Providing Quality Through Volunteers

On the importance of coordination in ensuring the quality of care provided by volunteers in a professional care organization

A case study

Master Thesis

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Preface

Studying for and writing this thesis has truly been a journey worth taking. In the beginning of January 2014, more than half a year ago, I summarized my ideas for this thesis in half a page. Now, at the end of August, my story consists of over 90 pages. In between, I took part in twenty shifts in Hospice Heuvelrug, and engaged in many interesting conversations with nurses and volunteers working there. In addition, I took part in peer groups with other volunteers and visited the amazing 15-year anniversary party of the hospice in the beginning of April. As time continued and my experiences accumulated, academic literature on active citizenship, coordination, and routines helped me in making sense of what I was observing. The results lie before you today.

In Hospice Heuvelrug, I learned much more than can ever be described in a mere 90 pages. I was able to experience firsthand what being a volunteer in a hospice was like and what it meant to be part of an organization of which the members all share one altruistic goal: to help and care for terminally ill people to the best of their abilities. I learned, and tried to reflect in the conclusion of this thesis, how important this shared normative view is for the successful coordination of volunteers, and ultimately for the quality of care that is offered.

I also learned to view the hospice's guests as people, not as patients, and I learned how to be open and responsive to their needs. I learned much about death, and even more about life. None of these lessons were necessary for my thesis, but to me they are unforgettable.

First and foremost, therefore, I would like to thank all volunteers, nurses and other staff at Hospice Heuvelrug for sharing their experiences with me and for teaching me how to be a good volunteer. Without them this thesis would not have looked the way it did. I specifically want to thank Emmie Bakker, the volunteer coordinator at the hospice who allowed me to study the coordination of volunteers there and without whom this thesis would not even exist. I will never forget my time there.

I also want to express my thanks to Mirko Noordegraaf, who guided me through the whole process and gave very valuable feedback that allowed me to keep improving my thesis as the months went by; Marlot Kuiper, Ulrike Weske and Minou de Ruiter for their comments on parts of my work; and Margo Trappenburg for agreeing to be the second reader for my thesis. And lastly Maarten, for helping me with the conceptual models, but most of all for being there, always.

As this master's thesis represents all I have learned in the last six years, as well as my passion for the care- and welfare sector, I am proud of the result. To the reader: I can only hope that you will enjoy reading my thesis as much as I did writing it.

Barbara Abspoel
August 2014

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Management Summary

Research focus and set-up

The welfare state is changing. Sparked by a changing idea of what it means to be a citizen, it is slowly transforming into a participation society. This development is about to culminate in the abolishment of the former AWBZ and the transfer of many types of care to a new, extended Wmo (Coevert, 2014 8 July). In this new society, citizens are expected to take more care of themselves and each other, including in areas that were formerly considered responsibilities of government or professionals. In the care- and welfare sector, this might lead to a heavier reliance on volunteers in the provision of care. Such an endeavor, however, might negatively impact the quality of care that is provided. Compared to professionally trained nurses, volunteers have less knowledge and skills (cf. Freidson, 2001) and for that reason are not able to provide the same quality of care . In addition, the voluntary nature of their work and the lack of organizational loyalty that comes with an individualized society might lead to high volunteer turnover (Dekker et al, 2007) and thus to problems with continuity of care. At the same time, volunteers' intrinsic motivation to care for vulnerable fellow citizens might affect quality of care in a more positive way (cf. Boxall & Purcell, 2011). Professional care organizations are provided with the challenge to shape volunteer involvement in such a way that quality of care remains ensured.

In this thesis, the shaping of volunteer involvement by professional care organizations is conceptualized as a question of coordination. To influence and direct the behavior of volunteers towards the provision of good quality care, organizations may use several coordinating mechanisms (cf. Mintzberg, 1980). However, for these coordinating mechanisms to become effective and to lead to stable coordinated behavior, they will need to become embedded into the actual daily patterns of action, or routines, on the work floor (Pentland & Feldman, 2008). With this theoretical background in mind, the study answers the following question:

> *Which means of coordination might professional care organizations use to ensure the quality of care given by volunteers?*

To answer this question, a case study has been conducted in Hospice Heuvelrug, an organization in which the provision of good quality care and a heavy reliance on volunteers are effectively combined. Through participant observation, interviews, and document analysis, data was gathered on the coordinating mechanisms and routines present in De Heuvelrug, and on the way in which they contribute to ensuring quality of care. By describing the mechanisms in Hospice Heuvelrug that lead to a heavy reliance on volunteers and quality of care to go hand in hand, this thesis provides a "good example" (cf. Flyvbjerg, 2001) which other professional care organizations might use in their own process towards an increasing or better use of volunteers in their organization.

Research outcomes

If professional care organizations aim to ensure quality of care whilst increasing the involvement of volunteers in the provision of care, they should focus, first of all, on minimizing the risks that come with a heavier reliance on volunteers, both to continuity of care as well to the effective provision of knowledge based and interpersonal care (cf. Campbell, 2000). At the same time, they should nurture and stimulate the intrinsic motivation of volunteers, to not lose the opportunities this motivation provides for increasing quality of care.

In Hospice Heuvelrug, this has been achieved through the emergence of four facets of coordinated volunteer work. *Continuous learning*, in the form of an introductory course and trial period, peer groups, briefings, and learning on the job, ensures that volunteers have the knowledge and skills to provide care to the hospice's guests. *Responsible action*, in turn, leads to volunteers knowing their responsibilities, both in terms of when to show up as well as in terms of how to perform. The latter is ensured through evaluation talks and feedback. Most important, however, is the informal and shared rule that volunteers do not conduct any care-related tasks they feel they are not able or comfortable doing. Responsible action thus leads to clear boundaries within which volunteers contribute to the provision of care to the hospice's clients. *Working together*, as a third facet, has created an atmosphere of equality and mutual respect between volunteers and nurses, which has enabled mutual adjustment about who does what. Working together, most importantly, happens with a shared goal in mind: to meet the requests and needs of guests as well as possible. Finally, *organizational membership* ensures that volunteer turnover is low and that volunteers' intrinsic motivation remains high. Part of this facet is the acknowledgement and appreciation of volunteers by all members of the organization, which is communicated both through formal as well as informal means.

For professional care organizations to ensure good quality of care provided by volunteers, it does not suffice to 'just' implement coordinating mechanisms which embody one or more of the four facets of coordinated volunteer work described above. Rather, the challenge is to make sure these coordinating mechanisms are translated into actual patterns of action on the work floor – to make sure, in other words, that they become part of *routines*. In Hospice Heuvelrug, routinization occurs because members in the organization – nurses, coordinators, volunteers – all share similar values, norms, and attitudes on what constitutes quality of care and how this quality of care can be achieved. What is more, the coordinating mechanisms aimed to direct volunteer behavior are based on these very same values, norms, and attitudes. As a result, volunteers as well as other organizational members have actively incorporated these coordinating mechanisms into their daily routines. This shared normative basis is a key element that ensures that coordinating mechanisms are translated into routines, which in turn leads to stable coordinated action and, because of the character of the four facets, to quality of care being ensured. This normative basis is, in turn, reinforced by these very same facets, since they incorporate the five aspects of normative control put forward by Mintzberg (1996).

Implications

To professional care organizations, this study provides a ‘good example’ from which insights can be gathered in order to extend or better the involvement of volunteers in their organization. It shows effective volunteer involvement requires thorough coordination, which is a time- and money-intensive process that needs a shared normative basis in order to come to fruition. In addition, inspiration may be drawn from the extensive descriptions of specific routines in Hospice Heuvelrug, provided in Chapter 6.

To policymakers, this study shows that involving volunteers in care provision can only go so far, and more importantly takes a lot of time, money, and effort. Policymakers should therefore hold more realistic expectations about the possibilities of a participation society and be careful not to combine new policies with too extensive budget cuts.

Finally, for academic purposes, this study points to the need for further comparative studies on effective volunteer coordination in different types of professional care organizations, in order to make more certain statements about the applicability of the outcomes. It also provides input to a more conceptual discussion on the relations between coordinating mechanisms, coordination, quality of care and the role of normative control. In that way, research will be able to contribute further to the societal discussion on volunteer involvement in care provision and to the scientific discussion on effective coordination in general.

Management Samenvatting (Dutch)

Onderzoeksfocus en –opzet

De traditionele verzorgingsstaat staat op het punt te veranderen in een participatiemaatschappij. Op 1 januari 2015 bereikt deze ontwikkeling zijn voorlopige hoogtepunt, in de vorm van de afschaffing van de huidige AWBZ en het onderbrengen van veel vormen van zorg onder een nieuwe Wet Maatschappelijke Ondersteuning (Wmo) (Coevert, 8 juli 2014). In de nieuwe participatiemaatschappij wordt van burgers verwacht dat ze meer gaan zorgen voor zichzelf en voor elkaar, ook op gebieden die voorheen werden beschouwd als het domein van de overheid of van professionals. In de zorg- en welzijnssector zou dit kunnen leiden tot een grotere betrokkenheid van vrijwilligers in de zorg voor medeburgers. Een dergelijke ontwikkeling kan echter negatieve gevolgen hebben voor de kwaliteit van zorg die wordt geboden. Vanwege hun beperkte kennis en vaardigheden in vergelijking met hun professionele collega’s (vgl. Freidson, 2001), zijn vrijwilligers niet in staat dezelfde kwaliteit van zorg te leveren. Bovendien zorgen het vrijwillige karakter van het werk en het door individualisering veroorzaakte algemene gebrek aan loyaliteit aan de organisatie voor een hoog verloop onder vrijwilligers (Dekker et al, 2007) en daardoor tot problemen op het gebied van continuïteit van zorg. Behalve deze risico’s biedt ten slotte de hoge intrinsieke motivatie van veel vrijwilligers juist mogelijkheden voor het bevorderen van kwaliteit van zorg (vgl. Boxall & Purcell, 2011). Al met al is het de taak van professionele zorgorganisaties zelf om, met het oog op deze risico’s en kansen, de bijdrage van vrijwilligers zó vorm te geven, dat kwaliteit van zorg gewaarborgd blijft.

In dit onderzoek wordt het effectief vormgeven van de bijdrage van vrijwilligers door professionele zorgorganisaties gezien als een vraagstuk van coördinatie. Professionele zorgorganisaties kunnen de handelingen van vrijwilligers proberen te beïnvloeden en te sturen richting het (kunnen) bieden van goede zorg, en hebben daarvoor een aantal coördinatiemechanismen tot hun beschikking (zie Mintzberg, 1980). Om tot een effectieve en stabiele vorm van coördinatie te leiden, dienen deze mechanismen echter wel te worden ingebed in de daadwerkelijke gedragspatronen op de werkvloer, ook wel *routines* genoemd (Pentland & Feldman, 2008). Met deze theoretische achtergrond in gedachten, is de volgende onderzoeksvraag geformuleerd:

> *Welke vormen van coördinatie kunnen professionele zorgorganisaties gebruiken om de kwaliteit van zorg gegeven door vrijwilligers te garanderen?*

Om deze vraag te beantwoorden is een case study uitgevoerd van Hospice Heuvelrug, een organisatie waarin het bieden van zorg van goede kwaliteit en een grote bijdrage van vrijwilligers in diezelfde zorg hand in hand gaan. Door middel van participerende observatie, interviews en documentanalyse is data verzameld over de coördinatiemechanismen en routines in De Heuvelrug en de manier waarop deze bijdragen aan het waarborgen van kwaliteit van zorg. Door de mechanismen te beschrijven die er in Hospice Heuvelrug toe geleid hebben dat een grote bijdrage van vrijwilligers en het bieden van goede zorg hand in hand gaan, biedt deze scriptie een “goed voorbeeld” (cf. Flyvbjerg, 2001), dat andere professionele zorgorganisaties kunnen gebruiken als inspiratie voor het vergroten en/of verbeteren van de inzet van vrijwilligers in hun eigen organisatie.

Onderzoeksresultaten

Als professionele zorgorganisaties de kwaliteit van zorg willen waarborgen en tegelijkertijd de inzet van vrijwilligers in het bieden van die zorg willen verhogen, zullen ze ten eerste moeten focussen op het beperken van de risico’s die komen kijken bij het inzetten van vrijwilligers voor dergelijke taken, zowel wat betreft de continuïteit van zorg als ook wat betreft de effectiviteit van *knowledge based* en *interpersonal* care (cf. Campbell et al, 2000). Tegelijkertijd is het van belang dat de intrinsieke motivatie van vrijwilligers gekoesterd en gestimuleerd wordt, om zo de voordelen van deze intrinsieke motivatie voor het verbeteren van kwaliteit van zorg te behouden.

In Hospice Heuvelrug is dit bereikt door middel van het ontstaan van vier facetten van gecoördineerd vrijwilligerswerk. *Blijven leren*, in de vorm van een introductiecursus, meeloopperiode, praatgroepjes van vrijwilligers, de overdracht, en door al doende te leren, zorgt ervoor dat vrijwilligers de kennis en vaardigheden hebben om zorg te verlenen aan de gasten van het hospice. *Verantwoordelijk handelen* zorgt er daarnaast voor dat vrijwilligers weten wat hun verantwoordelijkheden zijn. Zij weten voor welke diensten ze verwacht worden en hoe ze zich tijdens een dienst dienen op te stellen. Dat laatste wordt gewaarborgd in evaluatiegesprekken en via directe feedback van verpleegkundigen en mede-vrijwilligers tijdens het werk. Essentieel is ten slotte de informele en gedeelde regel dat vrijwilligers geen zorgtaken verrichten waarvan ze menen dat ze hier niet toe in staat zijn, of waarbij ze zich niet comfortabel voelen. Verantwoordelijk handelen leidt zo tot duidelijke grenzen waarbinnen vrijwilligers bijdragen aan de zorg voor gasten in het hospice. *Samenwerken* zorgt als derde facet voor een atmosfeer van gelijkheid en wederzijds respect tussen vrijwilligers en verpleegkundigen, wat wederzijdse afstemming en taakverdeling mogelijk maakt. Er wordt samengewerkt met één gedeeld doel voor ogen: het zo goed mogelijk tegemoetkomen aan de behoeften en verzoeken van gasten. Tot slot zorgt het *lidmaatschap van de organisatie* ervoor dat het verloop onder vrijwilligers laag is en hun intrinsieke motivatie behouden blijft. Belangrijk onderdeel van dit facet is het zien en waarderen van de vrijwilligers door alle leden van de organisatie, zowel via formele als via informele weg.

Als professionele zorgorganisaties de kwaliteit van zorg van vrijwilligers willen waarborgen, is het echter niet genoeg om coördinatiemechanismen gebaseerd op één of meer van deze facetten simpelweg te implementeren. De uitdaging gaat verder dan dat, namelijk over de vraag hoe ervoor te zorgen dat deze coördinatiemechanismen ook daadwerkelijk vertaald worden naar handelingspatronen op de werkvloer – hoe ervoor te zorgen, met andere woorden, dat zij daadwerkelijke worden opgenomen in *routines*. In Hospice Heuvelrug zijn de coördinatiemechanismen die vallen onder de vier facetten van gecoördineerd vrijwilligerswerk effectief geroutiniseerd omdat leden van de organisatie – vrijwilligers, verpleegkundigen, coördinatoren – dezelfde waarden, normen, en houding bezitten wat betreft kwaliteit van zorg en de manier waarop kwaliteit van zorg geboden kan worden. De coördinatiemechanismen gericht op het sturen van het gedrag van vrijwilligers zijn bovendien op dezelfde waarden, normen en houdingen gebaseerd. Om die reden hebben zowel vrijwilligers als ook andere leden van de organisatie deze coördinatiemechanismen actief opgenomen in hun dagelijkse routines. Deze gedeelde normatieve basis is dan ook een essentieel element voor de vertaling van coördinatiemechanismen naar routines, welke op hun beurt leiden tot gecoördineerd handelen en vanwege het specifieke karakter van de vier facetten bovendien tot waarborging van de kwaliteit van zorg. Tot slot zorgen de vier facetten ervoor dat de gedeelde normatieve basis verder versterkt wordt, aangezien zij de vijf aspecten van normatieve controle (cf. Mintzberg, 1996) in zich verenigd hebben.

Consequenties van het onderzoek

Voor professionele zorgorganisaties biedt deze studie een ‘goed voorbeeld’, waaruit belangrijke inzichten voor het uitbreiden en/of verbeteren van de betrokkenheid en coördinatie van vrijwilligers in de organisatie kunnen worden afgeleid. De studie laat zien dat het betrekken van vrijwilligers in de zorgvoorziening intensieve coördinatie vereist en een tijds- en geldintensief proces is dat bovendien een gedeelde normatieve basis nodig heeft om te kunnen slagen. Professionele zorgorganisaties kunnen bovendien inspiratie halen uit de uitgebreide beschrijvingen van specifieke routines in Hospice Heuvelrug in hoofdstuk 6.

Aan beleidsmakers toont dit onderzoek dat het betrekken van vrijwilligers in de zorg ook grenzen kent en bovendien veel tijd, geld en moeite kost. Beleidsmakers dienen daarom realistische verwachtingen te koesteren wat betreft de mogelijkheden van een participatiesamenleving en bovendien voorzichtig te zijn de hervormingen niet te combineren met te hoge bezuinigingen.

Tot slot wijst dit onderzoek op de noodzaak tot verder vergelijkend onderzoek, om betere uitspraken te kunnen doen wat betreft de toepasbaarheid van de uitkomsten op andere professionele zorgorganisaties. Het is bovendien van belang dat er een verdere conceptuele discussie op gang komt over de relaties tussen coördinatiemechanismes, routines, coördinatie, kwaliteit van zorg en de rol van normatieve coördinatie. Op die manier zal toekomstig onderzoek nog meer bij kunnen dragen aan de maatschappelijke discussie over het betrekken van vrijwilligers in de zorgverlening en aan de wetenschappelijke discussie over coördinatie in het algemeen.

Chapter 1: Introducing this study

1.1 Introduction

The Dutch welfare state is changing. Slowly but steadily, it is moving towards a ‘participation society’, in which citizenship is conceptualized as being about *duties*, rather than just about rights (Tonkens, 2011, p. 70). The introduction of new laws in the care- and welfare sector stimulates citizens to become more responsible for themselves and each other, for example through becoming a volunteer. In care for the elderly, volunteers have long since been actively involved. For years, they have been facilitating and supervising group activities in day care centers and nursing homes, and became active by becoming companions to elderly people, joining them for walks outside or just for drinking a cup of coffee. Less often, volunteers have joined in the actual care for the elderly, for example in helping elderly clients use the bathroom or get dressed in the morning. Due to the retreat of the Dutch welfare state and the rise of a ‘participation society’, volunteer involvement in care for the elderly is likely to increase, including perhaps in activities which were formerly designated solely to trained professionals.

However, this development might lead to problems concerning the provision of quality of care to the elderly. First of all, volunteers are not professionals and did not receive professional training. Compared to professional nurses, they lack a certain amount of knowledge and skills (cf. Freidson, 2001). How might these volunteers be able to provide good quality care nonetheless? What is more, the voluntary nature of their work entails that volunteers, in principle, may decide to cease their contribution at any time. Continuity of care is thus at risk, making the provision of quality care more difficult (cf. Campbell et al, 2000). However, a larger role for volunteers creates possibilities, too. The voluntary character of their work ensures that they possess a strong intrinsic motivation for providing good care. In that respect, a heavier reliance on volunteers may positively affect the quality of care (cf. Boxall & Purcell, 2011).

By emphasizing and possibly enlarging the role of volunteers, the retreat of the Dutch welfare state and transformation to a ‘participation society’ pose a challenge to professional organizations active in the care and welfare sector. A heavier reliance on volunteers has some significant risks, but it also has possibilities. The challenge, then, consists of organizing the involvement of volunteers in such a way that risks are minimized and possibilities fully used. It consists of making sure that volunteers contribute to, not endanger, quality of care. This thesis focuses on how professional care organizations might meet this challenge.

Upholding quality of care…

In the Dutch welfare state, controlling and increasing quality of care has become more important over the years. New public management and managerialism have triggered a wide-spread desire for improving performances in the public sector (Noordegraaf, 2011, p. 365), including in the health care sector. As a society, we feel quality of care is important, and in policies this is translated into specific aims to control quality as much as possible. Quality of care is monitored through numerous client satisfaction surveys[1] and other monitoring systems, with the underlying assumption that more transparency about quality will stimulate performance. In addition, much importance is placed on professionalization of care practitioners, through constant updating of knowledge[2]. The newly announced law on long-term care (Wlz), planned for January 2015, puts increasing quality of care as one of its three central aims (Van Rijn, 2014a). For professional care organizations, maintaining and if possible improving quality of care is therefore essential.

.. But leaving responsibility to citizens

At the same time, recent changes in the welfare state are aimed at increasing active participation and responsibility of citizens in care for themselves and each other. Responsibility for care is partly transferred to citizens, reducing the role of government and even of professionals. This idea of *active citizenship* entails amongst other things that citizens should take on public tasks such as care and support for vulnerable citizens by means of volunteering (Verhoeven & Tonkens, 2013, p. 25). The new Social Support Act (Wmo) and the announced new law on long-term care (Wlz) both incorporate these ideas, explicitly mentioning the importance of volunteers and other informal caregivers. As a result, in the future more care tasks might be assigned to volunteers instead of to professional caregivers. A heavier reliance on volunteers poses a challenge, however, provided the desire for quality of care has not disappeared. How to ensure quality of care, when that care is given by non-professional volunteers?

Meeting a challenge

For government, trying to ensure quality of care for the elderly whilst at the same time transferring responsibility for that care to non-professional volunteers creates a dilemma of control. On the one hand, government wants to control quality of care, but on the other hand it wants to transfer responsibility for that care away from government and professionals and towards citizens themselves. A dilemma is thus created between constraining and letting go, between staying firmly in charge and stepping back. Although it is undoubtedly useful to discuss this problem at the national level, in practice it will be on the level of professional care organizations that an answer will have to be formulated. After all, it is these care organizations that in practice have to ensure quality of care to their clients. A heavier reliance on volunteers will not change this requirement. At the level of professional care organizations, the dilemma thus becomes a challenge that needs to be met.

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[1] For example the widely used Consumer Quality Indexes, developed by NIVEL, the Dutch institute for Research in Health Care (http://www.nivel.nl/cq-index)

[2] In 2012, for example, a nationwide action plan for professionalization in the care sector was launched by numerous professional organizations of care workers, trade unions and consultancy agencies focusing on the care sector. See http://www.professionalisereninwelzijn.nl/content/over-deze-site-0.

How might professional care organizations meet this challenge? To find out, let's imagine first what would happen if they were to do nothing at all. If, in other words, an increasing involvement of volunteers in the care for elderly clients would not be accompanied by any thought-out policy from the side of the organization. Volunteers, then, would most likely have to figure things out for themselves. The following scenario would then seem likely:

> *A new volunteer enters the room of a client one morning, a client that needs to get out of bed, freshened up and get dressed – just like every regular person. The volunteer, being strongly motivated, wants to help the client. How would she do that? How, for a start, would she help the client out of bed? Would she let him try to get up himself or would she try and haul him up by the arms? Would she support him in walking to the bathroom or would she use some aid, such as a walker or a wheelchair? Maybe the floor is slippery. Did she remember to put on his shoes?*

Despite the volunteer's good intentions, a wrong choice at this moment might lead to the client getting hurt. Not to mention the wave of uncertainty that might emanate from the volunteer, resulting in a feeling of unease on the part of the client – even if all eventually turns out fine. In professional care organizations, days are filled with mundane tasks such as getting someone out of bed and walking them to the bathroom. As the example above shows, however, even mundane tasks such as these might fail if conducted through well-intentioned improvisation by an unknowing volunteer. When volunteers are involved in the provision of care, therefore, professional care organizations will need to make sure their behavior is sufficiently coordinated in order to ensure quality of care.

Of course, professional care organizations already try and coordinate their professional staff. With professional nurses, quality of care is largely ensured through standardizing their skills (e.g. Mintzberg, 1980). Although providing training for volunteer caregivers might be a solution for care organizations to ensure quality of care to their clients, it also risks turning volunteers into quasi-professionals, losing the inherent value they can bring to caregiving as volunteers rather than professionals (Dekker et al, 2007, p. 77). Other ways of coordinating the work of volunteers might therefore be more suitable, or at least serve as additional ways to ensure volunteers provide good quality care. Minzberg's six coordinating mechanisms (Mintzberg, 1980; 1996) form a fair overview of possible coordinating mechanisms organizations might use.

However, in practice a difference might exist between official coordinating mechanisms installed by the organization and actual work practices on the work floor. For example, a ten point code of conduct upheld by an organization, might in practice be virtually useless if volunteers (and professional staff) have not translated this code of conduct into actual ways of working. The literature on work routines (i.e. Becker, 2004; Feldman & Rafaeli, 2002; Pentland & Feldman, 2008) provides insights on this possible discrepancy. Not official coordinating mechanisms, but actual work routines provide coordinated action, according to these sources; at the same time, coordinating mechanisms might influence these routines, and thus still be of importance (e.g. Pentland & Feldman, 2008). In other words, to find out how the work of volunteers might be coordinated in such a way that quality of care is ensured, attention should be paid both to official coordinating mechanisms as well as to actual work routines, and to the relation between the two. Keeping these two aspects in mind, it is the aim of this study to find out how the work of volunteers in professional care organizations might be coordinated in such a way that quality of care is ensured.

1.2 Question and Focus

In order to achieve this aim, the following central research question has been formulated:

> *Which means of coordination might professional care organizations use to ensure the quality of care given by volunteers?*

This study, which has an explorative character, aims to answer this question. It has been divided in four distinct parts, each of which answers a number of sub-questions. Here, these sub-questions are introduced along with their relevance to answering the main question.

