



HEALTH CANADA

Secretariat on Palliative and End-of-Life Care

Best Practices and Quality Working Group

Task Group on Best Practices and Quality in the Volunteer Component

Our symbol is the Inukshuk in its traditional meanings:

To identify the best road to follow...

*To remind us of our dependence on each other
and the value of strong relationships.*

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Dear Colleagues,

Welcome to the *Task Group on Best Practices and Quality in the Hospice Palliative Care Volunteer Component*. We hope you will become involved in this important national initiative.

This packet of materials will provide you with the resources to understand the history and mandate of the Task Group and to join us in the work we have been asked to complete: **A Model for Volunteer Best Practices in Canadian Hospice Palliative Care**.

Your participation is the key to creating this a companion document to the Canadian Hospice Palliative Care Association's (CHPCA) *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice* (March 2002) for all aspects of volunteer services in hospice palliative care.

This work will help us address the essential question: "What constitutes core competencies and best practices for our work in the Volunteer Component, and how do we assure quality to those we serve?"

The model we jointly create over the next several years will be powerful. It will enable all programs, no matter how big or small, to address some key issues:

- What are the best principles and norms for volunteer resource management?
- How do we need to prepare volunteers for their work with patients, families and the other members of the team?
- What impact do volunteers have on patient and family goals and choices?
- How do volunteers feel about their work and the programs they serve?
- Are there gaps in the service we offer?
- How can our programs evolve to new levels of service?

Hospice palliative care volunteer services exist in many environments, with many levels of sophistication, numerous challenges and resource needs. With all the differences, however, we seek the common elements: the values and principles that are essential to our work.

The **Volunteer Model** that emerges from this consultation process will affirm the many exceptional efforts that have been made to guide the Volunteer Component. Many of our colleagues have worked to develop provincial standards of practice or have created many training courses and curricula to provide new volunteers with the

learning they need to begin their practice. The Task Group values and honours these efforts. We believe that the **Volunteer Model** will guide and support all of us in our goal to provide the highest quality care for patients and family members, and the highest quality involvement in the caring teams of which we are a vital part.

The Secretariat on Palliative and End-of-Life Care has partnered with the Canadian Council on Health Services Accreditation to develop accreditation standards for hospice palliative care. With the work of the Task Group, and its close connection to this initiative, **we believe that we are approaching a significant turning point for the understanding and valuing of the work of hospice palliative care volunteers.** Indeed, we see the development of the **Volunteer Model** leading the way to a new level of teamwork and interdependence.

The Task Group offers these materials not as a final product, but rather as a catalyst to help get the Canadian consultation process started. **Our guidance must come from the collective experience of volunteers and those who support them.** That is where we will find the competencies, best practices and quality criteria that we can shape into a Canadian framework.

Your involvement

You will have a chance to be involved in a number of ways:

- **Share this document** with volunteers, other team members, Board members and key partners.
- **Choose a communication contact** for your organization to liaise with the project.
- **Gather a local list of people** willing to be involved in providing input and reviewing the draft document as it emerges.
- **Gather this group** to do the exercise on page 14-15 to generate input information, and send it to us **by February 27, 2004.**
- **Commit yourself to the role of champion** and advocate for the process and become part of our *extended working group*. To do so, contact one of the Task Group members closest to you by e-mail or phone.
- **Use the Feedback Sheet** to let us know how you want to take part.

We need your or your group's input by **February 27, 2004**, to be able to consider it for inclusion in the Volunteer Model (see pages 11 and 14 of the attached document). On March 13-14, we will host a Canadian Working Forum in Montreal with invited delegates to develop the working draft. **If you would like to be considered as a delegate (all expenses paid), please contact me by February 13th.**

Please study these materials closely, and make a commitment to be involved. This is an opportunity for convergence with all our colleagues toward the humanistic values that the hospice palliative care volunteer component has always represented.

Sincerely,

Jerry Rothstein, Task Group Chair

*Volunteers are leaders on the Canadian soil, sea to sea.
We are Inukshuk guiding the souls
On the way in, on the way out...*

