



# Volunteer Orientation:

## Assisted Living (AL) and

## Licensed Dementia Homes (LDH)

Beacon Community Services

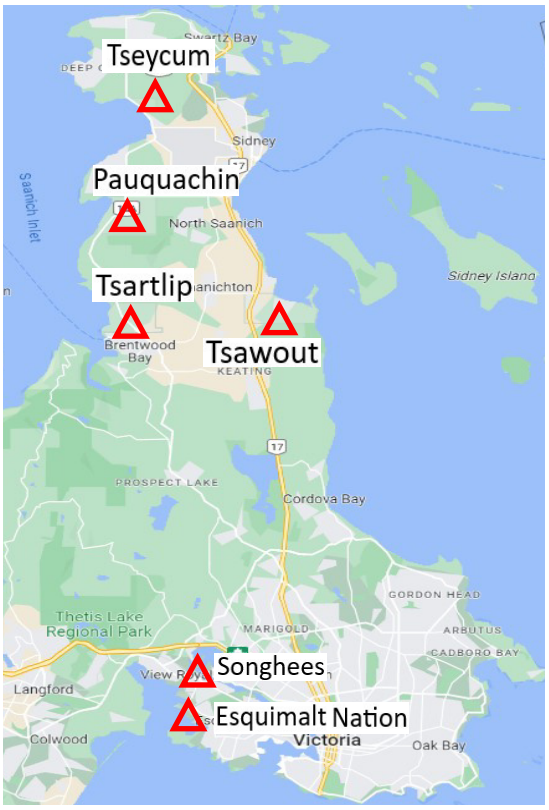
*Helping People…Improving Lives*

**Created August 2023**

# Territory Acknowledgement

*Beacon Community Services respectfully acknowledges that we live, work, play and serve on the traditional and unceded territories of many Indigenous Nations, including the W̱SÁNEĆ, SENĆOŦEN speaking people, and the lək̓ʷəŋən - speaking peoples of the Songhees and Esquimalt First Nations. Beacon Community Services' longstanding commitment to those we serve, including our staff and volunteers, is to work in partnership with Indigenous peoples and cultures to better understand how we can strengthen relationships and move forward together with care, love, truth and respect.*

Map credits: https://www.bcafn.ca/first-nations-bc/interactive-map




# Volunteer Information

Name: _____

Orientation date: _____

My site: _____

Site supervisor: _____

**For questions, contact:**

Volunteer Services

SHOAL Centre

10030 Resthaven Drive, Sidney, BC

V8L 3G4

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https://beaconcs.ca/services-programs/volunteer-services/

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# Assisted Living and Licensed Dementia Homes

## Assisted Living

- Parry Place Assisted Living: located at 408 Parry Street, James Bay, B.C.
  - 21 publicly-subsidized rooms in a four-story apartment building.
- SHOAL Centre Assisted Living: located at 10030 Resthaven Drive, Sidney, B.C.
  - 25 publicly-subsidized rooms.
  - Residents receive a yearly membership to the community centre co-located in the building.
- Individuals who reside in Assisted Living are referred to as 'clients' or 'Residents'.
  - Assisted Living Residents require assistance with both personal care (bathing, grooming, medication) and hospitality (housekeeping, laundry, linens).
  - Residents at Parry Place and SHOAL Assisted Living are medically stable and do not require intensive services such as hospital monitoring. Residents are not diagnosed with Dementia.
  - Residents are able to communicate, make informed and safe decisions, follow directions, and navigate familiar places independently.
  - Residents do not demonstrate behaviours that could endanger the wellbeing of others.
- Residents receive the following services:
  - Personal care assistance, including bathing, grooming, and medication dosing.
  - Hospitality assistance, including weekly housekeeping, laundry and linen washing.
  - Access to three hot meals and two snacks daily.
  - 24/7 emergency assistance.
  - Optional activities both on and off-site.

SHOAL Centre

Parry Place

# Licensed Dementia Homes

- Brentwood House: located at 1167 Stelly's X-Road, Brentwood Bay, B.C.
  - 15 publicly-subsidized units and 1 private-pay unit located in a two-story home. There is both an elevator and stairs leading to the second floor.
- Sluggett House: located at 1336 Marchant Road, Brentwood Bay, B.C.
  - 16 publicly-subsidized units located in a one-story building.
- Individuals who reside at Brentwood and Sluggett House are referred to as 'clients' or 'Residents'.
  - Clients are referred to Licensed Dementia Homes when their Dementia symptoms can no longer be managed safely in community care or Assisted Living settings.
  - Residents at Brentwood and Sluggett House have independent mobility and may use a cane or walker. They require a secured facility to prevent wandering from the home, but have access to a fenced outdoor area outside the home.
  - Residents are followed by a primary physician, but must be medically stable and not require inpatient hospital services to reside at Brentwood or Sluggett House.
- Brentwood and Sluggett House both follow a social model of care.
  - Emphasis is placed on maintaining Resident dignity and independence. Residents are empowered to make informed decisions about their lives and daily activities.
  - Residents are supported to use their cognitive and physical capabilities for as long as possible.
- Residents receive the following services:
  - Assistance with personal care, including bathing, grooming, using the bathroom, and medications. Residents can also access basic therapy services, such as physiotherapy.
  - Private rooms with weekly housekeeping and laundry.
  - Daily meals and snacks in a shared dining room.
  - 24/7 access to care from licensed nurses and care aides.
  - Optional activities including physical activities, games, art, music therapy, and pet visits.