The **first part of the study** aims to provide an overview of the changes in the welfare state that form the main motive for conducting this study. More specifically, it provides the answers to the following three questions:

1. Which administrative and societal changes in the welfare state contribute to a heavier reliance on volunteers in care and welfare?
2. How can these changes be theoretically interpreted?
3. What are the consequences of these changes for volunteers and for quality of care?

In answering these three questions, the thesis elaborates on the developments of the welfare state introduced earlier in this chapter, explicitly discussing possible consequences for volunteers and for quality of care. The questions are answered through an analysis of policy documents and a literature study.

The **second part of the study** theoretically explores the ways in which coordination of work can take form, in order to help identify how, in practice, the work of volunteers is coordinated to ensure the quality of care given. Furthermore, it will be shown how *organizational routines* might contribute to organizational coordination.

The following sub-questions are answered:

4. Which types of coordination of organizational work can be identified?
5. How can organizational routines contribute to coordination?

6. How are coordinating mechanisms and organizational routines theoretically related?

By systematically answering these three questions, a theoretical model of coordination can be achieved which will guide the interpretation of the empirical part of this study.

The **third part of the study** is the empirical part, which is the most central to answering the research question. To find out how professional care organizations coordinate volunteer work in order to ensure quality of care, a case study was performed in an organization which not only works with volunteers, but also provides high quality of care to elderly patients. The organization chosen is a hospice: an organization in which physical as well as psychosocial and spiritual care is delivered to terminal patients (Francke & Kerkstra, 2000, p. 25). Hospice Heuvelrug is a small-scale facility, with only six beds, providing high quality care. The latter entails that besides volunteers, trained professional nurses are present as well. Still, the ratio of volunteers and professionals – 80 volunteers vs. 12 professionals – means that the organization is heavily reliant on the help of volunteers. The empirical part of the study answers the following questions:

7. Which coordinating mechanisms contribute to the quality of care given by volunteers in Hospice Heuvelrug?
8. Which routines contribute to the quality of care given by volunteers in Hospice Heuvelrug?
9. How are these coordinating mechanisms and routines empirically related?

By answering these three empirical questions, it will be possible to systematically describe the way in which Hospice Heuvelrug coordinates their volunteers and thus create quality of care. The data for this empirical part was collected through participant observation – the researcher became a volunteer herself in the hospice studied – as well as through interviews with volunteers, nurses, and the volunteer coordinator of the hospice. In addition, relevant policy documents of the organization were studied.

Finally, the **fourth part of the study** aims to answer which implications this study has for relevant actors. Specifically, it aims to answer the following sub-questions:

10. What are the academic implications of this study?
11. What are the practical implications of this study, both to professional care organizations as well as to policymakers?

1.3 Relevance of the Study

Without going into the specific implications of this study for relevant parties, which will be presented at the end of this thesis, some initial remarks may be made about the relevance of this study. Academically, this study touches on two distinct theoretical debates. First of all, and most prominently, it presents a possible theoretical connection between Mintzberg's coordinating mechanisms and actual work routines. By connecting these two literature streams, the thesis provides further insights into the possible theoretical connections between the various concepts. These insights might be used to better study the dynamics of coordination in the future. At the same time, the study adds to the academic debate on active citizenship. Whereas many studies in this field emphasize the problems that come with making citizens more responsible through volunteering, this study identifies how professional care organizations might meet this challenge. In a way, it thus adds a more constructive approach to the academic discussion, by focusing not on what the negative consequences of the welfare state transition might be, but on how this transition might be successfully anticipated by professional care organizations.

This latter point brings us to the practical relevance of this study, which is also twofold. First of all, the study may be helpful to professional care organizations aiming to increase or better their use of volunteers. For these organizations, the study provides interesting insights into how another organization has successfully organized the involvement of volunteers in such a way that high quality care is realized. This practical contribution might become even more relevant as the transition of the welfare state further progresses, forcing professional care organizations to think about their use of volunteers.

Besides the practical relevance of the study to professional care organizations, this study also contains a strong message to society and policy makers. Responding to current welfare state transitions, this study aims to show that allowing volunteers to perform (more) care-related tasks for vulnerable elderly citizens is definitely possible, yet requires a large amount of time, energy and motivation. For this reason, welfare state reformers should not think lightly about the difficulties and investments that come with increasing volunteer involvement. Using volunteers to provide care is certainly not a ‘cheap’ alternative to using professionals, but requires thorough coordination. This entails an inevitable investment of time and money.

1.4 Thesis Outline

In this thesis report, the four parts of this study will be described in the order in which they were introduced above. First, Chapter 2 will focus on the transition of the Dutch welfare state. It describes recent and upcoming policy changes and explains the trend behind them, thus answering the first two sub-questions. In addition, it will explain what consequences these changes might constitute for care volunteers, and what the consequences, in turn, might be for quality of care provided. In Chapter 3, then, the theoretical background of coordinating mechanisms and routines will be outlined, effectively answering sub-questions four and five. Furthermore, an attempt will be made to link these two streams of literature (sub-question six), which results in a preliminary model that might be used to interpret the empirical findings. Chapter 4 will focus on the research design and methodology used. First, the phronetic and interpretive approach of this study will be outlined, followed by a more specific description of the way data was collected and analyzed. Where necessary, connections will be made with the previous chapter and the theoretical model presented there.

Because this study departs from an assumption that context is of the utmost importance, Chapter 5 provides a detailed description of Hospice Heuvelrug, the organization studied, and of the people working and living there. It also provides input to answering sub-questions seven to nine, by describing the ideas of nurses, volunteers and the volunteer coordinator on quality of care in their hospice and the role various actors play in reaching this quality. In its essence, Chapter 5 presents the required basis for readers to understand the findings presented in Chapter 6. Here, the empirical sub-questions are answered in earnest through an elaboration of the various means of coordination found in the hospice. Both coordinating mechanisms and work routines are described, as well as their connection if present. Chapter 6 thus forms the main chapter in which the findings are presented and on the basis of which the main research question is answered. In Chapter 7, first, answers to all sub-questions are provided, followed by an answer to the main research question. The concluding chapter finishes with an elaboration on academic and practical implications.

Chapter 2: The Welfare State in Transition

2.1 Introduction: Towards a 'participation society'

The welfare state is in transition. The traditional welfare state, which arose after the second world war and has since secured government assistance to many citizens, has always been considered a great good (Becker, 2005). However, causes for worry have long existed. Especially the aging population and the increasing costs that are its result have often been suggested as a reason for reform (see for example WRR, 2006) . However, the welfare state's main structure always remained intact. Times, however, are changing. In the Dutch King's speech of 2013, King Willem-Alexander spoke, on behalf of the Cabinet, of "a transformation of the traditional welfare state into a participation society", in which citizens should become "responsible for their own lives and for their environment as much as possible" (Rijksoverheid, 2013). To start with, this chapter outlines the main developments in the care and welfare sector which explain the increasing reliance on volunteers. In the subsequent paragraph, it will be shown that these developments are all based on a new notion of *active citizenship*, which in turn may be based on either a communitarian or neo-liberalist rationale. In paragraph 2.4 and 2.5, the possible consequences of these developments for volunteers and for quality of care will be sketched. Finally, the chapter will finish with one of the central challenges that arises from these developments and which stands at the base of this study: the question of ensuring quality whilst increasing the involvement of volunteer caregivers.

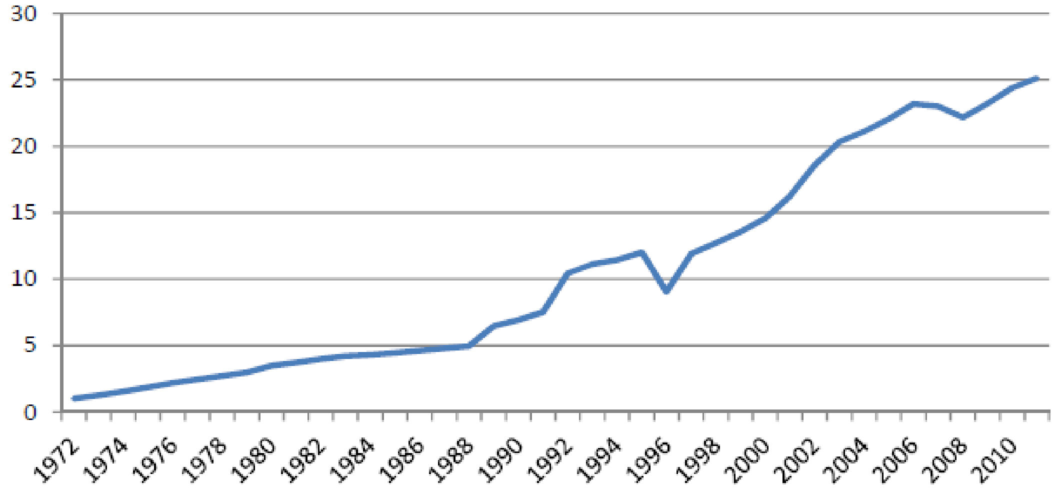
2.2 Care and welfare in transition

Societalization and cost control

One important development in the care and welfare sector has been a changing notion of what good long term care should look like. Whereas before the 1980s, intramural care in residential homes was encouraged, from the 1980s onward it has been felt that care should instead focus on maintaining and/or increasing the independence and participation of elderly in society (Koops & Kwekkeboom, 2005). As a result, the number of elderly (80 years and over) living in intramural care facilities decreased, even though the number of elderly in society more than doubled (Van Rijn, 2013, p. 6). Together, the changes deemed necessary to enable people with disabilities, such as the elderly, to live at home independently and participate in society are referred to as 'societalization' of care (Koops & Kwekkeboom, 2005, p. 1). Essentially, societalization of care entails organizing care as close to people as possible. Instead of making elderly go to care facilities – which is the case in intramural care – care facilities should go to the elderly. A number of policy goals and aims are brought together under this larger policy goal. Extramuralization of care; the realization of integrated facilities for care, living and working at the local level; and the contribution of society itself to the care and support of vulnerable fellow-citizens are amongst the most important of these (Koops & Kwekkeboom, 2005, p. 3).

Together, these developments are aimed at contributing to the participation in society of vulnerable citizens, including the elderly.

Another important factor that triggered welfare state transformation has been the increasing costs of long term care and the need for cost control that sprang from this development. Since 1968, long term care for the handicapped and the elderly had been collectively insured through the Exceptional Medical Expenses Act (AWBZ). Due to the collective character of the law, in addition to the wide array of expenses it covered – from residential care, to care at home and help with housekeeping – AWBZ expenses quickly increased. The figure below illustrates this development. Since the beginning of the 21st century, AWBZ expenditures' actual yearly increase has been 4,6 percent – more than three times the structural economic growth (Van Rijn, 2013, p. 3). This continuing increase in costs, combined with the realization that an aging population would only cause further increases in the future, has been an important trigger for the government to transform the laws on long term care.



AWBZ expenditures from 1972 - 2012, in billions of euros (Van Rijn, 2013, p. 3)

The introduction of new laws

Together, the societalization of care and the increasing expenditures for long-term care resulted in the stepwise dismantling of the AWBZ. In 2007, a new law was introduced. Through the Social Support Act (Wmo), municipalities provide social support to vulnerable citizens (SER, 2008). Although central government decides on the larger framework and guidelines, municipalities have a lot of freedom in the actual design and implementation of the law. The law's main goal is to increase and/or maintain citizens' participation in society. Most importantly, the new law does not have the character of a collective insurance, like the AWBZ. Citizens thus do not strictly have a *right* to the services provided through the Wmo. Rather, municipalities have an obligation to compensate physical or mental limitations that reduce self-reliance in the home, the ability to move in and around the house, the ability to use local transport or the ability to meet other people to socially connect with (SER, 2008, p. 43).

Initially, the Wmo operated next to the AWBZ. Citizens qualifying for the AWBZ could not claim services for the Wmo (SER, 2008, p. 44). Starting from January 2015, however, this is about to change. At that time, only the heaviest types of care, essentially residential care in nursing homes, will be insured for by a new downsized version of the AWBZ, the Long Term Care Act (Wlz). All other types of care will be transferred to the Wmo (Van Rijn, 2013) – and will thus no longer be an automatic 'right'. Rather, municipalities will receive a certain amount of money to distribute amongst those who need it (Tonkens, 2011, p. 56). Citizens will be encouraged to remain living at home for as long as possible, remain responsible for their own lives and participate actively in society (Van Rijn, 2013, p. 4). Moreover, the importance of informal caregiving and volunteers is explicitly acknowledged in the new law. Both the support and the appreciation of informal caregivers and volunteers are specific points of attention in the new Social Support Act (Van Rijn, 2014b).

Due to heavy political debate on the new laws, it was long uncertain whether it would be possible to implement the new laws – both the extended Wmo and the new Wlz – by January 2015. In April 2014, however, the government coalition of VVD and PvdA together with supportive opposition parties D66, ChristenUnie and SGP agreed on some final changes aimed at softening the transformation (Volkskrant, 2014 16 April). Nevertheless, since major societal actors are still worried about the speed of the transformation[3], it remains to be seen whether the deadline for implementation will be met.

2.3 Active Citizenship: the welfare state transition explained

The newly introduced laws, fed by the urge for societalization and cost control, can largely be explained by examining the changed notions of citizenship held in Dutch society. Traditionally, citizenship has often been conceived as a legal status, accompanied by certain social rights (i.e. Tonkens, 2011; Kampen et al, 2013, p. 13). In the 1960s and 70s, for example, it was felt that citizens ought to have autonomy (from paternalistic and authoritarian professionals) as well as voice and influence in policy making; As a citizen, these were your *rights* (Tonkens, 2011, p. 45-47). In the 1990s, however, a transformation happened. Citizenship was no longer directly linked to *rights*, but rather to certain *duties* (Tonkens, 2011, p. 50). Citizenship became an activity, rather than a passive status. According to this new meaning, citizens ought to become more responsible both for their own welfare as well as that of others (Kampen et al, 2013, p. 13). Following this changed notion of citizenship, the role of the welfare state has changed as well. Rather than providing dependent citizens with autonomy from fellow citizens, the welfare state should instead provide citizens with autonomy from government itself. This has been a drastic turnaround compared to traditional welfare state philosophy, which aimed to do the former (Kampen et al, 2012, p. 14). According to the new idea of *active citizenship*, citizens ought to be "no longer dependent on the welfare state and […] willing to

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[3] Trade unions, for example, are insisting the new laws should be postponed by a year (Volkskrant, 2014 20 April), and prominent Dutch citizens are calling for a halt to the budget cuts (Volkskrant, 2014 22 April).

take a full part in the remaking of society" (Newman & Tonkens, 2011, p. 9). It is this idea of what it means to be a citizen that is the main rationale behind the participation society, and in the care sector behind the societalization of care and the new Wmo and Wlz. The reasons for adopting this rationale, however, may be very different.

Citizen Activation: a communitarian or neo-liberalist rationale?

Ideologically, two main reasons exist for adopting the idea of active citizenship. One ideology that supports the idea of the active citizen is that of communitarianism. The 1990s brought with them a renewed valuation of the community in an individualized society. This development was marked by the rise of the communitarian movement in America (cf. Etzioni, 1993), and more recently in the Netherlands by the emphasis on norms and values by the government in the early 2000s. Communitarians, then, believe in "creating a new moral, social, and public order based on restored communities, without allowing puritanism or oppression" (Etzioni, 1993, p. 2). The importance of family, community, education, and citizenship are emphasized. In Dutch society, the communitarian ideal of responsible participation is partly used as a government rhetoric, but also appeals to a large group of Dutch citizens, who "repeatedly report to be happy about their own lives but unhappy about (what they conceive to be) a selfish, over-individualized society" (Tonkens, 2011, p. 62). The idea of an active citizen, and the corresponding new trends of societalization so present in the new laws, fit in the idea of increasing the role of communities vis-à-vis the government.

The second ideological reason for adopting the idea of active citizenship is very different in nature. In contrast to communitarians, neo-liberalists value citizen activation because it provides them with the means to decrease government influence in society. The costs of the welfare state have been rising for decades, and are expected to continue doing so because of the aging population. Active citizenship with its focus on citizen responsibility provides a solution for governments needing to lower budgets. Moreover, the development towards active citizenship ties in well with the idea of a smaller government held dear by neo-liberalists (Muehlenbach, 2012, in Verhoeven & Tonkens, 2013, p. 26). Providing citizens with autonomy from government, reducing government's role, is thus the main goal. Viewed more negatively, citizen activation might be used by governments "to delegate problems of management and cost reduction to citizens" (Tonkens, 2011, p. 62).

It could be argued that, contrary to communitarians, neo-liberalists favor the transfer of responsibility from government to citizens because more responsibility is thus granted to *individuals*, rather than to communities. Both ideologies, however, are in favor of decreasing government responsibility.

In that way, they explain part of the presence of active citizenship as a philosophy behind current policy developments. The fact that active citizenship might be supported by two partly opposing ideologies might also explain the support of the changes by both left and right parties in the Dutch

Parliament – although especially left opposition parties tend to criticize the neo-liberalist arguments they say are the main motives behind the new laws[4].

2.4 Consequences for volunteer caregivers

As the driving idea behind the societalization of care and the new laws that have been announced, the notion of active citizenship forms the mainspring for an increasing emphasis on informal caregivers, both family and friends of vulnerable citizens as well as citizen volunteers. It assumes citizens taking care of each other, more so than has previously been the case. The idea of enhancing citizens' responsibility so central to active citizenship will most likely enlarge the role of volunteers in the care for vulnerable citizens, including the elderly. The connection between volunteers and active citizenship has been made explicit by then Minister of Health, Welfare and Sport: "Volunteers and carers make an important contribution to the self-reliance and participation of others. And they contribute to the cohesion, to increasing involvement and the social coherence of our society […] Carers and volunteers are actively involved citizens" (Minister Jet Bussemaker, 2007, in Tonkens, 2011, p. 58).

What does this mean for volunteers providing care to the elderly or to other vulnerable citizens? Academic literature suggests that the answer to this question depends on the reasons behind increasing citizen – and volunteer – responsibility. Active citizenship, in practice, may work either as a liberating or as a disciplining force (Newman & Tonkens, 2011, p. 10). Phrased differently, it might reflect empowerment of citizens, accommodating a previously existing need in the community, or it may be used as an invention by politicians "to manage tensions emerging from the transformation of welfare states" (Newman & Tonkens, 2011, p. 10). Volunteers caring for citizens will most likely experience their work very differently depending on the philosophy behind the increasing dependence on them. Ham & Peeters (2010, p. 84) suggest that a too narrowly instrumental and functional approach undermines the intrinsic motivation so dominant in potential and current volunteers. Using informal care and volunteering solely as 'free' replacements "to help patients where paid care disappeared or will disappear in the near future" (Tonkens, 2011, p. 56) does not seem to be a good strategy. It seems likely that a more appreciating and empowering view towards volunteers would be more successful.

According to a report by The Netherlands Institute for Social Research (SCP), the Social Support Act may have positive as well as negative influences on volunteering. On the one hand, it may lead to more acknowledgement of and support for volunteers. On the other hand, the heavier and more explicit reliance on volunteers may lead to competition between volunteer organizations, higher

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[4] See for example the website of Green Left party GroenLinks (www.groenlinks.nl) and that of the Socialist Party SP (www.sp.nl), who both oppose the budget cuts that accompany the implementation of the new Social Support Act.

dependency on criteria for subsidies and higher demands to volunteers (Dekker et al, 2007[5], p. 12). In other words, both liberating as well as disciplining effects are expected. It will remain to be seen how, in practice, the balance between these two types of citizen activation will take form, and what consequences this will have for volunteers providing care for the elderly.

2.5 Consequences for quality of care

It is clear that the new policies based on the idea of active citizenship will result in a higher demand for care volunteers. But what consequences does an increasing reliance on care volunteers have for the quality of care provided? To answer this question, it is important first to consider the meaning of quality of care. What exactly constitutes ‘quality of care’ has been the focus of debate for many years (Blumenthal, 1996). In an attempt to bridge various definitions, Campbell et al (2000) formulate quality of care as consisting of ‘access’ to care, as well as ‘effective delivery’ of that care. As we will see, both aspects of quality of care might be threatened by a heavier reliance on volunteers, though the development creates opportunities for quality of care as well.

‘Access’ to care, the first dimension of quality of care, emphasizes “whether individuals can access health structures and processes of care which they need” (Campbell et al, 2000, p. 1615). Although general access to care does not seem to be influenced by a heavier reliance on volunteers in professional care organizations, one sub-aspect of the dimension, *continuity of care*, is relevant in this discussion. In general, clients appreciate the presence of a consistent core of staff providing care, since this *relational continuity* provides them “with a sense of predictability and coherence” (Haggerty et al, 2003, p. 1221). It is here that a heavier reliance on volunteer might pose a problem. Unlike regular employees, volunteers are not bound to the organization by an employee contract or financial dependence. According to a study by the SCP, individualization has caused people in general, and volunteers in particular, to be less loyal to the organizations in which they participate (Dekker et al, 2007). For organizations working with volunteers, this entails that volunteers are harder to bind to the organization for a long period of time, since volunteers are strongly led by personal interests and their current agenda and may thus leave at any moment (ibid, p. 76). Potentially, a heavier reliance on volunteers thus entails a risk to the continuity of care, specifically to relational continuity. There is, after all, no real guarantee that citizens who have committed themselves to a professional care organization as a volunteer, will continue to do so in the (near) future. Either their agenda or their personal preferences might change, causing them to leave.

The consequences of a heavier reliance on volunteers for the second dimension of quality of care, its effectiveness, are more extensive. According to Campbell et al (2000), effectiveness, or “the extent to which care delivers its intended outcome or results in a desired process, in response to need” (p. 1616), consists of two key elements: clinical care and interpersonal care. In case of the former, it is

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[5] Note: Since the SCP report is from 2007, it evaluates possible consequences of the Wmo as it was introduced in that year. Hardly any evaluations exist yet of possible consequences of the extended Wmo which will be introduced in 2015.

most clear that a heavier reliance on volunteers might have a negative impact, since it refers to the "effective application of knowledge based care" (Campbell et al, 2000, p. 1616). Here, the problem that was sketched in the introduction of this thesis is created. In the absence of professional training, volunteers do not possess the knowledge and skills to provide all types of knowledge based care. If professional care organizations expect them to perform these tasks nonetheless, for example because better qualified personnel is not available, quality of care becomes at risk. Even relatively mundane tasks might fall in this category, as the example of helping a client get out of bed[6] has shown. In first instance, it appears as though negative consequences of a heavier reliance on volunteers will be less serious when it comes to the effectiveness of interpersonal care. This key element of effectiveness, and thus of quality of care, is conceptualized by Campbell et al (2000) as being about patient-centered processes, which concern "the meaning of care for individuals" (p. 1616), and might be best characterized by what they are not: "technology centered, doctor centered, hospital centered, disease centered" (Stewart, 2001, p. 444). However, patient-centeredness, too, is "increasingly regarded as a set of skills which can be taught" (Campbell et al, 2000, p. 1616). Again, assuming volunteer caregivers already have these skills holds a risk. Correct attitudes towards clients and being able to view them as full persons instead of just in terms of their impairments, are not behaviors that come naturally to all people, especially not to people who have had no professional training or guidance on the matter. Here, too a risk to quality of care exists.

Possible negative consequences notwithstanding, there is one clear advantage to relying on volunteers for providing quality of care. With any financial incentives absent, volunteers are more likely to choose to work in a professional care organization purely because of their intrinsic motivation to help vulnerable citizens than are regular employees. Of course, regular employees might also choose to work in a professional care organization because of this motivation, but they inevitably also take financial stability into account. What is more, whereas volunteers who become unmotivated will most likely quit the organization, as the study by the SCP (Dekker et al, 2007) shows, regular employees who become unmotivated might feel forced to stay because of financial reasons. Many studies have shown that motivation is an important aspect in determining eventual performance (i.e. Boxall & Purcell, 2011), and the fact that volunteers are almost certainly intrinsically motivated for their work might thus result in good performances, and thus to good quality of care. This seems conceivable. Volunteers are motivated for providing good quality care – for being effective in terms of both clinical and interpersonal care. They will thus in principle try their utmost to do so. If this motivation is nurtured and encouraged by the organization, it might be possible to minimize the possible negative consequences on quality of care described above.

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[6] See Chapter 1, page 13.

2.6 Conclusion: A challenge for professional care organizations

The trend towards active citizenship, which reframed citizenship as being about duties rather than rights, has had considerable influence on the current direction the welfare state transition seems to be taking. The Wmo and Wlz both strongly emphasize the importance of people's responsibility for their own as well as other's wellbeing. Together, they will probably result in a heavier reliance on volunteers in the care- and welfare sector, including in professional care organizations. Whether this will have positive or negative consequences for volunteers themselves remains uncertain. This partly depends on whether this heavier reliance takes the form of a liberating and empowering movement, in which citizens are stimulated and encouraged to do give shape to their urge to do something meaningful for their fellow citizens by becoming a volunteer, or the form of a disciplining movement, in which citizen volunteers are seen as 'cheap' replacements for professional employees and as nothing more. The latter, research suggests, is not a good strategy, since it might undermine the intrinsic motivation prominent in volunteers which is so important to the quality of care provided.

At the same time, a heavier reliance on volunteers might have negative consequences for quality of care, despite volunteers' high intrinsic motivation. Not only do volunteers lack the knowledge and skills held by professional employees, especially concerning clinical care but also concerning interpersonal care, it appears difficult to bind them to the organization. As a result, (relational) continuity of care, a sub-aspect of access, the first dimension of quality of care, might suffer as well. If professional care organizations want to successfully use volunteers in providing quality care, they will have to coordinate their volunteers in such a way that the above two negative consequences occur as little as possible. At the same time, professional care organizations need to be careful not to reduce the inherent motivation and drive for their work volunteers inherently possess. After all, it is that motivation that makes them ideally suited to give attentive care to vulnerable clients such as the elderly. The question then becomes how to ensure good quality care, whilst at the same time not destroying those characteristics of volunteers that make them so suited to providing that care in the first place. This is the challenge that professional care organizations face. To meet that challenge, some type of coordination of volunteer work seems necessary. This study shows how one professional care organization, Hospice Heuvelrug, has realized high quality care whilst relying heavily on volunteers. First, however, the following chapter provides the theoretical concepts on coordination and routines that are required to provide an answer to the puzzle between an increasing reliance on care volunteers and maintaining quality of care.

