Client Service Standards for the Volunteer Hospice Visiting Services

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Table of Contents

Acknowledgements

The development of the Client Service Standards for the Volunteer Hospice Visiting Service was the result of the cooperative efforts of many individuals, hospices and organizations.

The driving force behind the project was the recognition that clients, funders and community are expecting and demanding quality services. The use of consistent standards by hospices is a key approach for achieving this.

The Hospice Palliative Care of Ontario (HPCO) was very fortunate to receive funding for the project from the Glaxo Wellcome Foundation. Ms. Tara Addis, a representative of the company and a member of the Standards Working Group, conveyed the interests of the company in assisting with the project and provided her personal insights as a hospice volunteer.

The members of the Standards Working Group deserve special recognition for their hard work and their thoughtful and challenging analysis of the wide range of issues experienced by the different types of hospices. They include:

- Tara Addis, the Glaxo Wellcome Foundation and hospice volunteer
- Jenny Barretto, Ontario Community Support Association
- Barbara Bowie, The Dorothy Ley Hospice, Etobicoke
- Shirley Dinsmore, Huron Hospice Volunteer Service, Seaforth
- Judy Bowyer, Ontario Community Support Association[1]
- Yvonne Kitchen, Seaforth Community Hospital (Chief Nursing Officer) and board member of the Community Access Care Centre for Huron County
- Carol Anne Smart, Palliative Care Volunteer Services, VON Hamilton-Wentworth Branch
- Pat Van Den Elzen, Ontario Palliative Care Association

I also wish to think the many HPCO hospice members who took the time out from their busy schedules to provide us with invaluable suggestions to the draft standards both through their feedback forms and the at the HPCO conference.

The Ontario Community Support Association very generously gave HPCO permission to use and/or adapt its draft standards document. This enhanced the spirit of sharing and working cooperatively.

Helpful comments were also received from Mr. Cam Jackson, Minister of Long-Term Care with Responsibility for Seniors, as well as from Community Care Access Centres and District Health Councils across Ontario.

Last, I would like to thank Mary Davies, our facilitator, for her keen interest in and support of the hospice palliative care movement. Mary's experience and expertise in the development of standards was invaluable to this project. She also managed to keep all of us on track and on deadline for more than a year of meetings – quite an accomplishment! From everyone on the Standards Working Group – thank you, Mary.

Janet Napper
Executive Director

[1] Jenny Barretto's replacement while she was on maternity leave.

Summary of the Standards
for the Volunteer Hospice Visiting Service

Quality Dimension: ***Accessibility***

Standard 1.1	The hospice has an ongoing process for informing the public and other service providers of its service.
Standard 1.2	The hospice services based upon the client's/caregiver's needs and the parameters of the service.*
Standard 1.3	The hospice has eligibility criteria which are consistent with the philosophy of hospice palliative care. [1]
Standard 1.4	Admission to the Volunteer Hospice Visiting Service is dependent upon an assessment and approval of the service.*

Quality Dimension: ***Client Perspective***

Standard 2.1	An individualized assessment is completed to determine the client's/ caregiver's specific needs.*
Standard 2.2	Clients and caregivers are respected as individuals and involved as appropriate in all aspects of their individual program plans as developed by a qualified coordinator at the Volunteer Hospice Visiting Service*.

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

[1] The Hospice Palliative Care of Ontario will review any changes in the long term care legislation, regulations or policy for their applicability.

Quality Dimension: ***Safety***

Standard 3.1	A qualified coordinator conducts ongoing intensive screening of all volunteers who visit clients/caregivers.*
Standard 3.2	The hospice has a process for informing volunteers of their roles and limitations.
Standard 3.3	The hospice has a process for optimizing the matches between the clients/caregivers and volunteers.
Standard 3.4	The hospice has a process for ongoing support/supervision of the volunteers.*
Standard 3.5	The hospice has a risk management process.
Standard 3.6	The service has a records management process.
Standard 3.7	The hospice has a process to maintain confidentiality of information.

Quality Dimension: ***Competence***

Standard 4.1	The hospice has a process for the ongoing education/training of the volunteers who provide hospice palliative care to clients.*

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

Quality Dimension: ***Continuity***

Standard 5.1	The Volunteer Hospice Visiting Service provides the client and caregiver with the consistent volunteer/volunteer care team members in order to promote continuity of care.
Standard 5.2	The hospice is committed to working collaboratively with other agencies/individuals serving the client/caregiver.

Client Service Standards for the Volunteer Hospice Visiting Service

Introduction

The Hospice Palliative Care of Ontario's (HPCO) members range from small, totally volunteer-operated hospices to sophisticated, well-established programs offering a comprehensive range of services. A neophyte hospice cannot be fairly compared to a long-established hospice which is well accepted and supported by its community. However, to assist in orderly growth and development, all hospices need consistent standards to help ensure quality of service and effectiveness.

