

# **Task Group on Best Practices and Quality in the Volunteer Component**

**Précis of Minutes**

**Ottawa, Canada**

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## Précis

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*Chair Jerry Rothstein, Coordinator of Volunteer Services and Quality of Care, Victoria Hospice Society, Victoria, B.C.*

Jerry welcomed the participants to the first meeting of the task group, and explained the tasks that the group had been asked to do by the *Best Practices and Quality Care Working Group of Health Canada's Secretariat on Palliative and End-of-Life Care*.

### Background

Jerry gave a summary of the process of developing the national norms effort for HPC, an effort to establish national principles and norms of practice and to provide guidelines for their implementation.

In 1997, observing that much of HPC in Canada began in communities at the grassroots level and yet there was little support for the volunteer component at the national level, the Board of the Canadian Hospice Palliative Care Association (CHPCA) founded an *ad hoc* committee on volunteer issues. At the committee's first meeting in 1998, members from across the country created a powerful agenda for volunteer component issues, including the important recommendation that the volunteer component be the first component to be supported in developing the national norms or standards. This recommendation led to the formation of CHPCA's *Standing Committee on Volunteer Issues*.

A lack of funding then caused a delay in the work of the Standing Committee while other norms efforts took place. In June 2001, Health Canada established the Secretariat on Palliative and End-of-Life Care to coordinate the development of a national strategy on palliative and end-of-life care. In March 2002, the Secretariat chose CHPCA's 2002 publication, *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice*, as the guiding document to delineate and facilitate the adoption of accepted norms of practice that will ultimately form the basis for a national model. This document is also referred to as "the Model." It was expected that the means by which the norms would be implemented would likely take the form of a companion document to the Model.

In March 2002, the Secretariat also agreed to support five working groups to address priority issues, one of which was Best Practices and Quality Care. In December 2002, when the proposal was made to form a task group to specifically focus on tackling the norms in light of the volunteer component, the Secretariat approved funding for this task group under the umbrella of the Best Practices and Quality Care Working Group. The task group has been asked to do the initial work of producing a **framework** for developing norms and best practices and to use the framework to create companion document to the Model to address the volunteer component of HPC.

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## Two Tasks for the Task Group to Accomplish

Before explaining the two tasks that the task group has been asked to accomplish, Jerry gave a summary of the key decisions made at the Best Practices Working Group (BPWG) meeting that took place over the two days just prior to this task group meeting.

At the BPWG meeting, Elma Heidemann, Executive Director of the Canadian Council on Health Services Accreditation (CCHSA), and Paula Greco, Manager of Research & Development at CCHSA, gave a presentation about their organization's current accreditation process that involves a framework developed by CCHSA called Achieving Improved Measurement (AIM). After the presentation, a key agreement was made to form a partnership between CCHSA and the BPWG to develop the necessary tools for including HPC in the national accreditation process.

HPC accreditation will be more complex than most accreditation issues simply because there are many models of hospice palliative care programs, of varying size and complexity and resources. After the norms development process was completed at the national level, the issue of authority was raised. This was an issue that CHPCA had not addressed, and it was appropriate to have the already-established body of CCHSA, with its humanistic approach to accreditation, partner with the BPWG to move toward authority and accreditation for HPC.

Jerry presented to the task group the two tasks it had been asked to accomplish:

- 1. Produce a framework for the development of best practices and quality in the volunteer component.**
- 2. Begin the process of providing content within that framework.**

Jerry explained how, over a six-month period, he had visualized and concretized his vision of such a framework into a spreadsheet format. He distributed a handout of the framework, which consists of a multi-column table that integrates the **CCHSA AIM** concepts with the **CHPCA Norms Model**. The handout shows the basic four columns of the framework. He then elaborated on the additional four columns that need to be included:

*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;

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- **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.

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 **Best Practices** as a continuum of ability, ranging from entry or “novice” level, to advancing practice, and on to expert. Jerry explained the idea that 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.

