The Importance of *Staff* Involvement in Volunteer Program Planning

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TENSIONS AND CONFLICTS BEtween paid staff and volunteers can become a threat to volunteer involvement in long-term care and services to the elderly. In fact, it would seem that the greater the actualization and achievement of volunteer potential, the greater the possibility of staff and volunteer tensions. Nevertheless, volunteers *can* extend and individualize the services provided to the chronically ill and the frail elderly living in the community and in institutions. Many human service agencies and institutions serving the elderly depend on volunteers to supplement services provided by paid staff.

A model volunteer program currently underway in the John J. Kane Regional Centers, the skilled/intermediate care nursing facilities serving residents of Allegheny County, Pa., has as its overall objective the improvement of staff/volunteer relations. During the mid 1970s, Kane Hospital faced a dual crisis of being in violation of the state and federal health and safety regulations and of experiencing an escalation of the patient population to 2,200, causing serious overcrowding. A decision was made in 1979 to abandon the existing one-million square foot facility and replace it with four 360-bed regional centers. Each of the regional centers subsequently was built in areas where a majority of the patients had lived prior to entering the nursing home. These centers were scheduled to open between November 1983 and February 1984. The actual physical move of patients to each of the new centers took four days.

This major reorganization presented an opportunity to design, implement and evaluate a model volunteer program based on advanced concepts in volunteer administration.

The demonstration program was initiated in July 1983 by an interdisciplinary team of researchers based at the University of Pittsburgh in conjunction with the administration at John J. Kane Regional Centers. Using a comparative case study evaluation research design, faculty in the Graduate School of Public Health at the University of Pittsburgh and staff at the nursing home introduced the volunteer program into two of the four long-term care regional centers. The other two regional centers are receiving no outside program intervention and are pursuing plans as developed by their respective volunteer coordinators.

The model was introduced in four stages. *Stage One* involved the development and implementation of a task force whose members were largely responsible for program design and implementation under the guidance of a consultant on volunteerism. *Stage Two* concentrated on the orientation and training of community volunteers drawn from each regional center's service areas and their introduction into the regional center. In *Stage Three*, the program was implemented during the four-day relocation of patients to the new regional centers and as an on-going program within the centers. *Stage Four* involved community outreach.

Program evaluation has been an ongoing process throughout the project; post-program evaluation will take place after the program has been in place three to four months in each regional center.

The Model Volunteer Program was designed to accomplish seven objectives:
1. To develop a volunteer program supported by and integrated into the institution's goals and objectives;
2. To involve the volunteer as a human resource to the institution and to serve patient needs;
3. To provide adequate orientation/training necessary for volunteers to carry out tasks in a respected manner leading to

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their personal development, the enhancement of patient care and good working relationships with staff;
4. To promote positive relationships between staff and volunteers;
5. To recruit volunteers to meet established patient needs;
6. To evaluate the effectiveness of the volunteer program; and
7. To promote the linking and integration of the volunteer program into the community.

These objectives were a result of a one-day workshop that assembled several of the leaders in the volunteer administration profession and selected University faculty and Kane administrators and staff. Funding for the workshop was provided by the University of Pittsburgh's Office for Urban and Community Affairs.

While all seven objectives are equally significant and interrelate in many areas, here we focus on only one: the design and implementation of a model volunteer program in a long-term care facility to promote positive relationships between staff and volunteers.

The Task Force

The model volunteer program began with the formation of a task force consisting of representatives of the nursing homes' administration, staff (union and non-union), volunteers, patients and local community agencies and institutions under the guidance of a volunteer administration consultant. Criteria for involvement of staff on the task force were interest and availability, although there was an attempt to assure representation from all departments in which volunteers were likely to be involved. Staff, volunteers, patients and community representatives were identified by administration and the research team, partially as a result of research undertaken prior to the move during the first six months of 1983. Through interviews with Kane staff, volunteers and patients, the research team obtained recommendations regarding a new volunteer program designed to fulfill patient needs.

The pre-study, therefore, gave the research staff an opportunity to
- assess the needs of Kane staff, volunteers and patients for volunteer program reorganization;
- identify potential members who would assist in the process;
- stimulate support from administration; and
- involve residents of the communities in which the long-term care regional centers would be located.

Given the need to gain the support of staff in the development and implementation of this program, the largest number of task force members was drawn from this category. The task force meetings began before all staff knew to which regional centers they were to be assigned and therefore represented all four centers.

Additional reasons for expanding task force representation were
- a desire to include the most creative and enthusiastic staff, even if they were not part of the demonstration program;
- the need to educate *all* staff concerning the appropriate involvement of volunteers; and
- the need to emphasize the cooperative aspects of the model volunteer research program.

