May God bless you as you begin your own journey.

*It is a blessing to others when
God sends you to them
as a voice of encouragement.*

*When they fear the future,
you can bring a word of hope.
When they question the past,
you can bring an assuring answer.
When they wonder
how they can face the day,
you can speak a word of faith.*

*God will use you to help others to press on,
to persevere, to remain faithful.
He will send you as a friend with words spoken from the heart,
as an ambassador with a message from the King,
and as a fellow pilgrim in whose eyes
shine the light of the celestial city.*

- Roy Lessin

INTRODUCTION TO HOSPICE

PHILOSOPHY OF HOSPICE

Hospice has adopted and adheres to the following philosophy:

Death, either of ourselves or of someone important to us, is a process which many face only with great difficulty. Hospice serves to promote the quality of life during the dying phase of life.

The hospice concept of caring for the terminally ill is designed deliberately to help persons through this process at the end of life's journey by encouraging them to cope with the implications of death and separation, as well as freeing them as much as possible from physical and psychic pain.

A community of caring persons is created around the dying in which there is mutual support for the givers of care, for the dying, and for the family. The family is the primary source of care, supported by the family physician and an interdisciplinary team of professionals and trained lay persons.

The care will be planned to meet the physical, emotional, spiritual, social, and economic needs of the dying person and the family. Such care will be given either at home or in an institution with needs of the terminally ill especially in mind. The community of caring persons does not dissolve upon the death of the terminally ill but continues through the process of grieving.

Hospice care expands the options available to and supports the decisions made by the dying person and the whole family about how their needs shall be met during the dying phase of life.

The goal is based upon the following assumptions, which are formulated from those listed by the National Hospice and Palliative Care Organization (NHPCO).

- The dying person AND the family are the unit of care.
- Dying is a normal process and persons are entitled to prepare for death, each in his/her own way.
- The dying person needs an opportunity (an environment) that facilitates living each day of the rest of one's life as one's uniqueness demands, with dignity, self-control, and self-respect.
- The dying person needs relief from pain, from fear of abandonment, and from isolation.
- Pain and physical symptoms of terminal illness can be managed so that suffering is kept within tolerable limits, the goal being a pain-free but alert patient.
- Where the care of a person who is dying takes place varied and depends on the priority needs of both the dying person and family at each point in time.
- Interdisciplinary team care assists the dying person and the family to meet their changing needs and provides the staff mutual personal and professional support.
- Health care professionals and lay persons need understanding of and the ability to cope with the phases of living called "dying" and "bereavement".
- The care of the dying is a process involving needs of the person, the family, and the caregivers.

*"You matter because you are you.
You matter to the last minute of your life,
and we'll do all we can, not only to help you die peacefully,
but to help you live until you die."*

- Dame Cicely Saunders
St. Christopher's Hospice

HOSPICE CARE

Hospice is NOT a place. Hospice is specialized care that provides support and care for persons in the last phases of incurable disease so that they may live as fully and comfortably as possible. Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care, and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain degree of mental and spiritual preparation for death that is satisfactory to them.

Is hospice care giving up hope? Hospice care is a different kind of hope. Hospice us the hope of being free from pain, the hope of improved quality of life, the hope of having the time to say the things that need to be said, and the hope of a peaceful death.

Is There a Difference between Hospice Care and “Palliative” Care?

Palliative care is treatment that enhances, comforts, and improves the quality of the patient’s life. The test of the palliative treatment lies in the agreement by the patient, the primary caregiver, the physician, and the medical team that the expected outcome is relief from distressing symptoms, easing of pain, and enhancement of quality of life. The decision to intervene with an active palliative care treatment is based on the treatment’s ability to meet the stated goals rather than its effect on the underlying disease.

When a person is diagnosed with a terminal illness, and there is no longer an opportunity to cure the disease, hospice is the form of palliative care which is implemented. Hospice care provides alternative care which helps patients to live the rest of their life in comfort and dignity, while providing support to both patient and family. Hospice palliative care focuses on comfort and peace of mind, including medical, social, emotional, and spiritual care.

