INTRODUCTION

It is universally recognised that hospitalised people with cognitive impairment such as dementia and delirium are at heightened risk of adverse outcomes. People with dementia and/or delirium who exhibit aggressive, agitated, resistive or wandering behaviours are time-consuming and challenging for hospital staff to care for. These challenges impact on staff stress and care burden, with lack of time to support the necessary emotional care and safety needs highlighted.

Carer dissatisfaction about the care provided to people with dementia in hospital relates to perceived poor care, lack of understanding of the needs of the person with dementia, deterioration in the health and function of the person with dementia, and limited involvement of and communication with carers. Care burden and exhaustion can also be experienced by carers who stay and support the person with dementia when hospitalised.

Providing person-centred care to people with dementia in hospitals is best practice and results in better outcomes, for both people with dementia and their carers. In Australia, there are a number of good practice initiatives aimed at improving care and support for people with cognitive impairment and their carers in hospitals. Despite this, the ability of hospitals to provide person-centred care has remained patchy and limited. This is largely attributed...
to task-oriented and medically focused systems of care, poor environmental design, time constraints, staffing limitations and lack of knowledge and understanding by staff of the particular care and communication needs of people with cognitive impairment.13

In recognising these barriers, the concept of using appropriately trained volunteers to support the provision of person-centred care for people with dementia and/or delirium in hospitals was adapted and piloted in a rural NSW hospital.16-18 The Volunteer Dementia and Delirium Care © Implementation and Training resource was subsequently developed to support wider implementation of the pilot program.19

In order to add to the limited evidence on the impact of volunteers in supporting hospitalised patients with cognitive impairment,20 the current study implemented and evaluated the program in a further seven rural hospitals in Southern NSW Local Health District (SNSWLHD) using a mixed-methods design. The quantitative patient outcomes are reported in an article by Blair et al.21 Across all sites, there was a significant reduction in rates of 1:1 specialling (1:1 observation by a nurse or security guard) and 28-day re-admission for patients receiving the volunteer intervention.

The current paper uses feedback from staff, families and managers to explore:

1. Whether the program succeeded in providing person-centred care in the acute environment;
2. The impacts of the volunteer program implementation for staff, managers and families; and
3. Enablers and challenges of implementation.

2 | METHODS

2.1 | Ethical considerations

The study was approved by the NSW Greater Western Human Research Ethics Committee (Project Number HREC/15/GWAHS/63).

2.2 | Study design

The full study involved a mixed-methods, non-randomised intervention study using historic controls for patients. Qualitative and quantitative data for staff, managers and families were collected via surveys, structured interviews and focus groups (see Table 1).

2.3 | Setting

The study was conducted in seven acute rural hospitals located in SNSWLHD. The hospitals ranged from 13 to 79 bed capacity (M = 41.14, SD = 20.37), most with only one ward (see Table 2).

Policy Impact

Well-trained and supported volunteers provide a low-cost strategy to improve the safety and care of older cognitively impaired patients in rural hospitals. Such programs require clear role delineation and policies and procedures for volunteers and staff. Ongoing resourcing for a volunteer co-ordinator role is key to sustainability.

Practice Impact

Trained volunteers may contribute to improvements in the quality of emotional and physical care for older cognitively impaired patients. Staff and families may also benefit from a reduction in care burden. An ongoing volunteer co-ordinator is required to carefully screen and support volunteers and foster relationships and teamwork between staff and volunteers.

2.4 | The intervention

The program involves recruiting and training volunteers to provide one-to-one practical assistance (eg, assisting with eating, drinking, walking, promoting use of visual/hearing aids), therapeutic activities and emotional support for people with dementia and/or delirium in hospitals (see Figure 1). Volunteers were recruited via local media articles, flyers and word of mouth. Volunteers underwent health service screening and an interview process to assess suitability. They participated in a 2-day group training program on dementia and delirium and their role.19 Once trained, the volunteers were provided with orientation to the ward and ongoing support by site implementation staff.

