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Volunteers do the fun stuff - Experiences from volunteer-professional caregiver cooperation in nursing homes

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Keywords: volunteer, professional caregiver, cooperation, experience, challenges, nursing home, palliative care, qualitative, phenomenological, symbolic Interactionism

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Abstract

Background:
The number of volunteers in Danish nursing homes is increasing. Volunteers cooperate with professional caregivers to improve the residents’ well-being and quality of life as part of their palliative care. The Danish government encourages this volunteer involvement, which is partly intended to alleviate the resource constraints in municipal healthcare. Although volunteer roles are defined as complementary to the professional caregiver role, volunteer–professional caregiver cooperation can be challenging.

Aim:
This article explores the challenges experienced in volunteer–professional caregiver cooperation in the general palliative care provided in nursing homes.

Method:
A qualitative design and a sociological phenomenological approach were adopted to answer the research question: What is experienced as challenging in the cooperation between volunteer and professional caregivers in the provision of care for elderly residents in everyday life in a nursing home? And what meanings and understandings are associated with these experiences? Data was collected by combining participant observations and interviews, and thematic analysis structured the analytical process.

Findings:
The analysis of 115 hours of participant observations in two Danish nursing homes with 50–60 volunteers involved and 16 interviews (eight with volunteers, eight with professional caregivers) identified two overall themes: ‘Symbolic indications of them and us’ (two sub-themes) and ‘Meaning and action regarding the residents best interest’ (three sub-themes).

Conclusions:
An institutional distinction between volunteer versus professional caregiver domains contributed to a sense of ‘them and us’, which hindered common experiences and raised challenges concerning
the mutual understanding of actions. The professional caregivers felt that they lacked the time to engage in social care activities with residents, for which volunteers otherwise had time. The coordinator role was a crucial link in coordinating the daily care activities for residents but marked by a sense of ambivalence among the professional caregivers.
Volunteers do the fun stuff - Experiences from volunteer-professional caregiver cooperation in nursing homes

Introduction
As elsewhere, there is increasing interest in Denmark in using volunteers in elder care to help provide the general palliative care required by the rising numbers of frail older adults living longer at home or in nursing homes, a population with complex needs in the final stages of life (1–4). In Denmark, 40% of the population is involved in volunteer work, with approximately 13% of these individuals in healthcare settings (e.g., nursing homes) (5). Volunteer work in health care is generally understood as formalised and unpaid work (5,6) and includes many types of contributions that are freely given to benefit individuals or groups outside pre-existing relationships (ibid.).

Eldercare in nursing homes is understood as part of general palliative care (1,7). In Denmark, palliative care is organised on general and specialised level (1,8). The former provides care to those affected by life-threatening diseases as an integral part of standard clinical practice and is provided by various trained professional caregivers in private homes, nursing homes, family physicians and hospitals. Specialist palliative care is found in palliative units such as hospices, palliative teams and hospital units, where palliative care is the main focus (ibid.).

Approximately 41,000 elderly people live in Danish nursing homes (9). Although the average length of residence is 30 months, one third of those who move into Danish nursing homes live there for less than a year (10). Volunteers are recognised as a valuable supplement to professional caregivers
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(4,7), and the Danish government encourages professionals to involve and cooperate with volunteers (4,11). Most Danish nursing homes include volunteers in daily social activities offered to residents (12).

This report provides insight into challenges experienced by volunteers and professional caregivers in daily cooperation of care activities in nursing homes, which is part of a larger study with the goal of investigating volunteer work and collaborative perspectives in general palliative care in Denmark (13).

