Implementation of Feeding Education to Increase Hospice Volunteer Knowledge

Hannah Franzwa

University of San Francisco, hafranzwa@dons.usfca.edu

Follow this and additional works at: https://repository.usfca.edu/capstone

Recommended Citation
https://repository.usfca.edu/capstone/1577

This Project/Capstone - Global access is brought to you for free and open access by the All Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Master's Projects and Capstones by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.
Implementation of Feeding Education to Increase Hospice Volunteer Knowledge

Hannah A. Franzwa, BSN, RN

School of Nursing and Health Professions, University of San Francisco

N670: Internship

Dr. Francine Serafin-Dickson

July 30, 2023
Implementation of Feeding Education to Increase Hospice Volunteer Knowledge

Abstract

Problem: Hospice volunteers have no formal training on end-of-life nutrition and how to feed patients. Insufficient knowledge of feeding patients presents safety issues, leading to decreased patient satisfaction and diminished volunteer role fulfillment.

Context: The setting was an independent non-profit hospice organization that serves around 1,000 patients within the San Francisco Peninsula and South Bay communities. The project was a collaboration between hospice leadership and the quality and education department.

Intervention: Volunteer education was implemented to increase volunteer knowledge about end-of-life nutrition and feeding patients. The educational session included a PowerPoint lecture, a small group discussion portion, and hands-on skills practice. Three in-person training sessions were delivered during June and July 2023. 62 out of 100 completed the training sessions.

Measures: Pre- and post-education assessment surveys were used to measure volunteer knowledge and confidence. The survey included ten questions, five true or false and five multiple choice questions, to assess volunteer knowledge. Volunteers rated their confidence in feeding patients on a scale from zero to ten.

Results: The post-education survey results demonstrated an increase in volunteer knowledge from 8.3 to 9.8 on a 10-point scale, exceeding the 90% project target. Volunteer feeding confidence also increased from 3.5 to 9.

Conclusions: Volunteer education is an evidence-based method to increase volunteer knowledge. Volunteers with inadequate knowledge and competency in feeding patients can lead to diminished patient care and safety issues. The implementation of comprehensive volunteer training on feeding patients increases volunteer knowledge, confidence, and competency.
Personal Leadership Statement

My vision for nursing leadership is to create effective and sustainable teams focused on staff well-being, improving the nursing profession, and continuous organizational improvement. As a nurse leader, my strengths include uniting teams by setting a clear purpose, promoting the growth and development of team members, and building a supportive and positive team environment. I value integrity, hard work, compassion, team unity, and a commitment to excellence and innovation. My leadership vision aligns with the purpose and mission of the Hospice Organization which is to provide the highest quality end-of-life care for patients and families. The Hospice Organization places high importance on building a resilient and compassionate workforce and creating meaningful connections with patients.

My quality improvement project focuses on increasing hospice volunteer knowledge. I chose this topic as I highly value individual growth and empowerment. Nurse leaders that engage staff through shared values create satisfying work cultures and highly efficient teams (Sherman & Pross, 2010). My values of staff engagement and uniting teams with a clear purpose and vision are visible throughout my project. Building cultures of engagement lead to staff feeling supported in their work, enhancing team resilience and trust. My project strengthens the volunteer group and enhances volunteer knowledge, increasing quality patient care and satisfaction.

Introduction

Background

Volunteers play an integral role within hospice organizations and help support high-quality patient care. Volunteers are shown to increase patient satisfaction by increasing
companionship and bridging the gap between clinical care and family systems (Lee & Lee, 2019). Under the State of Operations Manual, the Centers for Medicare and Medicaid Services (CMS) (2023) indicates that hospice volunteers may fulfill administrative and direct patient care roles and must complete orientation and training compliant with hospice industry standards. Proper education and training sessions are essential for volunteers to understand their roles and responsibilities to provide the highest quality end-of-life care.

**Problem Description**

The volunteer program is small, lacking training in essential areas such as feeding patients. Volunteers lack confidence and sometimes avoid feeding patients due to inadequate knowledge. Also, hospice RNs spend approximately fifteen extra minutes per patient home visit providing care beneath their scope of practice. Extra work leaves RNs feeling burnout, leading to decreased quality of care and customer satisfaction. The implementation of volunteer feeding education is an effective way to increase volunteer knowledge and decrease bedside RN time, resulting in improved patient satisfaction and a higher level of exceptional end-of-life care.

Based on a microsystem assessment, feeding patients was identified as the main area for volunteer knowledge improvement. Organizational priorities include strengthening the volunteer group and increasing volunteer education (see Appendix A, Gap Analysis). This quality improvement project aimed to enhance volunteer knowledge and confidence by implementing feeding education and addressing barriers to volunteer learning. With an increase in volunteer knowledge, bedside RN time is expected to decrease. Through feeding education, hospice volunteers will be better prepared to support hospice patients’ needs and promote the organization’s mission to provide compassionate and patient-centered end-of-life care.

**Setting**
The Hospice Organization is an independent not-for-profit organization that serves around 1,000 patients within the San Francisco Peninsula and South Bay communities. Registered nurses (RNs) provide the majority of clinical care, but volunteers are a method to supplement non-clinical RN time and decrease bedside RN time. In hospice organizations, well-planned volunteer training and consistent educational refreshers are essential to maintain volunteer knowledge and competency (Teixeira et al., 2019).

