

Rau ora
A hundred pathways to well-being



hospice

eastern bay of plenty

VOLUNTEER HANDBOOK



WELCOME!

Welcome to the Hospice Eastern Bay of Plenty team! Thank you for giving your time to volunteer at Hospice.

You are now a member of a team of dedicated volunteers who regularly give us their time and skills, which in turn enables us to provide a quality service to our patients, their families/ whanau and caregivers.

Volunteers are highly valued Hospice Eastern Bay of Plenty team members who together with staff are integral to Hospice achieving its mission of providing excellent, compassionate palliative care for everyone throughout the Eastern Bay of Plenty.

As a volunteer, you will be making a real difference to patients who have been diagnosed with a life-limiting illness. This may be directly as a Patient and Family Support Volunteer or indirectly as a Professional Services Volunteer. As a non-profit organisation, we are enthusiastic about the work we do and our hope is that you will enjoy being part of our friendly, happy team here at Hospice EBOP.

We want to make volunteering a rewarding and enjoyable experience for you. To help you have a good start with us we have provided you with this handbook which is intended to give a sound understanding of the work we do, services we offer and your role as a volunteer. It is important you take the time to read through this handbook which forms part of your orientation. If you do not find the information you are looking for please contact the Volunteer Coordinator.

As a Hospice Eastern Bay of Plenty Volunteer, you are a part of a dynamic team and your input is highly valued. Please contact me if at any time if you need support, guidance, have questions, concerns or feedback.

Thank you for your compassion and commitment!

Kind regards



Peter Bassett
Chief Executive

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ORIENTATION AND TRAINING

This Volunteer Handbook serves as part of volunteer orientation, and is designed to ensure that volunteers are familiar with Hospice Eastern Bay of Plenty history and services, as well as Hospice expectations of the volunteers. Specific training is required for volunteer roles such as Patient / Family Support, Bereavement Support and Life Story Writers. Professional Service Volunteers such as massage, hairdressing etc. require evidence of formal training or qualifications in their field of expertise.

Regular Volunteer training sessions are held throughout the year as per addendum.

Volunteer Acknowledgment

This Volunteer Handbook is designed and prepared to acquaint volunteers with Hospice EBOP and responsibilities of volunteer roles.

Your signature on this form is to acknowledge you have received a copy of the Hospice EBOP Volunteer Handbook.

- Please Read and sign

I understand it is my responsibility as a volunteer to read this Handbook. If I have questions concerning the information herein, I will bring them to the attention of the Volunteer Coordinator.

I understand the policies and procedure contained in the Handbook constitute management and volunteer guidelines only, and are in no way to be interpreted as a contract between Hospice EBOP and any of its volunteers.

I further understand Hospice EBOP reserves the right to add, change, modify or delete any of its policies at any time.

Signature_____

Name _____ (*Please print clearly*)

Date_____

ABOUT HOSPICE

The term "hospice" originated in the middle ages to describe way stations, which were established along the route to the Holy Land. Pilgrims would travel by day and seek shelter, food and other comforts at these hospices. The word has always had the connotation of a haven for people on a journey. In the 19th Century, the Irish Sisters of Charity cared for "incurables" in homes they called hospices.

The modern hospice originated in London, England, where Dr Cicely Saunders opened St. Christopher's Hospice in 1965. It has been a model for all developing hospices throughout the world. In New Zealand, there are well over 36 functioning hospices.

Many people think of hospice services as just a building, when in fact it is a philosophy of care. It is true that most hospice services in New Zealand have inpatient facilities, but most people are cared for in their homes.

Anyone living with a life limiting condition – e.g. heart failure, motor neurone disease, MS or cancer – can access and benefit from hospice services.

Our aim is to help people make the most of their lives; to live every moment in whatever way is important to them.

Hospice care has a unique whole person approach – which means physical, spiritual, emotional and social needs are equally important – a multidisciplinary team provides care for the person who is dying and their families and friends, both before and after death.

Hospice palliative care, which is free of charge, can be provided in hospice in-patient facilities, hospital rest homes or in a person's home or place of residence in the community.

Hospice care affirms life.

- ✓ Hospice care recognises dying as a normal process and neither hastens nor postpones death.
- ✓ Hospice care exists to help patients and families attain a degree of preparation for death that is satisfactory for them.
- ✓ Hospice care recognises grief as a normal response to loss. Support for the family continues into the bereavement period.
- ✓ Hospice care is free of charge, and access to services is available in a culturally appropriate manner and is based on need.

What is Palliative Care?

Palliative care is specialist care by a multidisciplinary team for patients with a limited prognosis and who are unresponsive to curative treatment. Hospice's holistic approach to palliative care focuses on quality of life for both the patient and their family & whanau.

It is stated that the way in which a person dies largely depends on the three factors:

- ✓ The nature of the illness and/or disease.
- ✓ The way in which he/she has lived their life.
- ✓ The quality of care available.

We cannot change the first two. However, we can commit ourselves to influence the third in a realistic manner, setting achievable goals for ourselves.

HOSPICE EASTERN BAY OF PLENTY

Hospice EBOP was established in 1985 and registered as a Charitable Trust in 1986, and registered with the Charities Commission 1 May 2008

MISSION STATEMENT

Provide excellent, compassionate palliative care for everyone throughout the Eastern Bay of Plenty.

VISION STATEMENT

Living well when time is limited.

VALUES

Respect We treat others the way we like to be treated

Whakaaro nui Whakaaro nui ki ētahi atu – Ōrite te whakaaro nui kia mātau

Excellence We strive for excellence and do our best

Taumata teitei Whaia ana te taumata teitei, ki to mātau kaha

Collaboration We are in this together

Ngātahi Mahi ngātahi ana tātau

Compassion We treat others with kindness & empathy

Arohanui He arohanui, te manaaki, te atawhai i te katoa

Integrity We are honest, sincere and open

Ngākau pono He ngākau pono, he tika, he tuwhera

HOSPICE EBOP SERVICES

Hospice services are provided in patients' homes or places of residence. Visits are also made to patients in hospital and residential care facilities. Some patients are seen in 'clinic' at Hospice.

Services include:

- ✓ Specialist palliative care nursing visits to patients in their homes or residential care facilities to assist with management of symptoms – physical, psychosocial, emotional and spiritual
- ✓ 24/7 nursing phone support and advice
- ✓ Coordination of care in collaboration with GPs and other healthcare providers
- ✓ Patient and family support visits for social work assistance and counselling
- ✓ Spiritual support and visits by our Volunteer Chaplain
- ✓ Grief and bereavement counselling
- ✓ Coordination of home help and personal cares
- ✓ Coordination of admission to funded palliative care beds at Golden Pond
- ✓ Volunteers who assist and support patients and whānau
- ✓ Weekly 'Time Out' for patients and carers to get together at Hospice headquarters
- ✓ Life story service
- ✓ Equipment loan
- ✓ Information via a small library and on our website
- ✓ Education programmes

REFERRAL CRITERIA

Services are provided to those who have consented to hospice input / care, and who:

- ✓ Live in the Eastern Bay of Plenty
- ✓ Have been diagnosed with advanced active progressive disease for which curative treatment is no longer an option
- ✓ Have a limited prognosis (generally 12 months or less)
- ✓ Have complex palliative care needs over and above those able to be managed by the primary care provider (e.g. GP, DN etc.)

Services are provided in a culturally appropriate manner based on need irrespective of age, gender, race, religious persuasion, sexual orientation or disease

Hospice service is provided free of charge.

AREAS COVERED BY HOSPICE EBOP

Hospice EBOP covers a large geographical area from Te Kaha to Murupara to Paengaroa including Whakatane, [32814], Opotiki [9201], Ohope, Taneatua, Edgecumbe, Kawerau [6975] and Matata.

This area encompasses peoples with affinity to a range of iwi including:

Ngati Awa; Whakatohea; Te Whanau a Apanui; Ngai Tai; Ngati Whare; Tuhoe; Ngati Manawa; Ngati Rangitihi, Te Whanau a Te Ehutu.

The rural nature of the area makes distance and accessibility key factors when attempting to provide services to all.

How does Hospice Referral Work?

- ✓ Referrals may be made by health care providers such as GPs, Practice Nurses, District Nurses, Māori health Providers, Oncologists, etc.
- ✓ Self-referrals from patients themselves and family / whanau / carers / friends are accepted
- ✓ Patients must consent to Hospice input and support before referral to Hospice, as well as meeting the referral criteria
- ✓ A referral does not mean automatic acceptance onto Hospice service
- ✓ Have a look at our website if you want to find out more www.hospiceebop.org.nz including our Board of Trustees and staff list.

HOSPICE EBOP VOLUNTEER SERVICES AND OPPORTUNITIES



DEFINITIONS

Volunteer: Anyone who, without compensation or expectation of compensation beyond reimbursement, performs a task at the direction of and on behalf of Hospice. A ‘volunteer’ must be officially accepted and enrolled by Hospice (except for special project volunteers) - a group brought to a project with supervision provided by another organisation – examples: high school, youth group, etc.). Volunteers must be at least 15 years of age to be officially accepted and enrolled by the Volunteer Coordinator.

Special Project Volunteers: Hospice EBOP also accepts as volunteers those participating in student intern projects, corporate volunteer programs and other volunteer referral programs.

BECOMING A VOLUNTEER

- ✓ Potential volunteers complete an application and submit this to the Volunteer Coordinator or his/her designee.
- ✓ A criminal history check is carried out on every person who applies for a role with Hospice, be it a paid or unpaid/volunteer role. This is a requirement for all agencies that provide care to children, older people and vulnerable members of society in New Zealand.
- ✓ At least two reference checks are completed on all those applying to HEBOP, be this for a paid or unpaid /volunteer role.
- ✓ Volunteers are interviewed by the volunteer coordinator, his/her designee and/or department manager to assure placement is in accordance with skills of the volunteer.
- ✓ Departmental training is done by department staff or another trained volunteer.
- ✓ Volunteers are provided with a copy of the Volunteer Handbook, which may serve as volunteer orientation however the expectation is that Hospice volunteers attend the regular meetings and training sessions scheduled.
- ✓ A record of individual hours of service by all volunteers will be maintained by the Volunteer Coordinator.
- ✓ Activities to honour Hospice volunteers are held once a year.
- ✓

VOLUNTEER COORDINATION

The Volunteer Coordinator is responsible for recruitment, training, placement and supervision of Hospice volunteers.

Volunteer programs and activities are monitored and evaluated on an on-going basis by the Volunteer Coordinator or his/her designee in conjunction with another staff member.

The Volunteer coordinator maintains a database record and a personnel file on each volunteer, which includes:

- ✓ Application form
- ✓ Background and reference check(s)
- ✓ Copy of driver’s licence, if applicable
- ✓ Evidence of completed training and annual evaluations

An assessment of a volunteer's time availability will be made periodically to ensure a successful volunteer experience. Volunteers can become inactive for a specific period.

On a yearly basis, each volunteer will be asked to complete a volunteer survey to evaluate the Volunteer Services, and to give the volunteer a chance to give feedback, suggestions and criticisms.

VOLUNTEER POLICIES – see addendum

ROLE OF THE VOLUNTEER

Hospice EBOP has cared for generations of Eastern Bay of Plenty residents nearing the end of their life's journey. Volunteers fulfil critical roles providing support to the individual, as well as their families and friends.

The Hospice Volunteer Program aims to provide a co-ordinated, organised and consistent volunteer service to enhance the care of clients and their families and support the delivery of Hospice services.

Our volunteers serve the Eastern Bay of Plenty as patient and family support volunteers, professional service volunteers, special event volunteers, sales assistants at the Hospice Shops, and as Ambassadors in a variety of community awareness and outreach programs. All volunteers receive training for their roles. Volunteers work in conjunction with other volunteers and under the supervision and guidance of staff members.

Role Description

Each volunteer opportunity is defined in the volunteer job description. This outlines who will supervise and support the volunteer, what activities the volunteer will normally be engaged in and any requirements and training involved for the role.

Volunteers may take on more than one volunteer role, if they are comfortable and have the time commitment to do so.

A volunteer job description for each volunteer role must be signed and placed in the personnel file.

Annual Review

Each volunteer role requires an annual review and signature of the confidentiality agreement, as well an annual background check.

The Patient and Family Support Volunteer role requires an annual review and signature of the confidentiality agreement and key policies, as well as a background check.

CONFIDENTIALITY

All staff and volunteers sign a confidentiality agreement to ensure the confidentiality of patients, patients' families, employees, volunteers and Trustees is maintained.

This covers the following aspects:

CLINICAL INFORMATION

- ✓ All information regarding the clinical nature of a patient's condition shall remain confidential to the patient and to those recognised members of Hospice EBOP and other clinical practitioners as designated by the patient.

PATIENT CONFIDENCES

- ✓ All information of a personal or confidential nature that is imparted by the patient or their family shall remain confidential by those members of the Hospice EBOP and /or other persons as designated by the patient or family.

INTELLECTUAL PROPERTY

- ✓ All information relating to the business of Hospice EBOP that could potentially be used by any other person or organisation to the detriment or loss of Hospice EBOP shall be confidential and not disclosed to any person or organisation other than recognised members of the Hospice EBOP.

ORGANISATIONAL LOYALTY

- ✓ No member of Hospice EBOP shall knowingly disclose information to any other person or organisation, which is detrimental to the reputation of Hospice EBOP.

COLLEAGIAL LOYALTY

- ✓ No member of Hospice EBOP shall knowingly disclose information to any other person or organisation that is detrimental to the reputation of colleagues or staff of Hospice EBOP.

PRINCIPLES OF CONFIDENTIALITY

- ✓ The identity of hospice patient/families is confidential information, and referring to patients/families by name should only occur within the hospice team.
- ✓ Discussions regarding patient/families must be held in private settings where others cannot overhear, and never in public places.
- ✓ Confidential information shared between the hospice volunteer and hospice patient/families must never be divulged to other family members or patients/families or friends.
- ✓ Consultation with hospice staff is required to ensure the most appropriate assistance to hospice patient/families.
- ✓ When in doubt about confidentiality issues, always contact the Volunteer Coordinator or other hospice team members (Clinical Services Leader or Social Worker) for clarification or assistance.

- ✓ Note: One confidentiality exception includes cases where the patient/family have shared they either have, or plan in the future to, hurt themselves or others. Please review these exceptions with your Volunteer Coordinator.

WHAT DO YOU DO WHEN YOU KNOW OF A DISCLOSURE OF INFORMATION OR SUSPECT A DISCLOSURE?

Example:

- ✓ As a Patient Care Volunteer, you notice an empty medication box on top of the trash. The bag has the patient's name and other information such as the medication name. What should you do?

Answer:

- ✓ You should take it to the supervisor as this would be a disclosure of privacy.

Example:

- ✓ You are going into a patient's room at a facility to provide care and you notice there is a nurse or doctor in the room discussing the resident's treatment with her. What should you do?

Answer:

- ✓ Explain that you will come back. Some patients may say it is okay for you to stay in the room; however, remember he or she may no longer feel comfortable to say everything while you are in the room.

Example:

- ✓ You are at Hospice offices sorting donations and you overhear two fellow volunteers discussing a patient's condition and using the patient's name. What should you do?

Answer:

- ✓ Inform your supervisor immediately. And do not repeat the information you have overheard.

HEBOP VOLUNTEER CODE OF ETHICS

- ✓ As a volunteer, I am subject to a code of ethics. I accept my assigned responsibilities and will account for my activities in response to my assignments.
- ✓ I will make a firm commitment of my time, talents and skills for a definite period.
- ✓ I intend to be faithful to my commitment. If I am unable to report for duty, I will notify my supervisor.
- ✓ I will conduct myself with dignity, courtesy and consideration.
- ✓ I will consider confidential all information that I may learn directly or indirectly about a client, co-worker, or any member of the staff.

- ✓ I will not seek information regarding a client unless it is essential to my assignment.
- ✓ I will take any problems, criticism, or suggestions directly to my Supervisor or the Volunteer Coordinator.
- ✓ I promise to take my work attitude of open-mindedness, to be willing to be trained and to accept supervision.
- ✓ I am willing to allow extra time with other volunteers and to keep simple records, as required.
- ✓ My attitude toward volunteer work will be professional.
- ✓ I know that I have a commitment to my work, to those who direct it, to my colleagues, to the clients and the public.

*A signed copy of the Volunteer Code of Ethics is kept in volunteer personnel file.

HEBOP VOLUNTEER BILL OF RIGHTS

The right to be treated as a co-worker, not just free help.

- ✓ The right to a suitable assignment with consideration for personal preference, temperament, experience, education, employment background and available time.
- ✓ The right to know as much as possible about the agency or service, its policies, people and programs.
- ✓ The right to preparation for the job and access to orientation that is thoughtfully planned and effectively presented.
- ✓ The right to continuing training on the job, including a follow -up to initial orientation, information about new developments and training for greater responsibility.
- ✓ The right to sound guidance and direction by someone who is experienced, patient, well informed and thoughtful and who has time to invest in giving guidance.
- ✓ The right to be heard, to have a part in planning, to feel free to make suggestions and to have respect shown for an honest opinion.

PATIENT AND FAMILY SUPPORT VOLUNTEERS

Criteria

- ✓ Mature persons with time, patience, energy, warmth and a willingness to make a commitment.
- ✓ Be in good physical and mental health.
- ✓ Provide own transportation. Volunteers can deduct the cost of transportation (at a standard rate per mile) from their tax returns.
- ✓ An assessment of a volunteer's time availability will be made periodically to ensure a successful volunteer experience. Volunteers can become inactive, if required and due to family or health reasons and so forth for a specific period. On a yearly basis, each volunteer will be asked to complete a volunteer survey to evaluate the Volunteer Services department, and to give the volunteer a chance to give feedback, suggestions and criticisms.