Hospice clients and primary caregivers must have assurances that, no matter where they live in Ontario and no matter the size of their local hospice, they will receive the same standard of quality care. Community agencies who refer their own clients to hospices must also be assured that these corporations, foundations and government – need to know that their support is being used to provide a particular standard of care.

In 1994, the Hospice Association of Ontario developed *Standards of Practice*, the first document of its kind in Canada to set hospice standards for client services, organization and administration and continuous quality improvement. The Association has now initiated a project to update the client service standards for the Ministry of Health's funded Volunteer Hospice Visiting Service. These standards are intended to be consistent with standards developed by other organizations/associations (e.g. Ontario Community Support Association and the Canadian Palliative Care Association) and more comprehensive as they are specific for the Volunteer Hospice Visiting Service.

Goal for the Project

The goal for the project is to involve key stakeholders in developing mutually agreed to client service standards for the Volunteer Hospice Visiting Service.

Quality Dimensions and Service Delivery Standards:

Client service standards relate to aspects of the service which directly affect the quality of the care provided to the client/caregiver. The standards have been grouped according to the following quality dimensions.[1]

Accessibility:	The community being knowledgeable about the service and the service being accessible to all major groups within the community.
Competence:	The volunteers having the appropriate knowledge and skill level to provide the hospice palliative care.
Client Perspective:	Clients and caregivers being involved in the decision making concerning their care and being satisfied with the care they received.
Safety:	The service to the client/caregiver being provided in a 'safe' manner.
Continuity:	The service being coordinated with other service providers.

Process for the Project

The project involved the following steps:

1. A Standards Working Group was established to provide expert advice and to develop the standards. The members of the Working Group included:

    - Tara Addis, the Glaxo Wellcome Foundation and hospice volunteer
    - Jenny Barretto, Ontario Community Support Association
    - Barbara Bowie, The Dorothy Ley Hospice, Etobicoke
    - Shirley Dinsmore, Huron Hospice Volunteer Service, Seaforth
    - Judy Bowyer, Ontario Community Support Association[2]
    - Yvonne Kitchen, Seaforth Community Hospital (Chief Nursing Officer) and board member of the Community Access Care Centre for Huron County
    - Janet Napper, Hospice Association of Ontario
    - Carol Anne Smart, Palliative Care Volunteer Services, VON Hamilton-Wentworth Branch

[1] Except for competence, these are some of the dimensions of quality adapted from the Ministry of Health's *Provincial Requirements for the Request for Proposal Process for the Provision on In-Home Services, Supplies and Equipment*. May 1996 which sources Donabedian. A. *The role of outcomes in quality assessment and assurance*. Quality Review Bulletin 1992: 18(ii), 356-60 and Macdonald,M. and Boulianne, R. *Governance for quality, getting to the heart of it*. Healthcare Management Forum 1995, 8(iii), 46.

[2] Jenny Barretto's replacement while she was on maternity leave.

- Pat Van Den Elzen, Ontario Palliative Care Association
- Mary Davies, facilitator

2. Key documents were reviewed including:

   - *An Act Respecting Long Term Care*, Dec. 1994.
   - Long Term Care Division. *1998/99 Planning, Funding and Accountability Manual Section 4,* January 1998.
   - Ontario Community Support Association. *Final Draft Standards, Criteria, Guidelines for Good Practice and Indicators for Selected Community Support Service*, February 1998.
   - Canadian Palliative Care Association. *Palliative Care: Towards a Consensus in Standardized Principles of Practice: First Phase Working Document* 1995.

3. The Standards Working Group developed *The Draft Client Service Standards for the Volunteer Hospice Visiting Service.* July 1998.

4. The draft document was sent to the HPCO membership in July to obtain feedback. Of those who responded, 98% found the document easy to read and understand; 97% indicated that the standards addressed all the minimum expectations for the client services anywhere in Ontario; and, 84.7% stated they would have some to no difficulty in meeting the standards.

5. The Standards Working revised the draft document based upon the feedback received.

6. The revised document was presented at the HPCO's annual conference, October 1998 for additional feedback.

7. Additional revisions were made based on the comments from the annual conference.

8. The final document was mailed to all HPCO members.

Relationship to Ontario Community Support Association's Draft Standards

The Ontario Community Support Association (OCSA) developed very extensive draft standards including generic client service standards (intake, assessment, development of a plan of service and referral/discharge) and support systems standards (management of service planning, management of records and confidentiality, risk management, management of human resources,

financial management, governance and senior management)[3]. Barbara Bowie, represented the Hospice Palliative Care of Ontario on one of the OCSA's standards working groups. In order not to 'reinvent the wheel', HPCO has received permission from OCSA to use and/or adapt some of its standards and criteria. An asterisk (*) in HPCO's standards indicates that the standard and/or criterion has been quoted and/or adapted from the OCSA's draft standards document.