Brentwood House


Sluggett House

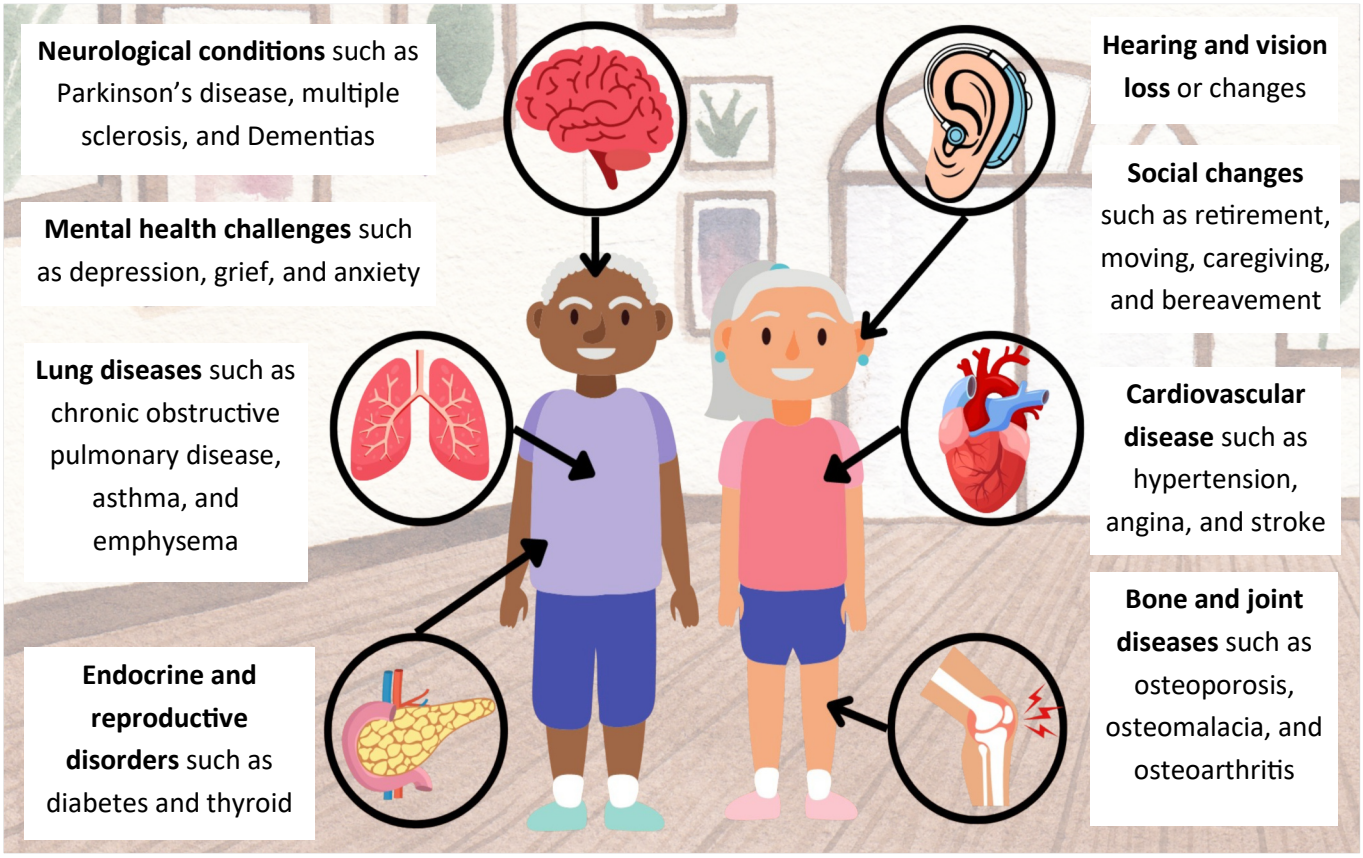
# Ageing, Dementia, and Other Conditions

## Ageing

### What is ageing?

- "At the biological level, ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time… ageing is often associated with other life transitions such as retirement, relocation to more appropriate housing and the death of friends and partners" (World Health Organization (WHO), 2022).
- Ageing causes a decline in mental and physical capabilities, but severity of declines vary significantly between individuals of the same age.
- Environment, health behaviours, and genetics influence the changes during ageing.
  - Environments include the womb before birth, homes, neighborhoods, and countries.
  - Health behaviours are actions that an individual takes to maintain and promote their health. These include eating a balanced diet, exercising regularly, and caring for mental health.
- Socioeconomic status also influences an individual's experience of ageing, by influencing an older adult's access to healthcare, social and cultural supports, nutrition, and caregivers.

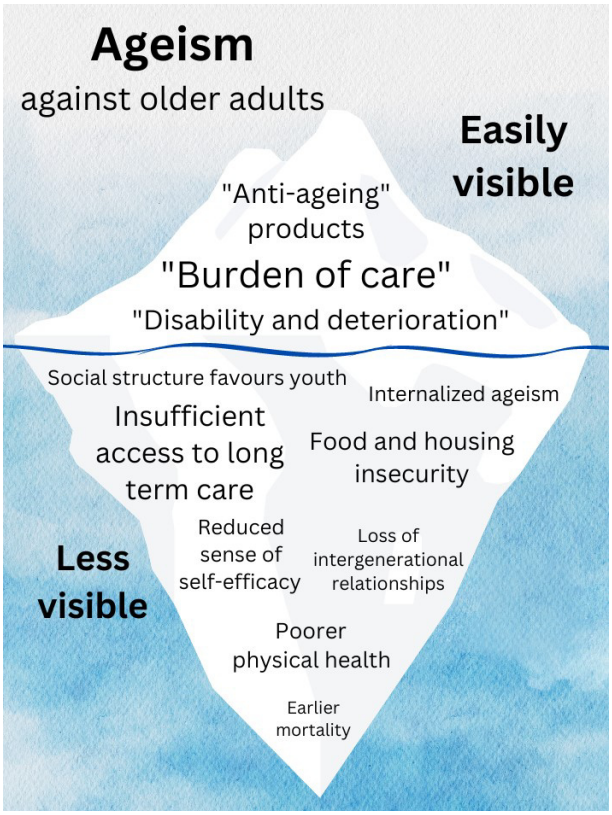
### Common conditions in older adults



# What is Dementia?

Ageing is not inherently negative:

- *Ageism:* Stereotyping and discrimination towards people because of their age.
  - Ageism can manifest as prejudiced attitudes, discriminatory behaviours, and social structures that strengthen biases towards certain age groups.
- Older adults tend to be more subject to ageism than individuals in other life stages.
  - Ageism is linked with poorer mental and physical health, and earlier death.
  - Older adults may be less able to access healthcare, housing, and other resources that people who are younger.
  - Elder abuse and social isolation are two direct consequences of ageism; both have negative impacts on the health and wellbeing of older adults.




- Older adults can (and do) contribute to society:
  - Provide care to spouses, friends, family, grandchildren, or other loved ones.
  - Contribute valuable volunteer services and charitable donations.
  - Share their stories or act as elders in their community.
  - Influence social and political change in their communities.

*Reflection:*

What are some misconceptions, stereotypes, or prejudices that I have about older adults?
What evidence do I have to dispute these beliefs?

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# Dementia

## What is Dementia?

- *Dementia* refers to a set of symptoms caused by underlying neurological disease or injury. These symptoms include memory loss, mood changes, difficulty making decisions, performing daily tasks, and using speech and language.
  - In 2020, approximately 124,000 people in Canada were diagnosed with Dementia, and a total of 597,000 people in Canada living with Dementia.
  - The number of people in Canada living with Dementia is expected to rise to 955,900 by 2030.
  - Alzheimer's disease is the most common cause of Dementia, but there are other diseases that can lead to Dementia.
- Changes to memory are normal with ageing, but the changes observed in Dementia are not.
  - *Age associated memory impairment* refers to the gradual deterioration in memory associated with ageing, and is not cause for concern.
  - *Mild cognitive impairment* refers to memory loss, disorientation, and speech difficulties that are present but don't impair daily functioning. This may be a precursor to Dementia.