Two examples of community participation were a suburban community library and a church. Both groups sent representatives who attended all of the planning sessions and aided in the training and implementation stages by offering or obtaining resources available to them.

Given a history of work stoppages involving unionized employees and the animosity that still prevailed towards those who ignored the picket lines to assist in patient care, there was a need to involve staff who represented the union position. Unfortunately, this segment of the staff (the largest in numbers proportionate to the entire staff) had the least amount of freedom in terms of work schedules and the lowest motivation, with some few exceptions, in participating in the volunteer program development process.

During the first quarter of the year-long project (July-September), the task force members, aided by the consultant, worked towards two objectives. The immediate objective was to develop very specific plans for utilizing volunteers to assist with the relocation of the nursing home patients into the two regional centers that would have volunteer demonstration programs. A second and longer-range objective was to create a new volunteer program consistent with the most recent developments in volunteer administration.

Separate meetings were held weekly by three sub-committees, which were responsible for internal communications, orientation and training, and community resources. These committee members met with representatives monthly, swelling ranks to a group of 45 to 50. Through such frequent sessions, task force members developed rapport with one another on many levels. The task force became a grassroots organization where members, regardless of their rank in the hospital or the community, freely participated in discussion about such issues as, How do you motivate paid staff to work cooperatively with volunteers? How do you educate staff to assume responsibility for volunteer assignment and satisfaction? How do you develop a training program for volunteers that will enable them to meet established patient needs, particularly during the relocation phase? How do you determine the number of volunteers needed to assist staff during the move to the regional centers? How do you develop a system for interviewing and assigning tasks to a large contingent of new volunteers? etc.

In addition, they sought a means to utilize community resources in the recruitment and training of volunteers, as well as the potential community resources that could meet the needs of long-term care patients. Each subcommittee concentrated on specific tasks related to the entire program (see table). At the monthly meetings of the entire group,

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committee activities were reported and problems common to all three subcommittees, such as planning for the move and reports on orientation and training evaluations, were reviewed.

Despite the distances that some had to travel to attend these meetings, the task force drew a loyal following from the two demonstration areas. Two examples of the community's participation were that of a suburban community library and one of the churches. Both groups sent representatives who attended all of the planning sessions and aided in the training and implementation stages by offering or obtaining resources available to them.

The librarian, for example, obtained lists of all of the organizations that could have potential volunteers from the entire service area (over 100 organizations). She contributed ideas about resources available in the community and library books on loan to the patients via volunteer carriers.

The church representative identified resources in her community to facilitate the training program, such as videotape capabilities to record the training sessions; the free use of bus service to transport local volunteers to the old nursing home for "hands-on" training. In addition, she provided information regarding the volunteer program to other organizations in the community who could not send representatives.

Patients, too, assisted in the development of the task force. One patient, despite extreme breathing problems, telephoned potential volunteers to determine their interests and willingness to serve the facility. She served as a vital link between the patients' needs and the task force potential, often intervening in issues where there was disagreement between staff as to the appropriate course to follow.

Participation by staff task force members was based on their respective interests, talents and desire to participate. The entire first draft of the orientation and training procedures for new volunteers in the first demonstration site was proposed by staff task force members, utilizing the talents of fellow staff. The administration strongly supported their involvement and provided the appropriate release time. Staff participating in the task force received a letter from the executive director of the facility commending them for their participation in the effort.

Volunteers serving as task force members also contributed to the program formation by serving as liaisons to newly recruited volunteers at the orientation and training sessions and by keeping the task force aware of the volunteer's needs.

The task force, therefore, was a crucial mechanism for early involvement of the community, volunteers and patients in decisions regarding program design. The task force format permitted a forum where all concerned could raise questions, clarify issues and plan toward common goals. Instead of a single staff member, i.e., the volunteer coordinator, carrying the responsiblity for the design and development of the volunteer program, responsibility was a shared concern.

Task force membership was remarkably consistent (although the rate of attendance varied) during the first four months of the program. In October, when the demonstration sites split off to form their own task force, membership began to change. Assignments to the regional centers stimulated the participation of new members and the attrition of some old members due to a variety of factors (such as the role of staff in the regional centers, the extent to which they continued to identify with the program, etc.).