## **Essential Principles of Best Practices and Quality in the Volunteer Component**

In the ensuing discussion, the group identified a set of overarching principles for Best Practices and Quality intended to help volunteers understand that they are on a continuum of ability and that they are part of a team. Volunteers must know to find help from others if they are uncertain as to how to deal with a situation. Jerry emphasized that trust and comfort are two important aspects of these basic principles.

1. **Take the time you need.**
2. **Self-reflection, self-exploration, self-knowledge, and understanding the importance of sharing.**
3. **Work from commitment.**
4. **Team.**
5. **“I am not comfortable.”**

The principle of “I am uncomfortable while you are uncomfortable” expresses how a caregiver might feel when the patient/family expresses a need. It is a feeling that invokes a sense of priority and urgency to fulfil the need.

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6. **Accept the fact of difficult feelings, sense of failure, and the need for team support.**
  7. **Necessity to mourn.**
  8. **Adjusting to change.**
  9. **Whose needs?**
  10. **Uniqueness of situations.**
  11. **Make no assumptions about the person one is with.**
  12. **Be responsive to the person one is with.**
  13. **Death happens, sometimes not according to plan, sometimes when you least expect it.**
  14. **Being versus doing, important versus urgent.**
  15. **Respect. Respect oneself as well, as a unique, autonomous individual.**
  16. **Accountability and quality.**
  17. **Need for ongoing education.**

### **Presentation of CHPCA's Model to Guide Hospice Palliative Care**

The CHPCA Norms Model uses language common to all settings and disciplines. It is based on the concept of “norms of practice” rather than the more specific or rigid concept of “standards.”

The Model has two major foci: care provision and organizational structure. The care provision focus is represented by a **Square of Care** matrix that lists the six process steps and eight domains or common issues associated with providing care. The organizations focus is represented by a **Square of Organization** matrix that lists the five resources and five principal functions related to organizational operation.

Jerry then gave a brief summary of the presentation by the Registered Nurses Association of Ontario (RNAO) at the meeting of the Best Practices and Quality Care Working Group. The RNAO was mandated by the Ministry of Health to develop a set of BPs for nursing. A total of 21 BPs have been identified thus far. He especially commended the RNAO on their work in promoting and marketing the guidelines through their newsletter, Web site, and the Champions network of nurses and administrators across the province, with different people working on different issues. He said that once a companion document to the Norms and AIM models is created, the next steps should be distribution, education, promotion, and monitoring its use in the quality improvement process.

To conclude, Jerry said that the CHPCA Model is a subtle document and a complex tool. The learning curve is not easy and one may need to read it several times to feel comfortable navigating it. However, he has found it analogous and consistent with the AIM framework of CCHSA, in particular noting that the AIM work has authority, as it is the document from which 1000 health services and 3000 health sites are accredited in Canada.

### **Values, Guiding Principles and Foundational Concepts**

The task group reviewed and discussed the Values, Guiding Principles and Foundational Concepts sections of the CHPCA Norms Model document. The Task Group's intention was to discuss these concepts fully, affirming that they represented a national consensus and therefore

would not be modified. However, because the Task Group’s job is to create a Volunteer Component Norms Document, **additions** to the Values, Guiding Principles and Foundational Concepts were offered from the perspective of the Volunteer Component. As a refinement of the original model, other components may choose also to adapt these additions and others from their own perspective.

