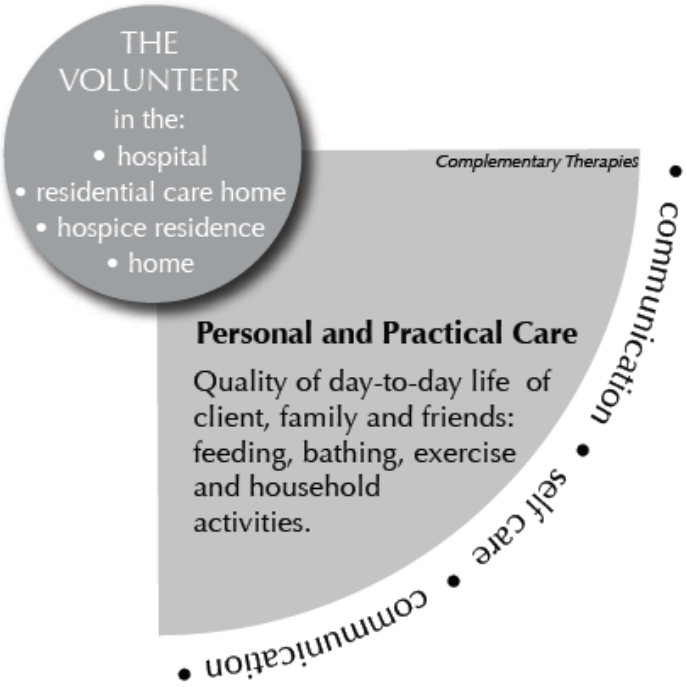
Module 3

PERSONAL & PRACTICAL CARE

This is the most fulfilling work
I have ever performed. The
opportunity to serve the patients
and their families during this period
in their life is a blessing.

Mike South, Hospice Volunteer

British Columbia HOSPICE PALLIATIVE CARE Association



Learning Outcomes

Upon completion of the Personal and Practical Care Module, the volunteers will:

1. Be aware of and respect the policies of their individual organizations regarding personal and practical care.
2. Understand what is involved in the personal and practical care of their clients.
3. Know the team members who are most involved in the personal and practical care of their clients.
4. Understand the changes in care throughout their client's journey.
5. Understand and have the competence and capacity to carry out their responsibilities.
6. Recognize and respect their own limits in providing personal and practical care to their clients.

Definition of Personal and Practical Care

Attention to personal and practical care helps maintain the quality of the client's day-to-day life during a stressful and consuming time. Focusing on physical comfort, personal care supports the client's medical care and provides reassurance to both the client and family.

Assistance with everyday practicalities can help to reduce stress felt by both the client and family when chores and errands are left undone. Hospice Volunteers play a key role in supporting the personal and practical care of the clients and families they serve.

Personal and Practical Care and the Role of the Hospice Volunteer in Different Settings

Setting	Personal & Practical Care	Volunteer Role
Hospital Hospice Residence Residential Care Home	• Bathing, comfort, meals, hydration, primarily carried out be staff and/or family members. • Primarily nursing care with visits from doctors • Comfort: turning, feeding	• Will vary in all three settings. • In some settings where permitted the volunteer may be able to help feed, hydrate, or bathe the client. They may provide other comfort measures such as massage or applying warm blankets. • May run errands or do chores for client and family. • If policies permit, may assist in transfers, repositioning and feeding.
Home	• Bathing, comfort, cooking, housework and other household chores, errands, dog walking etc.	• Support client and family/friends by assisting with such things as chores, cooking, dog walking and grooming, gardening etc. • If policies permit, may assist in transfers, repositioning and feeding.

Training

Orientation and Basic Training

1. Provide an overview of personal and practical care, including a description of how this care is managed throughout the client's journey in each of the settings where the volunteers will be working.
2. Ensure the volunteers are provided with the necessary policies and procedures on personal and practical care including feeding, hydrating, bathing and chores, etc.
3. Ensure that volunteers understand and respect their own personal limitations, particularly physical limitations when such things as heavy chores are involved.
4. Incorporate a practicum or "job shadowing" component to allow volunteers to learn on the job from an experienced volunteer.
5. Pair new volunteers with experienced volunteers as "mentors" to support the volunteer and provide opportunities for experienced volunteers to be supportive and refresh their knowledge.

