Music Share

Volunteers Making a Difference through Musical Visits

Program Evaluation Report
October 2017

Acknowledgments

Funding for this project was provided by the Room 217 Foundation and a private donor.Study participants included volunteers, residents and staff in five long term care (LTC) homes in the Greater Toronto Area. The Evaluation Team included:

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City of Toronto Long-Term Care Homes & Services is comprised of ten LTC homes and community programs. The LTC homes are located city-wide and are committed to care and offer inter-disciplinary medical care in a home-like, inclusive environment.

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Room 217
Care through Music

About the Room 217 Foundation
The Room 217 Foundation is a social enterprise dedicated to caring for the whole person with music by producing and delivering therapeutic music products, providing skills and training for integrating music into care and supporting innovative research in music and care.

Executive Summary

Volunteers play a meaningful role in long term care (LTC.) They serve in a variety of supportive capacities and may be able to offer more leisurely visits with residents. Music is increasingly being used and accepted in healthcare to intentionally improve wellness and is an accepted psychosocial intervention used to improve quality of life. Music is a tool that volunteers can use in LTC. The music care approach is a paradigm being developed by the Room 217 Foundation which promotes the use of sound and music to meet challenges of care, such as social isolation and loneliness of LTC residents. This approach empowers volunteers to use music as a holistic and human solution.

Music Share is a program in LTC where volunteers provide a musical exchange with residents through music visits and small group interaction. The program evaluation has provided valuable feedback in the design and necessary components of Music Share. It has also given preliminary data on volunteers' experience with LTC home, residents and Music Share program. Room 217 received funding from a private foundation in order to complete the program evaluation in five LTC homes, three in the City of Toronto and two Chartwell homes. A total of forty-two residents participated in the Music Share program evaluation, from the five participating LTC homes. Thirteen volunteers, ten female and three male, made the visits.

There were four steps in the Music Share program evaluation. The process we used was **reconnaissance discussions** (site expectations, volunteer and resident recruitment, evaluation, loneliness and isolation of residents), **training and resource collection** (baseline music care training for volunteers and lead staff, including sound and music theory with experientials and strategies and resource gathering), **implementation & evaluation** (implementing Music Share, and reflecting on experience, collecting and analyzing the qualitative and quantitative data), **reporting** (making meaning of the results).

The program evaluation indicated that Music Share has made a positive impact on residents. It has also provided volunteers with tools for developing and deepening relationships with residents. This was evident in the feedback provided by volunteers on an online survey at the conclusion of the 3-month evaluation period as well as a program evaluation form completed by staff and volunteers. Volunteers also tracked their reflections on a weekly log after each visit with a resident. Overall, both quantitative and qualitative feedback shows evidence the Music Share program is a potentially viable volunteer-based program in LTC.

There were several key learnings from this pilot study. Doing program evaluation in LTC settings is ideal because of the comprehensiveness of personal challenges that are faced within a community setting. There are inherent evaluation barriers in this setting including staff and volunteer fluidity, internal processes and dynamics, outbreaks, buy-in, and volunteer recruitment and availability. The nature of a volunteer-driven program means the program runs based on the availability of the volunteer which may be pre-empted by job or personal circumstances. Building rapport between volunteer and resident takes time in order to address a specific outcome like reducing loneliness and isolation. Rolling out and implementing Music Share in a LTC home requires competent leaders and adherence to a process.

Through this program evaluation, Room 217 is refining the Music Share program in order to be adaptable to all LTC homes. The Music Share Manual draft has been developed.

Introduction

Volunteers in Long Term Care

Volunteers are individuals who freely offer and apply their time, talents and skills for the purpose of advancing a cause, a purpose, a mission of an informal or formal group without expectation of compensation other than the reciprocal benefit of experiencing the personal satisfaction accompanying the effort of helping others (Falkowski, 2013.) According to Powers (1998), there are three types of volunteers: the volunteer looking for a specific need that can be met in a finite period of time; the volunteer that is highly committed and passionate about a cause and serves on an ongoing basis; and the volunteer that is coerced or forced to volunteer by someone in authority such as an employer.

LTC owners and operators value the volunteer force. In 2004, the US National Nursing Home Survey indicated that 82.7% of LTC homes use volunteers (US Dept of Health and Human Services. National Center for Health Statistics, 2004). Volunteers serve in a variety of capacities including socialization of the patients, administrative support, spiritual support, practical support, respite support, bereavement support and mental health support (Claxton-Oldfield, Gosselin, & Claxton-Oldfield, 2009; Wagner, Berstein, & Marziali, 2007; Gross, 1961; Moss & Remsburg, 2005; Musson, Frye, & Nash, 1997.)