Screening and Selection

- ✓ The volunteer will fill out an application and conduct an interview with the Volunteer Coordinator. The interview will help the Volunteer Coordinator identify skills, interests and experiences to determine the best type of placement. The interview will also give the volunteer a chance to ask questions or express any concerns about the organization or volunteer opportunities.
- ✓ The volunteer will complete the orientation training program.

Scheduling and Coordination

- ✓ The Volunteer Coordinator will match the volunteer with the patient/family, based on a team referral (through Palcare) or the assessment of needs.
- ✓ The Volunteer Coordinator (or designee) will explain each new assignment and give background information about the patient/family to the volunteer. The volunteer may decide whether to make the initial visit to the patient/family alone or with a nurse/hospice member.
- ✓ A volunteer will always be informed about patient's transfers or death as soon as possible.
- ✓ The volunteer is responsible for keeping track of volunteer time and services that are provided.

BEREAVEMENT VOLUNTEERS

Hospice EBOP team helps people cope with the death of a loved one. The Volunteer Bereavement Team fosters recovery by allowing the loved one to express his/her thoughts and feelings in a safe setting, and by providing reassurance and support in ways a person in grief can absorb and understand.

Criteria

- ✓ Mature persons with time, patience, energy, warmth and a willingness to make a commitment, and lack of own pressing personal issues (i.e. own grief).
- ✓ Be in good physical and mental health.
- ✓ Completed Police background check.
- ✓ Provide own transportation.
- ✓ Completed or undergoing current training for Bereavement volunteers.

Objectives:

- ✓ To help clients (and/or spouse-direct family members feel understood, accepted and supported throughout the bereavement.
- ✓ To help clients acknowledge their grief and provide a safe, non-judgmental opportunity for bereaved people to express their feelings.
- ✓ To assist grieving people recognise their individual support systems by helping them to realise they are not alone.
- ✓ To provide those grieving with acceptable coping strategies to use.
- ✓ To help those in grief understand that their feelings may be exaggerated during the grief process.

Screening and Selection

- ✓ The volunteer will fill out an application and conduct an interview with the Volunteer Coordinator and Social Worker or Clinical Services Leader.
- ✓ The volunteer will complete the orientation training program.

Scheduling and Coordination

- ✓ The Volunteer Coordinator will match the volunteer with the bereaved client in consultation with the Social Worker who is responsible for coordinating bereavement support
- ✓ The volunteer is responsible for keeping track of volunteer time and services that are provided.

PROFESSIONAL SERVICE VOLUNTEERS / EQUIPMENT AND PATIENT TRANSPORT VOLUNTEERS

Criteria

- ✓ Mature persons with time, patience, energy, warmth and a willingness to make a commitment. Be in good physical and mental health.
- ✓ Professional service volunteers must be registered with the relevant professional body and provide proof of this
- ✓ Equipment and patient transport volunteers must have a clean, current driver's license and a copy must be provided to HEBOP. Any infringement incurred must be reported to Volunteer Services Coordinator immediately
- ✓ Any vehicle used to transport patients must have a current warrant of fitness and registration

Screening and Selection

- ✓ The volunteer will fill out an application and conduct an interview with the Volunteer Coordinator. The interview will help the Volunteer Coordinator identify skills, interests and experiences to determine the best type of placement. The interview will also give the volunteer a chance to ask questions or express any concerns about the organization or volunteer opportunities.
- ✓ Meet all application and screening requirements, including personal references, a criminal background check and a driving record check.

Scheduling and Coordination.

- The Volunteer Coordinator and volunteer will determine a schedule that best accommodates the needs of both Hospice EBOP and the volunteer. The Volunteer Coordinator will explain any assignments and give background information necessary and if applicable.
- The Volunteer Coordinator is responsible for keeping track of volunteer time and services that are provided. Volunteer time is documented on a Patient Care Timesheet re "Professional Service Volunteer Hours"??

OTHER VOLUNTEER ROLES

- ✓ **Maintenance Team Volunteers** perform general maintenance tasks of interior and exterior of Hospice EBOP property. Assist with special projects in relation to facility upkeep.
- ✓ **Special Event Volunteers** work with Hospice PR Manager who co-leads, plans, organises hospice EBOP annual fundraising events: such as "Sunshine and a Plate" or "Remembrance Tree Week" or any Fund Drive or Hospice Fundraising initiative. Special event volunteers may also assist with special projects, such as acting as an ambassador

and manning a table at a fair; assisting with bulk mailing (newsletters); gardening and other on-off events that may occur.

EXPECTATIONS OF VOLUNTEERS WHO ACCEPT AN ASSIGNMENT

- ✓ Volunteer will follow through and make patient contact in manner agreed upon.
- ✓ Volunteer will treat all patient/family information as confidential, including the name of the patient.
- ✓ Volunteer will keep Volunteer Coordinator informed about any significant patient changes.
- ✓ Volunteer will track all patient contact.
- ✓ Record all volunteer hours (including travel time, phone calls, etc.) on the **Volunteer Visits Progress Notes form**, and return this to Volunteer Coordinator.
- ✓ Return all forms immediately upon the death of the patient.

BEING WITH THE PATIENT/FAMILY AS A VOLUNTEER

The most important role for you as a volunteer is to assist the patient and/or family in providing the best quality of life during their time with us. Here are some guidelines that may help:

- ✓ **Genuineness:** Be Yourself. Aside from modifications in behaviour to assure the comfort of the patient, e.g., quietness, less talking and more listening, conscious attentiveness, you need to relate with the same "personality" you display in any other situation. People who are ill appreciate being treated naturally, and in this way, are reassured that their illness has not set them apart any more than in the obvious ways. Relate to the patient, **not the illness**.
- ✓ This holds true for family members as well. The volunteer role is that of friend and supporter, **not** expert, authority, or therapist. You are not expected to know all the answers. It does not take long for the family and patient to know that the medical and technical questions are best answered by the nurse and physician. You are there to facilitate this communication, not to offer medical advice or theories. This role definition comes about most easily when you feel comfortable being yourself.
- ✓ **Communication with the Family:** It is your responsibility to state clearly to the family what you can and cannot offer in terms of time and availability. This will prevent awkward and possibly painful misunderstandings at another time. It may be helpful to ask the family their needs and expectations at the beginning (with the understanding that they may change as the patient's condition changes); and to indicate how you can help fill these needs.
- ✓ **Dependability:** To people in crisis whose lives are subject to so much unpredictability, it is essential to know that they can count on someone or something. **Never offer more than you know you can deliver.** The life of a seriously ill person has little variety and few distractions. Each outside contact assumes larger than usual proportions and importance. What may be a minor part of your week may be the single event that the patient has been

eagerly awaiting. It may also be an opportunity for the primary caregiver to have some private time away from the responsibilities of patient care.

- ✓ **Listening:** Always remember that your function as a volunteer is to first meet the needs of your patient/family, rather than your own. In most instances this means listening more than talking. It may mean listening to the same stories repeatedly. It may mean listening non-judgmentally to outbursts of anger, frustration, and resentment. You may even be the target for some of these negative feelings. Don't take it personally.
- ✓ **Confidentiality:** References to the patient/family by name should be confined to contacts with the hospice team. Information of extreme confidentiality divulged by a patient or family member should not be shared unless it bears directly on the patient's care plan. Such information may be shared with the individual team members if needed for your peace of mind. At no time, should a volunteer promise "not to tell anyone" any piece of information alluded to by a patient or family member. It is for the protection of both the patient/family and the volunteer that you can use your discretion as to whether information needs to be passed along to an appropriate team member.
- ✓ **Physical Contact:** Some people like to touch and be touched. Others don't. It is helpful if you can be flexible with this issue so that you can cue in to the needs of those you are serving. In most instances, patients welcome hand holding and other appropriate physical gestures as a means of communicating, caring, and connection without necessity for conversation. Family members often respond to a hand on the arm or across the shoulders as a gesture of "I'm here. I care." It goes without saying that the dimension of the relationship evolves naturally. Be open. Do what feels right. Again, your comfort or discomfort will communicate itself clearly, so it is important to be yourself.
- ✓ **Meet Them Where They Are":** The concept of tuning in to the family and meeting them in terms of their own values and life patterns are stressed. Regardless of how much you may disagree with a family's way of dealing with their situation, it is never appropriate to give unsolicited advice. Patterns of interaction between family members, no matter how counterproductive they may seem to you, have been formed over years of association and are rooted in a history of which you are not a part. Your responsibility is to work as helpfully and harmoniously as possible within the given structure and try not to change it.
- ✓ **Remember**
The first patient visit can bring both excitement and anxiety. "Will they like me?" "Will I be able to help?" "I'm excited to have my own patient." "What will I do?" These thoughts/feelings are natural. Remember at these times that you were chosen by your Volunteer Coordinator to serve as a hospice team member. People experienced in the field have confidence in you. Just "plunge in," taking with you an attitude of openness and receptivity to the needs of the patient/ family to whom you have been assigned. They will let you know what they need. You will let them know what you can offer. The relationship unfolds step by step in a very natural way.

"Little Things Mean a Lot"

- ✓ Your personal grooming and manner of dress can affect a patient's mood.
- ✓ Colour and attractiveness can help the spirit.

- ✓ Perfume or after-shave can be unpleasant to people on medication.
- ✓ A positive attitude and pleasant expression mean a lot. This does not mean phony cheerfulness or overly chattiness, but a clear message of caring and attention.
- ✓ Cards and flowers brighten a room and remind the patient that people care even when they cannot be present.
- ✓ Sometimes not talking, but sitting with a patient and letting him/her know you care by being there is the greatest gift of all.

VISITING WITH HOSPICE PATIENTS

One on one visitation provides the volunteer and the patient a wonderful opportunity to share with one another and establish friendships. Patients have a wealth of experience to share with someone who is willing to take time to listen. The volunteer can bring some of the outside world inside to share what is going on beyond the walls of the patient's residence, for those who cannot go out to experience it themselves.

- ✓ **Recognise** that there is nothing wrong with silence and that much support is given by just being in the room. You can maintain a presence while being silent.
- ✓ **Remember** to save something of yourself. Do not become involved beyond your capabilities--physical or emotional. Maintain your lifestyle with favourite activities and recreational outlets.
- ✓ **We do not need** to feel we have all the answers or solutions to all problems. It is an honest answer to say, "I don't know. I'll try to find out."
- ✓ **Do not judge** people or their reactions. Listen to and, when able, act upon needs that they express.
- ✓ **If family members** and friends wish to talk to you, allow them to do so; you may obtain much helpful information about the patient and family dynamics. Be aware that the family may share information with you that Friends should know. Remember all information is confidential and our team is available to respond to this information. If you have doubts about sharing information, check with the Volunteer Coordinator.

COMMUNICATION GUIDELINES

Tips for Effective Communication

- ✓ Call the patient by their formal name, (Mr., Mrs., Miss, etc.) until it is determined how they wish to be addressed. Some people are offended using first names. Addressing patients properly also shows respect.
- ✓ Always knock before entering a patient's residence, including at facilities. Assume that privacy is needed if a bed curtain is drawn in a nursing room.
- ✓ A patient may not be able to see to read, and may appreciate someone reading to them.
- ✓ A patient may wish to leave the area to which they are confined and have a walk or ride in the wheelchair through their home or facility (weather permitting). This may be rewarding to both the resident and the volunteer.

- ✓ A patient may enjoy playing games, doing a puzzle, making a craft or engaging in some other type of activity. The volunteer could spend some time helping the resident with these activities.
- ✓ A resident may appreciate having someone attend a chapel service or other activity with them and the volunteer may want to arrange visits at a time when this could be done.
- ✓ A patient may wish to have help with writing a letter or sending a card.
- ✓ Be a good listener. Having someone to share with may provide an outlet for frustrations and concerns. Understand the patient's problem and deal with it in a compassionate, understanding manner.
- ✓ A negative or hostile attitude should not be taken personally. Look beyond the behaviour to see the patient or family member as a person with special needs, problems and difficulties and let them know that you are willing to help them as a friend.
- ✓ Try to emphasize not sympathize—walk in the other person's shoes. Try to understand what they are experiencing · Recognise the strong and weak characteristics, limitations and abilities. As much as possible, build upon the positive.

Communication with a Confused Person

- ✓ Make sure you have the patient's attention by making eye contact or gently touching the person you are visiting.
- ✓ Identify yourself and state what you are going to do before doing it. Wear your volunteer ID badge while on assignment.
- ✓ Talk about an object or subject that may stimulate response. Call attention to an article of clothing, the weather or something in the room to get their attention.
- ✓ Try to find a time of the day for visitation when the person is rested and receptive to a visit. Try to visit at the same time of the day and establish a routine. The nurse in charge/clinical team can help by suggesting a good time for a visit.
- ✓ Visits need not be long. Sometimes shorter, more frequent visits are better than long, less frequent ones.
- ✓ Be sensitive to feelings. Facts sometimes are confused but feelings are genuine.
- ✓ Use the persons' name frequently.
- ✓ For those who seem to be living in the past, i.e., referring to a spouse that is no longer alive or feeling a need to care for children who are, in fact grown, Validation Therapy is a good method to use. This method of communication deals with a confused person where they are in their mind's eye. Ask the individual to tell you about their spouse, where he or she worked, or what they like to do.

Examples:

- ✓ Do you have children?
- ✓ What foods do you like to eat and prepare?
- ✓ Do you have brothers or sisters? Ask their names.
- ✓ Talk about games they played as a child or with their children.
- ✓ Talk about where they went to school.
- ✓ Ask about what kind of work they did?

- ✓ Encouraging the confused person to touch objects that have different textures can also be helpful.

Communication with a Hearing-Impaired Person

Make sure the hearing-impaired person knows you are in the room before speaking. Face the “hard of hearing” person directly when speaking to them and, if possible, sit at the same level.

Examples:

- ✓ Speak in a clear, slightly raised voice, but don't shout.
- ✓ Enunciate clearly and speak slowly and distinctly.
- ✓ Do not cover your mouth when talking. The “hard of hearing” person may try to read your lips.
- ✓ Be sure you have the hearing-impaired person's attention before speaking. · Try not to lower your voice at the end of a sentence.
- ✓ Do not eat or chew gum while talking to the “hard of hearing” person.
- ✓ If a person has a hearing aid and is not wearing or it appears that it is not working, ask if you may assist them by getting someone to put the aids into their ear or check the batteries.
- ✓ Sometimes writing a message can help when communicating with the hearing-impaired individual.

Communication with a Visually Impaired Person

Approach with a casual greeting. Identify yourself and tell the person why you are there. The visually impaired person usually appreciates having things described to them - colours, things in their surroundings, the weather, etc. Encourage the visually impaired person to feel items and discuss textures. Always let the person know when you are leaving the room. Encourage independence but offer help as necessary. Here are some things a visually impaired person might appreciate:

Examples:

- ✓ Reading mail (with permission)
- ✓ Reading the newspaper
- ✓ Reading the Bible
- ✓ Reading devotionals
- ✓ Reading short stories
- ✓ Reading church bulletins
- ✓ Writing cards and letters
- ✓ Combing their hair
- ✓ Assistance with meals
- ✓ Anything else that they may request

Guidelines for Patient Care Volunteers during Home Visits

- ✓ You may phone and speak to a nurse the day before the visit if you have any concerns or are wanting an update on a patient's condition so you are prepared for any changes you may need to be aware of when you visit.
- ✓ Phone before visit to confirm.
- ✓ Ensure the carer gives you his / her contact details before they leave the client in your care.

Before the primary carer leaves the client in your care, you need to ascertain the following:

MEDICATION REQUIREMENTS

Is the client likely to require any medications whilst the primary carer is out?

If yes:

- ✓ Is the client independent with medication administration – able to access the medications independently, able to dispense the medications independently, able to take the medications independently?
- ✓ If not completely independent, the carer must dispense the medications that may be required into a container and put these within reach of the client. The volunteer may hand the medications to the client and assist by holding the container whilst the client is taking the medications, provide a glass of water etc.

Volunteers may not dispense medications for the client or give any advice on medications, even if you feel you have the background / knowledge to do this.

MOBILITY

If the client is not independently mobile, ascertain their level of ability from the client / carer. Volunteers may assist the client to transfer from bed/ chair to wheelchair or commode or into and out of a car if the client is able to weight bear. **Refer to the Assisting Patients Guidelines.**

Volunteers are not able to assist with lifting or using a hoist.

EATING AND DRINKING

Will the client need a drink or snack whilst the carer is out?

Check:

- ✓ Is the client independently able to obtain these for him/her self?
- ✓ If not, what should you make or give to the client to eat / drink?
- ✓ Does the client need assistance with eating or drinking, e.g. needs to be fed?

- ✓ Is the client able to swallow without difficulty?

USING THE TOILET

- ✓ Is the client independent when going to the toilet?
- ✓ What kind of assistance may be required?
- ✓ If applicable, where are incontinence products kept?
- ✓ If the client has an indwelling catheter, does the bag need to be emptied by the carer before leaving the house?

It is not expected that volunteers' empty catheter bags or do any personal cares.

END OF LIFE

If your client is nearing the end of his / her life and the client / family / carer would like you to continue to provide respite and you are comfortable doing so, ensure the family / carer knows that they may be requested to return home at short notice and undertakes to be available to do so, should you have any concerns.

Rendering personal cares such as mouth care is not an expectation of volunteers and administration of medications is absolutely prohibited.

DISCLOSURE OF INFORMATION

It is expected that you will develop a connection with your client. You will draw on your life experience and discuss any topics that you are **both** comfortable with. Volunteers are not expected to 'hold secrets' or manage challenging behaviours. If information comes to light that causes concern (e.g. abuse or neglect of client / family member) this must be disclosed to a member of the clinical team.

Information provided to volunteers by clients / carers must be disclosed to a member of the Clinical team if "the disclosure is necessary to prevent or lessen a serious and imminent threat to public and safety, whether the individual's or the public's." (Rule 11(2) Health Information Privacy Act)

If you find yourself uncomfortable or feeling at a loss, please contact the Volunteer Coordinator, Clinical Services Manager or Social Worker/Counsellor to discuss.

