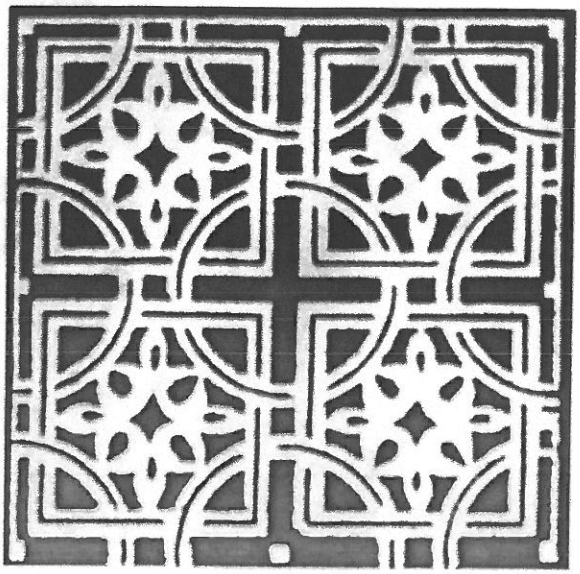


Tapestry of Faith

Communication

Connection

Care

The Church of St. Mary
Alexandria, MN

Visitor Training Seminar

Tapestry of Faith
Visitation Ministry to Nursing Homes
APRIL 2013

Visitation Ministry Goal

To provide regular and meaningful visits to persons who are nursing home residents at Knute Nelson and Bethany Nursing Homes.

Visitation Ministry Training Program Goal

To provide volunteers educational materials and guided group process to learn how to complete an effective visit to a nursing home resident.

Training Objectives:

1. To provide members of the visitation ministry team basic tasks involved in visiting nursing home residents.
2. To provide a basic format and understand how to make a nursing home visit.
3. To understand the physical, psychological and spiritual facets of the aging process.
4. To identify characteristics of good communication and to identify basic barriers to effective communication.
5. To understand the process of active listening.
6. To provide written materials to assist the volunteer with implementation and support of the ministry.

Training Session Outline
Tapestry of Faith

I Program Introduction

A. Goals of program
1. To connect, reconnect with an elder and our parish.
2. To bring hope and comfort.
3. To affirm their value as a past and present member of St. Mary's.
4. To show gratitude for many years of participation in our parish community.
5. To decrease isolation and feelings of invisibility—way to still be active in parish life.
6. To relay the reality of God's presence and love to those coming toward the end of their earthly life.

Communication Connection Communion

B. Client group description
1. Catholic residents of Knute Nelson and Bethany Nursing Homes—all may not be present or past St. Mary's parishioners.

C. Program specifics/visitor responsibilities:
1. Meet weekly with your assigned elders. Each individual will have 2-3 elders to visit.
2. Visit for 15-20 minutes with each elder. If going as a family, children must be accompanied by an adult.
3. Attend monthly group meeting (support, evaluation, seminars)
4. Commit for one year
5. Maintain confidentiality at all times
6. Communicate with program coordinator any concerns regarding visits, inability to make visits, etc.

D. Visitor qualifications
1. An interest in, and understanding of, older adults
2. A positive attitude toward aging
3. An ability to relate well to others
4. A good listening ear
5. Time to visit on a regular basis
6. Ability to maintain confidentiality
7. Be accepting and nonjudgmental of the elder
8. Be able to recognize the emotional, practical, and spiritual support and elder requires

E. Visitor Expectations of Tapestry of Faith Program
   1. To know in advance when meetings will be held
   2. To receive appropriate training and necessary information that contributes to a meaningful visit
   3. To be regarded as a respected and vital member of the Tapestry of Faith team
   4. To receive good communication from the coordinator, to be informed of changes in procedures and time, changes in the elder person, and information on appropriate resources and support

II. The Aging Process

A. Physical changes
   1. Structural
      A. muscles

      B. skeleton

      C. skin

   2. Sensory
      A. mouth

      B. taste

      C. smell

      D. vision

      E. hearing

      F. touch

      G. mobility

   3. Systems
      A. circulatory

      B. digestive

      C. urinary

      D. reproductive

B. Psychological
   1. Dementia
   2. Memory loss
   3. Decreased attention span
   4. Confusion
   5. Frustration
   6. Loneliness
   7. Anger
   8. Adaptation to change

C. Spiritual changes
   1. Guilt
   2. Loss
   3. Abandonment
   4. "Spiritual autobiography"

D. Personalities in later life
   1. Angry
   2. Dependent
   3. Depressed
   4. Anxious
   5. Delusional

E. Health Issues
   1. Egocentricity
   2. Anger/depression
   3. Guilt
   4. Anxiety

F. Myths and Stereotypes of the Elderly

III. Communication Techniques

A. Active listening techniques

B. Communication barriers

C. Non-verbal cues

IV. Making a Visit

A. Surroundings; perception vs. reality
B. Visitor concerns
   1. Inadequate skills

   2. Liability potential

   3. Confidentiality
      A. Legal

      B. Ethical

C. Guidelines for Visiting
D. Tips for a Successful Visit
E. Building Friendships

V. Visitor Forms

A. Elder Interview form
B. Visitor Log form
C. Visit Evaluation Form
D. Diocesan forms

Tapestry of Faith
Description of Visitor Role

The volunteer are trained visitors who will spend time visiting with assigned residents of Knute Nelson or Bethany Community Nursing Home on a weekly basis.