## Age associated memory impairment vs. early Dementia

| | Age associated memory impairment | Early stage Dementia |
|---|---|---|
| **Memory** | ♦ Forgetting details from a long time ago (e.g. a year)<br>♦ Occasionally getting lost in unfamiliar or new places | ♦ Forgetting details or events from several moments ago<br>♦ Frequently becoming lost in familiar places |
| **Speech and Language** | ♦ Forgetting words occasionally, but meaning is still conveyed<br>♦ Can follow and participate in conversations | ♦ Forgetting simple words, losing the meaning of speech<br>♦ Struggling to follow and participate in conversations<br>♦ Speech may be slurred |
| **Mood and Personality** | ♦ Moods are stable, predictable, and appropriate in context<br>♦ Personality is consistent with past personality | ♦ Mood changes for no apparent reason, or emotions are not appropriate in context<br>♦ Personality may change, or the person may seem "different" |
| **Daily Activities** | ♦ Everyday tasks are remembered and can be performed independently, or with some assistance | ♦ Everyday tasks or the steps to complete them are forgotten. May require significant help to complete tasks. |

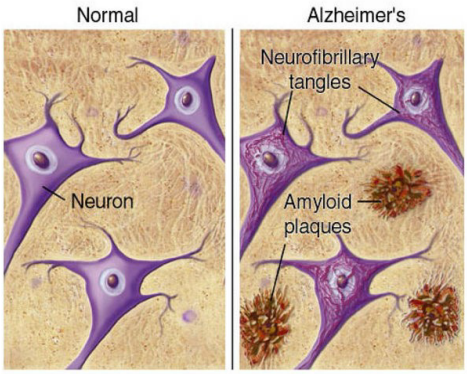
# Types of Dementia

Neuroscience introduction:

- The brain is made up of *neurons*, which are specialized cells that allow us to sense, interpret, and respond to our environment.
- Groups of neuron connections form functional regions in the brain that specialize in one or more skills, such as memory or vision.
  - When brain damage occurs, the skill that was controlled by the damaged region may become impaired or lost.
- Dementia is caused by neuron death leading to brain damage.
  - The symptoms of Dementia will depend on the which regions of the brain have been damaged. For example, if the memory region of the brain is damaged, memory impairments will occur.
  - Many Dementias are progressive due to the increasing number of neurons that die as the illness advances. Unfortunately, dead neurons cannot be regenerated.

Alzheimer's disease:

- Alzheimer's disease is the most prevalent type of Dementia, responsible for 60-0% of cases. Alzheimer's disease is progressive and terminal, and there is no cure.
- Caused by *plaques* and *tangles* forming in and around neurons, causing neuron death throughout the brain. The diffuse nature of damage results in disability in most areas of functioning.
- Symptoms progress slowly, and include loss of long and short term memory, impaired abstract thinking and judgement, personality disorganization, and speech impairments.
- Individuals generally do not recognize their deficits (anosognosia).




https://www.brightfocus.org/news/amyloid-plaques-and-neurofibrillary-tangles

Vascular Dementia:

- Vascular Dementia is the second leading type of Dementia, and accounts for 15-25% of cases. Onset of Vascular Dementia is rapid, and may follow a stroke or aneurysm.
- Caused by blockage, disease, or bleeding in blood vessels that supply neurons. Neurons die without consistent oxygen and nutrient delivery.
- Symptoms include short term memory impairment, mood swings, feeling discomfort in the body, difficulty organizing and executing plans, and unsteady gait.
- Individuals are often aware of memory impairments, and personality is not affected despite emotional changes.
- Symptoms tend to stay stable then deteriorate in suddenly and rapidly in stages.

Lewy Body Dementia:

- Caused by buildup of protein in neurons, leading to the formation of *Lewy bodies*.
- Lewy Body Dementia occurs when Lewy bodies form first in brain regions responsible for thinking and memory. Parkinson's disease also involves formation of Lewy bodies in brain, however these first form in regions responsible for movement.
- Initial symptoms appear as deficits in planning actions, and difficulty with attention. Later symptoms include memory loss, mood changes, sleep disturbances, and visual hallucinations.
- Individuals with late stage Lewy Body Dementia also exhibit Parkinsonian motor symptoms, including rigid posture and difficulty swallowing. Individuals may aspirate while eating.

Frontotemporal Dementia

- Caused by damage to neurons in the frontal and temporal lobes of brain only.
  - The frontal lobe controls high-level thinking, decision making, and social behaviours.
  - The temporal lobe manages emotion, speech and language, and sensory processing.
- Frontotemporal Dementia is rarer and has younger onset than other types of Dementia. It tends to affect behaviour, speech, and social skills more than memory, especially in early stages.
- Early symptoms include decreased social and personal awareness, behaviour changes, and difficulty with speech (aphasia). Later symptoms include inability to speak, repetitive behaviours, impulsivity, emotional changes, and memory impairments.
- Behavioural symptoms must be monitored, as impulsivity and lowered inhibitions may place the individual in danger.

## Summary of the types of Dementia

| Type of Dementia | Key features | |
|---|---|---|
| **Alzheimer's disease** | ♦ Slow onset and gradual, widespread brain damage<br>♦ Loss of insight into condition | ♦ Early memory impairments, speech difficulties, emotional and personality changes |
| **Vascular Dementia** | ♦ Rapid onset, inconsistent deterioration<br>♦ Maintains insight into losses | ♦ Marked short term memory losses and mood changes<br>♦ Personality remains intact |
| **Lewy Body Dementia** | ♦ Variable onset and course<br>♦ Initial impairments in attention and planning actions | ♦ Later memory loss, sleep difficulties, hallucinations, and body rigidity |
| **Frontotemporal Dementia** | ♦ Gradual deterioration to frontal and temporal lobes<br>♦ Early loss of self-awareness | ♦ Early loss of speech and behavioural inhibition<br>♦ Later apathy and memory loss |

## Common symptoms of early to mid-stage Dementia

- Memory loss:
  - Primarily short term memory impairments, which may appear as forgetfulness, disorientation, and wandering.
- Mood changes:
  - Depression and anxiety are common in early Dementia.
  - Aggression, agitation, and apathy may also be present.
- Speech and language losses:
  - May have difficulty understanding what others tell them (receptive language), or using words to express themselves their own thoughts (expressive language).
  - Speaking may become difficult (speech aphasia).
- Behavioural changes:
  - Difficulty following complex instructions or completing multi-step tasks.
  - Inability to recognize social cues, exhibiting inappropriate behaviours, or acting impulsively.

## Common symptoms of late stage Dementia

- Memory loss:
  - Unable to remember both recent and distant events.
  - Unable recognize familiar family members or caregivers
  - Becoming disoriented in familiar places, such as their home.
  - Time shifting: believing they are living in an earlier time of their lives, such as childhood.
- Behavioural changes:
  - Significant difficulty planning and executing tasks or following directions.
  - Require assistance in all areas of personal care, including using the bathroom and eating.
- Speech and languages changes:
  - May lose speech entirely, speak in single words, or become very hard to understand.
  - Non-verbal speech may be retained, and individuals may continue to understand facial expressions and gestures used by others.
- Psychological changes:
  - Increased depression, apathy, social withdrawal, or aggression. They may resist receiving care.
  - Some individuals experience delusions, hallucinations, and paranoia.
- Physical changes:
  - Bladder and bowel incontinence.
  - Difficulties eating and swallowing, which may lead to weight loss, malnutrition, and choking.
  - Mobility losses, and requiring mobility aides or assistance to move around.

# Reflection

1. Why might volunteers be placed at Parry Place, SHOAL Centre, Brentwood House, or Sluggett House? In what ways do you think having volunteers at these sites is beneficial for Residents?

