NO VETERAN DIES ALONE
VOLUNTEER TRAINER RESOURCE MANUAL

The information contained in this manual is to provide guidance for Veterans Affairs facilities striving to incorporate volunteers into the care for dying Veterans. The manual provides general guidance for developing and sustaining a volunteer program with the overall goal of enhancing end-of-life care for Veterans and their families.

Department of Veterans Affairs *(September 2016)*

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Foreword

The most powerful story that I know to share the value of the "No Veteran Dies Alone" (NVDA) program comes from an older volunteer at the facility where I work named Bob. Bob served in the Air Force and, now in his 80s, took on the role of covering the Ambassador's Desk as you enter our Veterans Affairs facility. He is helpful to anyone that comes through the door, and I love to see Bob showing the younger Veterans how to access the kiosk to check in.

In passing one day, I shared with Bob my belief that he would be an excellent volunteer on our hospice unit and that the training for the NVDA program was coming up the next month. He readily agreed, and I was delighted to see his smiling face at the training session. Sometime after the training session, as I was walking by the expansive entrance to our facility, I heard Bob calling out, "Dr. Shreve! Dr. Shreve!" Bob was out of his chair catching up to me to share a story. He had signed up for the NVDA program to sit at the bedside of a Veteran. This past week, he had been called to come in for a 2-hour session for a Veteran that was approaching death. Bob came and stayed long past his 2-hour "shift." That night, Bob went home and slept soundly through the night. I thanked Bob, told him how much we appreciated his coming to our hospice unit, and was sure that the Veteran and his family appreciated it, too. Bob nodded his head and said, "Dr. Shreve, after sitting with that Veteran, I went home and slept through the night, something I hadn't done in the 2 years since my wife died." He said "thank you" to me.

While this Resource Manual is titled "No Veteran Dies Alone", this program is so much more and may have different names at different VA facilities. There is no "one size fits all" volunteer program for the many VA facilities across the nation so please use part or all of this Manual in building your program. For the NVDA program, our vision is for volunteers to get to know "their" Veteran and if possible be a listening ear along a difficult journey. For many Veterans, the opportunity to share their stories can be fulfilling and often contributes to a sense of fellowship, life closure and peace. If the volunteer listening to these stories is also a Veteran, the sharing can be all that more powerful.

There are many people to thank for this Resource Manual, and we have only "scratched the surface" in our Acknowledgements section. On behalf of all the Veterans and families you will help with this Resource Manual, thank you for making it possible and for helping us to share the fulfillment that comes from serving those who have served us.

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Overview

The "No Veteran Dies Alone" (NVDA) program is inspired by the program called "No One Dies Alone," developed by Sandra Clarke, CCRN, of the Sacred Heart Medical Center. Several other programs, such as The Twilight Brigade, Last Watch, and Eleventh Hour, serve as inspiration on how to address the issue of people dying alone. To echo the observations of Ms. Clarke, the Department of Veterans Affairs (VA) hospice and palliative care (HPC) teams have witnessed the need for trained volunteers. NVDA is a program designed to honor Veterans and to meet the needs of those Veterans who, for whatever reason, find themselves alone. This manual will assist educators in engaging the community, especially Veteran volunteers, in improving end-of-life (EOL) care for Veterans. Volunteers will provide presence, companionship, and reassurance to the dying Veterans. VA staff will educate, nurture and support these volunteers in their journey with dying Veterans. After completing their training, these volunteers will have expertise in military culture and the dying process and be able to provide the comfort of presence at the bedside when family and friends are unable to be near their loved ones.

Years ago, most people died suddenly at home from injuries or sudden illness. They were surrounded by family and friends. The dying looked to their families and church communities for support. In the United States (U.S.), the first modern hospices were community-based programs led by volunteers. In the 20th century, death evolved into more of a medical event rather than a family event at home to the point that now most people die in hospitals or healthcare facilities. Today, because of modern medicine, the course of dying has been extended. Most Americans, including Veterans, die from chronic illnesses in the hospital instead of at home. Some have outlived their loved ones, or, due to other circumstances, find themselves alone at the end of life. For many, this can be a lonely experience.

There are currently over 23 million Veterans living in the U.S., with more than 600,000 dying each year. To put this in perspective, there are more Veterans anticipated to die each year for the next decade than died in all of World War II. With the aging of the World War II-, Korean-, and Vietnam-era Veterans, an increasing number will require end-of-life care, often in a VA medical facility. Although there are no solid figures to indicate how many of these Veterans die alone, the NVDA program is dedicated to making volunteers available to provide a comforting presence in the final weeks, days and hours of life as Veterans and their families desire.

Dame Cicely Saunders is credited as the founder of the modern day hospice movement. She founded the St. Christopher's Hospice in London, UK, in 1967, where she introduced effective pain management and insisted that dying individuals deserved compassion, dignity, and respect, along with a focus on holistic care and on treating their emotional and spiritual, as well as their physical, needs.

The VA has a long history of providing healthcare to elderly Veterans, with a focus on HPC for several decades. One of the leaders in this area was Zelda Foster, MSW, Chief of Social Work Services, at Brooklyn VA Hospital, who met Dame Cicely in 1963 and became a central figure in the evolution of hospice and palliative programs in the VA. Ms. Foster's objectives are summed up by what is now recognized as a "good death." The NVDA program acknowledges the importance of a human presence at the EOL as a component of that "good death."

The VA focus on EOL care has grown substantially in recent years, similar to the hospice movement, which seems to be gaining momentum. HPC is now a part of every enrolled Veterans benefit package. While the VA first issued a directive on HPC consult teams in 2003, today all VA medical centers have active interdisciplinary palliative care teams for the Veterans and families they serve.

The purpose of this volunteer trainer resource manual is to promote the development and enhancement of NVDA programs while supporting trainers in empowering volunteers specifically to meet the needs of dying Veterans. In the spirit of the interdisciplinary approach to HPC, the workgroup for developing this Resource Manual included representatives from VHA Leadership, Medicine, Nursing, Social Work, Chaplain Service, Education Service, and Voluntary Service, with input from other members of interdisciplinary HPC teams, current volunteers, and leading volunteer programs (such as the Twilight Brigade). The goal is that after attending a NVDA orientation program, volunteers will be able to contribute to the comfort of Veterans at EOL as part of a care plan to honor Veterans' preferences.

Section 1: Volunteer Recruitment and Retention

Goals

After reading this section, Department of Veterans Affairs (VA) trainers will be able to

- Understand why volunteer recruitment and retention is essential to successful volunteer programs;
- Understand and explain the nuances and different skills needed for the "No Veteran Dies Alone" (NVDA) volunteers compared to other volunteer programs;
- Learn how to recruit and select competent and caring end-of-life (EOL) volunteers through specific criteria, thoughtful positions descriptions, and flexibility in scheduling; and
- Develop ways to retain valued volunteers.

Introduction

Volunteers for Veterans at the EOL are a special group who will be interacting with a vulnerable population, and it is an earned privilege to assist in the care of a dying Veteran. As such, volunteer recruitment for the NVDA program is more finely nuanced than for volunteers being trained to serve in other areas of the VA medical centers. The units of this section are designed to provide staff with guidance on how to effectively follow and incorporate the following into their NVDA programs:

- Screening and Interviewing Criteria
- Available Hours and Schedule Flexibility
- Position Descriptions
- Retention
- Tips and Recommendations to Promote the Recruitment, Retention, and Development of the Volunteer Program

Helpful resource guides with examples follow this section.

Unit 1: Screening and Interviewing Criteria

Facilities across the VA engage specially trained, interdisciplinary palliative care teams with expertise in managing the unique needs of Veterans and their families with serious illnesses. Therefore, the volunteer needs to be INVITED into the care of a dying Veteran. The trained volunteer's presence can be incorporated into the overall EOL plan for the Veteran and his/her family. Some examples where the core interdisciplinary team (IDT), comprising a physician, nurse practitioner or physician assistant, nurse, social worker, and chaplain, may help direct the volunteer include:

- A female Veteran may prefer a female volunteer;
- A quiet Veteran may prefer someone who sits quietly (therapeutically);
- A Veteran may want someone to speak about the "old times," but NOT about the volunteer's family (as this could, unintentionally, open further psycho-social-spiritual distress); and
- A Veteran may enjoy playing checkers, but chess brings up negative images.

As difficult as it may be to understand, there ARE some Veterans who, even though they are alone, PREFER to be alone. Introducing a volunteer, just because it appears that the Veteran is alone, may not be part of the IDT's plan of care. Alternatively, the Veteran, being at the center of care, needs to be able to say or indicate, "No, I do not want to have a volunteer."

Using EOL volunteers needs to be a special consideration based on the expertise and direction of the IDT. As such, they MUST be consult driven and embedded into the care planning. In the interest of Veterans and their families, at no time should EOL volunteers have access to Veterans without the IDT's invitation and the Veteran's agreement. This invitation and subsequent consult is the product of a dialogue between the IDT and the Veteran. The need for NVDA volunteer support is based on initial and ongoing assessments made by members of the IDT and is incorporated into the Veteran's individual plan of care.

Veterans Affairs Voluntary Service (VAVS) Specialists recruit, interview, and screen (including doing background and reference checks) all volunteer candidates. It is important to ensure that the VAVS Specialists responsible for recruiting and interviewing potential NVDA volunteers are informed of service-specific screening and interviewing criteria. **NVDA volunteer candidates will receive additional training to provide supportive care and comfort to Veterans receiving HPC.**

Screening and interviewing criteria should include, but are not limited to, the following topics:

- Recent, personal losses, which may affect the volunteer's ability to serve seriously ill and dying Veterans. General recommendations support delaying service as a NVDA volunteer for at least a 1-year grieving period following the death of a close family member or friend.
- Relevant experience
- The potential volunteers' reasons for volunteering and expectations of the volunteer experience to better understand the personal motivation for volunteering. For example, questions to help determine those reasons are:
  - What do you think terminally ill Veterans and their families need?
  - What do you hope to contribute?
  - Is there anything that may limit your ability to be an effective volunteer, such as conflicting religious beliefs and practices, physical limitations, or emotional/mental distress?

Unit 2: Available Hours and Schedule Flexibility

At existing programs, NVDA volunteers are often Veterans, family members of Veterans, VA employees, non-Veteran related members of the community, and/or members of Veteran Service Organizations (VSOs). They may be homemakers, retirees, or employed full time. Irrespective of a volunteer's employment status, the value of his/her time is significant, so it is important to coordinate a schedule that aligns the time volunteers have to offer with the needs of the facility/unit/Veterans being served.

NVDA volunteer scheduling protocols should be coordinated in concert with VAVS Specialists and unit leadership. It is important to understand both the specific need for volunteer services, especially during alternate shifts and weekends, and the expectations to provide volunteers with appropriate site supervision. For example, volunteer hours may range from 2-4 hours on day shifts Monday-Friday, or extend for up to 8 hours/shift, 24 hours/day, 7 days/week depending on available supervision and the volunteer's description of

duties. Some volunteers serve once or twice a week, bi-weekly, or monthly. **Flexibility in scheduling is encouraged**, and volunteers are asked to commit to their schedules once they have indicated their preferences. Volunteers are also instructed to notify their site supervisor or designee, if unable to volunteer as scheduled.

NVDA volunteers are treated as part of the IDT and are invited to participate in IDT rounds, as well as the weekly IDT meetings.

- See Resource Guide 1-1 to view a Sample Voluntary Service Interview Form.

Unit 3: Position Descriptions

Volunteer position descriptions are developed by the unit, in collaboration with VAVS staff, and should include a description of major duties, qualifications, skills, and prerequisites for each position. It is important to work with VAVS in developing the descriptions to ensure that duties remain within the volunteers' scope of practice. Many position descriptions are already in use at the VA and may serve as a guide when creating descriptions to support the needs of the unit.

- See Resource Guide 1-2 to view a Sample Position Description Requirements Form.
- See Resource Guide 1-3 to view a Sample Volunteer Position Description.
- See Resource Guide 1-4 to view a Sample Volunteer Assignment Guide.
- See Resource Guide 1-5 to learn more about what a volunteer can provide in "What You Can Provide."
- See Resource Guide 1-6 to a view a Sample NVDA Brochure.

Unit 4: Retention

Volunteer recruitment and retention are essential to the success of any VAVS program. As much as one would like to think that all NVDA volunteers recruited will continue to volunteer permanently, they will not. Volunteer recruitment will always be ongoing. VA employees, Veterans, members of VSOs, and the community-at-large can be recruited as NVDA volunteers. Because volunteer retention compliments recruitment, once volunteers are recruited, they should be provided with all the information needed regarding their assignments and requirements and offered schedule flexibility and the resources that will enable them to do their assignments well.

It is also vital to acknowledge the service the volunteers have given by making them feel that they are valued members of the IDT. It is very important to recognize the worth of committed volunteers. If the volunteers perceive that their volunteer assignments are valued, they tend to stay in that assignment. Tips for increasing retention of volunteers include:

- Thanking the volunteers for their help
- Sending thank-you group emails to those volunteers who use computers and written thank-you notes to those who do not
- Visiting the volunteers during their shifts
- Providing a flexible volunteer schedule

- Having best-practices meetings to find out what is or is not working well and to learn/validate the volunteers' thoughts/suggestions
- Calling volunteers at home to thank them for their volunteerism, especially if they have not been seen lately.
- Having a NVDA Volunteer Appreciation event that is separate from the regular Volunteer Award and Banquet. These volunteers have unusually difficult volunteer assignments, and such gatherings also allow for continued fellowship and support among NVDA volunteers.
- Considering weekly or monthly meetings with the NVDA volunteers

Unit 5: Tips and Recommendations to Promote the Recruitment, Retention, and Development of the Volunteer Program

This section provides succinct bullet points to help VAVS Specialist, VA staff and trainers, and VSO coordinators in the development of their NVDA programs.