**Specific Project Aim**

To increase hospice volunteer knowledge on feeding from baseline in the pre-knowledge survey to 90% through the implementation of feeding education by July 2023 (see Appendix B, Project Charter).

**Available Knowledge**

**PICOT Question**

In hospice volunteers (P), how does the implementation of volunteer education on feeding (I) compared to no education (C) improve volunteer knowledge (O) over three months by July 2023 (T)?

**Search Strategy**

A comprehensive literature search used credible databases, including CINAHL, PubMed, and Cochrane. Source dates ranged from 2014 to 2022. Keywords included “hospice patients”, “volunteers”, “education”, and “feeding”. The search terms yielded eighteen articles including quasi-experimental studies, systematic reviews, and literature reviews. Articles contained information on older adult and hospice populations, improving volunteer knowledge, and volunteer training. From the articles, six were selected based on their relevance to increasing hospice volunteer knowledge and the development of effective educational strategies. The six
articles were analyzed, including a critical appraisal of the literature utilizing the Johns Hopkins Nursing Evidence-Based Practice Appraisal tool (see Appendix C, Evaluation Table).

**Synthesis of Literature**

Lee & Lee (2019) conducted a quasi-experimental study that focused on the effects of implementing a two-day palliative care program among nineteen volunteers. The study measured results from pre- and post-implementation surveys and interviews from volunteers and patients. Based on the post-training survey, volunteers felt more dedicated to their work, connected to themselves and confident with their volunteer abilities and skills. Volunteers rated their confidence levels at 3.32 out of 4 and training satisfaction at 8.79 out of 10. Based on the satisfaction survey, caregivers rated the effectiveness of volunteer education at 9.6 out of 10 and highly recommended volunteer services to others in similar situations. This evidence exemplifies the importance of education in increasing volunteer confidence and competency and the usefulness of pre- and post-education surveys.

Roberts et al. (2014) outlined an effective volunteer education program for feeding older patients. Topics included the importance of proper nutrition, safe feeding skills, identifying swallowing difficulties, and considering patients’ wishes. Thirty-eight volunteers completed the half-day training sessions including practical sessions. Following the feeding training, 62% of volunteers expressed increased confidence in their skills and felt more knowledgeable compared to the previous baseline of no feeding training. Patients and staff members highly valued the volunteers. This study provides evidence that volunteer feeding education is a feasible and effective method for improving volunteer feeding skills.

Howson et al. (2018) focused on the implications of trained volunteers on mealtime care for older hospital patients in England. The quasi-experimental study outlined mealtime
volunteers’ common tasks, including oral care, cutting up food, encouraging patients, social interaction, and feeding patients. A financial analysis was conducted over the fifteen-month study period, exemplifying a cost-saving of $59,662. Unpaid volunteers were found to fill in for nursing assistants and RN time, enabling RNs to focus on RN-specific tasks. Constant recruitment, leadership support, and training of new volunteers decreased volunteer turnover rates. This study provides useful information for the development of volunteer feeding education.

Candy et al. (2015) performed a systematic review that analyzed the implications of volunteers on patient and family well-being. The study found that volunteers provided several benefits, including respite care, extra emotional support, improving family well-being, and serving as patient advocates. Notably, the study found that patients who received volunteer services lived longer than those who did not. Volunteers positively impact patients and their families, and volunteers experience positive benefits for themselves. Claxton-Oldfield (2015) stated that volunteers viewed their work as a uniquely transformative experience and learned valuable life lessons and skills. Both reviews highlight hospice volunteers’ significant impact on patients and volunteers, indicating the need for consistent volunteer support and education.

Teixeira et al. (2019) explored the current state of education methods within palliative care organizations. The literature review found that participative teaching and learning strategies with opportunities to apply knowledge through simulation, case studies, and hands-on opportunities resulted in a higher impact on knowledge acquisition and retention compared to solely didactic teaching styles. The use of interpersonal skills and critical thinking within training sessions enhanced participants’ knowledge comprehension. Evaluation of learning outcomes such as through pre- and post-tests was found to be essential in measuring volunteers’ knowledge levels and the effectiveness of the delivery of education. Standardized hospice volunteer
education establishes a competency level among all volunteers to ensure that they possess a certain level of knowledge to maintain patient safety, recognize pertinent issues, and adhere to standards of care. This study provides useful information to guide volunteer education delivery.

**Rationale**

Change theories apply to organizational changes as they provide a framework for the implementation, management, and evaluation processes and increase the likelihood of success. The change theory that guides this project is Lewin’s Change Theory. Lewin’s three-step model of change includes unfreezing, changing or moving to a new level, and refreezing (Burnes, 2019). Lewin’s theory is based on the three major concepts of driving forces, restraining forces, and equilibrium.

Lewin’s framework provides a simple step-by-step model that focuses on understanding team motives and barriers to implementing smooth organizational change (Burnes, 2019). Strong emphasis is placed on team involvement which is crucial for this project. During the unfreezing stage, it is important to motivate team members. In order to overcome team resistance and unfreeze, the CNL student will present data surrounding the importance of volunteer education to the volunteer group and quality department members. Once the team is prepared for the change, the CNL student will implement volunteer education on feeding. If an increase in volunteer knowledge is confirmed through the post-education assessment, the project will be implemented regularly throughout the following volunteer training sessions. The final refreezing stage will be complete as the new change is ingrained into the organizational culture.