Ongoing/Advanced Training

1. Provide any updates to volunteers on policies and procedures around practical and personal care.
2. Provide periodic workshops/training to enhance volunteers' competence and confidence.
3. Encourage and support volunteers to take part in workshops relating to personal and practical care even if they are outside their limits of responsibility. The information will help them better understand the care being provided to their clients and may also be of personal value.

RESOURCES

Module 3
PERSONAL AND PRACTICAL CARE

RESOURCES

- **Caregiver's Role**
- **Do's & Don'ts of a Helping Relationship**
- **Maslow's Hierarchy of Needs**
- **Phone Support Guidelines**
- **Guidelines for Patient Visits**
- **Vigils: Volunteer Job Description**
- **Health and Safety Tips**
- **The Volunteer & Client Relationship**
- **Case Studies**
- **Touchstone – Experiential Endings Exercises**
- **The Power of Hands**

CAREGIVER'S ROLE

- Listen without judging.
- Maintain confidentiality.
- Be honest and sincere.
- Be available and reliable.
- Be knowledgeable of resources.
- Provide encouragement and support.
- Recognize limitations – yours and others.
- Communicate with team members.
- Follow the family agenda – not yours.
- Expect repetition and go with it.
- Be flexible and go with changing needs.
- Be informed - but not the teacher.
- See where you fit in – you most likely will not be the primary support person.
- Stick to reality – promise only what you can deliver.
- Do not equate talking and activity with support. Doing and speaking may not be helpful.
- Be aware that you can't be everything to everybody.
- Sit on your urge to do something.
- Be OKAY with SILENCE.

DO'S AND DON'TS OF A HELPING RELATIONSHIP

DO

- take your time
- listen with your whole self
- maintain the "volunteer" role
- build trust
- encourage independence as limitations permit
- reach out
- be respectful and non-judgmental
- be genuine, open, honest, and sensitive
- be dependable and consistent
- have a cheerful approach
- encourage person to initiate subjects they wish to discuss
- use open-ended questions
- err on the side of caution and a slow pace
- maintain confidentiality
- respect person's right to (physically and in emotional) privacy
- know and admit your strengths and weaknesses

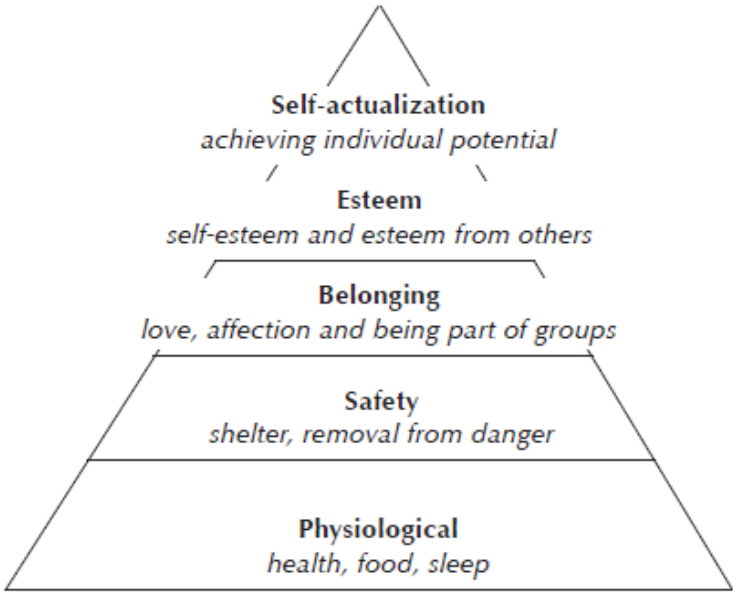
DON'T

- get into telling role
- use "you should"
- give advice
- focus on self enhancement (the "savior" role)
- over praise.
- intrude
- probe
- appear busy, distracted
- follow your own agenda
- talk down to person
- stay too long
- monopolize the conversation
- gossip
- direct premature discussion of action plans
- patronize or placate - "that's all right now"
- rely on the use of clichés
- change the subject
- ignore the problems raised by the person
- use closed, irrelevant or inappropriate questions
- use inappropriate warmth or sympathy
- use inappropriate, irrelevant or premature self-disclosure

MASLOW'S HIERARCHY

The hierarchical effect

A key aspect of the model is the hierarchical nature of the needs. The lower the needs in the hierarchy, the more fundamental they are and the more a person will tend to abandon the higher needs in order to pay attention to sufficiently meeting the lower needs. For example, when we are ill, we care little for what others think about us: all we want is to get better.