Chapter 3: Coordination and Routinization of Work
- a Theoretical Framework -

3.1 Introduction

Whereas in the previous chapter the developments were sketched and interpreted that led or will lead to a heavier use of volunteers in the elderly care sector, this chapter gets to the theoretical core of this study. To answer the main research question, theoretical knowledge on coordination is essential. The theoretical insights presented in this chapter were brought into the research throughout the entire research process and thus occurred simultaneously with and partly in reaction to data collection and initial data analysis. This order was chosen to ensure the theory would have as much explanatory power over the findings as possible. In Chapter 4, the research design will be introduced further. First, however, this chapter introduces the main theoretical concepts that were used as a lens in the interpretation of the findings.

Traditionally, the five coordinating mechanisms as introduced and made famous by Mintzberg (1980) are often referred to in discussions of organizational coordination. Three of these five concern a type of standardization, of either input, work processes or output of the organization. The other two coordinating mechanisms have a more face-to-face character, and are referred to as direct supervision and mutual adjustment respectively. Mintzberg's five mechanisms are often assumed to cover the wide range of possible types of coordination organizations might use in order to direct the behavior of their employees (see also Kärreman & Alvesson, 2004, p. 152). At a later stage, Mintzberg himself added a sixth coordinating mechanism, referred to as 'normative control', which he introduced as part of a 'normative-control-model' (Mintzberg, 1996; see also Mintzberg, 1984).

In the first part of this chapter, Mintzberg's six coordinating mechanisms will be introduced. In that way, a first understanding is gained of the various means of coordination professional care organizations might possibly use to provide good quality care with the help of volunteers. However, as Pentland and Feldman (2008) argue, imposing physical or written coordinating mechanisms as an organization does not automatically entail a translation of those mechanisms into specific patterns of action on the part of employees. Studying the official coordinating mechanisms used by the organization, therefore, is not sufficient if the goal is to find out how that organization effectively ensures quality of care with the help of volunteers. Instead, it is important to also study how exactly these coordinating mechanisms are translated into desired and recurrent patterns of action on the work floor.

To do this, the literature on *organizational* or *work routines* is useful (i.e. Becker, 2004; Feldman & Rafaeli, 2002; Pentland & Feldman, 2008; Pentland & Feldman, 2005). Not only does this literature provide insights into the various aspects of employees' routines and how these routines lead to coordinated behavior, they also show how official coordinating mechanisms such as those introduced by Mintzberg might play a role in these routines. In paragraph 3, the literature on routines will be outlined, followed in paragraph 4 by an elaboration on how Mintzberg's coordinating mechanisms relate to this concept. This results in a preliminary theoretical model showing the way in which the various concepts interrelate. In the next chapter on design and methodology, finally, it will be presented how this theoretical model and other insights provided in this chapter were used to analyze and categorize the findings.

3.2 Mintzberg's six coordinating mechanisms

Much has been written about the coordination of work. Not surprisingly, because coordination of employee activities is viewed as essential to organizational success. Coordination, or the use of *controls*, is necessary to limit undesired behavior and to stimulate desirable actions (Merchant, 1982). Coordinating mechanisms, then, are a central aspect of the structure of an organization (Mintzberg, 1980). Mintzberg's six coordinating mechanisms are often viewed as representative of the wide scope of coordination types used in practice. Here, they will be shortly presented.

Coordination through s*tandardization*

Mintzberg identifies three coordinating mechanisms which all focus on some type of *standardization*. First of all, coordination might focus on *input*. Here, input refers to the employees hired in the organization. Through the *standardization of skills*, "work is coordinated by the internalization by individuals of standard skills and knowledge, usually before they begin to do the work" (1980, p. 324). Coordination like this is most common in professional organizations, such as hospitals. Here, doctors and other professionals hired have all had extensive specialized education in their profession. Coordination of input, however, can be viewed more broadly. Merchant (1982) talks about controls that focus on *personnel*, amongst other things referring to control of their selection and training. So viewed, this type of coordination might be applied not just to professionals but to all types of personnel. Furthermore, selection and training might not be solely based on skills, such as Mintzberg (1980) suggests, but might also focus on other aspects, such as values and beliefs of future employees, or on the "will to conform" (Kaufman, 2006). This latter type of coordination will be further discussed below[7].

A second type of coordination might focus on the *work process*. In the *standardization of work processes*, "work is coordinated by the imposition […] of standards to guide the doing of the work itself – work orders, rules and regulations, etc. (Mintzberg, 1980, p. 324). Merchant (1982) is more elaborate in his description. Talking about the control of specific actions, he mentions work rules, policies and procedures and codes of conduct. In addition, he mentions behavioral constraints such as locks, security guards and the separation of duties in order to avoid undesirable behavior easily being displayed by one individual.

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[7] See the paragraph on 'normative control'

A third type of coordination focuses on the *output* or the *results* of work. This type of coordination "holds employees responsible for certain results" (Merchant, 1982) and thus has a lot of commonalities with accountability. Mintzberg (1980) refers to this type of coordination as the *standardization of output*, stating it involves "the imposition […] of standard performance measures or specifications concerning the outputs of the work" (p. 324). Measurement is often used in this type of coordination to assess whether targets have been reached (Merchant, 1982). Examples of this type of coordination are budget control and performance management.

Coordination through *face-to-face contact*

Whereas standardization aims to achieve desired behavior in employees by regulating their actions – either through controlling their skills, work, or performance – face-to-face coordination does not necessarily have this standardized character. For example, in *direct supervision*, employees are coordinated by giving them specific orders and actively overseeing their work (Mintzberg, 1980). Especially in small organizations, such as a local clothing store, this type of coordination seems an obvious choice.

Another type of face-to-face coordination is *mutual adjustment*. In this case, "individuals coordinate their own work, by communicating informally with each other" (Mintzberg, 1980, p. 324). This type of coordination is more organic than the standardized forms of input- output- and process-control by Mintzberg introduced earlier. It also differs from these types of coordination as well as from direct supervision in that is more horizontal in nature. In mutual adjustment, employees coordinate their work themselves, not guided or steered by hierarchically imposed controls by their superiors or the larger organization. Mintzberg suggests this type of coordination most often occurs in small groups of employees, since only then intensive informal communication is possible (Mintzberg, 1985, p. 325).

Coordination through *normative control*

The coordinating mechanisms described above were introduced simultaneously by Mintzberg in 1980. They are therefore the most well-known. At a later stage, however, Mintzberg added a sixth type of coordination as part of the *normative-control model*, called *normative coordination* (Mintzberg, 1996). In contrast to other methods of coordination, normative coordination is not about steering behavior, but about creating certain shared values and beliefs amongst organizational members, which in turn leads to coordinated behavior. The normative-control model has five main characteristics[8]:

1. *Selection.* People are chosen by values and attitudes rather than just credentials.
2. *Socialization.* This element ensures a membership dedicated to an integrated social system.

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[8] Copied from Mintzberg, 1996, p. 81

3. *Guidance.* Guidance is by accepted principles rather than by imposed plans, by visions rather than by targets.
4. *Responsibility*. All members share responsibility. They feel trusted and supported by leaders who practice a craft style of management that is rooted in experience. Inspiration thus replaces so-called empowerment.
5. *Judgment.* Performance is judged by experienced people, including recipients of the service, some of whom sit on representative oversight boards.

According to Mintzberg, government, but especially professional organizations in health care and education, desperately need to start working more according to this normative control model, rather than according to the bureaucratic model, in which employees are but a small cog in the governmental machine, or the performance model, in which citizens are treated as customers.

Minzberg's Five + One

Mintzberg's six mechanisms of coordination stand at the basis of six corresponding organizational configurations. Standardization of input, work processes, and output are typical for the professional bureaucracy, machine bureaucracy, and divisionalized form respectively, whereas direct supervision and mutual adjustment stand at the base of the simple structure and the adhocracy (Mintzberg, 1980). Normative control, which was introduced later, is part of the normative-control model as outlined above (Mintzberg, 1996). Although Mintzberg has succeeded in creating a fairly complete list of mechanisms for coordination, and carefully linked those to corresponding ideal-typical organizational configurations, he fails to show how these mechanisms lead to actual changes in employee behavior. Take for example his three types of standardization. Here, the silent assumption made is that when official coordinating mechanisms are in place, employee behavior will change accordingly. What is more, it seems to be assumed that not only ad-hoc behavior will change, but actual daily patterns of action. However, both common sense as well as scientific theory (i.e. Pentland & Feldman, 2008) tell us this is not necessarily the case. To name one obvious example: the fact that a checklist exists outlining all steps to be taken during the work process, does not necessarily mean all those steps are actually undertaken by the employees involved. Similarly, an attempt to standardize skills by providing extra training to a team of employees does not necessarily lead to those employees implementing the new skills in their work, let alone systematically. There can thus be a gap between measures of standardization and employees' actual patterns of action. As a result, coordination does not automatically follow the implementation of mechanisms of standardization. The same can be said for the other two coordinating mechanisms – mutual adjustment and direct supervision. Whereas these interactions take place vertically (direct supervision) or horizontally (mutual adjustment), they do not by themselves result in stable coordinated behavior. The link between the normative control model and coordination, finally, remains even more abstract. To examine closer how the various coordinating mechanisms identified by Mintzberg exactly lead to coordinated behavior, the next paragraph focuses on the latter, more specifically on the actual patterns of action of employees, also referred to as 'routines'. In the subsequent paragraph, then, it will be examined how the relation between these routines and the coordinating mechanisms introduced here may be theoretically shaped.

3.3 Work Routines

First introduced by Stene (1940), organizational routines, or work routines, are considered to be an essential aspect of organized work (Feldman & Pentland, 2003, p. 94). Not surprisingly, many researchers have "put routines at the center-stage of their analysis" (Becker, 2004, p. 643). First, more information will be given on what routines constitute. Afterwards, it will be shown how routines may lead to coordination, using the framework as presented by Feldman & Rafaeli (2002). Finally, some attention will be paid on the relation between work routines and the coordinating mechanisms introduced by Mintzberg.

Routines: what are they?

Although exact definitions of routines differ per author and each author in turn emphasizes different aspects, the literature does seem to agree on some core characteristics of organizational routines. Routines are recurring patterns taking place at the collective level and are inherently processual in nature. In addition, they are bound by the context in which they take place and change in a path-dependent manner (Becker, 2004). An often used definition of routines has been formulated by Pentland & Feldman (i.e. 2008). Organizational routines, according to this definition, may be conceptualized as "generative systems that produce repetitive, recognizable patterns of interdependent action carried out by multiple participants" (Pentland & Feldman, 2008, p. 236). As a generative system, routines "can produce a wide variety of performances depending on the circumstances" (ibid, p. 241). At the same time, together these performances constitute a repetitive, recognizable pattern. Finally, routines are always carried out by multiple participants whose actions are interdependent of each other. In that way, routines neither take place at the individual level (as would habits or skills) nor at the organizational level (as would Mintzberg's coordinating mechanisms), but at the level of interdependent actions of a certain collectivity involved in certain organizational tasks.

In the literature, a difference is made between so-called *ostensive* and *performative* aspects of routines. The first mostly refers to the structure of the routine, or the routine as an abstract idea (Feldman & Pentland, 2003, p. 95). The second, by contrast, refers to the specific actions, by specific people, at specific times and places that make up the routine in practice (ibid, p. 94). The performative aspect thus has more to do with *agency* than with *structure*. Both aspects are interweaving parts of what constitutes a routine. As Feldman & Pentland argue that, on the one hand "the ostensive aspect enables people to guide, account for, and refer to specific performances of a routine" (2003, p. 94). On the other hand, "the performative aspect creates, maintains and modifies the ostensive aspect of the routine" (ibid.). Because not all participants of the routine understand the routine in the same way, routines can be said to have more than one ostensive aspect (Pentland & Feldman, 2008, 241). The same can be said of the performative aspect, for the simple reason that every situation in unique, despite it being an element of a more often performed routine. In a sense, “practice is inherently improvisatory” (Pentland & Feldman, 2005, p. 796). A study of routines requires attention to both aspects of the routine, in order to study them completely. The ostensive aspect is necessary in order to be able to refer to the routine and to abstractly define it. The performative aspect is necessary to show what the routine looks like in specific situations, as well as how it is shaped. This study will look at both aspects.

It is worth dwelling some time upon the notion that routines, whether one considers their ostensive or performative aspect, are essentially a context-bound phenomenon. That is, they are “embedded in an organization and its structures, and are specific to the context” (Becker, 2004, p. 651). As a consequence, routines cannot be easily transferred from one context to another. A routine that works in one context, may not necessarily work the same way in another context. There are no universal ‘best practices’ when it comes to routines (Becker, 2004, p. 652). This is understandable, since routines are made up from the behavior of a certain collective of people – and those people are bound to that context. In addition, every collectivity in turn has its own unique environment. However, this does not mean that insights about successful routines in one organization are useless for other organizations. Rather than providing universal best *practices* (cf. Purcell, 1999), successful routines might serve as best *principles* which guide and inspire other, similar organizations. In Chapter 4, the generalizability of this study will be further discussed.

Achieving coordination through routines

Knowing what routines are, the next question becomes how they contribute to coordination. To explain this relationship, the framework of Feldman & Rafaeli (2002) is useful. According to these authors, organizational routines lead to coordination through a series of mechanisms, as depicted in the figure on the next page. First of all, it is stated that routines lead to connections between the participants involved in the routine. These connections, defined as *interactions between people that enable them to transfer information* (Feldman & Rafaeli, 2002, p. 312), are essential. They create shared understandings between the participants about what to do in a particular circumstance as well as about why certain actions are appropriate (or not). Routines, through these connections and the shared understandings that are the result, lead to coordination of behavior between organizational members involved in the routine. Okhuysen & Bechky (2009) explain the relation between routines and coordination in a similar vein, when they state that “routines coordinate by providing a template for task completion, by bringing people together, and by creating a common perspective across groups” (p. 477).

To the reader, this might sound a lot like the description of coordination as mutual adjustment, as presented earlier in this chapter. After all, in mutual adjustment, organizational members informally communicate with each other in order to coordinate their actions, and routines are said to coordinate through the connections and corresponding interactions that they provide. As will be shown in the next paragraph, however, there is a distinct difference between mutual adjustment, on the one hand, and routines, on the other hand. At the same time, they are closely interrelated. As the next paragraph will show, the same is true for the relation between routines and Mintzberg's other coordinating mechanisms.

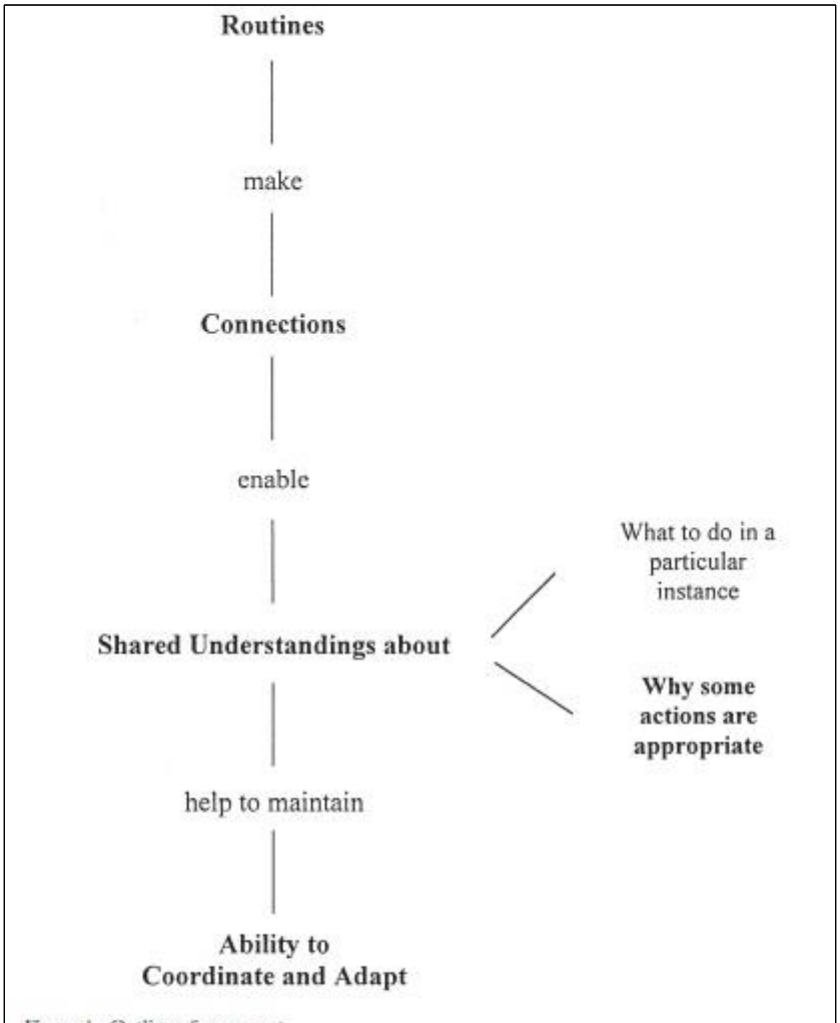


Figure 1. Outline of argument

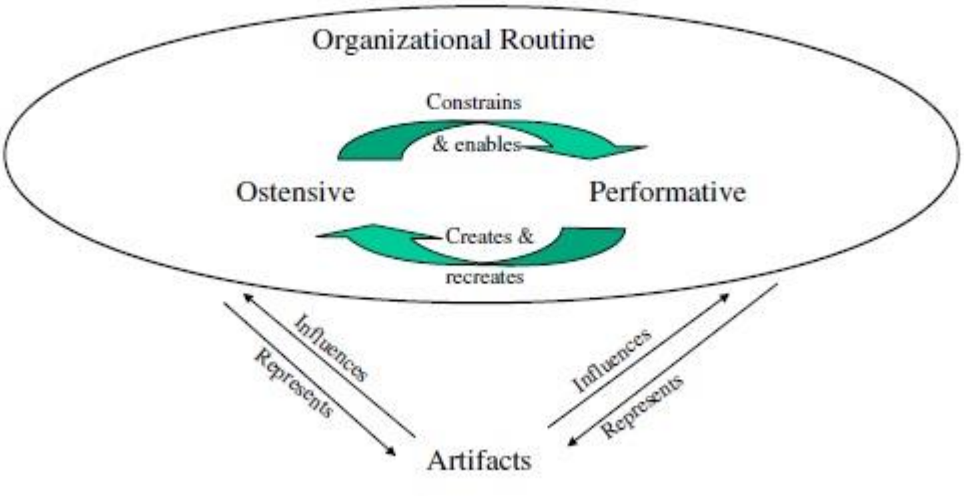
Reaching Coordination Through Routines (Feldman & Rafaeli, 2002, p. 311).

3.4 Connecting Mintzberg's mechanisms to work routines

If Mintzberg's coordinating mechanisms lead to coordination, but routines do too, then what is their underlying relation? Looking at Mintzberg's mechanisms, the underlying relation with routines seems unlikely to be the same for all mechanisms. Roughly speaking, the mechanisms can be divided into three distinct categories. First of all, three types of standardization are identified. As will be shown below, the routine literature explains the relation between these types of standardization and work routines by conceptualizing the former as *artifacts*. The second category of coordinating mechanisms have more to do with face-to-face *interaction* than with standardization. Mutual adjustment and direct supervision belong to this category. Finally, normative coordination seems to form a category of its own, by focusing on how coordination can be achieved through creating shared values and norms. Because of their differences, the three categories of coordination all have a distinct relation to the concept of routines.

Routines and Standardization

First, the relation between routines and standardization of input, output, and work processes needs to be shaped. Although some organizational routines emerge by themselves, "a great many routines are the product of explicit attempts to design efficient, effective work practices" (Pentland & Feldman, 2008, p. 235). Mintzberg's three types of standardization can be thought of as such attempts to shape work practices in a certain way. In the literature on routines, these types of mechanisms are referred to as *artifacts* (i.e. Pentland & Feldman, 2005; Becker, 2004). Not to be confused with actual work practices, artifacts are "physical manifestations of the organizational routine" (Pentland & Feldman, 2005, p. 797). Examples are work rules and standard operating procedures, the general physical setting, and other objects used during the practice of the routine, such as work forms, computer programs and other physical aids. Often, artifacts are used "to ensure the reproduction of particular patterns of action" (Pentland & Feldman, 2008, p. 241). A translation to Mintzberg's means of standardization is easily made. Standardization of work processes, for example, consists of exactly the types of coordination described as 'artifacts' in the routine literature: work orders, rules, and regulations. Similar connections could be imagined in the case of standardization of input and output. Coordinating mechanisms that focus on the standardization of skills, or of personnel more generally, may be artifacts in the sense that they form physical manifestations of the way selection and training of employees in the organization takes place. Examples could be official selection requirements and regulated procedures for on-the-job training. In the case of standardization of output, standardized rules on evaluation of employee work would be an example. As artifacts, these types of standardization are not equal to the routine. Rather, they may be "enrolled in the performance of a routine to varying degrees, at the discretion of the participants" (Pentland & Feldman, 2008, p. 244). This means that standardization mechanisms, whether they focus on input, work processes or output of the organization, are not necessarily effective, since their influence on actual work practices – on routines – depends on the employees involved in the routine. It would therefore not be enough to design certain standardizing mechanisms and leave it at that. Pentland & Feldman (2008) even refer to this often made mistake as "the folly of designing artifacts, while hoping for patterns of action". As artifacts, however, standardization mechanisms do influence and/or represent either the ostensive or performative aspect of the routine, or both, as represented in the figure below.



Routines as generative systems (Pentland & Feldman, 2008, p. 241)

Routines and Interaction

Although the relation between standardization mechanisms and routines can be made by conceptualizing the former as artifacts influencing and/or representing the latter, the same cannot be said of the other coordinating mechanisms identified by Mintzberg. Direct supervision and mutual adjustment, for example, might be best characterized as inherently *without* artifacts, since they consist of on-the-spot, face-to-face communication. Instead of being about artifacts, they are about *interaction* between the participants involved in a routine. In the case of direct supervision, this interaction has a hierarchical aspect, whereas mutual adjustment has more of a horizontal nature. It could be argued that without interaction taking place – whether it be through mutual adjustment or direct supervision – routines do not emerge. On the one hand, when a certain type of interaction is repeated for some time within a group of organizational members, a routine might be created. On the other hand, once a routine is in place, the interactions in that routine are shaped by what Okhuysen and Bechky (2009) refer to as the 'template' that is the routine. Phrased differently, interaction both shapes and is shaped by the routine. More importantly, it can be argued that mutual adjustment and direct supervision, as forms of interaction, only lead to stable coordination when they have become routinized. If interaction, by contrast, occurs randomly, on an ad-hoc basis, it seems difficult to imagine an outcome of stable coordinated behavior. At the end of the paragraph, the relationship between interaction (both mutual adjustment and direct supervision), routines and coordination is added to the theoretical model. First, however, the relation between routines and normative control needs to be examined.

Routines and Normative Control

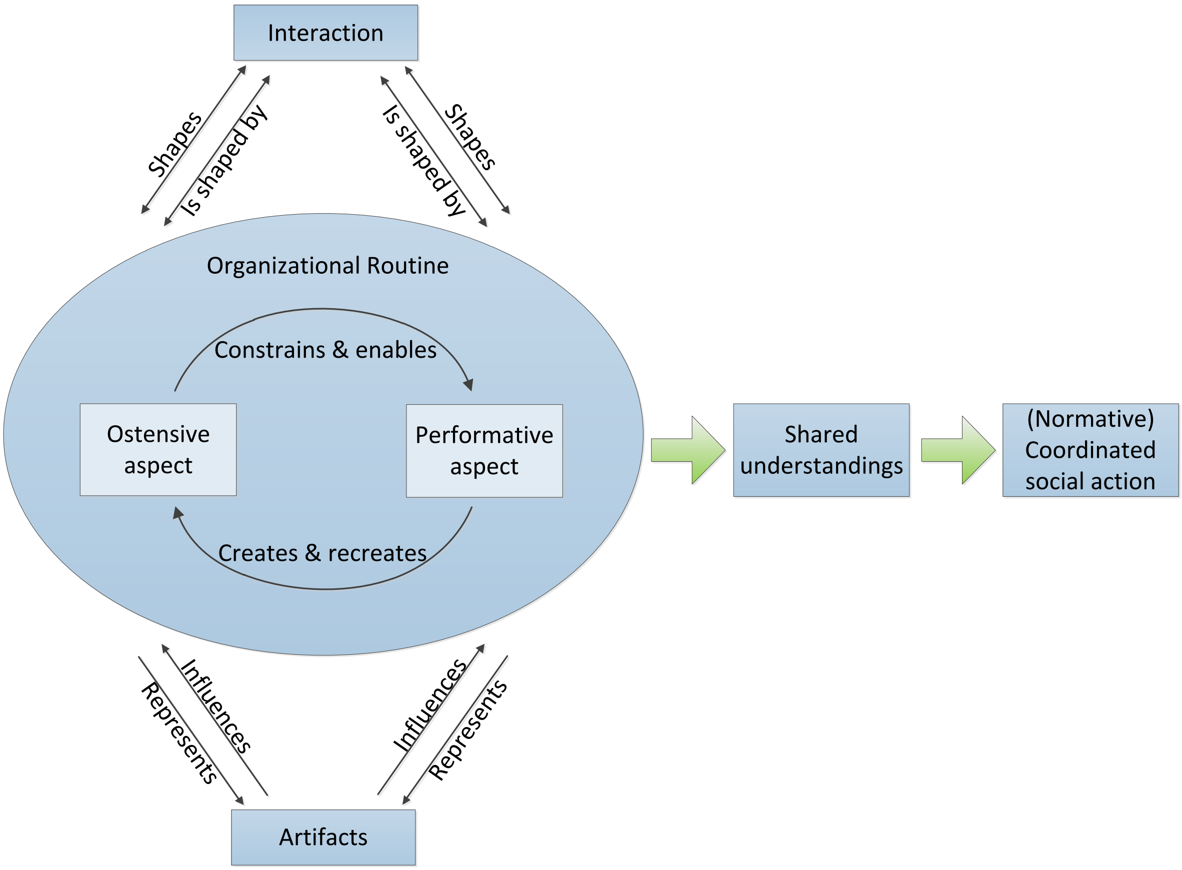
Unlike the other coordinating mechanisms presented by Mintzberg, normative coordination seems to be more embedded into its corresponding organizational configuration, the normative control model. Rather than outlining a specific mechanism through which coordination takes place, the normative control model provides a substantive interpretation of coordination. By emphasizing a specific normative character of selection, socialization, guidance, responsibility and judgment, the normative control model is thus more a description of a specific kind of coordination than of a mechanism through which coordination is reached. An example might explain this difference better. In the normative control model, selection is stipulated to have to take place according to values and attitudes rather than just credentials. This is a substantive stipulation, that does not say anything about the coordinating *mechanisms* through which this type of selection is to take place. It does not say whether selection takes place through a series of interviews, nor what these interviews should look like or who should hold them. In other words, normative selection is an aim, not a means. It is something to be achieved *through other coordinating mechanisms*. The same goes for the other aspects of the normative control model.