Who Qualifies for Hospice Care?

In order to meet hospice criteria for palliative care, the patient’s physical must be able to say that the patient has a terminal illness with a life expectancy of six (6) months or less.

Some of the illnesses that benefit from hospice care are:

- Advanced Metastatic Cancers
- End-Stage AIDS
- End-Stage Cardiovascular Disease
- End-Stage Heart (CHF) or Lung (COPD) Diseases
- End-Stage Renal Disease
- End-Stage Alzheimer’s Disease
- End-Stage ALS (Lou Gerig’s Disease)
- Other End-Stage Neurological Diseases
- Multi-Systems Failure

Other signs/symptoms experienced by a patient who may meet criteria for hospice care are:

Physical Symptoms

- *Uncontrolled or increased pain*
- *Increased shortness of breath, oxygen dependence*
- *Increased and profound weakness and fatigue*
- *Progressive weight loss and decline in spite of curative medical therapies*
- *Frequent infections*
- *Frequent hospitalizations*
- *Increased nausea and vomiting*
- *Increased swelling*

Emotional Symptoms

- Anger
- Fear
- Anxiety
- Isolation
- Despair
- Depression

WHAT SERVICES DOES HOSPICE PROVIDE?

A wide range of services are provided by nurses and other health care providers within the hospice program. The services provided by the hospice interdisciplinary team (IDT) include:

Nursing Care: Registered nurses coordinate the care for every patient, provide direct patient care, and check symptoms and medication. Patient and family education is an important part of every visit. The nurse is the link between the patient/family and the physician.

Medical Social Worker: Social workers provide advice and counseling to the patient/family during the crisis period. They assist other team members in understanding family dynamics and act as an advocate for the patient/family in making use of community resources. They help with legal documents such as DNR and medical power of attorney, also with funeral arrangements.

Physician Services: Patient's physician certifies the terminal diagnosis and refers to hospice. The Attending Physician will continue to monitor the patient and coordinate care with the IDT or turn over care to the hospice Medical Director. The hospice Medical Director is available to the Attending physician, the patient/family, and the IDT as a consultant and resource. The Medical Director meets regularly with the IDT to discuss and manage the patient's care.

Spiritual Support and Counseling: Clergy and other counselors are available to visit and provide spiritual support to the terminally ill and their families at home. Programs also use churches and congregations to aid the patient and family as requested.

Home Health Aide and Homemaker Services: Home health aides provide personal care for the patient, such as bathing, shaving, and nail care; and homemakers may be available for light housekeeping or meal preparation.

Trained Volunteers for Support Services: Early hospices were founded and operated by volunteers. These dedicated people continue to be the backbone of today's hospice. They are trained in good listening skills and provide compassionate, non-contact support for both patient and family. They offer companionship and help with everyday tasks such as shopping, meal prep, sitting with patients, reading to patients, and writing letters.

Physical, Occupational, and Speech Therapies: Daily living tasks such as walking, dressing, or feeding oneself can become frustrating and impossible during an illness. Therapists help the patient develop new ways to accomplish these tasks.

24-Hour On-Call Availability: A hospice RN is on call 24 hours a day, seven days a week. If a problem should arise, the RN may offer advice over the phone and, if necessary, make a visit.

Medical Equipment and Supplies: The hospice RN routinely assesses the need for medical equipment and supplies to aid in patient care. Medical equipment may include hospital beds, wheelchairs, walkers; supplies may include adult diapers, incontinence pads, gloves, and wound care supplies. These are included in the hospice service under Medicare and insurance benefits.

Continuous Care in the Home: If the patient's needs require it, or if the family can no longer manage the level of care required, hospice staff will provide short-term care for (8) 24-hour periods.

Hospice In-Patient Care: Although hospice care is centered in the home, it sometimes becomes necessary to admit the patient to a hospital, extended care facility, or the hospice in-patient facility. The hospice can arrange for this care and will stay involved in the patient's treatment, with the family resuming in-home care when appropriate.