2. What challenges do you anticipate while volunteering at Assisted Living or Licensed Dementia Homes? How might you cope with these challenges?

3. What do you think Residents at Assisted Living or Licensed Dementia Homes can teach or show you?

# Communication Strategies

## Respectful language

Person-first and identity-first language:

- *Person-first language*: emphasis is placed on the person before their disability.
  - Example: “person who is blind” or “person with a disability”.
- *Identity-first language:* emphasis placed on the disability as being part of identity.
  - Example: “autistic person” or “disabled person”.
- Person-first language is more commonly used in verbal and written communications, but many groups or individuals prefer identity-first language. Allow the individual to guide how they would like to be addressed. If in doubt and it is appropriate, ask the person.

Commonly used language:

- Person who is blind or visually impaired;
- Person who is d/Deaf or hard of hearing;
- Person with an intellectual disability;
- Person with a physical disability;
- Person with Dementia/Alzheimer’s disease;
- Person with a mental health disability.

### Respectful language for older adults

‘Older adults’ is the preferred term.

- ‘Seniors’, ‘the elderly’, ‘old people’, are generally considered bias terms as they evoke negative stereotypes around the abilities of older adults.

Elderspeak:

- Elderspeak: The speech pattern often used with older adults that involves simplified sentence complexity, higher pitch speaking, and other elements commonly used in “baby-talk”.
- Elderspeak is problematic because it infantilizes older adults, and assumes they are incompetent in their understanding regardless of ability. Research has suggested that Elderspeak may reduce speech comprehension, and increase challenging behaviours such as resistance to care.

The following are recommendations to avoid use of Elderspeak:

- Speak in a normal tone of voice. If the person asks you to speak louder, do so without changing raising the pitch.
- Use names, and avoid referring to older adults using terms of endearment like ‘sweetie’ or ‘dear’.
- Use the word ‘you’ instead of ‘us’ or ‘we’.
- Avoid phrasing statements as questions, or oversimplifying the meaning of speech.

# Starting a conversation: ABC's


Approach:

- When meeting a Resident, approach them slowly from the front. Address the Resident by name then introduce yourself and your role. Offer your hand for a handshake, and allow the Resident to accept or decline.
- Use a gentle and friendly demeanor to set the tone for the interaction.
- "Ask" the Resident what they would like to do, even if the options are limited. People like choice and feeling in control of their activities.


Body language:

- Use non-verbal communication as much as possible. Facial expressions, body position and gestures all contribute to how the Resident perceives you.
- Open body language and eye contact can show the Resident you are invested in the interaction.
- Pay attention to the Resident's body language. Consider if they have any needs to alert staff to, and whether it is a good time for a visit or not.


Communication:

- Speak clearly at a reasonable pace, in a normal tone of voice. The Resident might request that you speak louder if they are hard of hearing.
- Individuals with language or speech difficulties may take longer to understand and process language. Be patient and allow time for a response.
- If they are confused or don't understand, repeat the sentence, then rephrase with simpler words if necessary. Keep the original meaning of the sentence.
- Not all responses are verbal; noticing a change in body language or behaviour may also convey meaning and demonstrate understanding.

Why is it important to pay attention to your ABC's when first greeting a Resident?

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# Considerations for visiting

There are several factors to consider before and during your visit with a Resident:

- Environment: The environment can often be changed to make a Resident and their visit more comfortable.
  - *Lighting*: Consider how much light there is in the room. Low light can make it difficult for the person to see you and your body language.
  - *Background noise*: Excess background noise can be distracting to you and the Resident, or reduce your abilities to hear each other, especially if the Resident is hard of hearing.
  - *Distractions:* External distractions can overwhelm a person with sensory sensitivities or prevent them from being able to engage with you if they struggle with attention.
- Non-verbal communication*:* Much of communication is done non-verbally, through tone of voice, gestures, facial expressions, and body language.
  - *Body language*: A Resident's body language can tell you about how they are feeling, both physically and emotionally.
  - *Eye contact:* In Western culture, eye contact while speaking is considered respectful. In other cultures, eye contact may be considered disrespectful when speaking to an older adult, or even threatening. If in doubt, ask about their preferences.
  - *Tone:* The manner in which words are expressed provides insight into the meaning behind the words used.
  - *Behaviour:* Actions speak when words cannot; specific behaviours can provide clues into how a Resident may be feeling.
- Abilities and disabilities:
  - *Sensory needs:* Dementia and other disabilities can cause individuals to be sensitive to specific aspects of the environment, such as light, loud sounds, or peripheral distractions.
  - *Hearing and vision loss:* If the Resident has vision and/or hearing loss, they may use aids or require environment modifications to improve ease of communication.
  - *Cognition:* Intellectual disabilities or Dementia may affect cognitive abilities such as decision making, abstract thinking, and memory. Individuals may require modifications or adaptations to increase success in their environment, such as visual cues for people with memory deficits.
  - *Language:* Refers to the words we use and how we use these words. Individuals may have difficulties processing or using language, and it may be difficult to understand the meaning behind the words used. Dementia and other disabilities can cause language impairments.
  - *Speech*: Refers to how language is used verbally. Speech difficulties might make it hard to understand what a person is saying. Individuals may have difficulties with speech, language, or both. Dementia, hearing loss and other disabilities may cause speech to be difficult to understand. People who are d/Deaf or hard of hearing may use sign language instead of speech, or a combination of both.

# Strategies for visiting

These are some changes you can make to your environment and approach when visiting a Resident:

- Environment:
  - *Lighting*: If the Resident is in a dimly lit room, ask if you can turn more lights on so they can see you, and you can see them. It also helps get their attention, and provides a smooth transition to introduce yourself.
  - *Background noise*: With permission, reduce or eliminate sources of background noise, such as television or music. This allows you and the Resident to fully pay attention to each other.
  - *Distractions:* If there are other distractions in the room, try to reduce these so both of you can more fully engage with each other.
- Non-verbal communication*:* Ensure you take note of non-verbal communications, and incorporate them into your approach when visiting.
  - *Body language:* Take note of how Residents are using all aspects of non-verbal communication. Note how these expressions change over the course of the visit, and use your own body language to set the tone for interaction.
  - *Behaviour:* Individuals may engage in specific, potentially repetitive behaviours when experiencing overwhelming emotions. Noticing these behaviours can tell you if the activity should be changed, or if staff assistance may be needed to de-escalate the Resident.
- Abilities and disabilities:
  - *Sensory needs:* Ask the Resident or staff if there are any sensory preferences or accommodations. Adjusting these can enhance the Resident's comfort and reduce likelihood of challenging behaviours.
  - *Hearing and vision loss:* Please see 'Interacting With Low Vision or Hearing Residents'.
  - *Cognition:* Find activities that allow Resident strengths to be used, and modify activities if the Resident is experiencing significant difficulties. Often, it is possible to find alternate ways to achieve the same outcome, perhaps by slowing down and moving at the Resident's pace.