The five needs

- Physiological needs are to do with the maintenance of the human body. If we are unwell, then little else matters until we recover.
- Safety needs are about putting a roof over our heads and keeping us from harm. If we are rich, strong and powerful, or have good friends, we can make ourselves safe.
- Belonging needs introduce our tribal nature. If we are helpful and kind to others they will want us as friends.
- Esteem needs are for a higher position within a group. If people respect us, we have greaterpower.
- Self-actualization needs are to 'become what we are capable of becoming', which would our greatest achievement.
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Three more needs

These are the needs that are most commonly discussed and used. In fact Maslow later added three more needs by splitting two of the above five needs.

Between esteem and self-actualization needs was added:

- Need to know and understand, which explains the cognitive need of the academic.
- The need for aesthetic beauty, which is the emotional need of the artist.

Self-actualization was divided into:

- Self-actualization, which is realizing one's own potential, as above.
- Transcendence, which is helping others to achieve their potential.

Credit: www.changing minds.org

PHONE SUPPORT GUIDELINES

Prior to the first call:

When the office receives notice of a recent death that requires follow up, the Director of Client Care sends a sympathy card and information letter to the appropriate person. The letter outlines the bereavement services that we offer and informs the person to expect a phone call from a Hospice volunteer within 2 – 3 weeks.

Usually, it's the Grief Support Coordinator who makes the first phone call in order to establishcontact with the person, find out how the person is doing, and assess need. Should the coordinator feel that it is important to keep in contact with the client, she asks the client if it's okay if someone from Hospice phones again in a couple of weeks.

When making the call:

The first call is the hardest for both the volunteer and the bereaved client, but it becomes easier over time:

Always identify yourself, give the purpose for the call, and ask if the timing of the call is appropriate. For example:

> "Hello Mrs. Hanson, my name is Mary Peters and I'm a grief support volunteer with Cowichan Valley Hospice. I'm calling to ask how you are getting along. Is this a good time for you or would you prefer that I call at another time?"

Listen carefully to what the person says and how he or she is saying it. If the client cries, don't hang up. Allow time for the person to regain composure and be sensitive as to whether or not they wish the conversation to continue.

Ask how the client prefers to be addressed, i.e. by their first name or their surname. If you don't already know it, ask the name of the deceased and don't be afraid to refer to the deceased by name during the conversation.

Sorts of questions to ask during the first one or two calls:

- How are you sleeping, eating, feeling physically?
- Are you concerned about yourself or any other family member?
- How are you managing the practical issues—estate, daily routine, returning to work (if appropriate)?
- Are you getting the support you want?
- Do you have people you can talk to about the person who died?
- Would you like other Hospice services: 1:1, Thursday afternoon drop-in, on-going phone support? Mention the resources in the office: pamphlets, library books, etc.

Something to remember in the early days following the death or funeral

Client may feel some relief and euphoria that things went as well as they could, that family managed well, and that care was good. These feelings often sustain family members for a while before reality sets in and other feelings arise.

Some indicators of difficulty in the early days:

- Keeping busy all the time, no time for grief, "just get on with life."
- Can't cry or won't allow themselves to cry.
- Continuing shock, which prevents necessary functioning.
- Use of alcohol or drugs for coping; previous mental illness.

PHONE SUPPORT GUIDELINES cont'd
The early days following the death or funeral cont'd

Sorts of questions to ask in subsequent calls:

- How are you looking after yourself? Any changes in your own health?
- Do you have opportunities to talk about your memories, your emotions, and your worries with family or friends?
- How are you managing the ups and downs, the good days and the bad days?
- How different has life been since the person died? How are you coping with these changes?
- Have any other losses or major changes happened since the death?
- Are you concerned about yourself or any other family member?
- What expectations do you have about managing over the coming weeks and months?
- How are you planning to deal with upcoming events e.g. Christmas, Easter,
- Thanksgiving, birthdays, anniversaries etc? How are you feeling about these times?

Indicators of difficulty later on:

- Being overwhelmed by emotions.
- Stuck with a certain aspect of what happened.
- Going round and round without being able to resolve an issue.
- Feeling abandoned by usual support systems.
- Inability to return to most normal routines.
- Flashback images of the death.