Responsible to: Kathy Fischer, St. Mary's Parish Nurse

Responsibilities:

- **Comply with program policies and procedures of the Tapestry of Faith Program**
- **Provide visits to assigned elders**
- **Complete visitation log and visit evaluation forms after each visit**
- **Maintain confidentiality of information regarding elder**

Skills and Qualifications:

- **Desire and willingness to visit elderly residents of local nursing homes**
- **Good communication skills**
- **Understands and is accepting of people from diverse backgrounds**
- **Understand and is sensitive to the needs of the elderly**
- **Is dependable, reliable, people-oriented, flexible, possesses high levels of maturity, calmness, empathy, and tolerance**

Time Commitment:

- **Volunteer for a minimum of 4 hours per month**
- **A commitment of one year is desirable**
- **One hour per month in follow-up/seminar training**
- **Visit between 2-3 elderly residents per week (15-20 minutes per elder)**

Training:

- **Attend visitor training prior to beginning visits**
- **Ongoing in-service training will be available through Tapestry of Faith Program**
- **Monthly follow-up/ training seminars will be used to discuss and evaluate progress and visits**

Volunteer Screening:

- **Visitors are interviewed and screened by the parish nurse**
- **Visitors complete all necessary volunteer diocesan forms**

A Volunteer's Bill of Rights

The right to be treated as a co-worker.
Not just free help.
Not as a prima donna.

The right to a suitable assignment.
With considerations for personal preference, temperament, life, experience, education, vocational and avocation background; and which offers opportunity for further growth and development.

The right to know as much about the organization as possible.
It's policies, it's people, it's program.

The right to training for the job.
Thoughtfully planned and effectively presented.

The right to continuing education on the job.
As a follow-up to initial training.
Information about new developments.
Training for greater responsibility.

The right to sound guidance and direction.
By someone who is experienced, patient, well-informed, thoughtful, who treats others with mutual respect and who has time to invest.

The right to be heard and listened to.
To have a part in planning - to feel free to make suggestions.
To have respect shown for an honest opinion and feelings, both good and bad.
To be part of the decision making process.

The right to recognition.
Through day-by-day expressions of appreciation.
And by being treated as a significant member of the team.

The right to be informed about the older person.

The right to receive respect from the older care recipient.

The right to situations that are hazardous to one's well-being.

The right to privacy if they choose not to disclose their home address or phone number to the care recipient.

Vulnerable Adults Act

There is legislature in our state that protects adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment.

It is the policy of our state to require the reporting of suspected maltreatment of vulnerable adults.

Report your suspicions to Kathy Fischer, St. Mary's Parish Nurse

A person who makes a good faith report is immune from any civil or criminal liability that might otherwise result from making the report.

The identity of any reporter may not be disclosed except with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith.

Tapestry of Faith

Communication: listening, speaking, silence

Connection: space, safety, sacredness

Communion: a healing presence who is.....