**Previous research**

International studies have focused primarily on volunteer work in end-of-life care services and specialised palliative care (14–16), but a recent collection of international perspectives on the topic included no Scandinavian studies (17). Scandinavian countries generally share comparable welfare programme structures and high levels of social spending (18,19). As elsewhere, there has been increasing interest in how volunteers can be included in specialised palliative care. Little research has been reported on the topic (20,21), although some studies have focused on the role played by volunteers in long-term municipal healthcare services (22–25). These studies identify problems related to increased sharing of care-related tasks between volunteer and professional caregivers and barriers to their cooperation in the form of knowledge gaps and inadequate coordination (22,25,26). Some reports are critical of substituting volunteers for professionals in care provision, questioning whether volunteers in municipal health care are even equipped to simply interact with frail elderly individuals with many complex needs (27). Other studies show that volunteers are a valuable resource in palliative care, providing relief for next of kin (28,29) and contributing to the normalisation of everyday life for families (28). One report emphasises the importance of volunteers having access to support and training to ensure they feel comfortable caring for seriously ill and dying palliative care recipients (30). Professional caregivers identify role clarification and close monitoring of volunteers as important conditions for cooperation (31). Inadequate coordination creates challenges in the division of labour and communication between volunteer and professional caregivers (24,32). Although some cited studies investigate collaborative perspectives, none focus on how volunteers and professional caregivers experience cooperation in care provision in nursing homes as part of general palliative care offered in Denmark. The Danish government and healthcare policy encourage cooperation between volunteers and professionals,
and addressing this knowledge gap is important to enhancing and strengthening volunteer-professional cooperation in general palliative care provided in nursing homes.

Aims

The study aim was to identify challenges to volunteer and professional caregiver cooperation in general palliative care in Danish nursing homes. The research question guiding the study was:

- What are the challenges experienced in the cooperation between volunteers and professional caregivers to provide daily care for elders in nursing homes and what meanings do they associate with these challenges?

Theoretical framework

Volunteers’ social care activities (Table I) and interaction with professional caregivers in nursing homes are viewed from an phenomenological everyday life perspective (33) and analysed in terms of Herbert Blumer’s micro-sociological concepts (34). Blumer argues that human experience and meaning are social objects derived from human interaction (33–35), and they are altered, maintained or changed in interactive processes and influenced by a common human repository handed over by ancestors, history and tradition (ibid.). Symbols are aspects of meaning and signs used in communication and human interaction (ibid.). Symbolic interaction is an ongoing interpretive process in human social life that developed in multitudinous social situations and gives rise to what Blumer calls ‘joint action’ (34,36), which ranges from the ‘simple collaboration of two individuals to a complex alignment of the acts of huge organizations or institutions’ (35, p. 70). In this theoretical view, the constitution of human joint action is the ‘fitting together’ of humans’ separate and distinct acts from their different positions (34,36). Blumer’s ontology rests on three premises: (1) human beings act towards things based on the meanings they have for them, (2) these meanings are derived through social interaction between individuals and (3) meanings are altered and modified through an interpretive process within participants’ minds (34). The framework offered theoretical concepts as guides to perceptions in the analysis of human experience and meaning in social life: in this case, interactions between volunteers and professional caregivers cooperating to provide care for elders in nursing homes.
Design

A qualitative design with a phenomenological sociological everyday life approach (33,37,38) was used in two nursing homes to illuminate the experiences, thoughts, feelings, meanings and understandings derived from interactions between volunteers, professional caregivers and nursing home residents.

Method and setting

The qualitative design combined participant observations with qualitative interviews (38,39). The design contributed to the acquisition of ‘insider knowledge’ about existing social practices that was unavailable through interviews alone and provided direct observations of interactions between volunteers, professional caregivers and residents. The author participated in various social activities, such as sitting around a table drinking coffee with residents and volunteers or helping volunteers with practical tasks like moving tables and chairs and cleaning up after an event. Fieldnotes were recorded within 24 hours to preserve details from observations and valuable informal conversations. The use of both participant observation and interviews created opportunities to recruit informants for interviews, inspired the questions in the semi-structured interview guide and informed the subsequent analysis (ibid.). An example of an interview question inspired from observations is: “Yesterday, I noticed you volunteered on the bus tour. Afterwards, you stayed back for a while with some of the residents. It looked as if you were waiting. What happened there?” Interviews were conducted with both individuals and groups based on informant preferences and convenience.