Referral to the program was via a one page referral form completed by hospital staff for potentially suitable patients. Volunteers complete a personal profile with the patient and/or their carer which provides essential person-centred information to support their care and interactions with patient. The volunteer role is similar to that of a family carer.

2.5 | Participants and recruitment

Several participant groups are reported on:

1. Family/carers of patients receiving volunteer care;
2. Hospital ward staff; and
3. Managers

Table 1 outlines the inclusion and exclusion criteria and recruitment strategies for each group.
FIGURE 1  Person-centred dementia and delirium volunteer program description and impacts
| Participant group                                      | Inclusion/exclusion                                                                 | Recruitment                                                                 | Data collection                                                                 |
|--------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. Family carers of patients receiving volunteer care  | All family/carers of patients eligible for the volunteer program were eligible to provide feedback on the service as part of the research study | When hospital staff sought consent for patients to be included in the research, they also sought written consent from family members to release their contact details to the researchers. Alternatively, family/carers were provided with an anonymous paper survey (n = 21; 26.25%). Ward staff reported difficulty in recruiting family members due to difficulty meeting up with families face-to-face due to distance from the facility and visiting hours and families feeling “overwhelmed” during the admission | Structured phone interviews were conducted postdischarge by a female research assistant (MZ) with a Bachelor of Applied Science (Physiotherapy). Supervised by author (AB) with experience in interviews and focus groups. The interviewer also worked on data collection and entry for the project. Paper surveys were returned to project officers directly, researchers via stamped self-addressed envelopes or to locked boxes on intervention wards. No demographic data were collected |
| (n = 80)                                               |                                                                                     |                                                                              |                                                                                  |
| (Recruitment rate = 29.63% of 270 eligible patients)   |                                                                                     |                                                                              |                                                                                  |
| 2. Hospital staff on intervention wards                 |                                                                                     |                                                                              |                                                                                  |
| a. Paper survey (n = 119)                              | Any health professional (nurse, allied health professional, medical) employed on implementation wards was eligible for inclusion | At staff training sessions, the project officer sought written consent for hospital staff to be included in the research project | Anonymous paper surveys were handed directly or placed in pigeonholes of staff who had consented to participate at 6 mo. Surveys were returned directly to project officers or to locked boxes found on each ward |
| b. Focus groups (n = 46)                               | Any health professional (nurse, allied health professional, medical) who had encountered volunteers and was available on the day of the focus groups. Those not on duty at the time of focus groups were excluded. Staff who had already provided feedback via a paper survey were still eligible for inclusion in focus groups | All staff on duty on the day of the focus groups were verbally invited to attend by managers and the group facilitator. If necessary, repeat groups were run successively to enable some staff to remain with patients and allow all interested staff to attend. Written consent was sought from each focus group participant before the group began. Due to complex staffing arrangements including rotating shifts, casual staff and staff in multiple roles, the researchers were unable to ascertain whether any staff refused to participate or how many staff were unable to participate due to timing of the focus groups. | Focus groups exploring enablers and barriers to implementation and successes and challenges for the program were conducted at 9 mo. The same questions were asked in each site with limited prompting for clarification as required. Questions were taken from the pilot evaluation, expanded and piloted in one site before continuing with minimal amendments. (Rf Questions in Supporting Information). The author (AB) provided feedback to facilitator after the first three groups were conducted. Only the facilitator and participants were present in the closed room within the hospital. Participants had no prior relationship with the facilitator and were not given any information about her background. Participants were advised that groups would be audio-recorded then transcribed and that responses would be de-identified and aggregated. No field notes were taken. Transcripts were not returned to participants because of the large number of participants across sites. No demographic data were collected |
| 3. Managers on intervention wards (n = 15)            | All relevant managers with involvement in implementation, including nurse unit managers (NUM), hospital managers and directors of nursing and midwifery, were eligible to attend | Project officers invited all managers involved in implementation to focus groups either verbally or via email. Times suitable for each set of managers were negotiated. Written consent was sought from each focus group participant before the group began | See above |
|                                                       |                                                                                     |                                                                              |                                                                                  |
Outcome measures

Family carer outcomes
Carers rated how helpful having a volunteer was on a Likert scale (1 = harmful to 5 = helped a lot). Open-ended questions asked about the benefits and problems of the program and the difference the program made compared to previous admissions without volunteers. Respondents were asked if they would like to see the program continue (yes/no).