What does this mean for the relation between normative control and routines? The other coordinating mechanisms have been conceptualized as influencing and representing routines (in the case of standardization) and as shaping and being shaped by them (in the case of mutual adjustment and direct supervision). Eventual coordination is gained through the routines that emerge from this process. In some organizations, this coordination will have a normative character. For that to occur, the routines, artifacts and interactions leading to that coordination all need to embody the values central to the organization. More specifically, there would have to be routines that effectively select people according to their values and attitudes, routines that communicate membership to an integrated social system (socialization) etcetera. However, this does not change the theoretical mechanisms shaping these routines in general, but the substantive form these routines take in practice as well as the type of coordination that is the result. In a theoretical model that just stipulates the general mechanisms that lead to coordination, normative coordination is therefore only added as a possible end-result.

3.5 Theoretical Model

Considering the relationship between the ostensive and performative aspect of a routine, the relations between artifacts and interactions to routines, and the substantive interpretation provided by the normative control model, a theoretical model has been created that may guide the interpretation of the empirical findings and relate them to the main research question.

In this theoretical model, the original model by Pentland & Feldman of routines as generative systems has been edited and expanded. In the model, the three types of standardization are conceptualized as artifacts, following the insights provided by the literature on routines. Mutual adjustment and direct supervision, in turn, are conceptualized as forms of interaction. First of all, artifacts influence the routines and might sometimes be representative of a routine. Interactions, in turn, both shape as well as are shaped by the routine. The eventual routines, then, lead to shared understandings, which in turn lead to (normative) coordinated social action.



The relation between routines, artifacts, interactions and coordinated social action

Theoretical model

3.6 Conclusion

In this chapter, theoretical insights on coordination and work routines have been examined. Mintzberg's coordinating mechanisms were introduced as a fairly complete list of mechanisms organizations might use to coordinate the behavior of their employees. However, it was shown that the silent assumption that introducing these coordinating mechanisms automatically leads to corresponding changes in employee behavior is not necessarily a correct one. Examining these working patterns closer, the theory on work routines was outlined. Defined as "generative systems that produce repetitive, recognizable patterns of interdependent action carried out by multiple participants", routines provide the connections that lead to shared understandings about what to do in particular instances and why some actions are appropriate. Through these shared understandings, coordinated behavior becomes possible.

As artifacts, standardization mechanisms might play a role in shaping these routines, by influencing and/or representing both the ostensive and performative aspects of the routine. However, they are not the routine itself, and are almost never an exact representation of it. What is more, routines might emerge entirely without any artifacts implemented to design or influence them. In that case, they are shaped solely by the interactions between participants, which in turn are shaped by the routine that emerges. Both mutual adjustment and direct supervision may be conceptualized as types of interaction shaping and being shaped by routines. Finally, for normative coordination to occur, it seems important that the values and beliefs thought to be central to the organization are actually present in the routines that shape the various aspects of the normative control model (i.e. selection, socialization, etcetera). Together, the relations between the various coordinating mechanisms and routines were summarized in a theoretical model, that was used to further interpret the findings.

In the next chapter, the research design is introduced. There, more attention is paid to how the theoretical insights presented here have been used to further analyze and categorize the findings.

Chapter 4: Research Design and Method of Study

4.1 Introduction

This study aims to describe the means of coordination professional care organizations might use to ensure the quality of care given by volunteers. This chapter outlines the research design and method of study that was used to answer the main research question. In the previous chapter, theoretical insights on various types of coordinating mechanisms and their connection to organizational routines were outlined. Here, it will be shown how these insights were used to gather and analyze data. First, however, we need to take a step back and identify the central research perspective that lies behind many of the choices made throughout the research process. The study will be introduced as a *phronetic* study, aimed at contributing knowledge to praxis. In addition, it will be explained why a case study was chosen, as well as an interpretive research method. In paragraph 4.2, the three methods of data collection will be outlined, followed by an elaboration on data analysis in paragraph 4.3. In this latter paragraph, an explicit link will be made with the theory introduced in the previous chapter. Finally, the chapter will finish with a reflection on the research perspective and methodology used.

4.2 Research Perspective

A *Phronetic* Study

The central question of this study is essentially a very practical one. This has been a conscious choice. Many scientists argue that the social sciences ought to contribute to society in one way or another (i.e. Kitcher, 2001; Flyvbjerg, 2001; Miedema, 2012). Flyvbjerg (2001), however, takes this argument further than most, by redefining the essence of the social sciences. Rather than striving for epistemic knowledge, thus imitating the natural sciences, social scientists should aim for a different kind of knowledge, he argues. To find out what kind of knowledge that is, he reintroduces the Ancient Greek concept of *phronesis*. In contrast to epistemic knowledge, which is characterized by universal, invariable, and context-independent laws, phronetic knowledge “focuses on what is variable, on that which cannot be encapsulated by universal rules, on specific cases” (Flyvbjerg, 2001, p. 57). It takes “the analysis of values […] as a point of departure for action”, and “requires an interaction between the general and the concrete; it requires consideration, judgment, and choice” (ibid). A phronetic study, then, focuses on answering three questions (Flyvbjerg, 2001, p. 60):

1. Where are we going?
2. Is this desirable?
3. What should be done?

This study is phronetic, in that it tries to contribute to answering these questions. It describes the emergence of active citizenship and the probable heavier reliance on volunteers in caregiving for the elderly that is the result. It then questions whether this development is desirable, by asking what it means for the quality of care. Finally, the study aims to contribute to answering the question of what should be done: given that this development is happening, and given the fact that quality of care remains very important to our society, what should be done to ensure that volunteers provide good quality care? Hopefully, the answers this study provides will become “input to the ongoing social dialogue about the problems and risks we face and how things may be done differently” (Flyvbjerg, 2001, p. 61).

A Case Study: The Power of Example

In terms of research design, the study takes the form of a case study. The case chosen is an organization in which high quality care is delivered and in which, at the same time, care is partly provided by volunteers. By studying this case, the researcher hopes to be able to identify which mechanisms lead to this being possible. One advantage of a case study is that it is possible to extensively study the research subject and to come up with a very rich and extensive description of the phenomenon under study (Van Thiel, 2007, p. 98). An often mentioned disadvantage is that the generalizability of the findings to other cases is limited, due to the context-specific character of the findings (ibid). Where depth is its advantage, breadth is thus the case study’s weaker point (Flyvbjerg, 2001, p. 87). This study does not claim that all the coordinating mechanisms of volunteer work in the case studied are applicable in the very same form in all other professional care organizations. However, as a study of a case in which volunteers are successfully used to provide good quality care, it does have the power of being a good example of what such a successful organization might look like. It is this “strategic choice of case”, which “may greatly add to the generalizability of a case study” (Flyvbjerg, 2001, p. 75). At the same time, “formal generalization is overvalued as a source of scientific development, whereas ‘the power of good example’ is underestimated” (Flyvbjerg, 2001, p. 77). This study mainly aims to provide an image of a case that might serve as a good example, rather than to provide findings that are generalizable one-to-one to other cases.

An Interpretive Approach

Following Flyvbjerg’s philosophy of phronetic science, which emphasizes how knowledge[9] is always embedded in its context (Flyvbjerg, 2001, p. 42), an interpretive approach is used. As such, the study does not aim to acquire neutral, unbiased observations in the case studied – something which interpretive approaches deem impossible (Yanow, 1996, p. 6). Rather, the study aims to identify and understand the perceptions and meanings behind the coordinating mechanisms and routines present in the case studied, which contribute to volunteers being able to provide good care.

Using this approach has two important consequences. First of all, to properly understand perceptions held in a certain context, a case needs to be studied in its entirety (Van Thiel, 2007, p. 41). In order to approach this goal, data collection took place within the context studied by using various

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[9] In this context (no pun intended), the word ‘knowledge’ refers to ‘knowledge in the social sciences’ rather than in the natural sciences, in which universal context-dependent theories may well be possible.

methods, such as participant observation and interviews. Moreover, data collection took place over an extended period of time, in order to gather as much data as possible. More information on data collection can be found in the next paragraph. A second consequence concerns the role of theoretical knowledge in this study. In many studies, a theoretical framework is formulated first, and the empirical part follows at a later stage. In that way, data collection can be largely shaped according to theoretical concepts. Because this study aims to study context-dependent knowledge present in the case studied, the use of theory differs. Data collection had already started before the theoretical section as read in this thesis was fully crafted, or even before a complete research question was formulated. Based on initial findings, theory was brought in that the researcher felt might further explain what was going on as well as structure the findings. In the stages of the research that followed, this back-and-forth movement between theory and data continued. As such, the eventual knowledge produced is based on concepts derived from the local context as well as from existing theory (cf. Deetz, 1996, on local/emergent vs. elite/a priori concepts).

4.3 Data Collection

To increase the reliability as well as the richness of the findings, methodological triangulation was used (cf. Van Thiel, 2007, p. 105). In addition, using various means of data collection – participant observation, interviews and document analysis – allowed the researcher to study various aspects of routines found present in the hospice. It could be said[10], for example, that in interviews, more attention is paid to the ostensive part of the routine – how people view and describe a routine. During participant observation, on the other hand, the actual performance of the routine, and thus the performative aspect, is most prominent. Finally, document analysis might increase the understanding of some of the written rules and procedures that form the artifacts influencing and/or representing various routines. All three of these data collection methods were used in this study.

Participant Observation

The most extensive part of data collection took place through participant observation. By taking part in daily activities, it was possible not only to study behavior but also to find out more about that behavior by being able to ask about it to the people involved (cf. Van Thiel, 2007, p. 81). As the researcher herself is not educated as a nurse, and since this study focuses mostly on volunteers, the logical choice was to become a volunteer in the hospice studied and experience firsthand what that was like. Through the coordinator of the hospice, I was given permission to become a volunteer for the time of my research. Luckily, it was considered to be no problem that I would make notes during my shifts there. As agreed with the coordinator, I started with six shifts in which I accompanied the two experienced volunteers in the shift, after which they gave feedback on my performance in a special notebook I received for that purpose. After these shifts and an evaluation with the coordinator, I officially became a volunteer and took part in shifts about once a week. In total, my time as a volunteer in the hospice

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[10] As do Pentland & Feldman (2005, p. 799)

was between February and July 2014. In addition to the weekly shifts – which take place either in the morning, afternoon or evening and take around 5,5 hours – I took part in other activities organized by the hospice in the time I was there. These included peer meetings with other volunteers and a party organized in honor of the hospice's 15 years existence.

When becoming both a participant as well as a researcher, some choices have to be made. These choices relate, amongst other things, to the role taken in the case studied and to the openness given to people in the case about the research (Van Thiel, 2007, p. 81). Firstly, I consciously chose the existing role of volunteer in order to not disturb the daily activities in the hospice more than necessary. This was done both out of respect for the guests in the hospice, who I did not want to disturb with an extra presence in the room only there to make notes, and also to keep the findings as close to everyday reality as possible. In addition, by becoming a volunteer myself I was able to include my own experiences as a volunteer as research material. Secondly, I chose to be open about my role as a researcher towards the volunteers, nurses and other personnel at the hospice. At the beginning of my shift and when introducing myself to people I had not met before, I always made sure to mention my additional role as a researcher, and the fact that I would sometimes be making notes. I also always mentioned the topic of my study, although in a simplified manner ('how to realize good quality of care with the help of volunteers'). Reactions were always positive, and often volunteers or nurses started sharing their experiences with me without me having to ask. This lead to valuable input for my research. After spending some time at the hospice, people also started to ask about my findings up to that point. I was hesitant to share those, since I felt it required a more extensive explanation of my research design and sharing this information with other volunteers or nurses might influence my findings. In conversations, I therefore remained as vague as possible regarding this subject.

Whilst present at the hospice, notes were made concerning relevant situations and conversations held, and more generally on how the shift progressed and what tasks were performed by me and the other volunteers. As soon as possible after the shift, these notes were typed out more fully in an observation log. The description of each shift started by mentioning the date, kind of shift (morning, afternoon, or evening) and the volunteers and nurses I worked with that day. In the description, I tried to describe the shifts as chronologically as possible. However, since I could only make notes in between my work as a volunteer, it was not possible to record everything that happened. Notes made during events at the hospice other than shifts were kept in a different document.

Interviews

Although it was possible during participant observations to ask volunteers or nurses about certain behavior I witnessed or about their experiences working as/with volunteers, these conversations were always rather brief and spread out throughout the shift. During my time as a volunteer, I gradually learned more about the coordinating mechanisms and routines that seemed to be important in enabling volunteers to provide good quality care, but I was not always able to examine them more closely.

Therefore, I decided to supplement my findings with some interviews. To gain as diverse a picture as possible, five people were interviewed: the volunteer coordinator of the hospice, two nurses, and two volunteers. The interviews were set up as semi-structured, with much room for in-depth questioning. Questions were based on the findings from participant observation up to that point, combined with insights provided by the theory. Roughly speaking, the following topics were discussed:

	General topic	**Subtopics/ sub-questions**
1	History of the respondent	- Career up till now - Time at the hospice - Reason for joining the hospice - Specific tasks (when interviewing the coordinator)
2	Quality of care	- What does quality of care mean in this hospice? - How does it come about? - Specific examples
3	Cooperation between nurses and volunteers	- Task allocation - Relation to quality of care - Specific examples
4	What contributes to volunteers being able to provide good quality care?	- Coordinating mechanisms - Training - Work processes - Selection - Commitment to the organization
5	Successful and less successful aspects of the hospice in terms of volunteer coordination	- Strong points - Weak points
6	Any topics the respondent feels are relevant to include but haven't been discussed yet	- Depending on the respondent

The exact topic list that was used (in Dutch) can be found in the appendix. The first topic was mainly added to provide a personal context of the respondent, and as an easy way to start the interview. The respondents were then asked about what constituted good quality care in a hospice in their eyes, and how in practice, this quality of care came about. This information was used to create a narrative of quality of care according to the people working in the setting itself – nurses, volunteers, and the volunteer coordinator. This narrative is described in Chapter 5, and is used as the main source for what constitutes 'quality of care' in answering the research question. The third topic, about the cooperation between nurses and volunteers, was used as a good way to move from the more abstract topic of quality of care to actual work practices on the work floor. Concrete questions were asked, such as how a nurse and a volunteer would care for a guest together, and about the responsibilities of the nurse according to their own view and that of volunteers and the volunteer coordinator. Through this topic, not only important data was gathered concerning sub-question 6, but relevant routines that were found during participant observation were confirmed and their ostensive aspect described more elaborately. The fourth topic got to the core of the study, by directly asking for ways in which the hospice coordinated volunteers in such a way that they were enabled to provide good quality care. Here, respondents mentioned various coordinating mechanisms and routines. Finally, the fifth and sixth topic were added as different ways of approaching the subject, and explicitly left more room to the respondents to come up with relevant topics themselves. In most interviews, these questions led to valuable data.

During the interviews, the topic list was used as back-up for the researcher, not as a strict list of which all the boxes needed to be checked. In practice, the interviews started with the first topic and ended with the fifth and sixth topics, but the order of the topics in between varied. Not all subtopics were discussed in every interview. The interviews were held at the hospice, in one of the rooms (the coordinator office or one of the living rooms) that was not used at the moment of the interview. They took from one hour to 75 minutes. Finally, all interviews were recorded and transcribed verbatim.

Documents

In addition to participant observation and interviews, part of the data was gathered through document analysis. First of all, the first part of this study concerning the relevant transitions of the welfare state was entirely conducted by studying relevant research and policy documents (see Chapter 2). In the case study itself, however, documents were also analyzed. The organization manual on which the hospice had originally based its organization, for example, was studied, as well as other relevant documents present in the hospice during the shifts. These included to do-lists posted on the kitchen notice board, introductory manuals and a leaflet for new volunteers, editions of the hospice’s newsletter, etcetera. Where found relevant, these documents are mentioned and described in the description of the findings.

4.4 Data Analysis

Further analysis of the notes and interview transcripts occurred through categorization of the data. In this categorization, both concepts emerging from the local setting as well as the theoretical concepts introduced in chapter 3 were used. For example, many people I spoke with, both nurses and volunteers, mentioned that ‘seeing and appreciating’ the volunteer was very important. Because this concept was mentioned so often, it was interpreted to be central to the coordination of volunteers in the hospice. Other relevant themes were identified from the local setting in a similar manner. In finding the relevant themes, special attention was paid to the use of metaphors. Yanow (1996, p. 132) describes a metaphor as “the juxtaposition of two superficially unlike elements in a single context, where the separately understood meanings of both interact to create a new perception of each, and especially of the focus of the metaphor”. What makes metaphors so interesting, is that they do not only describe a reality, but also prescribe it. Through the comparison, metaphors “imply a whole narrative story and prescription for action” (Stone, 2002, p. 148). By studying metaphorical use of language, underlying meanings concerning the coordination of volunteers and its contribution to quality of care given could be deduced. At the same time, categorization occurred with the help of the theoretical concepts introduced in chapter 3. Because of the researcher’s knowledge of these concepts, it was possible to characterize certain phenomena as either a routine or a certain coordinating mechanism, and to categorize them accordingly.

In presenting the relevant routines and coordinating mechanisms identified in data analysis, both theoretical concepts as well as local metaphors are used. The theoretical concepts include concepts used in the theoretical model (performative and ostensive aspect, artifacts, interaction etcetera) but also underlying theoretical concepts (means of standardization, mutual adjustment etcetera) introduced in Chapter 3. Because of the attention to both local metaphors as well as theoretical concepts, the findings can be presented as a story that stays true to the local context, but contains adequate analytical depth at the same time.

In Chapter 6, the descriptions of the various routines and coordinating mechanisms are sorted in four broad themes, based on the categorization procedure described above.. During the writing of this thesis, the four themes were provided with working titles based on the categorization of the data, staying close to local metaphors. However, after the various routines and coordinating mechanisms belonging to the themes were fully worked out, the names of the four themes were re-formulated to better cover the range of routines and mechanisms belonging to them. As a result, the four themes represent four facets of coordinated volunteer work in the context of a professional care organization

4.5 Conclusion

In this chapter, the research perspective, methods of data collection and of data analysis were outlined. At the basis of this study stands a phronetic idea of doing research in the social sciences. The study thus tries to contribute to a societal discussion by providing an understanding of the circumstances within which volunteers might be able to provide good quality care in professional care organizations. In line with the phronetic tradition, it does so by presenting a case study as a ‘good example’. Hopefully, this study provides insights into what should be done in the face of active citizenship and corresponding consequences for volunteers and quality of care. To understand the case studied as well as possible, an interpretive approach was chosen. Specifically, this entails that data collection occurred through various methods, in order to study the case as completely as possible. In addition, theory was used to make better sense of the data, not the other way around. In the categorization and eventual presentation of the data, too, much room was left for local understandings, especially those formulated through metaphors. In Chapter 6, routines and coordinating mechanisms found present in the hospice are presented according to the four facets of coordinated work in a professional care setting identified during data analysis. First of all, however, Chapter 5 will describe the hospice setting in which data collection took place. After all, in view of both phronetic as well as interpretive views on research, a sense of context is essential.

Chapter 5: Hospice Heuvelrug – a description of a case

5.1 Introduction

How to understand the coordination of volunteers, let alone its influence on volunteers and the quality of care they provide, without a sense of the context in which this whole dynamic takes place? As argued in the previous chapter, *context matters.* In Chapter 2, the national policy context of care volunteers and consequences for quality of care was sketched. But the story of the successful coordination of volunteers cannot be told without paying attention to the organization in which it takes place. This chapter tells of Hospice Heuvelrug, a palliative care facility situated in the middle of the Netherlands. It provides the reader with a broad description of the hospice, including its history, mission and organizational structure. It will tell of the people working in the hospice and of those who live and visit there. Specifically, it pays attention to the roles played by volunteers and the various tasks they undertake. Finally, attention will be paid to the quality of care provided in the hospice. The information provided was gathered through participant observation, interviews and the study of the organization's website and official documents. For reasons of readability, more specific references to data sources are only given in case of a literal quote. This chapter has as its aim to make the hospice come alive to the readers, and increase their understanding of the successful relationship between routines, coordinating mechanisms and the quality of care provided by volunteers. To achieve this goal, first the chapter will provide the reader with an idea of what the hospice looks like if one were to enter through its doors.

5.2 A look inside..

De Heuvelrug is a small hospice, crammed in a separate part of the first floor in a building otherwise fully used as a nursing home. The building is situated next to a thoroughfare, in the middle of a small forest. Taking the stairs or elevator, you enter a corridor that holds a large comfortable chair and a place to hang your coat; In the corner stands a side-table, upon which a book lies open which holds inspiring spiritual quotes and poems – one for each day of the year. Next to it a large vase with flowers. Doors open to the nurses' office and that of the hospice manager. Walking down the corridor, the kitchen and a small living room can be found on opposite sides. The kitchen is fully equipped and includes a coffee machine, large fridge, freezer, microwave and large oven. Often, volunteers can be found at the dining table, chatting and drinking tea at times when it is not so busy. In the evening, guests eat at the dining table if they feel like it, joined by the cooking volunteers and sometimes by one of the nurses. Fresh herbs stand on the table near the window, and a large bulletin board fills part of the wall. On it are the volunteer schedules, phone numbers of the kitchen downstairs and the hairdresser's, announcements for classical concerts as well as thank you cards from former guests' relatives and former volunteers saying goodbye. In the small living room opposite the kitchen, there stands another table, along with a sitting area with some couches and a lazy chair. A large part of the left wall is covered by a bookcase, which holds books on palliative care and the end of life, but also religious and spiritual books, poems, novels and some children books. Both guests as well as visitors, but also volunteers and nurses, can borrow one of the books, as long as they return them after a while.

Continuing down the corridor, three guest rooms can be found on each side, each with their own bathroom attached. Rooms always contain a bed, closet, night stand, desk, a small fridge and a comfortable chair provided by the hospice. Guests often add some personal possessions to the room, such as photographs, cards and flowers sent to them or their own blanket. Recently, a man brought his painting supplies with him. At the end of the hallway, after moving through a door that effectively marks the border between the hospice and one of the floors of the nursing home, two more hospice rooms can be found. One is a bathroom which holds a large bath, in which the lighting can be changed and soothing music can be played. The other is a large living room, with couches and chairs as well as a table that could hold around 12 people. A computer, some books and toys for children are added. The room is most often used when guests get lots of visitors, in case of special occasions such as a birthday or for the more common reason that a guest is about to pass away and a lot of family members are present.

Before one knows it, one has already left the hospice again through the exit door at the end of the corridor. Although the hospice is small, it contains a lot of life[11]. In the rest of this chapter, more is told about the people present in the hospice, especially about those who work there.

5.3 A short history and description of the organization

In 2014, De Heuvelrug celebrated its fifteenth anniversary. In a large party on April 5th, complete with dinner buffet, a choir, passionate dancing and singing, the hospice’s board, its employees and volunteers celebrated the event. When the hospice was founded, on 1 March 1999, the hospice sector was only just emerging in the Netherlands and only a few hospices yet existed. Situated on the first floor of a larger building, which was otherwise occupied by a nursing home catering mainly to patients with Alzheimer’s disease, Hospice Heuvelrug initially offered room to four guests. In 2002, this number increased to six. As a hospice, De Heuvelrug provides care to people of all ages who, often due to illnesses such as cancer, are not expected to have more than three months to live. As its mission, the hospice aims to provide the highest possible quality of life to the terminally ill guests in its care, respecting their wishes as much as possible.

Financially, the hospice’s costs are only partially covered by the Exceptional Medical Expenses Acts (AWBZ). Only the official hours of care provided by nurses are paid for through that route. The costs for maintaining the building, buying food and drink, the salaries of the hospice

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[11] In one of the initial readings of this chapter, my tutor commented on this phrasing as ´intriguing, given the fact that a hospice is about the *end* of life´. Quite true, of course, but luckily, one thing does not rule out another. In Hospice Heuvelrug, people pass away, but they do not do so in a depressing environment. Surrounded by nurses, volunteers and family, there is also time for good conversations and smiles. In that sense, the hospice contains a lot of life indeed.

coordinators and other medical staff all need to be covered by different means. To be able to function, therefore, the hospice is highly dependent on voluntary donations which are gathered through the *Stichting Hospice Heuvelrug (Hospice Heuvelrug Foundation, SHH).* In addition, a small amount of money is asked from the guests per day of their stay.