One public nursing home in each of two regions in Denmark with at least five years of experience at involving volunteers participated. Nursing homes were recruited through a municipal network group located in the Danish Knowledge Centre of Rehabilitation and Palliative Care (REHPA). Each nursing home had more than 90 residents, 50–60 volunteers involved in activities and at least one employee responsible for recruiting, organising and coordinating volunteers and their work, referred to here as activity coordinators. Volunteers had different affiliations, reflecting the general diversity of volunteers in Danish nursing homes (40). Becoming a volunteer required no previous
training, and the work of volunteers ranged from practical help to direct support and social interaction with residents (Table I).

**Informant characteristics and data collection**

A convenience sample of 22 participants (9 volunteers, 13 professional caregivers) for interviews (12 individual interviews and 4 group interviews) was used to explore participants’ experiences of cooperating in everyday care activities for residents. All nursing home residents were included in participant observations, regardless of the degree of their palliative care needs related to life expectancy and concurrent chronic conditions and other life-threatening conditions (1,3,10). Palliative care takes place in parallel with all other care efforts as a part of general palliative care in community health care (41). To ensure volunteers had adequate experience, only those who volunteered regularly (2-12 hours each week) in nursing homes were asked to participate in interviews. Volunteers had been informed by mail about the project in advance, and interview requests were made in connection with participant observations. Most volunteers were retirees (aged 65–85 years), and they included three men and six women; one volunteer was 30 years old and employed full time outside the nursing home. Interviewed professional caregivers had varying educational backgrounds, but all interacted with volunteers during daily care activities. Professional caregivers were all female and employed as activity coordinators, social workers, social and care assistants, and nurses. The interviews took place at nursing homes and two by telephone, lasting 30-80 minutes. When interviews with caregivers took place during working hours, the ward manager arranged an appointment. Interviews were conducted in a quiet, closed room in the nursing home. Interviews were transcribed verbatim. Distributions of participant observations and interviews are listed in Tables II and III.

Table I. Examples of social care activities provided by volunteers

Table II. Participant observations

Table III. Interviews

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Ethical considerations

Ethical approval was sought from the Regional Ethical Committee, but this type of qualitative study did not require approval (Journal nr.: H-18032834). The principles for ‘The Danish Code of Conduct for Research Integrity’ were adhered to throughout the entire research process (42), and data were all processed according to the Danish Data Protection Regulations (43). The study respected the ethical principles stated in the Helsinki Declaration (44). The nursing home leaders provided written informed consent that their respective institutions would participate in the project, and all volunteers received written information explaining the aim of the project by personal mail. Weeks and dates for participant observations were provided in case volunteers wanted to opt out of their volunteer work during the observation period, although no volunteers chose to do so. All interviewed informants gave written consent before an interview, and individual informants and the institutions were assured anonymity.

Analysis

The analysis process alternated between a phenomenological and largely inductive approach in the initial stages and a more theory-inspired and deductive process in the final stages and the presentation of results. In this abductive approach, theory and empirical data were reinterpreted in light of each other in a creative, dynamic and flexible iterative process until data saturation was reached (45). Braun and Clarke’s (46) step-by-step model for thematic analysis helped structure the process. First, fieldnotes and transcribed interviews were read several times to get a sense of the whole dataset. Key phrases that made an impression were underlined, and the meaning of words and passages was tentatively noted. Second, an initial open coding for each dataset was conducted. In the third step, codes were aligned across data and organized into meaningful groups and matched with potentially relevant quotes. Fourth, the search for potential themes continued as an ongoing process of considering codes at various levels of information or that might represent an overarching theme. In this step, Blumer’s (34) understanding of experience as an social object derived from human interaction was helpful to identify and sort themes relevant to the study aim. Fifth, identified themes were refined, leading to the identification of two overall themes capturing important phenomena from the empirical data that met the study aim. Finally, the analysis and final

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manuscript centred on two overall themes with subthemes (Table IV). An example from the analysis process is illustrated in Table V.

Table IV. Final identified overall themes with sub-themes

Table V. The process of analysis related to the theme of symbolic indications of ‘them and us’

Findings

The following section presents an interpretation of the overall themes and subthemes. Quotations are from interviews, augmented by context from fieldnotes. Interviews are named with the letters A-P and the nursing homes named NH I and NH II.