Staff outcomes
The staff survey included demographic data and questions on previous training received.

Staff stress
Staff rated the amount of stress experienced in caring for patients with dementia/delirium (1 = no stress; 10 = very stressed).

Staff knowledge and confidence
Knowledge and confidence in recognising delirium and caring for patients with dementia and delirium were rated (1 = I know nothing at all/not at all confident; 10 = I am very knowledgeable/very confident).

Program expectations
Staff rated how well their expectations were met by the program on a 4-point scale from “not at all” to “exceeded my expectations.”

Staff satisfaction
Staff rated agreement with four statements such as “I am happy with how the program has been running” on a 5-point Likert scale (“strongly agree” to “strongly disagree”). Three open-ended questions were asked about what was working well/not working well and soliciting suggestions for improvements.

Focus groups
See Table 1 for details. Focus group questions are found in the Supporting Information.

Data analysis
Quantitative data are reported descriptively. Open-ended questions and focus group data were analysed using the process outlined by Braun and Clarke\(^22\) for thematic qualitative analysis with deductive coding for semantic themes. Free coding was applied by two raters to produce an initial thematic structure. Person-centred care theory\(^23\) was then used inductively to illuminate matches with deductive themes. Both inductive and deductive themes were refined and developed iteratively with the data to arrive at the final identified themes, by consensus between the two raters and another author (CB). Both inductive thematic saturation and data saturation\(^24\) were considered achieved during data analysis as themes across focus groups, interviews and surveys for all sites were consistent, with no new themes emerging with each site. The various data sources were synthesised in parallel.

RESULTS
Participant numbers are seen in Table 2. Demographic details of staff who returned the survey are reported in Table 3. Most staff were female, and 84% had a nursing background. A majority (79%) reported receiving sufficient training in working with confused patients. Demographic details of interview and focus group participants were not collected.
3.1 | Family interviews

Family interviews/surveys revealed that 96% (n = 77) of families interviewed rated the volunteer intervention as helping “a lot” (89%) or “a little” (8%). There were no reports of the program being harmful to patients. All families indicated that they wanted to see the program continue.

Of the 48 (57%) family carers who could recall a previous admission without volunteer assistance, 42 (87%) reported that the admission with volunteer assistance was a positive improvement in some way.

3.2 | Staff survey

As seen in Table 3, on average, staff reported moderate levels of knowledge and recognition of dementia and delirium, and moderate stress when caring for patients with dementia and delirium. Most (97%) staff survey respondents agreed the volunteer role supported them in their care of patients. A majority of staff survey respondents indicated that they were happy with how the program was running, the program had met or exceeded their expectations, volunteers were well prepared for their role, and that staff understood the referral processes (see Table 3).

| TABLE 3 | Staff demographics, experience, training, knowledge and program satisfaction ratings |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Background and knowledge | Mean | SD |
| Age (y) | 44.06 | 13.37 |
| Experience (y) | 16.19 | 13.20 |
| Working in current hospital (y) | 6.84 | 8.18 |
| Dementia knowledge | 6.97 | 1.71 |
| Delirium knowledge | 6.94 | 1.80 |
| Confidence to recognise delirium | 7.02 | 2.00 |
| Confidence in managing delirium | 6.88 | 2.10 |
| Stress when managing dementia/delirium | 6.28 | 2.23 |
| Staff characteristics and training | n | % |
| Sex | 102 | 85.70 |
| Staff role |
| Registered nurse | 55 | 46.22 |
| Enrolled nurse/AIN | 38 | 31.93 |
| Allied health | 11 | 9.24 |
| CNC/CNE/nurse practitioner/nurse manager | 7 | 5.88 |
| Other (ward clerks, hotel services) | 8 | 6.72 |
| Confused patient training received (yes) | 95 | 79.80 |
| Training sufficient (yes) | 75 | 78.95 |
| Staff satisfaction | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree |
| Happy with how the program running | n | % | n | % | n | % | n | % |
| Program is supportive in care of my patients | 53 | 44.5 | 59 | 49.6 | 6 | 5 | 1 | 0.8 | 0 | 0 |
| Aware of referral criteria and processes | 68 | 57.1 | 48 | 40.3 | 3 | 2.5 | 0 | 0 | 0 | 0 |
| Volunteers well prepared for role | 47 | 39.5 | 60 | 50.4 | 4 | 3.4 | 7 | 5.9 | 1 | 0.8 |
| Volunteer program met my expectations | 38 | 31.9 | 66 | 55.5 | 12 | 10.1 | 1 | 0.8 | 0 | 0 |