**Context**

**Microsystem Assessment**
The 5 P’s microsystem assessment tool analyzes the purpose, patients, professionals, processes, and patterns within a microsystem, a small, interdependent group of individuals that work together to provide care for a specific population (King et al., 2019).

**Purpose:**

The Hospice Organization is an independent not-for-profit that utilizes a team-oriented, holistic approach to provide patients and families the highest quality end-of-life care.

**Patients:**

Hospice patients must have a terminal diagnosis of six months or less. Common diagnoses include organ failure, end-stage cancer, ALS, and other terminal conditions. Patients describe their care as holistic, comforting, generous, and life-fulfilling.

**Professionals:**

Professionals include clinical staff, administrative staff, and volunteers. Clinical staff, led by the Medical Director, provide direct patient care. Quality and compliance leaders set goals and ensure standards are met.

**Processes:**

The care process encompasses a multidisciplinary approach, beginning with an intake request from the patient and an RN consultation service. On admission, the type of service and care plan is determined based on the patient’s needs and goals of care.

**Patterns:**

The microsystem meets weekly, monthly, and quarterly to discuss operational goals, improvement areas, and patient care. Desired organizational outcomes include improving staff education, streamlining transitions in care, and increasing patient and family satisfaction.

**IHI Culture Assessment**
The IHI Clinical Microsystem Assessment Tool (IHI Mat) provides a rating system that assesses the ten key success characteristics of high-functioning microsystems (Institute for Healthcare Improvement, 2023). The IHI Mat is a valuable tool for nurse leaders to better understand the overall microsystem and piece together key information to lead change. The student CNL used the IHI Culture Assessment to assess the hospice microsystem. Identified areas of strength include a compassionate, tight-knit team, a strong focus on patient care, and engaged leaders who set a clear vision and organizational goals. Areas of improvement include staff education and training, streamlining transitions in care, and integrating a more efficient charting system. The weakest areas identified include gaps in staff education due to irregular educational training and performance results.

**SWOT Analysis**

A SWOT Analysis was performed to analyze various aspects of the current microsystem and identify areas of improvement (see Appendix D, SWOT Analysis). Strengths, weaknesses, opportunities, and threats were identified that could potentially influence the project’s success. Strengths include a community-based approach, a well-rounded team, and supportive leadership. Weaknesses include resistance to change, knowledge gaps among volunteers, streamlining communication, and time allocation to train volunteers. Opportunities derived from implementing volunteer feeding education include increased volunteer knowledge and confidence, improved patient satisfaction, and potential new funding and donations. Threats include resistance among staff due to the increased workload, pushback from managers that may delay the project, and the loss of patients to competing hospice organizations.

**Communication Plan**
Clear and effective communication with various stakeholders is essential for the successful implementation of organizational change (Schulz-Knappe et al., 2019). A power interest grid was completed to identify specific stakeholders of power and their level of interest (see Appendix E, Power Interest Grid). Communication started with the CNL student and student’s preceptor, The Director of Quality, Education, and Compliance, to identify an area of improvement. Communication on the projects’ plans, implementation process, and evaluation occurred during meetings with the student’s preceptor and quality team. The CNL student worked closely with the Director of Volunteer Services as the Director possesses high power over the volunteers and a high interest in the project. The CNL student attended volunteer training sessions to create relationships and prepare them for the new volunteer education.

**Intervention**

The intervention was the implementation of volunteer education on feeding among hospice volunteers within the Hospice Organization. The CNL student led the project and created the educational resource based on findings from the review of literature. The in-person educational session included a PowerPoint presentation followed by a discussion portion and practical session which enabled the volunteers to practice the newly learned feeding skills (see Appendix F, Intervention Tool). Barriers to volunteer learning, such as time allocation, were analyzed. The first feeding training session occurred in June 2023 and continued through July 2023. A total of three educational sessions were completed. Sixty-two volunteers out of one hundred completed the training. A Gantt chart was completed to outline the project’s timeline (see Appendix G, Project Timeline).

**Budget/Return on Investment**
The implementation of volunteer education on feeding is expected to increase volunteer knowledge and skill set. Other benefits include maximization of clinical staff time, decreased bedside RN time, and increased patient care quality and satisfaction. Howson et al. (2018) found that volunteers supplemented RN time, decreasing bedside RN time per patient.

With volunteers supplementing bedside RN time, a 10% increase in patients admitted and seen by an RN could be seen per year, which equals four patients. According to the Centers for Medicare & Medicaid Services (CMS) (2023), for the 2023 Fiscal Year (FY), each new patient brings in a profit of $32,487. With an increase in four patients per year, the organization would increase revenue by $129,948. The estimated total cost is a one-time cost of $3,315 to cover the CNL salary to develop and deliver the volunteer education, resulting in significant cost avoidance within the following years. Volunteers are unpaid and would not affect the implementation cost. When the total implementation cost of $3,315 is subtracted from the improvement revenue of $129,948, the cost avoidance would be $126,633 (see Appendix H, Budget).

