Volunteers' Experiences Visiting the Cognitively Impaired in Nursing Homes: A Friendly Visiting Program*

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RÉSUMÉ

Aujourd'hui les soins médicaux en maisons de santé sont confrontés à la compréhension du concept de « qualité de vie » puisqu'ils touchent des personnes atteintes de déficits cognitifs, et à la recherche de moyens permettant l'application de ce concept. Le documentaire du réalisateur canadien Allan King, intitulé *Memory for Max, Claire, Ida and Company* (Mémoire pour Max, Claire, Ida et compagnie), filmé à Baycrest, dépeint une méthode utilisée pour améliorer la qualité de vie de six résidants atteints de déficits cognitifs. Bien que le film montre un modèle d'intervention effectué par des volontaires, il souligne aussi les problèmes spécifiques aux programmes d'intervention dans les établissements de santé, c'est à dire recruter et garder les volontaires. La peur que les volontaires peuvent éprouver en interagissant avec les personnes atteintes de déficits cognitifs représente un grand défit. Nous avons conduit une étude pilote sur un modèle de formation de volontaires qui vise à assurer une « visite sympathique » et avons étudié les effets obtenus sur les résidants ayant participé à l'étude. Les données concernant l'observation des interactions entre volontaires et résidants ainsi que sept interviews de volontaires ont été analysées et donnent lieu à plusieurs thèmes: a) la création des relations volontaires-résidants, b) l'effet de l'environnement, c) la préservation de l'intégrité de la personne, d) la nécessité d'être centré sur les besoins et la qualité du moment des résidants, ainsi que plusieurs autres thèmes liés au rôle des volontaires. L'implication de ces résultats pour les programmes de volontaires dans les établissements de santé à long terme est discutée.

ABSTRACT

Two challenges facing nursing-home care today are understanding the concept of *quality of life* as it relates to cognitively impaired residents and finding effective ways to ensure that it is achieved. Canadian director Allan King's documentary, *Memory for Max, Claire, Ida and Company*, filmed at Baycrest, captures a method for enhancing the quality of life of six cognitively impaired residents. While the film suggests an intervention model implemented by volunteers, there are challenges unique to institution-based programs (i.e., the recruitment and retention of volunteers). One of the challenges is the fear that volunteers may experience when interacting with the cognitively impaired. We conducted a pilot study of a model for training volunteers to provide *friendly visiting* and evaluated the impact on the participating residents. Observational accounts of volunteer–resident interactions and seven volunteer interviews were analysed and yielded several themes—(a) relationship building, (b) contribution of the environment, (c) preserving personhood, (d) resident-centred presence and the quality of the moment—and several themes related to the volunteers' role and their perceived impact on the residents. Discussed are the implications for volunteer programs in long-term health care settings.

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Background and Significance

Nursing homes today face the challenge of conceptualizing the term *quality of life* in ways that take into account the experiences of cognitively impaired residents (Pringle, 2003). An attempt at defining and enhancing the quality of life of Apotex residents was demonstrated when Canadian director Allan King (2005) produced a documentary film focusing on the lives of six cognitively impaired residents living in the Apotex nursing home at Baycrest. Over several months in 2004 and 2005, King captured countless interactions between the residents and a Baycrest friendly visiting volunteer. The film painted a picture of what life was like for these residents, documenting a range of feelings that included loneliness, boredom, and helplessness, while at the same time illustrating how effective listening and communication on the part of a visiting volunteer could lead to visible improvement in the quality of life of cognitively impaired nursing-home residents. One assumption underlying effective communication strategies for dementia care is that the person's sense of self or *personhood* continues to exist throughout the course of dementia. Kitwood (1997) describes this notion of personhood as "a standing or a status that is bestowed on one human being, by another in the context of relationship and social being" (p. 8). As such, personhood is not only an inherent quality of self but also something that is encouraged in the context of relationship.

Communication enhancement models seek to preserve the client's identity and personhood (Hagens, Beaman, & Ryan, 2003; Ryan, Schindel-Martin, & Beaman, 2005). Communication intervention strategies that consider the histories of residents can be affirming and can reinforce notions of personhood, as can holistically recognizing the many aspects of a person's existence besides their cognitive abilities (e.g., emotional, social, creative, and spiritual) (Beach & Kramer, 1999; Davis, 2004; Hagens et al., 2003; Perry, 2005; Pringle, 2003; Ryan, Meredith, MacLean, & Orange, 1995; Touhy, 2004). These strategies aim to affirm and preserve the complexity of the cognitively impaired person's identity in a social context.

The film suggests a possible model for an enhanced *friendly visiting* volunteer program that would have, as its long-term aim, to improve the quality of life in cognitively impaired nursing-home residents. A friendly visiting volunteer program is conceptualized as a program that provides companionship and friendly support visits to nursing-home residents. There are, however, challenges unique to institution-based volunteer programs, including the recruitment and retention of volunteers to work with the cognitively impaired. For example, at Baycrest, there are approximately 3,000 volunteers; yet only a few of these volunteers do friendly visiting in the nursing home. A likely explanation for this is that a fear of elders with dementia is common among volunteers (Robinson & Clemons, 1999). This fear may limit interaction with residents, ultimately affecting their quality of life.

Volunteer programs in nursing homes are common; however, there are many issues that need to be addressed when recruiting and retaining volunteers to work with cognitively impaired nursing-home residents. The current literature suggests that successful volunteer programs incorporate volunteer management principles applied to the recruitment, training, supervision, retention, and evaluation of volunteers (Govekar, 2004; Shin & Kleiner, 2003). Volunteer programs should effectively address the needs of cognitively impaired older adults and include two important components: clearly detailed orientation to interacting with persons with dementia and a volunteer liaison employed by the nursing home who can link nursing-home staff to volunteers (Holmberg, 1997) and professionals (e.g., nursing, social work). One study concluded that educational programs that include exposure to those with dementia would be helpful in reducing the volunteers' fears (Robinson & Clemons, 1999). Organizations that provide specialized training and ongoing mentoring are more likely to implement programs for cognitively impaired residents successfully. Furthermore, actively recruiting individuals who already have had personal experience with the cognitively impaired may also have a positive effect on volunteer retention. Of importance is the evaluation of whether or not these programs have a positive impact on the quality of life of cognitively impaired nursing-home residents. A first step in this evaluation is to explore how a friendly visiting program would be implemented, including orientation and mentoring, and to consider the impact these activities might have on volunteers' interactions with cognitively impaired nursing-home residents.