AIN, Assistant in Nursing; CNC, Clinical Nurse Consultant; CNE, Clinical Nurse Educator.
3.3 | Focus group and interview themes

3.3.1 | The volunteer role: Person-centred care

The overwhelming perception of staff, managers and families at each site was that the volunteers were successful in implementing the principles of person-centred care. Several managers and families pointed out the volunteers' contribution to person-centred care through eliciting information about the patient's past, providing occupation for patients focused on their choices, preferences and abilities and communicating these preferences to staff:

being able to elicit information from their background, and then sharing that with staff is a great strategy when you've got those difficult moments to engage with them and do a bit of that reminiscing type of therapy. [Manager F024]

Families and managers also noted that volunteers helped to mitigate the risks of the acute care environment using person-centred techniques such as occupation rather than restriction via security guard or nurse 1:1 supervision (specialling):

keeping [...] anyone with dementia/delirium, occupied, they've been an extra pair of hands then someone to talk to, a face that is familiar for an elderly person. [Manager F013]

The previous admission he had security guards sitting with him which was intimidating. The yellow ladies are a much better idea as they are trained to talk to him and are interested to hear what he says. [Family 364]

3.3.2 | Improving quality of care

Supporting quality physical care

All participant groups at every site identified the invaluable role of volunteers in providing general assistance, supporting hydration and providing nursing staff with person-centred information to assist with care:

It was great that she had somebody there to help with her breakfast, which was a time I couldn't be there, and that helped obviously the nurses, that they didn't have to assist her because she couldn't open packaging. [Family 693]

For the hospital staff it gave them insight into [her] personal hygiene and ability to understand her needs. Volunteers provided this information [to staff]. [Family 131]

Managers linked this practical assistance with improved clinical outcomes for patients:

You've got to feed people and if people can't open their packaging or don't get much food, they're not gonna be very well. [Manager F014]

Supporting patient safety

All groups at each site noted that having a volunteer present contributed to patient safety, particularly reducing the risk of wandering and falls:

If they've got a volunteer sitting with them, they're less likely to get up and wander or they'll take them for a walk [...]. So it does help us a lot instead of us just sitting there and having to keep an eye on them. [Staff F064]

He needed to have someone there for most of the time because he wasn't able to get out of bed or off a chair on his own. He was subject to falls. [Family 281]

Contrast with previous admissions without volunteer assistance

Families reported that the admission with volunteer assistance was a positive improvement on previous admissions in some way; either through comfort and support for patients, respite for families, improved nutrition and hydration or reducing staff burden:

The last admission [...] in the end I asked if I could bring her home. She wasn't eating and she was getting confused. The staff don't have time to sit there and feed elderly confused people. [Family 161]

3.3.3 | Promoting patient well-being

Addressing social and emotional needs

All groups noted the role of volunteers in reducing patient stress and helping them to feel happier and calmer:
The company, it made her feel better, kept her side-tracked and happy. [Family 563]

Some of the patients that we’ve had in particular who’ve been quite stressed, they’ve [volunteers] been really helpful to calm them down and to sort of have someone sitting with them and comforting them and that seems to have made a big difference for those patients. [Staff F084]

A valuable aspect of this interaction was that the volunteers engaged with both patients and their families/carers in everyday conversation that was not focused on the patient medical journey:

I think having the volunteer go in and just talk normal stuff and get away from what's actually happening was really good for elderly people and connect them back into what's going on […] I think the volunteers bring in an added dimension into staying normal. [Family 714]

Providing company and meaningful activities for patients was noted by managers as a key role for volunteers, sometimes leading to improved clinical outcomes:

One patient who was so lonely and she was at quite a high risk for a delirium and she didn't get a delirium, but she had a volunteer with her doing things, playing cards, reading magazines, talking about things […] She did feedback that it was lovely to have someone with her, listening to her, talking to her and she didn't feel so isolated. [Manager F013]

Managing patient distress
Specific instances of volunteers either distracting patients or playing a key role in reducing patient anxiety, distress and agitation were repeatedly given:

[She] always wanted to go home, especially when I was leaving. The volunteers got her mind off this by doing different things. I couldn't speak highly enough of them. [Family 492]

3.3.4 Reducing family care burden
Families repeatedly mentioned their appreciation of how the regular visits from volunteers alleviated their care burden by reducing their anxiety and stress:

They helped feed her because she couldn’t do that at the time. For me, knowing someone was there … I can't even tell you what a benefit that was. She was disoriented and scared on her own. [Family 161]

Carer respite
The volunteers provided opportunities for carers to take a break from often lengthy hospital vigils:

Sometimes like I might have had to go for an appointment or down the street shopping or something and I went when one of those ladies were around and they could stay with him. [Family 281]

It's almost the permission for them [families] to be able to leave because somebody is watching them. Because everyone recognises nurses are busy …. So there’s been a sense of relief I think from the family. [Manager 015]

Carer support
Some families mentioned that they enjoyed the company of the volunteers and the information and advice they provided; the interaction with someone other than clinical staff was a welcome interlude from the stress of supporting a family member:

On one occasion I was fortunate to be there at the time of the visit. The volunteer engaged with me and the knowledge and kindness she shared with me was invaluable. [Family 595]

3.3.5 Reduction in nursing care burden
Although volunteers did not engage in clinical care tasks such as showering, toileting or medications, all groups attributed volunteer assistance with non-clinical tasks to a reduction in the nursing care burden, both physical and emotional:

It takes a lot of pressure off us when they’re setting them up and helping them eat their dinner and stuff like that. We can continue on with our medications and all that. [Staff F064]

This time factor is a really big issue for clinicians when more and more is being required with less and less time […] So any opportunity
we've got to have somebody here that has time to be able to do these things is really valuable for us. [Staff F013]

3.3.6  | Freeing up nurses to “do a better job”

The flow on effect of volunteers assisting with feeding, hydration, supervision and social interactions was providing staff with time to be able to plan, prioritise and deliver their clinical care more effectively and equitably:

It influences how they [staff] set their day, it influences how they will manage their workload. [Manager 015]

I think it just frees up nurses so we can do a better job really. [The volunteers] are invaluable because we can do what we need to do medically, but half the time these people just need someone to talk to. If they have a volunteer talking to them, they're not on the buzzer every five minutes. [Staff F025]

Some staff noted that the benefits flow on to other patients:

For a nurse to provide that one-on-one [care] takes away from the other patients as well. So it sort of benefits everyone on the ward, not just the patients the volunteers are working with. [Staff F025]

3.3.7  | Staff management of dementia/delirium

Despite staff reporting that most had received training and felt confident recognising and managing dementia and delirium (see Table 3), family members noted that nursing staff were not always confident to deal with patients with dementia/delirium:

The nurses were apprehensive about having a patient with dementia and if they had someone [volunteer] to distract him (sic), that was of benefit to them too. [Family 512]

A small number of nurses and managers felt that their knowledge about how to handle a patient with dementia or delirium was improved by observing the interactions and actions of the volunteers. Strategies and program activity resources used by the volunteers also assisted staff:

I've learnt things too about when you have a dementia patient [sic] who is a little bit agitated, trying to find out what it is. Is it music? Do they like babies? [...] understanding that can save you time even when the volunteers aren't there [...] that's something that has come out of working with the volunteers, that we try and figure out: what is it that this person likes, what do they respond to? [Manager F025]

3.3.8  | Volunteers as part of care team

All groups stated that they considered the volunteers as part of the care team:

I think they're [volunteers] becoming more and more a recognised part of the team as they get more into their role. If the volunteers are seeing the patients, we want to document that in the notes and communicate with them and read their little progress notes [...]. So it's just a matter of ensuring they're part of the team and we communicate. [Manager F011]

I actually talked to the volunteers to work out times when I wasn't going to be there so that they could help Dad and let them know when I was going to be there so that they could help someone else. [Family 674]

Volunteers were an important avenue of information sharing between patients/family/carers and the nursing staff. One volunteer alerted staff to the suicidal thoughts of a patient, enabling timely referral and support. The role of the volunteers was seen as a unique and important link in the chain of care.

3.3.9  | Enabling factors and challenges

Staff, managers and families were asked about the successes and challenges of the program. Staff and families described the success of the program as being underpinned by careful selection, training and support of appropriate volunteers by the volunteer co-ordinator, and having clearly defined roles and procedures for volunteers (see Table 4).

There were multiple challenges reported, although none of these ultimately impeded implementation (Table 4). Staff at each site reported some minor issues where volunteers went...
beyond their authorised duties or made naïve mistakes early in the program. Staff emphasised that these incidents were isolated, quickly resolved and had not reoccurred. Initial staff concerns and mistrust about the program occurred in all sites. However intervention from the co-ordinator resolved these challenges in all but one hospital. The hospital with ongoing concerns was described by managers as having a pre-existing culture issue which had also impeded previous initiatives. In sites where staff found the referral form too onerous, volunteers made adaptations to smooth this process with some success (eg, volunteers complete referral forms based on verbal instructions from staff and have staff sign off). Managers reported that ongoing funding for the volunteer co-ordinator position was required to sustain the program. Referral to the program was via a one page referral form completed by hospital staff for potentially suitable patients.

4 | DISCUSSION

The aim of the program was to train volunteers to support person-centred care in acute rural hospitals, an environment recognised for being more medically rather than person-focused. The feedback from staff, managers and families strongly indicated that the volunteers were effective in integrating Kitwood’s key principles of person-centred care. This was underpinned by their completion of a personal profile with the patient and/or their carer, where volunteers gained important knowledge about the person’s background, family and personal preferences. The information provided an understanding of a patient’s abilities and preferences, enabling volunteers to connect and communicate with patients, to support their food choices and to provide meaningful activities.

Staff and family members perceived that the volunteers reduced emotional and physical burden for staff and families, increased patient well-being and contributed to improved quality of physical and emotional care as unique and well-linked members of the care team. These findings are consistent with other acute care dementia volunteer studies. The impact and interrelationship of volunteers for patients, family carers and staff is depicted in Figure 1.

Volunteers appeared to address the main barrier to providing person-centred care in acute hospitals: time. While a majority of staff reported that they had received sufficient training in dementia/delirium and were confident in recognising and managing dementia/delirium, they noted that they lacked the time to provide person-centred care. Staff consistently reported that volunteers freed up their time which assisted in managing their physical and emotional workload. They also appreciated the person-centred information that volunteers communicated about patients and saw this as assisting them to provide better care and appropriate referrals.

Volunteers also appeared to address several major environmental barriers prominent in acute care: they provided non-restrictive monitoring for patients at risk of falls or wandering in a risky and unfamiliar environment. They also provided occupation in an environment that primarily provides stimulation only around medical procedures and no appropriate stimulation at other times.