A MODEL FOR VOLUNTEER BEST PRACTICES IN CANADIAN HOSPICE PALLIATIVE CARE

Contents of this information packet

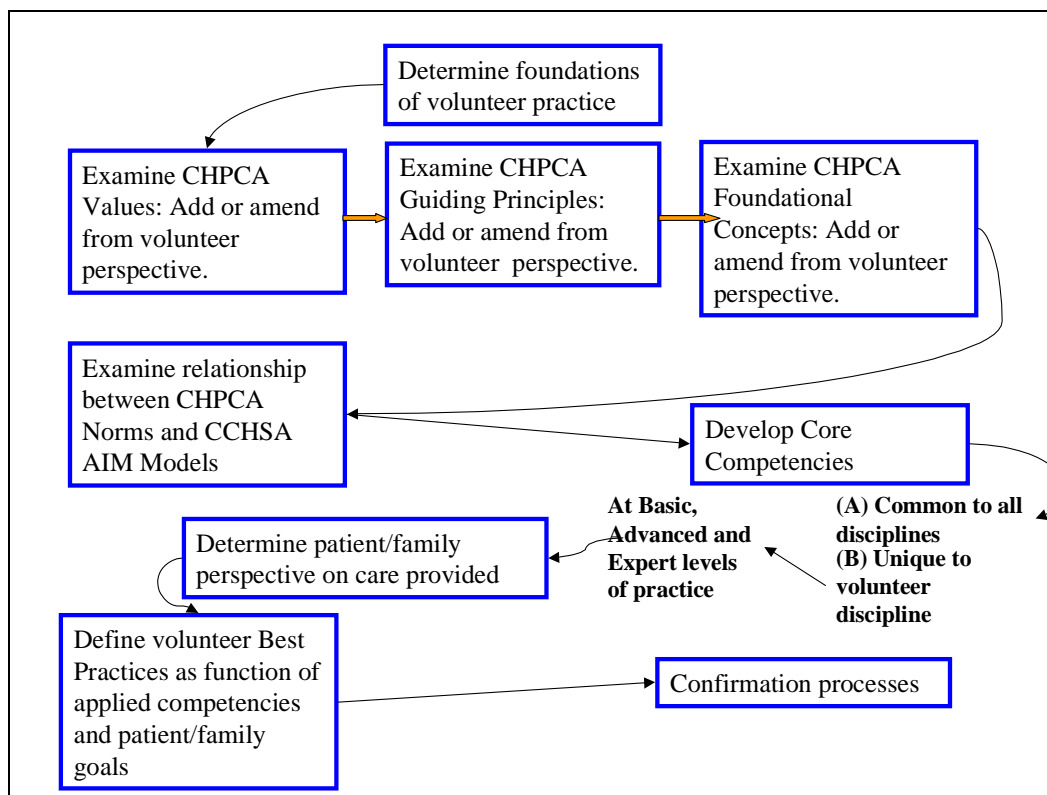
- Page 4 Flowchart and project goals
- Page 5 A first draft of **Foundational Principles** of volunteer practice created by the Task Group
- Page 6 A Volunteer Component perspective on the CHPCA Model: Values, Guiding Principles, and Foundational Concepts
- Page 8 Accreditation: overview of the Canadian Council on Health Services Accreditation (CCHSA) and its Achieving Improved Measurement Model (AIM)
- Page 9 Convergence: showing the relationship of CHPCA Model to AIM
- Page 11 The Task Group **Model**: how volunteer competencies relate to best practices and quality care at all levels of practice, from novice to expert
- Page 13 The Task group consultation process: how you can be involved
- Page 14 A **Feedback Sheet** for you to use to begin involvement with the Task Group
- Page 15 A **Time Line** for the project from its start to 2005 and beyond
- Page 15 **History**: significant developments in the Volunteer Component that have led to this initiative:
 - ◆ The development of national norms and principles
 - ◆ The formation of a National Volunteer Interest Group and a Standing Committee on Volunteer Issues by the Canadian Hospice Palliative Care Association
 - ◆ Federal Government involvement in hospice palliative care, culminating with the establishment of a Secretariat on Palliative and End-of-Life Care and its mission to create a national strategy
 - ◆ Alliance of the Secretariat with the Canadian Council on Health Services Accreditation and a commitment to create national accreditation standards for all forms of hospice palliative care programs
- Page 17 A **Worksheet** that will help you get started in thinking about competencies and best practices
- Page 20 Task Group members and contact information

A Model for Volunteer Best Practices in Canadian Hospice Palliative Care

Background Materials

Welcome. Our goal is to reach a national consensus on the competencies, best practices and quality dimensions of the hospice palliative care Volunteer Component,

We explore the following Flowchart in detail in the following pages.



What will the Volunteer Model accomplish?

- Every program will be founded on norms, competencies and best practices for organizational quality and quality of care. There will be evidence about the work of the Volunteer Component and the results of research will be adopted into planning and decision-making. The Volunteer Model will encourage convergence in our thinking about the work we do, a deeper sense of teamwork with all our colleagues and will guide our work while retaining the flexibility to change with changes in the landscape, the climate and the community.
- It represents the effort to build a wider community of hospice palliative care volunteers and Volunteer Service managers and trainers and affirms a commitment to quality and to evidence-based practice.
- The Volunteer Model embodies a cultural change in perception and learning and our culture is our curriculum from which we can learn and grow.
- We'll have a Canadian perspective on the work of programs at all levels and acknowledge the uniqueness, variety, community presence and caring of Volunteer Services in all contexts
- We'll be able to affirm and enhance efforts from small to large, rural to urban, poorly funded to less poorly funded.
- Programs will be able to identify gaps in service and access expertise and information to help address program, patient and family, and team needs.