Recruitment

- Scheduling recruiting activities regularly
- Sending activities announcements through various media, such as print and electronic newspapers, newsletters, bulletins, social media, and other broad-based community resources

Retention

- Sending an initial thank-you note for becoming a volunteer, signed by the directors of each facility, to each volunteer; resending thank-you notes each month or quarterly with the volunteer coordinators also signing
- Providing time for quarterly reflection with the Staff Chaplain or Psychologist
- Touching base monthly by email or phone to say hello, thank you, etc.
- Giving out certificates with volunteers' initial start dates and as annual recognition
- Facilitating a semi-annual banquet (e.g., spring and fall)
- Sending recognition pins from Positive Promotions with holiday appreciation cards
- Offering support groups
- Partnering new volunteers with experienced, competent peer volunteers
- Making changes in assignments, if necessary or to provide a more diverse experience
- Showing evidence of ongoing volunteer supervision
- Identifying the educational needs of hospice volunteers

Development

- Inviting volunteers to staff in-services
- Writing NVDA program criteria for recruiting, selecting, training, and assigning volunteers. Volunteer selection and evaluation methodologies include screening, checking background and references, evaluating performance annually, and observing care as part of the evaluation process.
- Ensuring that all volunteers complete a comprehensive orientation prior to engaging any Veteran or family member as part of their duties

- Assessing the volunteers' performances on hire and ongoing through observations made during orientation, evaluations made during care assignments, and the annual performance evaluation process
- Supervising each volunteer assigned to a Veteran by the hospice volunteer coordinator or other designated individual with supervisory responsibilities
- Maintaining a personnel record for each volunteer
- Ensuring that volunteers can articulate the information provided in their orientation and training as evidenced by interviews or evaluations with the hospice nurse, other team members, or the hospice Veteran or family
- Incorporating into the performance evaluations the valued educational components listed in the NVDA orientation and in ongoing educational initiatives. A review of these evaluations can demonstrate a positive correlation between the education material presented and the volunteers' demonstrated competence.
- Instituting a formalized process to elicit feedback from volunteers about the recruitment process, orientation and training, supervision, and their practice with Veterans and families
- Documenting, by the volunteer coordinator, of active and ongoing efforts to recruit and retain volunteers and a continuing level of volunteer activity
- Recording the expansion of services achieved through the use of volunteers, including the type of services and the time worked
- Using volunteers to educate the community at various activities in which they participate

After recruiting and selecting NVDA volunteers, the next section lays out a course of training for VA trainers to use to prepare the volunteers to develop the competencies they will need to serve EOL Veterans and their families effectively.

Resource Guide 1-1: Sample Voluntary Service Interview Form

Voluntary Service Interview Form

Date: _____

Applicant: _____

Interviewer: _____

Please check each item as you review them with the Applicant:

( ) Applicants committing to 75 hours per year are acceptable.
( ) Services are donated to VA with humanitarian/charitable reasons without compensation.
( ) All Patient and Health System information must be held confidential/HIPAA.
( ) No matter what your background, no patient care can be delivered.
( ) Follow your position description.
( ) Are you currently looking for a paid job? If so, will you still be able to volunteer? Please think about your commitment.
( ) Are you a Veteran? (Y) (N) VSO? (Y) (N)

Affiliation – Branch of Service _____

Affiliation – VSO _____

1. How did you hear about the Voluntary Service Program?

_____

_____

2. Why did you pick the (specific facility) to offer your volunteer service?

_____

_____

3. Have you volunteered for some other entity before? (Y) (N) Where?

_____

_____

4. Relative to the volunteer position you are interested in, please tell me about your experience or skills that will assist you in performing your volunteer assignment.

_____

_____

5. Give me a specific time when you had to deal with an upset co-worker, customer, or friend. What was the issue, and what did you do to resolve it?

_____

_____

6. Describe a change you had to make personally over the last couple of years. At the time, how did you feel about the change? What did you do to make the change?

_____

_____

7. For NVDA volunteer Applicants only: Have you had a recent death in your family or of a close friend? (Y) (N) How has this loss affected you?

_____

_____

8. Do you have any physical limitation or medical condition that I should be aware of when considering you for a volunteer assignment? (Y) (N) If yes, specify limitation/medical condition/restrictions.

_____

_____

9. Are you currently employed? (Y) (N) Where?

_____

_____

10. Have you been convicted of a felony/crime? (Y) (N) If yes, what crime?

_____

_____

11. What volunteer assignment are you interested in?

_____

_____

12. What day(s)/hours would you like to volunteer?

_____

_____

13. What do you hope to gain from your volunteer experience?

_____

_____

Reactions to questions: Appropriate | Difficulty w/syntax | Confused | Evasive

Comments: _____

Disposition: Outgoing | Confident | Reserved | Withdrawn | Moody Reserved
Antagonistic | Unusual mannerisms

Comments: _____

Interpersonal skills: Adept in dealing w/others | Relatively at ease | Uncomfortable

Comments: _____

Schedule for second interview _____

Start _____ Day _____ Hours _____

Department _____

Resource Guide 1-2: Sample Position Description Requirements Form

Physical Requirements

Circle the number of each function/safety requirement essential to the duties of this position.

1. Heavy Lifting
2. Moderate Lifting (45 lbs or over)
3. Light Lifting (Under 15 lbs)
4. Pulling (_____ HRS)
5. Pushing (_____HRS)
6. Reaching Above Shoulder
7. Both Hands Required
8. Use of Fingers (Dexterity)
9. Repeated Bending (_____ HRS) per Day
10. Walking (_____ HRS) per Day
11. Both Legs Required
12. Both Eyes Required
13. Hearing Required
14. Depth Perception Required
15. Ability to Distinguish Color
16. Ability to Speak Required
17. Mental & Muscular Coordination
18. Kneeling (_____ HRS) per Day
19. Standing (_____ HRS) per Day
20. Safety Shoes Required & Provided
21. Safety Glasses Required & Provided

Specify any other requirements needed to perform duties of the position description:

_____

_____

Environmental Factors

1. Excessive Heat
2. Excessive Cold
3. Excessive Noise (Intermittent)
4. Constant Noise
5. Dust
6. Slippery Surfaces
7. Uneven Walking Surfaces
8. Unusual Fatigue Factors
9. Work around Machinery
10. Work around Moving Vehicles
11. Work Alone
12. Work Closely with Others

Specify any other unique factors surrounding the volunteer's assigned work area:

_____

_____

Affidavit of Volunteer

I do not have any medical disorder, physical impairments, mental limitations, or physical limitations that would interfere, in any way, with the full performance of the factors or requirements of duties stated in compliance with this volunteer assignment.

_____

Volunteer Name (Print) / Signature Date

Resource Guide 1-3: Sample Volunteer Position Description

Voluntary Services Office: Request for Volunteer Assistance

Date: _____

Requesting Service / Section: _____

Volunteer Position Title: _____

Check all that apply to position: ( ) Short Term ( ) Long Term ( ) Existing ( ) New

Number of volunteers needed for this position: _____

Hrs. /Day the volunteer is needed: _____

Position Description (include lifting, walking, limitations, etc.):

- Support VA's "No Veteran Dies Alone" initiative
- Comfort Veterans during final hours of life through literature, music, or other forms of supportive presence.
- Assist in providing comfort for families of Veterans as they attend to their loved one
- Provide support for Veterans, family, and staff, as requested/scheduled to companion Veterans during their final weeks, days, and hours of living
- Provide documentation of specialized training in the care of individuals approaching end of life (e.g., The Twilight Brigade; Companioning the Dying, Inc.; Vigil/11th Hour Training from community hospice agency).

Qualifications, Skills, and Prerequisites for Position:

- Minimum age of 18
- Successful completion of the Voluntary Services Orientation
- Communication skills necessary to work with family and staff caring for seriously ill Veterans
- Willingness to be present with Veterans during their final weeks, days, or hours of living
- Ability to remain seated for extended periods of time
- Agreement to be "on call" (per volunteer's availability) to accommodate need for service
- Previous hospice experience and/or caregiving at end-of-life valued and welcomed
- At least one year beyond experience of a significant personal loss

Supervisor & Title: _____ Ext: _____

Alternate Supervisor & Title: _____ Ext: _____

If your service has a potential volunteer for this position, please give his/her complete name below:

Name: _____

Service Chief: _____

(Signature) (Date)

For Voluntary Service Completion:

Voluntary Service Specialist: _____

Date Received: _____ Date Filled: _____

(Form: 09/2012)

Resource Guide 1-4: Sample Volunteer Assignment Guide

Volunteer Assignment Guide

Volunteer Name: _____

Utilizing Service: _____ EXT. _____

Duty Location: _____

Supervisor: _____

Day/Time Needed: _____

Term/Duty Duration: _____

Start Date: _____

Uniform Required: YES NO

Duties/Responsibilities: _____

_____

_____

Qualifications: _____

_____

_____

Training Provided by Service: _____

_____

_____

Agreement: Volunteers must complete orientation prior to assignment. Site Supervisor is in charge of and responsible for the volunteer in the daily operation of assigned duties. Changes in assignment must be coordinated with Voluntary Service. Upon end of term, volunteer must check out through Voluntary Service. Volunteers must adhere to similar policies as do employees (e.g., privacy). Provide signatures below and return assignment guide to Voluntary Service.

_____

Supervisor Name (Print)/Signature Date

_____

Volunteer Name (Print)/Signature Date

Concurrences: _____ / _____

Resource Guide 1-5: What You Can Provide

What You Can Provide

- You are one of the caring people that Veterans, their families, and their friends come into contact with when they visit our facility. You offer companionship and assistance.
- Your positive and friendly outlook is vital.
- You assist our medical and administrative staff with making sure that Veterans are treated with the respect and consideration they deserve.
- You can be a friend, confidant, and connection to the community.
- You can help preserve Veterans' life stories through scrapbooking, photo preservation and life memory audio and video recordings. Supervisors will provide guidance on necessary consent forms for audio and video recordings and release forms in order to provide recorded or written stories to families (e.g., Veterans History Project located at www.loc.gov/vets).
- You can assist a Veteran or family member with letter writing.
- You can share their special memories.
- Sometimes there is nothing you can do except hold the Veteran's hand. Remember that not all Veterans want to be touched. Please ask permission. If the Veteran is unable to communicate, ask staff. At other times, the Veteran may talk to you or may want to hear what you have to say. Talk about shared experiences, the Veteran's life, your life, and what's going on in the world. Take cues from the Veteran. If he/she wants to talk about dying, listen and respond appropriately and honestly. If you don't know how to respond, simply assure him/her that you care and seek out assistance from the staff.
- ALWAYS ask for help or for permission from nursing staff before assisting a Veteran. The simplest thing, like giving a Veteran a drink of water, may require special skills or knowledge of the Veteran's condition.
- People with chronic pain may not show any outward signs of pain. However, you can often tell if a person is in pain simply by being observant. A grimace, a wrinkled brow, tense fingers, moans, etc., are all telltale signs. Even in an unresponsive person, these signs tell us they are in pain. Report signs of pain to nursing staff. Most pain can be effectively relieved with medical intervention.
- Always speak to the Veteran in his/her presence, not about him/her. Hearing is thought to be the last one of the senses to fade.
- It is essential for you to believe that whatever you do in loving service for the sick and dying, you are contributing to their comfort and happiness. You are not helpless in the face of illness and death, regardless of how much or how little you are able to do. What counts is your presence, not your activity.
- Whatever we do outwardly, it is our concern and respect for the Veteran that matters.
- Be mindful of your interactions with the Veteran and the family. Do not become overly involved in your relationship with them. Do not accept gifts of any type, e.g., food, personal items or money. Do not make plans to meet family members after the Veteran dies with the exception of attending funeral/memorial services.

Resource Guide 1-6: Sample NVDA Brochure

Sample NVDA Brochure

"NO VETERAN DIES ALONE" Volunteer	
Purpose	To provide non-medical supportive services to palliative care Veterans and their families
Department & Location	Community Living Center (CLC) and other areas that may be identified by the Palliative Care Team (PCT)
Supervisor & Phone Number	
Specific Duties	• Veteran Support: Provide support to Veterans by listening, providing reassurance, holding the Veteran's hand, sitting quietly and providing companionship, reading to the Veteran, assisting in writing letters, playing cards or games, and taking the Veteran for a ride in a wheelchair to visit other areas of the facility • Family Support: Provide support to family members by listening, allowing family members to vent emotions and concerns, giving reassurance, encouraging the use of the family room, directing the family to other facility services as needed/requested • Personal Care: While it is common for hospice volunteers in the community to assist with personal care, volunteers in VA facilities can only participate in non-medical care • Other: Keep Veteran and family rooms tidy, water plants and flowers as needed, keep family kitchen/lounge tidy and stocked with supplies • Tasks and activities as requested to maintain the PC area in the most appealing manner
Time Required	Flexible times/days to be coordinated with the PC Manager and on a call-back roster when Veteran is in need

Qualifications	Must understand and accept the palliative and hospice care philosophy of Veteran care and have the ability to: • Understand the VA Volunteer Policies and guidelines (see Volunteer Handbook) • Deal with people from a wide variety of backgrounds and ages in a pleasant, caring manner, including Veterans, their family members, visitors, staff, and other volunteers • Display a natural courtesy and capacity for love and a personal maturity • Be flexible in the acceptance of different lifestyles and cultural and religious orientations; resist the temptation to impose own values on the Veteran and family • Be a good listener, skilled in verbal communication, and comfortable when silence is appropriate; able to communicate effectively with Veterans, family members, and staff • Recognize personal human limitations and to maintain a balance between empathetic caring/ concern and inappropriate personal involvement • Understand the importance of punctuality and conscientiously carrying out assigned responsibilities. • Understand and accept the principles of confidentiality for staff and Veterans
VAVS Training	VA Voluntary Service (VAVS) Orientation Palliative Care Volunteer Training Quarterly Palliative Care Volunteer Meetings
Assignment-Specific Training	Additional training pertaining to the Palliative and Hospice Care Policy and the roles of volunteers in the hospice unit

Section 2: Training

Goals

After reading this section, the Department of Veterans Affairs (VA) trainers will be able to train volunteers to:

- Understand the purpose and focus of hospice and palliative care (HPC);
- Learn key concepts about the death, dying, and grief processes; and
- Develop core competencies in:
  - Communication skills
  - Care and comfort measures
  - Family dynamics
  - Cross-cultural diversity
  - Self-care and stress management

Introduction

It is vital that all "No Veteran Dies Alone" (NVDA) volunteers receive appropriate orientation and training prior to interacting with Veterans and their families. This section is again divided into several units and includes the following topics:

- Introduction to Hospice and Palliative Care
- Concepts of Death, Dying, and Grief
- Communication Skills
  - Confidentiality
  - Professional boundaries and Veteran/family boundaries
- Care and Comfort Measures
  - Conditions experienced by EOL Veterans
  - Reporting requirements related to Veteran changes, pain and other symptoms
- Psychosocial and Spiritual Dynamics of Death and Dying
- Post Traumatic Stress Disorder (PTSD)
- Understanding Families and Family Dynamics
  - Concept of the unit of care (i.e., the Veteran, family, and caregiver)
  - Coping mechanisms and psychological issues surrounding terminal illness, death, and bereavement
- Self-Care and Managing Personal Stress

The NVDA education course is a continuation of the screening and recruitment process discussed in the prior section. It is recommended that the volunteer manager or designated volunteer department staff attend all sessions of training in order to observe class dynamics. Each participant's responses during sessions on death

and dying, the spiritual needs of Veterans, PTSD, and the review of policies and procedures unique to your VA medical center often provide vital information for assessing the appropriateness of the applicant.