NOTE: Statements like, "I feel like I'm going crazy."; or "I feel depressed."; or "What's the point of getting up in the morning?" are normal, **but such statements need to be checked out further.**

At the anniversary of the bereavement, it's best to call a few days before the date and ask the following sort of questions:

- With the anniversary coming up, what plans do you have for that day?
- Who will you share it with you?
- Are you having thoughts and memories of this time last year? How has that been?
- Over the last months and weeks, how do you think you've been managing?

Indicators of difficulty around the anniversary of the death:

Feeling no change from earlier days of grief.

- More bad days than good days.
- Fears of facing the future or inability to see a positive future.
- Guilt or resistance about going on with life

NOTE: It's normal to feel worse close to the anniversary date, so it's important to check the extent and duration of difficult feelings and thoughts.

PHONE SUPPORT GUIDELINES cont'd

Risk Factors or Indicators of Difficult Grief

Make a note if clients express any of the following concerns and report all concerns to the Grief Support Coordinator or the Director of Client Care:

- Difficult relationships with family members or with the person who died.
- Lack of perceived support.
- Difficult circumstances surrounding the death such as a sudden, violent, or suicide death, or if drugs/ alcohol use/abuse were involved
- Multiple losses; concurrent deaths, or past unresolved losses.
- Mental or physical health problems or disabilities.
- Emotional or spiritual crises.
- Major changes in life circumstances.

Points to Remember

- Listen and accept where the client is at today.
- Provide information and normalize the grief process.
- Suggest other appropriate Hospice grief support services as appropriate.
- Do not just stop phoning the client because you think they are doing fine. The second year after a death is often worse than the first.
- Tell the client if you plan to go away and ask if they would like someone else to phone while you're away.
- Consult coordinator/Director of Client Care before finishing with a phone client.

Home phone number

It's a matter of personal choice whether you give a client your home phone number. Usually it's best to avoid sharing your home number until you have developed a rapport with the client.

GUIDELINES FOR PATIENT VISITS

- Program coordinator will introduce you to your patient.
- Match the patient's mood, a smile is important but don't overdo cheerfulness.
- Actively listen to the patient, tune into what is being said and not said.
- Avoid jumping to conclusions. If in doubt, ask the person to verify feelings.
- Be aware of the patient's environment. Take note of setting including things such as books on a bedside table, a certain tape playing, pictures of family, an afghan on the bed etc. These items might be the place to start a conversation and build a connection.
- Respond in language the patient can understand, use common vocabulary.
- Summarize what you heard the person say to ensure accurate communication. "What I heard you say is …" or "Are you saying …" or "To recap …" or "As I understand it our agreement is …" This lets the person know that you heard and understood what s/he said. It is important to summarize whenever an action or decision has been agreed to.
- Use the person's name in conversation.
- Watch for signs of fatigue. Try to leave before the person becomes overtired, or, give permission for her/him to rest and sleep in your presence. A patient who tires easily or fades in and out will often appreciate having a person there for the moments they are awake.
- Learn to recognize the person's non-verbal messages such as body posture, eye contact, voice tone and volume, position of hands and arms, etc.
- Remember that the family has many concerns. They may want a break while you sit with their loved one, however, they may want to talk about concerns of their own. Balance your support to both the patient and the family.
- Relay patient concerns to the nurse. You can relay simple messages to family such as a desire to be moved or have a particular food. You make no judgments on how the family handles the request nor on the validity of the request. You take every precaution to not become a go-between in the family, get caught up in disagreements, or take sides. If you have any concerns regarding patient care from the family, the nurse or anyone else … contact the program coordinator immediately. Do not intervene on your own.
- Do not accept money or gifts form patients. Donations may be made to the Prince George Hospice Society.
- Do not get involved with money, marital, legal or family structural issues. Refer to the social worker, the nursing staff, or other appropriate professional. If unsure of where to refer to, contact the program coordinator for direction.
- Maintain confidentiality at all times.
- **Do not administer medication at any time.** A family member, physician or nurse should be giving medication. If the family is going to take a break and leave you alone with a patient, make sure all medication has been brought up to date before they leave. You should never administer any medication. Ever.