CHPCA Norms Document	Task Group Additions
<b>VALUES</b>	
<p><b>All hospice palliative care activities recognize and support the following values:</b></p> <ul style="list-style-type: none"> <li>▪ <b>V1:</b> The intrinsic value of each person as an autonomous and unique individual.</li> <li>▪ <b>V2:</b> The value of life, the natural process of death, and the fact that both provide opportunities for personal growth and self-actualization.</li> <li>▪ <b>V3:</b> The need to address patients’ and families’ suffering, expectations, needs, hopes and fears.</li> <li>▪ <b>V4:</b> Care is only provided when the patient and/or family is prepared to accept it.</li> <li>▪ <b>V5:</b> Care is guided by quality of life as defined by the individual.</li> <li>▪ <b>V6:</b> Caregivers enter into a therapeutic relationship with patients and families based on dignity and integrity.</li> <li>▪ <b>V7:</b> A unified response to suffering strengthens communities.</li> </ul>	<p><b>Proposed additions to Values from the Volunteer Component perspective:</b></p> <p><b>Add to V1: Includes all team members</b> It’s a broader scope, not only patient and client family, etc.</p> <p><b>Add the following values:</b></p> <p><b>VA: Volunteer services are an essential component of the Hospice Palliative Care team.</b></p> <p><b>VB Engagement with patient/family in dialogue</b></p> <ul style="list-style-type: none"> <li>- the need to enter into a dialogue</li> <li>- learning to ensure clients/family know what is possible</li> <li>- being specific about “choices”</li> <li>- client controlling care</li> </ul> <p><b>VC The need to meet patient/family “where they are”</b></p> <ul style="list-style-type: none"> <li>- Not all are suffering, not all want/need change.</li> <li>- Each person/situation is unique.</li> </ul> <p><b>VD. Care is provided in a respectful, non-judgmental manner.</b> (Cross-reference to the third bullet under GP3 for details.)</p> <p><b>VE. The need for self-reflection and self-care is fundamental for caregivers.</b> (Cross-reference to the fourth bullet under GP3 for details.)</p>
<b>GUIDING PRINCIPLES</b>	
<p><b>The following principles guide all aspects of hospice palliative care:</b></p> <p><b>GP1. Patient/family focused.</b> As patients are</p>	<p><b>Proposed additions to Guiding Principles from the Volunteer Component perspective:</b></p> <p><b>Family support issues.</b></p>