NVDA embraces a "core training" model that addresses important training elements, to include observation of the volunteer performing his/her duties. Training programs should be concise, current, and use professionally accepted information using effective teaching techniques to engage the learner and provide for substantial interactive learning, not just lectures or PowerPoint presentations. Most sessions can be covered in two hours and can be adapted for shorter or longer versions. Incorporating principles of adult learning will facilitate successful learning.

Because of the breadth and depth of this section, each unit has a brief synopsis of its goals at the beginning. At the end of the section are resource guides that provide pertinent information and examples.

Unit 1: Introduction to Hospice and Palliative Care

This unit includes an introduction to the course, an overview of the hospice structure at your facility and throughout the VA, a history of HPC, discussion on the hospice concept and philosophy, and a group interaction exercise to enable volunteers in training to become better acquainted.

As discussed earlier in the overview, the contemporary hospice movement is credited to Dame Cicely Saunders. She founded the St. Christopher's Hospice in London, UK, in 1967. She introduced effective pain management and insisted that dying people deserved compassion, dignity, and respect. This was the beginnings of HPC. The first hospice in the U.S. opened in 1974 in Connecticut.

The VA has a long-standing history of providing healthcare to older Veterans and helped to establish the field of geriatrics through its research and clinical care of these Veterans. As a natural outgrowth of this care, the VA began to focus on EOL care for its Veterans in the late 1970s. The hospice movement for Veterans has gained great momentum, with its HPC widely available to all Veterans regardless of their service connection. The VA first issued a directive on HPC consult teams in 2003. In 2009, the VA launched a 4-year initiative known as the Comprehensive End-of-Life Care initiative. As a result of this initiative, the VA:

- Initiated interdisciplinary palliative care teams at every medical center and provided training in program development;
- Established 53 new inpatient hospice units resulting in more dramatic changes in the venue of inpatient deaths, i.e., more Veterans are able to die in hospice beds than in all of ICU or Acute combined;
- Implemented a national Bereaved Family Survey to obtain the "voice of Veterans" as the core of the HPC program's quality improvement program;
- Developed and disseminated EOL curricula specifically adapted for care of Veterans; and
- Created the *We Honor Veterans* program (www.WeHonorVeterans.org) to engage community hospices in committing to improved care of Veterans at end of life.

Palliative care promotes the quality of life across the length of an illness through the relief of suffering. It can optimally be provided for several years and simultaneously with curative measures. Modifying the World Health Organization's definition of palliative care, the VA believes the following: "Palliative care is an approach to care which improves the quality of life of Veterans and their families facing life-threatening

illness, through the prevention, assessment, and treatment of pain and other physical, psychological, and spiritual problems."[1] Hospice is care that is provided when the prognosis is believed to be less than six months of life. It is focused on pain management, symptom control, and life-closure tasks for the Veteran and his/her family. Both types of care focus on the person with the illness and on the family (defined broadly to include all those deemed "family" by the Veteran).

- See Resource Guide 2-1 for an example of an "icebreaker" exercise, "Committed to Having a Talk (CHAT!)."

Unit 2: Concepts of Death, Dying, and Grief

This unit is devoted to understanding one's personal feeling about mortality, the dynamics of loss and grieving, and the perspective of a dying Veteran. Family, cultural, and spiritual dimensions are also explored.

Death and Dying

Death is universal. Although dying is a process that all humans are destined to experience, the experience is unique to each person. There are some commonalities, however, in the dying process, and these will be addressed. In addition to the physical aspect of dying, there are also the cultural, emotional, and spiritual aspects. An added dimension to the dying aspect for a Veteran and his/her family is the military culture in which they were incorporated. The military culture has changed over time; the experience of the Veteran is dependent on the time and era of his/her military experience. World War II Veterans experienced a different military culture than that of the Korean War, Vietnam, or even the Desert Storm Veteran, etc. Military culture has helped shape the man or woman, often in many positive ways, and, ultimately, it has an influence on the dying process for the Veteran and his/her family.

Being a companion to someone as he/she is dying is a gift to both the dying and the living. Witnessing a death is sacred. Volunteers enter sacred ground as they cross the threshold of a room to be with the dying. To become a NVDA volunteer, one must be willing to look at his/her own mortality, to be comfortable in silence, to honor the dying process, and to be a witness to death. The following questions can help to stimulate conversation with NVDA volunteers:

- What are your thoughts on death?
- What are your thoughts on dying?
- What are your thoughts on grief?
- What is the custom of death and grief in your culture?

Often, though not always, the road to dying matches the road lived on—those who lived hard frequently die hard, and those who lived well frequently die well. It is important to also note that the disease also plays an important role in which road to death the Veteran takes.

Just as there are 'roads' to dying, there are also emotional and spiritual 'pathways' on those roads. Some Veterans have said "I'm dying. I've made peace with God and my family. I am ready when the time comes for me to die." A concern heard most frequently expressed at time of death is the uncertainty of what happens next. The Veteran wonders if there is a heaven or hell and if he/she is going to hell. Many war Veterans

1 http://www.euro.who.int/__data/assets/pdf_file/0003/98418/E82931.pdf, p. 14.

become fearful for what they have done during war—the taking of a human life, even when sanctioned, has an impact on all involved. Some have seen such atrocities that they are afraid to die. Some are afraid that there will be no forgiveness. And there are some Veterans who say, "When I die, that's it." Their certainty may give them a sense of peace. Some Veterans are fearful of being alone, and others are fearful of a "death watch." Ask the Veteran what is important to him/her.

Uncertainty can cause fear at the time of death, and fear adds stress to the dying process. It is important to be honest and authentic when reassuring Veterans because they will know if you are feeding them a line.

The Veteran's spiritual or religious beliefs may play a huge role in the dying process. A God of fire and brimstone may cause fear and concerns of retribution—a vision of an angry God. A God of love brings comfort and hope. At the time of death, beliefs may come into question. When one is not dying in a way consistent with his/her belief system, he/she may wonder, "Am I a bad person? Have I lost my faith? Where is God?" At times like this, it is helpful to allow the person to put the question out there. When the volunteer believes spiritual or religious support is needed, this should be communicated to the care team. In areas such as this, it is not helpful for volunteers to give the Veteran an answer or to try to "fix it." The dying Veteran is pulling the pieces together, and the question is more important than the answer.

Cultural practices also have a role in dying. (For more on this topic, see Unit 7: Understanding Families and Family Dynamics). Some cultures believe that one must have a quiet and peaceful place to die; wailing and crying in the room with the dying person is not allowed. Other cultures do not believe in speaking of dying; they believe that talking about it will make it happen. In this case, usually it is acceptable to talk about dying and death in the third person. Saying things such as "Someone who has an illness such as yours can expect …" or "What do you think is important to someone who is dying?" This allows the conversation to happen and not be threatening.

Some cultures have a designated family member who speaks for the person who is ill or dying. This person addresses all the concerns, makes all the decisions, and is with whom the interdisciplinary team must speak to in order to honor their culture. Some cultures require a ritual washing that must be done by certain members of their community or by a family member. Some require burial within a certain time frame. It is okay to ask, "What is important in your culture?"

Military culture also has its own affects. Many Veterans tend to be stoic and do not show emotion. Remember that they were conditioned to do so, and this was engrained deeply. Consequently, it may be difficult for a Veteran to speak of what is important at his/her time of death, for example, to say, "Forgive me. I forgive you. I love you. Thank you,"[2] and "Good-bye." The Veteran's family frequently feels unsupported by the Veteran, and the Veteran may feel isolated. In a conversation with someone who is struggling with the feeling of being left out, it may be helpful to ask, "Do you think you can share this with us?"

When someone is able to break the cycle by sharing how he or she is feeling, often the other person (Veteran or family) can speak words of love and comfort which have been kept close to heart. Sometimes it all comes together, and sometimes it does not. We cannot change a lifetime of behavior, but we can be a presence and a companion on the road.

2 Byock, I. (2014). *The four things that matter most: A book about living* (10th anniversary edition). New York: Simon and Schuster.

After the death of a Veteran, someone will need to tend to the paperwork that is needed to validate the death. A doctor will fill out a death certificate. A mortuary will prepare the body for burial or cremation. The family or a friend will tend to the necessary forms required by law. The paperwork has a tendency to delay the grieving process. Following up with the bereaved family, one frequently hears, "I'm still doing the paperwork and haven't had a chance to grieve yet," or "I don't have the heart to get rid of his clothes." A good reply may be, "You will know when you are ready. Maybe this is one thing that can wait for a while."

Grief

Grief is normal response to the death of a family member or loved one. The grief process is different for each person. Some may begin grieving prior to the actual death of a loved one (anticipatory grief), some may delay grief, and others may experience complicated grief. Some may work through their personal grief, and others will seek support from a grief counselor or an organization such as a faith community. The hospice team follows the family or loved ones to provide support for up to 13 months depending on the needs and wishes of the family.

Invite volunteers to reflect on their own experiences of loss by using the following resource guide:

- See Resource Guide 2-2 to learn more about Types of Grief.

Unit 3: Communication Skills

This unit focuses on the volunteer's personal interactions with the Veteran and family. Active listening and effective verbal and nonverbal responses to questions are essential communication skills.

Effective Communication

Communication is how we share and receive information and express our feelings and is integral in building relationships. Many factors often influence Individual communication styles. Our communication with others may be affected by our cultural references, our education and career experiences, the environment in which we were raised, our current lifestyle, and our physical attributes or limitations. For example, a volunteer who is hearing impaired will want to share this information with the Veteran and the family if he/she needs to ask others to repeat comments or to speak louder. A volunteer's personal history does not need to be shared with the Veteran; however, personal awareness of our own history is important to honest communication.

Effective communication with EOL Veterans and their families is based on honesty, integrity, sincerity, and compassion. Express your interest in the Veteran's well-being through good eye contact, active listening, and mindfulness. Being completely present in the moment is a gift you bring to the Veteran and his/her family. This can be communicated through body language by leaning into the conversation, keeping an open posture, or simply by maintaining a stature of attentiveness. Effective listening skills take practice and effort, and it is important to listen for the true meaning of what is being said. Asking questions or repeating what the Veteran has said for clarification will indicate that you are paying attention.

Communication can be challenging with certain Veterans and their families. Family situations may be complex, and their former effective communication skills may break down under stress. Some Veterans may have family members caring for them at home and be aware of the toll this can take on everyone over weeks, months and possibly years. Support the Veteran and his/her family with active listening and compassion; avoid, however, being drawn into family disagreements.

Some of the Veterans you encounter may have special needs to consider when communicating with them. Hearing-impaired Veterans do not always have or use their hearing aids effectively, so other adaptive equipment may be necessary. Speech or language difficulties are not uncommon, and some Veterans will need to use a writing board or other communication tool. Due to privacy policies, volunteers will likely not have information about Veterans' mental health histories or current conditions. The most common issues of this sort that the volunteer will encounter are depression, anxiety, confusion or delirium, and, in some cases, dementia. Awareness that EOL Veterans may have these special needs is important to communication. Volunteers will encounter Veterans at the EOL who are unresponsive. It is a common belief that hearing is the last sense to leave. Speaking or reading to the Veteran may be soothing and comforting, and giving a gentle touch will let the Veteran know you are present.

Volunteers will best serve Veterans by maintaining open communication and adjusting conversation by being attuned to the Veterans. Allow the Veterans to lead the direction of your conversation by asking what they would like to talk about. Refrain from asking too many questions about their background (military history, family, work history, etc.) unless they offer information or seem open to discussing their history as some Veterans may perceive this as intrusive. It is usually safe to ask, "What would you like to share about yourself so that I can get to know you better?" While following the Veteran's lead in topics of conversation, stay attuned to Veterans who may have an altered sense of reality; it is advisable to accept their reality and not try to reorient them. It is not uncommon for individuals to have visual or auditory hallucinations or "visions" at the EOL or in the case of dementia. If the Veteran states, "My wife is here, and she wants me to go with her" (the Veteran's wife is deceased), you could respond by saying "Tell me more about this," or "How does that make you feel?" In the case of agitation or anxiety during an interaction with the Veteran, it is best to use distraction or change the subject and to ask for staff assistance if the agitation is more severe.

Confidentiality is also an important aspect of communication. Unless the Veteran has given his/her consent to share information with family or friends do not assume that others are to be included in their confidence.

Boundary Setting

Just as a fence protects and preserves our property, so should personal boundaries protect our persons. Establishing boundaries is a very important part of effective hospice volunteering. While developing a relationship with the Veteran and his/her family is part of the work, the relationships are meant to be transitional in nature. We take responsibility for ourselves and are promoting equality and respect in our relationships with others when we establish boundaries. Personal boundaries are designed to protect and honor important parts of our lives.

Boundaries are necessary for us, regardless of the circumstances, when we learn to take care of ourselves. Effective boundary setting promotes safety and self-respect. Boundaries make clear what is acceptable behavior and what is not. A key component to effective boundary setting is possessing self-awareness. You should use a graceful or neutral tone and simple, direct language when setting firm boundaries. The following give examples of possible situations where boundaries need to be set:

- To set a boundary with an angry person:
  "You may not yell at me. If you continue, I'll have to leave the room."
- To set a boundary with someone who is critical:
  "It's not okay with me that you comment on my weight. I'm asking you to stop."
- To buy yourself time when making tough decisions:
  "I'll have to sleep on it. I have a policy of not making decisions right away."

When setting boundaries, it may be necessary to be direct, firm, and gracious. If faced with resistance, repeat your statement or request. In hospice care, having boundaries protects the Veteran, family, staff, and volunteers. While attending a funeral might be appropriate, having dinner in the family home is crossing a boundary.

Unit 4: Care and Comfort Measures

This unit focuses on some of the common signs and symptoms that are experienced by the dying, as well as comfort measures that the volunteer can provide to support the Veteran.

HPC programs recognize that the EOL experience is both an individual and a family journey that involves all dimensions of life: physical, mental, spiritual, familial, and community. As the illness progresses and the physical aspects decline or diminish, the other aspects gain more meaning and purpose. While the goal of the HPC team is to address the whole person, the role of the volunteer has legal and ethical limitations that must be clearly defined and understood by both the HPC team and the volunteer. It is not the intention of the NVDA program to provide direct hands-on care to Veterans.

Physical Care

When a person enters the dying process, physical changes begin to occur. These physical changes are a normal, natural progression that the body goes through. Our best response to these changes is to provide comfort, which includes consideration of the Veteran's physical environment. This means ensuring that the

- Veteran's appearance is clean and odor free and shows that we care and value the Veteran;
- Veteran's room is neat, clean, and clutter free;
- Aromatherapy is initiated by staff, if available;
- Garbage can is regularly emptied;
- Bed linen is clean and neat (e.g., if the Veteran is perspiring, inform staff); and
- Linens used have a homelike appearance, if available.

Figure 2: Possible Responses to the Most Common Signs and Symptoms of Imminent Death gives examples of symptoms that may occur while you are present at the bedside of a dying Veteran; they are not listed in any order of occurrence. More in-depth responses to these signs and symptoms follow the figure.