GUIDELINES FOR PATIENT VISITS cont'd

- You do not move a patient or take any lead role in patient care. You may assist a family member or home care nurse with moving, washing, feeding a patient. But it MUST ALWAYS been done under the supervision and direction of the family member or other professional and only as you are comfortable and physically able to do. Never take on a task that may push your own physical abilities or could possibly cause you any harm.
- Wear your hospice name tag to every visit.

When Visiting a Patient in the Hospital

- If visiting someone in the hospital, do not assist the nurse in moving a patient, there are enough professional people to take care of patient needs.
- Check in with the nurse on duty, let them know who you are and why you are there, ask if there is anything you need to know about before entering the patient's room.
- Obtain permission from the nursing staff before offering any food or drinks to the patient.
- If doctors, nurses or other hospital staff are with the patient when you arrive, wait a few minutes to see if they will be leaving. If it appears they will be awhile, or the patient is going for some tests etc. then you must call back later. Ask a nurse at the desk what a good time might be to come back.
- If hospital staff come in to see the patient while you are there visiting, ask if you can/should wait or if you should come back at another time.
- If the patient does not want a visitor at that time, ask if you can come back at another time.
- Before leaving the hospital, report any concerns or issues that may have come up during your visit to the nursing staff.

Things to Do When Visiting

- Share music, books, reading with the person
- Discuss topics of interest to the person
- Allow the opportunity for a life review
- Sit in silence – be a witness
- Listen to concerns, fears, stories of the person and the family
- Share information to allay fears
- Refer to appropriate agencies and professionals
- Pick up items, library books, medications, etc if requested
- Be a friendly ear and support

VIGILS

VOLUNTEER JOB DESCRIPTION SAMPLE

ORGANIZATION: Cowichan Valley Hospice Society

QUALIFICATIONS: must have completed 30 hours of initial Hospice training.

OBJECTIVES: to provide support to a dying person and his/her family or caregivers, in accordance with the principles of the Society, in a hospital, care home, or private residential setting.

VIGIL VOLUNTEERS ARE EXPECTED TO:

- adhere to strict rules of confidentiality
- know you may be asked to sit with someone at a **moment's notice**
- be aware that evening hours may be needed
- be comfortable with the final stages of dying
- respect differing personal, cultural and religious beliefs, and lifestyles
- be aware that some family members may wish to stay, and will welcome a calming presence and an excellent listener
- be sensitive to family needs for privacy – you are there to support not to take over
- in this time of great sensitivity be aware, and respectful, of family dynamics
- be respectful of staff and other caregivers
- seek input from a supervisor regarding any problems or concerns that may arise during the performance of one's duty
- attend scheduled meetings and training sessions
- prepare a self-care kit - books to read, refreshments etc., to take to vigils
- balance care of others with care of self

DUTIES:

1. sit with a person who is in the final stages of dying
2. discuss with staff what personal care they wish you to provide
3. provide support and comfort to patient when necessary
4. determine if, and when, family members wish to be notified of patient's status
5. notify staff of changes in patient's status
6. provide support and comfort to family members/caregivers, and staff, when indicated
7. normalize the dying process for family/caregivers, when needed
8. provide after death information, upon request
9. inform caregiver/family of other Hospice services available following a death
10. provide information on other community resources that may be helpful to caregiver/family, upon request

VIGILS cont'd

HOW DO VIGILS HAPPEN?

1. How do vigils happen?
Call to Hospice office or coordinator from CDH, Lodge, Cairnsmore or home nursing. All information on the client, address, floor, room # and some details of the family available, who is requesting it, etc are taken down to be passed on to the volunteers responding to the vigil.

2. How do we respond?
The coordinator starts by making calls to volunteers to find someone available to go immediately, and continues to make calls to line up a schedule for the rest of the period of time needed. Often volunteers who have been scheduled will have to be cancelled as the client has passed on.

3. What's expected from the volunteer?
When volunteer arrives you would head straight to the room given to you. Enter quietly and slowly. If they are alone approach the client, even if they are not conscious, and let them know you are there by quietly telling them your name and that you are from Hospice and have come to sit with them.

If family is with them again introducing yourself, they are most likely expecting you. If family comes in while you are sitting, introduce yourself and ask them if they would like to have some time alone with their loved one. They may not, and indicate they would like to sit and talk with you or may tell you that they will take it from there. We always take our cue graciously from the family and nursing staff. Do not be afraid to ask them if they would like you to leave the room, etc. Depending on what they are going to do, like clean and turn the patient, you will become familiar with the routine in time.