# Strategies for language and speech

These strategies can be used if Residents have disabilities that make communication more difficult:

- *Difficulties understanding language*: Sentences should be repeated then rephrased where necessary without losing original meaning. Writing can be useful if the Resident can read, and visual cues can be used to connect objects with meaning.
- *Difficulties expressing language*: Be patient and avoid interrupting or speaking for them. Ask clarification questions, offer visual cues, and notice if they use specific words or phrases (ex. asking for 'home' if they want to go to their room).
- *Difficulties using speech:* Active listening can be used to reflect back to them what you have heard, and provide opportunity for them to clarify the intention behind their words. Writing or asking them show you what they mean can allow them to express themselves more easily.

# Active listening

*Active listening*: A set of communication skills that enables individuals to listen, reflect, and clarify what another person is expressing. Active listening shows that you are listening with care and intent.

**Be fully present**

*Be fully present:*

- Reduce or eliminate internal and external distractions so you can engage completely with the Resident.
- Use all your senses, including sight, to interpret the meaning behind the words the Resident uses.

**Note non-verbal cues**

*Note non-verbal cues:*

- Attend to all aspects of the communication, including body language, tone of voice, gestures, facial expressions, and eye contact.
- Note as well what your body language may be telling the Resident about how engaged you are in the interaction.

**Reflect their words**

*Reflect their words:*

- Paraphrase and repeat back what you have heard the Resident saying.
- Reflecting shows that you have been listening intently, and provides the Resident an opportunity to clarify.

**Ask open questions**

*Ask open ended questions:*

- This should be used if the Resident has strong language and speech skills.
- When used well, open ended questions allow the conversation to flow, and encourages the Resident to continue talking and providing details.

**Withhold judgement**

*Withhold judgement:*

- Staying neutral encourages the Resident to feel comfortable expressing their thoughts and opinions, without you needing to agree with them.
- Practicing empathy and recognizing that the Resident's emotions and beliefs are valid for them can help reduce judgement.

**Be patient**

*Be patient:*

- Allow the Resident time to express their thoughts without interrupting, assuming you understand, or finishing their sentences for them.
- Let the conversation naturally conclude instead of abruptly changing topics, as quick topic changes can be confusing or seem like you are uninterested.

# Interacting With Low Vision or Hearing Residents

## Interacting with blind or visually impaired Residents

Vision loss and blindness can occur at all stages of life due to illness and injury.

- People may be blind or visually impaired from birth, or become visually impaired as they age.
- Ageing and associated conditions including diabetic neuropathy, macular degeneration, cataracts, and glaucoma can cause an individual to experience vision loss.
- People who are blind or visually impaired may still have some vision; the degree and type of vision loss a person experiences is highly individual.
- People who are blind may use a probing cane ('white cane'), use braille to read text, or have applications that speak to them on their devices.

Strategies for interacting with blind or visually impaired Residents:

- Always introduce yourself by name when you visit, as they may not recognize your voice. Verbally tell the Resident when you extend your hand for a handshake.
- Use their name throughout the interaction to get their attention and ensure they don't miss important information.
- Ensure the space has appropriate lighting. Some individuals with vision impairment are sensitive to excessive light while others prefer more light, so it is good practice to ask their preference.
- Ask or tell before you do something, like begin reading a book or touching the Resident's arm. This provides warning and reduces the likelihood of startling them.
- Offer assistance, but let the Resident choose to accept or decline.
- If you are outside, ask if they would like you to describe things of interest or the general environment. If it catches your attention, it might interest them too.
- When your visit is done, ensure you tell the Resident you are leaving so they don't assume you are still with them.

Activity ideas for Residents who are blind or visually impaired:

- Reading a book out loud, or listening to an audiobook or podcast.
- Listening to music or playing instruments.
- Gardening, weeding, or watering plants.
- Sharing a cup of tea or coffee and chatting.
- Recording the Resident's memories in a memory book.
- Playing games like trivia or wordle.
- Doing chair yoga or meditation.

# Interacting with deaf or hard of hearing Residents

People can be born deaf or hard of hearing, or lose their hearing as they age.

- People who are deaf or hard of hearing may have some hearing left, or be profoundly deaf.
- Not all people who are deaf or hard of hearing will communicate in the same way. They may speak verbally, read lips, or use assistive devices like hearing aids.
- Always speak directly with the deaf or hard of hearing Resident. It is disrespectful to speak to someone else for them, even if the other person is the interpreter.

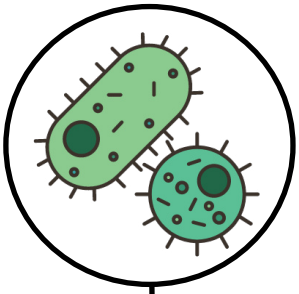
Strategies for interacting with deaf or hard of hearing Residents:

- Get the Resident's attention before speaking. This can be done by waving in the Resident's line of sight.
- Ensure you are in a space with minimal background noise and enough light so the Resident can clearly see your face. Be aware that dark rooms can cause anxiety for some deaf people, as they cannot communicate or see what is going on in the dark.
- Avoid obstructing the Resident's view of your face by chewing, touching your face, or turning your back while you speak.
- Speak clearly at a normal pace and volume. If the Resident asks you to speak louder, avoid yelling as this can make words more difficult to understand.
- Hold eye contact and use non-verbal communications to provide context for what you are saying.
- If the Resident is able to read and write, a pen and paper can be used to clarify topics or tell them important information.
- In a group, avoid having everyone speak at once, as this can be very difficult for a hard of hearing or deaf Resident to follow.
- Take the time to clarify if a Resident has missed part of the conversation. It is not appropriate or kind to simply "explain later".
- Visual cues, such as pictures or examples of objects can be helpful to ensure the Resident understand what is being communicated.

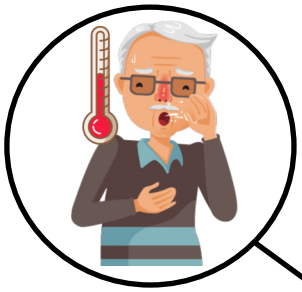
Activity ideas for Residents who are deaf or hard of hearing:

- Watch a movie or TV show with closed captioning.
- Work on a craft, colouring, painting, or puzzles.
- Go for a walk, sit outside, or garden. *Always check with staff before attempting to do any physical activities with a Resident.*
- Play a board game or cards.
- Doing yoga or meditation.

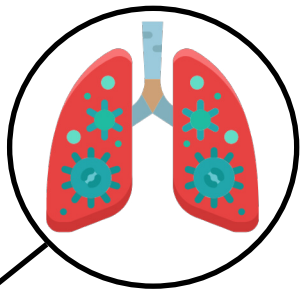
# Infection Prevention



**Infectious Agents**: The bacteria, viruses, and other germs that can cause sickness.



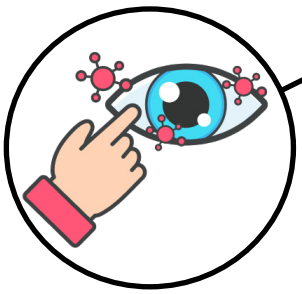
**Susceptible Host:** People who are especially vulnerable to infection (ex. older adults, people with chronic illnesses or suppressed immune systems)



**Reservoir:** Places germs grow and live, including people, animals, surfaces, and environments (ex. water).

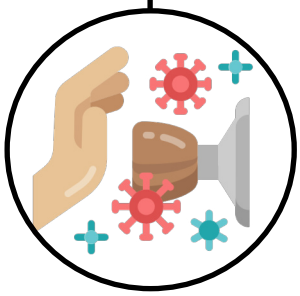
## The Chain of Infection:

This model describes how infectious diseases spread. Older adults, especially those living in long term care, may be particularly vulnerable to communicable disease.



