The 'Golden Angels' volunteer program for patients with dementia and delirium began in 2009 in one NSW rural hospital, has since spread across Australia, and is now being adapted for residential aged care settings. **Catherine Bateman, Katrina Anderson** and **Annaliese Blair** discuss the clinical outcomes for patients supported by the program, how it's implemented and the impacts and challenges of volunteer care for family carers and clinical staff

Older hospital patients with dementia and/or delirium are at far greater risk of adverse events and outcomes such as falls, pressure injury and death (Inouye *et al* 2013; Mukadam and Sampson 2011).

They can also experience significant fear, stress and anxiety when admitted to the busy, noisy hospital environment, which can pose particular challenges and stresses for staff and family carers. Volunteer support has been shown as one way of addressing the person-centred care needs of these patients and in turn provide support for families and staff (Bateman *et al* 2016).

The aim of the Volunteer Dementia and Delirium Care Program (VDDCP) is to provide person-centred emotional support and practical assistance to patients with dementia and delirium (or with identified risk factors for delirium) to reduce their risk of adverse outcomes.

The program originated as a pilot study in a rural NSW hospital in 2009 (Bateman *et al*, 2016). Findings from the pilot suggested improved patient outcomes such as enhanced safety, hydration and nutrition, reduced length of time in hospital and increase in analgesic medication. There was high acceptance of the volunteer support by staff. The volunteers became affectionately known as the 'Golden Angels' due to their gold-coloured uniform and compassionate care.

The NSW Agency for Clinical Innovation (ACI) subsequently funded the development of the Volunteer Dementia and Delirium Care Implementation and Training Resource © to support implementation of the program in other Australian hospitals. The resource, developed in 2014 in print format, is now available online and free to download at https://bit.ly/confused-hospitalised-aci

The hospital volunteers, affectionately known as the 'Golden Angels' due to their gold-coloured uniform and compassionate care, provide emotional support and practical assistance to patients with dementia and delirium. Photo courtesy the Volunteer Dementia and Delirium Care Program

‘Golden Angels’ going from strength to strength

Program evaluation

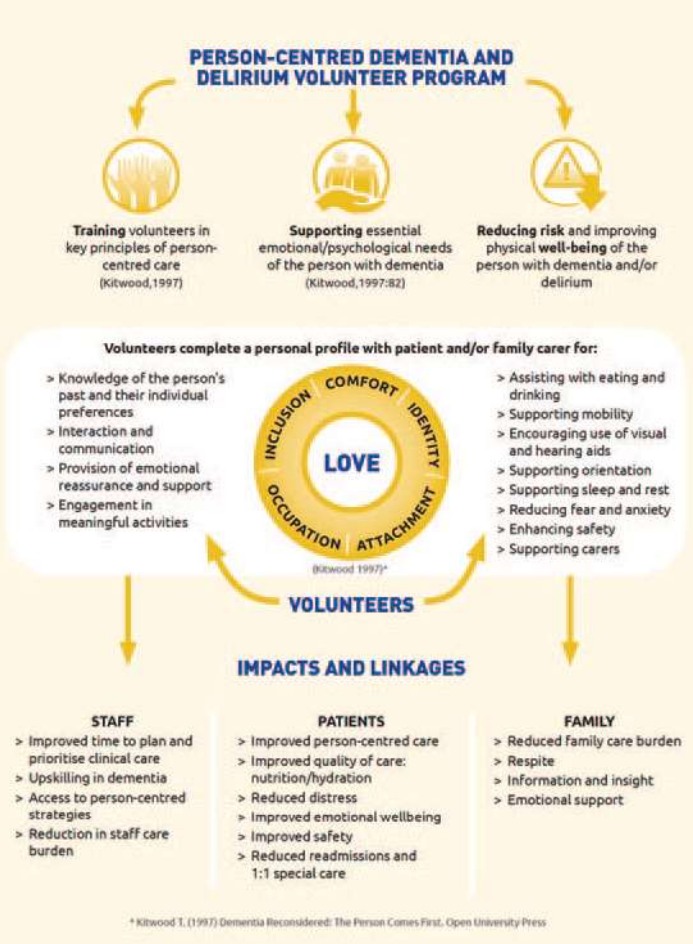
Following receipt of a Commonwealth grant, the Southern NSW Local Health District (SNSWLHD) Aged Care Evaluation Unit (ACEU) implemented and evaluated the VDDCP at another seven rural NSW hospitals between 2015-2017. Hospitals ranged from 13 to 79 beds, most with only one main ward.