Symbolic indications of ‘them-and-us’

The analysis identified phenomena encapsulating features of meanings derived from interactions between volunteers and professional caregivers that communicated a ‘them-and-us’ understanding. This made cooperating on care activities for residents more challenging for both groups.

Unspoken boundaries

During participant observations, the common area was the typical setting for social care activities involving volunteers. When volunteers went to the ward to pick up a resident to participate in an activity or deliver a resident to their room afterward, they reported feeling that they crossed an institutional boundary, which they understood as entering the professional caregivers’ domain. In this space, they felt uncertain about whether they unknowingly crossed pre-established and unspoken boundaries. As one volunteer who picked up the same frail resident from the ward every week explained:

‘To find out what to say and say the right things. That is difficult. There are lots of practical things I’d like to talk a little bit more about, like the boundaries between
what a volunteer can do and what the professional caregivers do—to have a better understanding of the nature of their professional work (…) I’m afraid of stepping on someone’s toes. I do not want my work to come at the cost of professional resources. I want to respect the boundaries. (Interview H p.5, nursing home’ [NH] II)

If professional caregivers were unavailable to answer questions or to offer volunteers help with residents, the lack of interaction made the volunteers feel unsure that they were welcome on the ward and that professional caregivers approved of their actions with residents. Many professional caregivers were cognisant of their role in welcoming volunteers, but some also felt that professional caregivers failed to see how volunteer work should be viewed as an integrated and valuable part of the overall nursing home care. One social and care assistant commented: ‘We can do better. I feel we sometimes look at [the volunteers] as “them” and then there’s “us”. We do our work and focus on that, but we do not connect it to the volunteers’ work. They’re a great part of what we can offer’ (I p.11, NH I).

Although volunteers had the impression that professional caregivers wanted to interact and cooperate with them about residents’ participation in social care activities, professional caregivers’ actions did not always reflect this. Neither volunteers nor caregivers articulated this dichotomy, which contributed to maintaining ‘them–us’ meanings and created a barrier to mutual understanding and coordination of their joint actions.

**Volunteers do the fun stuff**

Volunteers and professional caregivers engaged in different care activities in the everyday flow of nursing home life, which communicated obvious differences between being a volunteer versus a professional employed caregiver. Volunteers enjoyed spending time simply being with residents in common areas. They felt they contributed both to the residents’ wellbeing and to their own:

- I get a lot out of seeing the joy in their eyes when I serve coffee, something to eat or help them with other things (I D, p.4).
- Helping gives me an inner joy (I A, p.1)
- Having contact with working life keeps me going (I G, p.4)
However, professional caregivers felt that time to interact with residents in care activities other than the most urgent personal and medical tasks was a privilege they lacked. One social and care assistant mentioned: ‘It’s frustrating not to do the fun things. You must admit it. [The volunteers] have other experiences with the residents. See them in other situations. They see other sides and resources that we don’t’ (I O, p.3). As one nurse explained: ‘It’s like the icing on the cake. We never get it (…) I can see it. I do not think it is about envy at all. It is the feeling of insufficiency. You wish you could do it’ (J p.10, NH I).

For professional caregivers, interacting with residents in social care activities symbolised the best part of caregiving and was also an important way of acknowledging and using individual residents’ resources that otherwise went unnoticed during everyday care on the ward. Some professional caregivers indicated that they would prefer volunteers to be on the ward more frequently, nearer the frailest residents. As one social and care assistant explained:

I’ve suggested smaller activities. Bingo on the ward instead of in the common areas. That would contribute to the social life on the ward. Singing and music here, for example (…) More focus on what the residents want – small things and not always the big things, because they’re too much. (M p.3 NH I)

The pre-established meanings of volunteers’ locations in the nursing homes were not shared between the parties’ and contributed to maintaining a ‘them/us’ distinction not necessarily wanted of neither volunteers or professional caregivers.

*Meanings and actions regarding residents’ best interests*

Interactions that volunteers and professional caregivers experienced with residents played out differently in different domains in the nursing home, causing divergent expectations and perceptions of reality in relation to the residents and posing a challenge to volunteer-professional caregiver cooperation.