Foundations of Volunteer Practice in Hospice Palliative Care

The Task Group believes that volunteers in hospice palliative care constitute a **discipline**, analogous to the disciplines of counselling, medicine, nursing, spiritual care and other clinical components in our field. A disciple is one who follows a teaching and, in turn, teaches others. Thus, to recognize hospice palliative care volunteers as a discipline reminds us that our practice is grounded in deep values and principles.

We used the CHPCA's **A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice** to stimulate our thinking. We offer the following **overarching concepts** as a first step in defining a consensus-based list.

- ❑ Working from commitment
Volunteers are deeply committed to their work. We need to identify and explore the nature of that commitment with them.
- ❑ Volunteers are essential members of the interdisciplinary team
Volunteers work in partnership, and offer support to each other and the team.
- ❑ Accountability and quality
As part of the interdisciplinary team, hospice palliative care volunteers are *formal caregivers*, accountable to their program's values, standards, principles and norms.
- ❑ Self-reflection, self-exploration and deepening self-awareness
The person who chooses to enter the world of a dying person and offer his or her presence needs to be self-aware.
- ❑ Openness to ongoing learning
Volunteers receive much from patients and family members with whom they work. This deep learning needs to be enhanced through the program's efforts to help the volunteer move from novice to expert in practice over time.
- ❑ Respect
The volunteer affirms the personhood and inherent dignity of each person, through his or her willingness to be with them.
- ❑ Understand the importance of sharing
Sharing moments with a fellow being, whether patient, family or team member requires the ability both to give and to receive.
- ❑ Whose needs am I addressing?
Distinguishing, in the moment, between patient, family, team and personal needs and being able to prioritize appropriately.
- ❑ Uniqueness of each situation
Assessment and awareness of the special qualities of each person, in each situation.
- ❑ Being vs. doing
The central challenge for the volunteer is how to be actively present for the person he or she is accompanying. This presence and openness to the person in the moment conveys a unique message of acceptance.
- ❑ Adjusting to change
Volunteers are present as patients and family members experience the changes of advancing illness. They are affected, too, by organizational and community changes that impact on their work.
- ❑ Take the time you need
So much of what we do in working with patients, family members and team requires an open-ended time frame. Attentiveness, accompanying, being actively present, simply cannot be rushed.
- ❑ The sense of urgency
When patient, family or team discomfort is present, volunteers recognize the urgency to restore comfort and prioritize their work to achieve this end.
- ❑ Acceptance of difficult feelings
Volunteers recognize that they will at times experience a sense of failure or helplessness and have the need for support.
- ❑ Death happens
Awareness that a person's death really is the outcome—often unexpected, often not according to plan.
- ❑ Necessity to mourn
Feelings of grief and loss are part of our relationships with patients and families.

□ Making a difference

Given the uniqueness of persons and situations, the complexity of care, the mystery we are often involved with, you never can tell what will make a difference for someone in this moment. This can be a liberating concept for volunteers and all team members.

These essential **principles of practice** are deeply embedded in hospice palliative care volunteers' work. As with the Inukshuk, these concepts guide our practice but are not sufficient in themselves. We need to be able to read all the available signs in their context: the weather, the terrain, the season, the presence of unexpected company...

Examining the CHPCA Model through the lens of the Volunteer Component

The seven Values of the Model represent a Canadian consensus. Our intent is to view them through the lens of the Volunteer Component and propose additions and clarifications. The same process was used for the Guiding Principles and Foundational Concepts. *All italicized points are additions made by the Task Group from the Volunteer Perspective.*

All hospice palliative care activities recognize and support the following values:

- V-1: The intrinsic value of each person as an autonomous and unique individual.
 - *Includes all team members.*
- V-2: The value of life, the natural process of death, and the fact that both provide opportunities for personal growth and self-actualization.
- V-3: The need to address patients' and families' suffering, expectations, needs, hopes and fears.
- V-4: Care is only provided when the patient and/or family is prepared to accept it.
- V-5: Care is guided by quality of life as defined by the individual.
- V-6: Caregivers enter into a therapeutic relationship with patients and families based on dignity and integrity.
- V-7: A unified response to suffering strengthens communities.
- *V-A: Volunteer Component is an essential part of the hospice palliative care team.*
- *V-B: Volunteers engage with patient/family in dialogue (this will be elaborated in the process of developing the Volunteer Model).*
- *V-C: Volunteers need to meet patient and family "where they are."*
- *V-D: Volunteers provide care in a respectful, non-judgemental manner.*
- *V-E: The need for self-reflection and self-care is fundamental for volunteers.*

Examining the CHPCA Guiding Principles

The following principles guide all aspects of hospice palliative care:

- GP-1: The intrinsic value of each person as an autonomous and unique individual.
- GP-2: High quality. All hospice palliative care activities are guided by:
 - The ethical principles of autonomy, beneficence, nonmaleficence, justice, truth-telling and confidentiality
 - *The definition of justice needs to be expanded to include equitable sharing of resources and access to resources.*
 - Standards of Practice that are based on nationally accepted principles and norms of practice, and standards of professional conduct for each discipline.
 - *Ongoing monitoring and evaluation of the Volunteer Component is essential. Data collection and documentation guidelines are essential to the Volunteer Component.*
- GP-3: Safe and effective. All hospice palliative care activities are conducted in a manner that:
 - Ensures safety and security for all participants
 - *Provides planned, formalized support for paid and volunteer staff.*
 - *Volunteers have the right to refuse an assignment if it challenges their own wellness, safety or well being.*
- GP-4: Accessible. All patients and families [*should*] have equal access to [*appropriate*] hospice palliative care services, wherever they live...in a timely manner.

- Ensures safety and security for all participants
 - *Volunteer support is available in the patient's home and in all other care settings.*
 - *Volunteer services shall be well planned for a geographical area.*
- GP-5: Adequately resourced. The financial, human, information, physical and community resources are sufficient to sustain the organization's activities, and its strategic and business plans. Sufficient resources are allocated to each of the organization's activities.
 - *Sufficient resources are allocated for hospice palliative care Volunteer Component to meet the needs of patient and family.*
- GP-6: Collaborative. Each community's needs for hospice palliative care are assessed and addressed through the collaborative efforts of available organizations and services in partnership.
 - *Programs and communities need to examine the consequences of not seeing Volunteer Components as part of the community's hospice palliative care program.*
- GP-7: Knowledge-based. On-going education of all patients, families, caregivers, staff and stakeholders is integral to the provision and advancement of quality hospice palliative care.
- GP-8: Advocacy-based. Regular interaction with legislators, regulators, policy makers, healthcare funders, other hospice palliative care providers, professional societies and associations, and the public is essential to increase awareness about, and develop, hospice palliative care activities and the resources that support them.
 - *Volunteers can play a unique role in advocacy within the scope of their job description and agency policies.*
- GP-9: Research-based. The development, dissemination and integration of new knowledge are critical to the advancement of quality hospice palliative care.
 - *The Volunteer Component has a responsibility to advocate for inclusion in research initiatives in the field. For example:*
 - *Volunteer's motivations, needs, expectations, satisfaction*
 - *Their impact on care and outcomes of care*
 - *Their impact on team*
- *Task Group suggests the addition of a new Guiding Principle:*
 GP-10: *Hospice palliative care is committed to a learning model that includes mutual dialogue among all patients/families and caregivers concerning their needs, available resources, and the kinds of decision they have the right to make.*

Examining CHPCA Foundational Concepts

- FC-1: Effective communication is fundamental to both the processes of providing care and the function of a hospice palliative care organization.
 - FC-1.1: Share a common language and understanding of the definitions of the terms they use during the process of providing care.
 - *It is incumbent on the Volunteer Component to provide information to the volunteers on clinical terminology in lay language.*
 - FC-1.2: Use a standard protocol to communicate, and to listen and respond to the reactions that information creates.
 - *The Volunteer Component respects the uniqueness of each person, and offers training to volunteers to be effective communicators and sensitive listeners.*
 - FC-1.3: Collect data that documents the patient's and family's status and provides a record of each therapeutic encounter.
 - *The volunteer team member will record and/or share relevant information about their interactions with patient and family in accordance with agency policies.*
 - *Volunteers respect confidentiality and will not report privileged information unless it affects the health and well being of the patient/family. If the privileged information needs to be shared, the volunteer will inform the patient/family.*
 - FC-1.4: Educate patients, families, caregivers....
 - *The education of volunteer caregivers includes opportunity for self-exploration and self-reflection and understanding of the importance of sharing.*

- *The education of volunteer caregivers will include exploration of difficult feelings, sense of failure, and the encounter with loss and grief that comes with working in hospice palliative care.*
 - FC-2: Effective Group Function. All activities related to hospice palliative care revolve around multiple groups that have specific purposes and tasks:
Groups in hospice palliative care include:
 - FC-2.1: Patient and family....
 - *The education of volunteer caregivers includes exploration of family and experiences during illness and bereavement.*
 - FC-2.2: The care team...
 - FC-2.3: Regional team of caregivers.
 - *The education of the volunteer caregiver includes information about the function and dynamics of the interdisciplinary team. The volunteer caregiver is a Formal Caregiver as defined by the CHPCA Model: members of an organization are accountable to defined norms of conduct and practice.*
 - FC-2.4: The organization's management team(s), committees and workgroups.
 - *The Volunteer Component Manager or representative must be a member of the organization's management team or decision making body.*
 - FC-3: Ability to facilitate change. Hospice palliative care aims to help patients/families manage the challenges and opportunities they face during their changing illness and bereavement experiences. To fulfil that goal, caregivers must be skilled in maximizing openness and adaptability in the attitudes, knowledge, skills and behaviours of everyone involved in the therapeutic relationship. They must also have specific skills to assist patients and families through the transitions they experience during illness and bereavement.
 - *The specific skills of volunteers are not to be agents of change but to accompany the patient and family, to value their journey and to support the life being lived through the transitions experienced during illness, death and bereavement. Volunteers are present and responsive to patients and families and give the time needed to respond to the uniqueness of each person and situation.*