REPORTING BACK

Within a week of your visit, please complete a Volunteer Patient Contact Form and send it to the Volunteer Coordinator. Use this note to capture what you did with the patient during your visit, what behaviours you observed in the patient and what condition the patient was in. Changes are especially important to note.

*See addendum for Volunteer Patient Contact Form

THE VOLUNTEER AS A TEAM MEMBER

Team Meetings

Members of our Interdisciplinary Team (IDT) meet to discuss each patient/family case. Your input is an important part of the plan of care which is why it's imperative to submit your Patient Support Volunteer Contact Form and phone the Volunteer Coordinator, Clinical Services Leader or a member of the nursing team should you have specific or urgent concerns. The Patient Support Volunteer Contact Form is part of clinical records and is uploaded into each patient file accordingly.

Frustrations

Becoming involved as a Patient and Family Support Volunteer may present unexpected frustrations for some people. The team approach is delicately balanced and is driven by the needs of the patient and/or family. In most cases, the Clinical Service Leader assumes the primary support role for the hospice clinical team. The patient and/or family may not see a need for a volunteer, or may have difficulty sharing time/space with a stranger who is not a "professional". In other cases, the patient might need a friend more than professional nursing. Bear in mind that families may more often readily accept the presence of medical staff over volunteers. Volunteers have been frustrated by this and have wondered how to negotiate this. From those who have experienced this problem, the advice is: "tread lightly and hang in there." As always, your Volunteer Coordinator should be consulted if you have questions or concerns.

Personal Reactions

The relationship a volunteer has with a patient/family is sometimes a deeply personal one. Sometimes the volunteer is involved in helping support family members immediately following the patient's death. You may feel grief reactions as would be expected in the death of a friend or any other important person in your life. Sometimes these reactions are immediate and easily identified. Others may be delayed, perhaps making it more difficult to identify the source. It is important to understand that these reactions are normal and to realize that Friends staff stands ready to support you through the grieving process.

SUPPORT FOR THE VOLUNTEER

The team approach offers several avenues for us to talk through experiences. The Volunteer Coordinator and/or the Clinical Team Leader /Counsellor are always available to talk with you about your concerns and feelings. You are encouraged to "buddy up" with one or more fellow volunteers, so that you might have another person to talk with about your feelings and experiences. Some volunteers will have experienced the death of someone close to them however many volunteers have not been as close to or this involved with death before. For some volunteers, working with hospice brings up prior grief. If you find this happening or are confused about your feelings, please talk to our Counsellor or bring it to the attention of the Volunteer Coordinator.

Patient Care Volunteers are required to attend debrief or feedback meetings held after each Volunteer monthly meeting.

The following information is available to patients and their families. This is available on the HEBOP website and in hard copy. Patient care volunteers are expected to familiarize themselves with this information to be able to provide support. Please read through this information and contact the Clinical Team Leader if you need any additional information or have concerns that you would like to discuss.

PATIENT INFORMATION – FINAL DAYS OF LIFE

What happens in the final days of life?

Knowing that you or a loved one is close to dying can be very difficult for everyone involved. People often ask questions about how someone will die, especially relatives and friends. They often worry that they will not be able to cope or know what to do when the person they are caring for dies. It is very difficult to give exact details of how someone will die. Each person is different and will die in their own unique way. But we can give you some general information about what may happen and what you can do to support your loved one through their process of dying.

Physical changes

The body begins its natural process of slowing down all its functions. How long this takes varies from person to person - it may take hours or days. It can be emotionally very difficult to watch someone go through these physical changes but they are part of a natural dying process and don't mean that the person is uncomfortable or in distress.

When death is very near, the dying person may experience:

✓ Sleepiness and difficulty waking (semi-conscious)

People who are dying often sleep a lot and may not respond when you try to wake them. But this doesn't mean they can't hear you so it is important not to stop talking to them or comforting them. You can sit close to them and hold their hand. It is important not to say anything that you wouldn't want them to hear. It's also a good idea to tell them when you enter or leave the room.

✓ Difficulty swallowing or not wanting to eat or drink at all

Having difficulty swallowing may be one of the first signs that somebody's condition is beginning to deteriorate. Your Hospice nurse or GP will check to ensure that this is not because of anything that could be treated, such as oral thrush. It is common for people to lose interest in eating and drinking and very often all they may tolerate is a few teaspoons of food such as yoghurt or ice cream. There will come a time when the dying person will not want to eat or drink anything. It is important not to try and force them to eat or drink as this will make them uncomfortable and may cause coughing/spluttering or gagging. If they are still awake you can give them crushed ice to suck or sips of fluid to keep their mouth moist. You can put lip balm on their lips to help stop them getting dry and sore. If they really can't take anything into their mouth, you can moisten their lips, the inside of their mouth and their tongue with swabs dipped into water or another drink that they enjoy. Ask your Hospice nurse for some mouth swabs.

✓ **Loss of bladder and bowel control**

The dying person may lose control of their bladder and bowel. This happens because the muscles in these areas relax and don't work as they did. This can be very distressing to see and you will worry that they may feel embarrassed or lose their dignity. A urinary catheter may be an option for some people. As people become very close to death and are not eating or drinking, the amount of urine and stools they produce gets less and less. Occasionally when somebody passes away, their bladder or bowel may empty. The Hospice nurse can give you some draw sheets, nappies or pads.

✓ **Restlessness**

You may notice increased restlessness, pulling at bedclothes and trying to get out of bed when they are too weak to stand. There are many reasons why restlessness occurs, such as a full bladder or bowel, confusion and disorientation, pain, spiritual distress and emotions such as anger, guilt or fear. Let your Hospice nurse or GP know if restlessness is a problem and they can check to see if this is because of pain or other physical symptoms which can be relieved. Having loved ones near to comfort and support will bring reassurance.

✓ **Confusion**

Your loved one may seem muddled and confused or say things that make no sense. They may appear to not know who you are or may act in a way that is out of character, which could be hurtful and upsetting to you. You can help by saying who you are, talking calmly and clearly and holding their hand or touching them gently if they find this comforting. Being in familiar surroundings and maintaining their usual spiritual and cultural practices such as karakia (prayer) and waiata (song) may help.

✓ **Changes in breathing pattern**

When someone is dying their breathing often changes and often there may be short or long gaps between breaths. If their breathing is laboured or breathlessness has been a problem, a small dose of Morphine may ease this, even if they are not in pain.

✓ **Noisy breathing**

You may hear gurgling or rattling sounds as the dying person takes each breath. This is due to a build-up of saliva that they are unable to swallow or cough up. Sometimes secretions may pool in their mouth and leak out. Changing their position in bed or raising their head and turning it to the side may help to drain the secretions. You may find it distressing to hear this but it is not usually distressing for the person dying. Medication may also be prescribed but may not prevent this altogether. Some people wonder about using a suction machine. Suctioning can cause distress and discomfort and may increase the production of secretions so this is not usually an option.

✓ **Cold feet, hands, arms and legs**

The dying person's face, hands, arms, feet and legs often become very cool to touch. Their skin may also become pale and look blotchy or mottled. This happens because there is less blood circulation to these parts of the body. Keep them warm with blankets but don't use an electric

blanket as this may become uncomfortable. Thick socks can help to keep their feet warm. Don't overheat the room as this can make it stuffy. Just keep it at a comfortable temperature.

✓ **Complete loss of consciousness**

At the end of life the dying person slips into unconsciousness. This is usually right towards the end, maybe only a few hours or days before death. You won't be able to wake them at all. Their breathing will stay irregular for some time and will at some point stop.

How will you know when your loved one has died?

- ✓ Their breathing has stopped
- ✓ They do not respond to talking or touch
- ✓ Their eyes may be fixed on a certain spot or their pupils may appear dilated (large); their eyelids may be open
- ✓ Their mouth may stay open
- ✓ Their bladder and/or bowel may be empty
- ✓ They will not have a pulse or heartbeat

What do you do when your loved one has died?

- ✓ You don't have to do anything straight away - take your time to collect your thoughts.

You may want to:

- ✓ Have family or friends with you for support and to say goodbye to your loved one
- ✓ Contact the Hospice nurse to let her know and ask any questions you may have
- ✓ Reposition your loved one onto their back with their head on a flat pillow
- ✓ Contact your cultural and/or spiritual support person at this time
- ✓ When you are ready you can contact the funeral home you have chosen and they will guide you with what you need to do. They will contact the GP to confirm the death.
- ✓ If you wish to undertake funeral arrangements yourself, seek guidance from the *Before Burial or Cremation* information brochure from the Department of Internal Affairs.

PATIENT SAFETY

Incident Reporting

An incident is defined as any occurrence or event that creates or could create the risk of injury, liability, or both. **Examples of occurrences include:**

- ✓ Staff/volunteer endangerment or injury
- ✓ Damage to patient property
- ✓ Patient or family/caregiver injury
- ✓ Motor vehicle accidents while on company business
- ✓ Equipment or mechanical device failure or user error
- ✓ Unusual occurrences
- ✓ Falls

In the event of a patient occurrence:

Volunteer shall notify the Clinical Team Leader or designee that there has been an occurrence

Volunteer will be asked to complete the *Incident Report Form* within one working day of the occurrence and must submit it to the Clinical Team leader for review.

Documents the nature of the occurrence in the patient's clinical record.

Infection Control

If you are sick, please call in to the Volunteer Coordinator and wherever you are expected to work to report your illness and cancel your volunteering until you are well.

HOSPICE SHOP VOLUNTEERS

Role of the Hospice Shop Volunteer

The Hospice Shops exist to provide an ongoing revenue stream in support of Hospice EBOP. All who come to the Hospice Shops are welcomed with dignity and respect. Hospice Shop Volunteers assist the manager and assistant manager in raising funds that provide hospice services to the indigent, and fund bereavement and caregiver support to the community.

Hospice Shop assignments - Volunteers may contribute by sorting and displaying incoming donations; providing customer service; and running the cash register.

Expectations of Hospice Shop Volunteers

Volunteers assist the manager and assistant manager with the profitable operation of the Hospice EBOP Shops.

Criteria

- ✓ Mature persons with time, patience, energy, warmth and a willingness to make a commitment.
- ✓ Be in good physical and mental health.
- ✓ Provide own transportation
- ✓ Meet all application and screening requirements, including personal references, a criminal background check and a driving record check.
- ✓ An assessment of a volunteer's time availability will be made periodically to ensure a successful volunteer experience. Volunteers can become inactive for a specific period. On a yearly basis, each volunteer will be asked to complete a volunteer survey to evaluate the Volunteer Services department, and to give the volunteer a chance to give feedback, suggestions and criticisms.

Screening and Selection

- ✓ The volunteer will fill out an application and conduct an interview with the Volunteer Coordinator or Shop General Manager. The interview will help identify skills, interests and experiences to determine the best type of placement. The interview will also give the volunteer a chance to ask questions or express any concerns about the organization or volunteer opportunities.
- ✓ Volunteers should have excellent communication skills and the ability to interact professionally with the public and other Store Volunteers, including Hospice staff and Board.

Scheduling and Coordination

- ✓ The Store General Manager will share the volunteer's information with the Volunteer Coordinator. The Stores General Manager will contact the volunteer to determine a scheduled start-date.
- ✓ Hospice will orientate the volunteer to Hospice EBOP operations, policies and procedures.
- ✓ The volunteer is responsible for keeping track of volunteer time and services that are provided.

ADDENDUM – POLICIES, PROCEDURES AND FORMS

HOSPICE EASTERN BAY OF PLENTY SHOP POLICIES

Introduction

The Volunteer Handbook is designed to enable management and volunteers to function effectively and consistently in fulfilling their responsibilities to ensure success of The EBOP Hospice's mission.

Mission Statement

The EBOP Shops exist to provide an ongoing revenue stream in support of Hospice EBOP. All who come to our stores are welcomed with dignity and respect. We hope they leave as friends to shop with us again.

Everyone, including our customers, are treated equally without regard to race, colour, creed, age, sex, or national origin.

The Stores General Manager, and Store Coordinator, oversee operational issues, schedules and coordinates store volunteers for the stores, and are a focal point for daily activities.

The Stores Supervisors, and the Coordinator, assist the Stores General Manager in the overall profitable operation of the Stores.

The **Driver**, coordinates the pick-up schedule, picks up the scheduled pick-ups in a timely fashion, unloads the items picked up, and helps with miscellaneous projects around the store.

Store Volunteers – Store Volunteers are sought via any means possible, the only prerequisite being a commitment to and compliance with Hospice EBOP Policies and Volunteers Manual and Employment agreement. Carrying out all duties as requested by Manager including maintaining a clean and tidy shop.

Scheduling –The general manager keeps a schedule of when volunteers work. If a volunteer is to be absent on a day they are normally scheduled, they are to give the Manager reasonable notice. This will allow ample time to find a replacement for that shift. Call the Store Supervisor or General Manager as soon as possible if you are unable to work your shift. Please do not assume there will be someone to take your place, as others may have had to cancel as well.

It must be understood that any volunteers may be asked to resign, without prejudice, at the discretion of the General Manager.

Store Policies

Store policies are established by the Store Manager with the assistance of the Volunteer Coordinator and Chief Executive Officer. Policies are not options. If there is a disagreement as to policy, it should be brought up with the General Manager. Policies can be changed, but we cannot effectively run our stores if policies are open to individual interpretation. As and if, policy is made/changed, it will be communicated to all.

Ticketing and Pricing

Store prices are always posted in the store. All clothing prices are fixed except for designer clothing which is priced individually. Furniture, household items and books are individually priced whereas CDs are sold at a fixed price. Since these stores stock an enormous variety of items, you are encouraged to seek the advice of the General Manager or Supervisor/Coordinator if you have any uncertainty when pricing an item. Items that are thought to hold value will be researched to see what it sells for online so that we can accurately price it. The stores want to offer all goods at a fair price whilst gaining maximum value for our merchandise.

No prices are to be changed at the register. Any price changes need to be approved by the General Manager or the supervisor in charge. Items that need a price will be taken to the sorting area, where an independent price can be made on the item. Unmarked items are not to be priced in front of a customer.

Specials/Sales: Any sales or specials are determined by the General Manager.

Discounts: A storewide discount applies to all volunteer purchases at the EBOP Hospice. No other discounts or special pricing should be given to customers other than specials/sales. Volunteers are not to discuss their discount in front of customers. There are no additional discounts to volunteers on sales such as: Bag Sale, 25%-50% off furniture, and 50% off entire store.

Merchandise Leaving the Store: Merchandise should leave the store ONLY through sale. The Store Manager must personally approve any exception. This applies to both customers and volunteers. Since donors donate items for the benefit of Hospice EBOP, items will not be taken home on a trial basis, or have them leave the store for any reason other than purchase. All sales are final. All items are sold "as is." Customers are encouraged to test out electrical items before leaving the store. Our stores have no refund policy.

Items On Hold: Items can be held for 24hours, however after that time if the goods have not been paid for and collected the goods are returned to store stock. The stores have no lay-by policy.

Sorting Donated Items: We do not keep everything that gets donated. Not all clothing donations will be usable in the store. Look for general cleanliness, quality and in good repair clean with no rips or stains. We offer our customers the best, and we want to maintain our reputation for quality at reasonable prices.

Volunteer Checklist

There are numerous tasks that must be performed by shop volunteers, as follows:

- ✓ Check store racks making sure all clothing is on hangers and is saleable
- ✓ Put items in their place in the store
- ✓ Sort donations
- ✓ Work at the register as cashier
- ✓ Hang or place items on sales floor
- ✓ Accept donations and stack them properly
- ✓ Remove rubbish regularly throughout the day
- ✓ Help customers find what they're looking for
- ✓ Make sure all displays stay neat and orderly

Housekeeping

Maintaining an orderly store:

The Store layout should be maintained in the fashion designed by the General Manager. This requires ongoing observation of all racks and displays and in the case of clothing, removing empty hangers and replacing display clothing that has been sold. Any items left in the dressing room are to be returned to their original location.

Linens should be refolded, houseware items placed appropriately, etc. Shoe racks should be straightened as well at the tops of counter and racks. Dispose of items that have become unsaleable due to rough handling or breakage.

Shops Safety and Security

- ✓ For Staff and Volunteer safety the Hospice Stores will not be opened with fewer than one employee and one volunteer. At the Whakatane and Opotiki shops the minimum staffing requirement is a General Manager/Coordinator plus one other. Volunteers who are not able to keep their commitment should give ample notice so that other arrangements can be made so as not to impede day to day business.
- ✓ Each volunteer is required to enter their details in the emergency booklet at the store containing the name and phone number of an emergency contact in the event of an incident.
- ✓ **IMPORTANT!** If the store is "held up" and the money in the register or other goods is demanded, volunteers and staff must give the perpetrator whatever they demand. We will not put ourselves or others in danger. Immediately call 111 after to notify the police. The manager will notify the necessary people in the EBOP Hospice office.
- ✓ In the event of an emergency, evacuate the building and contact the relevant emergency service (police, ambulance, fire brigade) and the Hospice office immediately.

HOSPICE SHOP DAILY OPERATIONS

Opening the Store

All day to day operations in the stores are overseen by the Hospice Shops Manager. These may alter from time to time at her discretion.

The store should be opened promptly at the designated time. The management team should arrive early enough to place the money in the cash register and check the store. Only the main entrance should be unlocked and left unlocked. The back door should be unlocked only when a volunteer is in the sorting room.

Closing the Store

- ✓ At 4pm all pricing should stop and staff and volunteers should start end of procedures.
- ✓ Bring in all signs.
- ✓ Clear off countertop in sorting area.
- ✓ Put away clothing and items on the cart.
- ✓ Check all rooms: rehang fallen clothing, straighten items and return to proper place, pick up any fallen goods.
- ✓ Clean bathrooms.
- ✓ Vacuum all rooms.
- ✓ Take all trash to the outside bin.
- ✓ Sweep main floor and sorting area.
- ✓ Ensure all customers have exited the store.
- ✓ Lock front and back doors.
- ✓ Close off register, end of day till procedure and total eftpos.
- ✓ Ensure all outside bins are locked up.
- ✓ Turn off all lights, music, and AC.
- ✓ Check all doors are locked and windows closed.