Expectations of the Agencies with the Standards

It is the expectation that agencies which are members of HPCO will strive to meet all the minimum standards and criteria which are stated in this document.

A Glossary of Terms is available on pages 20-25.

[3] The document is still in draft form as it has not yet been approved by the Long Term Care Division of the Ministry of Health. It should be noted that the draft standards are a target for the Ontario Community Support Association's members and that the members will require time and resources to achieve them. However, the members are committed to working towards achieving the standards developed.

Client Service Standards for the Volunteer Hospice Visiting Service

The definition and units of service used in this document are from the Ministry of Health, Long-Term Care Division's *1999/2000 Planning, Funding & Accountability Policies & Procedures Manual for Long-Term Care Community Services (Section 4)*, January 1999. These were developed for the purposes of funding. Please refer to the Glossary of Terms for the definition of hospice palliative care.

Definition: A support service where volunteers are recruited, trained and supported to provide support to individuals in receipt of palliative care. Generally, the client will be matched with one volunteer. More than one volunteer may be provided where a volunteer is required to stay with a palliative care client for long periods of time, and on occasion for 24 hour periods. The palliative care visitor will supplement the support of family and friends. In some situations, the palliative care visitor may be the only source of support for the client. The service also includes bereavement support.

Unit of Service:

The unit of service is one hour or visiting. The unit of service includes all direct contact by a volunteer and paid supervisory staff with the client, caregiver, family member, either in person or by telephone, in the home, an office, hospital or Long Term Care facility. It includes both palliative care and bereavement visiting. Visiting should continue when the client moves from community into hospital or Long Term Care facility.

QUALITY DIMENSION I: Accessibility Standards

The community being knowledgeable about the service and the service being accessible to all major groups within the community.

Standard 1.1	The hospice has an ongoing process for informing the public and other service providers of its service.

Criteria

A. The information includes:

- how to access the service
- the types of supports provided
- who provides the service
- who needs the service
- availability of the service
- catchment area
- any specialty services.

B. A variety of mechanisms which can be used, include:
- pamphlets
- information sessions e.g. with Cancer Support Groups, HIV/AIDS, ALS, etc.
- meetings with physicians, Community Care Access Centres, etc.
- radio/television/newspaper and education fairs
- partnerships with health organizations (e.g. hospitals)
- other e.g. advertising.

C. The material and programs are sensitive to the needs of specific ethnocultural groups and special needs groups in the community.

D. Mechanisms are used to continuously identify areas for improving the process e.g. need for earlier referrals.

Standard 1.2

The hospice services based upon the client's/caregiver's needs and the parameters of the service.*

Criteria

A. Hospice palliative care is available in a variety of settings (e.g. home, hospital, long term care facility).

B. Bereavement support, if available, is either a component of the hospice program or by referral to an appropriate agency/individual.

C. The service days and hours are flexible to meet the needs of the clients.

D. The service is initiated in a timely manner.

E. The mechanism is in place to monitor and evaluate the service demands and timeliness of service.

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

Standard 1.3

The hospice has eligibility criteria which are consistent with the philosophy of hospice palliative care.[4]

A. Persons eligible for the service should include those:
   - living with life threatening or terminal illnesses and their families/caregivers
   - living within the geographic boundaries of the hospice agency.

.

B. Persons who do not meet the eligibility criteria are referred t the appropriate service(s).

Standard 1.4

Admission to the Volunteer Hospice Visiting Service is dependent upon an assessment and approval of the service.*

Criteria

A. A qualified coordinator at the service determines the individual's eligibility for service.*

B. Criteria for priority of service delivery is based on the individual's and caregiver's needs and applied to any existing waiting list.*

C. Prioritization may be developed in collaboration with other agencies.

D. If hospice is unable to serve a high need client, the hospice will refer the client to an appropriate service.

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

[4] The Hospice Palliative Care of Ontario will review any changes in the long term care legislation, regulations or policy for their applicability.

QUALITY DIMENSION 2: Client Perspective Standards

Clients and caregivers being involved in the decision making concerning care and being satisfied with the care they received.

Criteria

A. If an assessment has previously been completed, the qualified coordinator will gather with the authorization of the client, the following information from the appropriate members of the interdisciplinary team. If no prior assessment has been completed or some information is missing, the qualified coordinator will assess the following as necessary.[5]

i) Personal information:

- applicant identification (e.g. name, birthdate, address, telephone number
- principal caregiver
- alternate/other caregiver
- next of kin (address, phone number, relationship to client)
- emergency contact (e.g. family, nursing, case manager
- substitute decision maker
- languages spoken
- cultural background
- spiritual advisor
- living arrangements: type of accommodation, others in the home, pets
- personal interests/hobbies and work experience
- family physician/specialist
- client's/caregiver's instructions in case of emergency
- client's/caregiver's plans at time of death (e.g. do not resuscitate orders)
- Client's knowledge of diagnosis and prognosis

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

[5] After the Common Assessment Tool is in use province-wide, it is anticipated that hospices will not re-collect information that has been collected by the Community Care Access Centre unless there is a reason to believe that changes have occurred or that another aspect needs to be considered.