Relationship of CHPCA Model to CCHSA AIM Accreditation Program

Achieving Improved Measurement (AIM) is the Canadian Council on Health Services Accreditation's Model for assessing the strengths and weaknesses of programs seeking accreditation. CCHSA is now partnering with the Best Practices and Quality Care Working Group to develop accreditation standards for hospice programs in the community and in institutions. This will be a tremendous boost for hospice palliative care in Canada, and for the Volunteer Component as well. We will demonstrate an overview of the AIM framework, including quality domains and dimensions. We will illustrate the convergence between AIM and the CHPCA's Model to Guide Hospice Palliative Care. This convergence will allow hospice palliative care accreditation to develop fully consistent with the values, principles and foundational concepts on which we have already reached consensus through the work of the Canadian Standards Committee. The AIM and CHPCA Models challenge us to examine our practice, to develop clear understanding of competencies and to work toward best practices. As the Task Group process continues we'll be addressing all these goals.

Achieving Improved Measurement:

Canadian Council on Health Services Accreditation

The four quality dimensions with their quality dimensions/descriptors are:

- **Responsiveness**
 - Availability
 - Accessibility
 - Timeliness
 - Continuity

- Equity
- **System Competency**
 - Appropriateness
 - Effectiveness
 - Legitimacy
 - Competence
 - Safety
 - Efficiency
 - System Alignment
- **Client/Community Focus**
 - Communication
 - Confidentiality
 - Participation and partnership
 - Respect and caring
 - Organization responsibility and involvement in the community
- **Worklife**
 - Open communication
 - Participation in decision making
 - Role clarity
 - Learning environment
 - Well-being

Convergence of CHPCA and CCHSA Models

The following figures illustrate the convergence of two independently developed models. Using specific examples from the AIM and CHPCA texts, we show how AIM standards are equivalent to CHPCA principles, and AIM criteria are equivalent to CHPCA norms.

AIM Standards

The team accurately and appropriately assesses its clients

After transition or the end of service, the clients' ongoing needs are met and continuity of services is maintained.

The team's services are integrated and coordinated to ensure continuity of service for the population it serves.

The use of medications and other therapeutic technologies is safe, efficient, and effective and promotes the best possible quality of life.

The team gives its clients and families all the relevant information about its services.

The team protects and promotes the rights of the clients and families.

CHPCA Principles

Assessment guides clinicians to identify and understand each of the issues, risks and opportunities related to the patient's and family's illness.

There is continuity (a) of the plan of care and information across all settings of care, and among all caregivers and organizations, which are involved in the care team; (b) of the caregivers providing care.

All aspects of care are prioritized and delivered in a safe and timely manner.

It is a patient's and family's right to be informed about hospice palliative care and what it can offer through their illness and bereavement experiences.

All care is provided in a manner that (a) is respectful of the patient and their choices; (b) is understandable and acceptable to them; (c) maintains their sense of dignity; (d) maintains their privacy; (e) provides ample opportunity for intimacy.

AIM Criteria

The team uses the information it collects about service needs to define the scope of the services it offers.

The team integrates and co-ordinates its services with other providers, services, organizations or sectors.

Assessment is carried out by qualified individuals, using accepted methods and tools, in a safe manner and environment, with adequate resources.

The goals and expected results suit the client's capacities and needs [and choices], are possible, and can be measured.

The length of time it takes to deliver the services, how often they are delivered and the methods used are appropriate given the client's set goals and expected results.

The most appropriate team member provides information to clients and families.

There is evidence that the team is achieving its goal and desired results or outcomes.

The team regularly evaluates and improves the quality of its services by selecting and monitoring indicators, collecting and analysing data, identifying areas to improve, sharing results and changes made.

CHPCA Norms

The plan and setting of care are reviewed regularly by the care team and/of the organization's regional team and adjusted to compensate for changes in the patient's and family's status and choices.

The patient's and family's goals for care are assessed regularly.

The patient and family prioritize the importance of each of the identified issues.

All approaches to delivering care are reviewed regularly and adjusted to compensate for changes in the patient's and family's status and choices.

A designated formal caregiver leads, co-ordinates and facilitates care team activities and functions.

By the end of each therapeutic encounter, the formal caregiver assesses the patient's, family's and informal and formal caregivers' satisfaction with the process of providing care and their overall situation; perception of the complexity of the situation; perception of the level of stress; concerns, questions and desire for additional information; ability to participate in the plan of care.