H Hopeful

E Empathetic

A Attentive

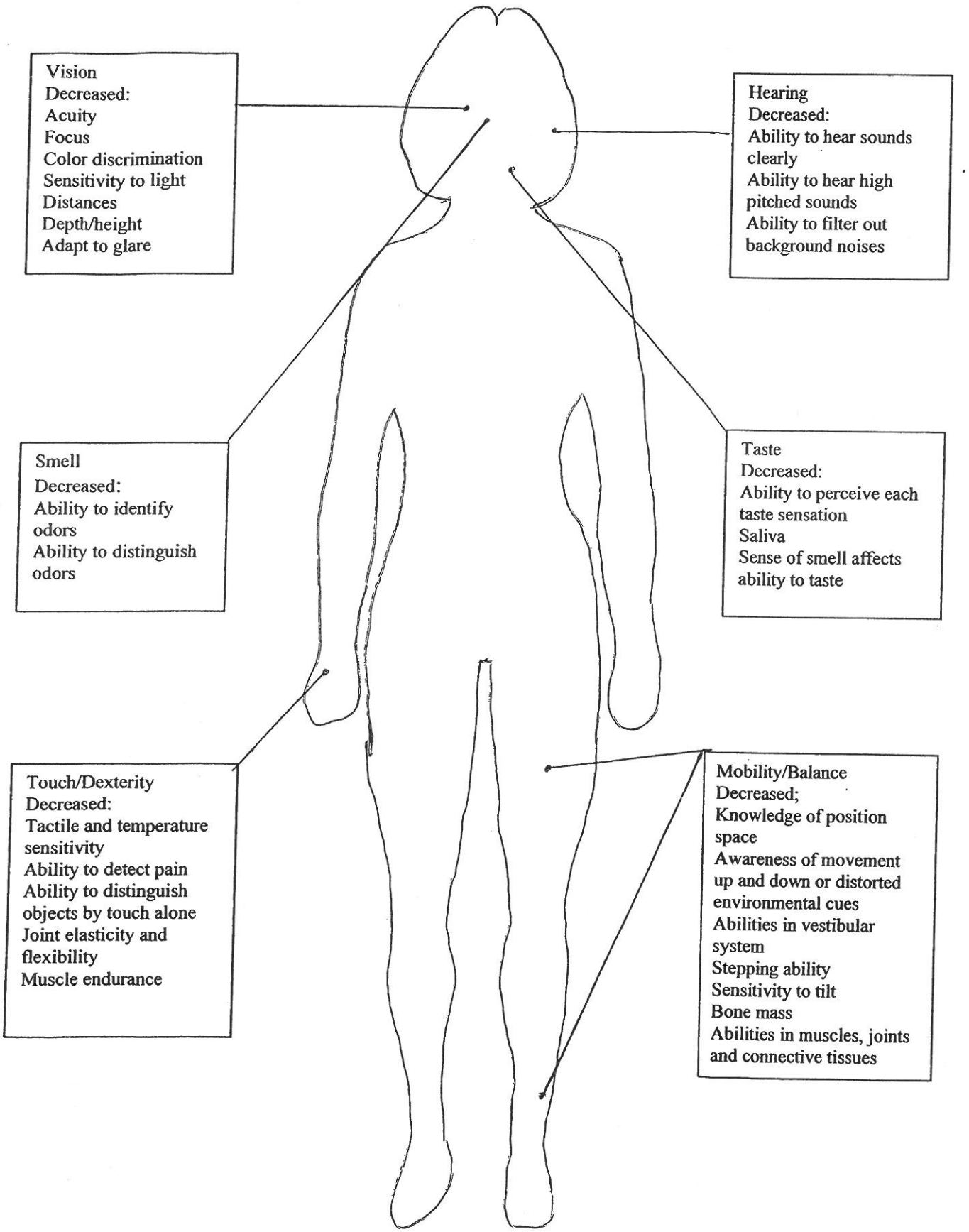
L Loving

I Intentional

N Nourishing

G Grateful

Age Related Sensory Losses



V. Myths and Stereotypes

A. Myths and Stereotypes about Senior Adults

Within American society, there are some common generalizations that are thought to be truths about older people. Many elderly people, who may expect these behaviors of themselves, believe these stereotypes. The myths, stereotypes, and negative attitudes greatly influence interactions with older people. Expectations about the later years are formed very early and are reinforced throughout life.

The truth is that there is great variety among individuals in later life. Individuals are what they have always been. There is as much diversity in personalities among older adults as there is among younger individuals. Problems arise when people act on their assumptions about the older person. Family members may unconsciously "watch" their elderly relatives to see when they will begin to exhibit these characteristics. Some major myths and stereotypes are listed below.

MYTH	REALITY
Older people are disengaged *–they live by themselves or with other older people; they lose interest in life and become more introspective and withdrawn; older people do not want to associate with other people.*	Opportunities for older people to associate with other people may be very limited. Physical handicaps, lack of transportation, lack of alternatives, and the death of a spouse or close friends may cause an older person to appear disengaged. Other people may have disassociated from the elderly person. Older people do prefer to stay involved in life as much as possible.
Older people are sick *– disease and disabilities are automatic with advancing age; older people are not expected to feel well.*	Chronic conditions such as arthritis or diabetes usually begin in middle age and may worsen with advancing age. Disabilities previously assumed to be automatic effects of aging, have been shown to have other causes, and can be influenced by diet, exercise, and life style. The elderly did not suddenly become sick when they became aged. Sometimes the elderly may use this myth to get out of activities or commitments. The older person may need or want some encouragement to participate in activity.
Once a man, twice a child *– they become childish, return to a second childhood, and must be treated like children.*	Adults remain adults and function as adults. If any person is expected by others to act like a child, that person may conform to those expectations over time.

MYTH	REALITY
Older people are dependent *– they need someone to take care of them.*	Most older people are independent, living in the community, and are taking care of themselves. Many times, "help" is given to older people because others are too impatient to wait long enough for the elderly to do the tasks themselves. While others may think they are helping older people by doing shopping or running errands, they may actually be denying the older person opportunities to go out, maintain control and independence in decision-making, and receive stimulation and mental and physical exercise. Older people may gradually become dependent on others for unnecessary assistance.
The old are unproductive *– they have already made their contribution to society.*	The majority of older people remain actively and productively involved in life. However, opportunities for meaningful work, education, or leisure activities may be less available. When incapacity develops, it can be more directly traced to a variety of losses, diseases, or circumstances rather than aging. Productivity may have to be redefined to include sharing reminiscences or knowledge as well as producing tangible products or results.
The aged are asexual *– Sexual desire is "only in their heads", sexual function ceases in old age.*	In reality, sexual desire continues throughout life. With advancing age, sexual function may change, but it does not automatically cease. If a person has remained sexually active throughout adulthood, there is no reason that should change in the later years.
Grandparents are always eager to be with their grandchildren *– All grandmothers love to bake cookies, and all grandfathers love to tell stories to their grandchildren; grandparents are always glad to keep their grandchildren.*	All grandparents are entitled to their own lives and schedules. Most grandparents do enjoy time with their grandchildren but within limits. Sometimes grandparents prefer visits that are planned in advance. Grandparents may be expected to keep grandchildren and will feel guilty if they must say "No." Out of necessity, a growing number of grandparents have become surrogate parents for their grandchildren.