Volunteers have the freedom to provide LTC home residents with something that the staff cannot provide, "personal and leisurely conversation". They are able to conduct one-on-one visits (Falkowski, 2013.) One such study examined the effects of volunteer-based one-on-one visits on residents in LTC. The purpose of the study was to understand volunteer/resident interactions and experiences. In this twelve-week study, volunteers were trained to provide one-on-one visits; then made visits, for the first 6 weeks supervised, and for the remaining 6 weeks unsupervised. (Damianakis, 2007.) Results of this study indicated that volunteers need for high quality training content, ongoing training and a variety of training modes to include manuals, workshops and seminars. The volunteers perceived that their role was to engage residents in both individual and group settings, improve residents' quality of life, and improve their own interpersonal skills. The emerging themes from the research were relationship building, contributing to the LTC environment, preserving personhood and resident-centered presence (Damianakis, 2007.)

Reality of isolation in LTC

Isolation and loneliness are increasingly being recognized as health risks for older adults (Grenade & Boldy, 2008.) Although we do not have a true gauge of the prevalence of isolation and loneliness in the Canadian population, some doctors and policy makers are calling it an epidemic (Kar-Purkayastha, 2010.) This is primarily a problem facing older adults, especially those living in LTC.

Isolation and loneliness are two separate concepts. *Isolation* is a concrete phenomenon: it refers to someone having limited access to individual relationships and community experiences. *Loneliness* is a subjective construct, occurring when an individual desires meaningful relationships that do not exist for them in reality.

Some researchers have attributed loneliness and isolation in LTC settings to perceived alienation from

society (Cattan, White, Bond, & Learmouth, 2005.) LTC residents can feel separated from their communities, both physically and emotionally, which can lead to isolation and loneliness. One doctor described his perception of lonely older adults that he encountered in his practice as being "left behind by a world that no longer revolves around them" (Kar-Purkayastha, 2010.)

Music Care

Music is increasingly being used and accepted in healthcare to intentionally improve wellness and is used in LTC homes across Canada. Music is an accepted psychosocial intervention increasing many aspects of quality of life. Room 217 has defined and developed a music care approach which allows the healing principles of sound and musical effect to inform our caring practices. Music Care not only meets the changing care culture – it can be an agent of culture change. Music care is intended to be person-centered and improve quality of life and care through empowering agency and decreasing loneliness, thus contributing to overall culture change in health care.

Music care allows for a variety of dimensions of delivery. Music programming integrates music into formal programming. It implies the use of staff or volunteers within a facility to plan for and employ the use of music into recreational or therapeutic programs that are delivered individually or in groups. One aspect of music programming is Music Share.

Music Share

Music Share is a program that gives volunteers an opportunity to provide a musical exchange with residents in LTC through music visits and small group interaction. Music Share volunteers are trained in the music care approach. Volunteers have full access to a range of ready-to-use music care resources that encourage music listening, music-making and music conversations. Music Share aims to reduce resident isolation and loneliness through music and targets all residents. Music Share is being developed by the Room 217 Foundation and two music care advocates who have completed Room 217's Level 3 Music Care Training. The advocates have developed Music Share through combining their lived experiences as LTC family members, volunteers, and certified music practitioners, with their music care training.

Purpose and objectives of the program evaluation

An assessment of the Music Share Program was needed to ensure that it meets standards in LTC programming and to make changes for greater impact. Specifically, objectives were to determine the process for a volunteer-based music program, provide feedback on the impact of Music Share on all LTC partners, and to observe how a LTC site can integrate Music Share into their programming.

Music Share methodology

In order to evaluate Music Share, there was a four-step process that was followed. **Reconnaissance** included two evaluation team meetings to become familiar with the Music Share program, discuss site expectations and integrating processes, volunteer recruitment and job description, resident recruitment, training logistics, evaluation, and any other implications.

Training and Resource Collection occurred in two locations - one east end and one west end - and at two times – one during the week, and the other on a weekend - to make it easier for volunteers to attend. Volunteers and staff who attended training received a certificate of completion for Music Care Level 1 training. Volunteers compiled music care kits at the training using Room 217 resources and were encouraged to build more resources into their kits prior to starting visits. Volunteers were also oriented to the Music Share program through the handbook.