**Study of the Intervention**

Measuring outcomes is essential to determine if the new change results in the targeted outcome. In order to measure volunteer knowledge, a pre- and post-assessment survey created by the CNL Project Leader was utilized (see Appendix I, Evaluation Tool). The performance goal was to increase volunteer knowledge from baseline in the pre-knowledge survey to 90%. 90% was identified as a competent level based on discussion with the Quality Director and Director of Volunteer Services. The pre-assessment survey gauged the baseline feeding knowledge level prior to education implementation. The assessment consisted of ten questions based on critical areas on feeding hospice patients. After education implementation, the same assessment was
used to re-assess volunteer knowledge. The post-assessment survey also measured volunteer confidence, satisfaction with the education, and effectiveness of presentation style.

**Ethical Considerations**

In line with the American Nurses Association’s Code of Ethics, this project promotes provision 2 which states, “the nurse’s primary commitment is to the patient, whether an individual, family, group, community, or population” (American Nurses Association, 2015). By identifying and implementing methods to improve patient care, nurses exemplify their commitment to the nursing profession, patients, and the healthcare system. This project relates to the Jesuit value of cura personalis, meaning “care for the whole person” including the mind, body, and spirit (University of San Francisco, 2023). By equipping volunteers with more knowledge and skills, they can better serve and honor patients through the end-of-life. This project has been approved as a quality improvement project by faculty using QI review guidelines and does not require IRB approval (see Appendix J, IRB Non-research Determination Form).

**Outcome Measure Results**

Various barriers occurred during the implementation period. One barrier was volunteer participation, specifically identifying the best time for a high volunteer turnout. Volunteers live all over the San Francisco Bay Area. Many volunteers work and have other personal obligations. Another barrier was classroom space as the maximum capacity was thirty people. Three in-person training sessions were completed during June and July 2023. Sixty-two volunteers completed the training.

Volunteer knowledge was measured through post-survey assessment scores. After the educational training session, the volunteers’ confidence and knowledge levels increased from
baseline data collected from the pre-survey assessment. The volunteers rated their confidence level an 8.5 out of 10, an increase from the pre-survey average of 4.5 (see Appendix K, Outcome Data Display). The average knowledge level was 9.8 out of 10, which increased from the pre-survey average of 8.3. The increase in confidence and knowledge demonstrates the benefits of volunteer education.

The expected results were met as the aim of the volunteer education was to increase volunteer knowledge on feeding patients. The feedback was favorable. Several volunteers provided positive verbal feedback regarding the teaching method and found the hands-on portion helpful within the learning process. One recommendation for improvement was including training on the Heimlich maneuver. The plan is to incorporate volunteer feeding education into the new volunteer manual and training process.

**Summary**

Evidence shows that implementing volunteer education on feeding increases volunteer knowledge and confidence. Volunteer feedback was positive and many expressed enthusiasm for expanding their role duties. The feedback received from the volunteers showcased an increase in the understanding of end-of-life nutrition and feeding hospice patients and how volunteer training is crucial in supporting volunteers. Volunteer training helps enhance patient care and ensures a standard competency level among all volunteers.

One lesson learned throughout this process is the importance of clear and effective communication. Closed-loop communication helps decrease misunderstanding and ensures that information is received. Another lesson is that creating relationships with stakeholders and participants is essential for successful quality improvement projects. By informing the volunteer staff of the purpose and goals of the new change prior to implementation, volunteers were more
prepared and engaged with the material. Early leadership buy-in and deliberate planning helped to ensure smooth implementation. Other factors contributing to the successful change included maintaining a flexible mindset and regular collaboration with team members.

**Conclusion**

Volunteer support and education are crucial in increasing volunteer knowledge and confidence in enhancing end-of-life patient care. Volunteers play a key role within hospice organizations and bridge the gap between healthcare services and families. Volunteer education within a hospice organization has shown to be an effective way to increase volunteer knowledge and confidence. With more knowledge and confidence, volunteers can better meet patients’ and families’ needs resulting in increased customer satisfaction.

Further evaluation is needed to determine the applicability of the training to actual patient care. The sustainability of the project will depend on the leadership’s ability to continue to present the feeding education to the new volunteer cohorts and incorporate the training into the volunteer onboarding process. This quality improvement project enhances patient safety, care quality, and satisfaction, aiming to improve hospice care experiences. This project can be applied to emerging educational topics and best evidence-based practices to further increase volunteer knowledge.
References


https://doi.org/10.1017/s1478951514000674

Howson, F. F., Robinson, S. M., Lin, S. X., Orlando, R., Cooper, C., Sayer, A. A., & Roberts, H.
https://doi.org/10.1136/bmjopen-2018-022285

https://www.ihi.org/resources/Pages/Tools/ClinicalMicrosystemAssessmentTool.aspx


https://doi.org/10.1108/ccij-04-2019-0039

https://doi.org/10.3912/ojin.vol15no01man01


University of San Francisco (USF). *Our Mission and Values.*

https://www.usfca.edu/who-we-are/reinventing-education/our-mission-and-values
Appendices

Appendix A

Gap Analysis

### Gap Analysis

**Area under consideration:**
Increasing hospice volunteer knowledge on feeding through the implementation of volunteer education

**AIM Statement:**
To increase hospice volunteer knowledge on feeding from baseline in the pre-knowledge survey to 90% through the implementation of feeding education by July 2023