MYTH	REALITY
Old people become senile– *Eventually all older people become forgetful, confused, and have reduced attention spans.*	"Senility" is one of the most misused words; it has come to be a catch-all term with little specific meaning. Similarly, "Alzheimer's" has become a general term used to describe all types of behavioral symptoms or memory loss that may have very different causes and therefore very different strategies for intervention. (See the discussion of dementia later in this material for more information.) The expectation of senility puts many elderly on guard against actions that may be viewed as indicative of mental loss. When an older person becomes distracted and lets cooking food burn, she may try to camouflage the odors to prevent family members from realizing the food was burned. Otherwise, they may begin to wonder if she is safe alone.
All old people end up in nursing homes *– if individuals live long enough, they will be institutionalized.*	About five percent of the elderly are institutionalized at any one point in time. The majority live in community settings. Although, nursing home care is not inevitable, particularly as alternative services are developed, about forty percent of the total elderly population will spend some time in a nursing home.

Tapestry of Faith
Active Listening

What are the characteristics of active listening?

This includes awareness of the tone and intensity of remarks, facial expressions, body language, even the dress and mannerisms of the speaker. Active listening clarifies and seeks to understand the meaning of what has been said and the feelings behind the content.

What helps a person become an active listener?

PRESENCE

1. Be present with the other.
2. Use eye contact. Show by your posture and your facial expressions that you are paying attention.
3. Be sincere, and show it.

LISTENING

1. Listen for themes in what is being said.
2. Listen with ears and eyes for more than what is spoken; notice body language, voice tremors, and gestures, rate of breathing, color complexion, muscle tension, and posture.

RESPONSE

1. Describe your feelings (for example, "I have the feeling you are unhappy, even though you are smiling. Am I wrong?")
2. Paraphrase what the speaker's remarks mean to you.
3. Reflect on the meaning of what is said, and wait for the person to elaborate.

Active Listening is not:

1. Finding solutions or trying to fix problems.
2. Giving orders, directions, commands, warnings, or lectures
3. Passing judgment, criticizing, disagreeing, blaming, arguing, praising, interpreting, sympathizing, consoling, probing, withdrawing, distracting, or humoring.

Tapestry of Faith
Barriers to Active Listening

What are some barriers to active listening?

1. Difference in age, sex, cultural background, language, lifestyle and priorities, negative feelings and attitudes, and lack of time.
2. Anticipating. The listener tunes out the speaker and what he/she has to say because the listener is anticipating a chance to respond and talk. Thas focuses energy on our own thoughts, and while we predict what will come next, we close ourselves off and lose contact with what is being expressed at present.
3. Fear. The listener fears being put down, ridiculed, or outreasoned; the listener fears that he/she might have to change, that his/her lack of knowledge will be exposed, that he/she might have to expose his/her real self.
4. Anger or hostility. Isolation is a way to punish.
5. Over-concern. The listener is too anxious and concerned about expressing his/her own ideas well.
6. Indifference. The listener lacks concern, care, or love and doesn't want to get involved.
7. Lack of self esteem. The listener has a poor self-concept.
8. Impatience. The listener is anxious to rush and fix the problem.
9. Over-identification. The listener takes on the feelings and problems of the other so that they become his/her feelings and problems, the listener thereby loses objectivity.
10. Rashness. The listener jumps to quick conclusions.
11. Fatigue. The listener tries to go visiting when ill or tired.
12. Prejudice. The listener makes judgments before listening.
13. Misinterpretation. The listener fails to find the speaker's true meaning.
14. Interrupting.

Nonverbal Communication Indicators

Body posture

POSITIVE	NEGATIVE
Leaning toward person at eye level	Sitting side on (discouraging to relationship and interaction)
Comfortable and relaxed position, settled, making it obvious that time is no problem	Cold, rigid, impersonal attitude; remaining standing and authoritative in position; looking ready to leave momentarily
Where possible, being three to four feet distant	Too distant or too close

Gestures and manners

POSITIVE	NEGATIVE
Extended, accepting arm/s	Arms by the side, in an indifferent manner
Firm handshake if appropriate	Limp handshake
Keeping head and body turned toward patient to indicate full attention; making patient the center of conversation	Talking to others, ignoring patient, yawning, fidgeting with anything, looking frequently at clock or watch

Facial expressions and appearance

POSITIVE	NEGATIVE
Warm, inviting, smiling	Cold, stiff, distant
Appropriate dress	Too formal, too casual dress
Groomed appearance (hair, makeup)	Careless appearance
Good eye contact	Roving or staring eyes, or no direct contact

Voice modulation

POSITIVE	NEGATIVE
Warm, natural	Dull, monotone
Circumspect tone	Embarrassingly loud or too soft
Understandable rate of speech	Too fast or too clipped speech
Fluent language	Stuck for words
Empathetic (understanding, supporting tone)	Artificial, false, insincere
Audible responses (*hm, hmm, aha,* etc.)	Hesitant, with many *ers, ums, ahs*
Appropriate silent gaps (for reflection)	Embarrassed silence with fidgeting
Interrupting to clarify or reflect before proceeding	Saying "yes, yes" when it should be "no"