Implementation and evaluation involved several components. Basic volunteer orientation to the LTC site is assumed in Music Share. Music Share facilitators provided Music Share orientation to staff leaders and volunteer coordinators (handbook) to any staff leaders who had not attended training. The handbook includes roles, expectations, forms and templates for the Music Share program and evaluation. Volunteers were mentored by Music Share facilitators with regular communication and coaching. Facilitators also communicated regularly with staff leaders to ensure smooth implementation. Volunteers were assigned residents by the staff lead. Volunteers logged in at each visit using the site specific Music Share binder, and recorded what happened after every visit anecdotally. Data was collected over twelve weeks. At the conclusion of implementation, staff and volunteers completed a program evaluation. Volunteers completed an online survey about their experience of Music Share. Program facilitators and Room 217 researchers analyzed the data.

Reporting occurred in two ways. The evaluation team gathered to make meaning of the collective results which were presented both quantitatively and qualitatively. Based on the findings, the group conducted a SWOT analysis which highlighted strengths, weaknesses, opportunities and threats of the Music Share program. A final report was disseminated to all stakeholders.

A wrap-up gathering in each home was optional and left to the discretion of the staff leads in each LTC home.

Results

A total of 207 resident visits were made by 13 volunteers to a potential 42 residents. During the project, 2 volunteers had to withdraw due to gaining employment and lack of time for volunteering. One resident died during this time, and an additional three residents didn't want to continue in the program. There were visits when a resident didn't feel "up to it". The average length of visit was 25 minutes. The number of volunteers at each site were either two or three. At Wesburn and Bendale, the two volunteers visited residents together. Most visits were done with one resident, although in some instances, a small group of residents gathered. Figure 1 shows how many volunteers visited how many residents how many times. 82% of the visits happened in the morning as shown in Figure 2.

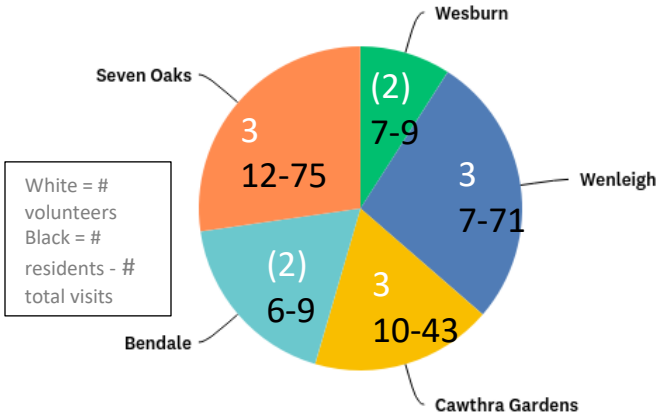

Figure 1. Number of volunteers, residents and MS visits

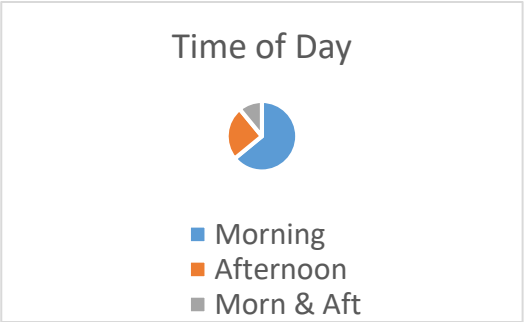

Figure 2. MS visit time of day

Volunteers ranged in age from 16 to 77. There were both experienced and new volunteers. Volunteer recruitment varied from home to home including high school co-op students, calling out to experienced volunteers, and using the music focus as a call-out for new volunteers who may be interested in music.

Volunteer experience

Volunteer experience was captured in three ways: interaction with the LTC home, implementing Music Share, and engaging with residents. In terms of volunteer experience with the LTC home, most volunteers felt they were given an appropriate amount of time to provide a musical exchange with residents. Fifty-five per cent of volunteers were able to have a meaningful exchange without interruption. Sixty-four per cent of volunteers felt valued and supported by LTC staff. Two-thirds of family members indicated a positive response to the Music Share program. Three quarters of volunteers felt that the overall environment in the residents' rooms seem to be calmer when doing the music exchange. Forty-six per cent of volunteers felt that the care residence became more peaceful and relaxed during the twelve weeks of music exchanges. Most volunteers felt they were provided with a safe space to create musical exchange. Fifty-five per cent of volunteers felt they were matched well with the residents.