<p>typically part of a family, when care is provided the patient and family are treated as a unit. All aspects of care are provided in a manner that is sensitive to the patient's and family's personal, cultural, and religious values, beliefs and practices, their developmental state and preparedness to deal with the dying process.</p>	<p>The group referred to the following related sections in the Model in their discussion about treating the patient and family as a unit and being sensitive to the patient's and family's "preparedness to deal with the dying process."</p> <ul style="list-style-type: none"> <li>• Value V4: "Care is only provided when the patient and/or family is prepared to accept it."</li> <li>• Value V5: "Care is guided by quality of life as defined by the individual."       <ul style="list-style-type: none"> <li>• Decision-making Principle P3.2: "The patient must provide voluntary consent to any therapy before it is initiated, may request to have any therapy withdrawn at any time, and may designate an alternate (proxy) decision maker and specify when that person will act on his/her behalf (according to the laws in effect in the jurisdiction)."</li> <li><input type="checkbox"/> The participants noted that even though care decisions are normally driven by the patient as the person to give permission, the patient/family focus in this Guiding Principle treats the two entities as being equal, and difficulties may arise when the patient and family do not agree.</li> <li><input type="checkbox"/> Under such circumstances, the caregivers must base decisions on the uniqueness of each situation and work with the family dynamics to conduct negotiations and to support the patient/family unit as a whole. For example, in home-based settings, the family's and the patient's needs must be critically balanced and the patient's wishes may not always be considered first. Challenging situations involving same-sex relationships, dysfunctional families, age group issues, family stress, second and third families, and the patient's and family's "developmental state" can add different dimensions and complications.</li> <li><input type="checkbox"/> In general, the concepts of respect,</li> </ul> </li> </ul>
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	<p>communication, and education are important for both the patient/family and the caregivers. Respecting the choice of the competent patient is important. Suggestions were raised to include best practices for volunteer education.</p> <p><input type="checkbox"/> In terms of effective communication, the volunteer must be provided with adequate information about patient competency and ask for help from the other team members if necessary. Family members may need to be informed of what they <i>can</i> do if what they <i>wish</i> to do is not acceptable to the patient. A common recording system for all team members may help with communication.</p> <p><input type="checkbox"/> Although volunteers may not need to know everything about the big picture and may only need to give their understanding based on their individual involvement, the participants agreed that continuity of care is a major issue across all disciplines, not only in the volunteer component. For example, nurses who work in institutional settings are on shift-work schedules, and the same is true of community-health nurses such as the VON. As well, discontinuity may occur due to illness, holiday leave, transfers, etc. In some cases, a patient may be asked the same question by two or three different nurses. The participants noted that the issue of continuity is addressed by both the P5.10 Care Delivery Principle and the GP3 Guiding Principle.</p> <p><input type="checkbox"/> Care Delivery Principle P5.10: “There is continuity: of the plan of care and information across all settings of care, and among all caregivers and organizations who are involved in the careteam; of the caregivers providing care.”</p> <p><input type="checkbox"/> <b>Sensitivity to the patient/family’s</b></p>
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<ul style="list-style-type: none"> <li>• Policies and procedures that are based on the best available evidence or opinion-based preferred practice guidelines.</li>   <li>• Data collection/documentation guidelines that are based on validated measurement tools.</li> </ul> <p><b>GP3: Safe and Effective.</b> All hospice palliative care activities are conducted</p>	<p>together. In cases where certain national standards did not hold up to law, practitioners have had to go back to using their original institutional regulations.</p> <ul style="list-style-type: none"> <li>• Cultural and diversity aspects are provided for in the last bullet of GP3. When such aspects are involved, it is especially important to actively inform patients and their families, before admissions, about those standards of practice that may affect them—for example, in terms of food.</li>   <li>• Jerry noted that best practices guidelines (BPG) must be adapted or even ignored if one’s judgment, heart, and experience say that they do not apply. Practitioners should not think that BPGs protect them, as doctors have been liable when they obeyed guidelines that led to poor patient care.</li>   <li>• <b>Data collection/documentation guidelines are essential to the volunteer component. (Put in details later.)</b></li> </ul> <p><b>Further addition to GP2:</b></p> <ul style="list-style-type: none"> <li>• <b>Ongoing monitoring and evaluation of the volunteer component is essential.</b> (Cross-reference to GP7 for details, and also to Quality Management (Evaluation) Principle P10.1: “Ongoing evaluation improves the quality of the organization’s activities.”)</li> </ul>
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<ul style="list-style-type: none"> <li>• Ensures continuity and accountability.</li> <li>• Aims to minimize unnecessary duplication and repetition.</li> <li>• Complies with laws, regulations, and policies in effect within the jurisdiction, host and hospice palliative care organizations.</li> </ul> <p><b>GP4: Accessible.</b> All patients and families <b>should</b> <i>[added by Task Group]</i> have equal access to <b>appropriate</b> <i>[added by Task Group]</i> hospice palliative care services: wherever they live; at home, or within a reasonable distance from their home; in a timely manner.</p>	<p>Value to include the need for self-reflection and self-care. (Refer to <b>Value VE.</b>)</p> <ul style="list-style-type: none"> <li>• <b>Appropriate settings should be discussed.</b> Jerry noted that there is a move toward provincial acknowledgement of the need for palliative care, accompanied by a need to advocate for resources. Linda S. and Gerard said this principle deals with ideals that are not always possible in practice, especially in small communities. Paula suggested there are alternative ways to provide services, such as teaching videos and volunteer support by phone. Jerry suggested the concept of the “virtual hospice service” in which access to services could be provided through the Internet as part of the care plan for people in isolated settings.</li> </ul> <p>The participants explored different ways of modifying the wording, including adding the words “should” and “appropriate” to the Principle, adding a bullet such as “Volunteer services are available in the patient’s home and all other care settings,” or “Volunteer services shall be well-planned for a geographical area.” The group</p>
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<p><b>GP5. Adequately Resourced.</b> 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.</p> <p><b>GP6. Collaborative.</b> Each community’s needs for hospice palliative care are assessed and addressed through the collaborative efforts of available organizations and services in partnership.</p> <p><b>GP7. Knowledge-Based.</b> Ongoing education of all patients, families, caregivers, staff, and stakeholders is integral to the provision and advancement of quality hospice palliative care.</p> <p><b>GP8. Advocacy-Based.</b> 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. All advocacy is based on the Canadian Hospice Palliative Care Association’s model to guide hospice palliative care.</p>	<p>asked that the notes indicate that further discussion is necessary.</p> <ul style="list-style-type: none"> <li>• <b>Sufficient resources are allocated for palliative volunteer services to meet the needs of the patient/family.</b> Jerry said that more information about the value of volunteer services is needed in order to advocate for adequate resources.</li> </ul> <p>Linda S. commented that the term “education” is very broad. Jerry suggested adding a Guiding Principle about learning models and mutual dialogue, as the term “ongoing education” seems to suggest a classroom setting. (Refer to <b>Guiding Principle GPA.</b>)</p> <p>Paula added a point about ongoing monitoring, not only for the volunteers but also for the program and staff. Suzanne suggested explicitly adding a Guiding Principle. (Refer to the fifth and last bullet under <b>Guiding Principle GP2.</b>)</p> <p>The participants had a concern about the last sentence. Gerard commented that advocacy should be based on needs identified by individuals, for example, a need for funding to make a specific purchase.</p> <ul style="list-style-type: none"> <li>• <b>Volunteers can play a unique role in advocacy within the scope of their job description and agency policies.</b> Lynda raised the issue of volunteers being interviewed by the media, which would be considered</li> </ul>
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<p><b>GP9. Research-Based.</b> The development, dissemination, and integration of new knowledge are critical to the advancement of quality hospice palliative care. Where possible, all activities are based on the best available evidence. All research protocols comply with legislation and regulations governing research and the involvement of human subjects in effect within the jurisdiction.</p>	<p>advocacy. She suggested that a policy may be needed to clarify issues surrounding contact and interactions with the media. Myriam added that the confidentiality issue must be addressed.</p> <ul style="list-style-type: none"> <li>• <b>The volunteer component has a responsibility to engage in research that explores volunteer issues, for example:</b> <ul style="list-style-type: none"> <li>• <b>Their motivations, needs, expectations, satisfaction, etc.;</b></li> <li>• <b>Their impact on care and outcomes of care;</b></li> <li>• <b>Their impact on team.</b></li> </ul> </li> </ul> <p>Linda S. noted that research is needed for the validation of volunteer services and to include evidence-based results into the volunteer component. Jerry added that research should be self-reflective and that the aim is for the research to be used.</p> <p><b>GPA. HPC is based on a learning model that includes mutual dialogue among all patients/families and caregivers concerning their needs, available resources, and the kinds of decisions they have a right to make.</b> This kind of learning model is needed not only for volunteers but also other components as well. (Cross reference to GP7 for details.)</p>
<p><b>FOUNDATIONAL CONCEPTS</b></p>	
<p><b>FC1. Effective Communication</b> is fundamental to both the process of providing care and the function of a hospice palliative care organization.</p>	
<p><b>FC1.1</b> Share a common language and understanding of the definitions of the</p>	<p>Suzanne noted that a “common language” is also needed among members of the caregiver team. Paula added that even within the team, a physician’s</p>