Officially, the hospice falls under the responsibility of a larger foundation, which owns multiple nursing homes and other care arrangements in the area, including the one located in the same building as the hospice. Together with the SHH, the board of this larger foundation is responsible for hospice policy and its financial situation. The daily management of the hospice, however, is done by the hospice coordinator. The coordination of the volunteers is the responsibility of the volunteer coordinator. Both are paid jobs. The actual caregiving in the hospice is done by trained nurses, around 12 in total, and by a large number of volunteers. They are assisted by a special counselor for relatives as well as a spiritual counselor. Both of these jobs are paid for by voluntary donations.

Plans exist for the hospice to move to a separate building in the future, becoming more independent from the nursing home that occupies the rest of the building. However, not only would this be financially challenging, but the reliance on volunteers for logistic tasks would increase as well. Already, the reliance on volunteers can be called substantial.

5.4 The role of volunteers

Not all volunteers in De Heuvelrug help provide care to the guests. Around 20 volunteers are responsible for providing the evening meals six days a week, and a handful of volunteers helps with more administrative tasks. The majority of volunteers, however, are care volunteers. They assist the nurses in caring for the guests, for example in washing or showering guests, helping them get dressed and get ready for the night. They are responsible for giving foot or hand massages to the guests before they go to sleep, if a guest so desires. They also sit with guests who are in pain or are about to die, or they just have a chat with one of them about their lives or hobbies. In addition, they are responsible for more mundane tasks such as keeping the closets in the room well-stocked with towels, taking out the trash and taking care of the plants. They take care of breakfast in the morning and lunch in the afternoon, and are hosts to those visiting their terminally ill relative or friend. Finally, they might join a guest for a walk outside or play a game with one of them. They are thus responsible for carrying out a myriad of activities, which are not covered by any of the paid employees at the hospice.

Around 60 volunteers are involved in the tasks mentioned above. Needless to say, this requires some organization as to who does what. For the volunteers, each day is divided into three shifts with two volunteers in each shift. The morning shift takes from 07.45 – 13.00, the afternoon shift from 12.45 – 18.00 and the evening shift from 17.45 – 22.30. There are no volunteers present in the night. Roughly speaking, most volunteers take on one shift a week – either a fixed shift, such as every Tuesday morning, or more flexible shifts depending on their availability. Most volunteers are female and forty years or older. Male volunteers – at least male care volunteers – can be counted on one hand.

In the morning, the two care volunteers are mostly busy with taking care of breakfast and assisting the nurses with the washing, showering and dressing of the guests. In some cases, when a volunteer has enough experience and a guest is relatively independent, the volunteer assists the guest by herself without a nurse being present. In the heavier cases, which are the most frequent, the volunteer assists the nurse, who remains the only one responsible for all medical-technical actions. For example, volunteers are not allowed to give pills or other medicine to the guests and cannot work with technical equipment such as a patient lift. In terms of tasks, the morning shift ends with providing lunch to the guests who still feel like eating something.

In the afternoon, the care volunteers finish lunch if necessary and undertake activities with the guests if so desired. They have more time for other tasks now since the guests require very little actual care in the afternoon, so more cleaning activities are done. Visitors are greeted and offered coffee or tea. Most of the time, afternoon shifts are relatively quiet ones. At the end of the shift, if the cooking volunteers already finished dinner, the care volunteers sometimes help the guests with their food.

The evening shift, then, starts by finishing dinner if this has not been done already. The kitchen is cleaned and visitors, again, are welcomed. Here, too, there is time to undertake activities with the guests if they so desire. When it is time to go to bed, volunteers help the guests get ready, sometimes independently and sometimes assisting a nurse. Guests have the option of a foot or hand massage before going to bed, which are provided by the volunteers. At 22.30, the volunteers go home.

5.5 Quality of care in Hospice Heuvelrug

De Heuvelrug is a so-called high-care hospice. This entails that professionally trained nurses are present at all times. In addition, specialized counselors for relatives and spiritual needs are part of the team. Volunteers, too, are schooled and have often been at the hospice for years. Because they are a high-care hospice, every two years an audit is held by the association of high-care hospices that tests whether the hospice is worthy of the name ‘high-care hospice’. In this audit, not only the medical-technical acts are judged, but the entire policy of the hospice, including its volunteer policy. Based on these audits, De Heuvelrug holds an official quality mark of the association of high-care hospices.

In interviews, I asked both the volunteer coordinator as well as nurses and volunteers what they considered to be good quality care for a hospice such as De Heuvelrug. Their answers were remarkably similar. All respondents, both the volunteer coordinator, the nurses as well as the volunteers, asserted that putting the guest central in all his or her facets was central to providing quality of care. As one of the volunteers put it: “[Quality means] that the guest is central. Not only in words, but in deeds as well. That when there is a call for help or a request, from the guest or his family, that they are heard and listened to, and that we respond as adequately as possible. I think that is the meaning of quality.” One of the nurses is more specific: “And of course, a person is not just a body. Someone might throw up – if they are a young mother and they are about to die and leave their children behind, well I would throw up too because of my misery. So you have to look to the psychological side as well, and the social side, the spiritual side. Those things are important as well. And to the families around them”. This approach, which puts the guest central in all his or her facets, is described by all respondents as central to providing quality of care in the hospice. According to most of them, this requires a lot of time and attention. One respondent mentions the importance of being ‘attuned’ to the guest and his or her wishes. In addition, both the volunteer coordinator as well as both nurses describe the importance of (medical) expertise to being able to provide this quality of care. As a nurse states: “Well, I think you need knowledge first of all. Because if I do not have the knowledge, I can be so nice and friendly and pay so much attention to you, but I will still miss the boat in the end”. To the volunteer coordinator, too, expertise is a condition to providing good quality. For every need a guest might have, professional help is available, or can be arranged if needed. This also means that both nurses and volunteers do not perform any tasks they are not qualified to do. That, too, is considered quality.

Although volunteers do not have as much expertise as professionally trained nurses, they are considered essential in providing quality of care. Because of their presence, more time and attention can be spend on the guests. According to the volunteer coordinator, volunteers are especially useful in providing the type of care that does not concern the body or illness of the guest, but go beyond that. She mentions the foot massages before guests go to bed, just sitting next to them for a while or having a chat, or taking then for a walk in the forest. All these activities are considered inherent parts of providing quality of care, and volunteers are seen as indispensable in making these types of care possible.

5.6 Conclusion

With room for only six guests at a time, Hospice Heuvelrug is a small organization. With two coordinators, 12 nurses, two councilors and over 80 volunteers, however, the organization might actually be called quite large. Together, the people involved in the organization, be they paid employees or volunteers, aim to provide quality of care to their guests. Quality of care is conceptualized as putting the guest central in all his or her facets, and answering their requests as well as possible. In order to provide this quality of care with so many people, of which so many are volunteers, some form of coordination is required. In the following chapter, the various routines and coordinating mechanisms present in Hospice Heuvelrug are described. As a result, we are better able to understand how De Heuvelrug is able to provide quality of care to all its guests with the help of volunteers.

Chapter 6: Coordinating Care Volunteers in Hospice Heuvelrug

6.1 Introduction

Now that we know a little more about Hospice Heuvelrug, it is time to get to the question we all want answered. How does the hospice ensure the quality of care provided by volunteers? Based on the observation and interview data, and inspired by the theoretical insights of Chapter 3, a large amount of routines and coordinating mechanisms were discerned. Together, they form four facets of coordinated volunteer work in Hospice Heuvelrug. First of all, several routines and coordinating mechanisms together shape a process of *continuous learning*. This facet of coordinated volunteer work can be characterized by continuous attention and motivation to learn more and develop yourself in your role as volunteer. Both at the start of your time as volunteer, but also during the years and shifts itself, this dimension is apparent. The second facet of coordinated volunteer work in Hospice Heuvelrug has to do with *responsible action*. Between the organization and volunteers, clear boundaries and expectations exist. Volunteers know what is expected of them, and the organization actively asks them to be clear about their own boundaries. Thirdly, another facet of coordinated volunteer work has to do with *working together*. During shifts, volunteers and nurses work closely together on a basis of equality and mutual respect. Nurses have final responsibility, but there is a strong sense of jointly working towards a common goal: providing quality of care to the guests. Finally, the fourth facet of coordinated volunteer work in Hospice Heuvelrug concerns *organizational membership*. Volunteers are considered an inherent part of the organization, and they are treated that way as well. 'Seeing and appreciating' volunteers is suggested by many as a very important aspect of the organization's success in working with volunteers. Volunteers, in turn, feel a strong bond with the organization, stating they feel at home there.

In the following pages, these four facets are described by means of their underlying routines and coordinating mechanisms. In describing the routines and coordinating mechanisms, use is made of experiences and observations during participant observation, of excerpts of interview transcripts and of theoretical insights. Based on these descriptions, all facets end with a concluding paragraph in which the facet is summarized. Finally, the chapter will finish with an initial analysis of the findings and a conclusion, which together will form the input for answering the empirical research questions in Chapter 7.

6.2 Continuous learning

When I asked a volunteer in an interview in which way he was enabled by the hospice to provide good quality care, his first answer was clear: schooling. Whilst talking to other volunteers during shifts, many gave the same answer. Both at the start of their career as volunteer as well as during the years and during shifts themselves, several coordinating mechanisms exist that stimulate the increase of knowledge and skills of volunteers. Some of these are more routinized than others, as we shall see. As one volunteer pointed out, most have become more routinized during the years. This was confirmed by the volunteer coordinator, who considered this development part of the 'professionalization of the hospice'. At the same time, some routines are not driven by a coordinating mechanism (as an artifact) but have rather emerged over time through the interactions between volunteers and nurses on the work floor. Together, these routines form a process of continuous learning.

6.2.1 Starting as a volunteer

When a person first starts as a volunteer, he or she is not immediately given all the responsibilities of experienced volunteers. First, the new volunteer accompanies experienced volunteers during six shifts. In addition, every now and then an introductory course is organized, in which all new volunteers are taught some of the basic knowledge and skills required for working in the hospice. Both coordinating mechanisms are aimed at attaining a basic level of skills shared by all volunteers. In that sense, they can be characterized as attempt to standardize the skills held by volunteers.

6 shifts of accompanying experienced volunteers

Before becoming regular volunteers, new volunteers start their time at the hospice by walking along with experienced volunteers. In six shifts, the new volunteer can thus get to know the hospice and the tasks required of volunteers, thereby gaining an idea of whether volunteering at the hospice really fits them as a person. The other way around, it is an opportunity for the volunteer coordinator and the nurses to figure out whether the person is suitable for being a volunteer. Although it does not happen often, according to one of the nurses, sometimes it is already clear during these trial shifts that "it is just not going to work". When the time comes to evaluate the trial shifts, then, the volunteer is let go. However, this evaluation, which takes the form of a meeting with the volunteer coordinator and the new volunteer, mostly results in the new volunteer becoming officially recognized as a 'regular' volunteer. The trial period of six shifts is expressly divided into two afternoon shifts, then two evening shifts and then two morning shifts. In that way, the volunteer becomes familiar with all shifts, starting with the most quiet one in terms of personal caregiving (such as showering, changing etc.) and finishing with the busiest.

To make sure the volunteer gets familiarized with all the important aspects of working in the hospice during this trial period, they are provided by the volunteer coordinator with a leaflet in which all practical aspects are named in a checklist. Very 'mundane' aspects, such as knowing how the microwave works, are included, but also more specific care-related tasks such as 'being able to care for a guest in bed, together with a nurse'. In addition, in the final pages of the leaflet there is room for the experienced volunteers and nurses to evaluate the new volunteer after each trial shift. When provided with the leaflet, the new volunteer is strongly encouraged to use it.

Both the volunteer coordinator as well as one of the volunteers I interviewed noted that this trial period has become more routinized during the years. First, according to the volunteer, it all went a bit randomly and arbitrarily[12]. The trial period only took three shifts, and there was no leaflet. The volunteer coordinator, too, mentions that it has only been a few years since the trial period – and other volunteer policy too – has started to have more direction. To her, this streamlining is part of the professionalization of volunteer policy in the hospice.

Since the trial period has become routinized during the years, the routine literature can be used to make more sense of the phenomenon. Ostensively, the routine is referred to in slightly different ways depending on who I asked. Terms like 'trial period', but also 'training period' and 'walking along' are used[13]. The routine seems to be considered quite generally as a period in which the volunteer can get to know the organization and vice versa, and in which it becomes clear whether the volunteer fits in the organization. As an artifact, the leaflet provided to new volunteers strongly influences the types of tasks volunteers become familiar with. Through the checklist, it helps both the new volunteer as well as the regular volunteers he or she works with to identify which aspects might still need to be explained or taught. The room for evaluation at the end of the leaflet stimulates reflection on the way the new volunteer performed and allows the regular volunteers and nurses present in the shift to provide the new volunteer with tips and comments. Because of this leaflet, and the volunteer coordinator's strong insistence to use it, the trial period has become more routinized.

Introductory Course

In addition to a trial period, all new volunteers follow a small introductory course, in which they are taught some of the basics in terms of practical caregiving, but also more generally about the hospice. Because the volunteer coordinator is also a nurse, she is able to provide these trainings herself. Roughly speaking, the introductory course is provided once a year, when enough new volunteers have entered the organization. The course is divided into four meetings, each with a separate theme. The volunteer coordinator named general information about the hospice, but also a training in providing food- and hand massages as examples. In addition, volunteers are taught what to watch for when caring for a guest independently – to check the skin for sensitive parts, for example. Because the introductory course is only taught about once every year, I was not able to participate in it myself. What is more, most volunteers I spoke with had been at the hospice for years, and were thus not able to provide me with much information about what it looked like in the recent years or how they experienced it. However, all of them mentioned it is important to guaranteeing quality of care provided by volunteers. Because of this limited information, an elaborate description of the introductory course cannot be given here. However, it is clear that it is an attempt to create a basis of knowledge shared by all volunteers. In that way, it is an attempt to standardize skills. At the same time, as we will see, the process of learning does not stop after the trial period or introductory course. Although both create a

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[12] In Dutch, 'een beetje hapsnapperig'.

[13] In Dutch, 'proeftijd', 'inwerktijd' and 'meelopen' respectively.

basis of knowledge and skills, much is taught and learned throughout the years, during shifts or in separate peer meetings.

6.2.2 During your time as volunteer

As said, learning does not stop after the introduction period. Especially given the fact that most volunteers have been at the hospice for years, the need for extra training is recognized. Every now and then – at least once a year – extra training evenings are organized, mostly on practical subjects such as lifting guests. In addition, more psychosocially, peer groups are organized in which volunteers can share experiences and learn from each other. As we will see, the latter are more routinized than the former, which increases their relative impact on the quality of care provided in the organization.

Extra training

About once or twice a year, additional training is offered to the volunteers. These can be on all kinds of subjects, but are mostly of a practical nature such as how to lift a guest or additional training in providing food- and hand massages. When asking the volunteer coordinator what things could be arranged better in the future, she mentions that perhaps she could offer some more schooling. However, when offered, not many volunteers sign up. “If six or eight people sign up, I should be happy”. According to the volunteer coordinator, apparently the interest for these types of schooling is not big enough. One of the volunteers confirms the lack of interest of volunteers for these types of training, but suggests that making them more routine could be a solution. “They say they are obligatory, but I’m sure not everybody goes. But there’s no structure either. It’s more like, oh right, we have to do that training again sometime. Oh yeah, we should do this again sometime. In my opinion, they should draw a much firmer line here”. In this volunteer’s opinion, the training should be offered on a regular basis, and the volunteer coordinator should check whether volunteers are present at least every once in a while. He adds: “It should not be too voluntary, because in the end that means quality will suffer”.

Extra training thus seems to be a coordinating mechanisms that attempts to keep volunteers’ knowledge and skills up to date, but so far the hospice has not succeeded in making it a routine practice. For that reason, its effects on the quality of care provided by volunteers seem limited. Whether turning it in a routine is feasible remains to be seen, as experience shows a portion of volunteers does not participate in these trainings. However, because of the importance of maintaining quality of care, it seems worth exploring what could be changed for volunteers to become more willing to sign up for these meetings. One suggestion at least is to offer the extra training on a more regular basis and communicate that, in principle, all volunteers are expected to participate. This would be in line with another facet of coordinated volunteer work in De Heuvelrug, *responsible action*.

Peer groups

Compared to extra training meetings, peer groups are organized more often. They are held every six weeks, with the intention of sharing experiences. Because of the large amount of volunteers, around five or six of these groups exist. They are led by volunteers, some who are active as care volunteers themselves but also some for whom chairing these peer groups is their only volunteer activity. Often times, the latter previously worked at the hospice, as a nurse, volunteer, or even as a coordinator. As the volunteer coordinator explains, these peer groups are explicitly meant for volunteers to be able to address things they feel unclear or uncertain about. She has very consciously chosen not to be present in those meetings herself, nor are any nurses present, so that volunteers have the option to voice any complaints they might feel about her or the other staff in a safe environment. Because not all peer groups are led by the same people, their process slightly differs per group. However, some elements are structural to each meeting. In two of the meetings I joined – both of the same peer group – first everyone was given the chance to shortly state how they were doing and if anything had happened in the hospice lately about which they were troubled. Some volunteers offered they had found dealing with a passing of a guest difficult, for example because it had been very hectic and bloody or because the nurse had been busy elsewhere when it happened. They are given room to voice their thoughts and other volunteers often answer in an understanding manner. Afterwards, the chair reads out all the names of guests who passed away recently from a list provided by the volunteer coordinator. Anyone who feels like sharing something about that guest, either a good or bad experience, is free to do so. Besides these two elements, there is also space for making comments about the organization. For example, in the first meeting I joined, enthusiasm but also worries were voiced about a possible move to a separate building. In the second meeting, all volunteers agreed that the new front door-policy of the nursing home occupying the rest of the building was detrimental for the hospice's hospitality, and that something needed to be done about it. The group chair promised to take this feedback back to the volunteer coordinator.

Most meetings take around 1,5 hours and are comprised of the above elements. However, groups are free to use the meetings to discuss other things if they so wish. In the first meeting I joined, we read a text on the main things people regret when they are on their dying bed, and we discussed whether we could understand these regrets and how we imagined they might impact a person. In addition, according to the volunteer coordinator, it sometimes happens that groups discuss a book or a documentary on a relevant subject. Although of course the peer groups are officially voluntary, they are not without obligation. The implicit assumption is that people will be there. In practice, however, not everybody is there all the time. Those who visit the meetings, however, are generally positive. During one of my shifts, a volunteer stated she found the meetings useful, and was often able to give tips to other volunteers who joined the hospice later than she did. In another shift, a volunteer told me that in these kind of meetings, volunteers were able to learn from each other. In an interview, another volunteer stated that the meetings help him to “first check whether things I feel ought to change are also recognized as such by other volunteers, […] or whether my view on the matter is too one-sided”.

In contrast to the extra training, peer groups have been routinized to a large extent. All volunteers take part in the regularly organized meetings, of which the dates are decided up front over the course of a year. Although the purpose of the meetings stay the same, and some aspects return every time, there is also much room for the volunteers taking part to decide how the meeting is structured. In that way, the performative aspect of the routine is different every time, and probably also differs depending on the group. The structurally planned meetings and the understanding that in principle you are supposed to go to them, combined with the flexible way in which volunteers can shape the content of the meetings, is one of the reasons the routine seems able to accomplish its goal: allowing volunteers to share experiences and learn from each other. The effectiveness is further enhanced because of the follow-up to the meetings. Any complaints or questions voiced by volunteers during the meetings are communicated back to the volunteer coordinator by the chair, who then actively tries to address them. In that way, the meetings become part of the learning process of the organization rather than solely standalone meetings in which volunteers can voice their thoughts. The routine thus provides for both the creation of shared understandings between the volunteers taking part in the group as well as for the communication of those shared understandings back to the volunteer coordinator, who can use these insights to adapt volunteer or general hospice policy.

6.2.3 During a shift

As is true for many jobs, part of the knowledge and skills needed for volunteers to be able to provide good quality care are acquired *on the job itself*. In a very routine way, briefings at the start of each shift help volunteers gain the knowledge required to deal effectively with the guests present at the hospice at that moment and with their family. Moreover, many of the skills required for proper caregiving, at least according to volunteers themselves, are learned through experience; through watching, and learning. It is mainly through this latter process that the process of learning in Hospice Heuvelrug truly becomes continuous.

Briefings

As is common in professional care organizations, employees in the hospice are briefed about the current status of their clients when they start their shift by the employees of the shift before. In contrast to most other organizations, however, volunteers are also briefed. This is deemed important, because volunteers also provide care to the guests and communicate with them and their family. As an attempt to standardize work processes, every shift starts with a briefing. Moreover, all briefings have a more or less routinized structure. It can therefore be said to be an example of a successful translation from an artifact (the rule to have briefings at the start of meetings) to a routine.

In morning shifts, volunteers arrive at 7.45 am to read information on the guests in the hospice, collected especially for this purpose in a binder. Whilst drinking tea or coffee – already put in the living room for that purpose by one of the nurses – they can thus inform themselves about new guests and about new developments of guests they have already met. From 8 to 8.30 pm, the verbal briefing takes place. In this briefing, one of the nurses addresses every guest in the order of the rooms (room 1 to 6). If a guest is new, or if one or both of the volunteers have not met the guest yet, some standard subjects are covered. These include their age, gender, (former) job and living situation, the disease(s) of the guest, relation with family and their current condition. In addition, specific information is given about aspects directly relevant to the actions of volunteers, such as the extent of help and care needed and whether this care can be provided by the volunteers or can only be done by a nurse. Existing guests are often discussed more shortly, with the main focus on their current physical and mental condition compared to the last time the volunteers saw them. In addition, she might suggest some activities the volunteers could undertake for the guests, such as going for a walk with them or just sitting and chatting with them for a while. After discussing all the guests, usually the nurse suggests a certain division of the tasks that need to be done, for example asking the volunteers whether they want to provide care to some of the guests individually or which of them wants to join her in caring for a guest who requires two people for caregiving.

The briefing of the afternoon and evening shift have a similar setup, except that the first 15 minutes (of the 45 minutes reserved for the briefing) are reserved for the volunteers of the previous shift to brief the volunteers of the next shift. Here, too, the binder with information is available, but in practice volunteers in the later shifts do not always read it, relying instead on the verbal briefings of the previous volunteers and the nurse.

The briefing is an example of a successful attempt to routinize work processes. To a large extent, the briefings are successfully structured by the information sheets used by the nurses (as artifacts) on which the main topics of information are summarized per guest. The binders with information for the volunteers are used for back-up information, but their use has not become as routinized as the verbal briefing, and they thus have less impact on the structure of the briefings. Of course, no briefing is an exact replica of another. Different nurses and volunteers are present in each briefing, each with their own way of performing the routine. As one nurse explained in an interview, some volunteers clearly indicate which tasks they want to perform, whether others expect her to suggest a division of tasks. As I myself experienced, some ask more questions or reminisce about guests who passed away, whether others are more to the point. What is more, the exact times at which the briefings are supposed to take place may change depending on the circumstances in the hospice. In that sense, the performative aspect of the routine is influenced by the context at the time. For example, if a nurse is very busy, it might be that the afternoon briefing takes place half an hour later. In any case, as a volunteer you are not supposed to provide care to a guest without having been briefed on that guest first, as one of the volunteers explained to me in a similar situation[14].

When asking a volunteer in an interview if he considered the briefings to be useful, he answered affirmative, “because you get a short overview of what is going on”. Through the briefings, the volunteers are effectively provided with the knowledge required to adequately deal with the guests in the hospice and their family. The artifacts used during the briefings, especially the information sheet on which the nurses base their briefing, ensure that no important information is left out. Besides providing the volunteers with much needed information, they also allow for a natural moment at the beginning of each shift to informally communicate with each other about who will be doing what. The briefings thus form a platform for mutual adjustment to take place. Because of both these functions, the briefings effectively enable volunteers to provide better quality of care.

Watching and learning

“But how – you had schooling of course, but how do you know exactly what to do? What to watch out for?” This is what I asked a volunteer during an interview, referring to how he knew how to care for guests individually, without a nurse present. How did he know what to watch out for, what to pay attention to? Surely those four evening in the introductory course eight years ago had not been enough? His answer was plain and simple: “I mainly just watched how nurses did it”.

Experience, according to this volunteer, was the only way you could properly learn to provide good quality of care to guests as a volunteer. Schooling was important, of course, but watching nurses or other volunteers at work, working with them again and again, that was how he gained most of his skills; “I would not know how else to learn it”. Based on my own experience at the hospice, I am inclined to think he is right. Even without having had the introductory course, I have already gained much experience in terms of the skills required for caregiving. I now know things and have learned how to do things that I was not capable of some months before. Still, after half a year as a volunteer, I still do not know hardly enough to feel completely comfortable taking care of someone by myself, without a nurse of more experienced volunteer present.