**Portal of Entry:** How germs enter the body (ex. by touching mucous membranes of the mouth, eyes, nose).

**Portal of Exit:** How germs exit the body (ex. by coughing, vomiting, or defecating).



**Mode of Transmission:** How germs are carried from one place to another (ex. contact with a contaminated surface).

# Hand hygiene

## What is hand hygiene?

- Hand hygiene is the practice of cleaning one's hands to kill or remove infectious agents.
- Hand hygiene breaks the chain of infection by killing infectious agents on the hands, and prevents the spread of infectious agents from one person or environment to another.

## Why use hand hygiene?

- Hand hygiene is routinely practiced before eating, after using the bathroom, and after touching garbage or recycling. It is a great way to prevent the spread of infectious agents in the community and at home.
- Hand hygiene is especially important in healthcare settings. Many Residents in Assisted Living or Licensed Dementia Homes have conditions that make them particularly vulnerable to illness or likely to become very ill if they do contract an illness.
- It is important to use hand hygiene every time you enter the space of a different Resident. Infection can be spread by touching a Resident or something in their environment then touching another person or surface with contaminated hands. Some infectious agents can live on surfaces for up to a week, and people may have infections without showing symptoms.

## When to use hand hygiene

Hand hygiene should be used:

- Before and after entering Assisted Living or a Licensed Dementia Home.
- Before and after entering a Resident's room or space.
- After coughing, sneezing, or touching your face or hair.
- After using the toilet.
- After touching an animal or pet.
- After disposing of garbage, compost, or recycling.
- When hands are visibly dirty.

Alcohol based hand rub (ABHR or 'hand sanitizer') can also be used for hand hygiene.

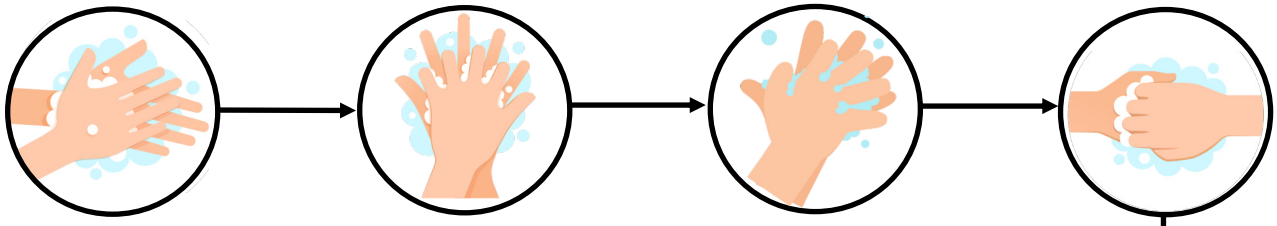
- ABHR has been shown to kill more germs than hand washing alone.
- Frequent use of ABHR is generally less irritating than using soap and water.
- AHBR is more widely available than soap and running water, and the convenience may improve compliance with hand hygiene procedures.

Soap and warm running water are preferred when hands are visibly dirty.

- Some infections that cause diarrhea and vomiting may not be killed by alcohol based hand rub, so it is still important to use soap and water after using the bathroom.

If you are wearing gloves, you must still perform hand hygiene after removing them, as some germs may be transferred to your hands when removing the gloves.

# Steps for hand washing

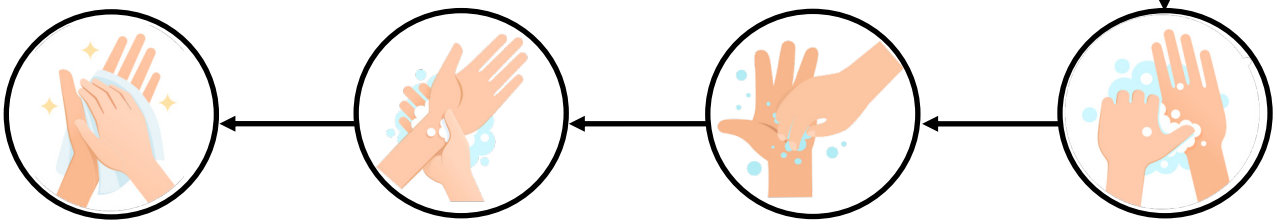


**Step 1:** Remove hand and wrist jewelry, and rinse hands under warm running water. Apply soap and rub hands palm to palm.

**Step 2:** Place the left hand on top of the right hand, rub the back of the right hand. Switch hands and repeat with right on top of left.

**Step 3:** With your hands palm to palm, interlock your fingers to clean between them.

**Step 4:** Make a fist with your right hand, and rub the middle section of the fingers on your left palm. Switch hands and repeat.



**Step 5:** Grasp your right thumb with your left hand, and rotate your right hand to clean your thumb. Switch hands and repeat.

**Step 6:** Place your right fingertips in your left palm, and rub the fingernails against the palm. Switch hands and repeat.

**Step 7:** Grasp your right wrist with your left hand. Rotate your right hand to clean the wrist. Switch hands and repeat.

**Step 8:** Use a clean paper towel to thoroughly dry hands. To avoid touching the sink, use the paper towel to turn the sink off.

Other hand hygiene guidelines:

- Rings, bracelets, splints and braces must be removed from hands/wrists for effective hand hygiene. These can act as a reservoir for germs if not removed.
- When applying soap or alcohol based hand rub, ensure you have enough to coat all sides of the hands and wrists.
- Warm running water is sufficient for washing hands with soap and water; hot water is not necessary.
- Hand washing should take at least 40—60 seconds.

The same hand-cleaning steps shown above should be used with alcohol based hand rub (ABHR).

- Unlike hand washing, hands do not need to be rinsed before or after using alcohol based hand rub.
- ABHR dries when exposed to air, but excess can be patted off with a clean paper towel.