<p>terms they use during the process of providing care...</p> <p><b>FC1.2</b> Use a standard protocol to communicate, and to listen and respond to the reactions that information creates (for example, the six-step protocol for effective communication developed by Robert Buckman)...</p> <p><b>FC1.3</b> Collect data that documents the patient's and family's status, and provides a record of each therapeutic encounter...</p>	<p>language may differ from that of other team members, for example Team members need to have a common understanding among one another. Gerard indicated the need to capture the concept of cultural appropriateness in the use of language. Peta added that the use of interpreters in different languages must be taken into consideration. Suzanne noted that it is incumbent upon the volunteer to have a broad understanding of cultural and multicultural issues. The participants decided to add a General Principle to incorporate culture and language. (Refer to the second bullet under <b>Guiding Principle GP1</b>.) Jerry also indicated that best practices should include providing an interpreter so that family members do not have to be part of the formal team.</p> <p><b>Bullet to FC1.1:</b></p> <ul style="list-style-type: none"> <li>• <b>It's incumbent upon the volunteer component to provide information to the volunteers on clinical terminology in lay language.</b></li> </ul> <p><b>Bullet to FC1.2:</b></p> <ul style="list-style-type: none"> <li>• <b>The volunteer component respects the uniqueness of each person and offers training to volunteers to be effective communicators and sensitive listeners.</b></li> </ul> <p><b>Bullets to FC1.3:</b></p> <ul style="list-style-type: none"> <li>• <b>The volunteer team member will record and/or share relevant information about their interactions with the patient/family in accordance with agency policies.</b></li> <li>• <b>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.</b></li> </ul>
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<p><b>FC1.4</b> Educate patients, families, and caregivers using strategies that are built on the principles of adult education—that is, education should be practical, participatory, considerate of the learners’ multiple demands, and include strategies to develop the learners’ attitudes, knowledge, skills, and behaviours...</p>	<p><b>Bullets to FC1.4:</b></p> <ul style="list-style-type: none"> <li>• <b>The education of volunteer caregivers includes opportunity for self-exploration and self-reflection and understanding of the importance of sharing.</b></li> <li>• <b>The education of volunteer caregivers will include exploration of difficult feelings, sense of failure, and the encounter with loss and grief that come with working in hospice palliative care.</b></li> </ul>
<p><b>FC2. Effective Group Function</b> All activities related to hospice palliative care revolve around multiple groups that have specific purposes and tasks...</p>	
<p><b>FC2.1 The patient and family.</b> Patients typically live in long-standing family groups with well-established group leadership and dynamics (which may or may not be effective.) During an illness and bereavement, membership, roles, group dynamics, and leadership may change dramatically, particularly as the patient dies, and a new family group forms.</p> <p><b>FC2.2 The care team.</b> Hospice palliative care is most effectively provided by interdisciplinary care teams. These teams form around individual patient/family units to provide care through a therapeutic relationships...</p> <p><b>FC2.3 Regional teams of formal caregivers.</b> Most hospice palliative care organizations develop regional teams of formal caregivers to help provide</p>	<p><b>Bullet to FC2.1</b></p> <ul style="list-style-type: none"> <li>• <b>The education of the volunteer caregiver will include exploration of family dynamics and experiences during illness and bereavement.</b> The participants agreed that interactions with the family should be seen as supportive rather than critical.</li> </ul> <p><b>Bullet to FC2.2:</b></p> <ul style="list-style-type: none"> <li>• <b>The education of the volunteer caregiver includes information about the functions and dynamics of the interdisciplinary team. The volunteer caregiver is a formal caregiver as defined by the CHPCA lexicon.</b></li> </ul>