- Funeral plans (if considered appropriate at the time of assessment)

may include:

- Health card number
- Preference for male or female volunteer

ii) Services Information

- Other services requested for the client (e.g. Meals on Wheels)
- Other services provided to the client
- Services provided by the caregiver
- Services requested by the caregiver
- Services provided to the caregiver

iii) Status of the Individual

Physical

- Diagnosis/basic medical history and communicable diseases
- Allergies
- Medications
- Pain and symptom management (e.g. breathing)
- Elimination
- Skin
- Vision
- Hearing
- Personal needs

Nutritional/feeding

- Mouth
- Feeding
- Swallowing
- Special diet and/or likes and dislikes

Rest/Sleep

- Resting/sleeping routines

Mobility

- Mobility aids
- Assistance required

Level of orientation i.e. mental status
Emotional
Other Serious Illnesses in Family
History of Loss

iv) Respite needs of caregiver(s)

v) Any other concerns the client/caregiver may have

Standard 2.2

Clients and caregivers are respected as individuals and involved as appropriate in all aspects of their individual program plans as developed by a qualified coordinator at the Volunteer Hospice Visiting Service.

Criteria

A. The individual program plan is:
- Based on the assessment information and in keeping with the statement of client rights[6], is developed with the client or substitute decision-maker and takes into account their expectations and preferences.
- A plan of action which reflects and builds upon the individual's strengths and abilities.
- Based upon the systematic and ongoing assessment of the client.*

B. The Volunteer Hospice Visiting Service has a format for recording individual program plans.*

C. The individual program plan is reviewed in consultation with the client as defined by the specific Volunteer Hospice Visiting Service or when there is a significant change in a client's status.*

D. The individual program plan outlines the type(s) of support to be provided or not provided by the volunteer to the client/caregiver:
- Social
- Physical
- Emotional
- Spiritual
- Nutritional
- Rest
- Mobility
- Information
- Household (e.g. walking the dog)
- Bereavement follow-up where available.

E. The individual program plan outlines the client/caregiver responsibilities.

F. The individual program plan as developed by the Volunteer Hospice Visiting Service forms part of the overall plan of service for the client.*

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document

[6] Part III of the Long Term Care Act states what rights must be respected and promoted.

QUALITY DIMENSION 3: Safety Standards

The service to the client/caregiver being provided in a 'safe' manner.

Standard 3.1

A qualified coordinator conducts ongoing intensive screening of all volunteers who visit clients/caregivers.*

Criteria

A. Interviews include determining each volunteer's:
- Skills/qualifications
- Reasons for volunteering
- Expectations from assignment
- Availability
- Suitability for the specific position
- Commitment.*

B. The selection process consists of a number of steps including:
- Application form is completed.
- Interview is conducted.
- References are checked.*
- Observations are made during the training program.
- Health screening is completed as required under Public Hospitals Act for those hospices that provide support in hospitals of LTC facilities.

C. Each volunteer must submit a current (i.e. dated no earlier than the date of the volunteer's interview with the qualified coordinator) police records check report, which the volunteer should seek from the police service in whose jurisdiction the volunteer currently resides. (If the person has moved in the last five years, the individual should identify this fact to the police service when applying for the police records check. In some regions, the police will make a request of other police services for information from local records).[7]

[7] Each police service determines what it will and will not include in a police records check, and how and to whom it will release police records check information, whether to the individual applicant or to the organization seeking the information. The Hospice agency should check with its local or regional police service, or the OPP where it provides regional police services, to understand what its police records check includes and does not include. (See Appendix A for further information.)

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

D. The agency has a written policy which identifies the categories of offences (federal or provincial), outstanding charges or convictions which will disqualify the individual from serving as a volunteer in the agency, based on the identified occupational requirements of the position the volunteer is seeking. If the qualified coordinator is uncertain about the application of this policy, he or she will discuss its contents with the most senior person in the organization (or the Board, if the coordinator is the most senior person) who will make the final decision.