Communication Tips for Apraxia of Speech

Verbal apraxia or apraxia of speech is an impairment in the ability to voluntarily produce speech. Apraxia is not due to disturbances of strength, coordination, or sensation. It is the inability to execute the voluntary oral-motor movements that are necessary to produce meaningful speech. A person with apraxia of speech is typically able to understand speech and language without difficulty. Even though it may be difficult to produce words and phrases spontaneously continue to talk with them about your activities and plans. Suggestions to decrease communication breakdowns include the following:

**Minimize or eliminate background noise if possible. The television, radio, or a nearby telephone conversation distracts the person who is trying to communicate. A person with apraxia needs to focus on the message they are attempting to communicate. Distractions make it very difficult to concentrate on sequencing the oral-motor movements that are necessary to produce meaningful speech.*

**Be mindful of the fact that fatigue, stress, or excitement will impact a person's ability to communicate easily. During these situations it is really helpful to ask questions that can be answered with a "yes" or "no" response. Providing a choice can also be helpful. An example would be, "Would you like to watch the news or a game show?" This is much easier than responding to an open-ended question such as, "What do you want to watch on TV?"*

**Be an attentive, patient, active listener. Allow extra time for the person to respond—stop what you are doing and give the person your full attention. Maintain good eye contact—this conveys that you are interested in their message.*

**When a communication breakdown does occur use these strategies to repair it before anyone becomes too frustrated. Ask if the person can repeat the message or restate it another way. If all else fails, ask what the topic is. "Tell me the topic." "Give me one word that helps me understand what you want to talk about."*

**Encourage and use all modes of communication--speech, writing, gestures, yes-no responses, and choice of 2 options.*

**Accept all communication attempts—focus on the message. Frequently let your loved-one know that you love them and care about them. Emphasize that it is the content of the message that is important to you.*

LISTENING SKILLS WORKSHEET

Effective listeners are enjoyed and respected by those individuals who talk with them. Effective listeners consistently practice certain actions which enhance their listening behavior. Most of the nonverbal actions appreciated by people who talk to you are listed here.

EFFECTIVE LISTENERS:	EVALUATION		
	Typically	Usually	Rarely
A. Smile at the speaker (if appropriate)	1	2	3
B. Focus eyes on the speaker's face	1	2	3
C. Assume same eye level as speaker	1	2	3
D. Nod head (up & down) occasionally	1	2	3
E. Turn body in the direction of the speaker	1	2	3
F. Point feet toward speaker	1	2	3
G. Move close to the speaker	1	2	3
H. Keep body quite still	1	2	3
I. Lean trunk of body toward speaker	1	2	3
J. Tilt body slightly off-center	1	2	3
K. Be aware of limb placement	1	2	3
L. Touch the speaker (when appropriate)	1	2	3
M. Mirror actions of speaker (if appropriate)	1	2	3
INEFFECTIVE LISTENERS:			
N. Shake head	3	2	1
O. Cover face and hands	3	2	1
P. Shrug shoulders	3	2	1
Q. Pat speaker on back	3	2	1
R. Scratch	3	2	1
S. Stifle yawn	3	2	1
T. Look at watch	3	2	1

TOTAL _____

Scale:
20 Ideal
40 Average
60 Improvement Needed

Fabian Communications
Adapted from Concordia Leadership - for Central Minnesota Elder Network 1996/97

COMMUNICATION WORKSHEET

1. Write your definition of communication.

2. What is necessary for effective and constructive communication to take place?

3. Write a list of things that get in the way of satisfying and effective communication you have with others.

4. Write a list of possible changes you could make to improve your communication skills.

POWER POINTS TO LISTENING

- YOU CANNOT NOT COMMUNICATE

- WHENEVER CONTACT IS MADE COMMUNICATION OCCURS

- NON-VERBAL COMMUNICATION SENDS THE MOST EFFECTIVE MESSAGE

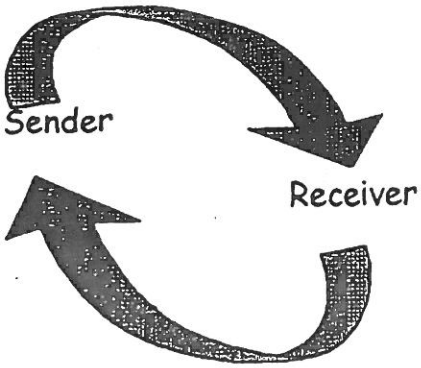
- MEANING CANNOT BE TRANSFERRED ONLY WORDS CAN BE TRANSFERRED

- 70% - 90% OF ALL COMMUNICATION IS SCREENED OR CHANGED BY THE RECEIVER

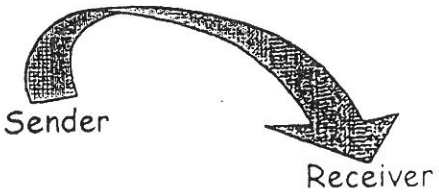
Fabian Communications
Adapted for Central Minnesota Elder Network 1996/97