<table>
<thead>
<tr>
<th>Desired State</th>
<th>Current State</th>
<th>Action Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in volunteer knowledge, confidence, and competency</td>
<td>-volunteer training lacks essential areas&lt;br&gt;-decreased volunteer knowledge&lt;br&gt;-inconsistent volunteer schedules</td>
<td>Assess volunteer knowledge via a knowledge assessment survey</td>
</tr>
<tr>
<td>Decrease in bedside RN time and increase in admitted patients per year</td>
<td>-patients feel isolated and have less socialization with others</td>
<td>Develop and implement a volunteer training program/educational resource on feeding for volunteer staff</td>
</tr>
<tr>
<td></td>
<td>-pressure among RNs to fulfill extra services beneath their scope of practices&lt;br&gt;-increased bedside RN time (an extra 15 minutes per patient visit)&lt;br&gt;-RN burnout and stress</td>
<td>Reassess volunteer knowledge through the same survey</td>
</tr>
</tbody>
</table>

Long-term: Investigate the cost implications of increased volunteer supporting staff
Appendix B

Project Charter

**Title:** Implementation of Feeding Education to Increase Hospice Volunteer Knowledge

**Global Aim:** To increase the knowledge, confidence, and competency of Hospice volunteers through the implementation of volunteer feeding education measured by the percentage of knowledge increase by July 2023

**Specific Aim:** To increase hospice volunteer knowledge on feeding from baseline in the pre-knowledge survey to 90% through the implementation of feeding education by July 2023

**Background Information/Rationale for the Project:**
Within the current microsystem, the volunteer program is small, with minimal volunteer training. Hospice RNs spend approximately fifteen extra minutes per patient home visit providing care beneath their scope of practice. Extra work leaves RNs feeling burnout leading to a decrease in the quality of care and customer satisfaction. The topic of feeding was identified as the main area for volunteer improvement. Focusing on providing the highest quality end-of-life care, a performance goal was created to increase volunteer knowledge regarding feeding from baseline in the pre-knowledge survey to 80%. Volunteers are shown to increase patient satisfaction by increasing companionship and bridging the gap between clinical care and family systems (Lee & Lee, 2019). The implementation of volunteer education on feeding will enable volunteers to provide nonclinical services and maximize the organization’s resources and staff skill levels.

**Sponsors:**
Director of Palliative Care and Transitions
Director of Compliance, Quality, and Education

**Interventions:**
To increase Hospice volunteer knowledge and competency through the implementation of:

1. Providing education on feeding patients
2. Addressing any barriers to volunteer learning

**Measures:**
**Outcome:**

1. Increase the percentage of volunteers receiving education
2. Decrease in RN time at the bedside per patient visit
3. Increase in yearly admission rate

**Process:** Implementation of a volunteer educational resource

**Balancing:** Volunteer dissatisfaction and overwork
**Measurement Strategy and Description:**
Data will be obtained from surveys. A pre and post-implementation survey will be conducted to compare the effectiveness of the educational materials and delivery method. Surveys will assess the volunteers’ knowledge levels, confidence levels, and overall satisfaction with the education and presentation style, and number of volunteers trained. Observation of volunteers working with Hospice patients will also be performed by the project leader to assess knowledge retention and applicability.

**Team Members:**
Director of Palliative Care and Transitions
Director of Compliance, Quality, and Education
Volunteer Coordinator
Volunteer Staff
The CNL Student
### Appendix C

#### Evaluation Table

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample</th>
<th>Outcome/Feasibility</th>
<th>Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candy, B., France, R., Low, J., &amp; Sampson, L. (2015). Does involving volunteers in the provision of palliative care make a difference to patient and family wellbeing? A systematic review of quantitative and qualitative evidence. <em>International Journal of Nursing Studies, 52</em>(3), 756–768. <a href="https://doi.org/10.1016/j.ijnurstu.2014.08.007">https://doi.org/10.1016/j.ijnurstu.2014.08.007</a></td>
<td>Systematic Review</td>
<td>8 studies (2 quantitative and 6 qualitative studies)</td>
<td>Volunteers' benefits include increased patient longevity, increased patient satisfaction, improved family caregiver well-being, and enhanced social and emotional well-being among patients. Provides useful information on the impacts of direct-care palliative care volunteers on patients and their families</td>
<td>III A</td>
</tr>
<tr>
<td>Claxton-Olfield, S. (2015). Hospice palliative care volunteers: The benefits for patients, family caregivers, and the volunteers. <em>Palliative and Supportive Care, 13</em>(3), 809–813. <a href="https://doi.org/10.1017/s1478951514000674">https://doi.org/10.1017/s1478951514000674</a></td>
<td>Literature Review</td>
<td>27 references cited</td>
<td>Patients, families, and the volunteers themselves experienced positive impacts from the volunteer services. Adds to the argument on why volunteer education is needed</td>
<td>V A</td>
</tr>
<tr>
<td>Authors</td>
<td>Study Type</td>
<td>Participants</td>
<td>Description</td>
<td>Evidence Level</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
<td>--------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Howson, F. F., Robinson, S. M., Lin, S. X., Orlando, R., Cooper, C., Sayer, A. A., &amp; Roberts, H. C. (2018). Can trained volunteers improve the mealtime care of older hospital patients? An implementation study in one English hospital. <em>BMJ Open</em>, 8(8). <a href="https://doi.org/10.1136/bmjopen-2018-022285">https://doi.org/10.1136/bmjopen-2018-022285</a></td>
<td>Quasi-experimental Study</td>
<td>Patients (aged 70 or older), 65 volunteers, and unit staff from 9 different units at an English hospital</td>
<td>The study indicates that trained volunteers can safely improve mealtime care and describes common tasks performed by mealtime volunteers. Volunteers decrease RN time and stress. Provides useful evidence that could guide educational topics</td>
<td>II A</td>
</tr>
<tr>
<td>Lee, J., &amp; Lee, J. E. (2019). A palliative care program for volunteers in a community setting: A mixed-methods pilot study. <em>American Journal of Hospice and Palliative Medicine</em>, 37(6), 455–464. <a href="https://doi.org/10.1177/1049909119895213">https://doi.org/10.1177/1049909119895213</a></td>
<td>Quasi-experimental Study</td>
<td>19 volunteers within a home-health hospice setting finished the training, 6 volunteers provided services over 10 weeks</td>
<td>After completing a two-day palliative care program, volunteers felt more dedicated to their work and confident with their abilities and skills. Volunteer confidence levels were rated at 3.32 out of 4 and training satisfaction at 8.79 out of 10. Useful evidence exemplifying the effectiveness of education in increasing volunteer knowledge and competency.</td>
<td>II B</td>
</tr>
</tbody>
</table>
| Literature Review | 21 studies | Highlights how education is an effective strategy to close knowledge gaps within palliative care settings  
Provides useful information in volunteer education development and educational strategies |  |
Appendix D