Respite Care: To provide relief for family members, the hospice may arrange a brief period of in-patient care for the patient.

Bereavement Care: Bereavement is the time of mourning that we all experience following a loss. The hospice care team works with surviving family members to help them through the grieving process. Support may include a trained volunteer or counselor visiting the bereaved at specific periods during the first year, phone calls and/or letter contact, and the opportunity for family members to participate in support groups. The hospice will refer the bereaved to medical or other professional care if necessary.

THE PATIENT'S BILL OF RIGHTS

The patient's Bill of Rights was first adopted by the American Hospital Association in 1973 and revised in October 1992. Patient rights were developed with the expectation that hospitals and health care institutions translate and/or simplify the bill of rights to meet the needs of their specific patient populations and make patient rights and responsibilities understandable to patients and their families. According to the American Hospital Association, a patient's surrogate or proxy decision-maker can exercise these rights if the patient lacks decision-making capacity, is legally incompetent, or is a minor.

Bill of Rights

- The patient has the right to considerate and respectful care.
- The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information about his/her diagnosis, treatment, and prognosis.
- Except in emergencies when the patient lacks the ability to make decisions and the need is urgent, the patient is entitled to a chance to discuss and request information related to the specific procedures and/or treatments available, the risks involved, the possible length of recovery, and the medically reasonable alternatives to existing treatments along with their accompanying risks and benefits.
- The patient has a right to know the identity of the physicians, nurses, and others involved in his/her care, as well as when those involved are students, residents, or other trainees. The patient also has the right to know the immediate and long-term, financial significance of treatment choices insofar as they are known.
- The patient has the right to make decisions about the plan of care before and during the course of treatment and to refuse a recommended treatment or plan of care if it is permitted by law and hospital policy. The patient also has the right to be informed of the medical consequences of this action. In the case of such refusal, the patient is still entitled to appropriate care and services that the hospital provides or to be transferred to another hospital. The hospital should notify patients of any policy at the other hospital that might affect patient choice.
- The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision-maker and to expect that the hospital will honor that directive as permitted by law and hospital policy.
- Health care institutions must advise the patient of his/her rights under state law and hospital policy to make informed medical choices, must ask if the patient has an advance directive, and must include that information in patient records. The patient has the right to know about any hospital policy that may keep it from carrying out a legally valid advance directive.
- The patient has the right to privacy. Case discussion, consultation, examination, and treatment should be conducted to protect each patient's privacy.
- The patient has the right to expect that all communications and records pertaining to his/her care will be treated confidentially by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the hospital will emphasize confidentiality of this information when it releases it to any other parties entitled to review his/her medical records and to have the information explained or interpreted as necessary, except when restricted by law.
- The patient has the right to expect that, within its capacity and policies, a hospital will make reasonable response to the request of a patient for appropriate and medically indicated care and services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a patient has so requested, a patient may be transferred to another facility. The institution to which the patient is to be transferred must first

have accepted the patient for transfer. The patient must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.

- The patient has the right to ask and be told of the existence of any business relationship among the hospital, educational institutions, and other health care providers, and/or payers that may influence the patient's treatment and care.
- The patient has the right to expect reasonable continuity of care and to be informed by physicians and other caregivers of available and realistic patient care options when hospital care is no longer appropriate.
- The patient has the right to be informed of hospital policies and practices that relate to patient care treatment, and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. The patient has the right to be informed of the hospital's charges for services and available payment methods.

The collaborative nature of health care requires that patients and/or their families and surrogates participate in their care. The effectiveness of care and patient satisfaction with the course of treatment depends, in part, on the patient's fulfilling certain responsibilities.