If the client is still with us at the end of your shift a new volunteer will have arrived to take over. Give them any information that is necessary. If the client is conscious and can converse, has shared personal information, this is NOT shared. Only information concerning the care level that we are doing, swabbing the mouth, holding a hand, reading or playing music. Most often you are just sitting and this is where bringing a book or craft is a good idea.
They know you are there and that is a comfort.

4. When the client has passed
If you are alone with the client at this time, call the staff and let them know that you think the client has passed. If you notice while sitting there that there has been a sudden change in the breathing etc, call the nurse. From there, usually more than one staff member will come into the room and check for vital signs. Stand back from the bed and let them do their job. If the client has passed they will indicate this to you, and at that time quietly leave.

If you are with the family in the room – sometimes when death is coming and you have called the nurse they will ask you to leave the room. If the family indicates that they would like you there or if the nurse does not say leave then again, stand back and be quietly available for the family, etc. until the time comes for you to leave. Leave a brochure or let them know that we will be available for them at a later time if they should need us. You will find that every vigil is different. Trust your instincts.

Note: If the client passes during your shift, be sure to phone the coordinator to let them know that the next volunteer is **not** needed.

VANCOUVER ISLAND health authority

HEALTH AND SAFETY TIPS

Stay Healthy and Use Antibiotics Wisely

The Vancouver Island Health Authority offers tips to stay healthy through cold and flu season – and cautions residents to use antibiotics wisely to prevent bacteria from becoming resistant to antibiotics.

Stay Healthy

Did you know that 80% of common infections are spread by hands?

Handwashing is the best way to stop the spread of infections.

Proper hand washing technique includes:

1. Fifteen seconds of vigorous rubbing of hands together until soapy lather appears.
2. Scrub between the fingers, under the fingernails, around the tops and palms of the hands.
3. Rinse under warm running water.
4. Dry the hands with a clean, disposable towel, and turn off the faucet using a towel as a barrier.

Always wash your hands:

- Before meals
- After blowing your nose or wiping your child's nose
- Before breastfeeding
- After changing diapers
- After using the toilet or helping your child use the toilet
- After playing with toys shared with other children

Use Antibiotics Wisely

Using antibiotics when they are not needed can lead to antibiotic resistance. Although both bacteria and viruses cause respiratory tract infections, antibiotics only work against bacteria.

Viral:

- Infections include: colds, flu, croup, laryngitis, chest colds (bronchitis) and most sore throats.
- Viral infections are more contagious (if more than one family member has the same illness, odds are it is a viral infection).
- Be patient if you have cold symptoms, cough or a sore throat. Most viral illnesses take 4-5 days before getting better and up to 3-weeks for full recovery.

Bacterial:

- Cause infections such as pneumonia and strep throat.
- Are less common and do not spread from one person to another as readily.
- Use regular soap. Antibacterial soap is not recommended because it promotes bacterial resistance.

CASE STUDIES

Facilitators'sNotes: The Case Studies are best suited to be first answered as a group of 4 – 6 people, and then acted out in a short role play, with subsequent discussion by the larger group. Since not all people are comfortable with doing role plays, having a larger number in the group gives those who chose not to act out the case study that opportunity

Scenario #1:

You have been visiting the Smiths in their home for the past three months. Mrs. Smith is going out for the next 3 hours for respite. Mr. Smith had just received a dose of pain medication given by Mrs. Smith, and is sleeping comfortable. Halfway through your visit, you go to get a glass of water. Upon returning, you enter his room to find that he is not breathing, his eyes are open and his skin colour is blue.

a) What is your initial reaction?
b) How would you handle this situation?
c) What do you say to Mrs. Smith when she arrives home?
d) Thoughts? Questions?

FACILITATOR: Topics to discuss: To call Mrs. Smith immediately or wait until she returns? Pros/Cons of each choice. How to break the news – When on the phone or as she arrives home?

Scenario #2:

You arrive at the hospice center / hospital. It is your first visit with this family. The nurse shows you to the room where the person you are scheduled to see is staying. You are standing outside the door.

a) How do you prepare yourself to enter the room?
b) The family is present. The person (client) is sleeping. (the group can choose a percentage on the PPS scale for discussion purposes). What would you say to the family?
c) Since the person is sleeping, what would you do while you are there (after the family leaves)?
d) Thoughts? Questions?