COMMUNICATION MODEL

Two-way Communication



One-way Communication



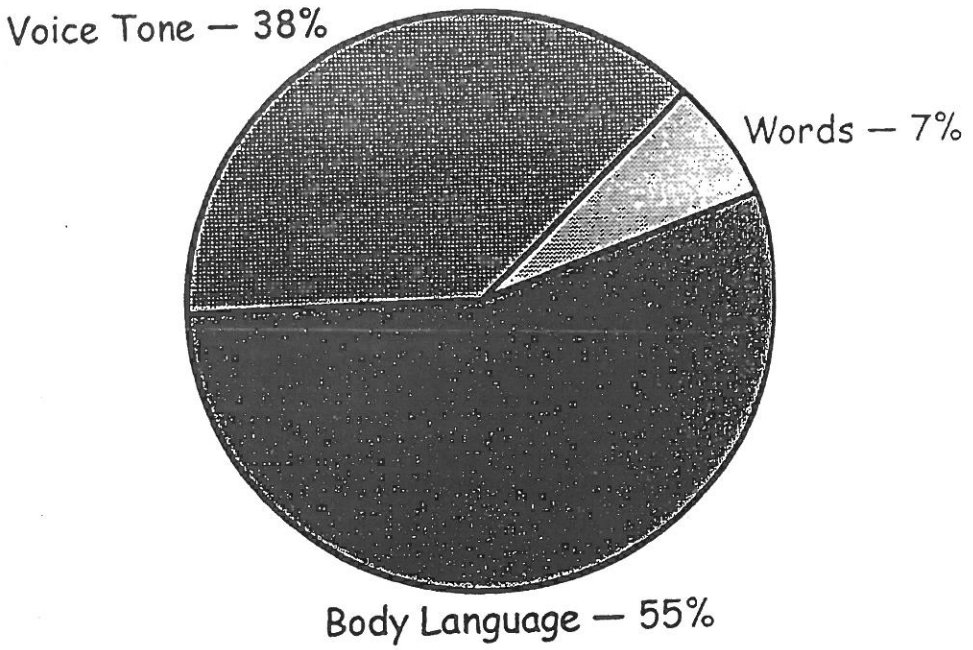
SENDER

- Communicates message to receiver
- Chooses form of communication
  - * spoken
  - * written
  - * non-verbal
- Chooses content of message
- Chooses style of delivery

RECEIVER

- Hears message
- Interprets message
- Reacts to message
- Chooses whether or not to respond to sender

IMPACT OF A MESSAGE



Communicating

We all need to communicate with other people. Communicating our needs, wishes and feelings is vital - not only to improve our quality of life, but also to preserve our sense of identity. If you need to communicate with someone with dementia, it's important to encourage the person to do so in whichever way works best for them.

We tend to think of communication as talking, but in fact it consists of much more than that. As much as 90 per cent of our communication takes place through non-verbal communication, such as gestures, facial expressions and touch.

Non-verbal communication is particularly important for a person with dementia who is losing their language skills. What is more, when a person with dementia behaves in ways that cause problems for those caring for them, it is important to realise that they may be trying to communicate something.

Dementia and language

An early sign that someone's language is being affected by dementia is that they can't find the right words - particularly the names of objects. They may substitute an incorrect word, or they may not find any word at all.

There may come a time when the person can hardly communicate through language at all. Not only will they be unable to find the words of objects: they may even forget the names of friends and family. People with dementia often confuse the generations - mistaking their wife for their mother, for example. This may be very distressing for their loved ones, but it's a natural aspect of their memory loss.

The person with dementia may be trying to interpret a world that no longer makes sense to them because their brain is interpreting information incorrectly. Sometimes the person with dementia and those around them will misinterpret each other's attempts at communication. These misunderstandings can be difficult, and may require some support.

Difficulties with communication can be upsetting and frustrating for the person with dementia and for those around them, but there are lots of ways to help make sure that you understand each other.

Tips: communicating with someone with dementia

General advice

- Listen carefully to what the person has to say.

- Make sure you have their full attention before you speak.
- Pay attention to body language.
- Speak clearly.
- Think about how things appear in the reality of the person with dementia.
- Consider whether any other factors are affecting their communication.
- Use physical contact to reassure the person.
- Show respect.

Listening skills

- Try to listen carefully to what the person is saying, and give them plenty of encouragement.
- If they have difficulty finding the right word or finishing a sentence, ask them to explain in a different way. Listen out for clues.
- If you find their speech hard to understand, use what you know about them to interpret what they might be trying to say. But always check back with them to see if you are right - it's infuriating to have your sentence finished incorrectly by someone else!
- If the person is feeling sad, let them express their feelings without trying to 'jolly them along'. Sometimes the best thing to do is to just listen, and show that you care.

Attracting the person's attention

- Try to catch and hold the attention of the person before you start to communicate.
- Make sure they can see you clearly.
- Make eye contact. This will help them focus on you.
- Try to minimise competing noises, such as the radio, TV, or other people's conversation.