Shop opening hours for the Whakatane Store:

Monday- Friday 9.30am – 5.00pm and Saturday 10.00am - 1.00 pm

Shop opening hours for the Opotiki Store:

Tuesday- Friday 10.00am – 4.00pm and Saturday 10.00am - 12.00 noon

HOSPICE SHOPS HOURS OF OPERATION AND EMPLOYMENT

There is to be a paid staff member in the shop each day. The volunteer roster is to ensure adequate volunteers are on hand to cover paid staff member's $\frac{1}{2}$ hour lunch break each day.

Shop hours

DAYS	TRADING HOURS	TRADING # HOURS	EMPLOYMENT HOURS	EMPLOYMENT # HOURS
Whakatane Shop				
Monday-Friday	9.30am – 5.00pm	7.5/day	9.00am – 5.30pm	8/day
Saturday	10.00am - 1.00 pm	3	9.30am – 1.30pm	4
TOTALS		40.5		48
Opotiki Shop				
Tuesday- Friday	10.00am – 4.00pm	6/day	9.45am – 4.45pm	6.5/day
Saturday	10.00am - 12.00pm	2	9.45am – 12.15pm	2.5
TOTALS		26		28.5

Staff rostered hours

Whakatane Store

Hospice Shops Manager
Monday – Friday 9.00am - 5.30pm
Total 40 hours

Part Time Day Coordinator
Friday 1.00 pm – 5.00pm
Saturday 10.00am– 1.00pm
Total 7 hours

Opotiki Store

Opotiki Store Manager
Tuesday – Friday 9.45am – 4.45pm
Saturday 9.45am – 12.15pm
Total 28.5 hours

Cover

- | | |
|--------------|---|
| Leave | To be covered by a Day Manager or Relief Supervisor (Casual). |
| Lunch breaks | Volunteer roster to ensure cover for $\frac{1}{2}$ hour lunch break (to be between 11am – 1.30pm) |

HOSPICE SHOP STAFF & VOLUNTEERS DAILY RECORD OF ATTENDANCE FORM

VOLUNTEER PATIENT SUPPORT CONTACT FORM

Patient Name _____ Date _____
 Time from _____ to _____

Visit Type:	Tick
Patient Care Home Visit	
Phone Call	
Golden Pond Visit	
Life Story Writer	
Bereavement	
Complementary Therapy	
Other (please specify)	
Patient Appeared:	Primary Caregiver / family present appeared:
(Please specify name if possible or relationship, e.g. son)	
Agitated	Agitated
Cheerful	Cheerful
Coping adequately	Coping adequately
Crying	Crying
Disoriented	Disoriented
Forgetful/Confused	Forgetful/Confused
Friendly	Friendly
Increased stress	Increased stress
Tearful	Tearful
Withdrawn	Withdrawn
Depressed mood	Depressed mood
Unresponsive	Unresponsive
Calm	Calm
Interventions:	
Offered emotional support/active listening	
Sat with patient to give rest to caregiver	
Read to/visited with patient/family	
Referred patient/family to the appropriate Hospice team member	
Drove patient to appointment/therapy/ errands	
Provided alternative services (Massage, Pet, Chaplaincy, etc)	
Life Story	
Comments:	
Volunteer Signature:	Date:
Volunteer Coordinator Initial:	Date:
Scanned and uploaded to Palcare:	

Please return this completed form to Anna Meredith at volunteerservices@hospiceebop.org.nz

CULTURAL SAFETY POLICY

Review History

Formerly incorporated within Tangata Whenua Cultural Safety Policy (change made in 2010)

Description

Hospice EBOP works in partnership with its community to develop and improve the appropriateness and responsiveness of its services through equitable access and the sensitivity of its providers towards diverse cultural traditions and values.

Responsibility

Chief Executive – delegated to all staff.

Aim

To promote a healthy environment, by identifying best practices for embracing diversity within the Hospice EBOP organisation. This aim is achieved through these objectives:

- Identify culturally competent practices that enhance outcomes for patients, families/whānau, organisation and systems.
- Identify organisational values, relationships, structures and processes required for developing and sustaining culturally competent practice.

Expected Outcome

- Culturally competent practices in the organisation, and individual competencies, management practices and policies reflect these.
- Educational requirements and strategies implemented to ensure a culturally competent workforce.
- Behaviours and practices that reflect cultural awareness and an embracing of diversity.

Definitions

Cultural Safety	Cultural Safety is an attitude which involves showing respect and sensitivity to people, taking into account their total spiritual, emotional, social and physical needs. This involved action recognises, respects and nurtures the unique cultural identity of each person to safely meet their needs, expectations and rights.
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Performance Indicators

Number of cultural training sessions held

Number of complaints related to cultural matters

Monitoring

Complaints related to cultural matters are documented and followed through to resolution.

Patient/Family Satisfaction Surveys are undertaken and analysed at regular intervals.

Community feedback as evidenced by thank you cards, anecdotal comments, etc.

Guidelines

In terms of New Zealand's population, there are many cultures to be aware of and they are not necessarily based on one's ethnicity, race, nationality or religion. Commonly recognised New Zealand cultures include (but not exclusively):

- Māori
- New Zealand/European
- Pacific Peoples (e.g. those from the islands of Polynesia, Melanesia and Micronesia)
- Asian (e.g. Chinese, Malaysian, Thai, Korean etc.)
- Indian
- European
- Other immigrant populations (e.g. Somali, Russian, etc.)
- Christian
- Jewish
- Muslim
- Arab
- Gay/Homosexual and Transgender
- Teenagers/Elderly

All of these cultures can have differing approaches to accessing, understanding and accepting health care, hence the need for health practitioners to develop cultural competence in the provision of health care.

It is also the case that patients can belong to multiple cultures simultaneously. As health practitioners, the key is to ascertain those cultural affiliations by routinely asking about a patient's ethnicity, religion, hobbies, profession, and other aspects of their life through a thorough social history. A positive patient outcome is achieved when practitioners and patient have mutual respect and understanding

Associated Documents

End of Life Care Policy

Tikanga Best Practice Guidelines

Māori Health Plan

Using an Interpreter Procedure

References

Hospice NZ Standards of Palliative Care

He Korowai Oranga / Māori Health Strategy MOH 2002

Best Health Outcomes for Māori: Practice Implications, Medical Council of NZ. (2006)

Statement on best practices when providing care to Māori patients and their Whānau, Medical Council of NZ (2006)

A guide for the staff of Hospice EBOP



*Rapua te huarahi whanui
Hei ara whakapiri i nga iwi e rua
Irunga i te whakaaro kotahi*

*Seek the broad highway
That will unite the two people
Towards the common goal*

Purpose:

The purpose of this document is to support staff and act as a reference for situations that may arise as a result of working with Māori patients and whānau in the community and in any health care setting.

It will contribute to providing services that are responsive to the needs and interests of Māori, and it is expected that if these ideas are implemented into practice that contribution will be made to Māori health.

We each have a commitment, as partners within Aotearoa, to build strong and healthy relationships between our cultures. By working hard to understand each other we will help build those relationships. Central to these guidelines is the expectation that all users of health services are treated with dignity and respect.

In the Health and Disabilities Code of Rights, Right 1 (3), states, ‘every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social and ethnic groups’.

Whānau are drawn to those who take time to communicate effectively and fully. If you are unsure of any cultural needs your patient may have, at any time, the patient and the whānau will be your greatest resource.

Tikanga Best Practice Guidelines is an overview of Māori expectations, but does not define practise for all Māori. It is helpful to remember that each person is an individual and what has been common cultural practice for Māori in the past, may or may not be the norm for Māori whānau today.

GLOSSARY:

aroha	Love / Sympathy
hapu	Section of a large tribe. Can also mean: Pregnancy, to conceive
hōhā	Not good, tired, bored
inu	Drink
iwi	A nation of people with a shared identity and genealogy/tribe
kai	Food, to eat, to drink
kanohi ki te kanohi	Face to face, in person

karakia	Blessing/incantation/prayer
koretake	Useless/no good
kōrero	Converse/talk
kura	School
mahi	Work
mana	Vested with effective authority/authority that is recognised/having influence or power
marae	Place of Māori gathering specific to a tribe. Often comprising of a carved meeting house, marae atea (sacred place in front of the meeting house), dining room and ablution.
mate	Dead/death also Sick/worn out
māuiui	Tired, weary, sickly
mimi	To urinate
mirimiri	Massage
moenga	Bed
nēhi	Nurse
noa	Free from restriction, ordinary
pōwhiri	Māori process of welcoming/to beckon
rongoā	Māori methods of healing including mirimiri, herbal remedies and always accompanied by karakia
tohu	Symptom
tākuta	Doctor
tapu	Under religious or superstitious restriction
tūroro	Person seeking or requiring assistance from a health professional – patients/clients

taonga	Treasure, valuables, property
tikanga	Custom or habits of a tribe. What is normal or usual.
tiko	Bowel Movement
tinana	Physical body
tūpāpaku	Deceased person
waiora	Health and wellbeing of a person
wairua	Spiritual element. Wairua is an integral part of tapu and noa that is inextricably linked to wellbeing.
whakamā	Abashed, state of shyness, ashamed, abasement.
whakataukī	Proverb used to deliver supporting messages or meanings.
whānau	Whānau (Family) refers to not only immediate relations (eg. those with blood or marital connection) but also includes others with whom the patient has a close association. Family may also include an appointed guardian (as defined under the Guardianship Act 1968). Can also mean – to birth or childbirth.
whare	House
wharepaku	Toilet
whenua	Placenta/afterbirth. Can also mean; land.

Engaging and Communicating:

- Māori make up a significant number of our patients so it is necessary to engage and communicate effectively.
- Kanohi ki te kanohi (face to face), is the preferred method when communicating and engaging with patients and whānau.
- Ensure that you attempt to pronounce Māori names correctly and ask when unsure.
- Whānau (extended family) is of fundamental importance to Māori, and can be crucial to the patient's wellbeing.
- The Māori patient and the whānau should be actively encouraged, supported and included in all aspects of care and decision making.
 - This could be supported by providing a copy of the care plan for the whānau.
 - Ask the tūroro (patient) and whānau if they wish to nominate a person as whānau representative.

Greeting:

- Using a welcome phrase like 'Kia Ora' or 'Welcome, Mr', will enhance a sense of welcome.
- Endeavour to use the preferred name of the person.
- Having Māori images or significant landmarks, in areas of the organisation that may be used by patients and/or whānau will give a sense of connectedness with the community.
- Having Māori magazines or Te Reo books in the waiting area will give a sense of acceptance of Māori being part of the community.

Specific Needs – Just Ask:

- It is OK to ask patients and whānau if they have any special cultural, spiritual, language or other needs that you can assist them with to ensure the care they receive is safe from their perspective.

- Document needs in the clinical notes.
- Often rongoa (Māori methods of healing) use is not disclosed, yet this could impact on the care being provided. Respect and support the importance of rongoa during care.

Bed Pans/Urinals:

- Bedpans/urinals and food will never be present at the same time.
- Excreta and food will always be kept separate. Excreta will not be placed on surfaces where food is placed.

Food:

- Food will never be passed over the head.
- If death is pending, then food will not be consumed around the patient.
- Fridges/freezers used to store food may not be appropriate to store medications in – ask whānau first.
- Tea towels are only to be used for drying dishes.
- Anything that comes into contact with the body should be kept separate from food.
- Do not sit on tables or workbenches and particularly on surfaces used for preparing food.

Going into homes:

- Remember that you are a guest in the home and you will be honoured as such.
- Take shoes off at the door.
- Be prepared to share a cup of tea with the patient, as hosting is important.
- Acknowledge others in the room (a nod and ‘Kia Ora’).

Karakia:

- Be open to the offering of karakia before, during or after a consultation, or procedure.

- Sometimes whānau may want to bless the medications before they are given.
- If a procedure is to be done or bad news is to be given, or an important discussion to be held – encourage whānau support to be present and ask if the patient would like to start with a karakia.
- Allow time for karakia and the health care professional does not have to be present.
- Do not interrupt karakia unless the physical care of the patient is compromised.
- Access to appropriate water and containers will be made available for the purpose of spiritual cleansing, if the karakia is occurring within the organisation premises.

Touching the Body:

- A simple request and explanation will be given and consent obtained from a patient before touching them anywhere on the body and especially on the head.

Tūpāpaku (Deceased Person):

- When possible, do not leave the body unattended following death. It is acknowledged that this may not always be possible.
- Be guided by the whānau on the cultural and spiritual practices for them at this time.
- Have water available for spiritual cleansing if requested, (if not in patients' home).
- Avoid removal or cutting of hair, and only in consultation with the whānau.
- Give whānau the opportunity to perform cultural and spiritual rites for 'karakia tuku i te wairua' before the tūpāpaku is removed, and in particular before a post mortem.
- Always transport the tupapaku feet first.
- A karakia should be performed in the room where the patient had died as soon as possible after the tūpāpaku is removed. From a Māori perspective the room is not spiritually cleansed until an appropriate karakia has been performed.
- Do not take into or remove flowers, food or drink from the room. It is best to give them to the whānau to take home.

Linen:

- Linen used for the head should not be used for other parts of the body, eg: pillows for head will only be used for head.

Taonga/Valuables:

- Consent will need to be obtained to remove taonga.
- Patients and whānau will have the option of removing and caring for the taonga.

Equipment:

- All equipment must be blessed by an appropriate person before being reissued to another patient.
- Sometimes whānau will bless the equipment themselves before they return it to Hospice.

The Lore of Tapu and Noa:

- **Tapu:** Physical, mental/emotional, spiritual and cultural wellbeing. Restrictions and prohibitions that protect tapu (wellbeing, dignity and sacredness) from violation.
- **Noa:** In the positive sense, it is the state of freedom of mind and spirit that comes about through being acknowledged, enhanced, restored and healed.
- Tapu and noa are key concepts that underpin many practices. For example, it is important to keep things that are tapu separate from things that are noa. In many cases, these align with good health and safety and infection control procedures that should be practiced by staff.

Ideas to Improve your Te Reo:

- Te Reo Māori is an official language of New Zealand and many Māori words are part of common New Zealand language. Learning Te Reo Māori enables you to communicate in a familiar way to Māori.
- Greet people using 'Kia Ora'.
- Post pin up notes around the Hospice building and your home with Māori words on them.

- Learn waiata/songs.
- Watch and listen to Māori language television programmes or music.
- Practice Māori words safely in your home, car or office.
- Look up and memorise new words in a Māori dictionary or at www.maoridictionary.co.nz.
- Practice Māori pronunciation, words, and common phrases using the websites www.korero.maori.nz and www.maorilanguage.net.

Te Whare Tapa Wha:

The Māori philosophy toward health is based on a holistic health and wellness model called Te whare tapa wha. Developed by Dr Mason Durie in 1982, it can be applied to any health issue, whether it involves physical or psychological well-being. Māori health is underpinned by four dimensions representing the basic beliefs of life: te taha hinengaro (psychological health), te taha wairua (spiritual health), te taha tinana (physical health) and te taha whānau (family health).



References:

Lakes DHB. Tikanga Guidelines.

Ryan, P. (1989). The revised dictionary of modern Māori. Auckland:Heinemann.
http://www2.careers.govt.nz/fileadmin/docs/career_theory_model_te_whare.pdf

FAMILY SUPPORT SERVICES POLICY

Description

Hospice Eastern Bay of Plenty (HEBOP) provides timely, appropriate, competent family support services to meet the assessed and expressed needs and desired outcomes, of patients and their family/whanau. In a palliative setting these needs are often best met by a multidisciplinary team addressing issues in a holistic manner.

This holistic approach is compatible with “Te Whare Tapa Whā” the well-recognised and endorsed health concept for Māori in which health and well-being is described in relation to four walls (cornerstones) of a strong house. (Family, Spiritual, Physical, and Emotional/Mental wellbeing) A person is considered unwell if any one of these dimensions is weak, and healthy if all four dimensions are strong/balanced.

Responsibility

Chief Executive (CE), as delegated to Clinical Services Leader (CSL) and Family Support Practitioner

Aim

To support patients and families/whanau with their spiritual, physical and emotional/mental wellbeing.

Expected Outcome

Patients and families/whanau will feel supported.

Performance Indicators

Patient & Family Satisfaction

Number of family support referrals

Number of grief & bereavement visits and phone calls

Number of family support volunteer hours

Complaints

Monitoring

Patient & Family Surveys

Family Support referral tracking and qualitative feedback

Bereavement support groups: Specific evaluation/assessment from both course participants and bereavement volunteer worker

Supervision for family support volunteers as per professional practice requirements

Guidelines

- 1 The Family Support Service provides support from entry to HEBOP service, through death and into the bereavement period.
- 2 The Family Support Service extends to include not just the patient, but also their family/whanau and carers. In this context ‘whanau’ is a more accurate description of a person’s support network.
- 3 The Family Support Service, through cooperation with other health organisations and community agencies, may provide or refer such services as counselling, social work,

chaplaincy and other support in order to help patients and families/whanau with practical concerns, family dynamics, grief and loss; to assist them to explore their feelings and attitudes about their situation and how to optimise it.

- 4 Personal, religious, cultural and ethnic values are identified and worked through in an appropriate and sensitive way.