OUR MODEL INTEGRATES CHPCA NORMS MODEL AND CCHSA AIM ACCREDITATION FRAMEWORK

Column 1	Column 2	Column 3	Column 4	Columns 5 to 7	Column 8	Column 9
Four AIM Quality dimensions	22 AIM Descriptors	AIM Standards and CHPCA Principles	AIM Criteria and CHPCA Norms	Best Practices continuum Basic, Advanced, Expert	Indicators and results of monitoring them	Confirmation: Repeat review rethink re-plan

Column 1 lists the four quality dimensions of CCHSA's AIM model:

- **Responsiveness**
- **System Competency**
- **Client/Community Focus**
- **Work Life**

Column 2 lists the AIM descriptors associated with each dimension:

- **Responsiveness** includes the five descriptors of Availability, Accessibility, Timeliness, Continuity, and Equity.
- **System Competency** includes the seven descriptors of Appropriateness, Competence, Effectiveness, Safety, Legitimacy, Efficiency, and System Alignment.
- **Client/Community Focus** includes the five descriptors of Communication, Confidentiality, Participation and Partnership, Respect & Caring, and Organization Responsibility & Involvement in the Community.
- **Work Life** includes the five descriptors of Open Communication, Role Clarity, Participation in Decision-making, Learning Environment, and Well-being.

Column 3 is for listing the standards associated with each descriptor. AIM "standards" are equivalent to the Norms Document "principles."

Column 4 lists the performance criteria associated with each descriptor. The AIM criteria are equivalent to the CHPCA Norms of practice. The performance criteria from AIM are cross-referenced with one or more of the **Square of Care** processes of providing care and **Square of Organization** functional areas defined in the Norms Model.

The six **Square of Care** processes are Assessment, Information-Sharing, Decision-Making, Care Planning, Care Delivery, and Confirmation. In addition, we propose a number of other important categories of competency/best practice: Advocacy, Team Functioning and Self-Reflection, Learning and Teaching.

The five **Square of Organization** functional areas are Governance and Administration, Planning, Operations, Quality Management, and Communications/Marketing.

Columns 5 to 7 are for representing **Competencies** as the foundation of **Best Practices** as a continuum of ability, ranging from entry or "novice" level, to advancing practice, and on to expert. The transition of changing from one level to the next is a gradual and continuing process of advancement, as "Best Practice" is meant to be a relative, not a rigid and absolute term. There are multiple ways to support this advancement, including education, mentoring, in-service training, experience, workshops and discussion groups, etc. It is desirable to have an individual learning plan for each team member.

Column 8 allows the organization to list the **performance indicators** it wishes to use.

Column 9 represents the **quality improvement** dimension of review and modification to improve services.

Expansion of Columns 5 to 7: Core Competencies and Best Practices in the Volunteer Component			
CHPCA Processes of Providing Care	Basic or "Ready to Practice"	Advanced	Expert

▪ ASSESSMENT	▪	▪	▪
▪ INFORMATION-SHARING	▪	▪	▪
▪ DECISION-MAKING	▪	▪	▪
▪ CARE PLANNING	▪	▪	▪
▪ CARE DELIVERY	▪	▪	▪
▪ CONFIRMATION	▪	▪	▪
▪ Additional Competency Categories	▪	▪	▪
▪ ADVOCACY	▪	▪	▪
▪ TEAM FUNCTIONING	▪	▪	▪
▪ SELF-REFLECTIVE PRACTICE	▪	▪	▪
▪ LEARNING & TEACHING , RESEARCH, ▪ EDUCATIONAL REQUIREMENTS	▪	▪	▪

In each section of this table, we'll be looking for the competency elements that enable a team member to provide the kind of process in question.

Competency elements include knowledge, skills, attitudes and awareness, discernment and judgement.

Worksheets at the end of this document provide an opportunity to explore competencies from the volunteer and volunteer manager point of view.

The Task Group Consultation Process

The Task Group sees core volunteer competencies as the starting point for understanding best practices and quality.

We suggest that best practices can be defined as a function of applied competencies **and** patient/family goals. The Picker Institute has surveyed over 75,000 health care recipients, providing a better understanding of quality through the patient's eyes. These dimensions of care echo the values and deep principles of hospice palliative care:

- Respect for patient's values, principles and expressed needs.
- Co-ordination and integration of care.
- Information and education.
- Physical comfort.
- Emotional support and alleviation of fear and anxiety.
- Involvement of family and friends.
- Transition and continuity.

The next phase of the Task Group's work involves our entire hospice palliative care volunteer community in drafting ideas of volunteer core competencies in all areas of practice.

Here's How You Can Get Involved

1. Complete and return the Feedback sheet on the following page, by **February 27, 2004**.
2. Choose a communication contact for your program to liaise with the Task Group.
3. Share this document with volunteers, other team members, Board members and key partners.
4. Gather a local list of people willing to be involved in providing input and reviewing the document as it emerges.
5. Commit yourself, or recruit someone in your program to advocate for the process and become part of our *extended working group*. Members of this group will be eligible to attend our Canadian Working Forum on Volunteer Best Practices, March 13-14, 2004, in Montreal with all expenses paid.