If experience is a big factor in enabling volunteers to provide good quality care, which seems to be the case, then this has some consequences. For one, in order to gain the experience required, it would be necessary for volunteers to remain volunteering at the hospice for a relatively long time. In the hospice studied, this is definitely the case. Meeting someone who had been a volunteer for less than 2 years was a rarity, most volunteers I spoke with had been at the hospice for seven years or longer; at least three volunteers now working at the hospice have been there since the very beginning, now fifteen years ago. A second requirement for gaining experience is that the organization stimulates

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[14] This situation took place in a morning shift. We had just arrived when we heard cries of pain come out of a room. My fellow volunteer went to check, but returned almost immediately. She told me she was not supposed to help a new guest without having had a briefing. New volunteers were almost always told this. I suspect she went to check anyway to see whether, for example, the guest had fallen or some other emergency had caused sudden pain. When that turned out to be not the case, she chose to wait for the nurse to brief us first.

learning through experience. There are several conceivable ways in which an organization could stimulate such a process. One example is the peer group meetings, which allow volunteers to learn from each other's experiences. It is on the work floor itself, during the actual caregiving, however, that most of the learning-through-experience takes place. It is also here that the main stimuli exist. In the following paragraphs, many routines will be discussed that, in one way or another, contribute to creating an atmosphere in which learning through experience is encouraged. In a way, then, providing volunteers with knowledge and skills is central to volunteer policy and the very essence of volunteer work in the hospice. It is by no means refined to just the coordinating mechanisms and routines described in this paragraph.

6.2.4 Conclusion: Continuous learning

Looking at all the ways in which the hospice tries to increase the knowledge and skills of volunteers, some conclusions can be made. First of all, the introductory schooling, trial period and extra training throughout the years all seem to be aimed at creating some sort of standardization of skills amongst volunteers. Especially the trial period and the introductory schooling succeed in this matter, mainly because they are more routinized than the extra training for more experienced volunteers, which has a more ad hoc character. In the case of the trial period, artifacts (in the form of the leaflet) have greatly stimulated this process of routinization. Secondly, standardization of skills notwithstanding, it remains important to brief volunteers on the present status of guests, so they can adequately respond to their needs. The final and most important conclusion, however, is that despite attempts to standardize skills, the main skills and knowledge held by volunteers are acquired through experience; through watching and learning. During shifts, but also via peer groups, volunteers are enabled and encouraged to learn from other volunteers and from nurses. It is this combination between introductory training, peer groups and extra training over the years, and learning through experience whilst working together with other volunteers and nurses on the work floor that has created a process of continuous learning in Hospice Heuvelrug. Especially the latter greatly contributes to this process. By creating a learning environment in which volunteers are encouraged and stimulated to learn more, the hospice has succeeded in making such a continuous learning process possible. In the following paragraphs, aspects of this learning environment will become evident as other coordinating mechanisms and routines are discussed. Especially in the cooperation between nurses and volunteers, continuous learning is evident.

6.3 Responsible Action

By its very nature, volunteering is done voluntarily. People choose to become volunteers and to contribute to some goal, without requiring any payment for services provided. Volunteering, however, does not necessarily mean an absence of any obligations. In Hospice Heuvelrug, volunteering is often described as ‘voluntary, but not without obligation’[15]. As the volunteer coordinator stated in answer to one of my questions: “I am not interested in people who only want to volunteer for a couple of months”. When becoming a volunteer, it is being expected that you stay there for an extended period of time – barring unforeseen events. In addition, as a volunteer, you are expected to act responsibly. Some specific coordinating mechanisms have been put in place in De Heuvelrug that are meant to structure volunteer contributions both in terms of quantity as well as quality. In this paragraph, these coordinating mechanisms, and the extent of their routinization, will be discussed.

6.3.1 The process of dividing the shifts

As mentioned many times by now, volunteers work in three shifts per day, with two volunteers scheduled to be present in each shift. This may sound mundane, but it has significant consequences in terms of the structuring of volunteer work. Volunteers do not come and go, they do not stay for only a couple of hours, but for the pre-scheduled duration of a set number of hours at a set date. When scheduled for a shift, the volunteer is expected to be there. In that sense, volunteering at the hospice is anything but voluntary. As a nurse puts it during an interview: “You cannot become a volunteer and be scheduled for a shift on Thursday and then be like, you know what, I don’t feel like it, I’m not coming”. Once agreeing to be there for a shift, a volunteer is expected to follow-up on that promise. In the hospice, this is considered by all parties to be a natural state of affairs. After all, quality of care cannot be guaranteed if there are no assurances who is going to show up when – at least not if care provided by volunteers is considered to be part of determining this quality. As became clear in chapter 5, the tasks performed by volunteers are considered essential for the quality of care provided. A certain continuity in terms of volunteer presence is therefore crucial.

That being said, volunteers do have a large amount of freedom in deciding the shifts for which they want to be scheduled. Schedules are made by the volunteer coordinator per month, and occurs through several phases. First, the coordinator schedules all volunteers who prefer doing a set shift every one or two weeks – for example every Tuesday morning. Then, she sends the schedule to all volunteers who prefer more flexible shifts per email. These volunteers have until a set date to reply to the e-mail with the shifts they would prefer that month. After scheduling these volunteers for their preferred shifts, they receive an e-mail back with the final schedule, which is also hung at the bulletin-board in the hospice kitchen. All volunteers are then left free to write down their name for any shifts still open. Finally, if shifts are not filled some days before they take place, all volunteers again receive an email requesting anyone willing to do that shift to email back or call the hospice. Most of the time, this results in all shifts being filled.

In an interview, the volunteer coordinator identifies making the volunteer schedule as one of her main tasks. Because of this routine, which occurs every month in approximately the same way, volunteers are always certain for which shifts they are expected to show up. At the same time, they are

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[15] In Dutch: ‘vrijwillig, maar niet vrijblijvend’

free in deciding the extent of flexibility in the shifts they sign up for – set shifts every one or two weeks or more flexible ones. Once they sign up for a shift, though, this is seen as a binding agreement between both parties, of course barring unforeseen circumstances such as illness or family-related issues. The routine thus serves three functions: it ensures continuity in terms of volunteer presence; it provides clarity for volunteers in terms of what is expected of them, and for the hospice in terms of who will show up when; and it provides the required flexibility for volunteers in terms of which shifts they want to be scheduled for. It is therefore an essential coordinating mechanism to ensure quality of care given by volunteers, and one that has successfully been turned into a routine.

6.3.2 Evaluation Talk

Whereas the volunteer schedule ensures the continuity of care provided by volunteers, which can be viewed as an important condition for quality of care to occur at all, the evaluation talk has the aim of ensuring the qualitative contribution of the volunteer. As a coordinating mechanism, it has been introduced as an in principle yearly moment of evaluation of the volunteer. In a meeting, the volunteer coordinator sits down with the volunteer and evaluates the contribution of the volunteer to the hospice and his or her experiences. Since a couple of years, this evaluation is preceded by a request of the volunteer coordinator to the nurses to provide feedback on the volunteer. The coordinator: "I have forms for that, which I put in the mail boxes of the nurses. I ask them to fill them out. Just general feedback, how is the volunteer doing, what about the attitude towards the guests, what about practical skills". In addition to these topics, during the evaluation the volunteer coordinator asks about volunteers' experiences in the peer groups, with other volunteers and nurses, and about their private life. To ensure she covers all topics, she uses a checklist. In very rare occasions, the evaluation talk takes the form of an exit interview.

According to one of the volunteers, the yearly evaluation is a way in which the organization can ensure the continued quality of volunteers. Together with training, he considers it part of the process that ensures people do not become overconfident, "thinking 'I can do it by now'". In addition, he views it as a good moment to show appreciation of the volunteer. Although he had no experience of this himself, he understands that in the case of critique, appropriate follow-up plans are made to ensure the volunteer can work with the feedback.

If this evaluation talk were to take the form of a routine – taking place on a regular (yearly) basis for all volunteers, recognized as such by all participants involved – it might be a very effective coordinating mechanism that actively stimulates quality of care provided by volunteers. This would be even more the case if the follow-up, too, would become routinized. However, due to various circumstances, it has not been possible to turn these evaluation talks into an actual regular routine, although the intention is definitely there on the part of the volunteer coordinator. By turning the evaluation talk into a more regular routine in the future, it might become more effective.

At the same time, as one of the nurses emphasizes, providing feedback only once a year through an official coordinating mechanism such as the evaluation talk is not enough. She feels that one of the conditions for providing feedback in the evaluation talk is that this feedback has also been given directly by the nurse during the shift itself. If negative feedback to the volunteer is only given to the volunteer once a year during an official meeting, and has never been mentioned to that volunteer before, she feels that communicates a lack of attention and care of the nurses towards the volunteer in question. Viewed like this, for evaluation talks to be effective they should not only become more routine, but they should also form just one central mechanism in an environment in which openly and honestly providing feedback to one another is considered normal and desirable. Interestingly, although the nurse quoted above claims that this should receive more attention, many of the volunteers already mention the open atmosphere in the hospice as one they appreciate. Providing feedback to the volunteers, in my experience, is already pretty common on the hospice work floor. In that sense, both the evaluation talk but especially the possibility of continuous feedback on the work floor is not only part of responsible action, but of continuous learning, too.

6.3.3 Being clear about your boundaries

As a volunteer, despite the voluntary nature of your job, you are thus supposed to hold yourself to certain standards in terms of both attendance and quality of care provided. As the two nurses whom I interviewed emphasized – each separate from each other – many tasks are demanded of a volunteer. So, what it you do not feel comfortable doing something as a volunteer? What if you do not feel ready to perform a certain task, for whatever reason? If a feeling of obligation on the part of volunteers is too high, this might result in some of them performing activities that are designated to them, but for which they personally feel they are not equipped. In the hospice, the general feeling seems to be that this should be avoided. When I started as a volunteer, I was worried myself about having to do things independently, such as washing a guest, without feeling confident about being able to do it properly. The volunteer coordinator assured me, however, that it was important to not do things I did not feel equipped to do. In an interview, months later, she stated she gave this instruction to all new volunteers: “If you are asked to do something, but you have the feeling you cannot do it yet or not sufficiently, please say so and don’t do it!”.

This feeling seems to be shared by the nurses and volunteers I worked with. Often, when a nurse asks me to do something, she also asks whether I feel up to it. Afterwards, most nurses ask me how I felt it went, and whether I found it difficult. The same goes for volunteers. One time I told my fellow volunteer that I often felt insecure about how to help a guest, for example in helping them go to bed. Her first reaction was that I could just ask the guest himself, since guests often know very well what they wanted done. The briefing was also important. But most importantly, “if you feel uncertain, you can always ask a nurse. I do that myself as well”.

This norm, which is not a clear-cut routine but definitely a norm that is being upheld in a quite routine matter, is important for the quality of care provided by volunteers. As the volunteer coordinator asserts: “This has to do with quality of care. If you do it anyway just because it is asked of you, that does not help the patient. And they feel that. They notice. If a volunteer is insecure or clumsy, that does not feel right to a guest”. Here, too, openness and honesty is required, this time of the volunteer about his or her own limitations. What is more, this openness and honesty is only effective if being clear about your limitations is also accepted. For example high work pressures could be detrimental to this practice, since it could induce the feeling of ‘do it anyway’ that is so harmful to the quality of care. Finally, although volunteers in De Heuvelrug are actively stimulated to be honest about their limitations, it is emphasized by the coordinator, but also by volunteers and nurses, that of course there are boundaries here, too. One nurse, during an interview: “If someone really wants to do morning shifts, but is not prepared to help guests with washing and showering, well then we have a problem”. In other words, there has to be a certain preparedness on the side of volunteers to learn and become acquainted with the tasks required of them, otherwise they cannot function as a volunteer.

6.3.4 Conclusion: Responsible Action

Based on the descriptions of the way schedules are made, evaluation and feedback to volunteers are handled and norms surrounding volunteer limitations are present, two conclusions can be made. The first is that continuity of care can be guaranteed by being clear about what is expected of volunteers. The schedules ensure that volunteers know when they are expected to work at the hospice, and feedback – both through official evaluation talks and on the work floor – steers them in the right direction in terms of more qualitative requirements. At the same time, and this brings us to the second conclusion, it is important that a certain openness and space exists that allows for flexibility for the volunteer. The way the schedule is composed, volunteers have a certain freedom in terms of the flexibility they would like in their shifts; in addition, volunteers are encouraged to be clear about their limitations and not do anything they do not feel comfortable doing. This combination of clear obligations with reasonable room for flexibility and stating your boundaries creates a sense of responsible action on the part of the volunteer. However, some mechanisms used to achieve this goal, most notably the evaluation talks, could become more effective if they were to become more routine.

6.4 Working Together

In the previous two paragraphs, many of the mechanisms and routines discussed are situated away from the work floor. Training, peer groups, evaluation talks: they all take place outside of shifts. Some mechanisms and routines, however, take place specifically on the work floor. Watching and learning, providing feedback and being clear about your boundaries are the most obvious and important examples noted thus far. Not surprisingly, most of the time volunteers spend in the hospice is by working actual shifts. When doing so, they are constantly working together with other volunteers and with nurses, at least one of which is always present at the hospice. In this dynamic, many routines exist, some enforced by artifacts. At the base of these routines, and of this dynamic more generally, seemed to be one important norm. Here, first this norm will be introduced, followed by the main routines evident in the way volunteers and nurses work together during a shift.

6.4.1 A basis of equality and mutual respect

In the very first shift I took part in, one of the volunteers spontaneously confided in me that she was very happy with the equal relationship between nurses and volunteers in the hospice. The nurses, but also the hospice board, greatly appreciated the work of volunteers, according to her. This made sense, though, because without volunteers the hospice would not be able to function. On the other hand, she stated: “Without nurses, the volunteers cannot achieve anything either. We need each other”.

On the one hand, it is clear that nurses have final responsibility in every shift, and that certain tasks may only be performed by them. My impression during the many shifts I worked, and this was confirmed by one of the nurses in an interview, is that everyone in the hospice is aware of these two basic principles. As part of their responsibility, many nurses asserted they saw themselves as in charge of what happens during the shift, and thus also as in charge of the volunteers. One stated that she saw it as her task to steer volunteers in the right direction. Another said during an interview that “I most definitely need to be in charge, and I most definitely am”.

In view of these remarks, I asked some of the nurses that if they were in charge of the volunteers, what was then the meaning of the ‘equal relationship’ many of the people in the hospice, including these nurses themselves, asserted was so important? One of the nurses became quite passionate when answering this question: “Yes, I am in charge, but we are also doing it together! I find this very important. Also because there are so many volunteers who – well, I’m really not their superior! I’m really not! These are all educated people with a past, and with knowledge, and.. I’m just not”.

The equal relationship between nurses and volunteers is definitely present, not only in words (ostensively) but also in deeds (performatively), and despite nurses being in charge of volunteers. One of the ways in which this equality emerges in daily practices is in the openness of nurses to questions and criticism of volunteers. Both of the volunteers I interviewed mention this. “If after caring for someone together, I say something like, ‘couldn’t you have better done this or that?’. ‘Well, you’re right’. Yes – then, if they are open to that, then it is fun to work together”, one said. A bit skeptical, I asked why this was so important, besides the fact that he appreciated it personally. He answered that if nurses instead became angry, or were to start pointing fingers that he ought not interfere, then it would not be an interaction. As a volunteer you would not feel appreciated or taken seriously. You would start thinking it would be better to keep your mouth shut, “and I do not think that is a good thing. In fact, I am sure that is not a good thing”. During one of my shifts, a nurse urged me not to hesitate to ask questions, because they kept her sharp. In an interview, she said: ‘I am in charge, but does that mean I cannot make mistakes that you can confront me about? I need to behave as well, right? What if I do something wrong?"

Other ways in which the equal relationship between nurses and volunteers becomes apparent is the way in which nurses divide the tasks that need to be done. At least in my experience, they never tell a volunteer to do something, but *ask* them. In the theoretical terms of chapter 3, tasks are divided mostly through *mutual adjustment*, rather than *direct supervision*, although nurses often take the lead when it comes to suggesting a division. As the volunteer coordinator states: "In general we manage quite well to work through collaboration, not by saying I am above you and tell you what to do". In the rare cases that nurses stray too far from this way of working, the volunteer coordinator reminds them: "I noticed one time that after a team meeting with all the nurses, they put their used cups and glasses on the kitchen counter, just like that. Well, to me that's just not done. That's not what volunteers are for, to clean up our mess". In that sense, the equal relationship between nurses and volunteers is part of hospice policy, not just something that emerged all by itself. In all the routines described below, a balance exists between, on the one hand, working together on the basis of equality and mutual respect, whilst, on the other hand, nurses are in charge.

6.4.2 Putting the guest central

As explained in Chapter 5, all parties in the hospice seem to agree that viewing the guest and his or her requests as central is one of the most important aspects of providing good quality care in a hospice. One of the ways in which volunteers are enabled to adequately respond to requests of guests is the pager system. All guests have a button nearby, most often it hangs on a cord from their neck, which they can push if they need something. As a result, the light on the ceiling in front of their room turns yellow, and two pagers go off. The first pager is held by the volunteers, who are thus the first ones alerted to the fact someone is calling. The second pager is held by one of the nurses, which goes off a few seconds after the first. As soon as someone – either a volunteer or a nurse – goes into the room of the guest who called, they press a button on the wall, which makes the light outside the room turn green. In that way, all other nurses and volunteers in the hospice know someone is in there. When the person leaves the room again, they press the button there once more, turning off the light.

The pager system is ingenious, first of all because it allows guests to let the people at the hospice know they need something, but also because it makes it possible to identify as a volunteer or nurse in which room your colleague is working at the moment. Even in an organization as small as De Heuvelrug, this can be very handy. Because of these two functions, the pager system plays an important role as an artifact. However, in practice, meeting requests of guests entails more than just answering calls when the pager goes off. Framed theoretically, the routine is more than just the artifact.

Ostensively, there seems to be a consensus that it is important to put the guest central in everything you do. During actual performances, however, volunteers differ in the way they actually try and meet this goal. According to one of the volunteers, volunteers as well as nurses develop a particular way of working which is also based on their personal conviction: “Do you wait for a pager to go off, or do you decide to check on someone by yourself? You know, that is a very different way of interpreting your work that might emerge”. The volunteer coordinator is clear about which option she prefers to see in volunteers: “You are here for the guest. So if you don’t have anything to do sometimes, it would be nice if you start thinking for yourself. […] Not everyone is equally good at that. There are those who start walking when a pager goes off, but otherwise just sit in the kitchen the entire afternoon. Well, in those cases we expect some more initiative”. According to the volunteer coordinator, when a volunteer consistently does not show enough initiative, this is brought up in the yearly evaluation as a point of attention for that volunteer. Although it is not considered so grave an error that someone is sent away over it, they do consider it as an important aspect of volunteering at the hospice. All things considered, however, there seems to be a difference between the way people in the hospice generally think and talk about the routine surrounding putting guests and their requests central – the ostensive aspect of the routine – and the way they actually perform the routine – the performative aspect. Although people seem to generally agree on the ostensive aspect, the performative aspect of the routine differs per volunteer. Interestingly, the artifact that helps volunteers (and nurses, but that is beside the point here) to identify when guests require something of them, is also the one that enables volunteers to be less proactive than is desired by the hospice organization. ‘Just’ answering calls is not considered enough in terms of providing quality of care.

6.4.3 Who will do it: the nurse or the volunteer?

Volunteers thus differ in the extend they proactively take on tasks or approach guests. All volunteers, however, answer when a pager goes off. As explained above, the pager system ensures that the pager held by the volunteers goes of some seconds before the one held by the nurse. In practice, this means that in first instance, a call from a guest is answered by a volunteer. At that moment, the volunteer needs to decide whether to meet the request his- or herself, or whether to call for a nurse. Although all volunteers make this decision, they all make it differently. Some boundaries are clear: providing medication is off-limits to volunteers, so are all medical-technical acts such as dressing a wound. For some guests, specific limits are put in place and communicated to volunteers in the briefing, such as ‘call me if that guest needs to go to the bathroom, don’t help them by yourself’. Still, there is a large area of activities in which volunteers need to decide for themselves whether they will meet the request of the guest themselves or call for a nurse. What decision is made, depends to a large extend on the experience of the volunteer. As one of the volunteers said in an interview: “When you gain more experience you start doing more – well, if I find a guest lying in his own poo, I’m not calling the nurse. Then you think, well.. you just do it yourself”. This volunteer had been at the hospice for over ten years, so he felt experienced enough to help a bedridden guest into new clothes in such an instance. By contrast, just starting as a volunteer myself and having no idea where to start in this particular instance, I would definitely call for a nurse. In these instances, when volunteers need to make the decision whether they do something themselves or call a nurse, strict limits combined with the rule to not do anything you do not feel capable doing is thus central to their decision. In that way, risks to the quality of care provided are minimized as much as possible.

In other cases, not the volunteer but the nurse needs to decide whether to ask a volunteer to do something independently or not. Especially in the morning, often guests are helped by volunteers with washing and dressing without a nurse being present. In these cases, the nurse needs to decide whether this is responsible or not. Usually, this happens at the end of the morning briefing. During my observations, I noticed that in some cases, nurses directly ask a volunteer whether she would like to shower a certain guest that day, and volunteers immediately agree. Sometimes, nurses ask a volunteer whether they have taken care of that guest before. After being at the hospice a couple of months, some of them asked me whether I felt comfortable yet to take care of one of the guests by myself, and I was free to say yes or no (I think I said no the first times). Nurses thus never *tell* a volunteer to do something independently, but always ask. In my experience, there is always room to refuse.

Whilst interviewing two nurses, I asked them how they decided whether to let a volunteer care for a guest herself. After all, as the one having the final responsibility, a nurse needs to be able to guarantee quality of care during her shift. Both of them emphasized the importance of knowing the volunteer. “It might be a bit obvious,” one said, “but the better you know each other, the easier things go. Because then you just know if a person is experienced in something. […] After some time you know the qualities of those volunteers”. If she asks a volunteer to care for a guest independently, she emphasizes that she always tries to brief them as much as possible about the care the specific guest requires. And of course, she adds, “mutual adjustment is very important”.

When the other nurse gave a similar answer, stating that you get to know the volunteers after a while, and then know what they can do, I asked her how *exactly* she knew. “Well, because I see what happens,” she answered. “I don’t have my eyes in my pockets. I see, I hear what is going on in the shower and sometimes you just check, and then you see. I think I have developed a sense for that. That I am able to see very clearly whether someone has got the hang of something”. In addition, she always asks whether a volunteer feels up to it. And sometimes, they say no. “Then the guest will have to wait until I myself have time to care for them”.

Summing up, several routinized mechanisms play a role in deciding whether the volunteer provides a certain care-related task themselves or whether that task is done with a nurse present or by a nurse herself. First of all, some hard limits exist concerning medicine and medical-technical acts that may solely be performed by nurses, in addition to some guest-specific limits that might be communicated in the briefing. Barring rare exceptions, these limits are upheld by all people involved. In addition, a second rule exists that is generally accepted by both nurses, volunteers and by the coordinators, which states that volunteers should refrain from doing things they do not feel capable of or comfortable doing. Nurses, when deciding whether volunteers can safely care for a guest without them being present, take all these rules in account and use both their knowledge of the qualities of a volunteer as well as mutual adjustment to make their final decision. In performing this routine, guaranteeing quality of care for the guests is the thing all people involved seem to view as the final goal.

6.4.4 Caring for a guest together

When a guest deteriorates, becomes weaker, or is in pain, often he or she is helped by two people instead of one. Most of the time, these guests are bedridden, and two people are necessary first and foremost to be able to provide care with as little fuss for the guest as possible. Because of their severe condition, these guests are never helped just by volunteers. Most of the time, a nurse and volunteer take care of the patient together. When this happens, a certain pattern is visible. First of all, the nurse is in charge. Although respondent phrase it differently, they all assert that this is the case. A volunteer: "The nurse is in charge. She has to be. In principle, I do what she asks me to do, and I anticipate the things I think will happen next". During my observations, whilst working together with a nurse in caring for a guest myself, I too noticed this dynamic. Besides being in charge, the nurse also takes the initiative, taking care of most things. The volunteer usually takes on the role of assisting the nurse. As a nurse herself explains: "I wash the patient, the guest. I wash them and I care for them. And the volunteer helps me to lift up a guest when that guest is very weak, and she helps me to put their pajama right. If I have to do all that by myself, that is very tiresome for the guest". In practice, then, the volunteer hands the nurse blankets, a bowl of water, or washcloths, and helps turn the guest around in such a way that the nurse can wash the guest. Interestingly, most of the time the nurse washes, but the volunteer dries. According to the volunteer coordinator "that is so routine to everybody here, we've been doing it like that for ages". The reason, she states, has to do with experience. Nurses, according to her, are better equipped to wash a client than a volunteer, because it requires more skill. With drying, this is less the case. Another reason exists. In an interview, one nurse states that she often takes care of washing the client herself because she feels that regardless of whether the volunteer is capable, she feels it is her task as a nurse to take initiative in such cases. A volunteer confirms this tendency, when he explains that nurses seem to feel that "they are the nurse, so if it comes to it and a dirty job needs to be done, I'd better take the initiative". This part of the routine, the division between washing and drying, is thus partly shaped because of a sense that nurses are better equipped to do it, but also out of a sense of courtesy towards the volunteers, who nurses feel should not have to deal with dirty jobs if that is not necessary. It takes place in a wider routine in which nurses are in charge of caring for a guest and volunteers assist them in doing so. It is during routines like these that volunteers are able to 'watch and learn'. This is actively encouraged by nurses and volunteers themselves, especially with new volunteers. Many times, I was encouraged to help a nurse in caring for a guest, especially if that guest required a type of care I was not familiar with yet. Nurses seem to feel they have a responsibility in these moments to teach the volunteers how things are done. One nurse, for example, states that when she cares for a guest together with a volunteer, she “constantly provides subtitles”, so that a volunteer understands what is being done and why.

Of course, each nurse and each volunteer has his or her own way of working in situations like these, so the performative aspect of a routine will differ depending on who provides the care, and also depending on the condition of the guest. However, a general template is followed that is the routine. In the end, it is the routine way in which nurses and volunteers jointly care for a guest that both ensures quality of care as well as facilitates the process of continuous learning. At the basis of this routine, interactions over the years, not artifacts, seem to play the main role.