- Patients are responsible for providing information about past illnesses, hospitalizations, medications, and other health-related matters.
- Patients must take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand the current information or instructions.
- Patients are responsible for making sure that the health care institution has a copy of their written advance directive if they have one.
- Patients are responsible for informing their physicians and other caregivers if they anticipate problems in following prescribed treatment.
- Patients should also be aware that the hospital has to be reasonably efficient and equitable in providing care to other patients and the community. The hospital's rules and regulations are designed to help the hospital meet this obligation.
- Patients and their families are responsible for being considerate of and making responsible accommodations to the needs of the hospital, other patients, medical staff, and hospital employees.
- Patients are responsible for providing necessary information for insurance claims and for working with the hospital as needed to make payment arrangements.
- A patient's health depends on much more than health care services. Patients are responsible for recognizing the impact of their lifestyles on their personal health.

DEATH AND DYING

WORKING WITH THE DYING

Sometimes health care workers believe their duties include shepherding their patients through each of Kubler-Ross' stages until acceptance is attained. Or, they try to fit their patients into the framework of stages by saying things like, "Now he's really in the anger stage!"

We need to recognize that our patients travel on their own path through the dying process. Rather than trying to categorize our patients, we need to remain fully present with them as they make their own way through the process of dying. When we try to hurry our patients into acceptance, we misinterpret Dr. Kubler-Ross' message and serve our own needs for "success" rather than our patients' need to "be".

Instead of thinking about dying in terms of progressive stages, we think of denial, anger, bargaining, depression, and acceptance as several of many "reactions" to news of impending death – reactions that come and go, co-exist, and replace each other from day to day or from hour to hour.

We can also think of reactions to the dying process in the broader terms of avoidance, confrontation, and re-establishment, as described by Therese Rando. Shock, denial, and disbelief help us avoid a frightening reality we are not yet ready to integrate into our lives. As avoidance fades and confrontation with the truth begins, we become highly emotional and filled with anger, rage, envy, and guilt. We're irritable, full of tension, and preoccupied with the bad news and all the losses it implies. However, at some point we begin to integrate the new reality – the new truth – into our being. We don't like the reality we face, but we make adjustments and begin to accept the inevitable.

As we enter the presence of the dying, we must do so without expectations about which reactions the dying person should be experiencing. A terminally ill person who was angry yesterday may be experiencing some acceptance today. New fears and anxieties may have surfaced, or previous ones resurfaced. We need to approach each patient, not with expectations, but with a loving heart and an open mind.

Dying is not a contest – there is no "right" way to do it. Just as in life, some of us will experience more avoidance and some of us will become more confrontational and emotional. As we travel along our path, each of us will experience varying degrees of integration and acceptance. No phase or reaction is better than another. It all just "IS".

THE DYING PROCESS

As a person enters the final stages of the dying process, two different dynamics are at work which are closely related: the physical and the mental-spiritual-emotional.

At the physical level, the body begins the final process of shutting down, which will end when all the body's systems stop functioning. Usually, this is an orderly and non-dramatic process. These physical changes are the normal, natural way in which the body prepares itself to stop, and the most appropriate response is comfort-enhancing measures.

The other dynamic of the dying process occurs on the mental-spiritual-emotional level and is a different kind of process. The "spirit" of the dying person begins the final process of release from the body, its immediate environment, and all attachments. This release also tends to follow its own priorities, which include the resolution of any "unfinished business," such as reconciliation of close relationships and getting permission from family members to "let go". This is the normal, natural way in which the spirit prepares to move from this life into the next dimension of life. The most appropriate response to the mental-spiritual-emotional changes are those which support and encourage this release and transition.

When a person's body is ready and wanting to stop but the person still has unresolved issues, he /she will tend to linger, even though very uncomfortable or debilitated, in order to finish whatever needs finishing. On the other hand, when a person is mentally-spiritually-emotionally ready for this release, but his/her body has not completed its final physical process, the person will continue to live until the physical shutdown is complete.

The experience we call death occurs when the body completes its natural process of shutting down and when the spirit completes its natural process of reconciling and finishing. These two processes need to happen in a way appropriate for the values, beliefs, and life-style of the dying person so that the death can occur as a peaceful release.