Associated Documents

Hospice NZ *A Guide for Carers* booklet

Understanding Grief NZ Cancer Society

Emotions and Cancer NZ Cancer Society

Referral Forms (paper or electronic) for grief, bereavement and volunteer support

Bereavement Flow Chart Procedures

New Patient Information Booklet

References

Hospice NZ Standards for Palliative Care

CHILD PROTECTION POLICY

(Formerly named 'Abuse and Neglect of Children Policy')

Description

This policy provides Hospice Eastern Bay of Plenty (HEBOP) with a framework to identify and manage actual and/or suspected child abuse and neglect. HEBOP recognises the important role and responsibility staff have in the accurate detection of suspected child abuse and/or neglect, and the early recognition of children at risk of abuse, and also ensures that any services provided or actions taken in respect of child abuse, neglect, or suspected or potential child abuse and neglect situations are guided by this policy.

Responsibility

Chief Executive (CE), delegated to Clinical Services Leader (CSL) and all staff (including volunteers)

Aim

HEBOP management and staff will understand their role and responsibilities in keeping children safe from abuse and neglect.

Expected Outcome

HEBOP staff will advocate for children to keep them safe from abuse and neglect.

Definitions

Child	The word child refers to a child / tamariki (ages 0-14) and young person / rangatahi.
Young person	Individual aged 15-17. (In this policy, 'child' will also encompass young persons.)
Child protection	The activities carried out to ensure the safety of a child where there is abuse / neglect or risk of abuse / neglect.
Physical Abuse	Physical abuse is any act or acts that result in inflicted injury to a child or young person. It may include, but is not restricted to bruises and welts, cuts and abrasions, fractures or sprains, abdominal injuries, head injuries, injuries to internal organs, strangulation or suffocation, poisoning, burns or scalds.

Sexual Abuse	Sexual abuse is any act or acts that result in the sexual exploitation of a child or young person whether consensual or not. It may include, but is not restricted to non-contact abuse such as exhibitionism, voyeurism, suggested behaviours or comments, exposure to pornographic material; contact abuse such as touching breasts, genital/anal fondling, masturbation, oral sex, object or finger penetration of the anus or vagina, penile penetration of the anus or vagina, encouraging the child or young person to perform such acts on the perpetrator; involvement of the child or young person in activities for the purposes of pornography or prostitution.
Emotional/ Psychological Abuse	Emotional abuse is any act or omission that results in the impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person. It may include but is not restricted to rejection, isolation or oppression; deprivation of affection or cognitive stimulation; inappropriate and continued criticism, threats, humiliation, accusations, expectations of, or towards the child or young person; exposure to family violence; corruption of the child or young person through exposure to, or involvement in illegal or anti-social activities; the negative impact of the mental or emotional condition of the parent or caregiver; the negative impact of substance abuse by anyone living in the same residence as the child or young person.
Neglect	Neglect is any act or omission that results in impaired physical functioning, injury, and /or development of a child or young person. It may include but is not restricted to: <ul style="list-style-type: none"> • Physical neglect - failure to provide the necessities to sustain the life or health of the child or young person. • Neglectful supervision - failure to provide developmentally appropriate and/or legally required supervision of the child or young person leading to an increased risk of harm. • Medical neglect - failure to seek, obtain or follow through with medical care for the child or young person resulting in their impaired functioning and/or development. • Abandonment - leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning. • Refusal to assume parental responsibility - unwillingness or inability to provide appropriate care or control for a child or young person.
Non-Accidental Injury	Injury inflicted and violence directed at a child.

CYF	Child Youth and Family - Statutory government agency for the investigation of child abuse and protection.
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Performance/Clinical Indicators

% suspected abuse/neglect reported

% staff aware of their responsibilities

Monitoring/Assessment

Complaints Register

Incidents Register

Training records

Patient records

Guidelines

1 Identification of child abuse/neglect

- 1.1 Child protection concerns can arise either by disclosure or recognition of signs and symptoms in a child receiving HEBOP services.
- 1.2 Child protection concerns can also arise by disclosure or recognition of signs and symptoms in a child indirectly involved with a HEBOP client, e.g. in the household.

2 Roles and Responsibilities

2.1 Management Responsibilities

- 2.1.1 Worker safety checks: NZ Police Vetting will be undertaken upon initial employment of all staff (including volunteers) and will be repeated within 3 years of the previous one.
- 2.1.2 HEBOP management will support its staff in all areas of child protection covered in this policy.
- 2.1.3 Inform staff of this policy and give training / updates to staff, as required.

2.2 Staff Responsibilities

- 2.2.1 Be alert to signs/symptoms: Staff must be alert to the signs and symptoms of neglect or abuse and take appropriate action to protect the wellbeing and safety of children and young people, whether the child/young person is directly or indirectly a client/patient of HEBOP.
- 2.2.2 Do not work alone: Staff who identify child protection concerns should consult with:
 - 2.2.2.1 A Team Leader or senior member of staff.
 - 2.2.2.2 Child, Youth and Family (CYF)
- 2.2.3 Immediate safety issues: If there is an immediate safety issue, the staff member should phone Emergency Services on 1-1-1 and ask for the police in the first instance.
 - 2.2.3.1 If the child is in immediate danger.
 - 2.2.3.2 If a child is found at home alone or unsupervised by an appropriate adult.
 - 2.2.3.3 Homicide.
 - 2.2.3.4 Any assault on a child or young person who has sustained serious wound or injury.
- 2.2.4 If staff are made aware, and given official legal documentation, that an order is in place restricting the access of another party to a child, they must inform the CE and other relevant staff members.

2.2.5 Staff members need to be aware that if they report suspected abuse, they could be called upon to testify in court. (This in no way should hinder a staff member from mandatory reporting responsibility.)

3 Referring to Child, Youth and Family (CYF) www.cyf.govt.nz

3.1 **Mandatory reporting:** All cases of child abuse or neglect must be reported to CYF, even if the child concerned is not a patient/client of HEBOP.

3.2 **Referral methods:** (CYF is available 24 hours/day)

3.2.1 Phone: 0508 FAMILY (0508 326 459)

3.2.2 Fax : 09 914 1211

3.2.3 Email : cyfcallcentre@cyf.govt.nz

3.3 **Do not attempt to investigate:** HEBOP staff should *not* attempt to investigate the abuse / neglect or suspected abuse / neglect themselves.

4 Cultural Input / Interpreting

4.1 Appropriate cultural input and resources should be accessed when appropriate.

4.2 Official interpreting services should be offered if English is not the first language or in case of deafness.

5 Disclosure to parents / caregivers

5.1 **Decision to inform:** The CSL and CE must be involved in the decision whether to inform parents / caregivers of the referral.

5.2 **Safety:** Communication with the child's parents / caregivers that a referral to the police or CYF has been made should be managed with consideration to the safety of the child, staff, and other family members. Do not inform the parents / caregivers unless it is safe to do so. (Refer to Section 7 - Security)

5.3 **Safe environment:** If the decision is made to inform the parents / caregivers of the referral, informing should be undertaken in a safe environment for both staff and client / patient, parents / caregivers, preferably by phone call.

6 Documentation

6.1 **Incident Reporting:** A HEBOP Incident Report Form must be completed.

6.2 **Letter to child's GP:** A letter to the child's GP must be completed, informing him/her that a referral has been made to CYF, even if the child is not a HEBOP patient/client.

6.3 **Clinical notes:** Clinical staff are required to document the following in the clinical notes:

6.3.1 **Observations and assessments:**

6.3.1.1 Record facts and observations, not 'feelings', as soon as possible after the event or discussion.

6.3.1.2 Use of the Child's Body Diagram (Appendix A) is strongly encouraged to record injuries.

6.3.1.3 Detail who was present at the time.

6.3.1.4 Clearly differentiate between what was seen and heard and what was reported or suspected and by whom.

6.3.2 Discussions with Team Leaders and others.

6.3.3 Where there has been a disclosure, write verbatim what was said in quotation marks.

6.3.4 **Child Protection Alert:** Full documentation is required to alert others on this situation, with the notation of 'Child Protection Alert' recorded in the child's clinical record. Note: The absence of an alert does not mean there are no child protections concerns, and the presence of an alert does not mean the child is currently at risk.

- 7 Security:** For circumstances where the safety of the child, family or staff member is at high risk, staff are to:
 - 7.1 Consult with a senior member of staff.
 - 7.2 Follow the HEBOP Risk Management in the Community Guidelines.
- 8 Staff Support:** Staff can access support throughout this process through:
 - 8.1 Debrief with senior colleague, Team Leader, HEBOP Counsellor
 - 8.2 Employee Assistance Programme (EAP)

Associated Documents

Employee Assistance Programme

Reportable Event Form

Risk Management in the Community Guidelines

References

Child, Youth and Family – Working Together to Keep Children and Young People Safe 2011

Hospice NZ Standards for Palliative Care

Ministry of Health - Family Violence Intervention Guidelines – Child and Partner Abuse 2002

National Child Protection Alert System Memorandum of Agreement with the Ministry of Health and NZ Paediatric Society 2012

Vulnerable Children Act 2014

Acknowledgements

BOPDHB – Sample Child Protection Policy

CONSUMER RIGHTS & RESPONSIBILITIES POLICY

Review History

Description

Hospice Eastern Bay of Plenty is committed to providing the best possible service to patients and families in a manner that is not discriminatory, is respectful of their rights and culture, and safeguards their dignity.

Responsibility

Chief Executive, delegated to all staff and volunteers

Aim

To provide guidelines for patients, families, carers and the community about their rights and responsibilities when accessing services provided by Hospice.

To protect patients through the adoption of legislation under the Consumer Rights Act 1996, and Human Rights Act 1993.

Expected Outcome

Patients, families, carers and the community are advised of their rights and responsibilities when accessing the service. Staff and volunteers know and understand consumer rights and responsibilities and work within this framework.

Patient rights and responsibilities are upheld to support the highest quality care by Hospice EBOP working in partnership with consumers.

Performance / Clinical Indicators

Complaints regarding consumer rights

Patient & Family Surveys

Staff Training: Code of Rights

Monitoring

Patient & Family Satisfaction

Completion of Confidentiality Signing Off Form by all staff & volunteers

Staff Training Log

Volunteer Monthly Meeting Agenda

Guidelines

Consumers receive services in accordance with Consumer Rights Legislation as follows:

- Patients are notified in a clear/understandable manner of their rights on admission to the service as per Code of Health and Disability:
 - Informed Consent

- Privacy/Dignity
 - Complaints Procedure
 - Fair treatment
 - Appropriate standards of service
 - Respect
 - Right to Advocacy
 - Information/communication
 - Support
 - Independence
 - Regard for cultural values and beliefs
 - Consideration of religious, social and cultural needs.
- Obligations in relation to this code are understood, carried out by service providers, as part of their everyday practice and outcomes audited.
 - Service is provided only after information is given to the patient, and informed consent is received by the service provider.
 - Dignity and independence of patients is respected.
 - Care is given free from discrimination on the grounds of race, gender, beliefs, marital/family status, employment, sexual orientation or disability.
 - Potential harm is minimised by risk identification, and prompt action taken by service providers.
 - Service providers are responsible for maintenance of 'best practice' standards which are compliant with documented legislation.
 - An interdisciplinary approach ensures quality and continuity of care by Hospice EBOP.

Code of Health and Disability Service Consumer Rights Act 1996 is made known/available to consumers using the service by:

- Code displayed on hospice walls
- Legislation explained to patients
- Informational material, including the Health and Disability Code of Rights in New Patient Packets
- Advocacy support information given to patients on Compliment or Complaint Form.
Nationwide Health and Disability Advocacy Service www.hdc.org.nz/advocacy

Code is available in formats appropriate to the communication preference:

- English
- Maori
- Read to patient by service provider
- Video, large print, special needs (Braille, signage for the deaf) available on request
- Interpreters available on request

- Hospice EBOP promotes patient freedom of choice, balanced with the need for service delivery, and this will be delivered in a manner that is respectful and recognises patient individuality.
- Patient's right to complain and to access independent advocacy is respected by the service provider, and all appropriate legislation regarding this is met.
- Initial assessment leads to a Care Plan being developed which includes documentation on:
 - Individual preferences
 - Quality of life
 - Normalisation/maintenance of daily routine
 - Right of association
 - Patient/service provider safety
- Consumers are not subjected to abuse or neglect as a result of service delivery

Associated Documents

Consent to Care Form

Health Information Privacy Policy

Confidentiality Signing Off Form

Informed Consent Policy

Support and Advocacy Policy

Complaints Policy

Compliment or Complaint Form

Abuse & Neglect Policy

Cultural Safety Policy

Tikanga Best Practice Guidelines

References

Hospice NZ Standards of Palliative Care

Code of Health & Disability Services Consumers' Rights Act (1996)

Health Information Privacy Code (1994)

Treaty of Waitangi

Health Act 1993

Privacy Act 1993

Human Rights Act 1993

Mental Health Act 1992

Patient Advocacy Services www.library.smc.edu/new/research/topics/patients_rights

Kempson, Elaine Consumer Health Information Services Review Article

www.blackwell-synergy.com/doi/abs

INFORMED CONSENT POLICY

Review History

Description

The principle of informed choice underpins Hospice EBOP policy on informed consent. Informed consent is defined as the process whereby someone who has the capacity/competence to consent, having been given sufficient information, arrives at an informed decision as to whether or not to agree to a proposed therapy, procedure or plan of care. Informed consent is not the process of filling out forms, but rather the exchange of information so that the person can make an informed decision. Consent may be written or verbal. The higher the probability of risk, or the greater the magnitude of potential harm, the more care and detail in the recording of consent is required.

Aim

To effectively communicate relevant information to allow our patients to understand and provide consent for their healthcare; and thus to provide treatment appropriate to the patient's wishes.

Responsibility

Chief Executive – delegated to all clinical staff. It is the legal responsibility of the clinician performing a procedure that requires formal consent, to have ensured that such consent is obtained before proceeding.

Expected Outcomes

Staff are orientated to, and practice within the current legislation, codes and guidelines.

Consumers/patient consent obtained in line with the requirements of the Code of Health and Disability Services Consumers' Rights 1996.

Patients and families are involved in the process, their rights are protected. They receive enough information to make the decision, in a manner that they can understand, and without coercion or pressure.

All patients/consumers who are referred to Hospice EBOP receive full information on the services available and their rights and obligations. They (or their designated proxies) consent to and understand the hospice palliative model of care.

Guidelines are available to define the consent framework within which staff work.

Communication is the key in the consent process, and there will be adequate time given for patients to discuss their concerns and to ask questions.

Standard consent forms may be used to document a patient's wishes, and these are stored in the patient's file; however, it is recognised that consent may be verbal or written. The following guidelines detail documentation requirements.

Definitions

Informed Choice	A pre-condition to informed consent that involves exchange/understanding of relevant information.
Patient	The term 'consumer' is used in the Code of Health and Disability Services Consumer Rights when referring to individuals who received health services. Hospice EBOP usually refers to patient's dependant on the type of service. To obtain consistency in this document, the term 'patient' has been used.
Reasonable Patient	The reasonable patient standard requires a health practitioner to disclose those risks which would be material to the decision of a reasonable person in the patient's position as to whether or not to submit to a proposed treatment
Representative	The term 'personal representative' is defined in – The Health Act and the Mental Health Compulsory Assessment and Treatment Act 1992. 1 Where the individual is under 16, the parent/guardian 2 Where the individual is dead, the executor / administrator of the estate; Where the individual is over 16, but is unable to give consent, the person 'appearing to be lawfully acting on the individual's behalf' (could be someone nominated by the patient, family, or friend).
Student	One in the process of obtaining registration/qualification.
Advance Directive	A written tool to record a person's thinking and planning for medical care which may come into effect only if that person is unable to communicate those wishes themselves.
(Personal Care and Welfare) Enduring Power of Attorney	A legal arrangement where one person can appoint another person to act on their behalf to make decisions about their personal care and welfare. The term "Enduring" means that it continues to operate, or only comes into effect, should the person become mentally incapable.

Performance Indicators

% of new patients consented to Hospice EBOP care.

Patient & Family Satisfaction

Monitoring

Patient & Family Surveys
Health Record Audits

Guidelines and Protocols

1 PATIENT RIGHTS IN INFORMED CONSENT

This policy is informed by Medical Council of New Zealand guidelines on Information and Consent, and the Health and Disability Commissioners' Guidelines.

○ 1.1 Right to Effective Communication (Right 5)

- 1.1.1 Communication is one of the most important issues in relation to consent. Keeping communication open is the key to ensuring families and patients understand the process, the issues and the care options.
- 1.1.2 Hospice EBOP will ensure patients receive information in a manner they understand, including written information. Interpreters are available if necessary.
- 1.1.3 Privacy is assured for discussion of diagnosis/treatment and options.
- 1.1.4 Patients are advised that they have a right to have another person present during any discussion relating to treatment/procedures.
- 1.1.5 A Patient Advocate may attend at the request of a patient.

1.2 Right to be Fully Informed (Right 6): Every patient has the right to:

- 1.2.1 Receive an explanation of their condition and the options available, including expected risks, benefits and costs of each option
- 1.2.2 Receive advice of the estimated time within which the services will be provided
- 1.2.3 Receive notification of any proposed participation in teaching or research
- 1.2.4 Access to results of tests/procedures
- 1.2.5 Information on the identity and qualifications of the provider
- 1.2.6 Information on how to obtain services from another provider, e.g. Rest Home availability, Funeral Directors. Hospice will refer the patient to these other sources, or make enquiries on behalf of the patient.
- 1.2.7 An honest reply to their questions by Hospice staff, keeping in mind the level of information that the patient is looking for. This includes acknowledging information that is not known.
- 1.2.8 Request a written summary of information provided.

1.3 Right to make an Informed Choice and Give Informed Consent (Right 7)

- 1.3.1 Many procedures, and much treatment in palliative care is a matter of choice for the patient, who is the sole arbiter of what would help their quality of life. Therefore, informed consent is aimed at discussing not only what might extend life, but what effect any intervention might have on the quality of life.
- 1.3.2 Sufficient time should be allowed for the patient to read written information and discuss this and any verbal information with whomever he/she wishes.