Purpose and Objectives

The purpose of this project is to explore the impact of a new friendly visiting volunteer program at the Apotex nursing home at Baycrest. The objectives of the current study are:

1. to understand the nature and meanings of interactions between volunteers and residents during an unstructured socialization activity,
2. to understand the subjective experiences of the volunteers participating as friendly visitors, including their personal motivation and concerns and their perceptions of their role and of the training and mentoring provided,
3. to explore the benefits of the friendly visiting program as perceived by the volunteers as well as through observations of volunteers interacting with the cognitively impaired residents.

The long-term aim is to determine whether this program could have an effect on the quality of life of nursing-home residents and to determine effective ways of implementation.

Description of the Friendly Volunteer Visiting Program

Each resident in the study participated in the standard unit-based recreation program as well as in the newly developed Friendly Volunteer Visiting (FVV) program. The FVV program was implemented over a 5-month period, from August 1, 2005, to December 30, 2005, and was directed by the Baycrest Volunteer Services Department. The research team observed the implementation of the program and collected observational and interview data. A part-time, paid volunteer coordinator recruited, trained, and mentored the volunteers who carried out the FVV program. Eight volunteers were recruited (e.g., through word-of-mouth, volunteer department interview, local rabbi, flyers, etc.) and agreed to commit at least 2 hours each week to the program.

Volunteers were trained to engage in empathic, supportive relationships with the residents so that rapport could be established. Each volunteer was exposed to three levels of orientation. First, each participated in the general Baycrest volunteer orientation. Second, each participated in *special care training* that gave general background information on the type of residents in the nursing home and instructions on how to communicate with them effectively. The special care training program was 5 hours long and consisted of the following modules: the brain and behaviour; the older person and his/her environment; communicating with the cognitively impaired; and culture and heritage. This information was presented verbally as well as included in a manual for the volunteer to keep. Third, the volunteers spent a few weeks orienting themselves to the layout of Baycrest and, in particular, the study unit in the nursing home. During this stage, the volunteers also observed residents participating in unit-based recreational program activities.

Following the orientation period, volunteers and residents engaged in friendly visitation for a period of 12 weeks (observation period); the interactions themselves were unstructured. The task of the volunteers was to engage the resident in the moment, depending on the residents' preferences (e.g., singing versus engaging in conversation). The volunteers were to spend approximately 30 minutes with each resident during a given visitation session. For the first six weeks, the Volunteer Coordinator individually mentored each volunteer and provided structured supervision. Mentoring included observation and debriefing following each session so as to identify questions or concerns that the volunteers might have and to provide supportive and constructive feedback. For the remaining 6 weeks of the observation period, each volunteer participated in friendly visiting with the residents independently.

Methodology

Design and Method

Observational and interview methods were used to generate data as to the volunteers experiences of participating in the program and as to how their friendly visits affected the quality of life of the residents. Observational methodology is frequently used in health care settings to record daily interactions among participants (e.g., staff and patients) (Mays & Pope, 1995). Its noted advantage is in systematically collecting actual accounts of behaviours or events as they occur while facilitating understanding of the phenomena under study (Watson & Whyte, 2006). The inclusion of the formal interviews (Creswell, 1998; Neuman, 1997) was for the purpose of hearing directly from volunteers what their experiences were at all phases of the project, from the initial stage of recruitment, to their volunteer training, and eventually to their direct interactions with the residents.

Study Site

Several discussions were held with senior level management regarding which unit would be appropriate for this study. The program ultimately took place on a nursing unit with 28 residents in the Apotex nursing home at Baycrest. All residents on this unit are moderately cognitively impaired, with minimal to no behavioural disturbances (e.g., agitation). Baycrest is a multi-level Jewish geriatric care facility and provides care and service to approximately 2,000 people a day through wellness programs, residential housing and outpatient clinics, research laboratories, a 472-bed nursing home, and a 300-bed complex-continuing-care hospital facility with an acute care unit.

Data Collection

The study was approved by the Baycrest Research Ethics Review Board. Data collection focused on (a) demographical and descriptive/statistical information to establish profiles of residents and volunteers, (b) observations of volunteers' interactions with residents, and (c) key-informant interviews with volunteers.

Resident and Volunteer Information

1. For descriptive purposes, profiles of the participant residents and volunteers were generated.
2. The total number of volunteer hours was also calculated.
3. In addition, averages and frequencies were used to summarize various characteristics of the sample, such as the number of residents in the study, their age, sex, and marital status.

Observations of Volunteers' Visits with Residents

A research assistant observed the resident–volunteer interactions during the visits and systematically recorded the conversations and behaviours of participants in their natural setting (Mays & Pope, 1995). While the general purpose of the study was known to the research assistant, she did not restrict herself to recording only information that appeared related to the study objectives. This approach is comparable to field-note taking, in that ''field notes are descriptive accounts in which the researcher objectively records what is happening in the setting . . . as much as possible'' (Morse & Field, 1995, pp. 112–113). Based on field notes; observations occurred daily, 3 hours per day, for 5 days, over 1 week in December 2005. A total of nine in-depth observations were recorded during this period, which included one-on-one and group interactions. The research assistant documented what was said between the volunteer and the resident, physical gestures and contact that occurred, facial expressions, eye contact, what occurred during the visit, and any other detail that caught her attention. This exhaustive and open approach to data collection opened up the possibility of obtaining richer data.

Key-Informant Interviews with Volunteers

Seven of the eight volunteers (three men and four women) were interviewed about their volunteering experiences. One volunteer was not interviewed due to a death in the family. Following the observational stage of data collection, semi-structured interviews were conducted using an interview guide (Neuman, 1997), developed specifically for the study, that focused on five topic areas. The first section contained questions that asked about the volunteer's early motivations for participating in the program and any fears or expectations they had had concerning their participation (e.g., ''What motivated you to volunteer in this program?'' ''Did you have any concerns or reservations about volunteering?''). The second section looked at the program and included questions about the training and mentorship components (e.g., ''How do you feel about the training that was provided?'' ''How did you feel about the mentorship component of the program?'' ''Is there any way that you wish it were different?''). The third section sought feedback from the volunteers about their experiences as participants in the program visiting with the residents (e.g., ''Can you tell me a little about what a typical visit was like?''). The fourth section asked the volunteers for insights into the residents' experiences in the program and for their estimate of the value of the program for the residents (e.g., ''What do you think the impact of these visitations has been on the residents' quality of life?''). Finally, the fifth section asked for information concerning the volunteers' background (e.g., years of volunteering experience, previous experience with the cognitively impaired, etc.). Additional probing questions allowed for clarification of responses. The interviews lasted from 20 minutes to 1 hour and were a one-time event.