Using body language

- A person with dementia will read your body language. Agitated movements or a tense facial expression may upset them, and can make communication more difficult.
- Be calm and still while you communicate. This shows the person that you are giving them your full attention, and that you have time for them.
- Never stand over someone to communicate: it can feel intimidating. Instead, drop below their eye level. This will help them feel more in control of the situation.
- Standing too close to the person can also feel intimidating, so always respect their personal space.
- If words fail the person, pick up cues from their body language. The expression on their face, and the way they hold themselves and move about, can give you clear signals about how they are feeling.

Speaking clearly

- As the dementia progresses, the person will become less able to start a conversation, so you may have to start taking the initiative.
- Speak clearly and calmly. Avoid speaking sharply or raising your voice, as this may distress the person even if they can't follow the sense of your words.
- Use simple, short sentences.
- Processing information will take the person longer than it used to, so allow them enough time. If you try to hurry them, they may feel pressured.
- Avoid asking direct questions. People with dementia can become frustrated if they can't find the answer, and they may respond with irritation or even aggression. If you have to, ask questions one at a time, and phrase them in a way that allows for a 'yes' or 'no' answer.
- Try not to ask the person to make complicated decisions. Too many choices can be confusing and frustrating.
- If the person doesn't understand what you are saying, try getting the message across in a different way rather than simply repeating the same thing.
- Humour can help to bring you closer together, and is a great pressure valve. Try to laugh together about misunderstandings and mistakes - it can help.

Whose reality?

- As dementia progresses, fact and fantasy can become confused. If the person says something you know isn't true, try to find ways around the situation rather than responding with a flat contradiction.
- If the person says 'We must leave now - Mother is waiting for me', you might reply, 'Your mother used to wait for you, didn't she?'
- Always avoid making the person with dementia feel foolish in front of other people.

Physical contact

- Even when conversation becomes more difficult, being warm or affectionate can help carers to remain close to their loved ones, or for the person with dementia to feel supported.
- Communicate your care and affection by the tone of your voice and the touch of your hand.
- Don't underestimate the reassurance you can give by holding or patting the person's hand or putting your arm around them, if it feels right.

Show respect

- Make sure no one speaks down to the person with dementia or treats them like a child, even if they don't seem to understand what people say. No one likes being patronised.
- Try to include the person in conversations with others. You may find this easier if you adapt the way you say things slightly. Being included in social groups can help a person with dementia to preserve their fragile sense of their own identity. It also helps to protect them from overwhelming feelings of exclusion and isolation.
- If you are getting little response from the person, it can be very tempting to speak about them as if they weren't there. But disregarding them in this way can make them feel very cut off, frustrated and sad.

Other causes of communication difficulty

It is important to bear in mind that communication can be affected by other factors in addition to dementia - for example:

- pain, discomfort, illness or the side-effects of medication. If you suspect this might be happening, talk to the person's GP at once

- problems with sight, hearing or ill-fitting dentures. Make sure the person's glasses are the correct prescription, that their hearing aids are working properly, and that their dentures fit well and are comfortable.

Your local Alzheimer's Society branch will always be willing to talk to you and offer advice and information to support your needs.

For more information, Dementia Catalogue, our specialist dementia information resource, is available on the website at alzheimers.org.uk/dementiacatalogue

Factsheet 500

Last updated: May 2008
Last reviewed: May 2008

Reviewed by Cathy Baldwin, Dementia Learning and Development Adviser, Alzheimer's Society

Tapestry of Faith
Guidelines for Visiting a Nursing Home

The general role of the volunteer visitor is to be of service in a meaningful and compassionate way. The first visit is always hard. "What will I say?", "Will he/she like me?", "Will I be able to help?" are common questions when preparing to meet an elder for the first time. The following guidelines are provided to offer suggestions regarding the visit and hopefully allay any concerns you may have about making the visit.

- Make arrangements for the visit. The best times to visit are late afternoon and early evening during the week, and anytime during the day and early evenings on the weekends.
- Knock before entering the room; do not interrupt a healthcare provider or other staff member.
- Introduce yourself at each visit—remember to wear your nametag.
- Explain the purpose of the visit, i.e. I'm a visitor from St. Mary's Church, I've come to visit and pray, share the news of the parish, etc.
- Ask what the elder would like to be called
- Be sensitive to the emotional and physical status of the elder. Is he/she tired, in pain, anxious? Use these clues to respond to the elder.
- Place yourself sitting or standing in direct line of vision of the elder to maximize opportunity for speaking and listening.
- Do not perform any physical/medical tasks for the elder
- Do not visit if you are ill
- Keep all information confidential

- When hearing complaints, be compassionate in seeing ways to be helpful, but do not make promises. Share these with the nursing staff.

- Be yourself, the visitor role is that of a friend and visitor. Be "where they are".

- Touch: some people like to touch and be touched, others don't. It is helpful if you can be flexible with this issue so you can cue in on the needs of the elder you are visiting. In most instances, people welcome a handshake or other appropriate physical gesture as a means of communication, caring, and connection.

- Don't discuss the person's illness or condition or others who have it. This can turn into an "ain't it awful" conversation.