Figure 1: Possible Responses to the Most Common Signs and Symptoms of Imminent Death

- Restlessness/Agitation
  - Remain calm.
  - Keep the Veteran safe.
  - Use aromatherapy, if available.
  - Gently apply lotions or creams to the arms, legs, or feet as staff and the Veteran permit.
  - Notify the charge nurse (There are medications available).
- Congestion/Noisy Moist Respirations (i.e., the Death Rattle)
  - Try raising the head of the bed.
  - Notify the charge nurse (There are medications available).

  - Changes the Veteran's position with discretion, e.g., turning him/her to the left will facilitate drainage.

- Dry Eyes
  - Notify the charge nurse (There are medications available).
- Dry Mouth/Cracked Lips
  - Use a moistened toothette to sooth the Veteran's mouth as instructed by staff.
  - DO NOT attempt to give the Veteran anything to drink without checking with the charge nurse first.
  - Apply lip balm to assist with dry lips.
- Pain
  - Inform the charge nurse about nonverbal signs of pain or other discomforts: restlessness, agitation, wrinkled/furrowed brow, fist clenching, facial grimacing, or any body movement changes the Veteran begins to exhibit that he/she was not displaying at your arrival.
- Dyspnea/Breathlessness (apnea)
  - Notify the charge nurse if:
- An uneven rate or rhythm of breathing occurs during your visit; or
- Periods of no breathing and then breathing again occur.
- Dysphagia (decreased ability or inability to swallow)
  - ALWAYS ask nursing staff before attempting to give the Veteran anything to eat or drink.
- Body Temperature Changes
  - Adjust covers per Veteran's wishes as being cold or hot can be uncomfortable.
  - Note if the extremities (hands, feet, arms, or legs) and nail beds have become cool, dark, and/or mottled. Other areas of the body may become dusky or pale.

Recognizing and Responding to Physical Distress

Notify hospice nursing staff of any significant physical changes. Examples might be restlessness, moaning, facial grimaces, change in skin color, rapid or very slow breathing, or if the Veteran soils him/herself.

- **Pain**—You can often tell if a person is in pain simply by watching them. A grimace, wrinkled brow, tense fingers, and cautious breathing/moans are all telltale signs. Even in an unconscious person, these signs tell us that he/she is in pain. Report signs of pain to nursing staff. Most pain can be relieved with medication or additional nursing intervention.
- **Pain Interventions**—Excitement, anxiety, and depression can also increase pain. Not all pain is physical. Keeping Veterans interested in life, having conversations with you or visitors, or providing distractions like music and reading will lessen suffering. Sometimes a gentle back rub or change in position can relieve restlessness, tension, and discomfort. Ask the Veteran if you can help in that way. Ask a staff member if you are not sure how to do this.
- **Incontinence**—If the Veteran has a bowel movement or urinates, it is important that he/she be cleaned up promptly. This promotes hygiene and comfort and avoids embarrassment to the Veteran. Please notify nursing staff so they can provide this care.

- **Mouth Care**—When a Veteran is very ill, frequent mouth care is important. Breathing through an open mouth dries the mucus membranes and can cause cracked lips and tongue. Check with staff about sips of water, and ask if you can help with mouth care (e.g., moist toothette).
- **Labored Breathing**—The Veteran who is having difficulty breathing may find relief by having the head of the bed raised or by being turned slightly on his/her side with the head propped up on pillows. Please report these observations to the nurse.
- **Profuse Sweating**—Veterans with high fevers and/or who are close to death may perspire profusely. Tell the Veteran what you are doing and wipe his/her face and hands with a cool, damp washcloth to relieve discomfort.

For more information on providing care and comfort:

- See Resource Guide 2-3 to learn more about NVDA Volunteer Guidelines.
- See Resource Guide 2-4 to learn more about Essential Care for the Sick and Dying.

Unit 5: Psychosocial and Spiritual Dynamics of Death and Dying

This unit highlights the importance of psychosocial and spiritual dynamics that may affect the Veteran's quality of life, which incorporates his/her beliefs and spiritual and cultural practices.

Veterans and their families bring with them a unique culture—the military culture—which has been integrated into their native culture and customs. In addition, many families integrate parts of other cultures to which they have been exposed during their lifetime. Basically, one size does not fit all. In order to be sensitive to the cultural needs and expectations of the Veteran and his/her family, it is appropriate to simply ask if there are cultural considerations or customs that would be important for us to know. (Cross-cultural competency is discussed in more depth later in this section).

Psychosocial and Bereavement Care for the Dying and Their Families

There are many aspects to psychosocial and bereavement care. The following bullet points illustrate how HPC staff and NVDA volunteers can provide comfort and support to dying Veterans who are alone and/or to their families:

- Verify that Veteran does not want to be alone. Ask volunteers to provide support for a dying Veteran who is alone or when families request additional support.
- Support the Veteran, family, and friends by using an interdisciplinary approach, which includes volunteers.
- Ensure that comfort care for the dying Veteran and his/her family and friends takes into account the Veteran's total pain (i.e., physical, emotional, and/or spiritual pain), room atmosphere (e.g., soft music, low lighting, aromatherapy), and physical environment of the Veteran's room (e.g., adequate chairs, comfort food).
- Be aware that healthcare team members will provide medical interventions in response to symptoms and observations reported by volunteers.
- Be present with the Veteran:

  - Provide a reassuring presence with a calm tone of voice.
  - Sit in silence with the Veteran as needed, offering a peaceful presence.
  - Hold the Veteran's hand (consider applying hand lotion with gentle massage of the hand).

- Provide psychosocial support by engaging in dialogue, including storytelling and legacy building (e.g., the Veterans History Project located at www.loc.gov/vets).
- Give spiritual support by offering quiet presence. Additional spiritual support is provided by Chaplain Services.
  - The role of the volunteer is to support the wishes of the Veteran without imposing his/her personal thoughts, religious perspectives, and/or cultural customs and practices on the Veteran.
  - If the family asks the volunteer to participate in prayer or something the Volunteer and/or Veteran are not willing to do, please inform the nursing staff for immediate intervention, which will likely include contacting Chaplain Services.

Spiritual Distress

Spiritual distress is defined as "the state at which an individual or group experiences or is at risk of experiencing a disturbance in the belief or value system that provides strength, hope, and meaning of life."[3] Common signs of spiritual distress include, but are not limited to, crying, expressions of guilt, lack of trust, refusal to participate in treatment, moderate to severe anxiety (may look like the Veteran is in pain), anger, or withdrawal (depressed state). In order to assist at such times, be present, offer encouragement and respect, listen actively, and convey a caring and accepting attitude. This is also a good time to offer a chaplain's visit or to request a chaplain consult.[4]

Spiritual Care and the Role of the Chaplain in the VA

It is important to understand how the Veterans Health Administration (VHA) has chosen to integrate spirituality within the overall care of Veteran's and their families. The best reference for understanding this process can be found in the VHA Handbook 1111.02, *Spiritual and Pastoral Care Procedures*,[5] which states:

All VHA staff need be sensitive to Veterans' desires, if any, for spiritual support. This is respecting Veterans' rights. VHA staff provides essential information, in the form of spiritual screening, to clinical chaplains who provide spiritual care to Veterans in promotion of health and wellness; however, clinical chaplains are the only health care professionals authorized to conduct official spiritual assessments at any VHA facilities.

Importance of the Spiritual Assessment

The spiritual assessment is an essential tool in addressing the spiritual or religious needs of Veterans and their families. As a member of the IDT, the Chaplain conducts and records the spiritual assessment into the computerized patient record system (CPRS). This assessment becomes a vital instrument for the HPC care team to understand the religious and spiritual needs of the Veteran and his/her family. As with any clinical assessment tool, it is a living document that changes and expands as more information is gathered. The chaplain shares the spiritual assessment findings and proposed care interventions as an active member of a HPC team. He or she translates the findings and interventions and discusses with the team how the Veteran's spiritual/religious needs may affect the plan of care.

3 Carpenito-Moyet, L. J. (2006). *Handbook of nursing diagnosis*. New York: Lippincott, Williams & Wilkins.

4 Puchalski , C. M. (2006), Spiritual assessment in clinical practice. *Psychiatric Annals*, 36,150; Maugans, T. A. (1996). The spiritual history. *Family Medicine*, 5, 11–16; Anandarajah, G., & Hight, E. (2001). Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. *American Family Physician*, 63, 81–89.

5 Section 5c, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1720)

Spiritual and Pastoral Care

VHA spiritual and pastoral care is a total program of assessment and care, administered and overseen by chaplains, which identifies Veterans' religious and spiritual needs and desires, addresses spiritual injuries, and enhances Veterans' spiritual health by using a full spectrum of interventions.

- See Resource Guide 2-5 to learn more about Spiritual Care Interventions.

Identifying Spiritual Needs of Veterans

Anyone who has worked in a hospice unit for any length of time knows that Veterans and their families will engage in various rituals, display family pictures, or place religious or spiritual articles around the room. When we slow down long enough to observe the setting that the Veteran and/or family has created around the room, we begin to see stories emerge about the life of the Veteran. We start to discover what brings the Veteran some type of hope, value, or meaning; to see what connections are important to the Veteran; and to learn who or what might bring some kind of peace or some type of distress. Many of us are not inclined to ask about such things in a Veteran's area; many Veterans, however, would love to have someone listen to some of their story. Asking the Veteran about something in his/her room is a good way to engage him/her, such as:

- What does the Veteran and/or family's routines and room arrangement tell us about his/her psychosocial and spiritual needs or desires?
- What seem to be the priorities?
- What is the story the Veteran is telling about him/herself?
- What types of TV programs are being watched or music listened to?
- Do photographs indicate any special interests or hobbies
- How does the Veteran respond to touch?[6]

Another issue that can affect the psychosocial and spiritual needs of the Veteran is Post Traumatic Stress Disorder, which is discussed in the next unit.

Unit 6: Post Traumatic Stress Disorder (PTSD)

This unit is designed to help trainees recognize PTSD and understand its effects on Veterans' lives. It focuses on the importance of understanding PTSD as a significant consideration affecting the healing process for those who are dying.

Background

Traumatic events often occur in the lives of Veterans, and the effects linger for years. They may have a significant impact on the Veteran's ability to "let go" during his/her last days. Additionally, there are varying attitudes toward Veterans from different wars, which can have an effect on how the Veteran copes with exposure to the traumatic experience. Some common perceptions include:

- WWII Veterans were seen as heroes.
- Korean War Veterans were ignored (e.g., It was a "conflict" not a "war.").
- Vietnam Veterans were shamed (with 1/3 of these Veterans experiencing PTSD). "Welcome Home" and "Thank You" are phrases some Veterans may not have heard, especially from the Vietnam era.

6 Information compiled from resources provided by the Bay Pines VA Medical Center, Boston VA Medical Center, and Albuquerque VA Medical Center.

In order to understand and support Veterans at EOL, it is important to recognize that they may feel they have "lost their souls." Therefore, it is important to give empathy and validation, as forgiveness may be a key to heal their heart from the guilt they may be suffering.

Sources of Trauma

Sometimes people in danger are overcome with feelings of fear, helplessness, or horror. The dangerous events that precipitate these reactions are called traumatic stressors. Some common traumatic experiences include being:

- Physically attacked
- In a serious accident
- In combat
- Sexually assaulted
- In a disaster such as fire or tornado

The stress can be traumatic, cumulative, protracted, periodic, or episodic and can range from occasional painful memories to ongoing devastation.

Characteristics

To receive a diagnosis of PTSD, several general criteria must be met along with the characteristics usually observed in a Veteran suffering from PTSD such as avoidance behavior, intrusive thoughts and hypervigilence. Perhaps the most important element of PTSD from a volunteer perspective is to be aware of the potential for "triggers". These triggers, such as loud noises or the sound of helicopters flying over the building, can bring about sudden changes in behavior by the Veteran to include fearfulness, anxiety and a desire to find a safe place. Volunteers should report any observations of agitated behaviors to the care team as these may represent the Veteran's response to a PTSD trigger or may be something entirely different such as the more common confusion at the end of life.

The best information about PTSD for the general public and professionals is available at www.ptsd.va.gov. General information about PTSD and resources for getting help are specifically provided at www.ptsd.va.gov/public/PTSD-overview/basics/index.asp.

Unit 7: Understanding Families and Family Dynamics

This unit reviews aspects of family structure, which may include characteristics unique to each family. It also discusses generational, religious, and cultural references that can affect family dynamics, such as patterns of communication and family boundaries.

Family Dynamics

The basic definition of family has evolved in recent years from the traditional nuclear family to extended family structures that may include individuals who are not related by blood or marriage, but are, however, considered by the Veteran to be his/her family.

Examples of family types include the traditional nuclear family with husband, wife, and children; joint custody families with divorced parents sharing child custody; cohabiting families where unmarried men and women may or may not be raising children; single-parent families where children are being raised by only one parent due to death, divorce, abandonment, or no marriage; child-free families made up of couples who choose not or

are unable to have children; blended or stepfamilies created by married couples who have one or more children from a previous marriage and may have one or more children of their own; families headed by gays or lesbians, which may or may not include children; and grandparents parenting grandchildren, due to illness, death or non-involvement of the parent. Individuals also may choose to lead a single life. Families and relationships can take on many forms. It is important to avoid judgments about the structure of relationships and/or a family. Additionally, family roles are subject to change as adult children are in a position to assist their aging parents.

In hospice care, the family is viewed as the "unit of care," and, based on the Veteran's preferences for family involvement; the family is included in goals of care discussions with the IDT. Family members may have close relationships with the Veteran and may have served as home caregivers prior to entering an inpatient setting. In other instances, families may have had minimal contact with the Veteran until the presenting illness became terminal. Regardless of the family history, the family will be experiencing the stresses of facing the death of a loved one; therefore, support and referrals for appropriate resources for them are also to be considered in the goals of care.

Cross Cultural Competency

"Preservation of one's own culture does not require contempt or disrespect for other cultures."

– Cesar Chavez

The 21st century brings heightened awareness of how beliefs, values, religion, language, and other cultural and socioeconomic factors influence health promotion and help-seeking behaviors.[7] The significance of assessing cultural considerations in HPC is vital. All team members play a key role in understanding and providing culturally competent palliative care to each individual Veteran.

Culture influences palliative care in several ways.

- **Communication**—How does the culture talk about illness and death? How open are people to talking about illness, dying, and death? What about eye contact or touch?
- **Decision making**—How are decisions made about care? Does the Veteran make his/her own decisions or does someone else in the family?
- **Rituals**—Death rituals and bereavement practices are specific to culture and religion. How will the body be managed after death (e.g., autopsy, embalming, cremation, organ donation)? Will there be loud wailing or quiet stoicism at the death of their loved one?[8]

Additionally, the military has its own culture with its own language and rituals. There are many subcultures within the military culture itself, for example:

- Branch of service (Army, Navy, Air Force, Marines, Coast Guard)? - Each has its own instilled value that influences culture.
- Officer (Commissioned or Noncommissioned)? Enlisted? Drafted?
- Special Forces (Army Green Berets, Navy Seals, Navy Seabees)?
- Service in wartime?