Data Analysis

Using SPSS, Version 11.5, descriptive statistics were used to describe the sample of residents and volunteers. Qualitative data analysis was guided by methods described by Berg (1995), Creswell (1998), and Graneheim and Lundman (2004). A research assistant transcribed verbatim the seven interviews with the volunteers. It had originally been planned that the data would be organized into categories that corresponded with the questions used in the interview guide; however, this idea was later rejected because it was found that this approach could potentially limit the emergence of new categories or themes. Therefore, an inductive approach (Creswell, 1998) to data analysis was adopted. The analyses consisted of open coding followed by hierarchical coding, and finally, comparisons among all of the interviews were made. The analysis included reviewing the transcription and identifying the *manifest content* (the visible, obvious components) and the *latent content* (interpretation of the underlying meaning of the text) as well as the underlying themes (Graneheim & Lundman, 2004). Statements and phrases made by volunteers were then extracted into an electronic document under the volunteer's identification number. Each statement was numbered, providing a link to the original text reference. The research assistant provided detailed documentation for the selection and development of codes and themes (i.e., an audit trail).

The research team employed a number of strategies to enhance rigour and interpretation of findings based on previously established criteria by (Lincoln & Guba, 1985): (a) methodological triangulation (e.g., observations, interviews, and a recording of the volunteer hours devoted to each of the residents were analysed and compared); (b) researcher triangulation (a second researcher independently coded and analysed the observations and all the interview transcripts; both the research assistant and the second researcher discussed consistencies and discrepancies as to codes, categories, and themes, and a final consensus was reached; (c) thick description (of participants' excerpts); (d) an audit trail; (e) persistent observation; (f) theoretical triangulation of the final analysis with the emerging data; and (g) inclusion of negative cases in the analysis. Pseudonyms are used in this report to maintain confidentiality of both the residents and the volunteers who participated in this study.

Results

Participant Profiles

Volunteers

Using purposive sampling (Neuman, 1997) a total of 8 volunteers were selected and participated in the FVV program. All volunteers were Jewish and middle-aged (approximately 50–70 years old); there were four men and four women. The volunteers committed a total of 343 hours to the FVV program; individual contributions ranged from 24 to 112 hours. The average number of hours volunteered by each volunteer during the 5-month period was 49. Table 1 describes the total number of hours devoted to each of the residents by the volunteers. This ranged from 22 minutes to over 26 hours, with a mean of 13 hours 57 minutes.

Table 1: Total number of volunteer hours devoted to each of the resident participants

Participant	Total Time
Participant 1	19 h 25 min
Participant 2	22 h 10 min
Participant 3	12 h 6 min
Participant 4	3 h 15 min
Participant 5	13 h 37 min
Participant 6	0 h 22 min
Participant 7	26 h 45 min

Residents

The interdisciplinary care team (e.g., nursing, social work, recreational therapy) identified residents they thought would be appropriate for and benefit from the volunteer program. A total of 15 residents' legal decision makers / family members were contacted regarding their willingness to consent to participate. However, only 7 agreed to provide consent. Of the 7 residents whose legal decision makers / family members gave consent, all were female and Jewish. Six of the 7 were widowed, whereas one had a spouse. The average age of the 7 participants was 89 years old, with a range from 86 to 92. Mini-Mental State Exam (MMSE) scores were 4, 5, and 21 in 3 of the residents, indicating severe to moderate cognitive impairment. One of the 3 residents was able to complete the depression and quality of life scales, both of which were unsubstantial. The other 4 residents were easily distracted or did not want to respond to questioning.

Volunteers Visiting the Cognitively Impaired: Emerging Themes

The qualitative findings are organized into two main sections. Part 1 reports the analysis of themes emerging from observations of interactions between volunteers and residents during visitation. Part 2 reports themes, categories, and subcategories of volunteers' experiences with the residents, as derived from the volunteer interview transcripts. Illustrative quotations highlight these results in Tables 2 and 3.

Part 1. Observations of Volunteers' Visits with Residents

Observations of volunteer–resident visits yielded four salient themes: (a) relationship building, (b) contribution of the environment, (c) preservation of personhood, and (d) resident-centred presence and the quality of the moment. Refer to Table 2 for illustrative quotations summarizing these results, as well as the

Table 2: Examples of volunteer–resident observations

Theme	Example	Helpful Attitudes or Behaviours
Relationship Building	Bonnie [volunteer]: ''I really like cruise ships . . . have any of you ever been on a cruise? Mara, I'm going to tell you a funny story''. Bonnie tells a story about going on a cruise with Bev and her husband and she ended up getting ill. Mara smiles as she listens to the story. Lynn: ''You're not supposed to do that . . . ''. (Referring to the volunteer's going on a boat when she knows she gets sick . . . . Mara starts singing to herself. Everyone gets back to singing, except Lynn—her mouth is closed and she isn't smiling anymore. Bonnie: ''Lynn, you didn't join in, we need you''. Lynn breaks into a smile again. Mara starts the next song ahead of everyone—she is eager to sing. They all start singing again. At the end of the song Lynn exclaims, ''Hooray!''	Volunteers demonstrated empathy, patience, and persistence; encouraged resident participation; and engaged in storytelling.
Environmental Contribution	Mara and the volunteer arrive at the Heritage Museum. There is a baby doll on display in a washtub that is very adorable. Mara remarks, ''That is just darling . . . just beautiful . . . I've never seen anything like it''. Proceeding through the museum, looking at the various relics of the 1950s and 60s period. Mara is looking around with interest and admiration, and says, ''I have never seen anything like it. . . . I don't know any of these things . . . ''.	Volunteers recognized and used prompts in their immediate environment to stimulate volunteer–resident dialogue.
Preserving Personhood	Arrive at the market place. A vendor is selling coats, sweaters, and other nice clothing. Kay [volunteer] to Shirley [resident]: ''Look at the coats. . . . [W]anna have a look and see?'' Shirley nods in response. Shirley is caressing one of the sweaters with her hand, and holding it up. She seems to be assessing the quality of the garment. Kay: ''Shirley, you used to sew beautiful dresses, right?'' Shirley says, ''Yes, that's right . . . a long time ago''. She is smiling proudly.	Volunteers respected resident personhood; they recognized residents past achievements and identity.
Resident-Centered Presence and the Quality of the Moment	They start singing ''Take me out to the Ballgame''. Christina [resident] signs with emphasis in the right places, suggesting that she enjoys singing the song. At the end of the song Bonnie [volunteer] exclaims, ''Terrific! Good voice today''. They move onto the next song in the book (''Home on the Range''). Next song. Everyone sings. Lynn [resident] is smiling and she touches Bonnie's shoulder as she sings. Next song (''Zippidydoodah''). Bonnie [volunteer] to Mara [resident]: ''We're both wearing pink; we're pretty in pink''. Mara: ''Yes, we are; we are just pretty''. Bonnie chuckles. (Next song: ''Let Me Call You Sweetheart''). Last lines of the song are ''I'm in love . . . with . . . you!'' Christina says these lines with emphasis, looking at Bonnie [volunteer].	Volunteers' careful selection of words, the tone they used (accepting, life-affirming, validating), and appropriate touch helped to improve the quality of the moment for each resident.

volunteers' helpful attitudes/behaviours in interacting with the residents.