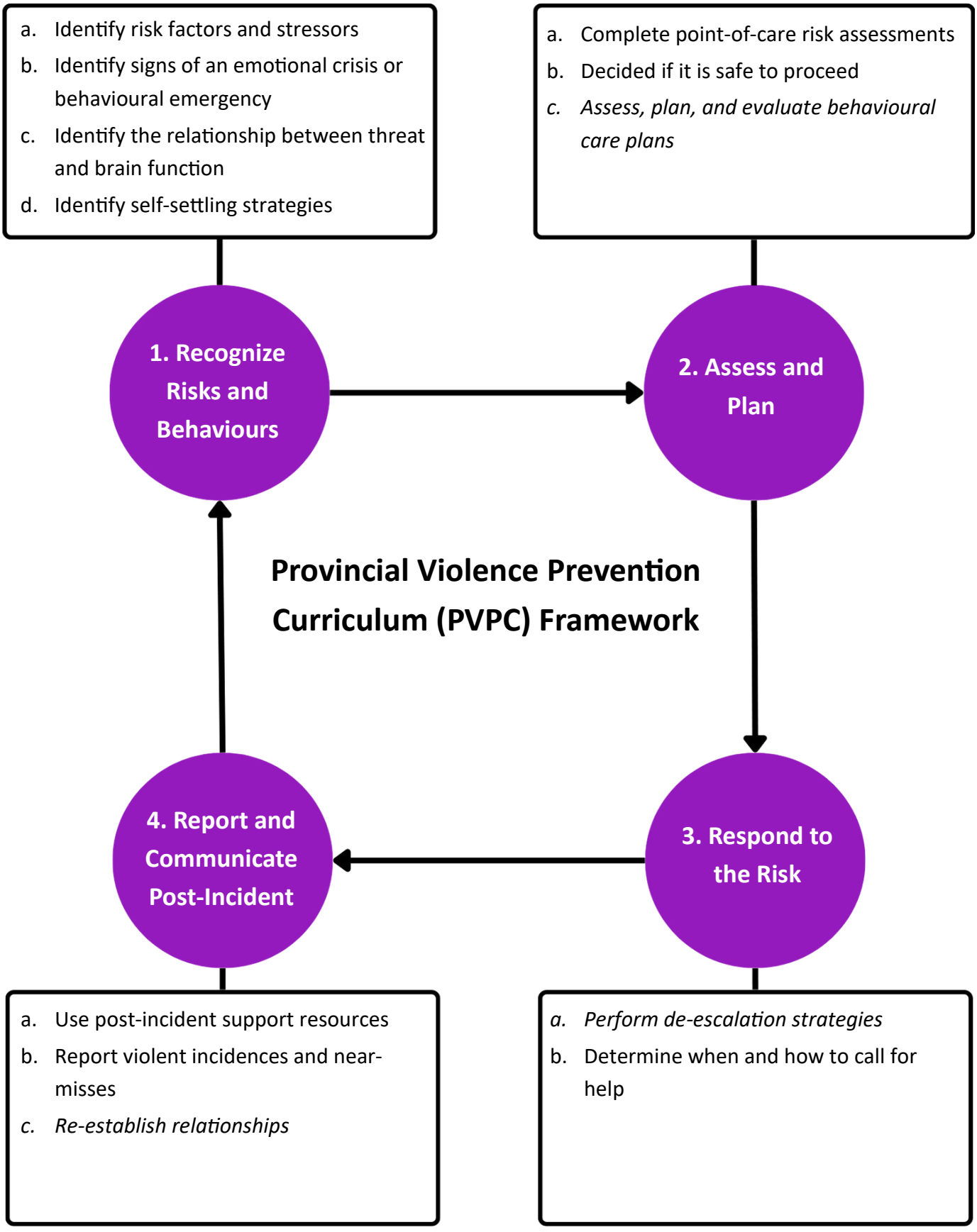
# Violence Prevention

## What is violence in the workplace?

- Workplace violence is "incidents where persons are abused, threatened, or assaulted in circumstances related to their work, involving a direct or indirect challenge to their safety, wellbeing, or health." (BC Provincial Violence Prevention Steering Committee, 2008).
- There are two types of violence:
  - *Intentional*: the person has exhibited violent behaviours on purpose and not due to another condition.
  - *Unintentional:* the person has not exhibited violent behaviours on purpose, but rather because of an injury or illness (such as Dementia).
- Violence can take many forms, including:
  - *Physical violence*, such as hitting, spitting, kicking, grabbing.
  - *Verbal violence*, such as threatening or name-calling.
  - *Non-verbal violence*, such as invading personal space or making offensive gestures.
  - *Sexualized violence*, such as inappropriate touch, sexual coercion, or behaviour threatening someone because of their sex or gender identity.
- Violence can be actual or attempted, and can occur regardless of the intent behind the behaviours. Injury does not need to occur for violence to have happened.
- Violence prevention has been included in this orientation so volunteers in Assisted Living and Licensed Dementia Homes know how to keep themselves and others safe, and what to do in case violence does occur.

## Introduction to the Provincial Violence Prevention Curriculum (PVPC)

- The Provincial Violence Prevention curriculum (PVPC) was established in 2010 to improve violence prevention among healthcare workers in British Columbia. The PVPC aims to teach healthcare workers, including volunteers, how to prevent violent incidences as often as possible.
- A key principle of the PVPC is that violence prevention is everyone's responsibility. Volunteers, staff, managers, and organizations are expected to follow violence prevention procedures, and report any instances of violent behaviour so investigation and corrective actions can be taken.
- There are aspects of the PVPC that should be managed by staff, not volunteers. These will be outlined in later pages, and have been included in the orientation so volunteers know what to do in case of emergency.
- Volunteers are encouraged to utilize support systems in place for victims of workplace violence. Please speak with the Manager of Volunteer Engagement should any questions arise.




Adapted from Health Employers Association of BC: https://www.heabc.bc.ca/AssetFactory.aspx?did=3754

# Provincial Violence Prevention Curriculum (PVPC)

## Part 1: Recognize Risks and Behaviours

a. Identify risk factors and stressors:
   - *Risk factors:* Uncontrollable characteristics of a person that increase potential for violence.
     - Examples: History of violence, brain injury or other conditions, substance use, or difficulty with communication.
   - *Stressors:* Events or conditions that increase risk of violence because of the stress they add. These are controllable, and each person will respond differently.
     - Examples: Pain, confusion, unmet needs, or lack of control over a situation.

b. Identify signs of an emotional crisis or behavioural emergency:
   - *Emotional crisis:* Occurs when a person cannot no longer cope and behaviours begin to escalate. Nobody is being hurt and there is possibility of settling the individual.
     - Signs can include crying, yelling, pacing, wringing hands.
   - *Behavioural emergency:* Occurs when an individual is significantly escalated and exhibiting behaviours that could seriously harm themselves or others.
     - These behaviours can include threatening with a weapon, severe self-harm, or assaulting another person by kicking and punching.
   - Emotional crises can escalate to behavioural emergencies. If this occurs, it is no longer safe to try and settle the distressed person.

c. Identify the relationship between threat and brain function:
   - *Fight, flight, freeze response:* When threatened, our body may take over to protect ourselves from danger. This response can include fighting the threat, running away, or freezing.
     - Signs of the fight, flight, freeze response: Increased heart rate, shallow or rapid breathing, tense muscles, shaking, or cold extremities.
   - Thinking can become less clear during threat and fight, flight, freeze. It may be difficult to problem solve, control emotions or responses, and respond to simple questions.
   - Knowing how and when to respond to crisis situations can help manage your response, and deal with potentially violent situations more effectively.

d. Identify self-settling strategies:
   - *Take deep, slow breaths.* This can calm your nervous system and help you think more clearly.
   - *Pinch or squeeze your fingers or palms.* This can ground your senses if you are overwhelmed.
   - *Repeat a calming or grounding phrase in your head.*

## Part 2: Assess and Plan

a. Complete point-of-care risk assessments:

- A *point-of-care risk assessment* (PCRA) is a set of questions used to determine an individual's risk of violence. This should be completed before and during a volunteer's visit with a Resident.