<p>hospice palliative care within a specified geographic region or setting...</p> <p><b>FC2.4 The organization’s management team(s), committees and workgroups.</b> Strong and effective group function is also essential to the development of hospice palliative care organizations and their management team(s), committees and workgroups...</p>	<p><b>Bullet to FC2.4:</b></p> <ul style="list-style-type: none"> <li>• <b>The volunteer service manager must be a member of the organization’s management team.</b></li> </ul>
<p><b>FC3 Ability to Facilitate Change</b> Hospice palliative care aims to help patients and families manage the challenges and opportunities they face during their changing illness and bereavement experiences. To fulfil that goal, caregivers must be skilled at 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.</p>	
<p>Linda S. remarked that the title of this foundational concept does not match its description, which does not mention facilitating change but only talks about helping patients/families manage change during illness and bereavement experiences and having specific skills to provide assistance through the transitions. She said volunteers are not task-oriented and task-driven and have no pre-set agenda to be agents of change. They are there to be responsive to the persons they are with. The participants decided to add a new Foundational Concept to address this issue. (Refer to <b>Foundational Concept FCA</b>.)</p> <p><b>FCA. The specific skills of volunteers are not to facilitate change but to accompany patients and families, to value their journey, and to support the life being lived by patients and families through the transitions they experience during illness, death, and bereavement. Volunteers are present and responsive to patients and families and give the time that is needed to respond to the uniqueness of each person and situation.</b></p>	