Although a number of implementation challenges were identified, these were addressed quickly in most instances by

| TABLE 4 Program enablers and challenges reported by staff, managers and families |
|-----------------------------------------------|-----------------------------------------------|
| **Enablers** | **Challenges** |
| Well-conceived role with clear scope of duties and delineation of roles from paid staff | Issues with volunteers “overstepping the mark” early in the program (eg, walking or feeding inappropriately). All resolved quickly |
| Careful screening of volunteers leading to appropriate selection | Staff unsure about what confidential information to disclose to volunteers at handover |
| Thorough training of volunteers (2 days, manualised, consistent) | Initial staff mistrust and uncertainty regarding “untrained” volunteers “taking their jobs” or behaving “unprofessionally” with patients |
| Written and verbal handover procedures to ensure clear communication between staff and volunteers | One page referral form was too time-consuming for some staff. Proactive referral seeking required from volunteers |
| Proactive paid volunteer co-ordinator role to recruit, train and mentor volunteers and addressed any challenges quickly | Staff culture of mistrust and disengagement in one hospital ongoing |
| Volunteer personal qualities—helpful, cheerful, amicable | Sustainability of the program without ongoing funding for a volunteer co-ordinator |
the skilful intervention of the project co-ordinators and did not hinder the program or its outcomes. Similar challenges (eg, initial staff anxiety) have been noted and addressed by sound implementation and communication in previous studies.20 The volunteer role was described as safe and well delineated from that of paid staff.

4.1 | Limitations and strengths

Due to complex staffing arrangements in acute care, it is uncertain how many staff refused or were unable to participate in the research. However, managers did not indicate any major dissenting groups and all staff responses were very positive about the program. Similarly, due to the difficulties recruiting families to the study, it is not possible to determine how representative this group are. Patients were not interviewed due to logistical issues with recall and timely access to patients.

5 | CONCLUSIONS

The volunteer Dementia and Delirium Care © program is reported by families, staff and managers to be an effective way to address some of the main barriers to providing person-centred care in rural hospitals, namely lack of time, lack of person-centred processes, and knowledge and environmental limitations. With appropriate support from a paid volunteer co-ordinator, clear role delineation and sound implementation utilising the implementation and training resource package, volunteers contributed to increased quality of emotional and physical care and a reduction in family and staff care burden. Volunteers integrated into wider care teams provide a low-cost way of improving acute care for older adults with cognitive impairment. As the numbers of people with dementia increase, volunteers may become an important link in the chain of care.

ACKNOWLEDGEMENTS

This project is supported by the SNSWLHD staff who have gone above and beyond their usual duties to assist in implementation. In particular, we thank the project steering committee and the support of the Executive Sponsor Julie Mooney. We thank the NSW Health Agency for Clinical Innovation for funding the development of the Volunteer Dementia and Delirium Care © Implementation and Training Resource and for providing copies of the resource package as in-kind support. We are grateful for the support provided by the NHMRC Partnership Centre on Dealing with Cognitive and Related Functional Decline in Older People (CDPC) and the strong CDPC consumer representative, Elaine Todd, for her assistance. Thank you to Maria Zylinski for her work in conducting focus groups and interviews and collating data and to Alison MacTaggart for her assistance in reviewing and coding the qualitative data. We thank all the “Golden Angel” volunteers, staff, patients and families for their feedback and ongoing support for the project.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