E. The qualified coordinator fills in a form for each volunteer which includes:

- Name of volunteer
- Date
- Date of police records check
- Name of police department providing the records check
- Volunteer's signature that the police records check relates to him/her
- Statement that the police records check did not contain any information which would prohibit the volunteer from participating in the service according to the agency's current policies
- Signature of qualified coordinator
- Signature of individual
- Date of signatures[8]

F. Screening is ongoing and includes regular monitoring, ongoing supervision/support and evaluation.*

G. All steps are documented in each volunteer's record.*

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

[8] Criteria C, D and E are based on *The Screening Handbook*, the centerpiece of the National Education Campaign on Screening (a project of Volunteer Canada), on *Screening Volunteers and Employees Providing Direct Service to Vulnerable Individuals Through Police Records Checks* and on discussions with Lorraine Street, the author of both documents and a consultant to the Law Enforcement and Records Managers Network (LEARN), a subcommittee of the Information and Technology Committee of the Ontario Association of the Chiefs of Police, in its efforts to establish consistent guidelines for police records checks in Ontario.

Standard 3.2

The hospice has a process for informing volunteers of their roles and limitations.

Criteria

A. The agency has written policies and procedures known to the volunteers outlining:
- Assistance with medications and medical equipment e.g. oxygen
- Provision of transportation to clients
- Prevention and reduction of risk
- Response to emergency situations
- Response to abuse/harassment
- Acceptance of gifts or gratuities
- Lines of communication e.g. who to contact, when and what type of information to provide
- Report of unusual incidents (e.g. theft, client fall)
- Conflict of interest
- Do not resuscitate orders
- Extent of physical care e.g. emptying urine bag
- Response to an unexpected change in the client's condition or an unexpected death of a client.

Standard 3.3

The hospice has a process for optimizing the matches between the clients/caregivers and volunteers.

Criteria

A. A qualified coordinator matches each client/caregiver with an appropriate volunteer.

B. Matches consider the following:
- Language
- Cultural background
- Specific needs of the client
- Preferences of the client and volunteer
- Skills, abilities and experience of the volunteer
- Specific interests of the volunteer and client
- Volunteer's personal bereavement experience.

C. The agency evaluates and changes the volunteer – client /caregiver match as required or requested by the volunteer and/or client/caregiver. The clients/caregiver and volunteers are informed of this procedure.

Standard 3.4

The hospice has a process for ongoing support/supervision of the volunteers.*

Criteria

A. The agency has written policies and procedures which address the support and ongoing supervision of volunteers, including:

- An experienced volunteer or an appropriate paid staff person with the hospice service being able to accompany each volunteer: on the first visit and at the request of the volunteer for any visit where there is a need.
- The volunteers having access to appropriate support while on duty for the hospice after regular office hours.
- The volunteers having access to regular support regarding their role with the hospice. The format includes: one-on-one support with an appropriate paid staff/volunteer, volunteer support meetings and access to professionals related to the field of hospice as deemed necessary.
- A designated, qualified paid staff/volunteer being directly responsible for the ongoing supervision of the volunteer. Ongoing supervision includes, at a minimum monthly contract with the client/caregiver and the volunteer(s) assigned, which provides for evaluation of the volunteer. If the volunteer-client contact is sporadic (i.e. once a month or less), then ongoing supervision is bimonthly.

Standard 3.5

The hospice has a risk management process.

Criteria

A. The agency has a mechanism for:[9]*

- Identifying and describing areas of potential risk (e.g. with people, services and settings)
- Assessing the severity of the risk and likelihood of its occurrence
- Assessing the level of risk versus the value of the service to the client.

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

[9] Criteria adapted from informant in the Canadian Association of Volunteer Bureaux and Centres' The Screening Handbook and the Ontario Office for Senior Issues' Transportation Manual for Coordinators.

B. The process identifies the risk the agency is willing to accept and/or needs to eliminate, change, transfer to another agency and/or insure.*

C. The agency has written policies and procedures to:
- Assist in the identification, prevention and reduction of risk[10]
- Inform clients, paid staff and volunteers of potential risks
- Handle emergency situations
- Deal with unusual incidents
- Address issues related to client, volunteer and/or paid staff abuse/harassment.*

Standard 3.6

The service has a records management process.

Criteria

A. Each client has a record. It includes:
- The individual's assessment
- The individual's program plan
- Relevant information from visits e.g. client's major concerns
- Consent for release of information
- Hospice visiting hours per month, identified by the volunteer[11]

B. Each volunteer has a record.[12] It includes:
- Application form
- Training received
- Results of ongoing screening process
- Signed confidentiality form
- Performance reviews
- Hours of service.

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

[10] Categories of risk as outlined in The Screening Handbook include abuse (physical, emotional, psychological, sexual), bodily harm, personal injury, property damage, financial loss, loss of reputation/goodwill.

[11] The rationale for this criteria is that the information will be helpful for data management, potential funders and accountability (including legal).

[12] For effective human resource management including the retrieval of information, there should be a record for each volunteer. It is also helpful to an agency which currently might have a small number of volunteers to begin with individual volunteer records as the number of volunteers may grow.