7 American Association of Colleges of Nursing, CULTURAL COMPETENCY IN BACCALAUREATE NURSING EDUCATION (2008) Retrieved November 10, 2015 from http://www.aacn.nche.edu/leading-initiatives/education-resources/competency.pdf.

8 Wilson, S.A., Coenen, A., & Doorenbos, A.Z. (2006). Dignified dying as a nursing phenomenon in the United States. Journal of Hospice and Palliative Nursing, 8, 34–41.

- Military service of family members?
- Gender?

The era of military service also has its own unique culture, which can influence the outcome of a soldier's experience. For example, WWII Veterans are more likely to have had areas of safe haven than Vietnam Veterans. The latter were often in immediate physical danger, which resulted in a higher incidence of stress-related disorders (e.g., PTSD). Korean Veterans were often told not to discuss their military service and are sometimes overlooked in the discussion regarding the needs of Veterans. A significant number of Korean Veterans were Prisoners of War (POWs) held by the Chinese and subjected to torture and other mistreatment. Respectful inquiry into understanding the military history of Veterans is important.[9]

Unit 8: Self-Care and Managing Personal Stress

This unit focuses on the necessary practice of self-care and the ability to manage personal stress as a volunteer. Using creative expression, it also highlights compassion fatigue and introduces engagement, self-transcendence, and wellness plans as valuable antidotes. The unit invites learners to assess current self-care practices and identifies creative expression as a path towards improved balance, resiliency, release, and hope for all caregivers. Approaches to creative expression include the use of expressive arts, stories that heal, and rituals. The unit incorporates supplemental teaching materials from the End-of-Life Nursing Education Consortium (ELNEC)[10] for Veterans curriculum which can be used to foster additional reflection and group discussion.

Self-Care

Individuals, including volunteers, who care for themselves while caring for seriously ill and dying Veterans and their families can expect to provide better-quality care with a greater sense of satisfaction. Avoiding emotional exhaustion helps prevent negative feelings which can undermine a volunteer's sense of usefulness and success. Caregiving that caregivers characterize as stressful, fatiguing, and burdensome can lead to compassion fatigue and burnout. Practicing self-care is often easier said than done and requires intentionality. Being intentional about self-care invites volunteers to incorporate techniques that infuse their caregiving with meaning, connectedness, and presence.

"Being extremely honest with oneself is a good exercise."

– Sigmund Freud

In order to be intentional about self-care, a volunteer must also cultivate self-awareness. **Figure 2: Truth Be Told: A Quick Assessment** provides helpful questions for volunteers to ask themselves. Several of the resource guides may also be useful.

- See Resource Guide 2-6 for a Mindfulness and Self-Care exercise.
- See Resource Guide 2-7 to learn more about Self-Care and Creative Expression.
- See Resource Guide 2-8 to learn more about Stress Reduction, Health, and Well-being.
- See Resource Guide 2-9 to learn more about Spiritual Practice for Stress Reduction, Health, and Well-Being.

9 *ELNEC for Veterans Curriculum*. Permission granted to use these materials by Betty Ferrell, PhD, RN, MA, CHPN, FPCN, FAAN, Principal Investigator of the ELNEC Project, City of Hope, Duarte, CA and Pam Malloy, MN, RN, FPCN, FAAN, Co-Investigator of the ELNEC Project, American Association of Colleges of Nursing, Washington, DC. For further information about copyright and use of materials, go to http://www.aacn.nche.edu/elnec/planning-elnec-course

10 *ELNEC for Veterans Curriculum* - Module 7: Loss, Grief & Bereavement – Supplemental Teaching Materials, Pages M7:66-75, Revised – May 2010.

Figure 2: Truth Be Told: A Quick Assessment

- Truth be told, I rarely have time to do everything that needs to be done; I almost always feel like I'm playing catch-up. **Agree or Disagree?**
  - Explore:
    - Do I find myself that thinking I'm the only one who can do what I'm doing, or the only one who seems to care about doing what needs to get done?
    - Do I ask for help easily? If not, what prevents me from doing so?
    - Are there resources I've not taken time to tap into, i.e., things for myself that I know would make life easier?
- Truth be told, it all seems important, and I often find myself with only enough time to do what absolutely needs to get done. **Agree or Disagree?**
  - Explore:
    - More often than not, I can look at what needs to be done and focus on the things that are most important. What would help me do this better?
    - How do I feel when I'm told not to worry about getting everything done?
    - Do I believe that things will sort themselves out?
    - Can I see ways that I might simplify my life?
- Truth be told, peace of mind isn't as much about me as it is about knowing those is my care are getting what they need. **Agree or Disagree?**
  - Explore:
    - When was the last time I put myself first? Was it easy to do?
    - What's the most recent recommendation I offered a family caregiver about taking care of him/herself?
    - How would I answer if that same caregiver asked me if I follow my own advice?

Burnout

If self-care is not done, the volunteer can often experience burnout, also known as compassion fatigue. There are three aspects of burnout:

- Emotional exhaustion—Being depleted of your own emotional resources to the extent that you can no longer respond at an emotional level, i.e., feeling emotionally overextended
- Depersonalization—Viewing others and their issues negatively in an unfeeling and impersonal way, perhaps even blaming others for their problems or developing a distant, callous approach
- Personal accomplishment—Placing a decreased sense of value and satisfaction on your own personal accomplishments, competency, and achievements in life

To avoid burnout, it is helps to be aware of the differences between helping, fixing, and serving others.

- Helpers may see others as weaker or needier than they are; in fixing, we see others as broken and respond with our expertise. Relying on our expertise, we may miss seeing the wholeness in another person.
- Fixing and helping are draining, contributing to emotional exhaustion and depersonalization, and, over time, we may burn out.
- When we serve, we see and trust the wholeness of the other person—we respond to it and collaborate with it, and we strengthen it, which, in turn, renews us.
- In helping and fixing, we may find a sense of satisfaction, but in serving, we find a sense of gratitude that complements the value we place on our accomplishments and achievements.[11]

"Helping, fixing, and serving represent three different ways of seeing life. When you help, you see life as weak. When you fix, you see life as broken. When you serve, you see life as whole. Fixing and helping may be the work of the ego, and service the work of the soul."

– Rachel Naomi Remen, M.D.

Antidotes to Burnout

"In contrast to burnout, engagement consists of involvement, energy, and efficacy."

– Christina Maslach[12]

There are numerous ways to prevent burnout, including engagement, self-transcendence, and enhancing our own well-being.[13] Engagement in our own creativity promotes vitality, the opposite of burnout. It is

- Aliveness or thriving in relationship to others and one's self;
- Energetic passion;
- Involvement; and
- Creation of a culture of learning—physically, mentally and emotionally—that is meaningful, joyous, satisfying, and reflective.

Finding ways to enhance self-transcendence, or compassionate presence, may enable volunteers to cope with high levels of stress and to continue to find engagement, meaning, and personal satisfaction in their work. Self-transcendence may be restorative, enabling volunteers to endure, diminish, or rise above burnout. It comprises of:

- Finding meaning in life and death
- Learning to connect our past and future with the present in a way that affords us new understandings

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11 Remen, R. N. (1999, September). Helping, fixing, or serving. Shambhala Sun. Available from https://www.uc.edu/content/dam/uc/honors/docs/communityengagement/HelpingFixingServing.pdf; Thompson, E. (2012, January 12). Zen brain: Emotions, equanimity, and the embodied mind [podcast]. Available from https://www.upaya.org/2012/01/evan-thompson-01-13-12-zen-brain-emotions-equanimity-and-the-embodied-mind-part-2/

12 Maslach, C. (2003). *Burnout: The cost of caring*. Cambridge, MA: Malor Books.

13 Figley, C. (2002) Helping traumatized families. New York: Brummer-Routledge; Figley, C. (1998). Burnout in families: The systemic costs of caring. Boca Raton, FL: CRC Press LLC; Maslach, C., Jackson, S.E., & Leiter, M.P. (1996). Maslach Burnout Inventory (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.

- Having an awareness of our
  - Spiritual nature
  - Connectedness with others and the environment
  - Relationship with a higher being or a purpose greater than ourselves
- Offering a coping resource when feeling threatened or vulnerable[14]

"Presence quite simply is being present to one's self and other, with no separation. Presence is being fully aware of what is occurring in one's self in each moment. Presence is breath. Presence is inhale-exhale."

– Robert Chodo, HHC, Zen Priest

14 Hunnibell, L. S., Reed, P. G., Quinn-Griffin, M., & Fitzpatrick, J. (2008). Self-transcendence and burnout in hospice and oncology nurses. *Journal of Hospice and Palliative Nursing*, 10(3), 172-178; Reed, P. G. (2003). The theory of self-transcendence. In M. J. Smith & P. R. Liehr (Eds.), *Middle range theory for nursing* (pp. 145-165). New York: Springer Publishing.

Resource Guide 2-1: Committed to Having A Talk (CHAT!) - Relationship Building Exercise

Committed to Having A Talk (CHAT!) - Relationship Building Exercise	
Time:	15-20 minutes
Goal:	As an icebreaker, this exercise has two instructional objectives: **1.** To introduce people to a highly interactive, fun way of learning. **2.** To provide participants with an opportunity to start to know each other in a more personal way than most work situations allow.
Description:	• Explain to participants that they will be taking part in an activity that is a fun way for them to get to know each other better. Ask them if they are familiar with the game of BINGO. Explain that this is very similar to BINGO. • Pass out the CHAT! Cards and explain that the center square is for their name. In this activity, they will have to fill in TWO rows, similar to DOUBLE BINGO. Rows can be diagonal, up and down, or straight across. • To fill in a row, they must ask people in the room if the statement applies to them. If it does, then they ask the person to sign the space provided at the bottom of the square. **THEY MAY ASK EACH PERSON ONLY IF TWO STATEMENTS APPLY TO THEM AND THEN THEY MUST MOVE ON TO THE NEXT PERSON.** • Variations: You may opt to have only one winner—the first to fill-in two rows, or you may want everyone to complete two rows. If you start to feel the activity is going on for too long, and some people are having a hard time filling in some of the blocks, you can ask out loud what they are having trouble with and then ask the group if there is anyone that can sign that box, for example, "So is anyone here left handed?" • Tell people the prize is getting to know each other.

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C	*H*	*A*	*T*	*!*
Speaks more than one language _____	Loves to fish _____	Sings in a choir or band _____	Screens their phone calls _____	Has been in a job for more than 10 years _____
Loves Jell-O _____	Has grand kids _____	Has taken dance lessons _____	Has ridden a horse _____	Is particular about their shampoo _____
Been on a thrilling adventure _____	Drives an SUV _____	*YOUR NAME* _____	Buys from catalogs _____	Hates breakfast _____
Traveled to a foreign country _____	Has a picture of a dog or cat with them _____	Jumps “double dutch” _____	Can name three old movies _____	Loves to garden _____
Loves old TV shows _____	Drinks 3 cups of coffee daily _____	Walks every day _____	Met a rock star or politician _____	Is left handed _____

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Resource Guide 2-2: Types of Grief

Type of Grief	*Definition*	*Characteristics*
• **Anticipatory Grief** *(Rando, 2000)*	• Anticipated and real losses associated with diagnosis, acute and chronic illnesses, and terminal illness • Experiencing anticipatory grief may provide time for preparation of loss, acceptance of loss, finishing unfinished business, life review, and resolution of conflicts • For survivor, anticipatory grief provides time for preparing for life without the deceased, including preparation for role change or mastering life skills, such as paying bills and learning how to manage a checkbook.	• With acute illness, chronic illness, accidents, and other changes in health, a Veteran may experience loss of general health, functionality, independence, role in the family (breadwinner, caretaker), or lifestyle as a result of dietary or activity restrictions. Loss of a limb or body part (limb, breast, uterus) may cause loss of self-confidence or changes in perception about body image. • Family members and significant others will also experience losses when Veteran is ill, including loss of role in the family, relationship, finances, security, or companionship, etc. • Cancer can cause multiple losses over periods of time, such as loss of a job, material possessions, and body image, due to changes in physical appearance, functionality, privacy (the secret is out), family, friends, and social acceptance. • With diagnosis of terminal illness, additional losses may include loss of control (choice), physical and/or mental function, relationships, body image, future, dignity, or life.
• **Normal Grief** *(Doka, 1989; Parkes 1999; Worden 2001).*	• Also known as uncomplicated grief • Normal feelings, reactions and behaviors to a loss; grief reactions can be physical, psychological, cognitive, or behavioral.	• Reactions to loss can be physical, psychological, and cognitive.

Type of Grief	*Definition*	*Characteristics*
• **Complicated Grief includes:** – Chronic Grief – Delayed Grief – Exaggerated Grief – Masked Grief *(Corless, 2006; Brown-Saltzman, 2006; Loney, 1998; Parkes, 1999; Worden, 2001)*	• Normal grief reactions that do not subside and continue over very long periods of time. • Normal grief reactions that is suppressed or postponed. The survivor consciously or unconsciously avoids the pain of the loss. • Survivor resorts to self-destructive behaviors such as suicide. • The survivor is not aware that behaviors that interfere with normal functioning are a result of the loss.	• **Those at risk for any of the four types of complicated grief may have experienced loss associated with:** – traumatic death – sudden, unexpected death, such as heart attacks or accidents – suicide – homicide – dependent relationship with deceased – old-old person or those with chronic illnesses (survivor may have difficulty believing death actually occurred after years of remissions and exacerbations) – death of a child – multiple losses – unresolved grief from prior losses – concurrent stressor (the loss plus other stresses in life, such as divorce, a move, children leaving home, other ill family members, financial issues, etc.). – history of mental illness or substance abuse – difficulty of the Veteran's dying process, including poor pain and symptom management or psychosocial and/or spiritual suffering – poor or few support systems – no faith system, cultural traditions, religious beliefs • **Complicated grief reactions can include any of the normal grief reactions, but the reactions may be intensified, prolonged, last more than a year and/or interfere with the person's psychological, social, and physiological functioning. Other complicated grief reactions may include:** – severe isolation – violent behavior – suicidal ideation – workaholic behavior – severe deterioration of functional status – symptoms of Post Traumatic Stress Disorder (PTSD) – odenial beyond normal expectation – osevere or prolonged depression – oloss of interest in health and/or personal care – osevere impairment in communication, thought, or motor skills – oongoing inability to eat or sleep – oreplacing loss and relationship quickly – social withdrawal – searching and calling out for deceased – avoidance of reminders of the deceased – imitating the deceased Survivors experiencing complicated grief should be referred to a grief and bereavement specialist/counselor

Type of Grief	*Definition*	*Characteristics*
• **Disenfranchised Grief** *(Doka, 1989)*	• The grief encountered when a loss is experienced and cannot be openly acknowledged, socially sanctioned, or publicly shared • Usually survivor experiencing disenfranchised grief is not recognized by employers for time off for funeral or memorial service or for grief. May not be recognized by biological family members and could be excluded from rites, rituals, and traditions for loss	• Those at risk for experiencing disenfranchised grief include partners of HIV/AIDS Veterans, ex-spouses, ex-partners, fiancé(e)s, friends, lovers, mistresses, co-workers, children who experience the death of a stepparent, and other persons close to the Veteran, but not biological family members. • The mother of a stillborn delivery may also experience disenfranchised grief, as society may not acknowledge a relationship between the mother and a child who experienced death prior to birth.