TASK GROUP ON VOLUNTEER BEST PRACTICES AND QUALITY

CANADIAN WORKING FORUM

We are planning an exciting two-day working forum March 13+-14, 2004 for volunteers and Volunteer Services managers and trainers.

- Explore the fundamental principles of hospice palliative care volunteer services.
- Review the Task Group's work on values, guiding principles and foundational concepts.
- Begin to define clinical and organizational competencies for hospice palliative care volunteers and volunteer-based programs.
- Our outcome: a Working Draft that we can use for further consultation and refinement (see Task Group Timeline).

FEEDBACK SHEET

Please take a few moments...Respond by February 27, 2004

We realize that this information packet is quite complex. You can help immediately by providing the Task Group with some impressions and comments:

Please tick all that apply...My immediate reaction is:

- This package is too big and confusing
 I'm excited by all this wonderful information
 I can't wait to get involved

Other _____

- Are there areas of the overall plan that need clarification? Please give details.

- Is anything missing or not given enough emphasis that you feel is important?

- What are the five most important issues that we need to address in the national process?

1. _____

2. _____

3. _____

4. _____

5. _____

- With which of the following groups will you be able to share this material?

Volunteers

Board members

Volunteer Services staff

Community partners

Other members of the interdisciplinary team

Allied health agencies, support groups.

Your

Program: _____

- Who will be the **communication contact** for your program?

Name: _____ e-mail: _____

Work phone: _____ Home phone: _____

- Who would like to join the **extended working group** and become more involved in advocating and supporting the Task group work?

Name: _____ e-mail: _____

Work phone: _____ Home phone: _____

- Who would like to be considered as a **delegate** to the Canadian Working Forum in Montreal on March 13-14, 2004 (all expenses paid)? **PLEASE RESPOND BY FEBRUARY 13, 2004.**

Name: _____ e-

mail: _____

Work phone: _____ Home phone: _____

Please e-mail to taskgroupinukshuk@shaw.ca or fax to Jerry Rothstein at 250.370.8625

Mailing address: **Rothstein Associates, 306-620 View Street, Victoria, BC V8W 1J6**

Task Group on Volunteer Competencies and Best Practices Timeline

March 2003	Task Group formed. First face-to-face meeting in Ottawa.
June 2003	Task Group meets in Québec City before CHPCA National Conference. Holds joint meeting with CHPCA Standing Committee on Volunteer Issues . Presents Task Group Project to National Volunteer Issues Interest Group (150 in attendance).
July to November 2003	Task Group meets by teleconference. Work on Information Packet proceeds.
November 2003 to January 2004	Face-to-face meeting in Ottawa. Final draft of information packet edited. Methods of distribution determined. Support from CHPCA essential. National distribution of information packet.
January to February 2004	Information-gathering from volunteers and Volunteer Services managers and trainers. Draft One working document on competencies and best practices.
March 2004	Canadian Working Forum , using the Draft One Document as a guide, continues to explore competency and best practice issues.
April to August 2004	Continuing dialogue and refinement of the draft materials, using on-going electronic feedback process. Draft Two Working Document.
September 2004	Draft Two is presented at a workshop and at the National Volunteer Issues Interest Group at the 15 th International Congress on Care for the Terminally Ill in Montréal.
October 2004 to August 2005	Continuing work and consensus building on the Companion Document to the CHPCA Model for the Volunteer Component.
September 2005	Formal launch of the Companion Document to the CHPCA Model for the Volunteer Component.
October 2005 and following	Implementation phase for the Document . Integration with CCHSA Accreditation for Hospice Palliative Care. On-going refinement.

A history of significant developments in Volunteer Component Standards

	1985-1990	1991-1995	1996-2000	2001	2002	2003
Standards Development	Various efforts, especially in Ontario and BC. Publication of BCHPCA's Hospice: A Resource Guide	Processes merge into CPCA national Standards Committee. Committee reaches consensus and publishes Palliative Care: Towards a Consensus in Standardized Principles of Practice (1995)	Core document distributed; Revisions Workgroup formed; consensus-building workshops (17) in all provinces. How Close are We to Consensus (1998) and in Québec Le Rapport Final (2000)	Revisions of 1995 document issued as 2001 Proposed Norms of Practice . Web-based survey; dissemination by provincial champions; analysis of data; drafted final document; received approval of CHPCA Board	Publication of Model to Guide Hospice Palliative Care	
CHPCA approach to Volunteer Component			Established <i>Ad Hoc Committee on Volunteer Issues</i> (1998). Committee presented national	Committee status changed to that of <i>Standing Committee of the Board</i> . Funding sought		Joint meeting with Task Group : Committee endorses work of Task Group in partnership with