Standard 3.7 The hospice has a process to maintain confidentiality of information.

Criteria

A. The agency has documentation of each client's consent of release of information. The client is informed of what the release of information entails.*

B. All paid staff and volunteers are educated on the need for confidentiality and a sign a statement of confidentiality form.*

C. The agency has written policies and procedures concerning confidentiality of information which includes:*

- Privacy of information for volunteers, paid staff and clients
- A secure storage system
- Accessibility to the information
- Removal, use and release of information
- Retention period for inactive records[13]
- Storage of records if the agency closes
- Approval of, supervision of, and method for destruction of documents
- Sharing of information
- Penalty for breaching confidentiality e.g. reprimand, dismissal.

QUALITY DIMENSION 4: Competence Standards

The volunteers having the appropriate knowledge and skill level to provide the hospice palliative care.

Standard 4.1 The hospice has a process for the ongoing education/training of the volunteers who provide hospice palliative care to clients.*

Criteria

A. Volunteers are actively involved in determining their education /training needs and how best to address them.*

B. A variety of education/training techniques are used.*

C. Education/training occurs in comfortable settings with trainers experienced in the topic area and in working with volunteers.*

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document.

[13] The length of time client records should be kept still needs to be clarified by the Ministry of Health. Currently hospitals keep patient records for 10 years and home care for 20 years.

D. The training program for the volunteer consists of a minimum of 30 hours of instruction as outlined in the HAO Visiting Volunteer Training Curriculum.[14] It includes the following modules:

- Introduction to Hospice Care and its Philosophy
- Communication
- Emotional and Psychological Issues of Death and Dying
- Spiritual Issues of Death and Dying
- The Family
- Illness Specific Information
- Infection Control
- Pain and Symptom Management, Practical Comfort Measures
- The Challenges of Eating
- Body Mechanics, Assists and other Skills
- Recognizing the Signs of Death, Providing Care
- Grief and Bereavement
- Ethical Issues in Hospice Care
- The Responsibilities of the Volunteer
- Care for the Volunteer Caregiver

In addition, training must include:

- Hospice's policies and procedures (e.g. confidentiality, roles and limitations of the volunteer)

It may include:

- Continuous quality improvement
- Services available in the community

E. It is mandatory that all volunteers have completed the HAO modules.

F. All volunteers receive a training manual containing course materials and other relevant hospice information.

G. The agency may liaise with other community agencies to provide joint education days.

H. The volunteers have access to up-to-date resources within the agency.

I. The agency promotes and provides to the volunteers continuous educational opportunities.

J. Evaluation by volunteers of their education/training is incorporated in improving future education/training sessions.*

*indicates that the standard and/or criterion is directly quoted and/or adapted from the Ontario Community Support Association's draft standards document

[14] The modules reflect the information collected at HAO Regional Consultations in April 1997.

K. Volunteers who have completed the introductory training sessions are encouraged to attend any specific ones again as required to refresh their skills/knowledge.

L. The volunteers' education and skill levels are current and appropriate for what they are doing (e.g. Universal/Standard Precautions).

M. The hospice has a mechanism for identifying new training needs of experienced volunteers and developing educational modules to support the teaching required.

QUALITY DIMENSION 5: Continuity Standards

The service being coordinated with other service providers.

Standard 5.1

The Volunteer Hospice Visiting Service provides the client and caregiver with the consistent volunteer/volunteer care team members in order to promote continuity of care.

Criteria

A. The volunteer/volunteer care team is developed to best balance the needs of the client/caregiver and the volunteers.

Standard 5.2

The hospice is committed to working collaboratively with other agencies/individuals serving the client/caregiver.

Criteria

A. The client's individual program plan lists the contact names and telephone numbers of other agencies/individuals who are providing service to the client/caregiver. These include:

- Physician
- Community Care Access Centre
- Minister/Spiritual Advisor
- Visiting Nurses, physiotherapists, occupational therapists, personal support workers, home help workers and other care team members
- Friends.

B. The hospice:
- obtains written permission from the client to contact and share relevant information with other service providers.
- notifies all other service providers of its involvement.
- initiates and/or participates as appropriate in interdisciplinary team conferences.

C. The hospice works with other members of the interdisciplinary team to avoid duplication of services.

D. The hospice works with other members of the interdisciplinary team (e.g. in-service training, improved communication) to ensure that appropriate agencies/services are notified prior to potential clients being discharged from the hospital.

E. The hospice recognizes the importance of all members of the interdisciplinary team working towards and participating in the use of:
- a common assessment form
- a common release of information form
- a common plan of service
- agreed upon methods of communication among its members
- an information booklet kept with the client in which all members of the team, including the client and family make notes and comments.