1.4 Right to Refuse: Hospice EBOP recognises that every competent person has the right to withdraw consent or refuse services at any time, without prejudicing their future care. This is covered under the New Zealand Bill of Rights Act 1990 and Right 7 of the Code.

This is subject to any statutory negation of that right by the provisions of Acts, such as those mentioned in laws.

2 Initial Consent for Hospice Care

- 2.1 The hospice model of care is actively discussed by nursing staff with patients and family/whanau at first assessment in the community.
- 2.2 Time is allocated at the initial assessment to explain the Hospice EBOP Consent For Care Form to the patient and their family / whanau.
- 2.3 It sets out the principles of informed consent used by Hospice EBOP, and also indicates what emergency procedures the hospice does not provide.
- 2.4 The consent does not need to be signed at the initial visit, but may be left with the patient and family/whanau to read and think about.
- 2.5 Care must be taken to reduce as much as possible the patient's feelings of vulnerability and discomfort, and they are to be encouraged to ask questions and suggest alternative points of view.
- 2.6 It is the responsibility of the Nurse doing the initial assessment in the community to initiate getting the Hospice Consent for Care Form signed. This must be obtained by the third face-to-face contact with the patient.
- 2.7 The signing of the Hospice Consent for Care Form should be done by the patient themselves. If this cannot be done, it is still necessary to give an explanation of the Hospice Consent For Care Form to the Next of Kin and other available family / friends. Reasonable effort should be made to contact such a person.
- 2.8 Patients are encouraged to take the form to their General Practitioner to discuss and assist in decision making. If, after the patient has discussed the consent form with their General Practitioner, they wish to have treatments that are not provided by hospice, this should be documented in their record and an appropriate plan of care developed in consultation with patient and family/whanau.
- 2.9 One Consent for Care Form is to be signed and to be kept in the individual patient clinical record. Patient's consent to involve family/whanau in the assessment, planning, delivery and evaluation of their service and the sharing of information is obtained and documented at initial assessment.

3 Types of Informed Consent, Responsibility & Occasion

3.1 Written Consent

3.1.1 Written Consent has two main purposes:

- The protection of the patients and their rights, and to alert the patient to the fact that some procedures are more significant than others.
- The protection of the health professional and the institution as evidence that legal and ethical requirements for gaining informed consent have been carried out.

3.1.2 **Media Use:** Written informed consent should be obtained for any recording, filming, or photography of patients or of their care or treatment. How the photographs or recordings will be used and stored should be discussed with the patient and documented with the consent.

3.2 Verbal Consent

Verbal consent should be obtained from either the patient or next of kin for any services/ interventions identified as a moderate risk and documented in the patient file.

- S/C fluids and/or drugs
- IM drug administration
- Conversion from one opiate to another, or commencement of opiate therapy
- Commencement of new clinically significant medications
- Nursing procedures such as catheterisation, enemas, digital PR examinations

3.3 Who is responsible? The primary responsibility for ensuring information is imparted and consent given lies with the person who is responsible for the procedure.

In some situations it is impracticable for all information to come from the health professional conducting the procedure. In such cases, a health professional familiar with the treatment/procedure and with adequate knowledge of the risks/benefits of the treatment/procedure should impart the information.

In situations where a team is involved in management/treatment, the process of imparting information may be shared. In this case, special care must be taken in documenting information given to the patient in the process of gaining informed consent. It is strongly recommended that for all procedures requiring verbal consent, the discussion with the patient is documented in the patient record.

3.4 Conventional Treatments for Complications: There are conventional treatments used for the immediate management of acknowledged common potential complications related to a procedure for which consent has been obtained. In this case, it may not be possible to gain the patient's informed consent or that of his/her representative for the specific treatment because of the complexity or urgency of the situation. This should never be used to imply prior consent to treatment or procedures that are not routinely used in the clinical procedure for which the patient has consented, and/or are unproven in the situation, even in an emergency. See also guidelines on competence to consent.

3.5 Other Activities that Require Consent

- 3.5.1 Hospice EBOP organisational procedures and best practice also requires consent for bed delivery, and home personal cares.
- 3.5.2 As a general guide, verbal consent should be sought for things that may incur a cost to the patient (such as ambulance transfers from home to hospice)
- 3.5.3 Needlestic injuries and Accidental Blood/Body Fluid Exposure (BBFE): Consent must be obtained for the testing of the person from whom the blood/body fluids came. They are often unaware of the accidental BBFE and/or of the potential risk, so sensitivity is often required. Refer to the Blood and Body Fluid Exposure Policy.

4 Competence to Consent

- 4.1 For consent to be valid it must be voluntary, informed and competently given. Medical conditions, intellectual disability, mental illness, inebriation, physical injuries, emergency situations and unconsciousness or distress all may affect the informed consent process.
- 4.2 Notwithstanding any of this, any procedure or treatment will be explained to the patient, and questions answered as far as possible. This applies also to people who are thought to be unconscious. Any procedure will be explained to them before it is carried out, and

they are given the same respect as if they were conscious. Under the Code, every patient is presumed competent to make an informed choice and give informed consent to some degree.

- 4.3 A lack of decision making capacity should not mean that individuals miss out on necessary health care, support and other services.
- 4.4 Clinicians are required to determine competence, i.e. to form an opinion as to whether a patient has the capacity to give informed consent. If clinicians are uncertain about a particular patient, a multidisciplinary review can be called for.
- 4.5 The nature of palliative care at Hospice EBOP means that patients may lack wholly or partly the capacity to understand, or make decisions in respect of matters relating to his/her personal care and welfare. Hospice EBOP will at all times act in an ethical and professional way when caring and dealing with patients who have diminished capacity to consent.

4.6 Medications and Competence to Consent

Medication given for pain relief or psychiatric illness may affect competence to consent. Although consciousness may sometimes be impaired, there is often an improvement in concentration and thinking ability with the relief of symptoms such as pain, anxiety and depression. Conversely unrelieved pain, anxiety or depression may themselves impair competence.

- 4.6.1 When a patient's competence clearly has been impaired by medication and the procedure is not urgent, recovery should be allowed before consent to further treatment is sought.
- 4.6.2 In principle, consent should not be sought when a patient is drowsy or unable to concentrate, but in practice consent for further treatment will sometimes be necessary from patients, who have for instance received medication for pain relief.
- 4.6.3 It would be impractical to suggest that consent should never be sought from patients on any medications with the potential to affect concentration and thinking. Sound clinical judgment and common sense should always be exercised.

4.7 Emergencies

- 4.7.1 Treatment or care provided in an emergency when the capacity to consent is impaired or absent should only be that which is necessary to treat or care for the immediate problem.
- 4.7.2 In the event of an unforeseen event such as a fire, staff will take whatever action is needed to save the patient's life. This may be the need for restraint to stop disorientated patients walking back into the burning building or restraining patients who will not leave the building. The events and the action taken will be documented on the patient's clinical record.

4.8 Children

- 4.8.1 The Code of Health and Disability Services Consumer Rights applies to children as it does to adults. A child must be treated as an individual, presumed competent, and have the right to make his/her own informed choice, and give or refuse consent. There is no age of consent.
- 4.8.2 The provider must make an assessment of a particular child's competence, and this will depend on understanding and maturity, and the gravity of the procedure.
- 4.8.3 A person entitled to make an informed choice on a child's behalf (e.g. parent) can only do so if the child is not competent to do so. However, parents can assist the provider in

deciding whether a child is competent to understand the information needed to make an informed choice.

5 Staff Training On The Principles And Practice Of Informed Consent

- 5.1 Hospice EBOP is committed to ongoing education of its staff and will offer regular training on Informed Consent.
- 5.2 The principles and practice of informed consent is included as part of clinical staff orientation.
- 5.3 All staff are expected to know and practice within the Code of Rights.

6 Consent for Teaching, Observers and Research

- 6.1 Hospice EBOP acknowledges patients/whanau have a right to consent or decline involvement in teaching or taking part in research.
- 6.2 The paramount consideration must always be the welfare and interests of the patient. Patients are not to be involved in clinical teaching or research without their being fully informed and their consent freely given in writing.
- 6.3 Any research involving patients must have the permission of the Hospice GM and Bay of Plenty Ethics Committee.
- 6.4 Patients have the right to withdraw from teaching sessions or research studies at any stage, and must receive a clear assurance that refusal to participate or withdraw will not jeopardise care in any way.
- 6.5 Students, observers and researchers are responsible for ensuring that personal information acquired by them about a patient remains confidential.
- 6.6 Verbal consent is gained for the involvement of students. The patient should be informed about the extent of the involvement of the trainee and the trainee's experience.
- 6.7 The quality of patient care is the responsibility of the clinical team, and students must be supervised by their clinical team leader and supported by the staff.

7 Cardiopulmonary Resuscitation: Decisions must be made with regard to:

- 7.1 The clinical needs of the patient
- 7.2 The wishes and best interests of the patient
- 7.3 Current legal obligations including the Health and Disability Commissioner's Code of Rights
- 7.4 Avoiding the burdening of the patient/family/whanau with a resuscitation decision when cardiopulmonary (CPR) resuscitation would fail, or the circumstances cannot be anticipated.
- 7.5 **Medical Futility** (Refer to the flow chart on the following page)
 - 7.5.1 Medical futility is a recognised ethical and medico legal concept. This concept has been tested legally in many countries and applies under New Zealand law.
 - 7.5.2 Although Hospice EBOP do not have a physician it is helpful for all staff to understand and promote the concept in advocating for our patients.
 - 7.5.3 Physicians have no obligation to offer futile interventions based upon the ethical principle of beneficence, which requires a Physician to act in ways that benefit the patient. Since futile interventions lack benefit, there is no obligation to provide them.
 - 7.5.4 There is no clear definition of medical futility; however, futile treatments have generally been subdivided into two types:
 - Physiologic or quantitative futility – very low statistical probability of achieving the desired physiological response and;
 - Qualitative futility - In which treatment may have a physiological effect, but fails to benefit the patient as a whole.

Legal Implications of Consent

Consent covers a number of legal requirements, including financial, service, procedural, ethics, teaching, research and consent for the collection of health information

If there is any doubt as to whether consent should be documented, written consent should be obtained.

Signed consent forms are a *prima facie* evidence that a patient consented to the procedure or treatment described.

In any circumstances involving apparently contentious issues of informed consent, or if the patient does not consent, relevant information should be recorded in the clinical record. It is strongly recommended that for all procedures requiring verbal consent, the discussion with the patient is documented in the patient record.

Service providers have a duty to inform patients of their rights to seek a second opinion.

Advance Directives, surrogate decision makers and Enduring Power of Attorney (POA)

(Right 7 – “You may make a decision in advance, in accordance with common law.”)

8.1 Hospice EBOP will have an information leaflet available to give to patients and families who inquire about Advance Directives and Enduring Power of Attorney.

8.2 Hospice EBOP will honour any Advance Directive made by a patient under the following circumstances:

- That it is available or has been documented in the patient file
- That it is clear and easily understood
- That the circumstances identified in the directive are appropriate to the patient's actual clinical condition
- That there is no conflict of interest with the needs of the patients' family

8.3 If there has been an **Enduring Power of Attorney (POA)** appointment made, a copy of this will be placed in the clinical record.

8.4 Difficulties arise when there are no clear prior instructions from the patient, and their ability to comprehend and analyse information is compromised, as commonly happens in advanced disease. Even minor degrees of delirium can hinder a patient's ability to fully understand details related to informed consent. This makes it important to discuss a patient's intentions early on in their disease, to inform decisions that need to be made later on. This includes information regarding who has Enduring Power of Attorney, or who the patient trusts and wishes to be consulted about their care

8.5 Where a family member has not been appointed, Hospice EBOP will recognise that person who is next of kin and discuss and inform that nominated person of care options and concerns, unless there is clear evidence that would not be the patient's wish.

8.6 If at any time the decisions that the nominated family member is making is seen to be detrimental to the patient's wellbeing, the nurse will document concerns and discuss with the Palliative Care Services Coordinator.

8.7 No staff will carry out any procedure that they feel is incorrect / unethical or in any way detrimental to a patient or patients.

In cases where consent is being sought for a particular treatment or procedure, and the patient or Enduring Power of Attorney is unable to give it, discussions are held with the Next of Kin or family, which are documented. If consensus is gained, this is noted. Where there is dissention about the best course of action, taking into account all the views, and their degree of closeness to the patient, and any

previously expressed views of the patient, the General Practitioner may make a decision in the best interests of the patient.

Invoking the Protection of Personal and Property Rights Act

- 8.8 If a clinically incompetent patient lacks wholly or partly the capacity to understand the nature and to foresee the consequences of decisions in respect of matters relating to his/her personal care and welfare, or continues to decline treatment despite discussion and involvement of significant others, and is considered a danger to himself, herself or others, an application to the family court under the Protection of Personal and Property Rights Act 1988 may be invoked.
- 8.9 A welfare guardian under the above act will exercise the rights of the patient under the Code of Rights including the right to give written consent.
- 8.10 The patient's best interests and the futility versus the benefits of treatment being considered will guide all medical decisions.
- 8.11 **Overriding an individual's rights:** While consent procedures must be consistent with the Code of Rights, some legislative provisions where individual rights may be seen to be against the public good, override the individual's right to decide. These include:
 - Mental Health (Compulsory Assessment and Treatment) Act 1992
 - Tuberculosis Act 1948
 - The Health Act 1956
 - Coroner's Act 1988
 - Protection of Personal and Property Rights Act 1988
 - Criminal Justice Act 1985, Part 7
 - Intellectual Disability Compulsory Care Act

Associated Documents

Code of Health and Disability Services Consumers' Rights brochure

Consent for Care (Initial Consent) Form

Enduring Power of Attorney, Advance Directives, Making Health Care Decisions Brochure

Blood and Body Fluid Exposure Policy

Blood and Body Fluid Procedure & Consent For Testing Form

Consent To Media Form

References

Hospice NZ Standards for Palliative Care

MOH New Zealand. Health and Disability Services Standards. NZS 8134.1.1.2008

Code of Health and Disability Consumers' Rights. 1996

Protection of Personal and Property Rights Act. 1998
Mental Health Compulsory Assessment and Treatment Act. 1992
Guardianship Act. 1968
Coroners Act. 1988
Children, Young Persons and their Families Act. 1992
Medical Council of NZ Guidelines on Information and Consent
<http://www.osc.govt.nz/enduring-powers-of-attorney/index.html>

Acknowledgement

Waipuna Hospice *Informed Consent Policy*

ABUSE & NEGLECT OF OLDER PERSONS POLICY

Description

It is Hospice EBOP's policy that the safety of the older person is paramount. Any staff member who suspects abuse or neglect of an older person, or to whom abuse/neglect is disclosed, has a mandatory responsibility for managing the reporting of that abuse.

Responsibility

Chief Executive, Palliative Care Coordinator

Aim

Health and disability services should contribute to the nurturing and protection of the older person and advocate for them as part of their role to promote protect and preserve the public health.

Definitions

Abuse of the older person	Any pattern of behaviour that causes physical, psychological or financial harm to an older person. It can be intentional or unintentional. Abuse or neglect occurs in a relationship of trust. Anyone with a long-term disability is at increased risk.
Physical Abuse	Infliction of physical pain eg. Hitting, slapping, pushing, burning.
Sexual Abuse	Sexually abusive or exploitative behaviour.
Psychological Abuse	Verbal intimidation, humiliation and harassment.
Financial/Material Abuse	Illegal or improper use of an older person's money or property.
Neglect	Failure of a caregiver to provide necessary food, shelter, clothing or medical care. Neglect can be active or passive.
Institutional Abuse	Institutional abuse occurs when an institution actively or passively allows, or accepts, any form of abuse or neglect to occur. This may arise from the action or inaction of an individual as an employee, or it may be embodied in organisational systems, which fail to provide adequately for the safety and well being of the individual patient/client. The person is denied or limited in their choices, dignity or privacy.

Guidelines

TEN PRINCIPLES OF ADULT PROTECTIVE SERVICES

1. **Freedom over Safety** - the older person has a right to choose to live at risk of harm, providing he/she is capable of making that choice, harms no one and commits no crime.
2. **Self Determination** - the older person has a right to personal choices and decisions until such time that he/she delegates or the court grants the responsibility to someone else.
3. **Participation in Decision Making** - the older person has the right to receive information to make informed decisions and to participate in all decision-making affecting his/her circumstances to the extent that he/she is able.
4. **Least Restrictive Alternative**- the older person has a right to service alternatives that maximise choice and minimise lifestyle disruption.
5. **Primacy of the Adult**- Primary focus should be on the older person, their needs and rights.
6. **Confidentiality** - the older person has a right to privacy.
7. **Benefit of Doubt**- if there is evidence that the older person is making a reasoned choice, the worker has a responsibility to see that the benefit is in his/her favour.
8. **Do No Harm** - the worker must take no action that places the older person at greater risk of harm.
9. **Avoidance of Blame** - the worker has a responsibility to understand the origins of any maltreatment and do nothing, which will antagonise the perpetrator as this may reduce the ability to stop the abuse.
10. **Maintenance of Family** - the worker has a responsibility to deal with the maltreatment of a family member, if the perpetrator is a family member, and give the family the necessary services to resolve the problem.

Ref: Decalmer, P., & Glendinning, F. (1997). *Guidelines for Reporting Abuse or Neglect*

ACTIONS IN AN EMERGENCY

1. Notify and discuss with your supervisor. If the situation requires it the police should be notified. Share decision-making at this stage and consider your own safety e.g. do not work alone in an isolated area.
2. Ensure after this is done that the person is located in a safe environment. The person and/or whanau could determine this if they are not perpetrators of the abuse.
3. Refer to appropriate professionals – Duty Social Worker during work hours (Whakatane), General Practitioner, Maori Health Services, Mental Health Services, etc who will implement any further action if necessary. Share all knowledge of the older person's health & social circumstances that will assist in decision making because part of their role may be to assess if the person has the ability to make decisions.
4. Ensure during all steps of the process that the person is kept informed of action taken unless they are unable to comprehend what is happening.
5. Record your actions and put in the Patient's Record.
6. Staff members need to be aware that if they report suspected abuse, they could be called upon to testify in court.