Type of Grief	*Definition*	*Characteristics*
• **Children's Grief**	• Children mourn/grieve based on their developmental level.	• **Symptoms of grief in younger children:** – nervousness – uncontrollable rages – frequent sickness – accident proneness – antisocial behavior – rebellious behavior – hyperactivity – nightmares – depression – compulsive behavior – memories fading in and out – excessive anger – excessive dependency on remaining parent – recurring dreams, e.g., wish fulfillment, denial, disguised grief • **Symptoms of grief in older children:** – difficulty in concentrating – forgetfulness – poor schoolwork – insomnia or sleeping too much – reclusiveness or social withdrawal – antisocial behavior – resentment of authority – verdependence, regression – resistance to discipline – talk of or attempted suicide – nightmares, symbolic dreams – frequent sickness – accident proneness – over- or undereating – truancy – experimentation with alcohol or drugs – depression – secretiveness – sexual promiscuity – staying away or running away from home – compulsive behavior

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Resource Guide 2-3: NVDA Sample Volunteer Guidelines

NVDA Sample Volunteer Guidelines	
Volunteer Responsibilities	**1.** Report on time for scheduled assignments, or inform the Palliative Care Coordinator (PCC) or Voluntary Service Office as far in advance as possible when you are unable to attend. **2.** Be properly groomed. Observe the rules of hygiene and neatness. **3.** Provide support for Veterans by listening; providing reassurance; holding the Veteran's hand, with his/her permission; sitting quietly; and providing companionship. **4.** Read to the Veteran, assist in letter writing, play cards or games, take him/her for a ride in a wheelchair to visit other areas of the facility, or attend an activity if desired. **5.** Provide support to family members by listening, allowing family members to vent emotions and concerns. **6.** Encourage family members to use the family room located on the hospice care unit or direct the family to other facility services as needed/requested. **7.** Assist Veteran with non-medical care, as directed by the nurses or other staff caring for the Veteran (e.g., sips of water). **8.** If the Veteran is ambulatory, ask the Veteran if he/she would like to take a walk/get fresh air after seeking permission from the nurse caring for the Veteran. **9.** Support family members and/or visitors in a caring and supportive manner. If the family has a medical question, refer them to the nurse manager or nurse caring for the Veteran. **10.** Keep the Veteran's room and family lounge areas tidy; water plants and flowers as needed. **11.** Be flexible in the acceptance of different lifestyles and cultural and religious orientations, and resist temptation to impose your own values on the Veteran and the family. **12.** Listen, Listen, Listen… be a good listener, and be comfortable with silence when appropriate. **13.** Understand and accept the principles of confidentiality for staff and Veterans.

NVDA Sample Volunteer Guidelines	
Visit Procedure	**1.** Report in to the appropriate staff before starting visits to ascertain which Veteran(s) has the most need for a visit. Be sure to where your ID badge. **2.** Before visiting him/her, ask staff about the Veteran in order to get pertinent information about the Veteran's needs. **3.** Proceed with visit. Always knock on the Veteran's door before entering the room. Ask if this is a good time to visit or if the Veteran would like to visit. **4.** Introduce yourself to the Veteran, and begin a conversation if the Veteran is willing. Use active listening skills. Be present in the conversation. Allow the Veteran to direct conversation. If the Veteran is not conscious, introduce yourself to the Veteran and talk to the Veteran. This type of Veteran can benefit from you reading the newspaper or a magazine article. **5.** Maintain open communication with treatment team members. Report events or changes regarding the Veteran and family after each of your visits. **6.** If family members are visiting, and Veteran visits are not needed during the time that you are on the unit, ask hospice care staff for other duties. **7.** Participate in hospice care training updates and in services as available. **8.** Ask the Veteran how he/she wishes to be addressed, e.g., Joe versus Mr. Smith. **9.** Observe personal space. Sometimes Veterans wish to have 'space' between them and the person visiting. **10.** If the Veteran is hard of hearing, make sure he/she has the hearing aide on, and it is working, or sit by the side of the "good ear," if possible. Check with staff concerning a hearing aid. **11.** Look at the person; maintain eye contact. **12.** Adopt an open posture. **13.** Lean forward and look interested. **14.** Repeat or paraphrase what you have heard. **15.** Ask Veteran if it is okay to mute/turn off the TV during the visit

NVDA Sample Volunteer Guidelines	
Barriers to Volunteer Effectiveness	1. Expressing personal problems—Your experience and personality will enable you to understand what the Veteran is going through. Do not "compare" your problems with the Veteran's problems. You may want to, but discipline yourself to listen. The Veteran needs you to just listen. 2. Losing your temper—If you are rejected or the Veteran's mood is an angry one, it is not your fault. Never display anger. You will make mistakes, as will any staff member; the Veteran is human and will understand. You will learn from each experience and become more confident. Prepare yourself, hone your skills, and develop your relationship with the Veteran at his/her pace.

Resource Guide 2-4: Essential Care for the Sick and Dying

Introduction

Volunteers, visitors, relatives, and friends bring their unique and special abilities to the care of the sick and dying. You are an essential part of the healthcare team!

A natural reaction for those not accustomed to helping the dying is to withdraw and leave the dying person alone. Thus, dying people are often lonely and depressed. They often feel abandoned and hopeless and may become resentful and withdrawn.

Sometimes there is nothing you can do except hold the person's hand. At other times, they may talk to you or want you to talk to them. Talk about shared experiences, their life, your life, and what's going on in the world. Take cues from the Veterans. If they want to talk about dying, listen and respond appropriately and honestly. If you don't know how to respond, simply assure them you care.

Pray with a resident only when asked to do so by the Veteran or family. Prayer should be comfortable for both of you. It can be either spontaneous or formal prayer. The Lord's Prayer is the most universally known among Christians and can be comforting.

Imagine a dying person who feels abandoned—an example of real suffering! You have the ability to relieve that suffering, even if all you do is simply sit by the bedside and comfort Veterans with your presence.

Some Skills You May Want to Know:

End-of-life caregiver skills are best learned by practice. These include the ability to be a good observer and to follow directions carefully. A word of caution: In the Community Living Center (CLC), ALWAYS ask for permission and/or help from nursing staff before assisting a resident. The simplest thing, like giving a resident a drink of water, may require special skills or knowledge of the Veteran's condition. Do not let your hesitancy or discomfort deter you. Remember, if one person is to receive comfort, someone else has to give it!

Recognizing Pain and Assisting in Relief of Pain

- You can tell if a person is in pain simply by being observant. A grimace, a wrinkled brow, tense fingers, cautious breathing moans, etc., are all telltale signs. Even in an unresponsive person, these signs tell us they are in pain.
- Report signs of pain to nursing staff. Most pain can be effectively relieved with medical intervention.
- Excitement, anxiety, and depression can also contribute to pain, because not all pain is physical. Also, the brighter and more alert Veterans remain, the more enjoyable and frequent their company, the more they are kept interested in life, and the less they will suffer.
- Sometimes a gentle back rub or change in position can relieve restlessness, tension, and discomfort that may be perceived as pain.

Vomiting

- Usually there is a basin for this purpose close at hand. Hold the basin against the Veteran's cheek and under the chin. Call for help. Antiemetic medications can assist in controlling nausea and vomiting.

Conversation

- Always speak to residents when you are in their presence, not about them, as if they are not present. Careless conversations over an unconscious person have been reported as being heard by the unconscious person, afterwards. Hearing is thought to be the last one of the senses to fade.

Attention to the Veteran's Appearance

- You can help by shaving a man or by assisting a female Veteran with her hair and makeup. These small tasks boost morale; help Veterans feel more "normal;" and promote comfort, improving the overall atmosphere in the CLC.

Feeding a Resident (only in a supervised setting or following "Caring Spoons" training)

- Always ask for permission from the hospice staff before feeding a resident. Make certain that the Veteran is sitting up in a comfortable position before beginning the meal. Take a real interest in helping the individual enjoy the meal. Be patient and always mindful of the person's dignity. Try to keep the food warm. If feeding takes a long time, ask for an extra plate. Put small amounts of food on it and keep the rest covered until needed. Give the Veteran the feeling that there is nothing you'd rather be doing at the moment. Give him/her your undivided attention throughout the meal.
- Know about special difficulties the Veteran may have. Is swallowing difficult? Give small amounts of food and frequent sips of water or other liquids. They may choke. Don't panic. If they are unable to cough the food up, call a nurse. Is chewing difficult? Cut food into very small pieces. You may observe that dentures do not fit well, or that food gets caught under the dentures. If so, remove the dentures and rinse them and rinse the Veteran's mouth before replacing them. This will make eating more comfortable and enjoyable.
- Does the Veteran drool or does food run out of one side of the mouth? These are frequent problems. Simply place a napkin on the Veteran's chest, wipe the chin as necessary, and give small amounts of food. Feed slowly. With the person who has suffered a stroke, turning the head slightly to the unaffected side may help. Always help the Veteran with oral hygiene after eating.
- Check with nursing staff to see if the Veteran is on a particular type of diet or may be "pleasure fed."

Care of the Veteran with Incontinence

- If the resident has a bowel movement, it is important that they be cleaned promptly for comfort and hygiene and to avoid embarrassment to the Veteran. Please notify caregivers so they can provide this care, and you may assist if needed.

Mouth Care

- Adequate care of the mouth is essential. When an individual is debilitated, frequent mouth rinsing is important. The mouth may drop open and become dry. Water should be given frequently, in small quantities, if the Veteran can swallow.
- Brushing the teeth and tongue with toothpaste is often helpful.
- Use toothettes for residents who are unresponsive.

Abdominal Distention and Constipation

- The observant visitor may notice that the Veteran's abdomen is distended, or the Veteran may complain of constipation to a friend or family member who is available to listen to his/her concerns. These are common problems when pain medications are used and/or when the individual is immobile. Abdominal distention and constipation are additional causes of discomfort and distress. They can usually be relieved with medications or medical interventions. Please report these findings to the nurse.

Labored Breathing

- The Veteran who is having difficulty breathing may find relief by being turned slightly on his/her side with the head propped up on pillows. Please report these observations to the nurse.

Profuse Sweating

- Residents with high fevers, and often those who are close to death, will perspire profusely. Use cool, damp washcloths, placed on the face and hands, to relieve discomfort.

Cultural Considerations

- Use an interpreter—family, friends, or staff—if you are having difficulty understanding the Veteran.
- Ask the Veteran how he/she prefers to be addressed, e.g., "Joe" versus "Mr. Smith."
- Observe personal space. Sometimes Veterans wish to have "space" between them and the person visiting.
- Observe reactions to eye contact. In some cultures, eye contact is a sign of disrespect.
- Timing–make sure the Veteran is ready for a visit and not distracted by pain or discomfort.
- If the Veteran is hard of hearing, make sure he/she has the hearing aid on, that it is working, and sit by the side of the "good ear," if possible.

Listening Skills

- Look at the person.
- Adopt an open posture.
- Lean forward and look interested.
- Verbally follow the content the resident is sharing.
- Maintain eye contact (if appropriate).
- Consider closing the door and turning off the TV/radio, or consider turning the TV to a channel with relaxing and soothing music.

Conclusion

As a volunteer, there are unlimited elements of caring you can provide seriously ill Veterans. It is our hope that these tips will help you realize your importance in caring for Veterans, promoting their comfort and dignity until the moment of death.

Touch the Veteran; hold his/her hand as you offer reassurance. Allow your outward gestures to help relieve suffering. Your service will support VA's mission in *'caring for him who shall have borne the battle and for his widow and his orphan"* and the mission of HPC as well, *"to honor Veteran's preferences for care at the end of life."*

Please understand that all you do in loving service for the sick and dying contributes to their comfort and happiness. You are far from helpless in the face of illness and death. Regardless of how little or how much you are physically able to do, it is your presence that offers the greatest gift of care and compassion. Thank you for your service to those who have served our nation.

Resource Guide 2-5: Spiritual Care Interventions

Sample Spiritual Care Interventions

- Renewal of vows
- Readings
- Faith reaffirmation and rededications
- Spiritual life review
- Guided meditation
- Receiving sacraments
- Fostering hope
- Addressing spiritual pain issues

Source: ELNEC for Veterans – Module 5. Permission granted to use these materials by Betty Ferrell, PhD, RN, MA, CHPN, FPCN, FAAN, Principal Investigator of the ELNEC Project, City of Hope, Duarte, CA and Pam Malloy, MN, RN, FPCN, FAAN, Co-Investigator of the ELNEC Project, American Association of Colleges of Nursing, Washington, DC.

For further information about copyright and use of materials, go to http://www.aacn.nche.edu/elnec/planning-elnec-course
Fauser, M., Lo, K., & Kelly, R. (1996). Spiritual care. In *Trainer certification program* [Manual]. Largo, FL: Hospice Institute of the Florida Suncoast. Reprinted with permission.

Resource Guide 2-6: Mindfulness and Self-Care

- When you awaken, express gratitude for your home, work, family or friends, and health or movement toward health.
- Say "thank you" and "you're welcome" frequently.
- When caught up in a stressful situation, ask yourself, "What is the most important thing right now?"
- Take mini-stretch breaks throughout the day.
- Be willing to say, "I don't know."
- Ask for help and support when you need it.
- Create a personal mission statement for your work.
- Place a post-it at the nursing station or on your computer that says BREATHE.
- Try substituting water or fruit juices for carbonated beverages. Monitor your intake of caffeine, alcohol, salt, and sugar.
- Take a technology break—spend one day at home without answering the phone, email, or fax.
- Take a media break—spend one day at home without listening to the radio news, watching TV, or reading the newspaper.
- Place photos or pictures in your workplace of things or people who bring you joy.
- For four hours, try and do one thing at a time; avoid multi-tasking.
- Keep a humor file.
- If you feel a little too busy, stop and take 5 conscious, deep, diaphragmatic breaths.
- If you feel moderately busy, stop and take 10 conscious, deep, diaphragmatic breaths.
- If you are excessively busy and feel overwhelmed, stop, sit down, close your eyes, and take 10 conscious, deep, diaphragmatic breaths. Quiet your thoughts, and gently remind yourself that you are capable of moving through this situation. Repeat. This will take less than 5 minutes and will help to restore your perspective and energy.
- When you go to bed at night, express gratitude for the day you were given, for your home, work, family or friends, and health or movement toward health.