The study aimed to evaluate the clinical outcomes for patients with dementia, delirium, or at risk for delirium, who were supported by the VDDCP, as well as the impacts and challenges of volunteer care for family carers and clinical staff. The study also explored the enablers and barriers to implementing the program.

It compared outcomes for 270 patients who were visited by a volunteer with outcomes of a control group of 188 patients who were admitted to the same hospital 12 months before the volunteer program started.

Using patient medical records, we looked at the number of volunteer visits, diagnosis, length of stay (LOS), behavioural incidents, readmission, specialling, mortality, admission to residential care, falls pressure injury and medication use.

We interviewed and surveyed 80 family carers of patients who received volunteer care about their perceptions of the program. Additionally, we surveyed 119 staff about their care confidence, care stress and their satisfaction with the program. We also held focus groups with 46 staff and 15 managers nine months after the volunteers started. Staff and managers were asked about what they saw as the enablers and barriers to implementation and the successes and challenges for the program.



Graphic courtesy of the Volunteer Dementia and Delirium Care Program

The volunteer intervention

We had four project officers working with us to oversee the implementation across the seven hospital sites. They were all clinical nurses experienced in aged and dementia care. The developer of the implementation and training resource (Catherine Bateman) provided the project officers with training and support over the course of the project.

Steering committees were set up to ensure everyone was kept in the loop, resolve any teething issues and monitor how the project implementation was progressing. Information sessions were provided for staff about the program and the role, scope and boundaries of the volunteers.

Volunteers were recruited via local media, shop flyers, word of mouth as well as promotion through existing volunteer groups. Selection requirements for volunteers included age greater than 18 years; preference that they had not experienced a significant loss in the preceding 12 months; an interest or experience with older people or people with dementia; good communication skills; respect for beliefs, values and culture of others; ability to be part of a team; current driver’s licence; desire and availability to become a volunteer.

A total of 101 volunteers were initially recruited across the seven sites. Selected volunteers participated in a two-day training program which used the VDDCP training resource (see Table 1). The role of the volunteer was clearly documented in their duty statement and covered in training, as were the specified boundaries (specific roles and boundaries are outlined in Table 2). Volunteers were required to sign their duty statement and a health service confidentiality agreement.

Our project officers provided the volunteers with orientation to the wards, introduced them to staff and managers and ensured they

Table 1: Volunteer training sessions

- About the program and the volunteer role
- Understanding Dementia and Delirium
- Communication and person-centred care
- Activities for patients
- Understanding and responding to behaviours that can occur in patients with dementia and delirium
- Assisting with eating and drinking
- Safe walking with patients
- Commencing as a volunteer
- Other hospital mandatory training such as infection control, PPE and fire safety

were well supported as members of the care team over the course of the project. The volunteers were easily recognised in their gold polo t-shirts by staff and families. Regular communication and networking meetings were held with the volunteers, who developed new friendships with each other and valued the opportunity to share their experiences of supporting patients.

A roster system was set up with volunteers indicating which day and shift they would prefer. Most volunteered to do either one shift a week or fortnight which allowed coverage for a morning and afternoon shift five days a week. The morning shift was from 8am-12.30pm and the evening shift 3pm-7pm.

To ensure the program was safe for the patients and volunteers, there was a one-page referral form completed by staff (see Table 3 for referral criteria) and written procedures for staff and volunteers. The volunteers gained valuable individualised information about the background of the patients, their likes, dislikes and activities they enjoyed by completing a personal profile with the patient and/or their carer. This was shared with staff and other volunteers. The volunteers also had a documented communication process between each other which conveyed information about their patient to the next volunteer, such as activities their patient may have enjoyed or things they liked to talk about.

Patient outcomes

Across all sites, there was a significant reduction of 6.4% in rates of one-to-one specialling by a nurse or security guard ($\chi 2$ (1, N=458) =6.51, p=.011) and a reduction of 8% in 28-day readmission for patients receiving the intervention (17.0%; $\chi 2$ (1, N=457) =7.501, p=.006). There was no significant difference in other outcomes such as length of stay, behavioural incidents, falls, pressure injury, admission to residential care, medication use and death rates for those who received volunteer assistance and those who did not.