6.4.5 Time for some tea!

Part of working together means taking a break together. At least, that is how things are done in Hospice Heuvelrug. Especially during morning and evening shifts, it is common that volunteers and nurses drink coffee together. In the morning, this takes place around ten o’clock and in the evening around eight o’clock, though the exact times vary depending on the circumstances. In the afternoon, taking a break happens less often, because nurses change shifts in the middle of the afternoon shift of the volunteers. In the mornings and evenings, however, drinking coffee or tea together has become more or less a routine, and a useful one at that. Not only is it a time in which volunteers and nurses can relax together, but it is also used to reflect on the work so far and discuss what still needs to be done. In that way, the routine of drinking tea together serves as a facilitator to important mutual adjustment. Finally, it ensures the feeling of being a team together, working from a basis of equality.

6.4.6 Conclusion: Working Together

In Hospice Heuvelrug, volunteers and nurses work together as a team. Despite nurses having the final responsibility, there is a sense of equality and mutual respect. In working together in the hospice, volunteers and nurses share the same goal, which is to meet the requests and needs of the guests as adequately as possible. Partly, this entails answering the pager when it goes off, but in the opinion of the volunteer coordinator and many nurses and volunteers, it also means that volunteers should take initiative in checking in on a guest. In practice, every volunteer handles this differently.

In terms of a division of responsibilities, nurses and volunteers have different but overlapping tasks. Although volunteers are mainly responsible for mundane tasks such as getting something to drink for a guest and welcoming their family, they also play an active role in providing care to the guests. Depending on the situation of the guest and their own experience, they might do so independently or together with a nurse. Both the nurse and the volunteer have a responsibility here, in the sense that they both need to consider whether a volunteer is up to a task or not. Finally, when a nurse and volunteer take care of a guest together, the volunteer often takes on the role of assistant to the nurse, whereas the nurse takes the initiative and provides most of the actual care.

All in all, the routines through which nurses and volunteers work together have a large effect on the quality of care provided. It is on the work floor that volunteers gain most of their experience, it is also at the work floor whilst working together that volunteers and nurses have to decide who does what – and thus who is *capable* of doing what. The mutual adjustment made possible because of the sense of equality and mutual respect present in all routines makes it possible to maintain the same goal and jointly work towards reaching it.

6.5 Organizational Membership

Besides continuous learning, responsible action and working together, a fourth facet of coordinated volunteer work in Hospice Heuvelrug can best be described as *organizational membership*. Rather than viewing volunteers as passing guests in the organization – as you sometimes hear is the case in other professional care organizations – volunteers are considered appreciated members of the organization. Nurses, the volunteer coordinator and volunteers themselves all mention the importance of 'seeing and appreciating' the volunteer. As a result, many volunteers report that they feel at home in De Heuvelrug, and would not consider leaving. In this last part of Chapter 6, the routines and mechanisms will be described that work towards creating this sense of feeling appreciated and at home. First, however, some more on the latter.

6.5.1 Feeling appreciated and at home

During my trial period, a fellow volunteer told me she worked in the hospice since the very beginning. She said that a lot of people stay at De Heuvelrug relatively long, and that if they leave, it is hardly ever because they don't like working there anymore. Rather, they leave because of a paid job that gets in the way, ill family members they need to care for or simply because they get too old and volunteering at the hospice becomes too much of a burden. The reason, according to this volunteer, was that as a volunteer in Hospice Heuvelrug, you are appreciated and taken seriously. "This is very important," she said, "because otherwise you'll never hold out".

Being 'seen' and 'appreciated' as a volunteer is mentioned many times in the hospice as being very important. The reason, according to the volunteer coordinator, is twofold. First of all, she strongly believes that if volunteers do not feel seen and appreciated, they will leave. And of course, for the continuity of the hospice it is important that volunteer turnover is limited. More importantly, however, she considers seeing and appreciating the volunteers as an inherent part of hospice philosophy: "I think it has to do with a certain attitude. With what you stand for as an organization. For our guests, we consider it very important that they feel truly seen and acknowledged by us as people with certain needs. If we do not acknowledge our own volunteers, we would be communicating something other than what we stand for. It would not match our philosophy".

As a result of this philosophy, many volunteers express that they feel truly at home in Hospice Heuvelrug. During one of my shifts, a volunteer mentioned that "it always feels like coming home, every time you get here. It's like a warm bath. I think everybody feels that way". In an interview, a volunteer compared the hospice to a family, not only because of the closeness to life and death in their work, but also because of a 'feeling of family' that was sometimes shared: "I think that sometimes we have quite a family feeling together. We are responsible together. That’s how all of us feel. It’s part of the culture. Not the nurses decide, nor the volunteers, […] no, we are responsible together for that which we stand for. […] To care for the guests to the best of our ability. To help them die with dignity”.

This feeling part of a team, of a family, expressed by so many of the volunteers, is reinforced by some distinct routines and coordinating mechanisms which focus on seeing and appreciating the volunteers. Some of these have already been mentioned, for example the way in which nurses are open to criticism and suggestions of volunteers during their work[16]. In general, the basis of equality and mutual respect present in the way volunteers and nurses work together results in volunteers feeling appreciated as part of the team. In addition, some other routines and coordinating mechanisms exist as well. These will be described below.

6.5.2 Using physical artifacts: badges

In the central corridor that connects all the rooms in the hospice, a big noticeboard hangs on one of the walls. On it are the pictures of all nurses and volunteers working that day, along with their names. Under the picture of each volunteer hangs a badge with their name on it. When a volunteer arrives for a shift, he or she takes the badge and puts it on. At the end of the shift, the badge is put back on the noticeboard. The effect of wearing these badges is that to all guests at the hospice and their visitors, it is clear that the person wearing the badge belongs to the organization. Since volunteers wear regular clothes, this is the only visible indication of this fact. At the same time, the distinction with nurses remains evident, since nurses wear a white uniform jacket typical in their profession. In that way, volunteers are shown as part of the organization, but in a distinct role.

Besides communicating to guests and visitors of the hospice that volunteers are members of the organization, it also communicates this fact to the volunteers themselves. When, after my trial period, the volunteer coordinator walked up to me and offered me a volunteer badge with my name on it, I felt strangely proud. It was like I was accepted as a regular volunteer, as part of the team. It was as if from now on, I belonged. Of course, it may be that not all volunteers experience the badges in a similar way. One volunteer, having been at the hospice since pretty much the beginning, responded to my question why she wasn’t wearing her badge that she never did, because she didn’t like them. According to her, nobody ever made a fuss that she wasn’t wearing it, so she thought it was all right. The badge might thus install different meanings to different people. However, to new volunteers such as myself it is perceived as a sign of acceptance. As an artifact of the organization, moreover, it communicates that volunteers are seen as members of the organization to both guests, visitors and to hospice personnel themselves. However, as we have seen in Chapter 3, an artifact does not make a routine but only affects and represents it. In practice, more influential routines and work practices exist, which show both an appreciation of volunteers by the organization as well as on the work floor.

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[16] See paragraph 6.4.1 (a basis for equality and mutual respect)

6.5.3 Seeing and appreciating the volunteer

As said, seeing and appreciating the volunteer is viewed as part of hospice philosophy. Not surprisingly, then, by way of standard policy, some recurrent signs of appreciation are provided for. As one volunteer sums up whilst we are drinking tea one morning: as a volunteer, you receive a card on your birthday, a chocolate letter on December 5th , and a Christmas box at the end of the year. She adds that things like these make her feel special and appreciated, and also part of the group. Signs of volunteer appreciation do not end with these types of gifts, though. In addition, every year a sort of 'volunteer party' is organized, during which nurses show their appreciation for the volunteers. Laughingly, my fellow volunteer explains that on those occasions, nurses serve the volunteers, asking them what they want to drink. To her, that always feels kind of odd.

These little signs of appreciation which occur every year are valued. But, as one volunteer explains, they are not necessarily the kind of appreciation volunteers look for: "I think it is important that you feel appreciated for what you do, and as a person. I think that is the most important thing. And that doesn't have to be in the form of presents or something. It's just nice if, at the end of a shift, the nurse says 'thank you, it went well today'. I think those are the best moments, and they contribute most to volunteers feeling appreciated". According to this volunteer, it is more the nurses that can contribute to volunteers feeling appreciated, rather than the organization. This observation rings true to some extent, I believe, but I think the distinction between the two types of appreciation might best be described as one between official hospice policy and unofficial but at the same time strongly routinized signs of appreciation on and surrounding the work floor. On the work floor, it is indeed very common for nurses to thank volunteers for their work at the end of their shift. When you arrive for a morning shift, tea is already waiting for you. At the same time, the volunteer coordinator also shows her acknowledgement and appreciation of volunteers, asking how they are doing, checking on those who are ill, sometimes thanking them if she sees them during a shift, etcetera. These signs of active interest and appreciation are inherent part of the daily routines in De Heuvelrug, and this seems to be the reason they are so effective. Volunteers enjoy receiving positive feedback, during shifts as well as during more official moments, such as the evaluation talk. It makes them feel appreciated and part of the organization, since the feedback shows their contribution matters. In addition, simply welcoming volunteers, inquiring how they are doing and saying goodbye when they leave again makes volunteers feel more welcome, more than a yearly birthday card or chocolate letter could ever do. By seeing and appreciating volunteers through all these various routines, volunteers feel appreciated and at home and as a result, remain motivated to volunteer at De Heuvelrug.

6.5.4 Conclusion: organizational membership

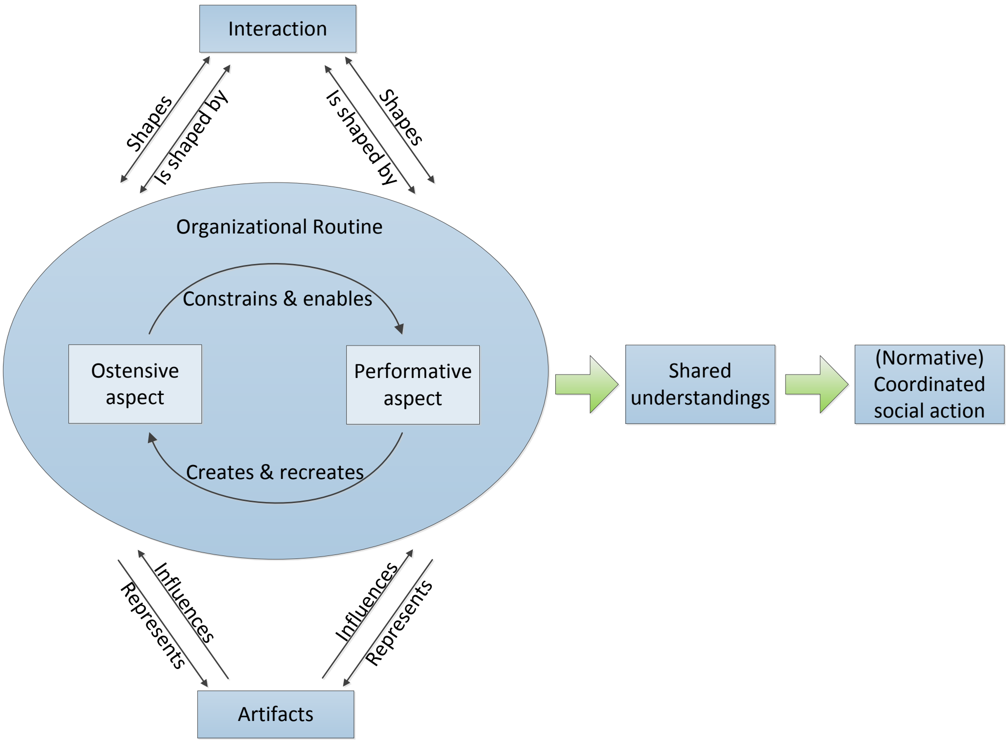
This fourth facet of coordinated volunteer work in Hospice Heuvelrug is more diffused, since it is present in all aspects of working in the hospice and therefore closely integrated with the other three facets outlined in this chapter. When volunteering in Hospice Heuvelrug, you are accepted as a full member of the organization. You are acknowledged both for your work at the hospice but also as a person. You are taken seriously when offering suggestions and appreciated for your efforts. Appreciation is shown through yearly gifts and events, but most importantly during face-to-face contact on the work floor. As a result, volunteers do not only feel appreciated but also at home in the hospice. As one volunteer, who had moved away some years ago, stated: “I could go and volunteer in another hospice more close by, that would be easier. But I don’t want to leave this place!”.

6.6 Analysis: interrelated and mutually reinforcing

Together, the four facets of coordinated volunteer work in Hospice Heuvelrug result in coordinated social action. In this paragraph, it will be examined how exactly this dynamic takes place. In doing so, the theoretical model introduced in Chapter 3 will prove useful.

As we have seen, each facet discussed above is made up of various routines and coordinating mechanisms. In practice, these are closely interrelated. An example might illustrate what this interrelation looks like. Consider the way volunteers and nurses respond to the needs of guests (paragraph 6.4.2). The pager system here serves as an attempt to standardize work processes. By notifying them when their help is required, the system takes the form of an artifact that guides the behavior of both nurses and volunteers. However, the routine surrounding the way nurses and volunteers respond to the needs of guests consists of more than just simply answering the pager when it goes off. Amongst other things, it involves both volunteers and nurses having to make a decision on whether the task on hand requires a nurse or can be performed by a volunteer; a decision that seems to be routinely based on a consideration of the extent to which the volunteer feels able and comfortable conducting a task and on mutual adjustment with this informal rule in mind. What is more, both volunteers and nurses check on guests regularly, even when the pager does not go off. Although some volunteers do so more often than others (the performative aspect of the routine varies), it is still considered important by most (they agree on the ostensive aspect). The pager system, then, is an artifact that usefully structures the routine of responding to needs of guests, but does not constitute the entire routine. Rather, the routine forms a generative system that produces repetitive, recognizable patterns of interdependent action by volunteers and nurses; a generative system in which multiple coordinating mechanisms – the pager system, but also informal rules and mutual adjustment, all play a role but which cannot be captured by those mechanisms alone.

In effect, the relation between routines and coordinating mechanisms in Hospice Heuvelrug can be captured by the theoretical model of Chapter 3 (see next page). As interactions or as artifacts, various coordinating mechanisms influence routines and vice versa. The routines that are the result, then, have led to shared understandings about how to act in certain circumstances and why. Volunteers in Hospice Heuvelrug know what is expected of them; they know when to show up, what general tasks need to be performed during their shift and how to act in response to the requests communicated by guests. Extensive experience with taking part in the routines that surround these acts have led them to acquire these shared understandings. It is through these shared understandings, then, that coordinated social action is achieved.



The relation between routines, artifacts, interactions and coordinated social action

Theoretical model

Above, the various routines and coordinating mechanisms were presented as belonging to either one of four facets of coordinated volunteer work in Hospice Heuvelrug. In their descriptions, however, it already became apparent that through these routines, the four facets are interrelated and mutually reinforcing. When nurses provide feedback, for example, this not only encourages continuous learning, but it also plays an integral part in the way nurses and volunteers work together and it communicates to volunteers what is expected of them and that their work is appreciated. In one routine, therefore, all four facets of coordinated volunteer work might be present. Through interactions between the participants of the routine, and aided by the artifacts put in place by the organization, all routines present in Hospice Heuvelrug and identified in this chapter continually reinforce these four facets, leading to coordinated social action that is stable and which is based on widely shared understandings about how to act and why.

6.7 Conclusion

In this chapter, the empirical findings of this study were described and interpreted. In Hospice Heuvelrug, four facets of coordinated volunteer work were identified. Continuous learning, responsible action, working together and organizational membership all play central roles when it comes to the coordination of volunteers in Hospice Heuvelrug. They each consist of various more specific routines, which are sometimes influenced by artifacts but many times emerge through interaction between the organizational members involved. All four facets are integral parts of day-to-day practices in the hospice and have been routinized to a large extent. Through the process of continuous learning, volunteers are provided with the skills and knowledge required for them to provide good quality care. Because of the routines that stimulate responsible action, volunteers know what is expected of them, which results in continuity of care and the prevention of errors due to lack of experience. Whilst working together with nurses, the basis of equality and mutual respect results in various routines of mutual adjustment that allow volunteers and nurses to maintain the same goal of providing good quality care and to jointly work towards reaching this goal. Finally, organizational membership leads to volunteers feeling appreciated and at home in De Heuvelrug, encouraging them to remain volunteering at the hospice for longer periods of time and ensuring a good team spirit. Both the continuity as well as the quality of care as thus encouraged.

The theoretical model presented in Chapter 3 was shown to adequately depict the way in which the routines and coordinating mechanisms (artifacts and interactions) interact and together form the four facets of coordinated volunteer work in Hospice Heuvelrug. By studying this model, then, it becomes clear that through interactions between the participants of the routine, and aided by the artifacts put in place by the organization, all routines present in Hospice Heuvelrug and identified in this chapter continually reinforce these four facets, leading to coordinated social action that is stable and which is based on widely shared understandings about how to act and why.

In the descriptions of the four facets in this chapter, and the analysis of the findings according to the theoretical model, it became clear how, in Hospice Heuvelrug, coordinated volunteer work comes about. However, although connections have been made between this coordination and supposedly positive effects on quality of care, this relation has not been described to satisfaction. In Chapter 7, then, a more thorough interpretation of the findings will be given, focusing specifically on why and how the four facts of coordinated volunteer work in Hospice Heuvelrug positively affect the quality of care provided. As we shall see, in doing so we will have to go beyond the original theoretical model and expand it so as to capture the various unique aspects present in Hospice Heuvelrug.

Chapter 7: Conclusions and Interpretations

7.1 Introduction

This study tries to examine which means of coordination professional care organizations might use to ensure the quality of care given by volunteers. As we have seen, Hospice Heuvelrug has organized their coordination in such a way that volunteers effectively contribute to high quality care. By studying this organization, therefore, useful insights are provided that point towards an answer to the main research question. Before moving towards the thesis's main conclusion, however, first we need to take a step back.

In the introduction to this thesis, the study has been divided into four distinct parts. The first part, which can be found in Chapter 2, describes the changes in the Dutch welfare state which might contribute to a heavier reliance on volunteers in the future as well as corresponding possible effects on volunteers and quality of care. In the second part, Chapter 3, a theoretical model was conceived through which the process of coordination might be better understood. In turn, the third and main part of the study is described in Chapters 5 and 6, and consists of a case study of an organization in which the use of volunteers and the provision of high quality care go hand in hand. In Chapter 4, the research design and methods underlying this study were outlined.

In this chapter, first the answers to the sub-questions of these first three parts of the study will be provided. Building on these answers, in paragraph 7.5 an answer to the main research question will be formulated. Finally, the final part of this study, which consists of two sub-questions on the implications of this study, will be answered in paragraph 7.6. At the end of the chapter, the thesis will finish with some concluding remarks.

At the start of this thesis, I spoke of a challenge to professional care organizations that might arise in the future. Changes in the welfare state might lead to a heavier reliance on volunteers, whereas demands for quality of care will remain high. By examining how the work of volunteers might be coordinated in such a way that they contribute, not endanger, quality of care, this study aims to help professional care organizations meet this challenge. Here, all elements of the study are brought together.

7.2 Answering research sub-questions: part 1

In order to provide a background against which the main research question becomes relevant, part 1 of this study, covered in Chapter 2, describes the changes in the welfare state which contribute to a heavier reliance on volunteers in the care and welfare sector. In addition, it explains the consequences of these changes for volunteers and for quality of care. Together, an answer is thus provided to the first three sub-questions (see paragraph 1.2).

In 2013, the Dutch government announced a change from the traditional welfare state into a participation society. In fact, by then the change had been going on for years. The societalization of care – organizing care as close to the citizen as possible – as well as increasing expenditures for long-term care throughout the years resulted in a stepwise dismantling of the AWBZ, starting with the introduction of the Wmo in 2007. In 2015, a new downsized version of the AWBZ will be introduced, through which only the heaviest types of care will be insured. Most other types of care will be transferred to a new extended Wmo. In the Wmo, however, care is not considered a *right*, as it used to be under the AWBZ. Rather, municipalities receive a certain budget to ensure as much citizen participation in society as possible by taking away any barriers. Citizens are encouraged to become more responsible for their own welfare and others. The importance of volunteers is mentioned specifically as a point of attention.

Behind these changes in laws lies a new idea of what it means to be a citizen. Rather than viewing citizenship as being about rights, it is now conceptualized as being about duties. According to this conception of *active citizenship*, the welfare state should provide citizens with autonomy from government and encourage them to participate in society as much as possible. Adoption of this notion of citizenship might occur because of an idea of *communitarianism*, in which the importance of family and community is emphasized, or because of an idea of *neo-liberalism*, in which active citizenship is valued as a means to decrease government influence in society. Depending on which philosophy is behind active citizenship, the consequences for volunteers might differ. If, as communitarians believe, citizen activation occurs to accommodate a previously existing need in the community, volunteers might become more empowered. If, on the other hand, citizen activation is just used instrumentally, as free replacements where paid care disappeared or will disappear, the intrinsic motivation of volunteers might decrease.

Finally, a heavier reliance on volunteers due to citizen activation might have both negative as well as positive consequences for the quality of care provided. On the one hand, a heavy reliance on volunteers entails on average less qualified personnel caring for patients. Volunteers, after all, are not trained professionals. As a result, both the effectiveness of knowledge-based care and that of interpersonal care are at risk. If one or both are affected, quality of care will decrease. In addition, because of the voluntary character of volunteer work and the lack of commitment volunteers often have to their organization, they might leave at will, leading to high volunteer turnover. Here, another aspect of quality of care, its continuity, is at risk. On the other hand, a heavier reliance on volunteers might have positive consequences for quality of care as well. In the absence of extrinsic rewards – volunteers are not paid for their work – they are almost surely intrinsically motivated to help vulnerable clients. This might result in more attentive care. For professional care organizations wanting to work with volunteers and guarantee quality of care, coordination will have to focus on minimizing the above three negative consequences, whilst using the opportunities offered by volunteers' high intrinsic motivation. If they succeed in doing that, a heavier reliance on volunteers and providing quality of care will be able to go hand in hand.

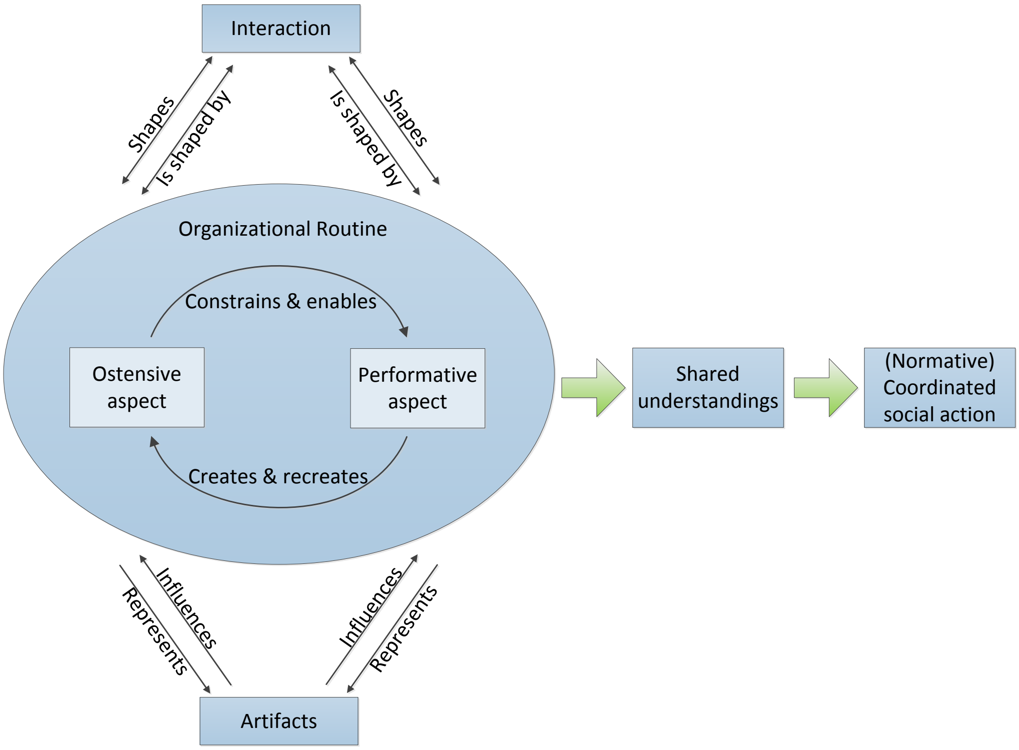
7.3 Answering research sub-questions: part 2

Chapter 3 forms the theoretical core of this study and focuses on answering the three theoretical sub-questions belonging to part 2 of this study. First, the various types of coordination are described which, from a theoretical perspective, might be used by organizations to influence the behavior of their employees. Based on the work of Mintzberg, several coordinating mechanisms are discussed. First of all, organizations might coordinate their work through the standardization of input, output or work processes. Standardization of input mainly focuses on the internalization by employees of standard skills and knowledge, whereas standardization of work processes has to do with the imposition of standards that guide the work process itself. Standardization of output, then, involves the use of standard performance measures and other types of output control. A second type of coordinating mechanisms concerns those that occur through face-to-face contact. Mutual adjustment, in which organizational members informally communicate about their work, and direct supervision, in which a supervisor directly tells an employee what to do, fall under this type of coordinating mechanism. Finally, normative control aims to create shared norms and values held by organizational members, which in turn leads to coordinated behavior.