Adapted from Kraybill, K. (2003). Creating and maintaining a healthy work environment: A resource guide for staff retreats. Available at http://www.nhchc.org/wp-content/uploads/2011/10/ResourceGuideforStaffRetreats.pdf. Used with permission.

Resource Guide 2-7: Self-Care and Creative Expression

Grace
Give me the **grace**
To care
Without neglecting my needs,
The **humility**
To assist
Without rescuing,
The **kindness**
To be clear
Without being cold,
The **mercy**
To be angry
Without rejecting,
The **prudence**
To disclose
Without disrespecting my privacy,
The **humor**
To admit human failings
Without experiencing shame,
The **compassion**
To give freely
Without giving myself away

– Unknown

Self-care exercises using the poem Grace:

Written Self-Reflection Exercise
After reading the poem Grace, write about the parts of the poem that apply to you.

OR

Art Reflection Exercise
Using any media of your choice, create an art reflection that expresses your response/emotions to the poem Grace.

Source: ELNEC for Veterans – Module 7: Loss, Grief, & Bereavement. Permission granted to use these materials by Betty Ferrell, PhD, RN, MA, CHPN, FPCN, FAAN, Principal Investigator of the ELNEC Project, City of Hope, Duarte, CA and Pam Malloy, MN, RN, FPCN, FAAN, Co-Investigator of the ELNEC Project, American Association of Colleges of Nursing, Washington, DC.

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Resource Guide 2-8: Stress Reduction, Health, and Well-Being

Exercise

When you are in a stressed "fight or flight" state, exercise is a natural outlet to help restore your body to its normal state. "Good" chemicals, such as endorphins, are released.

Aerobic exercise, such as walking, biking, dancing and swimming:

- Strengthens your cardiovascular system
- Increases your stamina
- Helps regulate blood pressure
- Helps regulate blood sugar
- Helps you work off "emotional steam"
- Relieves chronic tension
- Decreases feelings of depression and anxiety
- Helps you sleep better (Caution: Aerobic exercise should not be done 2 hours before bedtime; exercise in the morning, afternoon, or early evening.)

Stretching exercise, such as yoga, tai chi, Pilates, or general stretching routine:

- Helps you relax
- Relieves chronic tension
- Decreases feelings of depression and anxiety
- Improves your circulation
- Increases your muscle strength and tone
- Helps with joint mobility
- Helps you sleep better if done before bedtime

Creating time to exercise:

- Set up a schedule of at least 3 times per week.
- Decide what days and times are best.
- Use music to help motivate you.
- Exercise with a friend if you need support.
- Familiar excuses:
- I'm too tired.
- Exercise is boring.
- I walk a lot at work.

Resource Guide 2-9: Spiritual Practice for Stress Reduction, Health, and Well-Being

Spiritual Practice

Spirituality means feeling centered, connected with a higher power or feeling that life has meaning and purpose. It may include religious practices or rituals. It usually includes some type of quiet time. We all have a need to express ourselves spiritually. However, the manner in which we do so is very individual.

Think about what is important to you and how you may already be experiencing meaning and purpose. Consider what would be helpful to you in expressing your spirituality consistently.

Examples of Spiritual Practice:

- Meditation
- Prayer
- Quiet reflection, time in nature
- Spiritual or inspirational reading
- Meditative walking
- Going to worship services
- Looking at an icon
- Creating a home altar
- Bible (or other holy book) study group
- Singing/chanting
- Drumming
- Spiritual Dance
- Yoga

Serenity Prayer:

The Serenity Prayer, a very old prayer adopted by Alcoholics Anonymous, is a helpful prayer for everyone:

God grant me the serenity to
Accept the things I cannot change,
To change the things I can,
And the wisdom to know the difference.

Adapted from:

Self-Care Strategies for Healthcare Professionals, Department of Nursing Research and Education, City of Hope; Kate Kravits, RN, MA, Principal Investigator; and supported by a grant from the UniHealth Foundation.

Reference:

ELNEC for Veterans Curriculum, Module 7: Loss, Grief & Bereavement – Supplemental Teaching Materials, Pages M7:66-75, Revised – May 2010. Permission granted to use these materials by Betty Ferrell, PhD, RN, MA, CHPN, FPCN, FAAN, Principal Investigator of the ELNEC Project, City of Hope, Duarte, CA and Pam Malloy, MN, RN, FPCN, FAAN, Co-Investigator of the ELNEC Project, American Association of Colleges of Nursing, Washington, DC.

Section 3: Competencies and Evaluation

Goals

After reading this unit, the trainer will understand how to help supervisors of volunteers know why performance evaluation is important and how to use evaluation tools effectively.

Unit 1: Competencies

The first section in this manual discussed how to recruit, select, and retain competent and carrying volunteers for the "No Veteran Dies Alone" (NVDA) program. The next session went in depth about the skills and competencies these volunteers will need to do their work effectively and compassionately. A competency should be based on the volunteer's position description and provide the measurable skills, knowledge, and behaviors expected of the volunteer. Some resource guides to illustrate particular competencies are provided at the end of this section.

- See Resource Guide 3-1 to view a Sample NVDA Program Coordinator Competency Checklist.
- See Resource Guide 3-2 to view a Sample: NVDA Volunteer Skill Assessment Checklist
- See Resource Guide 3-3 to view NVDA Competency: Bereavement, Grief, and Loss.
- See Resource Guide 3-4 to view NVDA Competency: Communication/Active Listening.
- See Resource Guide 3-5 to view NVDA Competency: Pain and Symptom Management.
- See Resource Guide 3-6 to view NVDA Competency: Psychosocial Spiritual Support.
- See Resource Guide 3-7 to view NVDA Competency: End-of-Life Nutrition.
- See Resource Guide 3-8 to view NVDA Competency: Last Hours of Living.

Unit 2: Evaluation

The next step is performance evaluation. Competency evaluations are necessary to confirm that volunteers have the needed skills and knowledge to perform their assigned duties. Evaluators should also have written competencies on file, such as those listed in the resource guides, for the specific tasks being evaluated.

Competency evaluation tools should be developed in collaboration with Veterans Administration Voluntary Service and the hospice and palliative care team. There are many methods of competency assessment that may be used to establish the skill set of volunteers, such as:

- Pre- and post-tests
- Written exams
- Direct observation/supervisory visits
- Competency fairs
- Games, such as universal precautions "Jeopardy"
- Individual or group testing/observation

The following resource guides provide sample evaluation forms and an example.

- See Resource Guide 3-9 to view a Sample NVDA Volunteer Training Evaluation.
- See Resource Guide 3-10 to view a Sample Volunteer Evaluation Form.
- See Resource Guide 3-11 to view a Compassion Corps Six-Month Follow-Up Evaluation.
- See Resource Guide 3-12 to view a Sample Volunteer Issue Summary.

Conclusion

It is hoped that this NVDA volunteer trainer resource manual has been helpful. Its goal is to provide the trainer with material to effectively

- Recruit, select, and retain good NVDA volunteers;
- Convey relevant information for volunteers to develop core competencies through training; and
- Evaluate volunteers as a means of assessing their capacity to fulfill their role.

The next section lists supplemental resources, including books, videos, PowerPoint presentations, and toolkits, available to help trainers, volunteers, and others involved in caring for our valued Veterans at the end of their lives.

Resource Guide 3-1: Sample NVDA Program Coordinator Competency Checklist

NVDA Program Coordinator Sample Competency Checklist

This is a sample checklist one can use to assess the skill level of a NVDA volunteer program coordinator. It can also be modified to fit volunteer position descriptions.

Name: _____ Date: _____

Skill	*Exceeds Standards*	*Satisfactory*	*Improvement Needed*	*Not Applicable*
Can verbalize VA hospice and palliative care (HPC) program goals, philosophy, and mission				
Articulates an understanding of accreditation and VA standards for NVDA volunteer management				
Demonstrates the ability to recruit volunteers sufficient for the HPC nursing unit/program				
Shows/proves the ability to effectively interview and screen volunteers				
Exhibits the ability to develop and conduct a training program that complies with VA standards				
Is able to articulate and/or demonstrate principles of effective volunteer management				
Is able to describe the methods and procedures involved in creating/executing an effective departmental strategic plan				
Understands volunteer needs and what is required to retain volunteers				
Demonstrates an ability to work effectively with other team members to achieve optimal volunteer assignments				

Skill	*Exceeds Standards*	*Satisfactory*	*Improvement Needed*	*Not Applicable*
Demonstrates the ability to provide a plan to address volunteer interventions				

NVDA Program Coordinator Comments:

_____

_____

Supervisor Comments:

_____

_____

Supervisor Signature: _____ Date: _____

Volunteer Signature: _____ Date: _____

Resource Guide 3-2: Sample NVDA Volunteer Skill Assessment Checklist

NVDA Volunteer Skill Assessment Checklist

This is a sample checklist one can utilize to assess the skill level of NVDA volunteers. It can be modified to fit volunteer position descriptions.

Name: _____ Date: _____

Skill	*Exceeds Standards*	*Satisfactory*	*Improvement Needed*	*Not Applicable*
Can verbalize VA hospice and palliative care (HPC) program goals, philosophy and mission				
Has completed all regularly scheduled volunteer processing				
Adheres to all VHA privacy standards				
Demonstrates ability to follow infection control, fire safety, and OSHA standards				
Demonstrates the knowledge of volunteer non-patient care role to support an end of life (EOL) Veteran and his/her family				
Utilizes active listening skills				
Demonstrates the ability to bridge communication between the Veteran, family, and Patient Care Team (PCT)				
Shows the ability of understanding high-risk patient/family behaviors and the referral of such information to the PCT				
Demonstrates knowledge of bereavement and caring for the caregiver principles				
Understands spirituality/religious support standards and the NVDA volunteer role				

NVDA Program Manager Comments:

_____

_____

Supervisor Comments:

_____

_____

Supervisor Signature: _____ Date: _____

Volunteer Signature: _____ Date: _____

Resource Guide 3-3: NVDA Competency: Bereavement, Grief, and Loss

NVDA Competency: Bereavement, Grief, and Loss

Volunteer: _____ Date: _____

Directions: Check the correct answer.

Statement	*True*	*False*
1. Many Veterans have witnessed horrors on the battlefield and have learned to become stoic so they are able to continue their mission.		
2. Grief is a process that begins before death and is not always orderly and predictable.		
3. Types of grief include anticipatory, normal, complicated, and disenfranchised.		
4. Disenfranchised grief is characterized by normal grief reactions that do not subside and continue over a long period of time.		
5. A succession of too many deaths in a row experienced by a volunteer is called accumulative loss (unable to resolve grief issues between deaths).		
6. The presence or absence of support systems (emotional support by family, friends, and staff) can influence the ability to move through the stages of adaptation.		
7. Normal grief reactions to a loss can be physical, emotional, cognitive, and behavioral.		
8. Self-care is protection from occupational stressors and allows one to renew him/herself.		
9. Grief should never last longer than 6 months.		
10. All symptoms of grief are considered normal.		

Resource Guide 3-4: NVDA Competency: Communication/Active Listening

NVDA Competency: Communication/Active Listening

Volunteer: _____ Date: _____

Directions: Check the correct answer.

Statement	*True*	*False*
1. Veterans' communication needs include: need for information, disclosure of feelings, sense of control, need for meaning, and sense of hope/communication for a meaningful and purposeful life.		
2. Fears of mortality, avoidance of emotion, insensitivity, and stoicism are some of the barriers to communication.		
3. Four elements of communication are imparting information, listening, gathering information, and displaying sensitivity.		
4. As much as 95% of communication can be nonverbal (includes body language, eye contact, gestures and tone of voice).		
5. Listening is being present, not just physically, but mentally and emotionally.		
6. One should always listen, but be ready to give input as quickly as possible (Your opinion is important).		
7. Being present and silent are valuable communication skills.		
8. It is important that volunteers finding out at-risk information on a Veteran and/or a family member should relay the information to a Patient Care Team (PCT) member.		
9. The Patient Care Team (PCT) will need to consider the ethnic, cultural, and religious background of the Veteran and his/her family in order to understand their attitude toward illness, medical care, suffering, and family roles.		
10. There is no need to practice active listening.		

Resource Guide 3-5: NVDA Competency: Pain and Symptom Management

NVDA Competency: Pain and Symptom Management

Volunteer: _____ Date: _____

Directions: Check the correct answer.

Statement	*True*	*False*
1. Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage/change in the nervous system.		
2. Pain is whatever the Veteran says it is.		
3. For some Veterans, past pain experience can be related to trauma or violence witnessed on the battlefield.		
4. Some barriers to pain relief are fear of side effects or addiction; stoicism; attitudes; and beliefs and religious or cultural practices.		
5. Constipation may be a highly embarrassing issue for the Veteran and could lead to other issues.		
6. Addiction to morphine can be a serious issue for end-of-life (EOL) Veterans.		
7. Music therapy and other relaxation therapies do not assist in relieving a Veteran's pain.		
8. Dyspnea or difficulty breathing can be relieved by using a fan in the room, a cool cloth on the face, and re-positioning the Veteran.		
9. Volunteers can be helpful with pain assessment by making the Patient Care Team (PCT) aware of any changes they see in the Veteran.		
10. Pain can cause loss of appetite, sleeplessness, and changes in mood and movement.		

Resource Guide 3-6: NVDA Competency: Psychosocial Spiritual Support

NVDA Competency: Psychosocial Spiritual Support

Volunteer: _____ Date: _____

Directions: Check the correct answer.

Statement	*True*	*False*
1. Chaplaincy Service support strives to meet the needs of Veterans with life-limiting illness, including physical, emotional, and spiritual needs.		
2. Chaplaincy Service is not true a member of the Patient Care Team (PCT) since this service deals with holistic care and faith tradition only.		
3. A Veteran or family members must accept any chaplain that is available regardless of the family's faith tradition.		
4. It is important to have knowledge and understanding of the different faith traditions.		
5. Cultural diversity is very important in understanding a Veteran's spiritual preference.		
6. Life review is a customary and helpful way for many Veterans to prepare for death.		
7. If the volunteer is aware of an excellent funeral home service, he/she is encouraged to share the information with the Veteran and family.		
8. If the Veteran or family becomes upset and starts to cry, the volunteer should show support by providing a "caring presence."		
9. When caring for an end-of-life (EOL) Veteran, it is appropriate to talk about your religious faith if asked directly by the Veteran; however, redirect the Veteran to the support of Chaplaincy Service.		