SWOT Analysis

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>- community-based approach that meets patient needs (emotional, spiritual,</td>
<td>- resistance to change from staff/volunteers</td>
</tr>
<tr>
<td>physical, and psychological)</td>
<td>- issues with retaining/finding volunteers</td>
</tr>
<tr>
<td>- well-rounded team - MDs, NPs, RNs, HHAs, social workers, spiritual</td>
<td>- streamlining services and communication</td>
</tr>
<tr>
<td>workers, diverse volunteers</td>
<td>- documentation protocol</td>
</tr>
<tr>
<td>- willing management and supportive leadership</td>
<td>- education/training of volunteers</td>
</tr>
<tr>
<td></td>
<td>- time allocation to train volunteers</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunities</td>
<td>Threats</td>
</tr>
<tr>
<td>- improve care quality and patient satisfaction and well-being</td>
<td>- volunteer resistance to more work and change</td>
</tr>
<tr>
<td>- increase patient support and companionship</td>
<td>- push back from managers who may not want the extra work</td>
</tr>
<tr>
<td>- improve education on patient/family communication</td>
<td>- emotional exhaustion from staff</td>
</tr>
<tr>
<td>- improvement could lead to more funding/donations</td>
<td>- lose patients to competing hospice organizations</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

Power Interest Grid

- High Power, Low Interest (Keep Satisfied)
  - Licensed clinical staff - physicians, RNs, social workers

- Low Interest, Low Power (Minimum Effort)
  - Administrative staff - clerical staff, HR staff, staffing members
  - Home health aides and assistive staff
  - Government

- High Power, High Interest (Manage Closely)
  - Director of Volunteer Services
  - Director of Quality, Education, and Compliance and Quality team
  - Hospice Executive Team

- High Interest, Low Power (Keep Informed)
  - Volunteer staff
  - Patients and families
Appendix F

Intervention Tool

Dysphagia and Food Pocketing

Dysphagia: difficulty swallowing due to
weakened muscles
• muscle mass decreases leading to
impaired muscle strength and function

Food Pocketing: patient holds
food in their mouth leading to
the accumulation of food as
the pt continues to eat

Aspiration

Aspiration: food, drink, or other material enters a
person's airway and eventually the lungs by
accident (“going down the wrong tube”)
• can lead to serious issues: choking, infection
(pneumonia), lung scarring
• thickened liquids are often used

If a pt has HIGH aspiration risk, DO NOT feed them

Overview: End-of-life Body Processes

1. Body shifts from anabolic to catabolic state
2. Body's metabolic processes slow down
3. Digestion takes longer
4. Patients have decreased appetite

Common Nutrition-related Signs and
Symptoms:
• refusal of food/poor appetite
• dry mouth
• constipation, diarrhea
• nausea, vomiting
• altered taste and smell
• pressure injuries

Nutritional Goals

Maintain comfort and quality of life by providing the patient maximum
enjoyment during mealtimes and minimizing discomfort

1. Primary goal: always comfort!
   • Listen to the patient's requests
2. Offer favorite foods and drinks
3. Allow patients to enjoy eating and drinking

Refusal of Food

The refusal of food is common due to
natural body changes.

Facts:
1. “Research indicates that intake
during the dying process does not
improve the quality of life.”
2. Going without food is not painful.
3. Overfeeding can cause discomfort
   as the body can not handle food at
   the same rate or volume.

Comfort/Safety Tips

-oral swabs: promotes oral cleanliness
and comfort
- offer ice chips or lip moisturizer
- intermittent sips of water to encourage
hydration—rather than all at once
- alternate between food and water
- offer frequent, smaller portions
- keep in mind temperature of foods

Food Refusal Signs

Refusal Reason:
• conscious decision to stop
  eating
• medications may alter hunger
  response
• lack of appetite & normal body
  processes and/or other medical
  issues
• difficulty chewing and low
  energy levels

Refusal Signs:
• cough
• bite the utensil
• clamp their mouth closed
• turn their head away
• spit the food out
How to Safely Feed a Patient

1. Check with staff about aspiration risk.
2. Perform hand hygiene.
3. Position patient—sitting up 45 degree.
4. Speak in short, simple sentences.
5. Prepare food—cut food into small pieces.
   - alternate between solid foods and liquids (every 2-3 bites offer liquid).
6. Start with a partially full spoon.
7. Allow to eat in small bites.
8. Ask to open mouth to check for pocketing of food.
9. Check mouth for food.
10. Keep head of bed up.