When implementing the Music Share program, most volunteers felt supported and valued the support given by their mentors (program facilitators.) Ninety-one per cent of volunteers felt that the music care training was beneficial to creating an effective music exchange with residents. Two-thirds of volunteers found the music care kits helpful in creative an effective music exchange. Music Share has helped improve technology skills in 55% of volunteers.

All volunteers felt that MS made them aware that music is an important means of relating to residents in LTC. Three-quarters of them said MS made their relationships with residents and staff stronger. Most of them felt MS made a positive difference in how they used music to relate to residents. Most of them felt MS increased their confidence level in using music to relate to residents.

Emerging ideas

Six key ideas were identified as barriers and enablers for the MS program.

1. **Rapport takes time –** Building rapport between volunteers and residents takes time. One volunteer commented "by week 3 they [the resident] was looking forward to it." Another stated, "Very good, especially as residents got to know volunteers.

2. **Staff leadership and support –** LTC staff anchor volunteers and provide non-musical support. One volunteer felt "my contribution to the program was valued. Staff expressed their excitement about the program as it unfolded and as results were documented, I was encouraged to continue. MS was well received and supported." Other volunteers said they need "more information on residents" and that "additional training with memory loss/aggressive behaviours/language would be valuable."

3. **Relationships through music** – Music is a starting point in building relationships. Being able to share stories, memories, songs, listen to and make music together creates bonds between people. Music is a tool to support communication across cultural, and language barriers, and especially with residents who may be non-verbal. Staff commented "the volunteer and resident were able to build a friendship weekly." One volunteer said that MS was "Made deep connections with past memories stimulated by the music."

4. **Resident responsiveness** – Music elicits response from residents. While responses are varied, residents do respond.

"Resident still **confused** but **enjoyed socializing and talking**."

"Resident showed a **great improvement** with the MS program. She now sings when she sees me. She is always **looking forward** to my visit and loved to **show/tell me the words** to the various songs. She now sometimes **sings in the dining room**. Music **calms her down**."

"**Before: Quiet After: Excited** to know about music care. Says she **enjoys, loves songs**."

"**Enthusiastic**. She immediately reacted to music by **moving hands and feet**. She **participated** in karaoke **singing all songs**. **Eagerly**. We made an **emotional connection** to her youth in Capetown."

"**Eagerly** and **enthusiastically shared her knowledge** and love for tap dancing. **She shared her performance technique** with a unique **hand gesture**."

"Is blind. We started her favourite season playing dvd "Summer". The music prompted her to **open up** about her past memories of food, dancing and music. She **shared** many memories of her profession as a nurse."

"She was a **burst of energy**. We played summer dvd. She was **swaying and singing** and **happily joining us in our song and dance**. She **shared memories** of Manila, and **looks forward** to our returns."

"**Was not responsive**. We started with light jazz on my phone which he held but as soon as we put on dvd, he didn't want to participate anymore by **covering his ears with a blanket**."

"Most residents were isolated in their rooms. Some residents who didn't talk responded to music by **squeezing volunteer's hand**. Agitated residents **calmed down** with the music."

5. Musical preference – Musical choices are most effective when based on resident preferences. In MS, preferences varied. There were ethnically diverse preferences. One volunteer said about a resident, "She enjoyed the Hindi song I played for her on my mobile and the music from the CD. She seemed

relaxed." Another said, "She told me she loved to hear Urdu songs. So I played Gazal of Meredith Hassan on YouTube." Musical genres were also varied. Volunteers reported, "Played country music for her on the mobile. Dolly Parton's music/Eric Clapton." "Very religious. Seemed isolated and lonely. Played my favourite hymns we sang together. Stayed 45 minutes. She loves to talk. Seems quite moved by my visit."

6. Technology accessibility – Volunteers understanding of how to use technology as well as the LTC home's ability to provide technology varied. One volunteer mentioned that WiFi was needed throughout the home. Another suggested that "having the entire music available in a shared drive where a mobile device can be used to easily select and play music" would be helpful. More training around creating playlists may be needed as one volunteer commented, "provide a session to teach how to create own playlists technically."

SWOT analysis and suggestions
A SWOT analysis (strengths, weaknesses, opportunities and threats) of the MS was conducted by evaluation team after discussing quantitative and qualitative results and making meaning of them. Volunteer training and mentoring in MS program empowered volunteers and gave them an opportunity to grow and develop skills. Training was comprehensive and research-based. The music care kit and materials were helpful as a starting point. The trolley storage idea worked well and was easy to use. The Conversation Cards were a helpful tool for communication. Anecdotally, MS appeared to decrease loneliness with residents.