Relationship Building

Several observational examples emerged of the volunteers' capacity for relationship building with the residents. Examples of relationship building included empathy, patience, persistence; encouraging inclusion and participation of the residents; and engaging in storytelling. The volunteers enlivened interest in the residents and supported a meaningful and engaged communication that appeared to be enjoyable both for the residents and for the volunteers:

> A Jewish song is next. Decide to skip ''Hava Negela''. On to ''My Bonnie''. As Lynn [resident] sings her feet rise and fall—like tapping. Mara's [resident] feet tapping. Bonnie [volunteer]: ''I really like cruise ships. . . . [H]ave any of you ever been on a cruise? Mara, I'm going to tell you a funny story''. Bonnie tells a story about going on a cruise with Bev and her husband and she ended up getting ill. Mara smiles as she listens to the story. Lynn: ''You're not supposed to do that . . . ''. (Referring to volunteer's going on a boat when she knows she gets seasick). Christina [resident]: ''I forget'' (in response to question about whether or not she's been on a cruise). Mara starts singing to herself. Everyone gets back to singing, except Lynn—her mouth is closed and she isn't smiling anymore. Bonnie: ''Lynn, you didn't join in, we need you''. Lynn breaks into a smile again. Mara starts the next song ahead of everyone—she is eager to sing. They all start singing again. Mara and Lynn are still tapping their feet, evidently enjoying themselves. At the end of the song. Lynn exclaims, ''Hooray!''

Contribution of the Environment

The long-term care environment played a significant role in the development of the volunteer–resident relationship. Volunteers recognized and used prompts in their immediate environment to facilitate communication with the residents. For example, several

Table 3: Excerpts from volunteer interviews

Theme	Example
Volunteer's Motivations for Participating in the Friendly Visitation Program	''[W]hen I'm at home I feel completely useless. I have to be doing something that I feel that... there is a purpose for me to be on earth.... Otherwise, I just, I get very depressed. I don't like being at home, sitting, doing nothing. I want to be useful, and this has given me the satisfaction that I had when I was working. That I am doing something worthwhile'' (Volunteer 13).
Volunteers' Expectations and Fears Concerning Participation in the Program	''No... no.... There's no expectations. No fear... no fear'' (Volunteer 12). ''I thought you just go and you talk to someone, I had no idea that they were cognitively impaired or anything'' (Volunteer 8).
Volunteers' Needs: Training, Supervision, and Retention Issues	Another volunteer expressed a feeling of helplessness at not knowing how to assist a depressed resident: ''[Y]ou have to be together with a doctor or specialist to help them. Because it had a negative impact. I am not helpful.... I want the best and I cannot... it's not easy. I talked to a friend at home and I say, it's very nice doing what I'm doing but I want to be helpful'' (Volunteer 14).
Volunteers' Perception of the Overall Role of the Friendly Visitor in Enhancing Resident Quality of Life	''...And I was there to sort of spark the conversation''. They used active terms to describe their role as, ''sparking something'', in the resident; ''it's a matter of hitting the spark'', ''if you hit the right spark''. They further described how their direct efforts facilitated a response in the resident: ''[resident's name] will actually come alive'', ''[resident's name] whole face would light up'', her ''eyes light up''... how ''something is there'' and ''life affirming'' for the residents.
Balancing Flexibility and Structure; Personalized Approaches	''[The volunteers] know the people now, so they come in and everybody sort of... gets to have a favorite. You're not supposed to do that but! You just sort of gravitate towards the same person, or the same two people'' (Volunteer 15).
Perceived Volunteer Skills Needed for Managing Challenging Situations	They identified the following skills: patience, flexibility, persistence, compassion and concern. ''It's really sad....[W]ell, I said to myself, 'If I ever wind up in this situation, I hope that there will be somebody around to do for me what I tried to do for them''' (Volunteer 13).
Volunteers' Perceived Impact on the Residents Facilitating Interpersonal Engagement, and Decreasing Social Isolation	''I think that personal visits are so energizing for the residents here. I think that is what we're trying to get across.... Of course they're lethargic, and they lose interest in the world around them, and they retreat into their own world. Because there is no one to talk to. So, social interaction, of any kind, enlivens their world'' (Volunteer 8).
Stimulating Residents' Recognition and Memory Recall	''Not all of them, but some of them do gain.... It can break your heart. They just sit there, they look at the television, and I don't think they know what they're looking at.... And Bev got some songbooks, and you'd be surprised, they didn't know anything, but they knew the words to the songs, and they remembered that'' (Volunteer 9). ''So, yeah, it's a huge impact on the people.... They do have recognition of some kind, I don't know what that is and it isn't necessarily to a particular person, but there is definitely recognition ad awareness, on whatever level it might be for each individual.... [I]t makes a huge difference'' (Volunteer 10).

points of interest, such as a café, a bird-cage with two lively parrots, a gift shop, the Jewish Heritage museum, and other interesting venues supported volunteer–resident stimulation and dialogue. The following account demonstrates the role played by the environment in the interactions:

> Arrive at the birdcage. Mara is looking at the birds, smiling. She says ''hi'' to the birds.
>
> Mara: ''I have never seen that before.... [T]hey are so friendly to people''. She is still watching them and smiling. She seems to be really enjoying them. Bonnie [volunteer] is talking to the birds and petting them. They walk away from the birdcage and stop at the nearby display of ancient figurines enclosed in a glass case. They are both commenting about how beautiful and delicate they are. Mara reads the plaque that says they were donated to Baycrest. Walking towards the market place. The menorahs on the front table at the gift shop catch Mara's attention. She remarks at the beauty of all of the pieces. Arrive at the Heritage Museum. There is a baby doll on display in a washtub that is very adorable. Mara remarks, ''That is just darling... just beautiful... I've never seen anything like it''. Proceeding through the museum, looking at the various relics of the 1950s and 60s period. Mara is looking around with interest and admiration, and says, ''I have never seen anything like it.... I don't know any of these things...''.

Thus, the role of the environment in health care settings should not be underestimated.