Family carers and staff

Families rated the volunteer intervention as helping "a lot" (89%) or "a little" (8%). All families indicated they wanted to see the program continue. Of those who had had a previous admission without a volunteer, 87% of family carers reported a positive improvement in some way for the admission with volunteers. Overall, families talked about a sense of relief that someone else was able to be with their loved one when they were unable. They particularly valued the volunteers assisting with eating and drinking and individualised care.

In relation to staff, 97% of those surveyed agreed that the volunteers positively supported them in their care of patients. The majority were happy with how the program was running, felt that the program met or exceeded their expectations and that the volunteers were well prepared for their role. Staff conveyed a sense of reduced emotional and physical burden.

Managers, staff and families all considered the volunteer to be part of the care team and that volunteers were successful in implementing the principles of person-centred care:

"…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."

"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."

Cost savings

The evaluation of the VDDCP demonstrated an 8% reduction in 28-day readmissions. Even if readmissions were half the length of the initial stay (ie, five days on average), based on our 2018 analysis, this could save $32,000 per year per site. Therefore, just the savings from reduction in 28-day readmissions would cover the cost of the program.

There was a 6.4% reduction in 1:1 patient specialling. Due to lack of consistent data on specialling within the Local Health District, a sample of specialling data for older patients was taken from one hospital in 2015/16. These patients were specialled for an average of 15 hours by various staff from RNs, ENs, AINs and security staff. Based on these estimates, a reduction of 6.4% of specialling at 15 hours per patient at EN Year 5 wages, would save $20,519 for a rural health district over 12 months.

Estimated costs

The $29,860 estimated costs of running the program per annum in one hospital of 40-80 beds is calculated assuming a NSW Health Service Manager (HSM1; Paypoint 2) salary ($128,100 including 22% on-costs for 2021/22 FY) and assuming recruitment of no more than 15 new volunteers each year at each site.

Table 2:

Role of the volunteer	Specific boundaries for volunteers
• Completion of a person profile with the patient and or their carer	Volunteers *were* not to:
• Communicate and interact with assigned patients	• Assist assigned patients with walking unless instructed or agreed to by volunteer coordinator or NUM, RN in charge or physiotherapist
• Sit with assigned patients one-to-one and in group activities	• Assist with care of any other patients that you are not assigned to - always talk with the NUM or RN in charge if you are concerned
• Assist and support assigned patients with therapeutic activities	• Assist with duties a nurse might ask you to do that is not in your duty statement
• Assist assigned patients with completion of their menus	• Assist any other patients (not assigned) with eating or drinking
• Assist assigned patients with eating and drinking	• Buy food or other items for patients unless permission is obtained from the NUM
• Assist assigned patients with wearing visual and hearing aides	• Enter a room where the door is closed without requesting or receiving approval from the NUM or RN in charge
• Report any concerns or changes in the assigned patients to the nurse	• Discuss or criticise a patient's treatment with them, their carers or relatives
• Report any other concerns or worries to the coordinator or Nurse Unit Manager (NUM)	• Discuss any aspects of the patient's care outside of the health service
• Keep a record of time spent with assigned patients	
• Encourage assigned patients' walking as instructed by NUM, RN in charge or physiotherapist	

Table 3: Patient referral criteria for the volunteer program

- Patients with dementia or cognitive impairment identified with cognitive screen
- Delirium **OR** is confused or agitated or unusually lethargic

OR patients > 65 years or if Aboriginal > 45 years and has one or more of the following risk factors:

- Cognitive impairment
- Visual or hearing impairment
- Dehydration
- Severe illness
- High falls risk

Patients were excluded if they were exhibiting behaviours that posed risk to themselves or others OR consent was not obtained from patient and/or family for volunteer support

Efficiencies can be gained in smaller sites (<40 beds) by having one volunteer manager overseeing several sites or incorporating volunteer management into an existing role at the hospital, with extra time of up to one day per week allocated. Note that volunteer program resources such as large print playing cards, CD players, music, etc are also required and are not part of the costing. (For additional details on costings, refer to the links in 'Further reading' at the end of this article).

Success and challenges

In all new projects, there are always success factors and challenges. We found the key ingredients for success were careful selection of volunteers, comprehensive training, clearly defined roles and procedures for the volunteers, staff information sessions, and support by our project officers (for details, refer to the links to further information and published papers at the end of this article).