F. The hospice evaluates with the other members of the interdisciplinary team the effectiveness of the team's collaborative approaches.

Glossary of Terms
Specific to the Volunteer Hospice Visiting Service

Bereavement Support: Hospice volunteers may offer support to caregivers and family after a death. The support may include attendance at the funeral, accompanying a client to support groups, follow up telephone support, bereavement support resource material as well as personal visits and information and/or referrals to other community bereavement resources.

Caregiver: He/she is the person who provides care/support to the client such as a family member, friend or neighbor. This person does not include paid staff and hospice volunteers.

Client: He/she is:

- A person living with a life threatening or terminal illness and his/her family/caregivers
- Someone in need of bereavement support

Criteria: They are the steps taken to promote the achievement of a standard.[15]

Emotional Support: It is the provision of sensitive listening and non-judgmental discussion. Taking cues from the client, this support can include:

- Encouraging clients to take active roles in their own care
- Acting as an advocate by ensuring the clients' wishes are respected
- Providing non-verbal support, e.g. holding a hand or giving a hug
- Sharing an activity
- Discussing illness openly[16]

[15] Canadian Council on Health Services Accreditation. Standards for Home Care Organizations: A Client-centred Approach. Ottawa: 1997, p.31

[16] Hospice Association of Ontario

Family: Those closest to the patient in knowledge, care and affection. This includes:

- The biological family
- The family of acquisition (related by marriage/contract)
- The family of choice and friends (not related biologically or by marriage/contract)[17]

Hospice Palliative Care It helps people with life threatening and terminal illnesses to live comfortably and as fully as possible no matter where they are.

The focus is on caring, not curing and on life, not death. The care also extends to friends and family members, helping them to care for their loved one and to care for themselves during times of grief.[18]

Individual Program Plan: The amount and type of service to be provided by the hospice agency to the client/caregivers to achieve the client's/caregivers' goals.

Information Support: It is the provision of support or a response to a client's request for information and provides a climate of openness to client's questions.

Interdisciplinary Team: The term interdisciplinary team often has two connotations in palliative care. One is defined by the structure of the program and provides principal functions of the program. The other forms around an individual patient and family in order to provide care to them.

Program-based Team:
A team of caregivers from different backgrounds and professional disciplines and sometimes via linkages and contractual arrangements from different programs or services, who work together to deliver palliative care services. They share mutual respect, a common philosophy, develop common goals and work collaboratively toward achieving these goals. The level of collaboration will permit some role sharing or overlap in achieving the common goals.

[17] Canadian Palliative Care Association. Palliative Care: Towards a Consensus in Standardized Principles of Practice. (First Phase Working Document), Ottawa: Canadian Palliative Care Association, 1995, p.31
[18] Hospice Association of Ontario

The membership of this team should include physician, nurse, social worker, spiritual advisor and volunteer with other disciplines available to the team as resources permit.

Care Team that Forms around a Patient/Family:
A team of caregivers who work with a specific patient/family and embody all the features of a program-based interdisciplinary team. The membership of this team will vary depending on identified expectations and needs of the patient/family and may include individuals from the community as well as palliative care program members. The leadership of this team will vary from time to time depending on the principal expectations and needs of the patient/family.[19]

Life Threatening Illness: A disease or illness that may lead to death, as opposed to one which is stable and chronic.[20]

Nutritional Support: The support is to assist the client with intake of fluids and food as tolerated and to provide companionship during meals.

Physical Support: The volunteer is expected to give physical care within the specific agency's guidelines of a volunteer. Hospice volunteers also offer a compassionate response to client's physical and personal care needs which may include assisting with bed pans or urinals, ambulation to bathroom, positioning in bed and aspects of grooming.

Plan of Service: The amount and type of service to be provided to the client to achieve his/her goals.[21] This is coordinated by the Community Care Access Centre (CCAC) with the other agencies involved in the client's care if the CCAC is involved with the client.

[19] Canadian Palliative Care Association. Palliative Care: Towards a Consensus in Standardized Principles of Practice. (First Phase Working Document), Ottawa: Canadian Palliative Care Association, 1995, p.32
[20] Ibid, p.32
[21] Ontario Community Support Association. Final Draft Standards, 1998. p.G-2

Primary Caregiver:	It is the person who provides the majority of care to the client such as a family member, friend, or neighbor. This person does not include paid staff and hospice volunteers.
Process:	It is the steps taken in an activity.
Qualified Coordinator:	The person(s) is to have knowledge and expertise in palliative care with access to resource persons as required. To be qualified to recruit, screen, train and support the hospice volunteers, the individual should possess a certification (e.g. Ontario Association for Volunteer Administration (OAVA), Ontario Directors of Volunteer Administration (ODVH)[22] or equivalent education/experience. The competencies are outlined in OAVA's *Standards of Practice: Entry Level Competencies for the Management of Volunteer Resources* include: • Planning programs • Developing and maintaining systems • Marketing volunteer services • Training volunteers and staff • Supervising volunteers and staff • Motivating/recognizing volunteers, staff and community • Interfacing with other internal staff • Administrating the programs and systems • Managing the finances • Conducting public relations • Interfacing with the community • Pursuing professional development.
Respite Support:	It is the relief provided to caregivers which helps to relieve the stress placed on the client's family/friend/neighbour relationship.