Facilitator: Topics to discuss: "Going Empty" in preparation-different ways that it can be done. What questions might you ask of the nurse? The family? What is permissible at your local facility? Reading? Therapeutic Touch? Music?

Experiential Endings Exercises and Practices
Hospice Volunteer Training Classes

Touchstone

Session beginning

- Let everyone choose a rock/stone

While choosing or holding your chosen stone, focus on the qualities of a stone: solid as a rock; shaped by its experience; present by its weight, texture, edges and grooves; silent; still; not needing to be other that what it is.
The stone is a touchstone, a reminder, a symbol it represents the earthy qualities, coming from mountains, bedrock. Rocks and stones found in the ground and soil, create space and breathing room for the earth; or are used to fill in gaps. Stones and rocks can be used both as barriers or bridges, boundaries or archways.
Let this stone be a talisman to keep you connected to earth, to keep you grounded in presence even as your mind an thoughts try to pull you elsewhere. Feel how it warms in your hands as you hold it and yet the essence of the stone, it's structure, remains the same.
Focus on the attributes and qualities of your stone, infuse it with the quality of your presence. Get comfortable with it; get to know it; listen deeply to what it has to say about the qualities and characteristics of a stone.

Session Ending

Ask that participants return the stone. Acknowledge their various responses. i.e surprise, resistance, attachment, disappointment, that it is unfair to have been given it and then asked to give it back; desire to keep it; some may even have surreptiously kept it or thought of doing so, hiding it away. And for some there may have been no reaction one way or another. Neutral to it.
Relate it to how quickly we can make attachments, even to a stone. Relate it to how quickly we can make attachments to the clients and families we work directly with. Let them know that next week they have the option of choosing the same rock, or a different one.

Part of the process of working in hospice is about learning to and living with impermanence, connecting and letting go.

Story examples of how the attachment can play out

- Jealousy of shared clients/specialness of relationship
- Vigils – not wanting to leave after your shift - certain that their time is moments away – relating stories of clients who have lasted many days longer
- Unable to take on new clients needing support because one has not let go of their previous client, client situation

Practicing ways to say good bye each time – as if for the last time – because one of those times it will be.

Examples

- Trouble tree
- Christina and her rock
- Phil Lander's cutting ties
- Holding them in your thoughts and prayers in between your visits

Remember, what you imbued in the stone is already within you. Sometimes, yes we need reminders, touchstones, talismans to represent the qualities, to carry the energy, as reminders. But at the same time it is important to recognize, internalize, and integrate these qualities that really are already in us, needing to be uncovered and brought to consciousness – that we be them.

Courtesy: Christy Linder

THE VOLUNTEER AND CLIENT RELATIONSHIP

The volunteer does not carry the primary responsibility for medical care or psychosocial support. Instead, he/she complements the other team members. Freed from these responsibilities she is really at the disposal of the client, and can allow the client to choose how she can best serve him - to share, to listen, to accept without judging. The volunteer will be able to give of her time and of herself, without expecting in return, and often not knowing the fruits of the gift. As Kahlil Gibran wrote:

> "There are those who give and know not pain in giving
> nor do they seek joy, nor give with mindfulness of virtue;
> They give as in yonder valley the myrtle breathes
> its fragrance into space.
> Through the hands of such as these Gods speaks, and
> from behind their eyes He smiles upon the earth."

In giving of themselves however, the volunteer must recognize their own limits. They are there as helpers and if they get too involved they are no longer able to be objective and helpful. Volunteers must learn to follow the narrow line between empathetic sharing and personal over-identification. In finding this balance, volunteers are helped by the presence of other team members.

SUPPORT FOR THE VOLUNTEER

It is sometimes assumed that because volunteers may work only one period a week, they are not stressed. It is true that they usually bring a freshness and vitality that may be more difficult to sustain in full-time staff, but they do need support and encouragement. This comes in a variety of ways:

- peer support from other volunteers. It is essential that volunteers working together be communicative and cooperative.
- informal interactions between volunteers and nurses.
- the availability of the coordinator for ready advice and counsel.
- staff meetings in which they can see how their effects are playing an important part in the total effort.
- meetings between new volunteers and experienced ones to share reactions, problems and insights
- social events organized for the whole team.