- Don't apologize, argue or contradict. Your task is to build trust and show caring. Try to understand what lies behind the statements that evoke the impulse to apologize, argue or contradict.

- Don't make excuses for coming late or leaving, for example, "I'm sorry I didn't get by to see you sooner, or 'Well, it's late I must go visit other people." The message that can be conveyed is "You really are not worth my time" and you may rush the visit.

- Upon leaving, let the elder know you will be returning.

- Wash your hands when entering and leaving the room.

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Tips for a Successful Visit

- Be consistent in visits
- Show acceptance
- Allow resident to talk
- Listen, listen, listen
- Do not take not wanting to talk as rejection, don't take personally
- Be sincere
- Be pleasant, but not overwhelmingly cheerful
- Build rapport with the elder by sharing a bit of information about yourself, your family, etc.
- Be sensitive to loss of sight, memory, vision
- Speak slowly, make eye contact
- Don't challenge their reality
- Use short words and simple sentences
- Limit visit to an appropriate amount of time
- Use prayer as a way to end the visit

Tapestry of Faith
Elder Interview

This form is a guide only to assist with the first visit. The elder may not be able to provide answers to all the questions.

Elder name: _____ Preferred name_____

Birthdate: _____ Length of Time at Facility: _____

Married____ Widowed____ (How long?)_____Spouse Name: _____

Children: _____ In local area? _____

Parish Affiliation: _____

Interests as an adult:

_____

Activities involved in at home parish:

_____

Previous employment:

_____

Activities enjoyed at nursing home:

_____

Favorite memories of parish life:

_____

Favorite childhood memories:

_____

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Elder Interview

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Visit Information

Name_____ Clergy Visit?_____

Facility_____ Room #_____

Visitor Assigned_____Date assigned_____

Date	Notes (problems, requests, reminders)	Review

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Evaluation of Visit

Tapestry of Faith Visitor_____

Person Visited_____Date_____

After a visit, it is helpful to reflect on what we did right, how we can improve, and how we can help the person visited more closely linked to the rest of the parish community. Following the visit, mark each item with a "+" (yes) or "-"(no)

Preparation
____ I prepared for the visit with prayer
____ I familiarized myself with the person's situation ahead of time
____ I was on time for the visit

Expression
____ The person visited showed signs of appreciating my visit
____ I used the person's name frequently
____ I did less talking and more listening
____ I kept eye contact with the resident
____ I used touch appropriately to show my caring
____ I maintained a pleasant spirit

Reactions
____ I am satisfied with our conversation. Next visit, talk about _____
____ The resident seemed to be able to express his/her feelings
____ I believe I built trust with the resident I visited
____ There were moments of comfortable silence
____ I focused on the resident's interests

Listening
____ I listened well
____ I was aware of what my body language was saying
____ I paid attention to the resident's nonverbal communication
____ I was able to paraphrase accurately most of the other's expressions

Values
____ I will have no problem keeping matters confidential
____ This visit will require more discussion
____ Prayer flowed naturally and was a part of the visit

Planning
____ I intend to help link the person visited to the church community. I will do this by:
_____.
____ I made plans with the person for my next visit
____ I asked the person what he/she would like to visit about the next time
____ I learned from this visit: _____

Tapestry of Faith
From: Ministry to the Homebound

Tapestry of Faith
Resources

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2. Johnson, Richard P. Parish Ministry for Maturing Adults. New London, CT.: Twenty-Third Publication, 2007.

3. Kirkwood, Neville A. Pastoral Care to the Aged. Harrisburg, PA.: Morehouse Publishing, 2005.

4. Musgrave, Beverly Anne. Partners in Healing, Bringing Compassion to People with Illness or Loss. New York: Paulist Press, 2003.

5. Miller, Kent C. Ministry to the Homebound. San Jose, CA: Resource Publications, 1995.

6. Normile, Patti. Visiting the Sick, A Guide for Parish Ministers. Cincinnati, OH: St. Anthony Messenger Press, 1992.

7. Roccapriore Sr. Marie, MPF. Caring for the Sick and Elderly, A Parish Guide. New London, CT: Twenty-Third Publications, 2003.

8. Thomas, Leo O.P. Healing Ministry, A Practical Guide. Kansas City, MO: Sheed and Ward, 1994.

9. Webb, Marie White. Building a Ministry for the Homebound and Nursing Home Residents. Nashville, TN: Discipleship Resources, 2003.

Tapestry of Faith
Volunteer Visitor Confidentiality Agreement

I understand that in assuming my responsibilities as a volunteer visitor in the Tapestry of Faith program, I may have access to personal and medical information about the elders with whom I work. I will consider all elder information to be strictly confidential and not to be shared with or discussed with anyone but the parish nurse as appropriate.

I further understand that in the event I observe or am told of behavior that would indicate that my client may be a victim of abuse, neglect, or self-neglect to the extent that his or her safety is in danger, I am required to report this to my program director (parish nurse) immediately.

The Church of St. Mary expects all of its volunteers to follow the code of conduct covering confidentiality and ethics. Your signature verifies you understand the code of conduct of this confidentiality policy governing volunteers at the Church of St. Mary.

_____

Signature of volunteer

_____

Date