*Social activities support the wellbeing of the individual resident*

Volunteers had a firm understanding of the care activities offered in the nursing home common areas as being highly appreciated by elderly residents. Volunteers felt that residents who did not
appear at activities were being deprived of social activity that improved their wellbeing. As one female volunteer explained:

Fellowship with others is very important. They want to participate and listen and be together with others. When you do something together, you have something to talk about. They do not get out anywhere else. This place is their ‘out’. (D p. 3-4, NH I)

Many residents required help and support to participate in social activities due to their physical or mental conditions. When joint actions about social care activities did not take place, the volunteers interpreted this primarily as a professional caregiver responsibility and a lack of action on their part. As one male who volunteered several times weekly commented:

Some of the residents cannot come down here. Or maybe the professional caregiver does not want them to. They must feel lonely. If they are used to sitting together with others eating, drinking coffee, or watching TV – and then they are left alone. (F p.6, NH I)

Volunteers felt obliged to encourage residents to participate to improve their wellbeing and acted based on experiences and meanings generated from their interactions with residents. A male volunteer came every week to sing and play music with residents. He said: ‘When we play, some of them move their feet and sometimes some get up and dance. They seem happy, and it’s as though it contributes to their will to live’ (G p.2, NH II).

Professional caregivers acted based on meanings derived from their professional interactions with residents on the ward. When professional caregivers’ and volunteers’ meanings did not result in joint actions related to social care activities for the residents, both could find it challenging.

*Shielding residents from excessive activity*

Professional caregivers had access to in-depth clinical information about individual residents’ physical and mental condition and a long-term professional perspective on residents’ wellbeing that volunteers lacked. They acted on the basis of their professional knowledge, and volunteers did not always interpret their actions as being in the residents’ best interests. One social and care assistant explained that she felt she sometimes had to shield residents from activities offered by volunteers: ‘We know the residents, their reactions and how to support them. It’s important to avoid overwhelming some of them’ (O p.7, NH I). When professional caregivers felt a social activity did
not optimally promote a resident’s wellbeing, they acted on this impression by keeping the resident on the ward.

The professional obligation of confidentiality was a strong symbol for volunteers and professional caregivers alike, communicating their differing knowledge, roles, and authority, as well as the protection of the residents’ personal integrity. Knowing what information could be given to volunteers was not always easy. A social and care assistant explained the difficulty of trying to find a way to give important information to volunteers: ‘They can ask me about things I’m not allowed to tell them about. It is about confidentiality. Then you try to find a way, so the resident does not lose their dignity’ (O p.4, NH I). Many professional caregivers felt it was better to give no information at all about residents to avoid any wrongdoing. The lack of information was challenging for volunteers when it left them in a difficult situation in relation to their interaction with residents. A volunteer mentioned an example: ‘If someone dies, they can’t tell you. Then you happen to find out accidently. When you are in the house a lot, this is strange (...) You know the resident’ (B p.6, NH I).

Another complicated situation occurred when volunteers served food and drinks to residents during social activities in common areas without information about residents’ dietary limitations.

During participant observations, these challenging experiences occurred regularly, with implications for volunteers’ feelings of acting in the resident’s best interest. Nursing homes had no formal guidelines for sharing information with volunteers on a need-to-know basis. In these situations, activity coordinators often acted, becoming the link between the volunteer and professional care domains and translating actions between domains if misunderstandings occurred.

The link

The activity coordinator role was a symbol that communicated the meanings that volunteers were wanted in the nursing home and that involving many volunteers required coordination. These employees interacted with volunteers when they did voluntary work and offered diverse social care activities in nursing home common areas. As professionals, activity coordinators also had confidential information about residents, in addition to knowing them personally, and could act across institutional boundaries. This made the coordinator an important link in negotiating meanings and actions when cooperation was difficult or misunderstandings occurred. For professional caregivers, the activity coordinator role communicated priorities about the primary
contact and responsibility for volunteers and cooperating with them about offered social care activities. Some professional caregivers felt that this role could be a barrier to daily cooperation and mutual understanding. As one social and care assistant explained:

‘It’s a barrier when we don’t arrange encounters between volunteers and professional caregivers (...) It isn’t enough for the activity coordinator to have third-person contact to the volunteers. If they are not on the ward, we do not get to know each other. It is about trust. It is about developing a mutual understanding.’ (M p. 4, NH 1)

In addition to limiting contact between volunteers and professional caregivers, the activity coordinator role also reinforced the practice of most social activities offered by volunteers being held in common areas, which limited the ability of the frailest residents to participate. Neither volunteers nor professional caregivers articulated these meanings, which contributed to maintaining an ‘them/us’ perspective rather than developing or changing meanings important to cooperating in joint action related to social care activities for residents.

Discussion

Interactions between volunteers and professional caregivers in everyday life in nursing homes can seem ordinary and trivial and may be taken for granted. Skatvedt (47) argues that interactions in common everyday life situations can be something extraordinary and of great importance for the human beings involved. The phenomenological everyday life perspective from Schutz (33) and theoretical concepts from Blumer (34) provided a lens for deeper understanding and knowledge of not only challenging experiences arising from interactions between volunteer and professional caregivers and the meanings associated with these experiences, but also of conditions related to cooperation in care activities for residents in everyday life in two nursing homes. This can be an important pathway to understanding, developing and strengthening volunteer work and volunteer-professional caregiver cooperation in social care aspect of general palliative care.

The analysis revealed that both volunteers and professional caregivers had visions of developing traditional understandings of their respective roles and the work they carried out in nursing homes. Still, the actual interactions between these two groups and their actions reflected no such visions. According to La Cour (48), creative new ways of playing out both the professional caregiver and
volunteer roles can be hindered by insisting on very clear boundaries. This study’s findings call for questioning existing boundaries about the location of volunteer work and how cooperation between volunteers and professional caregivers traditionally takes place in everyday life in nursing homes. Van Bochove et al. (49) used the concept of ‘welcoming work’ to describe the social act by which professional caregivers invite volunteers into what is traditionally understood as the professional domain. In contrast to Van Bochhove et al.’s concept this study found that welcoming work was not motivated exclusively by professional caregivers’ tight schedules and work pressure, but more by their wish to include the frailest residents in offered activities. An expanded concept of welcoming work might contribute to better integration of volunteers as a part of the team providing general palliative care. Volunteers providing care activities in both common areas and wards could address the finding from this study that professional caregivers valued involvement in social care activities with residents but felt they lacked the time to do so. Volunteer–professional caregiver interactions on the ward could provide a pathway to strengthening their mutual understanding of individual and joint actions on behalf of residents.

In contrast with other Scandinavian studies (22,50), activity coordinators in this study were in daily contact with volunteers and served as the important link across institutional boundaries and domains. This role also included daily coordination of care activities offered to the residents. In Denmark, the municipal interest in employing well-trained volunteer coordinators has increased in recent years, and these professionals are seen as important bridge builders between civil society and institutions with volunteers involved in daily activities (51). This study found that limited direct contact between volunteers and professional caregivers was reinforced by the activity coordinator role, but these meanings were not articulated. Other studies have shown that professional caregivers felt an extra workload when many volunteers were involved, and a professional activity coordinator symbolizes the involvement of many volunteers (22,24).

The meanings on which the cooperating parties acted were closely interwoven with how the institutions traditionally involve volunteers. According to Blumer (34,52), meanings are maintained, developed or changed in the process of human interaction, and institutions consist of these human interactions. Berger and Luckman (53) focus on the dialectic relationship between micro and macro conditions in human social life and reality, and they emphasise that roles and actions are determined by objective meanings and attributed socially in context, arguing that meanings exist
because of the acting parties’ reiteration (ibid.). The findings from this study indicate that the traditional or historical objective meanings of the roles of volunteer and professional caregivers in nursing homes were experienced as challenging and rigid by participants, who wanted more flexible boundaries. If meaning sharing takes place, the identified pre-established meanings this study identified can become a basis for cooperating parties to reflect on alternative kinds of interaction in social care practices in nursing homes. In this way, a pathway can be potentially cleared to creating new ways of joint action in volunteer–professional caregiver cooperation with positive implications for nursing home residents.