Resource Guide 3-7: NVDA Competency: End-of-Life Nutrition

NVDA Competency: End-of-Life Nutrition

Volunteer: _____ Date: _____

Directions: Check the correct answer.

Statement	*True*	*False*
1. Veterans often experience a loss of appetite. Strategies to support the Veteran may be to have the Veteran eat when appetite is best; choose favorite foods; limit fatty, greasy foods; rest after eating and eat slowly.		
2. Nutrition supplements are sometimes used to enhance a meal or sometimes as a meal replacement.		
3. Dehydration causes pain at the end of life (EOL)		
4. Fasting can result in ketonemia, which can bring hunger relief and euphoria.		
5. Nutrition at EOL should be to provide pleasure and to enhance the quality of life. A liberal diet is encouraged if the Veteran is able to tolerate.		
6. Using finger foods can assist in the Veteran maintaining independence with feeding.		
7. Veterans with life-limiting illness can digest food without much issue.		
8. Family and friends always understand that their loved one may lose his/her appetite and would never encourage the Veteran to eat anyway.		
9. The EOL body is in the process of shutting down, and the Veteran no longer requires a great deal of nutrients or calories to convert to energy; therefore, his/her appetite or desire for food may diminish.		

Resource Guide 3-8: NVDA Competency: Last Hours of Living

NVDA Competency: Last Hours of Living

Volunteer: _____ Date: _____

Directions: Check the correct answer.

Statement	*True*	*False*
1. The dominant symptoms during the last weeks of life are fatigue and weakness. For the most part, this is the result of low calories and iron intake.		
2. Veterans may regress and become child-like, and sometimes he/she may be incontinent.		
3. The Veteran may have difficulty relating to a crowd or visitors.		
4. Cyanosis, a gray pallor from lack of oxygen around the lips and nail beds, may be present.		
5. In the last hours of living, skin is warm and moist, and the pulse is normal.		
6. Breathing may be a loud rattle, caused by collected secretions, and there may be long periods between breaths.		
7. The Veteran's facial muscles may relax, mouth drops open, or eyes stay half open.		
8. There may be various levels of mental clarity, although some Veterans stay alert until the very end		
9. The senses of sight and touch are the very last abilities to cease functioning		
10. Fluid may accumulate in the limbs and back of the Veteran.		
11. If the family is present and the Veteran is actively dying, the volunteer should stay with the family and Veteran.		

Resource Guide 3-9: Sample NVDA Volunteer Training Evaluation

NVDA Volunteer Training Evaluation

Volunteer: _____ Date: _____

Please rate the following statements	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*	*Not Sure*
I develop new knowledge/skills as a result of this training program	1	2	3	4	5
The teaching strategies were varied and easy to understand	1	2	3	4	5
Appropriate training/program materials were distributed to me	1	2	3	4	5
The physical accommodations contributed to learning	1	2	3	4	5
I would recommend this training program to a friend/co-worker	1	2	3	4	5
Having completed the training, I feel competent to apply my new knowledge/skills	1	2	3	4	5

If you do not feel prepared to begin volunteering in end-of-life care, please tell us how we could better prepare you. _____

_____

_____

What aspects of the training did you find most valuable? _____

_____

_____

Can you suggest any changes or improvements for future trainings? _____

_____

_____

Please comment on the quality of instruction and/or the teaching ability of the instructors: _____

_____

_____

Resource Guide 3-10: Sample Volunteer Evaluation Form

Volunteer Evaluation Form

Volunteer: _____ Date: _____

Period of Evaluation FROM (mm/yy) _____ TO (mm/yy) _____

Rating Scale: 0=Not Applicable, 1=Needs Improvement, 2=Fair, 3=Good, 4=Excellent

Circle the best response:

- Ability to interact appropriately with Veterans and/or families (maintains confidentiality; respects values of others): 0 1 2 3 4
- Availability: 0 1 2 3 4
- Dependability/Follow-through (completes given assignments or notifies appropriate person when not able to fulfill commitment): 0 1 2 3 4
- Accountability (accurate/timely documentation; contacts office when appropriate): 0 1 2 3 4
- Ability to interact with the interdisciplinary team: 0 1 2 3 4
- Flexibility (ability to adapt to change): 0 1 2 3 4
- Participation in on-going support (team meetings, in-services, support groups, special events): 0 1 2 3 4
- Self-care (ability to utilize effective time management skills; verbalizes own limitations): 0 1 2 3 4
- Follow through on program policies and procedures: 0 1 2 3 4
- Overall impression of performance: 0 1 2 3 4

Additional Comments: _____

_____

Signature of Volunteer: _____

Signature of Volunteer Coordinator: _____

Resource Guide 3-11: Sample Compassion Corps Six-Month Follow-Up Evaluation

Compassion Corps Six-Month Follow-Up Evaluation

Volunteer: _____ Date: _____

Please rate the following statements:	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*	*Not sure*
1. The knowledge/skills I learned, as a result of the CC Training Program, adequately prepared me to be an end-of-life care volunteer.	1	2	3	4	5
2. I have referred back to the training materials since attending the training.	1	2	3	4	5
3. I would feel comfortable contacting any/all of the trainers with questions or concerns about anything related to the training or a volunteer situation I've encountered.	1	2	3	4	5
4. It would be a good idea to have follow-up/refresher training (outside of the monthly support meetings).	1	2	3	4	5
5. I would recommend the training to a friend.	1	2	3	4	5

Please answer the following questions in as much detail as possible:

1. Now that almost six months have lapsed since the training, can you suggest any changes or improvements for future trainings? _____

_____

_____

2. If you have had the opportunity to attend any of the monthly support meetings, please give feedback about the quality of the time spent together. _____

_____

_____

3. Describe an encounter with a Veteran, his/her family, or staff member that was not addressed in the training that you think should be in future trainings. _____

_____

_____

4. What has been the most rewarding and the most difficult aspects of the time spent with our Comfort Care Veterans? _____

_____

_____

5. How has your presence been received by the staff members at the Community Living Center or the ICU?

_____

_____

_____

6. Do you have any concerns or questions that you would like addressed, either individually or as a group, at monthly support meetings? _____

_____

_____

7. As we prepare for another training, do you have any suggestions about where we may find other gifted volunteers like you? _____

_____

_____

Resource Guide 3-12: Sample Volunteer Issue Summary

Volunteer Issue Summary

Volunteer: _____ Date: _____

Describe Problem/Issue:

_____

_____

Possible/Suggested Solution(s):

_____

_____

Additional Volunteer Comments:

_____

_____

_____

Volunteer Signature Date

Action/Resolution:

_____

_____

Follow-Up (if needed):

_____

_____

_____

Signature of Volunteer Coordinator Date

NOTE: One copy of Issue Summary to Team Coordinator; original returned to Voluntary Services office following resolution.

Section 4: Supplemental Resources

This section provides additional resources for the trainer and volunteers, as well as all hospice and palliative care staff. Note, the following list of widely used resources was brought together by a work group of VA staff and volunteers and does not infer endorsement by the Department of Veterans Affairs.

Books

Volunteer

- Hospice Volunteer Program Resource Manual, National Hospice and Palliative Care Organization: www.nhpco.org/marketplace.

Hospice and Spirituality

- The Art of Listening in a Healing Way, James E. Miller ISBN: 1-885933-35-5
- The Art of Being a Healing Presence, James E. Miller with Susan C. Cutshall ISBN: 1-885933-32-0
- Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death, Joan Halifax ISBN: 978-1-59030-718-2
- Dying Well: Peace and Possibilities at the End of Life, Ira Byock ISBN: 1-57322-051-5
- The Four Things That Matter Most, Ira Byock ISBN: 0-7432-4909-7
- Peace at Last: Stories of Hope and Healing for Veterans and Their Families, Deborah L. Grassman ISBN: 978-0-918339-72-0
- Final Gifts: Understanding the Special Awareness, Needs, and Communications of the Dying, Maggie Callanan & Patricia Kelly ISBN: 978-1-4516-6725-7
- Final Journeys: A Practical Guide for Bringing Care and Comfort at the End of Life, Maggie Callanan ISBN: 978-0-553-38274-7
- On Death and Dying, Elisabeth Kubler-Ross ISBN: 0-02-089141-5
- Praying Our Goodbyes: A Spiritual Companion through Life's Losses and Sorrows, Joyce Rupp ISBN: 10 1-594471-205-0
- Kitchen Table Wisdom – Stories that Heal, Rachel Naomi Remen, M.D. ISBN: 1-59448-209-8
- Caregiving: Hospice-Proven Techniques for Healing Body and Soul, Douglas C. Smith ISBN: 0-02-861663-4
- The Nature of Suffering and the Goals of Nursing, Betty R. Ferrell & Nessa Coyle ISBN: 978-0-19-533312-1
- The Last Dance: Encountering Death and Dying, Lynne Ann DeSpelder & Albert Lee Strickland ISBN: 978-0-07-292096-3
- Spirituality, Health, and Healing, Caroline Young & Cyndie Koopsen ISBN: 1-55642-663-1
- Cultural Issues in End-of-Life Decision Making, Kathryn L. Braun, James H. Pietsch, & Patricia L. Blanchette ISBN: 0-7619-1217-7
- Creating a Life Legacy [Booklet], Dot Landis, (www.fvfiles.com/521157.pdf)

Military Culture

- Nam Vet – Making Peace with Your Past, Chuck Dean ISBN: 0-9679371-0-8
- Down Range – to Iraq and Back, Bridget Cantrell, Ph.D. & Chuck Dean ISBN-13: 978-1-933150-06-2

- Peace At Last, Deborah L. Grassman, ISBN-978-0-918339-72-0
- Once a Warrior – Wired for Life, Bridget Cantrell, Ph.D. & Chuck Dean ISBN-13: 978-0-615-14132-9
- An Operators Manual for Combat PTSD – Essays for Coping, Ashley R. Hart II, Ph.D. ISBN: 0-595-13798-9
- Moving a Nation to Care – Post-Traumatic Stress Disorder and America's Returning Troops, Ilona Meagher ISBN-13: 978-0-9771972-7-9
- The Things They Carried, Tim O'Brien ISBN: 978-0-618-70641-9
- Chicken Soup for the Veteran's Soul – Stories to Stir the Pride and Honor the Courage of Our Veterans, Jack Canfield, Mark Victor Hansen, & Sidney R. Slagter ISNB-13: 978-1-55874-937
- Invisible Heroes – Survivors of Trauma and How They Heal, Belleruth Naparstek ISNB-13: 978-0-553-38374-4
- War and the Soul – Healing Our Nation's Veterans from Post-Traumatic Stress Disorder, Edward Tick, Ph.D. ISNB-13: 978-0-8356-0831-2

PowerPoints and Other Resources (for VA staff)

- Available at the Hospice and Palliative Care Program Office VA Pulse Site

Videos

- Hospice Foundation of America DVD: Understanding Grief, January 2011
- Wounded Warriors: Their Last Battle

Websites

- We Honor Veterans - www.wehonorveterans.org
- National Hospice and Palliative Care Organization – www.nhpco.org
- National Cancer Institute - www.cancer.net
- Centers to Advance Palliative Care (CAPC) - www.capc.org, including Online Fast Facts for palliative care at www.capc.org/fast-facts
- Supportive Care Coalition - www.supportivecarecoalition.org
- American Academy of Hospice and Palliative Medicine has Unipac Palliative Care education for physicians - http://aahpm.org/self-study/unipacs
- Twilight Brigade - www.thetwilightbrigade.com

Program Support Tools

- Tool #1- Comfort Care Bags, which may include:
  - Bottled water
  - Crystal Light® packets
  - Snacks, e.g., cookies, dried fruit, protein bars)
  - 2 microwavable soups
  - Breath mints or gum

- Chapstick®
- Lotion
- Travel sizes of toothbrush, comb, mouthwash, deodorant, and soap
- Puzzle book of some sort
- Kleenex®
- Salty snack, e.g., chips, popcorn
- Paper and writing utensil
- Pudding or Jello®
- Small stuffed animal
- 2 canteen books
- Hand-knit comfort shawl
- Neck pillow

- Tool #2 – Comfort-Care Prayer Shawls

  This shawl was made just for you
  To bring comfort
  To know you are loved
  To share in your concerns
  This shawl is to wrap you up
  When you're cold
  When you're hurting
  When you need to snuggle
  This shawl was knitted
  With Blessings
  With Love
  With Prayers

  From: An Angel on Your Path at the Terre Haute First Baptist Church And the Palliative Care Team at the Illiana VA

  OR

  This shawl was made just for you
  To bring comfort
  To know you are loved
  To share in your concerns
  This shawl is to wrap you up
  When you're cold
  When you're hurting
  When you need to snuggle
  This shawl was knitted
  With Blessings
  With Love
  With Prayers

  From: Comfort-Care Shawl Ministry VAIHCS Palliative Care Team

- Tool #3: Sample Training Agenda

  May 31, 2011
  8:00 a.m. – 3:30 p.m.
  AGENDA

Time	*Content*	*Speaker*
8:00 a.m. – 8:45 a.m.	Registration, Continental Breakfast	All CAVS, Voluntary Service Specialist, LR CLC Hospice/Palliative Care, VAMHCS Program Manager, Voluntary Service VAMHCS
8:45 a.m. – 8:50 a.m.	Welcome, Introductions, Handouts	
8:50 a.m. – 9:00 a.m.	Appreciation/Guiding Principles	
9:00 a.m. – 9:45 a.m.	Overview: EOL Care and Philosophy at VAMHCS "A Veterans Story" video HPC Interactive Exercise	Nurse Specialist Hospice/Palliative Care, VAMHCS
9:45 a.m. – 10:30 a.m.	Pain & Symptom Management at EOL; Communication and the Interdisciplinary Team	
10:30 a.m. – 10:45 a.m.	BREAK	
10:45 a.m. – 11:30 a.m.	Nutrition in EOL: Food & Nutrition Services Resources LR VA CLC/General Food instructions for Volunteers	Dietician Dietician, LR Hospice/Palliative Care
11:30 p.m. – 12:00 p.m.	Spiritual Aspects of EOL Care; Special Instructions for Volunteers	Pastoral Care, LR VA CLC
12:00 p.m. – 12:45 p.m.	LUNCH	
12:45 p.m. -1:15 p.m.	Last Hours of Living	VAMHCS Volunteer
1:15 p.m. – 2:00 p.m.	Grief & Bereavement; Caring for the Caregiver	MSW, Hospice/Palliative Care
2:00 p.m. – 2:15 p.m.	BREAK	
2:15 p.m. – 3:00 p.m.	Voluntary Service Expectations; Volunteer Position Description	
3:00 p.m. – 3:30 p.m.	Questions; Evaluations; Tour Sailor's Point Nursing Unit	

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VOLUNTEER TRAINER RESOURCE MANUAL