[22] OAVA and ODVH are now the Professional Administrators of Volunteer Resources of Ontario (PAVRO)

Screening:	Screening of applicants refers to the range of procedures and processes used by organizations to carefully scrutinize individuals who apply for paid or unpaid positions in order to choose the best candidates and to weed out, as far as possible, those who would be incompetent or who would do harm. But screening does not stop when someone is hired or engaged. Screening continues throughout the length of an individual's work with an organization, it takes somewhat different forms after hiring but it does and should continue.[23]
Social Support:	The volunteer provides companionship to the client and support to the caregivers.
Spiritual Support:	The volunteer promotes spiritual support. Spirituality as defined by the National Hospice Association is that part of each individual which longs for meaning, integrity, beauty, dignity, love, acceptance and hope.
Standard:	It is desired and achievable level of performance against which actual performance can be compared.[24]
Support with Mobility:	When it is required and when an appropriately trained volunteer is available, the volunteer assists an individual to move about to promote optimal functioning.
Support with Rest:	The volunteer promotes an atmosphere conducive to the client resting.

[23] Street, L. *Screening Handbook*. Ottawa: Canadian Association of Volunteer Bureaux and Centres, 1996, p. 1.3

[24] Canadian Council on Health Services Accreditation. *Standards for Home Care Organizations: A Client-centered Approach.* Ottawa: 1997, p.41

Unusual Incident:	It is any unusual occurrence or event which poses actual or potential harm to a recipient of service, volunteer, employee, visitor or student; or results in damage/loss of property and could result in litigation against the organization[25].
Volunteer:	A volunteer is a non-paid person who: • is committed to the mission, vision and values of the organization. • meets the screening requirements of the agency. • has completed a minimum of 30 hours of instruction as outlined in the HPCO Visiting Volunteer Training Curriculum. • understands the agency's policies and procedures. • is a member of the interdisciplinary team.
Volunteer Hospice Visiting Service:	A support service where volunteers are recruited, trained and supported to individuals in receipt of palliative care. Generally, the Client will be matched with one volunteer. More than one volunteer may be provided where a volunteer is required to stay with a palliative care client for long periods of time, an on occasion for 24 hour periods. The palliative care visitor will supplement the support of family and friends. In some situations, the palliative care visitor may be the only source of support for the client. The service also included bereavement support[26].

[25] Ontario Community Support Association. *Final Draft Standards*, 1998, which was adapted from VON Ontario, 1990, p85.

[26] Definition is from Ministry of Health, Long-Term Care Division. *1999/2000 Planning, Funding & Accountability Policies & Procedures Manual for Long-Term Care Community Services (Section 4)*. January 1999.

Appendix A. Information Available to the Police for Police Records Checks

The following information has been obtained from Volunteer Ontario's *Screening Volunteers and Employees Providing Direct Service to Vulnerable Individuals Through Police Records Checks.* July 1995.

The information available to the police include:

- The Canadian Police Information Centre (CPIC) records are compiled from police reports from across Canada. The information is held in Ottawa and is administered by the RCMP.
- Local records contains information about individuals in contact with the police at the local level. The information may be in computer files, microfiche and/or paper files.
- Regional databases. This varies from region to region.

The search of the above databases can produce information about any, some or all of the following:

1. Information Available to the police through CPIC
    - Criminal records of adults
    - Criminal records of young offenders
    - Records of "not guilty (of a criminal offense) by reason of metal incompetence"
    - Charges pending under federal statutes
    - Probation, prohibition and other judicial orders.

2. Information that may be available to the police locally or through regional databases:
    - Convictions for summary conviction offenses (minor Criminal Code offenses)
    - Charges pending under the *Child and Family Services Act*
    - Records of conviction for offenses under the *Child and Family Services Act*
    - Records of civil judicial proceedings with respect to the abuse of children
    - Admissions of abuse against vulnerable people, where charges were not laid
    - Pardoned *Criminal Code* convictions or convictions for which a Conditional or Absolute Discharge was given
    - Suspect data (information about an individual identifying that he or she was a suspect in a crime)
    - Information about the individual as a complainant, victim or witness to an occurrence.

It is important to note that even though this information may be available to the police, each police service determines what it will and will not include in the police records check and how and to whom it will release police records check information, whether to the individual applicant or to the organization seeking the information.

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