Preserving Personhood

Observational accounts showed both the struggle with and the recognition of ''self'' in the interactions between volunteer and resident. The volunteers showed consistent efforts to engage positively with the residents:

> Bonnie [volunteer] has arrived and is talking to Mara [resident].
>
> Bonnie to Mara: ''Want to go down for a walk?''
>
> Mara: ''I'm not myself yet dear. I don't think you'll wanna be with me''.
>
> Bonnie: ''That's okay''.
>
> Mara: ''You don't like me anyway''.
>
> Bonnie: ''Oh Mara . . . don't put yourself down. I came through the snow just for you specifically''.
>
> Mara: ''What are we going to do? Go for a walk?''
>
> Bonnie: ''Yes. We'll sing songs. You always like that''.
>
> Mara: ''I think you might want someone else. I'm a dope today''.
>
> Bonnie: ''Oh Mara. I want you''.
>
> Mara: ''You have to remember, I'm not myself. . . . [B]ut maybe I can get myself back. I feel like a dope today''.
>
> Bonnie: ''Oh Mara, stop saying that. You're a nice lady. You have to say: 'I'm a nice lady'. I know you think so but . . . ''. Bonnie's tone is sincere and energetic.
>
> Mara: ''What? That you're a nice lady?'' Bonnie laughs and Mara joins in.
>
> Bonnie: ''No! You! *You're* a nice lady. . . . [Y]ou just have to say that to yourself . . . ''.
>
> Mara: ''I just don't remember ever feeling like such a dope like this''.
>
> Bonnie: ''Well, Mara, you never disappoint me''.
>
> Mara: ''Where are we going?''
>
> Bonnie: ''For a walk''.
>
> Mara: ''I don't know why I can't wake up''. Mara starts humming a little song to herself. ''I know I'm not good company''.
>
> Bonnie (emphatically): ''Yes you are!'' Bonnie is emphatic and yet not dismissive or impatient. She maintains a cheerful yet concerned manner.

In the next excerpt, the volunteer connects directly with the resident's past identity as a person who used to sew beautiful dresses:

> Arrive at the market place. A vendor is selling coats, sweaters, and other nice clothing. Kay [volunteer] to Shirley [resident]: ''Look at the coats. . . . [W]anna have a look and see?'' Shirley nods in response. Shirley is caressing one of the sweaters with her hand, and holding it up. She seems to be assessing the quality of the garment. Kay: ''Shirley, you used to sew beautiful dresses, right?'' Shirley says, ''Yes, that's right . . . a long time ago''. She is smiling proudly.

Resident-Centred Presence and the Quality of the Moment

A further examination of the observations and related discourse uncovered several phrases that focused attention on the present moment (e.g., ''good voice today'') and that were resident-centred (e.g., ''Mara, we need your voice''). In an examination of the discourse, the importance of language in constructing relationships and the *here and now* of the *present* moment between the resident and the volunteer became clear. Volunteers' careful selection of key words or phrases, as well as the tone they used (e.g., whether it was accepting, life-affirming, validating, sensitive) and physical touch, all helped facilitate the quality of the moment:

> Heather [volunteer] greets Christina [resident] in a friendly warm voice, attempting to make eye contact. Heather asks her if she wants to go for a walk. Christina says ''okay''. Heather helps Christina up out of her seat and to her walker. They start to head toward the elevator. . . . Sitting beside each other on a bench in the atrium. Christina coughs loudly. Heather remarks playfully, ''That's a cough right from your toes!'' Christina: '' . . . to your nose!'' Heather laughs. Heather says, ''It's nice and early. . . . [W]e can do some people watching''. Heather looks up at the trees in the centre of the atrium. She comments about how beautiful they are. Christina looks up at the trees.

Another observational excerpt of the volunteer–resident interaction was related to their singing together as part of a group activity:

> They start singing ''Take Me Out to the Ballgame''. Christina sings with emphasis in the right places, suggesting that she enjoys singing the song. At the end of the song, Bonnie [volunteer] exclaims, ''Terrific! Good voice today''. They move onto the next song in the book (''Home on the Range''). Next song. Everyone sings. Lynn [resident] is smiling and she touches Bonnie's shoulder as she sings. Next song (''Zippidydoodah''). Bonnie [volunteer] to Mara [resident]: ''We're both wearing pink; we're pretty in pink''. Mara: ''Yes, we

> are; we are just pretty''. Bonnie chuckles. (Next song: ''Let Me Call You Sweetheart''). Last lines of the song are ''I'm in love . . . with . . . you!'' Christina says these lines with emphasis, looking at Bonnie [volunteer].
>
> Bonnie [volunteer]: ''Mara, we need your voice. . . . [D]on't close your eyes''. Everyone starts singing the next song . . . very lively. Next song is ''Babyface''. Christina exclaims, ''Babyface!'' They all start singing. Mara is singing too, and she is tapping her feet as she sings, and tapping her fingers on her lap. Bonnie: ''Next one is '''When You're Smiling'' . . . and everyone better smile when they sing this song''. Christina grins. Mara laughs.

Part 2. Volunteer Interviews

Analyses of the volunteer interviews yielded five salient themes related to the nature and benefits of the volunteer program: (a) volunteers' motivations for participating in the friendly visitation program; (b) volunteers' expectations and fears concerning participating in the program; (c) volunteers' needs in relation to training and supervision, as well as issues relevant to volunteer retention; (d) volunteers' perception of their role as the friendly visitor, and (e) volunteers' perceived impact on the residents. Table 3 provides examples of responses from the volunteers in each of these five areas.

Volunteers' Motivations for Participating in the Friendly Visitation Program: All seven of the volunteers shared a general motivation to help others (e.g., ''I'd like to help others'') representing, according to volunteer management theory, a type of volunteer who performs formal volunteer service with personal commitment and a sense of accomplishment (Govekar, 2004; Shin & Kleiner, 2003). Within volunteers' general motivation to help others lay more specific interests, backgrounds, and intentions. These included the volunteer's family experiences with Alzheimer's (e.g., ''my father had Alzheimer's''); extra time available for volunteering (e.g., ''I'm retired. . . . [S]o I just wanted to get involved''); and the quality of the facility in which the volunteering occurred (e.g., ''this is a fabulous facility''). One volunteer spoke of a sense of purpose and meaning that volunteering provides:

> [W]hen I'm at home I feel completely useless. I have to be doing something that I feel that . . . there is a purpose for me to be on earth. . . . Otherwise, I just, I get very depressed. I don't like being at home, sitting, doing nothing. I want to be useful, and this has given me the satisfaction that I had when I was working. That I am doing something worthwhile'' (Volunteer 13).