Practical Session

Applesauce Feeding
1. Find a partner.
2. Take turns feeding your partner.
3. Give each other feedback.

Oral Swab Practice
1. Explain what you are doing.
2. Dip swab in water.
3. Dab on and inside partner’s mouth.

Summary

- make mealtime enjoyable!
- focus on patient comfort and quality of life:
  - pillows for hydration
  - offer favorite foods and drinks
  - patient positioning is key
  - dysphagia, pocketing of food, aspiration
  - frequent mouth checks
  - highly individualized—every pt is different

Questions?

Group Discussion

Choose #1 or #2:
1. Discuss a difficult situation you have encountered when feeding a patient and describe what you did.
2. If you haven’t experienced a difficult situation, think of a difficult situation you may encounter and discuss what steps you would take to resolve the situation.

References


# Appendix G

## Project Timeline

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Stakeholder</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform microsystem assessment</td>
<td>CNL</td>
<td>Completed</td>
</tr>
<tr>
<td>Identify project and goals and finalize aim statement</td>
<td>CNL</td>
<td>Completed</td>
</tr>
<tr>
<td>Identify team members and key stakeholders</td>
<td>CNL</td>
<td>Completed</td>
</tr>
<tr>
<td>Meet with team discuss implementation plans/strategies</td>
<td>CNL, Team Leaders and Volunteer Director</td>
<td>Completed</td>
</tr>
<tr>
<td>Create education</td>
<td>CNL</td>
<td>Completed</td>
</tr>
<tr>
<td>Deliver volunteer educational training</td>
<td>CNL</td>
<td>Completed</td>
</tr>
<tr>
<td>Volunteers work with patients</td>
<td>Volunteers</td>
<td>Completed</td>
</tr>
<tr>
<td>Collect and analyze data</td>
<td>CNL</td>
<td>Completed</td>
</tr>
<tr>
<td>Task</td>
<td>Team</td>
<td>Status</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>Update team with results</td>
<td>CNL, Team</td>
<td>Completed</td>
</tr>
<tr>
<td>Finalize volunteer training</td>
<td>CNL, Team</td>
<td>Completed</td>
</tr>
</tbody>
</table>
## Appendix H

### Budget and Return on Investment (ROI)

<table>
<thead>
<tr>
<th>Improvement Revenue</th>
<th>Extra RN Time Per Week</th>
<th>Increase in Pt Admissions</th>
<th>Increased Revenue Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra RN time</td>
<td>15min (0.25hr)</td>
<td>-10% more pts = 2 more pts/wk</td>
<td>4 pts x $31,298 = $125,192</td>
</tr>
<tr>
<td>30 FTEs</td>
<td>20 patients/wk x 0.25hr = 5 hrs/wk</td>
<td>-4 more pts/yr -CMS- $31,298 per pt</td>
<td></td>
</tr>
<tr>
<td>$50/hr + 30% benefits = $65/hr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Patients/Week</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation Cost</th>
<th>Number</th>
<th>Education Development and Delivery (hrs)</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNL</td>
<td>1</td>
<td>-30hrs for development -4hrs for delivery (send educational materials via email)</td>
<td>$3,315 (initial one-time cost)</td>
</tr>
<tr>
<td>$75/hr + 30% benefits = $97.50/hr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td>10</td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

| Total Cost:         | $3,315 |

### Project Revenue/Cost Avoidance (ROI)

<table>
<thead>
<tr>
<th></th>
<th>Total Projected Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Revenue</td>
<td>$125,192</td>
</tr>
<tr>
<td>Cost of Implementation</td>
<td>$3,315</td>
</tr>
<tr>
<td><strong>Gross Revenue:</strong></td>
<td><strong>$121,877</strong></td>
</tr>
</tbody>
</table>
Appendix I

Evaluation Tool

Pre-education Survey and Assessment:
1. How many months have you been a Hospice Volunteer?

2. Do you currently or have previously worked in healthcare with patients?

3. Have you fed patients before? If so, how confident do you feel feeding patients?

True or False:
1. You should ask a staff member before feeding a patient.
2. As a volunteer, you can feed patients who are at aspiration risk.
3. Oral swabs and lip moisturizer are ways to minimize oral dryness and discomfort.
4. Proper patient positioning minimizes the risk for food pocketing and aspiration.
5. Alternating between solids and liquids can be dangerous for patients.
6. The refusal of food and drink is common at the end of life.