The physical and mental-spiritual-emotional signs and symptoms of impending death which follow are offered to help you understand the natural aspects of the dying process which may occur and how you can respond appropriately. Not all these signs and symptoms will happen with every person, nor will they happen in this particular order. Each person is unique, and what has been most characteristic of the way your loved one has lived will affect the way he/she dies. This is not the time to try to change your loved one, but the time to give full acceptance, support, and comfort.

Normal Physical Signs and Symptoms with Appropriate Responses

Coolness – The person's hands and then arms, feet, and then legs may become increasingly cool to the touch, and at the same time, the color of the skin may change. This is a normal indication that the circulation of blood is decreasing to the body's extremities and being reserved for the most vital organs. Keep the person warm with a blanket, but do not use an electric blanket.

Sleeping – The person may spend an increasing amount of time sleeping and appear to be uncommunicative and unresponsive. This normal change is due in part to changes in the body's metabolism. Sit with your loved one, hold his/her hand; do not shake or speak loudly, but speak softly and naturally. Do not talk about the person in his/her presence; speak to him/her directly as you normally would, even though there may be no response.

Disorientation – The person may seem to be confused about the time, place, and identity of people surrounding him/her. Identify yourself by name BEFORE you speak; do not ask the person to guess who you are. Speak softly, clearly, and truthfully when you need to communicate something important for the patient's comfort. Appropriate statements include, "It's time to take your medicine," followed by an explanation, such as, "So you won't begin to hurt". Do not use this method to try to manipulate the patient to meet your needs.

Incontinence – The person may lose control of urine and/or bowel matters as the muscles in that area begin to relax. Discuss with your hospice nurse what can be done to protect the bed and keep your loved one clean and comfortable.

Restlessness – The person may make restless and repetitive motions. This happens often and is due in part to the decrease in oxygen circulating to the brain. (This change also may temporarily alter personality.) Do not interfere with or try to restrain such motions. Speak in a calming, natural way, lightly massage the forehead, read to the person, or play soothing music.

Fluids and Food Decrease – The person may begin to want little or no food or fluid. This means the body is conserving for other functions the energy that would be spent in processing these items. Do not try to force food or drink into the person or use manipulation, as this only makes the person much more uncomfortable. Small chips of ice, frozen Gatorade, or juice may be refreshing in the mouth. Glycerin swabs may help keep the mouth and lips moist and comfortable. A cool, moist washcloth on the forehead may also increase physical comfort.

Urine Decreases – The person's urine output normally decreases due to the reduced fluid intake, as well as a decrease in circulation through the kidneys. Consult with your hospice nurse to determine whether there may be a need for a catheter.

Breathing Pattern Change – The person's regular breathing pattern may change. He/She may experience alternating periods of breathing and not breathing; this is called the "Cheyne-Stokes" symptom and is very common. It indicates a decrease in circulation in the internal organs. Elevating the head may help bring comfort. Hold his/her hand. Speak gently.

Normal Emotional-Spiritual-Mental Signs and Symptoms with Appropriate Responses

Withdrawal – The person may seem unresponsive, withdrawn, or in a comatose-like state. This indicates preparation for release, a detaching from surroundings and relationships, and a beginning of "letting go". Since hearing remains until the end, speak to your loved one in your normal tone of voice, identify yourself by your name when you speak, hold his/her hand, and say whatever you need to say that will help the person "let go".

Vision-Like Experiences – The person may speak to or claim to have spoken to individuals who have died already. The person may say he/she sees or has seen places you cannot see. This is not a hallucination or drug reaction. The person is beginning to let go of this life and is being prepared for the next life so it will not be frightening. Do not contradict, explain away, belittle, or argue about what the person claims to have seen or heard. Just because you cannot see or hear it does not mean it is not real to your loved one. Affirm his/her experiences. They are normal and common. If they frighten your loved one, explain to him/her that they are normal.