Volunteers' Expectations and Fears Concerning Participation in the Program: In an effort to explore potential concerns the volunteers might have about working with residents with cognitive impairments, interview questions explored expectations or fears about participating in the program. Three of the 7 volunteers interviewed had had prior experience with a family member or friend with cognitive impairment. Generally, the volunteers did not have any negative preconceptions about what participating in the program would be like. One stated, ''No . . . no . . . There's no expectations. No fear . . . no fear'' (Volunteer 12), or ''No, because this is . . . [M]y aunt has the same problem'' (Volunteer 15). One volunteer expressed some misconceptions suggesting the need for additional information at the recruitment stage: ''I thought you just go and you talk to someone, I had no idea that they were cognitively impaired or anything'' (Volunteer 8). Another volunteer expected that the residents would be ''far worse'' behaviourally (Volunteer 10). This expectation turned out to be related to her own experience with her father, whom she saw through the late stages of Alzheimer's (Volunteer 10). One volunteer reported that she felt somewhat ''intimidated'' when she first started volunteering, but that this feeling eased as she got to know the residents (Volunteer 13).

Volunteers' Needs: Training, Supervision, and Retention Issues: Volunteers were asked a number of questions about the training, mentorship, and supervision they received during the course of volunteering. The volunteers identified three primary needs: (a) the need for quality information that is readily accessible, (b) the need for ongoing support at all stages of volunteering, and (c) flexibility in the modes of communication and training. Volunteers expressed a need for high-quality and accessible information to give them confidence in their role as a volunteer. This included administrative information (scheduling) and information about other volunteers' visits with the residents. Two volunteers expressed an interest in having the residents' medical and personal information to enhance the visits and their interaction with the residents. Several volunteers valued the volunteer coordinator's ongoing presence for information and ongoing support (Volunteer 10; Volunteer 14; Volunteer 13). Some volunteers were frustrated when the volunteer coordinator was absent due to the conclusion of her contract. Volunteers varied in their need for support. One volunteer expressed the need to conduct his visitations independently (Volunteer 6). Another volunteer expressed a feeling of helplessness at not knowing how to assist a depressed resident: ''[Y]ou have to be together with a doctor or specialist to help them.

Because it had a negative impact. I am not helpful. . . . I want the best and I cannot . . . [I]t's not easy. I talked to a friend at home and I say, it's very nice doing what I'm doing but I want to be helpful'' (Volunteer 14). This would indicate a possible need for additional supportive mechanisms, in the form of training and/or supervision.

The volunteers had preferences as to how information was communicated to them. Some stated that, had their specific training needs been met, they would have enjoyed the training more fully. Some preferred the 3-hour seminars, finding them to be very helpful and instructive, while one felt that the presentations were long and uninteresting (Volunteer 8). Some participants appreciated the manual as facilitating confidence in their role as volunteers; others thought the manual alone was not useful in helping them with application of information and therefore preferred guidance from the volunteer coordinator.

Volunteers' Perception of the Overall Role of the Friendly Visitor: We asked volunteers to describe their overall role as a friendly visitor, which they perceived as (a) enhancing the quality of life of the residents, (b) balancing flexibility and structure in residents visitations by utilizing both group and one-to-one approaches, and (c) requiring certain personal skills and qualities for managing challenging situations.

Enhancing Residents Quality of Life: Six of the seven volunteers described their overall role as enhancing the residents' quality of life; for example, ''And I was there to sort of spark the conversation''. They used active terms to describe their role as, ''sparking something'', in the resident; ''it's a matter of hitting the spark'', ''if you hit the right spark''. They further described how their direct efforts facilitated a response in the resident: ''[resident's name] will actually come alive'', ''[resident's name] whole face would light up'', her ''eyes light up'' . . . how ''something is there'' and ''life affirming'' for the residents (Volunteers 8, 9, 10, 13, 14, 15).

Balancing Flexibility and Structure; Personalized Approaches: Because the program was unstructured in terms of how the visits were to be conducted, there was room for personal tailoring of the visitation format (group or individual approaches), which may have had a positive impact on volunteer retention and in defining the volunteers' role. Some volunteers preferred to work independently rather than join a group activity: ''Well, singing's not my thing. . . . I am a history buff, so I got to hear [residents'] stories. . . . It was great, it was fine'' (Volunteer 8). For others there was a feeling that the dynamic created by having more than one volunteer on hand was essential to stimulating interaction among the residents. There was also the issue of the amount of time volunteers spent with each of the residents. For example, ''they [the volunteers] know the people now, so they come in and everybody sort of . . . gets to have a favorite. You're not supposed to do that but! You just sort of gravitate towards the same person, or the same two people'' (Volunteer 15). Further documentation of volunteer hours devoted to each resident illustrates this variation; the total number of volunteer hours devoted to each of the volunteers varied—in some cases significantly (see Table 1).

Perceived Volunteer Skills Needed for Managing Challenging Situations: Volunteers indicated a number of traits they thought were essential to the performance of the role of 'friendly visitor': patience, flexibility, persistence, compassion, and concern. For example, one volunteer felt sad for the residents, while her own fears about end of life issues were buffered by her awareness that she was doing something to help: ''[T]his is what you live for, and you wind up being like that. . . . It's really sad. . . . [W]ell, I said to myself, 'If I ever wind up in this situation, I hope that there will be somebody around to do for me what I tried to do for them''' (Volunteer 13).

Volunteers' Perceived Impact on the Residents: Volunteers described their impact as a) facilitating interpersonal engagement and decreasing social isolation, and b) stimulating residents' recognition and recall.

Facilitating Interpersonal Engagement and Decreasing Social Isolation: One participant described the resident's need for engagement and the potential consequences should this need go unmet: ''I think that personal visits are so energizing for the residents here. I think that is what we're trying to get across. . . . Of course they're lethargic, and they lose interest in the world around them, and they retreat into their own world. Because there is no one to talk to. So, social interaction, of any kind, enlivens their world''. (Volunteer 8)

Stimulating Residents Recognition and Memory Recall: The volunteers spoke of the realities of residents' cognitive limitations, but maintained a positive attitude of their ability to impact residents' recognition and memory recall. As one volunteer explained: ''Not all of them, but some of them do gain. . . . It can break your heart. They just sit there, they look at the television, and I don't think they know what they're looking at. . . . And Bev got some songbooks, and you'd be surprised, they didn't know anything, but they knew the words to the songs, and they remembered that'' (Volunteer 9). Another volunteer highlighted the impact of the volunteers' role on residents' recognition and awareness:

> So, yeah, it's a huge impact on the people. And I think people think because they're mentally impaired, that it doesn't matter, but it does. I don't care how far gone they are, they do have recognition of some kind, I don't know what that is and it isn't necessarily to a particular person, but there is definitely recognition and awareness, on whatever level it might be for each individual . . . it makes a huge difference. (Volunteer 10)

Discussion

This study examined the impact of a new friendly visiting program for cognitively impaired nursing-home residents at Baycrest. It captured the nature, quality, and impact of interactions between volunteers and residents during unstructured socialization activities, as recorded through observations and volunteer interviews. The results support the need to enhance residents' quality of life and quality of the moment by carefully promoting their personhood and by using person-centred communication strategies that affirm their identities, current capacities, and past accomplishments as much as possible.