#### Further tasks

- To examine the proposed framework against the Model’s Values, Guiding Principles, and Foundational Concepts in order to arrive at convergence and to confirm the framework’s workability;
- To provide volunteer content by asking process questions, recognizing the efforts that have already been made, and considering holding more meetings and providing a budget;
- To produce a work plan for the Secretariat on Palliative and End-of-Life Care.

Jerry said he wished to leave the group with the message that he is totally aware that many programs across the country have worked extremely hard on developing their volunteer training

programs. Our work on a Best Practices/Quality Model will not detract from that work. Rather, he said the framework will help programs evaluate the processes, outcomes, and measurements of volunteer training and involve the volunteer component of HPC in the quality circle and in the norms-based movement both at the local and national levels.

Linda S. noted the need for a continuum of standards to address the range of needs from hospices in smaller communities, which may be run only by volunteers, to the larger programs and facilities. Jerry agreed and asked the group to consider how to make sure their document helps the smallest of the volunteer programs, citing **GP6, Collaborative**, on page 20 of the HPC norms document. Peta suggested that the accreditation might serve to give these smaller programs “a vision of the whole banquet” available to them in training and support.

Jerry noted that the Application of the Model outlined in section V of the HPC Norms document acknowledges the changing continuum of care, similar to our efforts to identify the continuum of Best Practices development for staff and programs.

#### 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 <i>Quality dimensions</i>	22 AIM <i>Descriptors</i>	AIM <i>Standards</i> and CHPCA <i>Principles</i>	AIM <i>Criteria</i> and CHPCA <i>Norms</i>	<i>Best Practices</i> continuum Novice /Advanced/ Expert	<i>Indicators</i> and results of monitoring them	<i>Confirmation:</i> Repeat review rethink re-plan

Our work with the model will include a learning process, perhaps a manual. Linda S. suggested that smaller organizations would have dimensions they just wouldn't have to measure and “we'll offer ways to measure whether what they're doing is reasonable and good.” She said those groups that don't fit the model may find it provides the impetus needed to move forward. Suzanne called it “a solid lens” through which to look at things. Linda C. commented that all too often standardization means establishing a gold standard that everyone is expected to reach. She said she liked this model because it allows for the many different levels and stages that exist. Jerry noted also that this model could provide an opportunity for anyone to identify gaps in their program and access the expertise and information necessary to address client/family needs.

### Workplan

An outline workplan was developed:

- Five regional meetings (two in Québec) plus electronic means (teleconference, e-mail)
- One task group meeting (June, 2003, Québec)
- Translation of materials
- Task Group teleconferences
- Task group meeting in March 2004
- Draft writing and presentation to International Congress, Montréal, Fall, 2004
- Consensus building process during 2004-2005 and building “champions' network”
- Launching of final document at national conference, Edmonton, Fall, 2005
- Implementation strategies

Gerard agreed to work up a budget for submission to the Secretariat.