Restlessness – The person may do repetitive and restless tasks. This may indicate unfinished business that is disturbing and preventing letting go. The hospice team members will help identify what may be happening and help find ways to help the person find release from the tension or fear. Other things which may help calm the person are to recall a favorite place your loved one enjoyed, read something comforting, play music, give assurance it is okay to let go.

Fluids and Food Decrease – When the person wants little or no fluid, this may indicate that the person is ready for the final shut down. You may help your loved one by giving him/her permission to let go when ready. At the same time, affirm your loved one's ongoing value to you and the good you received from him/her that you will carry forward into your life.

Decreased Socialization – The person may want to be with only a very few or even just one person. This is a sign of preparation for release and an affirmation of who the person needs to support him/her in making the approaching transition. If you are not part of this "inner circle" at the end, it does not mean you are not loved or are not important. It means you have already fulfilled your task with him/her, and it is time for you to say "goodbye". If you are part of the final "inner circle", your loved one needs your affirmation, support, and permission.

Unusual Communication – The person may make gestures or statements that are out of character. This indicates that he/she is ready to say "goodbye" and is "testing" to see if you are ready to let go, too. Accept the moment as a beautiful gift when it is offered. Kiss, hug, hold, cry, and say whatever you most need to say.

Giving Permission – Giving permission to your loved one to let go, without making him/her feel guilty for leaving or trying to keep him/her with you for your own needs, can be difficult. A dying person will normally try to hold on, even though it brings prolonged discomfort, in order to be sure that those who are going to be left behind will be alright. Your ability to release the dying person from this concern and give him/her assurance that it's alright to let go when he/she is ready is one of the greatest gifts you have to give your loved one at this time.

Saying Goodbye – When the person is ready to die and you are able to let go, it is the time to say "goodbye". Saying "goodbye" is your final gift of love to your loved one and makes the final release possible. Say everything you need to say so afterward you won't say to yourself, "Why didn't I say...?" It may be as simple as saying, "I love you." It may include recounting your favorite memories and shared activities. It may include saying, "I'm sorry for whatever contributed to any tensions or difficulties in our relationship". It may also include saying, "Thank you for..." Tears are a normal and natural part of saying goodbye. Tears do not need to be apologized for or hidden from your loved one. Tears express your love and help you let go.

Volunteer Services

VOLUNTEERS IN HOSPICE

Hospice programs rely on trained, compassionate volunteers to provide extra sets of hands and ears for both the patient and the family. With their varied interests and special talents, volunteers can greatly expand both the number and scope of services a hospice program is able to offer.

Hospice volunteers work in many capacities, including helping in the office and with fundraising, cooking or light housekeeping, and staying in the patient's home for several hours at a time so caregivers can take a break. Volunteers also act as a liaison capacity with the community to maintain and increase community awareness and support of hospice care. Most importantly, volunteers act as loving companions who listen with "long ears" to their patient's/family's concerns, anxieties, and joys.

In most other health care settings, volunteers help by delivering mail and assisting with clerical work or fundraising, but rarely are they considered integral parts of the patient's health care team. In hospice, volunteers are an important part of the care team and have the opportunity to contribute greatly to a patient's quality of life. Because patients/family members are sometimes more comfortable talking to a "regular person", volunteers can act as extra ears and eyes for paid staff. Any by working without financial remuneration, volunteers help contain the rapidly escalating costs of health care.

Many hospice programs in the United States were developed by members of the community who volunteers their time to plan and deliver hospice care for the terminally ill. To encourage the continued use of volunteers, Medicare requires hospice programs to provide documentation proving that volunteers provide the equivalent of 5% of the paid staff's hands-on patient care time.

WHO ARE PROFESSIONAL HEALTH CARE VOLUNTEERS?

Professional Health Care volunteers are very special people. They are caring individuals who have taken time out of their own busy lifestyle to offer support and companionship to hospice patients and families.