Common challenges were ensuring everyone knew about the roles and boundaries of the volunteers, building trust between staff and volunteers and having nursing staff complete the one-page referral form. Over the course of the six months these were mostly resolved.

The longer-term and continuing challenge is securing funding to support the program's continuation at all sites. A 2019 feedback survey conducted for other hospitals across Australia who have implemented the program highlighted similar success factors and challenges.

Conclusions

The VDDCP was seen by families and staff to be effective in addressing some of the main barriers to providing person-centred care to older patients with cognitive impairment in rural hospitals – namely lack of time, limited person-centred processes and knowledge and environmental limitations. Families and staff felt supported in their care, thereby reducing some of their care burden.

The volunteer intervention was found to be a safe, cost-effective and replicable way to support older patients with cognitive impairment in rural hospitals.

For residential care

In 2020, the SNSWLHD Aged Care Evaluation Unit was awarded a World Class Dementia Collaborative Research Grant to translate the existing VDDCP for hospitals into the residential aged care (RAC) setting. It involves adapting the existing implementation and training package for the RAC setting using a co-design workshop and consultation process with selected facilities.

Implementation and evaluation of the outcomes is occuring in two metropolitan and two rural RAC facilities over 2021 and 2022. Recruitment of rural and metropolitan intervention and control RAC facilities has occurred. The co-design workshop was held with the rural intervention facility in May 2021 and the co-design workshop with the metropolitan intervention facility was held in early August.

Program implementation committees with key stakeholders have been established at each implementation facility with fortnightly meetings being held to plan and monitor the program implementation.

Media releases and volunteer promotional material for volunteers, families, residents and staff have been developed and draft adaptations to the education modules and procedures have been made.

Consent is being gained from families and staff with a very positive response from families at the intervention facilities about the program's concept and the potential support it will provide their loved ones.

Although the COVID lockdowns this year have significantly impacted on the project timelines (including volunteer recruitment, definitive dates for training and commencement of the program), all facilities are very positive about the program being implemented and are continuing to work collaboratively towards this occurring. ■

Further reading

Further information about the project and team can be found at: https://bit.ly/golden-angels-dementiaresearch

The authors' two published papers are freely available:

Blair A, Anderson K, Bateman C (2018) The "Golden Angels": Effects Of Trained Volunteers On Specialling and Readmission Rates For People With Dementia and Delirium In Rural Hospitals. *International Psychogeriatrics* 30(11) 1707-1716. Available at: https://bit.ly/effects-of-trained-volunteers-article

Blair A, Bateman C, Anderson K (2019) "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. *Australasian Journal on Ageing* 38(S2) 34-45. Available at: https://bit.ly/AJAStudy

References

Bateman C, Anderson K, Bird M, Hungerford C (2016) Volunteers Improving Person Centred Dementia Care In A Rural Hospital. *Rural and Remote Health* 16 3667.

Inouye S K, Westendorp RGJ, Saczynski JS (2013) Delirium In Elderly People. *The Lancet* 383 911-922.

Moyle W, Borbasi S, Wallis M, Olorenshaw R, Gracia N (2011) Acute Care Management Of Older People With Dementia: A Qualitative Perspective. *Journal of Clinical Nursing* 20(3-4) 420-428.

Mukadam N, Sampson EI (2011) A Systematic Review Of The Prevalence, Associations And Outcomes Of Dementia In Older General Hospital Inpatients. *International Psychogeriatrics* 23(03) 344-355.

Nolan L (2006) Caring Connections With Older Persons With Dementia In An Acute Hospital Setting – A Hermeneutic Interpretation Of The Staff Nurse's Experience. *International Journal of Older People Nursing* 1(4) 208-215.

For more about the VDDCP, including full costings, visit www.journalofdementiacare.com

■ (From left) Catherine Bateman is a Dementia Delirium Clinical Nurse Consultant with Southern NSW Local Health District who established and piloted the original Dementia Delirium Volunteer Program and is the author of the NSW Agency for Clinical Innovation (ACI) VDDCP Implementation and Training resource; Dr Katrina Anderson is a Clinical Psychologist and researcher with the Aged Care Evaluation Unit, Southern NSW Local Health District; Annaliese Blair is a clinical research officer in rural NSW based in Southern NSW Local Health District. Contact the authors via Catherine.bateman@health.nsw.gov.au