More training in technology is required to support the development of individualized playlists for residents. Volunteers need access to DVD and CD players. Diversity of music in the music care resources is limited to due to the large range of preferred culturally diverse music. Volunteer recruitment is a challenge. More information about the residents from staff and family members would help residents. More contact with residents' families about the MS program may be beneficial for family members. Staff buy-in needs to be addressed. A presentation to all staff regarding vision of MS would be helpful. One staff lead was not enough. Two would be better.

MS comes alongside a volunteer's scope of practice and provides a set of tools and something "to do" with residents in 1:1 visits. An opportunity of the program is that it is person-centered and focuses on the relationship between volunteers and residents. MS visits can be worked into the LTC home calendar. MS could be sustained by family councils taking the lead. MS could be rolled out "in a box". Volunteers, mentors and music therapists could work together to adapt MS to a "home wide" program.
Real-world factors must be accounted for when doing program evaluation in LTC settings. Depending on the site-specific context, these factors can act as enablers, barriers, and in some cases as both. Barriers during this evaluation included outbreaks, staff and volunteer turnover, staff leadership, volunteer integration, volunteer availability, volunteer recruitment and retention, time commitment required by staff and volunteers, death, lack of WiFi.

Key Learnings

Programs that are volunteer-based have certain risks that need to be addressed prior to roll out and during implementation. Recruiting responsible and committed volunteers, particularly for a niche

program that is music-based did not depend on a volunteer's musical ability. The volunteer's success with MS depended more on their experience of volunteering. Volunteer retention varied. This may or may not have anything to do with MS, rather the nature of volunteering in LTC. While volunteers attempted to keep visits frequent at the same time and day of the week, visits were not always consistent due to changes in volunteer schedule, lack of interest on the part of the resident, or one of the barriers listed above.

The LTC sites where there was most consistency during the 12-week period had three characteristics: experienced volunteers, staff support and simple process. Experienced volunteers mentored new volunteers not so much in the use of music care, rather in relating to residents. Staff support was communicated and palpable to volunteers. Volunteer sign-in, and feedback processes were clear and contained.

Matching volunteers and residents is key to the MS program. Where there was an apparent mismatch, visits were awkward, short or non-existent. This can be discouraging for volunteers. Care needs to be taken when matching volunteer capacity with resident needs as well as preferences and personalities. The emphasis on pairing needs to focus on the relationship between volunteers and residents.

Volunteers need to have received standard training that the LTC home provides. A special emphasis on relating to residents with behaviours could be a necessary prerequisite to recruiting volunteers for MS as it is an intimate, 1:1 situation.

Having sufficient time to develop a relationship is fundamental in the MS program. Building rapport simply takes time. 8-12 weeks is a recommended time frame to initiate the MS program. Signage saying "Visit in Process" would help protect volunteers' time with residents .Integrating volunteer visits into individual resident care plans may be a solution to sustaining MS over time and tracking its impact during regular RAI-MDS assessments.

There appears to be five key components that are predictors of MS program success. **Recruitment** of committed volunteers is an ongoing task. There needs to be periodic asks to draw in volunteers willing to try MS. **Music Care Training** is essential to the confidence level of volunteers, especially those who may be insecure in using music in care. Providing context, music theory, music care experientials and strategies strengthens volunteers. **Mentoring and supporting** volunteers is necessary to implementation so that volunteers know they have somewhere to turn if something goes wrong, if they are unsure of how to respond, or if they get stuck in any way. **Program orientation** at LTC home needs to be clear and intentional. Having a stepwise process with clearly defined roles and responsibilities of all care partners is essential.

Conclusion & Recommendations

We anticipated that by creating a comfortable, intentional music exchange between residents and volunteers, relationships would be built through sharing songs and stories. We hoped that residents' identities and self-worth would be strengthened through connecting to meaningful memories, and that

loneliness and boredom would be reduced by connecting to volunteers. While the program evaluation had limited evaluation of resident impact and focused more on the process and volunteer experience, MS did provide some meaningful, and beautiful connections between volunteers and residents at Cawthra Gardens, Bendale Acres, Wesburn, Wenleigh and Seven Oaks LTC homes.

Recommendations for further study would include doing a pilot study of the impact of MS on resident loneliness and isolation in LTC using validated tools like the Friendship Scale and RAI-MDS. Recruitment and implementation processes need to be refined, particularly staff orientation. Further training for MS will need to include a deeper focus in technology, particularly playlists, more specialized dementia care training for volunteers, and musical approaches to using diverse sounds with residents.

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