Our volunteers range in age from 18 years old to 100 years old. They come from all walks of life. While some are homemakers or retirees, others hold full- or part-time jobs. Some volunteers have experienced the benefits of hospice in their own families and desire to volunteer their support and experience to others in need.

Professional Health Care volunteers may be of different races or nationalities, have different beliefs, or have physical limitations, but they all have one common goal – the compassion to help those in need!

QUALITIES OF HOSPICE VOLUNTEERS

- **Minimum age of 18 years old**
- **Compassionate** – Volunteers focus on the needs of patients and/or family members and assist in meeting those needs.
- **Emotional Maturity** – Working as a hospice volunteer can be an intense experience. Volunteers must be up to the task emotionally.
- **Committed and Dependable** – Volunteers are as dedicated to their work as other health care professionals.
- **Comfortable Talking about Death and Dying** – Hospice workers approach death and dying in an open, direct, and practical way. This can help patients and families to prepare for death by giving comfort and support, as well as empowering the patient and family to make informed choices about hi/her care. This brings dignity to the dying process.
- **Accepting of the Differences in other Cultures and Value Systems**
- **Good Communication Skills**
- **Flexibility**
- **Patience**
- **Respect Confidentiality of Patient Information**
- **Sense of Humor** –
 - “Humor, like hope allows one to acknowledge and endure what is otherwise unendurable.” – Gail Sheehy
 - “Sometimes a laugh is the only weapon we have.” – Roger Rabbit

ROLES OF A HOSPICE VOLUNTEER

CELEBRANT OF LIFE

- Help patients and their families live life to the fullest.
- Help celebrate life events, such as birthdays, holidays, etc.
- Encourage patients to tell stories. Life stories are told and retold. Patients and families have a need to reminisce with a caring, non-judgmental listener.

TRUSTED CONFIDANT

- Demonstrate compassion and respect. Patients and family members may often tell volunteers things they would not tell each other.
- Be a good listener. Patients and family members may pour out their hearts when you spend time with them.
- Always respect principles of CONFIDENTIALITY.

COMPANION TO OVERCOME LONELINESS

- Be a presence to provide comfort and support. Words sometimes are unnecessary.
- Your presence reminds the patient/family that they are cared for by others. Patients will let you know if they want to be alone.

FAMILY HISTORIAN

- Review life experiences.
- Write/Tape/Record memoirs/thoughts.
- Reflect on good things in life rather than focus on illness.
- Ask questions. “What kind of work did you do?” “How did you meet your spouse?” “What is your favorite childhood memory?” “What do you want people to know about you?” “What is the legacy you want to leave?”

MENTAL HEALTH PROVIDER

- Provide relief/respice time-out for a caregiver to rejuvenate, run errands, etc.
- Ask: “What do you do for a break?”
- Encourage caregivers to take care of and nurture themselves.

We encourage our volunteers to use their creative skills when working with our patients, families, and staff. As you learn about your patients’/family’s beliefs, hobbies, interests, tastes, dietary requirements, etc., you may want to cook something special for them, bring them something you’ve made, share a story or a spiritual reading, engage them in a hobby or game... The possibilities are endless. Just remember to respect your patients/family’s likes and dislikes, and remember to enjoy yourself.

THE VOLUNTEERS' BILL OF RIGHTS

Volunteers deserve...

- The right to be treated as a co-worker – not as free help
- The right to a suitable assignment, with consideration for personal preferences, temperaments, life experiences, education, vocational and ad vocational backgrounds. The assignment should offer the opportunity for growth and development.
- The right to know as much about the organization as possible.
- The right to thorough training for the position applied for.
- The right to continuing education on the job.
- The right to sound guidance and direction by someone who is experienced, patient, well-informed, and thoughtful.
- The right to a comfortable workplace.
- The right to a variety of experiences.
- The right to recognition.
- The right to be treated as a significant member of the team.

HOSPICE VOLUNTEER CODE OF ETHICS

In accepting your volunteer assignment, you also accept responsibilities and some restrictions. A volunteer is subject to the same code of ethics governing the professional staff of **Professional Health Care**. It is important therefore:

To respect all information as confidential.