ACTIONS IN A NON-URGENT SITUATION

1. Discuss observations, concerns and disclosures of abuse with your supervisor.
2. If more investigation is needed refer to Kaiawhina/Health Social Worker to Elder Abuse and Neglect Prevention Service/Duty Social Worker (Whakatane), Mental Health Services for Older People or the appropriate cultural support worker.
3. Ensure during all steps of the process that the person is kept informed of action taken unless they are unable to comprehend what is happening.
4. Record your actions and put in the Patient's Record.

IF THE OLDER PERSON DOES NOT WANT ACTION

1. Discuss observations, concerns and disclosures of abuse with your supervisor.
2. Let client know you are required by the organisation to report abuse and/or neglect to Elder Abuse and Neglect Prevention Service or a Kaiawhina/Health Social Worker/Te Pou Kokiri/ because of the concerns for the client's safety.
3. Record your actions and put in the Patient's Record.

GUIDELINES FOR CHIEF EXECUTIVES

1. Ensure process is followed and the staff member is supported and not put at risk.

2. Ensure the least disruptive solution is sought. This can often be achieved by referring to a Kaiawhina/Health Social Worker/Te Pou Kokiri if the client is an inpatient or to the Elder Abuse and Neglect Prevention Service if the client is in the community or in areas where this does not exist MHSOP.
3. Ensure informed consent from the older person is given prior to informing other agencies. Verbal consent is sufficient but it must be documented in your notes. Where there is a safety issue and the older person does not give informed consent to pass on their information to other agencies, contact the privacy officer prior to acting.

Associated Documents

Reportable Event Form

Staff Conduct Policy

References

Hospice NZ Standards for Palliative Care

Age Concern. (1992). *Promoting the Rights and Responsibilities of Older People and Those Who Care For Them*. New Zealand: Author. This contains:

- International Federation of Aging. *Declaration of Rights and Responsibilities of Older People*.
- United Nations General Assembly. (1991). *United Nations Principles for Older Persons*.

Decalmer, P., & Glendinning, F. (1997). *The Mistreatment of Elderly People*. Second Ed. London: Sage Publications Ltd.

Decalmer, P., & Glendinning, F. (1997). *Guidelines for Reporting Abuse or Neglect*

Domestic Violence Act 1995

Health Act 1956

Mental Health Act 1992

Privacy Act 1993

Protection of Personal and Property Rights Act 1988

Human Rights Act 1993

Children Young Persons and their Families Act 1989

Children Young Persons and their Families Amendment Act 2001

Health and Disability Commissioner Act 1994

APPENDIX I: Signs of Possible Elder Abuse

Physical Abuse

- Frequent visits to the emergency department with traumatic injuries
- Delays in medical treatment
- Missed appointments or non-compliance with treatments
- Bruising, bite marks, scratches
- Fractures (eg face)
- Black eyes or broken teeth
- Loss of hair from hair pulling
- Burns
- Does not want a bath because injuries may be seen

Physical Neglect

- Malnourishment (eg weight loss, lack of energy, sleepy)
- Dehydration (eg skin turgor, sunken eyes)
- Poor hygiene (eg dirty clothes, decayed teeth, dirty nails)
- Pressure ulcers (bed sores) at any site
- Unsafe living conditions (eg inadequate heat or air, high crime)
- Lack of clean bedding or clothing, incontinence without protection
- Faecal impaction or diarrhoea
- Broken or missing glasses, dentures or hearing aids
- Signs of over medication or under medication and not recovering from a short term illness
- Contractures caused by lack of movement of joints.

Psychological Abuse

- Paranoia or depression or fear of strangers or fear in own environment
- Ambivalence toward caregiver or quiet around caregiver
- Confusion or disorientation

Psychological Neglect

- Hunger for attention and socialisation
- Depression
- Withdrawal
- Anger or indifference
- Low self-esteem
- Abuser speaks for abused and won't leave the person alone with the interviewer
- Not included in decision making
- Anger, rage
- Social or physical isolation
- No clear explanation for injuries.

Financial Abuse

- Utilities turned off because lack of payment when another person is supposed to pay such bills
- Cheques signed or bank account accessed by another person without legal authority
- Purchase of expensive goods, supplies, or services not needed or wanted
- Pressured into endorsing cheques received in the mail
- Poor work or no work in house or garden when previously paid for
- Person takes out large amounts of money from an ATM

Financial Neglect

- Very little food in house
- Prescribed medications not available
- Stacks of mail, bills and uncashed cheques.
- Does not remember writing large cheques for repairs

If you have any concerns whatsoever, contact Clinical Services Leader or Volunteer Coordinator as soon as possible

SUPPORT & ADVOCACY POLICY

Review History

Description

Hospice Eastern Bay of Plenty informs patients/consumers of their right to advocacy and/or support during entry and provision of services, and facilitation of this occurs where this is identified or requested.

Responsibility

Chief Executive – Delegated to all clinical staff

Aim

Hospice EBOP will ensure patients and families are aware of their rights to support and advocacy information, and encourage their access to cultural support persons, community groups, and persons of special interest.

Expected Outcome

Patients/families feel supported in their:

- Involvement in care planning/review
- Request for support and advocacy

Performance Indicators

Complaints

Patient & Family Surveys

Monitoring

Staff Training Log

Complaints Log

Guidelines

- 1 Ensure patients, family/whanau are aware of their rights to support/advocacy. A copy of the brochure "having a problem with a health or disability service?" Is included in the new patient information packets.
- 2 Family/whanau involvement is sought in care planning/reviews when requested by the patient.
- 3 Access cultural support persons / community groups and people of special interest on request (includes information relating to sexual health).
- 4 Arrange for independent advocacy services to visit at the request of the patient/family/whanau.
- 5 Record contacts made with any of the above into clinical record.
- 6 Advise consumers that health & disability educational information/pamphlets are available in any language.

7 Staff receive training on support/advocacy at orientation and at regular training intervals.

Associated documents:

Complaints management policy

Complaint procedure

Compliment or complaint form

References

Hospice NZ standards for palliative care

Code of health and disability services consumers rights

Advocacy brochure “having a problem with a health or disability service?”

RISK MANAGEMENT IN THE COMMUNITY GUIDELINES

PURPOSE

To ensure safety of Hospice EBOP staff in the community and that risks are communicated to other agencies, when appropriate. Risk assessment commences upon receipt of new referrals and is done on a continual basis.

RATIONALE

- 1 All practicable steps are taken to ensure that risks/hazards are identified, communicated, isolated, minimised or eliminated where possible.
- 2 Staff safety is preserved whilst appropriate standards of patient care are supported.
- 3 Risks are communicated to downstream caregivers/other agencies involved. (Rule 11 Health Information Privacy Code 1994 '*Limits on Disclosure of Health Information*').

DEFINITIONS

Hazard: An activity, arrangement, circumstance, event, occurrence, phenomenon, process, situation, or substance (whether arising or caused within or outside a place of work) that is an actual or potential cause or source of harm; and includes:

- 1 A situation where a person's behaviour may be an actual or potential cause or source of harm to the person or another person; and
- 2 Without limitation, a situation described in subparagraph (1) resulting from physical or mental fatigue, drugs, alcohol, traumatic shock, or another temporary condition that affects a person's behaviour.

Risk: A probability or threat of damage, injury, liability, loss, or any other negative occurrence that is caused by external or internal vulnerabilities, and that may be avoided through pre-emptive action.

GUIDELINES

1 General

- 1.1 **Timeframe:** Risk assessment commences when triaging new referrals and is done on a continual basis.
- 1.2 **PalCare Risk Management Module:** A full Risk Management Assessment must be entered for every new patient even if no specific risks are identified. This is updated each time the risk status changes.
- 1.3 **Security Risks reported to leader:** All identified Security Risks are to be communicated to the Clinical Services Leader, or in her absence to the CE or Administrative Services Leader, and a decision will be made about the appropriate measures to be implemented.
- 1.4 **Care Plans:** For any identified risks, a care plan is to be raised and needs to include the actions planned and taken to isolate, minimise, eliminate, and communicate.

- 1.5 Security risks identified are to be entered under 'Special Instructions' on the Patient Details page, and updated as required.
- 1.6 Patients / families where possible security risks have been identified will not be referred for volunteer support / services
- 1.7 Equipment delivery – risk information must be included on every Equipment Request Form. Prior to each delivery of equipment by a volunteer, the risk assessment is to be reviewed.
- 1.10 **Risk Communication to Other Agencies:** An identified security risk is communicated to other service providers known to be involved, by sending the standard '*Risk Communication to Other Agencies*' letter.
- 1.11 **Patient in new location:** If a patient moves to a new location (e.g. moves in with family member), a new risk assessment is to be conducted for the new location.
- 1.12 All staff and volunteers have a right to feel safe while providing hospice care at a private residence. If at any time a hospice staff member or volunteer feels unsafe initiating or continuing a visit to a private residence they should excuse themselves (if appropriate) and leave the premises immediately. This is to immediately be brought to the attention of the Clinical Services Leader, Chief Executive or another member of the management team. The reason for suspending the visit is to be documented, the risk management module updated and good faith attempts be made to address the underlying care in the future. At no time is a staff member or volunteer expected to enter a situation in which they feel unsafe, in order to provide care. A staff member or volunteer will not be penalised in any way for not entering a situation they believe to be unsafe. If the safety concern cannot be resolved then alternative care arrangements may be required to enable to provision of ongoing Hospice services. This may include but not be limited to hospital transfer, care by the general practitioner or transfer to residential care. Should these options be declined by the patient / family, Hospice reserves the right to provide telephonic support only as long as visiting is deemed unsafe.

2 New Referrals

- 2.1 **Triage:** Risk assessment commences when triaging new referrals.
 - 2.1.1 **Risk assessment methods during triage:** Identification of risks/potential risks may be made by:
 - 2.1.1.1 Reviewing referral documentation.
 - 2.1.1.2 Liaising with other services involved; e.g. district nurse, GP.
 - 2.1.1.3 Discussion with the referrer.
 - 2.1.2 **Incomplete referral:** If the question regarding risks on the referral (Community Hospice Palliative Care Services Referral Form) is *incomplete*, this information should be sought from the referrer, prior to scheduling an initial visit.
- 2.2 **Telephonic risk assessment**
 - 2.2.1 **Upon initial contact:** Telephonic risk assessment is to be completed upon initial contact to arrange a home visit.
 - 2.2.2 **Document identified risks:** All identified risks are to be clearly documented in PalCare 'Intake Module'.
 - 2.2.3 **Joint visits:** A joint visit is to be undertaken if there are any risks identified during the triaging process.
 - 2.2.4 **Verbal handover:** A verbal handover to the relevant Team Leader and team member is to be undertaken.
 - 2.2.5 **Information to be obtained:** The following information is to be obtained:

- 2.2.5.1 Verification of the location
 - 2.2.5.2 Mobile phone coverage
 - 2.2.5.3 Access to premises
 - 2.2.5.4 Time of visit
 - 2.2.5.5 Persons present on the home visit (e.g. 'Could you tell me if there will be other people present when we visit you?')
 - 2.2.5.6 Presence of potentially dangerous animals and pets
 - 2.2.5.7 History of violence, aggressive behaviour or domestic violence
 - 2.2.5.8 History of mental illness, medical conditions and substance abuse
 - 2.2.5.9 Family conflict
 - 2.2.5.10 Cultural needs (Ask if they would like a cultural support person present during the visit. If English is not their first language, ask if an interpreter is needed, etc.)
- e.g. 'Are you aware of anything or anybody who may be a threat to the safety of people visiting you?'

3 Environmental Risk Assessment during community visits: When conducting community visits, the following environmental risks are to be assessed:

3.1	Location and accessibility of house, visibility of house and house number from street, e.g. high fence, overgrown foliage, down R.O.W.	Obtain specific directions and / or location. Identify landmarks to assist location.
3.2	Easy and clear access to house via driveway?	Can somebody meet you at the car?
3.3	Will gate be open at time of visit?	Make practicable arrangements.
3.4	Which door is used for entry?	Assess the access for risks.
3.5	Is pathway leading to house in good condition?	Assess the access for risks.
3.6	Will somebody be able to open the door?	Clarify other arrangements if this is not possible. If patient is alone and is unable to get to the door, make specific arrangements for access.
3.7	Is there operational external lighting?	If yes, inform patient / family that light must be switched on for visits after dark.
3.8	Are there any other risks identified outside of or inside of the patient's home?	Assess risk and discuss appropriate measures with Team Leader as necessary.

4 Measures to Minimise Personal Risk

- 4.1 **Mandatory compliance:** All team members are to comply with the risk management measures implemented. (e.g. If joint visits are agreed upon, then all team members will comply with this, even if individual team members do not believe themselves to be at risk.)
- 4.2 **Mobile Phones:** All clinical team members are to carry a mobile phone on their person during all community visits.
 - 4.2.1 **Switched 'on':** Mobile phones are to remain switched 'on' at all times but may be on silent/vibrate mode
 - 4.2.2 **Smartrack Personal Locator which is attached to car keys must be kept close to hand at all times during home visits.** - highlighted area pertains to clinical team members only

- 4.2.3 **Record on Clinical Admin whiteboard:** Each clinical team member is to record the mobile phone they are carrying on the In/Out whiteboard in the Clinical Administrator's office.
- 4.3 **Scheduled visits only:** Only scheduled visits listed on the Team Daily Worker Record are to be conducted.
- 4.3.1 **'Cold calling' / 'popping in':** 'Cold calling' / 'popping in' is discouraged, but if this is done (e.g. if a clinical team member is already in the area and has extra time), it must be communicated to the Clinical Services Leader, Triage Nurse or Clinical Administrator *prior to entering the client's home*.
- 4.3.2 **Unscheduled visits must be communicated prior to visit:** If a visit is required by a patient whose name is not on the Team Daily Worker Record (e.g. the patient or family rings during the day requesting a visit), this is to be communicated to the Clinical Services Leader, Triage Nurse or Clinical Administrator *prior to leaving for the visit*.
- 4.4 **During Community Visits:**
- 4.4.1 **In vehicle or arriving at premises:**
- 4.4.1.1 **Sitting in parked car:** When sitting in a parked car (e.g. to look at map, take a phone call, etc.), remain observant, keep windows up and doors locked, leave engine on.
 - 4.4.1.2 **Public Toilets:** When using public toilets, make sure there is good visibility and you are not isolated; be aware of surroundings.
 - 4.4.1.3 **Drive by to observe:** When arriving at client's premises, if possible do a quick drive by past house to observe surroundings before parking vehicle.
 - 4.4.1.4 **Parking:** When parking at client's premises, think how best to park if a quick get away were necessary (e.g. backing in, where possible and safe). Make sure car is visible (e.g. not blocked by trees, other vehicles, etc.)
 - 4.4.1.5 **Observe for activity/dogs:** Before leaving vehicle, observe activity at client's home and surroundings and look for evidence of dogs (e.g. bones, chain around a tree, etc.)
 - 4.4.1.6 **Leaving vehicle:** When leaving vehicle, ensure windows are up, doors are locked, and no valuables are in sight.
 - 4.4.1.7 **Keys:** Keep keys on your person at all times, do not leave them on counter, etc. Keys in your hand can also serve as a defensive weapon, if necessary.
- 4.4.2 **Do not enter premises:** Do not enter premises in the following circumstances:
- 4.4.2.1 Nobody answers door and it is unusual for them not to do so.
 - 4.4.2.2 The door is left open.
 - 4.4.2.3 Evidence of break-in.
 - 4.4.2.4 There are conflicts, sounds of arguments or unusual noises coming from within.
 - 4.4.2.5 The client does not know who you are or why you are there.
 - 4.4.2.6 The person answering the door gives any cause for concern.
 - 4.4.2.7 The person answering the door, or any other person present, is alcohol- or drug-impaired.
- 4.4.3 **Inside the premises:**
- 4.4.3.1 Follow the person into the home – never walk ahead.
 - 4.4.3.2 Choose carefully where to sit and identify possible escape routes. Try to remain near the exit.
 - 4.4.3.3 Be alert for items that may pose a risk, e.g. walking stick, sharp items.
 - 4.4.3.4 Treat client courteously.
 - 4.4.3.5 Avoid reacting to environment e.g. smells, untidiness.
 - 4.4.3.6 Keep belongings at hand so they are easily accessible if a quick get-away is needed.

- 4.4.3.7 **Remain alert to changes:** Remain alert to changes in mood or demeanour from client or other persons present, including:
- 4.4.3.7a Heightened level of anxiety or sudden mood change.
 - 4.4.3.7b Hostile or aggressive body language.
 - 4.4.3.7c Complaints about service provision.
 - 4.4.3.7d Uncooperative behaviour.
 - 4.4.3.7e Physical signs of anxiety or aggression such as clenched fists/teeth, restlessness or talking loudly or aggressively.
 - 4.4.3.7f Excessive swearing or sexually explicit language.
 - 4.4.3.7g Threats.
- 4.4.3.8 **In case of aggression/abuse:** If client or other person present becomes aggressive, abusive, or sexually suggestive:
- 4.4.3.8a Stay calm and don't panic.
 - 4.4.3.8b Leave as quickly as possible using an excuse if necessary, e.g. suggesting you need to obtain something from the car for the client.
 - 4.4.3.8c If you are unable to remove yourself, attempt to diffuse the situation and press 'emergency call' on your mobile phone, followed by green call button.
- 4.5 **After-hours Call-outs:** Nurses when called out for a patient visit at night will:
- 4.5.1 **Telephonic Risk Assessment:** Ask the questions listed in 2.2.5.
 - 4.5.2 **Review PalCare Risk Management Module and Care Plan:** PalCare Risk Management Module and Care Plan are to be reviewed to understand the patient's risk status and identify measures implemented to manage risks.
 - 4.5.3 **Contact Security Contractor:** *Watchdog Security* is to be contacted on 07 349 2111 to monitor visit and organise security to accompany nurse on visit, if required.
(Note: Watchdog Security does monitoring, but subcontracts to Computech for security guards and/or any onsite needs.)
- See page 5 for After Hours Call-Outs / Security Contractor Process.**

REFERENCES

Department of Labour. Managing the Risks of Workplace Violence to Healthcare and Community Service Providers: Good Practice Guide. (2009)

Health Information Privacy Code 1994

RECEPTION VOLUNTEER DAILY TASKS FORM

Date: _____

Name of Volunteer: _____ Time In: _____ Time
Out: _____

**Receiving visitors in the reception area is the most important task during your shift.
Please remain in the reception area as much as possible.**

Don't forget to sign in and fill in your hours on the Volunteer Daily Hours Form.