Volunteer–Resident Interactions

The volunteers in this study encouraged and stimulated residents and showed compassion and patience with the residents' cognitive limitations. They chose to focus on the person and not the disease. Observational accounts revealed the volunteers tried persistently to engage the residents and to find ways in which they could ''connect'' with them, ''spark the conversation,'' and enhance their quality of life. This study supports previous work by Pringle (2003) on the need to evolve strategies to address the quality of life of cognitively impaired nursing-home residents. The volunteers' role was to stimulate and engage residents in order to enhance their ''quality of life'' (Pringle, 2003) or the ''quality of the moment'' (David Streiner, as cited in Pringle, 2003) while decreasing social isolation.

Volunteers adopted their own communication strategies, using the environment or storytelling and/or engaging in dialogue tailored to address residents' identities—their unique personal qualities and past or present experiences. Kitwood's (1997) notions of personhood and person-centred care (Touhy, 2004) were reflected in both the implicit and explicit attitudes of the volunteers. The volunteers' behaviours were consistent with communication models that view residents' histories as potentially affirming and as helping to reinforce notions of personhood (Beach & Kramer, 1999; Hagens et al., 2003; Ryan et al., 1995). Volunteers also described the impact of their strategies as stimulating recognition and recall, at times in surprising ways. Making warm caring connections with the residents was central to a positive volunteer experience, resulted in greater volunteer satisfaction, and enhanced the perceived benefits for residents. Volunteers' careful and empathic selection of words and the use of appropriate physical touch alongside accepting, life-affirming, and validating attitudes helped to facilitate the residents' engaged responses.

Despite the general view of cognitive impairment and the potential for volunteers to have reservations about working with the cognitively impaired (Davis, 2004; Touhy, 2004), the volunteers in this study reported no anxiety or fear over relating to this population of residents. Why this sample was not afraid to work with cognitively impaired residents is an interesting question and worthy of further consideration, although some possible indicators included their age (all were middle-aged or greater), their ethnicity (all were Jewish), their strong desire to help, their being retired or semi-retired, and, in some cases, their prior volunteer experiences and/or experiences with a family member's dementia. A couple also noted a kind of projection as to how they would like to be treated if they were residents in a long-term care facility. The fact that the volunteers in this sample did not fear working with this group of cognitively impaired residents may attest to the recruitment strategies that were utilized. Targeting family members was definitely an advantage and has implications for future recruiting. Another important part of the recruiting process was to have the volunteer spend some time with the volunteer coordinator on the units, prior to committing to the experience. Ideally, volunteers would make a 1-year commitment, which would give them time to learn to work with the cognitively impaired, learning that might, in turn, improve the quality of residents' experiences.

Friendly Visiting in Long-Term Health Care Settings: Implications for Program Implementation

Volunteers and cognitively impaired residents appear to benefit mutually from flexible, unstructured, group and individual approaches to friendly visitation. Furthermore, there is a positive impact on the resident. In an overburdened health care system, volunteers have the potential to assist in the enhancement and maintenance of cognitively impaired residents' quality of life. However, this testimony suggests that there may be some limitations or risks associated with the implementation of such programming.

First, too much flexibility and a lack of structure, while having noted advantages, could lead some volunteers to gravitate toward certain residents rather than others, depending on degree of ease, on personality, on common interests, and so on. Thus we recommend implementing a structured model that assures equal visitation time for all residents while providing flexibility of approach to accommodate the volunteer's style of relationship building. The use of a volunteer coordinator to standardize care, provide accurate and quality information, and oversee to make sure that residents are getting as close to equal time as possible is an important component of a sustained visitation program, enhancing each resident's quality of life. Furthermore, avoiding potentially ''difficult'' residents would be contrary to the overall intention of the visitation program to enhance residents' quality of life and would leave a service gap. Training volunteers to feel competent and confident with a range of resident personalities, styles of interaction, and levels of difficulty will help prepare volunteers for maximum resident interaction.

Second, volunteers may want to help residents in ways more appropriately addressed by skilled professionals (medicine, nursing, social work, etc.). Volunteers are not professional clinicians and cannot be expected to intervene clinically with the residents. Yet, while volunteers are not a replacement for professional staff, it is important to provide education and support on issues that can arise over the boundary between volunteers' personally strong commitment to helping, on the one hand, and their clearly described volunteer roles, on the other. A mutually respectful interdisciplinary team environment facilitates integration of all role functions within a shared commitment to serve resident needs positively and productively (see Geriatric Interdisciplinary Team Training funded by the John A. Hartford Foundation) (Fulmer, Flaherty, & Hyer, 2003; Mellor, Hyer, & Howe, 2002). Additional supportive mechanisms should be put in place in order to prevent either potential harm to the resident or a negative experience for the volunteer.

Third, volunteers should be trained to ensure skills in self-reflection, specifically to manage the difficult situations or emotions that may arise in working with cognitively impaired residents. Given the themes emerging in this study of preserving personhood and stimulating resident memories, volunteer training could address a number of conceptual and practical issues. For example, volunteers wanted more background information on the residents in order to enhance their understandings and try to build relational connections. This raises issues of privacy and confidentiality, of ''how much should they be told'' and whether the information will be used in a helpful manner. These issues, including ethical concerns about the potential for risk/harm if the volunteer touches on difficult memories or issues, need to be further explored. Clear guidelines could be included in the volunteer training on how to make appropriate referrals and/or contact the appropriate professional within the existing system. The volunteer coordinator would need to provide ongoing supervision and close mentoring through regularly scheduled meetings with the volunteers.