	1985-1990	1991-1995	1996-2000	2001	2002	2003
			agenda that was adopted by CHPCA Board. Key item: when national standards process completed, Volunteer Component will be first to develop its standards as a companion document.	for standards development without success.		<i>Standing Committee</i> and CHPCA.
National Volunteer Interest Group		Begins meeting at the national conference, and in alternate years at the Montréal Congress.	Publishes occasional items in national newsletter, <i>AVISO</i>	Major meeting at Victoria conference. Affirms need for national volunteer component standards.		Major meeting at Québec Conference introduces work of Task Group . High level of interest shown from all regions.
Federal Government involvement in Palliative and End-of-Life issues		Special Senate Committee on Euthanasia and Assisted Suicide issues its report: Of Life and Death	Subcommittee to update Of Life and Death issues its report Quality End-of-Life Care: The Right of Every Canadian , calling for a national strategy on End-of-Life Care as a key priority. Health Canada supports CHPCA in convening key stakeholders. <i>Quality End-of-Life Coalition [QEOLC]</i> .	March: QEOLC workshop issues Blueprint for Action Senator Sharon Carstairs appointed by the Prime Minister as Minister with Special Responsibility for Palliative Care. June: Health Canada establishes Secretariat on Palliative and End-of-Life Care	March: Secretariat convenes National Action Planning Workshop. September: Secretariat forms five Working Groups: (1) <i>Best Practices and Quality</i> ; (2) <i>Surveillance</i> ; (3) <i>Research</i> ; (4) <i>Education for Formal Caregivers</i> ; (5) <i>Public Information and Awareness</i> . December: Best Practices and Quality WG establishes Task Group on Best Practices and Quality in the Volunteer Component.	January-June: Task Group formed; creates model for development of competencies, best practices & quality in the <i>Hospice Palliative Care Volunteer Component</i> September: <i>Task Group</i> begins dissemination of model, process for gathering input from volunteers and volunteer support staff.
Accredita-tion		<i>Canadian Council on Health Services Accreditation (CCHSA)</i> has some palliative care standards embedded in other accreditation components (eg acute care, cancer	⇒	⇒	<i>CCHSA</i> Executive Director joins <i>Best Practices and Quality Working Group</i> .	<i>CCHSA</i> and <i>Best Practices Working Group</i> agree to work together to develop accreditation standards for palliative care programs, and explore feasibility

	1985-1990	1991-1995	1996-2000	2001	2002	2003
		care) but does not offer palliative care program accreditation.				of accreditation for free-standing hospices and volunteer-based hospice palliative care programs. Task Group members serve on the Advisory Committee for this project.



Task Group on Volunteer Competencies and Best Practices

Worksheet

The following exercises can be used individually or in small group work with volunteers and Volunteer Services managers and trainers. The aim is to begin to explore the idea of competencies as the foundation for best practices and quality care

Exercise I

Competencies represent the elements with which we accomplish our work. When we think about providing hospice palliative care from the perspective of the Volunteer Component, we want to know what **knowledge, skills and attitudes** a volunteer needs to have in each area of their work.

One way to look at these areas is to identify larger **Domains of Practice** and see what elements are needed to work in each of them

In the **CHPCA Model**, six domains of care are identified, and the Task Group has added a few more that seem essential.

The **Domains** we are working with are as follows:

- | | |
|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Information sharing |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Care planning |
| <input type="checkbox"/> Care delivery | <input type="checkbox"/> Confirmation |
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Team functioning |
| <input type="checkbox"/> Self-reflective practice | <input type="checkbox"/> Teaching, learning and research |

For each **Domain** think about and discuss the elements that are required. Record the results so that you can share them with the **Task Group**.

Knowledge elements: _____

Skill elements: _____

Attitude/awareness/judgement elements: _____

Exercise II

[A] This is another way to approach the idea of competencies.

Think of a situation in which volunteer involvement in patient care contributed to an excellent result. This might be thought of as a **best practice**, when everything comes together to meet patient, family and team needs and choices.

Now assess this situation by listing the **competency elements** that contributed to the good outcome. As above, these would include knowledge, skill and attitudinal elements.

[B] Now let's take a 180° turn.

Think of a situation where the outcomes of care were not excellent. Perhaps patient goals were not met; perhaps team functioning was not up to par. Assess this situation by asking what **competency elements** were missing that might have meant a different outcome.

Both these experiments help to illustrate the relationship between competencies and outcomes. We are interested in defining competencies, best practices and quality dimensions for the hospice palliative care Volunteer Component. Your work is an essential part of this task.

Please share the results of your work with the Task Group! We will be collecting and collating ideas **BY FEBRUARY 27, 2004** to create a Draft Working Document. This document will serve as the basis for the Canadian Working Forum on Volunteer Competencies and Best Practices to be held March 13-14, 2004 in Montreal.

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THANK YOU

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