Multiple Choice:
1. Nutritional goals at the end of life include all EXCEPT:
   A. Maintain comfort and quality of life
   B. Force food to maximize intake
   C. Listen to the patient’s requests
   D. Offer favorite foods and drinks

2. If a patient aspirates, what is the first course of action?
   A. Give the patient water
   B. Immediately stop feeding the patient
   C. Have the patient lie down in bed
   D. Do nothing, aspiration is not an issue

3. When you are feeding a patient, how high should the chair or head of the bed be? At least…
   A. 30 degrees
   B. 45 degrees
   C. 15 degrees
   D. 60 degrees

4. Define food pocketing:
   A. difficulty swallowing
   B. food accumulates in the mouth
   C. issues with the patient’s digestive system
   D. patient refusing food

5. All of the following are ways to prevent food pocketing EXCEPT:
   A. Providing oral care such as oral swabs
B. Regularly checking the inside of the patient’s mouth for food  
C. Feeding the patient lying down in bed  
D. Feeding patients slowly with small bite sized portions  

**Post-education Survey and Assessment:**  
1. After completing the training session, how confident do you feel feeding patients?  

2. Did you find the practical hands-on portion helpful within the learning process?  

3. Was the session (ppt, group discussion practical session) effective in reaching the objectives?  

4. How would you rate the training from 0-10 (10 being the highest)?  

**True or False:**  
1. You should ask a staff member before feeding a patient.  
2. As a volunteer, you can feed patients who are at aspiration risk.  
3. Oral swabs and lip moisturizer are ways to minimize oral dryness and discomfort.  
4. Proper patient positioning minimizes the risk for food pocketing and aspiration.  
5. Alternating between solids and liquids can be dangerous for patients.  
6. The refusal of food and drink is common at the end of life.  

**Multiple Choice:**  
1. Nutritional goals at the end of life include all EXCEPT:  
A. Maintain comfort and quality of life  
B. Force food to maximize intake  
C. Listen to the patient’s requests  
D. Offer favorite foods and drinks  

2. If a patient aspirates, what is the first course of action?  
A. Give the patient water  
B. Immediately stop feeding the patient  
C. Have the patient lie down in bed  
D. Do nothing, aspiration is not an issue  

3. How high should the chair or head of the bed be when a patient should be in when eating? At least…  
A. 30 degrees  
B. 45 degrees  
C. 15 degrees  
D. 60 degrees
4. Define food pocketing:
A. difficulty swallowing
B. food accumulates in the mouth
C. issues with the patient’s digestive system
D. patient refusing food

5. All of the following are ways to prevent food pocketing EXCEPT:
A. Providing oral care such as oral swabs
B. Regularly checking the inside of the patient’s mouth for food
C. Feeding the patient lying down in bed
D. Feeding patients slowly with small bite sized portions
Appendix J

IRB Non-research Determination Form

CNL Project: Statement of Non-Research Determination Form

Student Name: Hannah Franzwa

**Title of Project:** Implementation of Feeding Education to Increase Hospice Volunteer Knowledge

**Brief Description of Project:** This project aims to increase hospice volunteer knowledge on feeding patients through the implementation of volunteer education. Education will be created by the CNL and presented to all volunteers. Volunteer education has been shown to be effective in increasing volunteer knowledge, confidence, and competency and useful in preparing volunteers to fulfill the multidimensional care needs of hospice patients. With education, trained volunteers can provide supplemental non-clinical care to better meet patients’ and families’ needs and in the long run, decrease RN time per patient visit and ease the RNs’ overwhelming workloads.

A) **Aim Statement:**
To increase hospice volunteer knowledge on feeding from the baseline in the pre-knowledge survey to 90% through the implementation of feeding education by July 2023

B) **Description of Intervention:**
Volunteer education reflects evidence-based practices on feeding patients and was created by the CNL. The topics covered include end-of-life body processes, nutritional goals, aspiration, food refusal, and safety tips. The CNL will deliver the educational materials, consisting of a PowerPoint presentation and practical hands-on session to the volunteers.

C) **How will this intervention change practice?**
Volunteer education will increase volunteer knowledge enabling volunteers to supplement non-clinical RN time and play an active role within patients’ care. It is expected that RNs will have more time to focus on RN specific tasks, increasing the quality of care. Other benefits include decreased RN burnout, increased patient satisfaction, and enhanced communication.

D) **Outcome measurements:** Pre- and post-surveys will be utilized to assess volunteer knowledge and the effectiveness of the educational materials and delivery method. In the long term, it is expected that bedside RN time will decrease, and
admission rates will increase. Audits will be utilized to collect data.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.bhs.gov/ohrp/categories/1569)

- This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

- This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

**EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST**

<table>
<thead>
<tr>
<th>Instructions: Answer YES or NO to each of the following statements:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Title:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The specific aim is to improve performance on a specific service or program and is a part of usual care. ALL participants will receive standard of care.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does <strong>NOT</strong> follow a protocol that overrides clinical decision-making.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does <strong>NOT</strong> develop paradigms or untested methods or new untested standards.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does <strong>NOT</strong> seek to test an intervention that is beyond current science and experience.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The project has <strong>NO</strong> funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., <strong>not</strong> a personal research project that is dependent upon the voluntary participation of colleagues, students and/or patients.</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: "This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was formally supervised by the Institutional Review Board."  

**ANSWER KEY:** If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

**STUDENT NAME (Please print): Hannah Franzwa**  
Signature of Student:  

DATE: 4/16/23

**SUPERVISING FACULTY MEMBER NAME (Please print):**  
Signature of Supervising Faculty Member:  

DATE 4/19/23
Appendix K

Outcome Data Display

Hospice Volunteer Knowledge and Confidence on Feeding Patients

Pre-Survey vs. Post-Survey

Knowledge

Confidence