Please *initial* each task as it is completed. Please do not wait until the end of your shift to tick the completed tasks, in case you need to leave abruptly, etc. so admin staff will know what still needs to be done.

We rely on you to complete these tasks; if you were unable to complete them, please let us know before you leave.

Initial if complete. If not necessary, please write "NN".

Daily Tasks for Villa:

- ✓ Check the recently deceased patient list (kept in bottom drawer in brown manila folder).
Cut out death notices and bereavement thanks of Hospice patients from the *NZ Herald*.
Put in Patient Death Notices plastic sleeve.
- ✓ TUESDAYS, WEDNESDAYS, and FRIDAYS only: Cut out *ALL* death notices and any bereavement thanks to Hospice from the *Beacon* and the *Whakatane News* (Wed.). If any non-patient death notices mention donating to Hospice, please highlight it in yellow.
Put patient death notices in Patient Death Notices plastic sleeve and put non patient death notices in Non-Patient Death Notices plastic sleeve.
- ✓ Check the *Beacon*, *Whakatane News* & *Opotiki News* for news stories or advertisements about Hospice.
- ✓ Scan & cut out Whakatane News & Opotiki News. Cut out articles from Beacon. Put articles in the "Hospice in the News" blue plastic sleeve and let Administrative Assistant know.
- ✓ File Fax Transmission Reports and Vehicle Mileage Logs in their binders.
- ✓ Check & refill all four paper trays in the villa photo copier.
- ✓ Put out a fresh tea towel in villa kitchen & put soiled towel in dirty laundry box under sink.
- ✓ Refill the plastic water pitcher in villa kitchen (even if it's not empty).
- ✓ Empty/refill dishwasher, as necessary.
- ✓ Restock coffee/tea/sugar/salt/pepper/Milo, etc, wipe counter & tidy kitchen.

- ✓ Tidy reception area & Interview Room. If there is fresh flower arrangements, please remove dying pieces.
- ✓ Empty Reception rubbish bin & kitchen recycling bin.
- ✓ Sweep outside front entrance & steps (broom is kept in bathroom).
- ✓ FRIDAYS only: Cut out the weekend duty doctor notice from the *Beacon* and give to Clinical Administrator.

Daily Tasks for #37

- ✓ Check & refill all four paper trays of the photo copier.
- ✓ Check & refill the paper in the fax machine.
- ✓ MONDAYS & FRIDAYS only: Check pens at the Nurses stations (3x per desk).
- ✓ WEDNESDAYS only: Check supplies at the nurses stations including Equipment Room.
- ✓ Pencils, black/red/blue pens, yellow highlighter, stapler & staples, staple remover, correction tape, paper clips, scrap paper, cellotape, ruler, phone book, phone messages pad, post it note pad, calculator.
- ✓ TUESDAYS & FRIDAYS only: Empty the recycling bins in nurses' room and kitchen.
- ✓ TUESDAYS & FRIDAYS only: Check the water cooler. Get help to lift it if it needs refilling.
- ✓ TUESDAYS & THURSDAYS only: Restock staff coffee/tea/sugar/milk etc in kitchen.

Daily Errands:

- ✓ Hospice Shop: Count takings and have ready to take to the bank.
- ✓ Westpac Bank: Deposit Shop & Hospice EBOP banking.
- ✓ Post Office: collect mail from our PO Box (key kept in bag) & post any outgoing letters from Hospice
- ✓ New World: (usually Mondays & Wednesdays).
- ✓ If using the red car, put petrol in if car is near/less than ½ full.

On completion of the above tasks:

- ✓ Inform administrative staff of any incomplete tasks.
- ✓ File this completed form in the Reception Volunteer Binder.
- ✓ **Additional Tasks:** After you have completed the daily tasks, please check admin volunteer desk or see administration for additional tasks.

TRANSPORTATION OF CLIENTS POLICY

Review History

DRAFT

Description

Hospice Eastern Bay of Plenty (HEBOP) takes all reasonable steps to ensure clients (patients and their family / whanau) are safe if driven by HEBOP staff or volunteers.

Responsibility

Chief Executive (CE), as delegated to all staff and volunteers

Aim

HEBOP will take all reasonable steps to ensure the safety of clients who are driven by HEBOP staff or volunteers.

Expected Outcome

Clients are safe when being driven by HEBOP staff or volunteers.

Performance Indicators

Number of safety incidents involving clients driven by staff or volunteers

Monitoring/Assessment

Patient and Family Surveys

Incident Log

Guidelines

- 1 Volunteer Training
 - 1.1 Volunteers who are drivers for HEBOP must undertake the training necessary for working with patients.
 - 1.2 Volunteers must work within the boundaries covered in their training sessions.
- 2 Volunteers must have a current driver's licence which is sighted by the volunteer Coordinator, signed and a copy held on the personnel file of the Volunteer.
- 3 It is the volunteer's responsibility to have a car with a current Warrant of Fitness, insurance and registration.
- 4 Drivers are required to immediately inform the Volunteer Team Coordinator and/or Health and Safety Officer in the case of an accident or near miss and to complete an incident form.
- 5 In no circumstances will the volunteer:
 - drive the patient's car
 - drive under the influence of drugs or alcohol.
- 6 Patients will be carefully assessed by medical staff to ascertain suitability for a Volunteer to safely transport them, prior to departure.

- 7 Volunteer drivers have the right to decline transportation of a patient if for any reason they feel uncomfortable with the request.
- 8 Drivers and passengers are required to wear seat belts.
- 9 Volunteers are not permitted to accept payment of any kind. (???DHB Travel vouchers??? – need to investigate further) Gifts of monies from patients are regarded as donations and must be given to the HEBOP Accounts Administrator for receipt and acknowledgement. Petrol vouchers may be given to volunteer drivers at the discretion of the Volunteer Team Leader/CE.
- 10 Staff who drive clients may only use a HEBOP vehicle. Clients are never to be driven in a staff member's personal vehicle.

Associated Documents

Transportation of Clients Procedures (Not yet developed)

References

Hospice NZ Standards for Palliative Care
Code of Health and Disability Services Consumers' Code of Rights
Health and Safety in Employment Act

Acknowledgements

Waipuna Hospice – Volunteer Drivers Policy

HEALTH & SAFETY HAZARD MANAGEMENT POLICY

Review History

Jan 2007, Jul 2011, Oct 2013 separated from "Risk & Hazard Management Policy"

Description

Hospice EBOP is committed by taking all practicable steps and following approved codes of practice to maintain a safe environment for staff, patients/clients, volunteers and visitors by effective hazard management.

Responsibility

Chief Executive, Health and Safety Representative(s)

Aim

To identify, assess and manage actual and potential hazards and to ensure staff are trained in the management of hazards.

Expected Outcome

A safe environment is maintained for staff, patients/clients, volunteers and visitors.

Definitions

All practicable steps	<p><i>Is a situation foreseeable?</i> Taking all steps to achieve the result that it is reasonably practicable to take in the circumstances, having regard to:</p> <ul style="list-style-type: none">• <i>Consequence:</i> The nature and severity of the harm that may be suffered if the result is not achieved; and• <i>Degree of risk:</i> The current state of knowledge about the likelihood that harm of that nature and severity will be suffered if the result is not achieved; and• <i>Information available:</i> The current state of knowledge about harm of that nature; and• <i>Best Practice:</i> The current state of knowledge about the means available to achieve the result and about the likely efficacy of each; and• <i>Cost Benefits/Effectiveness of hazard control:</i> The availability and cost of each of those means.
Hazard	The potential of something to cause harm. An activity, arrangement, circumstance, event, occurrence, phenomenon, process, situation, or substance (whether arising or caused within or outside a place of work) that is an actual or potential cause or source of harm, and includes a situation where a person's behaviour may be an actual or potential cause or source of harm to the person or another person. "Hazardous" has a corresponding meaning.
Hazard Identification	The process of identifying within a workplace, situations where there is an actual or potential cause or source of harm.
Safe	In relation to a person, means not exposed to any hazards; and in every other case, means free from hazards. "Unsafe" and "safety" have corresponding meanings.

Significant Hazard	A hazard that is an actual or potential cause or source of: <ul style="list-style-type: none"> • Serious harm; or • Harm (being harm that is more than trivial) the severity of whose effects on any person depend (entirely or among other things) on the extent or frequency of the person's exposure to the hazard; or • Harm that does not usually occur, or usually is not detectable until a significant time after exposure to the hazard.
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Performance Indicators

Number of Reportable Events/Near Misses

Staff, Volunteer, Board Training

Staff & Volunteer Satisfaction

Monitoring / Assessment

Reportable Events/Near Miss Register –Health & Safety category

Training Log; Training Evaluations

Staff & Volunteer Surveys

Guidelines

1 Hazard Management Process: Actual and potential health and safety hazards will be minimised by carrying out a systematic process of hazard identification and control.

1.1 Identify

- 1.1.1 Hazards will be identified from workplace inspections by people appropriately trained and experienced in hazard identification (with ongoing training and upskilling occurring every two years at a minimum), hazard reports from staff or others, and as a result of near miss/incident investigations.
- 1.1.2 Hazards will be recorded in the Hazard Register.
- 1.1.3 Hazardous substances will be identified and recorded in the Hazardous Substances Register.

1.2 Assess

- 1.2.1 Hazards will be assessed to determine which are significant.
- 1.2.2 Hazards will be prioritised as high, medium or low priority for action.

1.3 Implement Controls

- 1.3.1 All practicable steps will be taken to put appropriate controls put in place for each significant hazard by eliminating it, isolating it to reduce exposure to it, or minimising its impact.
- 1.3.2 Protective clothing and equipment will be provided where necessary and training will be provided in how to use them properly.
- 1.3.3 Signage will be utilised to minimise the exposure to hazards, especially by visitors.
- 1.3.4 The identification of certain significant hazards may make pre-employment health screening appropriate to ensure that the potential for work injury or work-related illness through exposure to those particular tasks is minimised.
- 1.3.5 Safe work procedures and guidelines for specific hazards will be developed whenever necessary.
- 1.3.6 Hospice facilities and vehicles owned by Hospice EBOP will be equipped with first aid and fire equipment.

- 1.3.7 Staff and volunteers will be notified about hazards through induction/orientation and ongoing training.
 - 1.3.8 Staff will be adequately trained for all tasks they perform as part of their duties that have been identified as a hazard.
 - 1.3.9 Specialist advice will be used when necessary and appropriate.
 - 1.3.10 Preventive maintenance of equipment (patient and non-patient) will occur according to prescribed timetable and when necessary, equipment repairs will occur in a timely manner.
- 1.4 **Monitor**
- 1.4.1 Significant hazards that have been isolated or minimised will be monitored on a regular basis.
 - 1.4.2 Health and safety-related incidents and near misses will be monitored on a regular basis to identify trends and recommend corrective actions.
- 1.5 **Review**
- 1.5.1 An annual review of the identified hazards and hazard controls will be undertaken, the effectiveness of the controls will be evaluated, and the compliance with all legislation, standards, policies and procedures relevant to Hospice EBOP will be ensured.
 - 1.5.2 Identified hazards will be reviewed annually to determine whether or not they are a significant hazard.
 - 1.5.3 Health and safety training and education programmes will be reviewed two yearly for appropriateness and effectiveness.
 - 1.5.4 All health and safety-related policies, procedures, guidelines, forms, and other documents will be reviewed and evaluated two yearly.

2 Roles & Responsibilities

- 2.1 Health and Safety Representative(s):
 - 2.1.1 Will be responsible to identify and bring hazards to Hospice EBOP management's attention and discuss with management ways that the hazards may be controlled.
 - 2.1.2 Will serve as the link regarding hazards to management from the Health and Safety Committee and staff.
- 2.2 Health and Safety Committee
 - 2.2.1 Will serve an advisory role to the Quality Team, CE and Board of Trustees to assist them in their responsibilities for health and safety/ hazard management matters.
 - 2.2.2 Will ensure staff have a reasonable opportunity to be involved in the development and maintenance of safe workplace practices.
 - 2.2.3 Will monitor and review hazards, as listed in Sections 1.4 and 1.5.
 - 2.2.4 Will perform other specific responsibilities as outlined in the Health and Safety Committee Terms of Reference.
- 2.3 Staff and volunteers: Will have an ongoing opportunity and responsibility to be actively involved in the development and maintenance of safe workplace practices, including identifying and managing hazards.

Associated Documents

- Daily Record of Attendance Form
- Hazardous Substances Register
- Health & Safety Hazard Register
- Health & Safety Inspection Form
- Health & Safety Inspection Report Form
- Health & Safety Risk Rating Guidelines

Health & Safety Committee Terms of Reference
Hazard Identification Form

References

- ACC Workplace Safety Management Practices
- Health and Safety in Employment Act 1992 (and amendments) Sections 7-10
- Occupational Health and Safety Management Systems NZS 4801:2001
- Hazardous Substances and New Organisms Act 1996 (reprinted 31.8.05 with amendments)

Acknowledgement

EMA Health & Safety Representative Stage I Training materials

VOLUNTEER DISMISSAL POLICY

Based on our commitment to providing the highest quality service to our patients, staff and stakeholders Hospice EBOP reserves the right to terminate a volunteer's involvement within our programs. Dismissal of a volunteer will occur only as a last resort, and will generally take place following a progressive performance management and disciplinary process. Summary dismissal of a Volunteer may occur in extreme cases.

Misconduct

The following are offences which constitute serious misconduct and which may give rise to summary dismissal:

- ✓ Unauthorised possession of property, money, or information, or intellectual property, belonging to or under the control of the employer.
- ✓ Unauthorised disclosure of information that breaches the Health Information Privacy Act.
- ✓ Unauthorised disclosure of information that breaches the "privacy & confidentiality" of the Hospice-patient relationship.
- ✓ Unauthorised disclosure of personal information about other Hospice colleagues.
- ✓ Possession or use of the property of other employees or patients without the owner's permission.
- ✓ Refusal to undertake the duties of the employee's position, or to carry out any proper and lawful instruction given by the Chief Executive or any other person acting with the authority of the employer.
- ✓ Physical violence against any person on the employer's premises; or at a workplace where the employer's employees work.
- ✓ Racial, sexual or other improper harassment of any other employee, volunteer or of any patient.
- ✓ Being at work in such a state of intoxication (whether drugs or alcohol) as to prevent or impede the proper performance of duties (whether of the employee or any other employee).
- ✓ Deliberate failure to declare a conflict of interest to the employee's Chief Executive.
- ✓ Deliberate use of an authorised password or unauthorised access to enter a computer known to contain information to which the employee is not entitled to have access.
- ✓ Failure to adhere to all safety policies and procedures.
- ✓ Interfering with safety equipment or otherwise acting in a manner that threatens safety, health, or hygiene in the workplace or in a manner that hinders the safe and proper performance of the duties of other employees.

The following are acts or omissions, which may, after the appropriate warnings, lead to dismissal:

- ✓ The use of abusive, obscene, or threatening language or behaviour to another person.
- ✓ Unauthorised gambling on the employer's premises.
- ✓ Disrupting the workplace by acts of undesirable behaviour or disrupting any other employee from carrying out that employee's duties.
- ✓ Cyberbullying of employer or colleagues, which includes, but is not limited to the use of any electronic communication device to convey a message in any form (text, image, audio or video) that defames, intimidates, harasses or is otherwise intended to harm, insult or humiliate another in a deliberate, repeated or hostile and unwanted manner under a person's true or false identity.

Performance Management Process

- ✓ Hospice EBOP staff and the Volunteer Coordinator will investigate and document all performance concerns and incidents which may serve as grounds for dismissal. This investigation will include hearing the Volunteer's account of the incident, or perspective on the situation.
- ✓ Where appropriate, verbal warnings may be issued to the Volunteer, and documented in his/her file.
- ✓ Dismissal of a Volunteer will take place after due consideration and consultation
- ✓ Staff supervising the Volunteer, the Volunteer Coordinator, or Chief Executive may dismiss a Volunteer.
- ✓ There will be written documentation of this dismissal.
- ✓ Where appropriate, the Volunteer will be permitted to bring closure to the patient, with whom he/she is matched. If this is not deemed appropriate, Hospice staff will ensure that the patient, and his/her family is informed of the termination by phone or in person, and followed up with a letter.
- ✓ After dismissing a Volunteer, all appropriate EBOP Hospice staff should be made aware of the dismissal.
- ✓ A formal notice of termination should be sent to the Volunteer following the dismissal.

Appeals Process

- ✓ If a Volunteer disagrees with the termination, he/she has the right to appeal the decision. This may be done in writing to the Volunteer Coordinator and/or Chief Executive within 7 days of dismissal. The Volunteer Coordinator and Chief Executive will then review the situation and decide based on careful reconsideration of the issues.
- ✓ If the Volunteer is not satisfied with the decision of the Volunteer Coordinator and Chief Executive, he/she may appeal in writing to the EBOP Hospice Board of Directors within 7 days of the decision on appeal. The Board will consult with the Volunteer Coordinator and Chief Executive and a decision will be made within 30 days. The decision of the board is final.