Fourth, there is a risk that volunteers may create more concern and worry for existing staff in their daily roles and responsibilities. One of the issues this project aimed to clarify was what should be the relationship between nursing staff and the volunteer services department and who should supervise the volunteers while they are on the floor. Volunteer management theory indicates that the supervision of volunteers often times falls on already burdened staff and the need to have a person dedicated solely to an organization's volunteer program is a necessary consideration for any future programming (Govekar, 2004). It seems apparent that a volunteer coordinator is essential to the success of the program; he or she should be further supported by an effective volunteer department. The volunteer coordinator requires several attributes, including being her/himself motivated and being able to adopt a professional approach with the interdisciplinary care team, to be an effective team player, to serve effectively as a mediator or bridge between staff and volunteers, and to problem-solve when a difficult situation arises. He or she must be well versed in established volunteer management principles and implement those principles at all stages of recruitment, screening, training, supervision, and evaluation of the volunteers. Consequently, institutions wishing to replicate the friendly visitors program will need to establish a management structure that can accommodate the volunteer program within the overall care programs of the institution.

Study Limitations

This study was not without limitations. Obtaining family consent was a challenge; in future, families need to be better informed about the value of the research and should be included as part of the project. Many family members had not participated in research before, and they did not want to ''upset'' their loved ones. The more family members become involved in the research process, hopefully, the more they will be interested in participating in future studies. In addition, further testing of quality of life measures that can be used to assess moderately to severely cognitively impaired residents also needs to be considered, in order to capture the resident's experience. We attempted to use the Dementia Quality of Life (Brod, Stewart, Sands, & Walton, 1999); however, those in our sample were too cognitively impaired to participate in the interview. Observational methods (Kitwood & Bredin, 1994; Lawton, Haitsma, & Klapper, 1996) have also been tested in previous research but require further study. Replication of these findings would help ensure that volunteers were not acting differently (i.e., positively) because they were being observed. Finally, a pre-test–post-test design would have allowed us to examine any changes in the residents as a result of the enhanced interaction; such a design is worthy of future implementation. Satisfaction surveys could also be distributed to future volunteers, front-line staff, and the family members of the residents. A multi-faceted, ongoing evaluation strategy will be a necessary component of any future programming.

In conclusion, this study confirms the results of previous studies on the importance, in long-term care settings, of notions of personhood, of person-centred communication, and of enhancing the quality of life of cognitively impaired residents. Volunteers play an important role, alongside health care professionals, in enhancing residents' experiences in nursing-home settings. Future research and policy decisions aimed at increasing volunteer opportunities for friendly visiting with the cognitively impaired are needed to improve the quality of lives in this frail and under-served population of nursing home residents.

References

Beach, D., & Kramer, B. (1999). Communicating with the Alzheimer's resident: Perceptions of care providers in a residential facility. *Journal of Gerontological Social Work*, *32*, 5–26.

Berg, B.L. (1995). *Qualitative research methods for the social sciences*. Boston: Allyn and Bacon.

Brod, M., Stewart, A.L., Sands, L., & Walton, P. (1999). Conceptualization and measurement of quality of life in dementia: The Dementia Quality of Life Instrument (DQoL). *Gerontologist*, *39*(1), 25–35.

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Davis, D.H.J. (2004). Dementia: Sociological and philosophical constructions. *Social Science and Medicine*, *58*, 369–278.

Fulmer, T., Flaherty, E., & Hyer, K. (2003). The geriatric interdisciplinary team training (GITT) program. *Gerontology and Geriatrics Education*, *24*, 3–12.

Govekar, P.L. (2004). Are you making it hard to volunteer? *Non-Profit World*, *22*(5), 24–25.

Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112.

Hagens, C., Beaman, A., & Ryan, E.B. (2003). Reminiscing, poetry writing and remembering boxes: Personhood-centered communication with cognitively impaired older adults. *Activities, Adaptation and Aging*, *27*(3/4), 97–112.

Holmberg, S.K. (1997). A walking program for wanderers: Volunteer training and development of an evening walker's group. *Geriatric Nursing*, *18*, 160–165.

King, A. (Director/Producer). (2005). *Memory: For Max, Ida, Claire, and Company*. Toronto: Allan King.

Kitwood, T. (1997). *Dementia reconsidered: The person comes first*. Buckingham, UK: Oxford University Press.

Kitwood, T., & Bredin, K. (1994). *Evaluating dementia care: The DCM method* (6th ed.). Bradford, UK: Bradford Dementia Research Group, Bradford University.

Lawton, M.P., Haitsma, K.S.V., & Klapper, J.A. (1996). Observed affect in nursing homes residents. *Journal of Gerontology, Psychology and Social Science*, *51*, 3–14.

Lincoln, Y.S., & Guba, E.G. (1985). Establishing trustworthiness. In Yvonna S. Lincoln, and Egon G. Guba (Eds.), *Naturalistic inquiry* (pp. 289–330). Beverly Hills, CA: Sage.

Mays, N., & Pope, C. (1995). Qualitative research: Observational methods in health care settings. *British Medical Journal*, *311*(6998), 182–184.

Mellor, M.J., Hyer, K., & Howe, J.L. (2002). The geriatric interdisciplinary team approach: Challenges and opportunities for educating trainees together from a variety of disciplines. *Educational Gerontology*, *28*, 8867–8880.

Morse, J.M., & Field, P.A. (1995). *Qualitative research methods for health professionals*. Thousand Oaks, CA: Sage.

Neuman, L. (1997). *Social research methods: Qualitative and quantitative approaches*. Boston: Allyn and Bacon.

Perry, J. (2005). Expanding the dialogue on dementia: (Re) positioning diagnosis and narrative. *Canadian Journal of Nursing Research*, *37*(2), 166–180.

Pringle, D. (2003). Making moments matter. *Canadian. Journal of Nursing Research*, *35*(4), 7–13.

Robinson, K.M., & Clemons, J.W. (1999). Respite care: Volunteers as providers. *Journal of Psychosocial Nursing and Mental Health Services*, *37*(1), 30–35.

Ryan, E.B., Meredith, S.D., MacLean, M.J., & Orange, J.B. (1995). Changing the way we talk with elders: Promoting health using the Communication Enhancement Model. *International Journal of Aging and Human Development*, *41*(2), 87–105.

Ryan, E.B., Schindel-Martin, L., & Beaman, A. (2005). Communication strategies to promote spiritual well-being among people with dementia. *Journal of Pastoral Care and Counseling*, *59*, 43–55.

Shin, S., & Kleiner, B.H. (2003). How to manage unpaid volunteers in organizations. *Management Research News*, *26*(2/3/4), 63–71.

Touhy, T.A. (2004). Dementia, personhood and nursing: Learning from a nursing station. *Nursing Science Quarterly*, *17*(1), 43–49.

Watson, H., & Whyte, R. (2006). Using observation. In K. Gerrish, and A. Lacey (Eds.), *The research process in nursing* (5th ed.; pp. 383–398). Oxford: Blackwell.