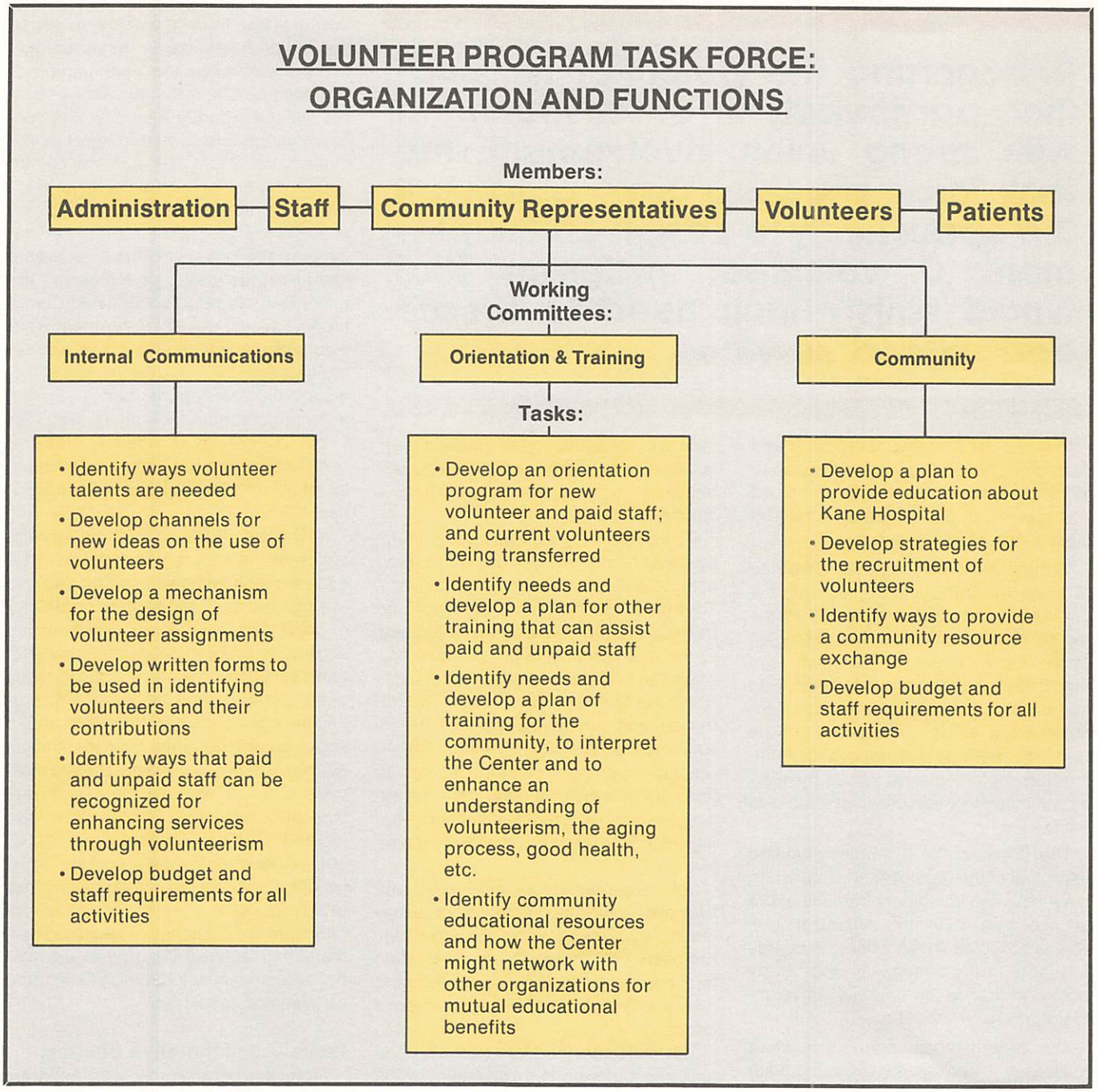
Initially, the volunteer administration consultant influenced the direction that the program took, but with considerable input from the task force members. The major tasks to be accomplished during the first six months of the program were

- volunteer orientation, training and recruitment;
- staff/volunteer rapport; and
- the incorporation of all of the task forces' subgroups (community, staff, patients and volunteers) into a consortium for program planning and implementation.

In October 1983, as the time for relocation to the first regional center drew near, the task force was subdivided into two groups, each led by the coordinator of volunteers who would direct his/her respective program in each demonstration site. Each task force began to focus more specifically on the needs of its particular regional center. Even though the regional centers were almost identical in structural features, patient size and staff, there were differences, notably in the type of community in which they were located. One was located in a middle- and upper-middle class suburb, while the other was located in a working-class, urban area with a relatively high unemployment level. Each volunteer program, therefore, required tailoring to the particular community's characteristics and its available resources.

Issue: Administrative Support

From the beginning it was apparent that *if* this program were to succeed, it would require the support and intervention, when needed, of the nursing home's administration. Even though the administrator fully supported the University's research effort to the point of securing funding through the county commissioners for the research staff, *on-going and continuous involvement of some representative of the administration was necessary.* From time to time issues arose during task force meetings that required an immediate decision regarding the nursing home's administrative policies and procedures. Many bureaucratic matters were facilitated by the participa-



tion and presence of a representative of administration at most task force meetings. Such matters included

- developing new record forms without dealing with the delays incumbent on submitting them for approval to the "new forms" committee (there is a committee that approves all new forms developed for use in the nursing home; since the model program was considered a research project, certain administrative procedures were suspended to facilitate the program.);
- setting dates for staging the orientation and training sessions;
- allowing staff to volunteer their time to participate in these sessions; and
- securing secretarial support to perform task force clerical work, and the like.