**Strengths and limitations**

Giving voice to the lived experiences of volunteer and professional caregivers provides opportunities for reflections on present and future social practices in nursing homes. Combining participant observation and interviews provided a unique opportunity to elaborate on informants' interpretations of interactions. The study included two larger nursing homes at which activity coordinators oversaw many volunteers. The findings may not be applicable in smaller nursing homes with few volunteers and other ways of coordinating volunteer work. This study did not take into account volunteers’ age, gender, life experience, previous paid work or professional background and factors pertaining to professional caregivers’ varying educational backgrounds that may have influenced their perspectives. For example, a Danish survey (26) showed that differences in professional training influenced professional caregivers’ views on what were understood as complementary care tasks versus core tasks requiring professional attention. The findings may be transferable to other palliative care contexts, but further research is needed to explore this possibility. Future studies should also include the perspectives of residents to understand the implications of the challenges described here for the individuals who are intended to benefit from social care activities.

**Conclusion**

The clear institutional distinction between volunteers and professional caregivers’ locations in nursing homes was experienced as a challenge in daily cooperation about social care activities offered to residents. Neither volunteers nor professionals necessarily wanted this institutional
distinction, but unshared meanings hindered the development of new forms of interaction, meaning and joint action related to care activities offered to residents. Nursing home institutions should aim to establish specific frameworks that allow greater flexibility in terms of where volunteers offer social care activities. Professional caregivers should be aware of their unspoken expectations for volunteers and be willing to explicate and adapt these expectations. Furthermore, the activity coordinator role was essential for coordinating volunteer work and generating a mutual understanding of actions and flexibility. This role also underscores the need to pay attention to proportional professional caregiver resources when many volunteers are involved if cooperation on daily care activities for residents is to be strengthened.

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Conflicts of interest and funding

The author has no conflicts of interests to disclose.
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(Vancouver system)

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26. Thomsen MK, Jensen UT. Service Professionals’ Response to Volunteer Involvement in


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Table I. Examples of social care activities provided by volunteers

Making coffee, baking, preparing food together with residents, and setting up chairs and tables or other practical tasks in connection with social or cultural events and care activities

Going for walks, pushing a wheelchair, bicycling, and bus tours outside the nursing home

Socialising with the residents in the common areas and/or visiting residents on their ward

Reading, singing, playing cards or bingo

Helping residents to partake in religious services with the local clergy

Vigil services related to dying residents*

*The care provided by these volunteers is not included in the study in hand and is analysed in another article (4).
Table II. Participant observations

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<th>NH II</th>
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<td>37</td>
<td>115</td>
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Participant observations took place over 21 days in the period 01.08–20.12.2018
Table III. Interviews

<table>
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<th>Nursing home II</th>
<th>Informants</th>
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</thead>
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<td></td>
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<tr>
<td>Volunteers</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Professional caregivers</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Group interviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td>0</td>
<td>1 (2 informants)</td>
<td>2</td>
</tr>
<tr>
<td>Professional caregivers</td>
<td>1 (3 informants)</td>
<td>2 (5 informants)</td>
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</tr>
<tr>
<td><strong>Number of informants</strong></td>
<td>13</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td><strong>Number of interviews</strong></td>
<td>11</td>
<td>5</td>
<td>16</td>
</tr>
</tbody>
</table>

Table IV. Final identified overall themes with sub-themes.

<table>
<thead>
<tr>
<th>Overall theme</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Symbolic indications of ‘them-and-us’</td>
<td>- Unspoken boundaries</td>
</tr>
<tr>
<td></td>
<td>- Volunteers do the fun stuff</td>
</tr>
<tr>
<td>2. Meanings and actions regarding the resident’s best interest</td>
<td>- Social activities support the resident’s wellbeing</td>
</tr>
<tr>
<td></td>
<td>- Shielding residents from excessive activity</td>
</tr>
<tr>
<td></td>
<td>- The link between</td>
</tr>
</tbody>
</table>
Table V. The process of analysis related to the theme of *symbolic indications of ‘them and us’*