It is your moral obligation not to reveal the name, diagnosis, or any other information about any patient and/or family.

To be dignified and pleasant.

Your dignity will inspire confidence. Your courteous manner should be extended to everyone – patients, families, staff, and other volunteers. your cheerfulness and willingness to help will be appreciated by the terminally ill and their anxious family and friends.

To follow instructions

Every regulation and procedure has a reason, and these are designed for the good of the patients and families.

To remember that, while volunteering, you represent Professional Health Care.

Conduct yourself so that you and **Professional Health Care** will be respected. The greatest discretion should be used in mentioning at any time criticism of a patient, family member, or **Professional Health Care** while you are working or visiting. If you feel something should be brought to the company's attention, please report it to the Volunteer Coordinator. This will help in avoiding difficult situations and in seeing the problems are handled properly.

VOLUNTEER VISITS

VISITATION GUIDELINES FOR HOME PATIENTS

- Call in advance so the family to set a time to visit and/or a regular visitation schedule.
- Telephone the family one hour prior to the visit to verify that you are coming. Be aware if the possibility of the family changing their plans at the last minute.
- Never be critical or judgmental of a patient's living conditions.
- Communicate with the family regarding what you can and cannot offer in terms of time and availability. This will prevent awkward and possibly painful misunderstandings at another time. It is helpful to ask the family to outline their needs and expectations at the beginning (with the stated understanding that these may change as the patient's condition changes), and to indicate how you can help fill these needs.
- Regular telephone calls to check in" are often appreciated, and sometimes result in meaningful and substantive conversations. Some people find it easier to open up in an unplanned phone contact than during a scheduled visit.
- **IN THE EVENT THAT THE DEATH OF A HOSPICE PATIENT OCCURS WHILE A VOLUNTEER IS IN THE HOME:**
 - The volunteer should call the **Professional Health Care** Hospice office immediately.
 - The volunteer should NOT call 911.
 - Remain calm and comforting.
 - Stay with the family until another hospice team member arrives.

DO'S AND DON'TS OF HOSPICE PATIENT VISITS

DO:

- Wear your Professional Health Care name tag.
- Familiarize yourself with the patient's needs, general condition, and attitude before visiting.
- Be punctual and dependable
- Report to the Volunteer Coordinator the needs of the patient/family which may be met through Professional Health Care or community resources. (Realize that discussion of problems with the Hospice Team does **NOT** betray confidences. The sharing of information can be important in adjusting the plan of care to better serve the patient and family.)
- Be sensitive to the patients/family's need for privacy.
- Be a good listener. Be attentive to "leads" about areas of interest.
- Touch (if you AND the patient/family are comfortable with physical contact)
- Leave the patient/family with an opportunity to set up a schedule when you will return.
- Call the hospice office if you are ever in doubt about anything. It is easier to make a telephone call than it is to make a mistake.
- Relate to the patient – not the illness.
- BE YOURSELF!
- ENJOY YOURSELF!

DON'TS

- **Administer medications!** (even if the medication has been pre-measured)
- Transport patients or families anywhere.
- Provide sweets or other foods without checking with the nurse regarding dietary restrictions.
- Visit if you have even the slightest cold.
- Serve the patient any alcoholic beverage without the physician's written permission.
- Use alcohol before making your visit.
- Smoke in the patient's presence.
- Wear cologne or perfume in patient's presence. (Often medications can alter one's sense of smell, making certain scents offensive to the patient.)
- Take money for services rendered.
- Give out personal numbers. (Have the patient/family contact the office if they need to reach you.)
- Become involved beyond your capabilities – emotionally, physically, or in counseling.
- Feel that you must know all the answers or have a solution to every problem. It is okay to say "I don't know" or "I'll try to find out for you".
- Stay too long unless the patient really wants you to "be there". You may say, "We don't need to talk if you're tired. If you like, I can sit here and hold your hand."