More complete issues, such as the development of the policy and procedures of the volunteer program, were also dealt with expeditiously by Kane administrative staff.

There is no substitute for participation in task force meetings by a representative of the administration. Such participation provides support to those who are attempting to change established patterns of behavior. In fact, the presence of administration at all major meetings often allayed the underlying tensions that emerged when staff felt their authority was being challenged by the volunteers and the new volunteer program. The need for administration to support the concept of the model volunteer program became most critical when the tensions of relocation were highest for staff. At the last moment, staff felt it would be easier to postpone volunteer involvement until

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after the move. Only the intervention by administration who foresaw the long-term benefits of the volunteers allowed the program to continue during the relocation period.

Issue: Staff/Volunteer Conflict

One of the project's initial objectives was to promote better staff/volunteer interaction. Recognizing the potential for conflict, particularly in an environment with strong union involvement, the task force structure gave paid staff the opportunity to design and implement a volunteer program that would satisfy their need to create and extend services beyond those currently provided by the institution.

By including representation from most of the departments in the facility, particularly those who use volunteers frequently, such as nursing and recreation, and by including both union and non-union staff, a strong sense of loyalty to the volunteer program was promoted. Potential threats to unionized staff, when they arose, were candidly discussed by task force members who belonged to a union. These union representatives worked closely with the volunteer coordinator and the institution's union staff to educate each group about the other's concerns and intentions.

However, lack of staff awareness of the potential of trained volunteer assistance, or staff unwillingness to accept the additional responsibility of supervising the volunteers assigned to them, sometimes led to their unwillingness to participate in the development of the new program. Their "resistance" took the form of refusing to have volunteers assist with particular tasks or simply not requesting volunteers for their units. The least amount of resistance to volunteer assistance generally came from the recreation program where volunteer assistance has been a long-standing and acceptable form of staff extension. In the area of nursing, however, where a more highly structured patient care is required, there was greater resistance to the use of volunteers.

Conclusions

Overall, the Model Volunteer Program Task Force process made three major contributions to the development of the volunteer program:

1. Emphasis on the shared responsibility for the volunteer program by staff, patients, volunteers and community representatives;
2. Maximization of talents, skills and resources of all those who have an investment in the welfare of the patients and the effectiveness of the institution; and
3. Development of a mechanism for broad-based socialization to the most advanced concepts in volunteer administration.

The goal of the Model Volunteer Program Task Force has been to prepare the way for program implementation with little or minimal conflict between staff and volunteers; however, the achievement of this goal is far from completion. In fact, the Model Volunteer Program has heightened the awareness of Kane's administration and volunteer task force to the significance of the problems related to paid staff/volunteer interaction. As a result, administration and task force members have made a strong commitment to focus on this issue during the ensuing months by scheduling classes for staff to sensitize and inform them of the value of volunteer assistance; by the proposed development of a manual for staff in regard to volunteers; and by including in the hiring process a 30-minute session with the coordinator of volunteers prior to entry into the system.

Not all administrators are as keenly aware of the volunteer potential as were those who were involved in this program. It is therefore highly recommended that both administration and staff receive basic orientation to the principles and rationale of volunteer administration *before* the program is introduced into the organization so that they have an opportunity to raise questions and explore issues of mutual concern.

We conclude with a list of recommendations and guidelines for volunteer task force development during the first stage of a program. (Note: The volunteer administrator is the manager and coordinator of the program; he/she makes final decisions regarding the program contingent on approval of administration or designated superior. The task force is essentially an advisory group whose members can also participate in the design and development of the program.)

Recommendations

1. Involve administration prior to program implementation and educate them to the volunteer program objectives and to currently accepted volunteer administration principles.
2. Involve the administration in forming the program, particularly as liaison to staff and external representatives.
3. Select task force members to represent *all* categories of staff, if possible, except in work areas where it is unlikely that volunteers will participate.
4. Provide adequate representation from unionized and nonunionized employees.
5. Identify community support linkages, interested volunteers and clients (patients).
6. Educate these three groups to volunteer program objectives and the principles and rationale of volunteer administration.
7. Involve administration in all decisions regarding program implementation.
8. Plan to meet with the task force group regularly (at least weekly) for the first four to six months to routinize the planning process.
9. Provide continuous evaluation feedback to the task force regarding their successes and failures.
10. Develop programs only in sites where there is an experienced volunteer administrator who is comfortable with the program process and objectives.