<table>
<thead>
<tr>
<th>Step 1: Transcription, familiarisation of data, key phrases underlined for initial coding.</th>
<th>Initial codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fieldnote extract (providing context):</td>
<td>The common areas are central settings in the nursing home</td>
</tr>
<tr>
<td>They deliver the tray with coffee and cookies to the kitchen and then walk around a bit. They seem to be waiting. One of the residents from the bus tour cannot find her way back to the ward by herself. The other three residents go to the ward (...) Ten minutes pass. The volunteers are waiting. Then they begin following the resident to the ward. One of them says to the other: ‘it’s typical’. A professional caregiver arrives and meets them on their way to the ward (Fieldnote NH I).</td>
<td>A place for meeting – and for waiting</td>
</tr>
<tr>
<td>Interview extract:</td>
<td>Some residents need help</td>
</tr>
<tr>
<td>‘You could, if [the volunteers] are on the ward playing and singing we could be together. We could drink coffee and sit there together for 10 minutes and sing with them (...) It’s a barrier when we don’t arrange encounters between volunteers and professional caregivers (...) It isn’t enough for the activity coordinator to have third-person contact to the volunteers. If they do not come to the ward, we do not get to know each other. It is about trust. It is about developing an understanding of each other (Nursing assistant, M p. 4, NH I).</td>
<td>Some residents help themselves</td>
</tr>
<tr>
<td></td>
<td>Professionals are on the ward</td>
</tr>
<tr>
<td></td>
<td>Professionals are expected to pick up the residents after a bus tour</td>
</tr>
<tr>
<td></td>
<td>Waiting triggers emotions</td>
</tr>
<tr>
<td></td>
<td>Waste of time</td>
</tr>
<tr>
<td></td>
<td>Volunteers act if professionals do not</td>
</tr>
<tr>
<td></td>
<td>Professional caregivers (often?) let volunteers wait</td>
</tr>
<tr>
<td></td>
<td>Volunteers not usually on the ward</td>
</tr>
<tr>
<td></td>
<td>A vision</td>
</tr>
<tr>
<td></td>
<td>Meeting with volunteers on the ward</td>
</tr>
<tr>
<td></td>
<td>Being together in social activities</td>
</tr>
<tr>
<td></td>
<td>Playing, singing, drinking coffee together</td>
</tr>
<tr>
<td></td>
<td>Lack of doing things together</td>
</tr>
<tr>
<td></td>
<td>Lack of encounters</td>
</tr>
<tr>
<td></td>
<td>inherent barriers in the organisation of the volunteer work</td>
</tr>
<tr>
<td></td>
<td>An activity coordinator is not enough to ...</td>
</tr>
<tr>
<td></td>
<td>The activity coordinator a third person</td>
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<tr>
<td></td>
<td>The activity coordinator another role</td>
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<tr>
<td></td>
<td>Lack of contact</td>
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<tr>
<td></td>
<td>Lack of knowing each other</td>
</tr>
<tr>
<td></td>
<td>Lack of understanding</td>
</tr>
<tr>
<td></td>
<td>...</td>
</tr>
<tr>
<td>Step 2: Initial coding of each dataset. Recoded across the entire dataset</td>
<td>Step 3: Codes recoded across the entire dataset and put in meaningful groups</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Volunteers do not usually set foot on the ward&lt;br&gt;Professional caregivers are on the ward&lt;br&gt;Professional caregivers do not usually stay in the common areas&lt;br&gt;Do not meet&lt;br&gt;Do not sit together&lt;br&gt;Volunteers afraid of breaking rules</td>
<td>Them–us&lt;br&gt;Unspoken boundaries&lt;br&gt;Different whereabouts&lt;br&gt;The institutional distinction</td>
</tr>
<tr>
<td>e.g. codes</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | | | |</p>
<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunte</td>
<td>Unspoken</td>
<td></td>
<td>Symbolic</td>
<td>It isn’t enough for the activity coordinator to have third-person contact to the volunteers. If they do not come to the ward, we don’t get to know each other.</td>
<td></td>
</tr>
</tbody>
</table>