ORCID

Annaliese Blair https://orcid.org/0000-0002-5558-8396

REFERENCES

1. Inouye SK, Westendorp RGJ, Saczynski JS. Delirium in elderly people. Lancet. 2013;383(9920):911-922.
2. Mukadam N, Sampson EL. A systematic review of the prevalence, associations and outcomes of dementia in older general hospital inpatients. Int Psychogeriatr. 2011;23(03):344-355.
3. Jones J, Borbasi S, Nankivell A, Lockwood C. Dementia related aggression in the acute sector: is a Code Black really the answer? Contemp Nurse. 2006;21(1):103-115.
4. McCormack B. Person-centredness in gerontological nursing: an overview of the literature. J Clin Nurs. 2004;13(Suppl 1):31-38.
5. Nolan L. Caring connections with older persons with dementia in an acute hospital setting—a hermeneutic interpretation of the staff nurse’s experience. Int J Older People Nurs. 2006;1(4):208-215.
6. Moyle W, Borbasi S, Wallis M, Olorenshaw R, Gracia N. Acute care management of older people with dementia: a qualitative perspective. J Clin Nurs. 2011;20(3–4):420-428.
7. Byers D, France N. The lived experience of registered nurses providing care to patients with dementia in the acute care setting: a phenomenological study. Int J Clin Nurs. 2008;13(Suppl 1):31–38.
8. Fessey V. Patients who present with dementia: exploring the knowledge of hospital nurses. Nurs Older People. 2007;19(10):29-33.
9. Moyle W, Bramble M, Bauer M, Smyth W, Beattie E. ‘They rush you and push you too much … and you can't really get any good response off them’: a qualitative examination of family involvement in care of people with dementia in acute care. Australas J Ageing. 2015;34(2):E30-E34.
10. Jurgens FJ, Clissett P, Gladman JR, Harwood RH. Why are family carers of people with dementia dissatisfied with general hospital care? A qualitative study. BMC Geriatr. 2012;12(1):1-10.
11. Bloomer M, Digby R, Tan H, Crawford K, Williams A. The experience of family carers of people with dementia who are hospitalised. Dementia. 2014;15(5):1234-1245.
12. Jamieson M, Grealish L, Brown J-A, Draper B. Carers: the navigators of the maze of care for people with dementia—a qualitative study. Dementia. 2016;15(5):1112-1123.
13. Dewing J, Dijk S. What is the current state of care for older people with dementia in general hospitals? A literature review. Dementia. 2016;15(1):106-124.
14. Australian Commission on Safety and Quality in Health Care. A Better Way to Care: Safe and High-Quality Care for Patients With Cognitive Impairment (Dementia and Delirium) in Hospital – Actions for Health Service Managers. Sydney, NSW: ACSQHC; 2014. https://www.safetyandquality.gov.au/publications/a-better-way-to-care-actions-for-health-service-managers. Accessed January 9, 2019.

15. Australian Commission on Safety and Quality in Health Care. Caring for Cognitive Impairment: Programs and policies, 2018. http://cognitivecare.gov.au/resources/programs-policies/. Accessed January 9, 2019.

16. Bateman C. Research into practice: volunteers improving person centred dementia care in a rural hospital. An intervention study [Masters]. University of Canberra, 2012.

17. Bateman C, Anderson K, Bird M, Hungerford C. Volunteers improving person centred dementia and delirium care in a rural hospital. Rural Remote Health. 2016;16(2):3667-3679.

18. Inouye SK, Bogardus ST, Baker DI, Leo-Summers L, Cooney LM. Models of geriatrics practice; The Hospital Elder Life Program: a model of care to prevent cognitive and functional decline in older hospitalized patients. J Am Geriatr Soc. 2000;48(12):1697-1706.

19. NSW Agency for Clinical Innovation. Volunteer Dementia and Delirium Care Program: A Hospital Program Implementation Guide. Sydney, NSW: NSW Agency for Clinical Innovation; 2014. https://www.aci.health.nsw.gov.au/resources/aged-health/confused_hospitalised_older_persons/dementia-and-delirium-care-implementation-training. Accessed January 9, 2019.

20. Hall CL, Brooke J, Pendlebury ST, Jackson D. What is the impact of volunteers providing care and support for people with dementia in acute hospitals? A systematic review. Dementia. 2017. https://doi.org/10.1177/1471301217713325.

21. Blair A, Bateman C, Anderson K. The “Golden Angels”: effects of trained volunteers on specialising and readmission rates for people with dementia and delirium in rural hospitals. Int Psychogeriatr. 2018;30:1707-1716.

22. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101.

23. Kitwood T. Dementia Reconsidered: The Person Comes First. Buckingham: Open University Press; 1997.

24. Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018;52:1893-1907.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

How to cite this article: Blair A, Bateman C, Anderson K. “They take a lot of pressure off us”: Volunteers reducing staff and family care burden and contributing to quality of care for older patients with cognitive impairment in rural hospitals. Australas J Ageing. 2019; 38(Suppl. 2):34–45. https://doi.org/10.1111/ajag.12612