1. Person: Are there any indications that the individual might act violently (risk factors, stressors, emotional crisis)? Have you checked in with staff regarding any potential safety risks?
2. Environment: Are there objects that could be weapons, do I have a clear exit, and can I easily access help if needed?
3. Task: Does this task need to be done now?
4. Self: What am I observing/feeling/sensing? Am I wearing anything that could be grabbed?

b. Decide if it is safe to proceed:

- If there are no concerns identified during the PCRA, it is safe to proceed with the task.
  - Ensure you are always positioned so you can access an exit without the Resident or other obstacles blocking you.
  - If you notice potential weapons, remove these before starting the task when possible.
  - Remove items on yourself that could be grabbed, such as lanyards, necklaces, and dangling earrings.
- **As a volunteer, if warning signs of an emotional crisis or escalation arise, stop the task, remove yourself, and seek help of staff.**

c. Develop a behavioural care plan:

- A *behavioural care plan (BCP)* is used to inform staff and volunteers about an individual's violence risk and outlines how to reduce escalation or violent behaviours. As a volunteer, you will not create BCPs, but you need to understand what they are and how to follow them.
- A BCP is confidential but should be communicated to all relevant parties caring for a Resident, including volunteers. **Volunteers are encouraged to ask staff members if there are any safety concerns each time they arrive for their shift.**
- Discussing a BCP, except with staff for violence prevention purposes, is a violation of the Beacon Community Services confidentiality agreement.

## Part 3: Respond to the Risk

a. Perform de-escalation strategies:

- *De-escalation:* Using strategies to reduce the intensity of the situation, with the goal of settling a person enough to discuss and problem-solve.
- It is unsafe to attempt to de-escalate if there is immediate danger of harm to any person, you are escalated yourself, or the person cannot follow simple instructions.
- *Providing time and space* is often the most effective de-escalation strategy. Volunteers are encouraged to provide time and space should a Resident become escalated.
- *Redirection* is useful for both visiting and preventing escalation. Redirecting a conversation involves validating the emotion without answering the question. For example, if a person is frustrated they can't go outside, you could respond with "That sounds frustrating for you. Come help me pick a book to read in the living room."
- Communication skills and active listening can be used to de-escalate.
  - Stay calm: Use non-verbal communication and your voice to show the person you are calm. Verbal communication should be simple, empathetic, and caring.
  - Avoid telling the person to "calm down," as these are likely to escalate the person further.
- Active listening can also be used for de-escalation. Validate their emotions, paraphrase and clarify what the person has told you, and avoid judging or correcting them.

b. Determining how and when to call for help:

- If de-escalation strategies have not worked, you feel the situation could become unsafe, or you are unsure of what to do, be cautious and seek help. Do not wait until a situation becomes a behavioural emergency to get staff assistance.
- **Staff should be the first point of contact for help in any violent or potentially violent situation**.
  - When informing staff of the situation, be factual and concise. Tell them about any threats made or potential weapons the person could have access to.
  - If staff are unavailable and there is a weapon or serious threat to safety and life, call 911.

Part 3 has been included to inform volunteers of de-escalation and emergency procedures should violent situations unfold and the volunteer cannot remove themselves.

**Volunteers should remove themselves from any threatening, escalating, or violent situations and seek staff as the primary managers of threats where possible.**

## Part 4: Report and Communicate Post-Incident

a. Use post-incident support resources:

- Conduct a wellness check:
  1. Self: Am I feeling safe and supported? Can I keep working?
  2. Environment: Are others injured, in shock, or needing assistance? Are there any hazards or other dangers?
  3. First aid: Does anybody need first-aid, including myself? Do I need to see a doctor?
- Managers and supervisors are responsible for assessing the situation, placing necessary safety measures in place, and checking in with workers.
- Volunteers are encouraged to debrief with the site manager and the Manager of Volunteer Engagement if they witness or are involved in a violent incident.

b. Report violent incidences and near-misses:

- Volunteers are legally required to report all violent incidents or situations that could have ended in violence. This includes any scenario where an individual is threatened or psychologically traumatized even if no physical injury occurs.
  - Reporting is important because it communicates risk of future violence.
  - When reporting, be objective, accurate, and detailed. Explicitly state what you witnessed during the incident without using euphemisms.
  - Volunteers involved in a violent incident will be interviewed to better understand the situation and outcomes. Investigations help inform managers of changes that need to be made to prevent future violent incidents.

c. Re-establish relationships:

- Depending on the nature of the violent incident, there may be the opportunity to re-establish a working relationship between a volunteer and Resident. This will be considered on a case-by-case basis by the site supervisor, Manager of Volunteer Engagement, and the volunteer.

### Notes or questions about violence prevention:

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# Supporting Your Wellbeing

## Mental health supports

Being a volunteer in Assisted Living or Licensed Dementia Homes is incredibly rewarding, but can be emotionally difficult. There are a variety of mental health supports available in British Columbia.

**If you are in immediate danger, call 911.**

- Vancouver Island Crisis Line: https://www.vicrisis.ca/
  - VI Crisis Line (24 hours): **1-888-494-3888**
  - Crisis Chat (6—10 pm): https://www.vicrisis.ca/crisis-chat/
  - Crisis Text (6—10 pm): text **250-800-3806**
- Crisis Centre BC: https://crisiscentre.bc.ca/
  - Crisis phone line (24 hours, interpreters available): **1-800-784-2433**
  - Seniors' Distress Line (24 hours): **604-872-1234**
  - Online chat (12 pm—1 am): https://crisiscentrechat.ca/
- KUU-US Crisis Line Society: https://www.kuu-uscrisisline.com/
  - For Indigenous individuals in BC.
  - Adult and Elder Crisis Line (24 hours): **250-723-4050**
  - Youth Crisis Line (24 hours): **250-723-2040**
  - Metis Line (24 hours): **1-833-638-4722**
- Hope for Wellness Help Line: https://www.hopeforwellness.ca/
  - For Indigenous individuals across Canada.
  - Help line (24 hours): **1-855-242-3310**
  - Online chat: see website
- Talk Suicide Canada: https://talksuicide.ca/
  - Phone (24 hours): **1-833-456-4566**
  - Text (4pm—12am EST): **45645**
- BC-211: https://bc.211.ca/ online directory of community, government, and social services in BC.
  - Call or text (24 hours): **211**
- VictimLinkBC: call or text **1-800-563-0808** (24 hours) to access help if you are the victim or a crime.
- Psychology Today: https://www.psychologytoday.com/ca/therapists
  - Resource to find therapists based on location, area of expertise, and other criteria.
- Psychiatric Emergency Services (Royal Jubilee Hospital): provides specialized mental health care and acute crisis intervention for individuals living in Victoria.

# Welcome to


Thank you for choosing to volunteer here.

We are so excited to have you!

Beacon Community Services

*Helping People…Improving Lives*