Although Mintzberg's mechanisms give a good overview of the types of coordinating mechanisms that are possible, these coordinating mechanisms do not automatically lead to coordination. In order for a coordinating mechanism to be effective, it has to be translated into daily patterns of action on the work floor. These patterns are referred to in the literature as *routines*, and defined as 'generative systems that produce repetitive, recognizable patterns of interdependent action carried out by multiple participants'. Routines have both ostensive as well as performative aspects, where the former refers to the routine as an abstract idea, and the second to the specific actions by specific people at specific times and places that make up the routine in practice. Routines lead to coordination by providing the connections between people that lead to shared understandings about what to do in particular circumstances and why certain actions are (in)appropriate. These shared understandings, in turn, lead to coordinated social action.

Mintzberg's initial five coordinating mechanisms are not part of actual work routines, but do influence them. His three types of standardization, first of all, influence routines as *artifacts*, which may be defined as 'physical manifestations of the routine'. Examples are standard operating procedures or checklists. As forms of *interaction*, mutual adjustment and direct supervision have a similar relation to work routines: they shape them, and in turn are shaped by them. Normative control, finally, is not so much a coordinating mechanism by itself but rather a certain type of coordination that might be the result of routinized work patterns when these are infused with certain values and norms.

Based on all these theoretical considerations, the following theoretical model has been conceptualized, outlining the main concepts and their interrelation. As a model, it was used not only to structure the findings but also to provide a better answer to the main research question (see paragraph 7.3).



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7.4 Answering research sub-questions: part 3

In Chapters 5 and 6, Hospice Heuvelrug was introduced. As a high-care hospice, De Heuvelrug is recognized as a provider of good quality care. At the same time, over eighty volunteers are present in the organization, of which around sixty are so-called care-volunteers. These volunteers take part in care provision to the hospice's vulnerable clients, alongside professional nurses. Without the commitment of these volunteers, the hospice would not be able to function. It was in this hospice that participant observation and interviews were used to formulate an answer to the three empirical research sub-questions of this study.

The first two questions aim to identify which coordinating mechanisms and routines contribute to quality of care in Hospice Heuvelrug. As became apparent in Chapter 6, coordinating mechanisms and routines in Hospice Heuvelrug turn out to be closely interrelated and are not always separable empirically. For that reason, the first two empirical sub-questions will be answered together. Subsequently, the answer to the third question will be provided.

7.4.1 Routines and coordinating mechanisms in Hospice Heuvelrug

During participant observation and interviews, various coordinating mechanisms and routines were discerned which contribute to the effective organization of volunteers in Hospice Heuvelrug in terms of the quality of care they provide. Roughly speaking, these coordinating mechanisms and routines form four facets of coordinated volunteer work which contribute to volunteers providing good quality care.

The first facet concerns a process of *continuous learning*. Various routines, both when a new volunteer first enters the organization as well as over the years and during shifts, contribute to the continuous updating of the knowledge and skills of volunteers. Much knowledge is gained by experience, by watching and learning while taking part in shifts. In addition, a trial period (along with a leaflet that serves as a useful artifact) and introductory course are supplied to all new volunteers, and extra training as well as regular peer groups are offered. Finally, briefings which are held at the beginning of every shift ensure that volunteers have relevant information about the current situation and needs of guests in the hospice.

The second facet focuses on *responsible action.* Although volunteering is inherently voluntary, in Hospice Heuvelrug it is not without responsibilities. Volunteers are expected to show up for the shifts they agreed to take part in, although there is a lot of flexibility in terms of which shifts they would like to sign up for. What is more, their qualitative contribution to the organization is also expected to be up to par. To ensure this is the case, yearly evaluation talks take place and feedback is often given by nurses during shifts. Finally, although much is expected of volunteers, their main responsibility lies in being clear about those things they feel they cannot be responsible for. As a general rule, volunteers are expected to say so when they feel they are not capable of doing something, and to actually refrain from doing it if they feel that is the case.

The third facet of coordinated volunteer work in De Heuvelrug has to do with *working together*. Although nurses have final responsibility, they work together with volunteers on the basis of equality and mutual respect. Through routinized forms of mutual adjustment and assisted by artifacts such as the pager system, they decide together who takes care of requests made by guests. Depending on their experience, some volunteers provide care independently, whereas in some cases a guest is cared for by a nurse and volunteer together. At all times, volunteers and nurses have the same shared goal: to put the guests and their requests central and to meet those requests as well as possible.

Finally, the fourth facet of coordinated work focuses on *organizational membership*. Volunteers in Hospice Heuvelrug are considered an inherent and important part of the organization, and are treated as such. Through signs of appreciation, both official ones such as birthday cards and chocolate letters on 5 December as well as more informal ones such as a thank-you at the end of a shift or positive feedback, volunteers are made to feel at home in the hospice. To guests and visitors of the hospice, organizational membership of volunteers is communicated through the badges they all wear. As artifacts, these badges tell everyone that volunteers are recognized by the hospice itself as part of the organization and awarded a specific role. As a result of this facet, many volunteers stay in the organization for years, feeling at home there and not even thinking about leaving.

Together, these four facets, comprised of all these routines which in turn are influenced by coordinating mechanisms, lead to coordinated social behavior and eventually have a positive effect on quality of care. How, exactly, is part of the answer to the third empirical sub-question.

7.4.2 From coordinated volunteer work to quality of care

Identifying which facets of coordinated volunteer work contribute to the quality of care provided by volunteers in Hospice Heuvelrug is not enough to make the empirical case study relevant to answering the main research question. Instead, it is important to ask a follow-up question: *how and why* do the coordinating mechanisms and routines belonging to these four facets contribute to the quality of care provided? The answer to this question consists of many layers.

First of all, the content of the four facets of coordinated volunteer work in Hospice Heuvelrug has a large influence on their positive effect on quality of care. Through the processes of continuous learning, volunteers are provided with the knowledge and skills required to provide the care that is requested of them. Combined with the informal rule to refrain from doing any tasks you do not feel comfortable doing, this facet of coordinated volunteer work ensures that a heavy reliance on volunteers, who are less qualified than nurses, does not lead to less quality of care. At the same time, organizational membership ensures that volunteers feel appreciated and at home and thus tend to remain volunteering at Hospice Heuvelrug for long periods of time. In combination with clear communication about shared responsibilities, this has led to continuity of care being largely guaranteed. Finally, through signs of appreciation, treating volunteers as equals, and providing opportunities to learn more about caring for terminally ill patients, the four facets actively contribute to volunteers remaining motivated for their work and thus encourage them to remain trying to provide care to the best of their abilities. Through nurturing this inherent motivation of volunteers, the four facets of coordinated volunteer work in Hospice Heuvelrug result in coordinated behavior that positively affects quality of care.

Were it not for the routine character of the four facets, however, this positive effect would disappear. In Hospice Heuvelrug, those coordinating mechanisms serving as artifacts are not just hollow words or formal operating procedures. Rather, they are an inherent part of daily routines. The briefing at the beginning of each shift is an example, as is the pager system. Similarly, interactions – most notably mutual adjustment – do not occur on an ad-hoc basis but have become routinized to a large extent. If these coordinating mechanisms had not been translated into actual routines on the work floor, it seems unlikely not only that they would positively affect quality of care, but even that coordinated social action would emerge. Coordinating mechanisms thus contribute to quality of care in Hospice Heuvelrug *because they have become routinized*. Moreover, because many of the resulting routines consist of elements of more than one facet of coordinated volunteer work, the four facets have become interrelated and mutually reinforcing. The coordinated social action that is the result is therefore even more stable than might otherwise be the case, which enhances the positive effect of the four facets on quality of care.

How, then, did coordinating mechanisms in Hospice Heuvelrug become routinized? And why does the resulting coordination positively affect quality of care? This mainly has to do with the importance all actors involved themselves seem to give to the coordinating mechanisms installed by the organization, as well as to the routines that have emerged through time. In interviews and while talking to volunteers and nurses during my own shifts at the Hospice, it became apparent that all people I spoke to share the same goal: to increase the quality of life and death of guests in the hospice by meeting their requests and those of their family as well as possible. This idea of selfless service and a focus on the guests and their needs is so central and widely shared between all actors involved, that coordinating mechanisms based on the same values have become accepted as important parts of the daily routines. Other coordinating mechanisms and routines embody different values – such as the idea that volunteer appreciation is important, that nurses have final responsibility but you work together on a basis of equality and mutual respect, that you should not have to perform a task you are not ready for; these values, too, are widely shared, and because of that, the coordinating mechanisms and routines embodying them are upheld.

Summing up, coordinating mechanisms and routines which contribute to quality of care in Hospice Heuvelrug do so, first of all because of their content. Together, the four facets ensure that a heavy reliance on volunteers does not result in negative consequences for quality of care. By stimulating and nurturing volunteers' inherent motivation, they even contribute to quality of care. The four facets of coordinated volunteer work are only able to do so, however, because of their routinized character and because they mutually reinforce each other. This routinization, finally, has become possible because both volunteers and other actors in the hospice believe in the values and norms on which the coordinating mechanisms and routines are based. It is for this reason, that coordinating mechanisms and routines, of which the content positively affects quality of care, are upheld.

7.4.3 Preconditions

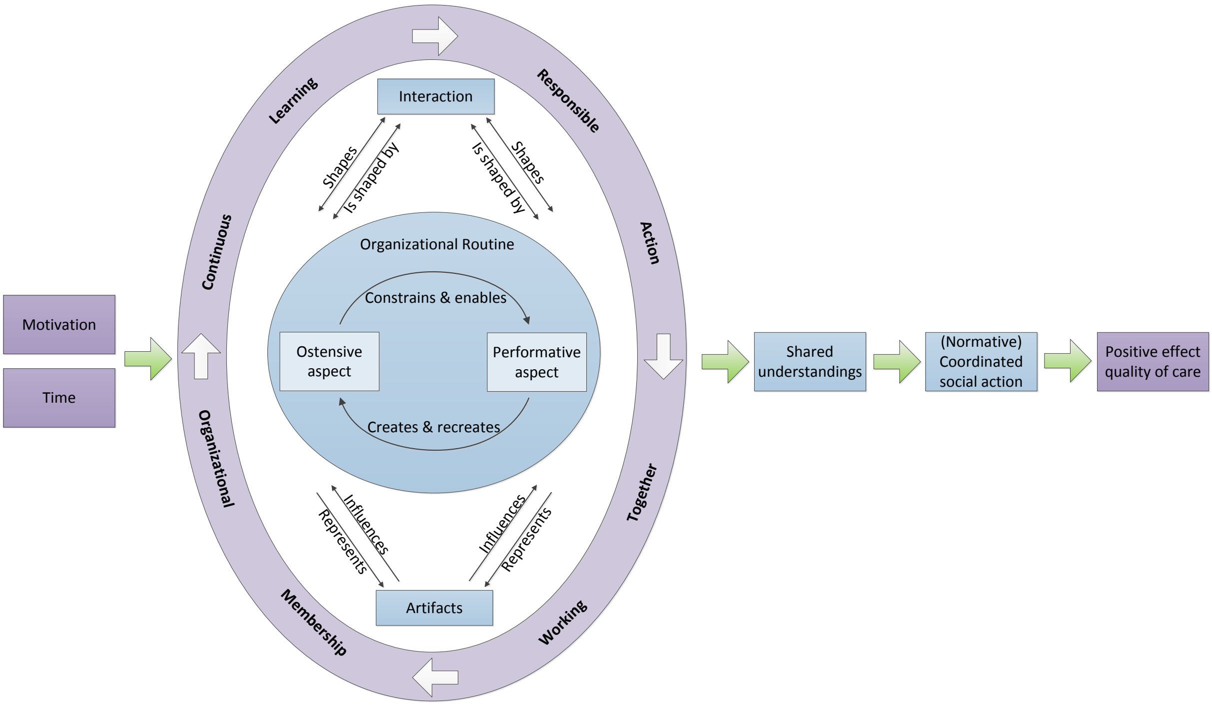
So far, we have focused on the coordinating mechanisms and routines within the organization which contribute to quality of care. During participant observation and interviews, however, it became apparent that the way volunteers are coordinated in Hospice Heuvelrug is only possible because of two preconditions that have been met.

First of all, to be able to meet the requests of guests as well as possible, to provide good quality care, both nurses and volunteers need to feel they have enough time to do so. In Hospice Heuvelrug, this is the case. There is enough personnel, especially with the volunteers being present as well, to take your time in caring for each guest, not having to rush to be able to finish all tasks on time. It is hard work, sometimes, but there is no sense of stress caused by, for example, a lack of personnel available. If this were the case, one could imagine that parts of the facets of coordinated volunteer work which contribute to quality of care could not be maintained. For example, it would be very difficult, as a volunteer, to refrain from doing a task because one feels not yet fully capable of doing it in an environment in which all personnel is working their tails off to finish all tasks on time. Similarly, in such a stressful environment, nurses might refrain from giving feedback or ‘subtitles’ to volunteers, simply because the time is not there. Moreover, official coordinating activities at the hospice take so much time that a special volunteer coordinator is hired, who is responsible for making the schedules, holding evaluation talks and volunteer schooling, amongst many other things. Eliminating this job, too, would entail increasing work pressure for those that remained and probably result in less routine and thus less effective coordinating mechanisms. Time, therefore, is an important precondition for Hospice Heuvelrug to be able to coordinate volunteers the way they do.

A second precondition to the facets of coordinated volunteer work being possible, is the high intrinsic motivation of all organizational members present in the hospice. All organizational members constantly turn their efforts towards meeting requests of guests and their family, sincerely caring for their well-being and trying to contribute to that well-being as much as possible. This is so common an attitude, that according to one of the volunteers, if on a very rare occasion someone exhibits behavior not inhibiting this attitude, he immediately notices it because it feels so out of place. This intrinsic motivation, which is seemingly shared by all members of the organization and which is also used as a criterion in the selection of both volunteers as well as paid personnel, heavily influences the success of the four facets of coordinated volunteer work, which in turn contribute to quality of care provided. For example, if nurses lacked such motivation, they would not see reason to do more than strictly necessary, refraining from giving feedback to volunteers and from being a good example from whom volunteers could learn a lot. At the same time, if volunteers would not be intrinsically motivated to care for the guests, they would just sit and drink tea in the kitchen for the entire shift, catching up with each other but not doing anything substantive. In the end, they would most probably leave the hospice. As stated before, this intrinsic motivation is stimulated and nurtured by the organization, but if there were no intrinsic motivation to begin with, the routines that make up the four facets of coordinated volunteer work would not have emerged.

7.4.4 Coordinating volunteers to ensure quality of care: a model

In the empirical part of this study, it was examined which routines and coordinating mechanisms contribute to quality of care in Hospice Heuvelrug, and how and why they do so. As we have seen, the relation between coordinating mechanisms (artifacts and interactions) and routines, and between routines and coordination, turned out to work similar to the relation depicted in the theoretical model presented in Chapter 3. To depict the mechanisms at work in Hospice Heuvelrug, however, the theoretical model needs to be expanded. Based on the answers to the three empirical research sub-questions presented in this paragraph, the following model can be created:



Realizing quality of care through four facets of coordinated volunteer work in Hospice Heuvelrug

In the middle, the original theoretical model can be found in blue. All additions specific to Hospice Heuvelrug have been added in purple. Both the four facets (sub-questions 7 and 8), the preconditions, and the positive effect on quality of care (sub-question 9) have been added. By depicting the four facets as a circle with arrows around the dynamic of routines, artifacts, and interactions, the interrelatedness and mutual reinforcement of the four facets and the routines that belong to them is reflected. Motivation and time are added as preconditions, and a positive effect on quality of care as the eventual end-result. In the next paragraph, it will be shown what the consequences of these findings are for the way in which professional care organizations, in general, might coordinate their volunteers in such a way that quality of care is ensured.

7.5 Answering the main research question

The core aim of this study has been to answer the main research question posed in the introductory chapter of this thesis. Because of changes in the welfare state and a probable heavier reliance on volunteers in the care- and welfare sector in the future, quality of care might become under pressure. Professional care organizations who wish to start working with volunteers in the providing of care next to their professional staff need to work out how they might coordinate these volunteers in such a way that quality of care is ensured. To identify the conditions under which volunteers might successfully be used in the provision of care in professional care organizations, the study has asked itself the following question:

> *Which means of coordination might professional care organizations use to ensure the quality of care given by volunteers?*

7.5.1 Consequences for quality of care

To find out which means of coordination professional care organizations might use to ensure the quality of care given by volunteers, it is important to first identify which problems for quality of care might occur due to a heavier reliance on volunteers. As this thesis has shown, the risks to quality of care are threefold. A heavier reliance on volunteers in professional care organizations might, first of all, contain a risk in terms of the continuity of care. Because their contributions are voluntary and individualization has resulted in decreasing organizational loyalty, volunteers might decide to stop volunteering at any moment. Volunteer turnover might thus be high, which contains a risk to especially relational continuity. Secondly, a heavier reliance on volunteers entails a risk to the effectiveness of the provision of knowledge-based care. Volunteers are not professionals and do not possess the knowledge and skills to perform many of the tasks required in the provision of care. If they perform these tasks nonetheless, quality of care becomes at risk. Finally, a similar albeit less certain risk exists to the effectiveness of the provision of interpersonal care. Although some people might possess the right attitudes for interpersonal care without professional training, assuming all volunteers possess these attitudes creates a danger to the quality of care delivered. Besides these risks, an important opportunity of a heavier reliance on volunteers is their intrinsic motivation, which ensures that, in principle, they make an effort to provide good quality care.

The first conclusion of this thesis, then, is that for professional care organizations to ensure the quality of care provided by volunteers, they should at least focus on limiting the risks that come with a heavier reliance on volunteers, both to continuity of care as well as to the effective provision of knowledge-based and interpersonal care. At the same time, they should nurture and stimulate the intrinsic motivation of volunteers, to not lose the opportunity this motivation provides for increasing the quality of care.

7.5.2 What to focus on in the coordination of volunteers

In Hospice Heuvelrug, the risks to quality of care that come with a heavy reliance on volunteers are effectively minimized and the opportunities seized, through the way volunteers are coordinated. This coordination, then, exists of four facets of coordinated volunteer work. Without going into their specifics[17], here it will be shown how continuous learning, responsible action, working together, and organizational membership might contribute to ensuring quality of care provided.

Continuous learning

One of the risks of a heavy reliance on volunteers is their lack of knowledge and skills compared to professional nurses. One way in which to minimize this risk to quality of care is through a continuous learning process. By offering training when volunteers enter the organization, in the form of an introductory course and trial period, volunteers all start their time in the organization with a similar basic level of knowledge. Over the years, extra training and peer groups allow volunteers to increase this knowledge and exchange experiences. By instructing volunteers at the start of each shift about the current condition and needs of clients, moreover, briefings ensure that volunteers possess relevant and up to date practical information they need to provide good quality of care. Most important, however, is that volunteers, apart from these official moments, are given the opportunity and time to learn by watching nurses and more experienced volunteers at work and to steadily gain the experience required for providing good quality of care.

Responsible action

Although volunteering is, of course, voluntary, this study shows that it pays to communicate clearly to volunteers their responsibilities. By clearly defining times for shifts and making schedules which volunteers take part in which shifts based on volunteers' own input, volunteers know what is expected of them. In terms of quality of their work, too, it pays to give honest feedback and tips on how to improve. Especially when feedback concerns the way care is provided, this might benefit quality of care. These types of feedback might come from the organization in yearly scheduled evaluation talks, but their effectiveness seems largest if given by experienced nurses or other volunteers during shifts themselves. In that way, volunteers can immediately start applying their newly learned knowledge in practice. Finally, part of responsible action entails that volunteers should refrain from doing tasks they are not capable of or comfortable with. To ensure quality of care, it is essential that professional care organizations communicate this rule, both in words as well as in deeds. After all, it is when volunteers start doing things they are not capable of or aren't even allowed to in terms of care provision, that quality of care can no longer be guaranteed.

Working together

To ensure quality of care, it is important that volunteers do not work separately, but together with and next to professional nursing staff. First and foremost, this ensures that, if needed, nurses possessing professional knowledge and skills for caregiving are present. Second, the alignment and division of tasks between nurses and volunteers ensures that all tasks that need to be performed are in fact

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[17] For specific descriptions of coordinating mechanisms and routines belonging to the four facets of coordinated volunteer work in Hospice Heuvelrug, please consult Chapter 6 and/or paragraph 7.4 of this chapter.

performed and clients are not bothered by either volunteers or nurses unnecessarily. It is important, furthermore, that in working together, nurses always retain final responsibility. Through mutual adjustment with volunteers, and depending on that volunteers' experience, they need to be the ones to decide whether a volunteer can independently care for a client or whether the help or presence of a nurse is required. Finally, it is important for nurses and volunteers to work on a basis of mutual respect and understanding, in order for volunteers' intrinsic motivation to not be impaired and to create a team atmosphere that is perceived as positive by both employees (including volunteers) and clients.

Organizational membership

By considering and treating volunteers as part of the organization and showing appreciation for their work, volunteers remain motivated to stay and provide care in the organization for longer periods of time. It is important that this attitude towards volunteers is not only taken by organizational management, but also and especially by the nurses with whom volunteers work daily and from whom they learn a lot about providing quality of care to clients. Nurses can communicate their appreciation of volunteers by thanking them after shifts, providing positive feedback after taking care of a client together, etcetera. Management, in turn, can organize yearly parties in honor of the volunteers, and provide small signs of appreciation in the form of birthday cards or gifts to volunteers who work during Christmas. Finally, providing volunteers with badges of the organization with their name on it communicates to clients and visitors what their role is, reinforcing their organizational membership. Not only does organizational membership thus ensure that volunteers remain motivated, it also binds them to the organization, ensuring continuity of care by decreasing volunteer turnover.

7.5.3 Without routinization, coordination will fail

If professional care organizations want to coordinate their volunteers in such a way that quality of care is ensured, they can thus try to implement the four facets of coordinated volunteer work described above. Through these facets, the risks of a heavier reliance on volunteers are minimized and the opportunities for quality of care caused by volunteers' intrinsic motivation are seized. However, for these effects on quality of care to ensue, and thus for quality of care to be ensured, coordinating mechanisms brought into the organization by management need to be translated into actual routine work practices by the actors – volunteers, nurses, management – involved. Only then will the four facets of coordinated volunteer work lead to actual stable coordinated action by volunteers and, thus indirectly, to quality of care. Empty policies that have no bearing at all on daily practice remain just that: empty policies. Think of volunteer badges that are actually never worn, or are not offered to new volunteers; think of official documents outlining how volunteers and nurses should work together, but really nobody ever reads or follows them; and think of the existence of a rule that volunteers do not perform tasks they feel not capable of doing, but in reality rejecting to perform a task is not accepted by fellow volunteers or nurses. In all these cases, coordinating mechanisms have not become routinized and neither coordination nor quality of care will ensue. Similarly, ad-hoc mutual adjustment every now and then between volunteers and nurses, albeit it might result in temporary coordination and good quality care right then and there, can hardly be expected to result in good quality care on a stable basis, without that mutual adjustment becoming a routine part of daily practices. Another conclusion that can be made based on this thesis, then, is that for professional care organizations to ensure good quality of care provided by volunteers, it does not suffice to 'just' implement coordinating mechanisms which embody one or more of the four facets of coordinated volunteer work described above. Rather, the challenge is to make sure these coordinating mechanisms are translated into actual patterns of action on the work floor – to make sure, in other words, that they become part of *routines*.

7.5.4 Routinization through normative control

Unfortunately, it is not possible, based on a case study, to formulate a universal way in which professional care organizations can make sure this translation from coordinating mechanisms to routines actually occurs. For all we know, more than one way may exist. In Hospice Heuvelrug, however, routinization has been acquired because of the commitment of all members of the organization – volunteers, nurses, coordinators and other staff – to the values and norms behind the coordinating mechanisms and emerging routines. Most importantly, all members of the organization share the same goal: to provide quality of life and death to hospice guests as much as possible by meeting their requests and needs as well as possible. Similarly, all people I spoke to about the subject told me volunteer appreciation is very important; the same goes for the informal rule that volunteers refrain from doing things they do not feel capable or comfortable doing. It is because of this commitment that members of the organization have, over time, incorporated artifacts and interactions based on these norms and values in their daily routines. The commitment to these shared values and norms is partly caused by organizational members already being motivated and sharing these values and norms when they enter the organization, but also because their commitment is fostered through the coordinating mechanisms and routines in the organization itself. By looking closely at the four facets of coordinated volunteer work in Hospice Heuvelrug and to the routines and coordinating mechanisms of which they consist, many similarities can be identified with the model of normative control Mintzberg describes.

First of all, in the normative control model, *selection* takes place by looking at people's values and attitudes rather than just to their credentials. In Hospice Heuvelrug, this is the case both for volunteers as well as paid personnel. A shared intrinsic motivation for providing quality of care and shared attitudes and values are thus ensured. Secondly, members of the organization, including volunteers, are indeed *socialized* into an integrated social system. This is what the facet of organizational membership refers to, and which also comes back in for example the way nurses and volunteers jointly work towards the same common goal. *Guidance*, similar to that in the normative control model, at least partly occurs through accepted principles. Examples are the informal rule, or principle, that volunteers themselves are responsible for indicating they do not feel up to a task and to then refrain from doing it, and the accepted principle that when nurses and volunteers care for a guest together, the nurse takes the initiative. *Responsibility*, as present in the facet responsible action but also in that of working together, is indeed shared between organizational members, including volunteers. Through watching and learning, moreover, the experience of nurses is recognized as an important source for guidance. Finally, the fifth element of normative coordination, *judgment* by experienced people, is also present, albeit not by representative oversight boards nor by recipients of the service. Volunteers are evaluated, after all, by the volunteer coordinator – who is also active as a nurse in the hospice – and by using the feedback of experienced nurses who worked with the volunteer before.

Routinization of coordinating mechanisms can thus be acquired, first of all, by ensuring that people entering the organization (volunteers but also paid personnel) share the values and norms believed by the organization to contribute to good quality of care (an element ensured by the aspect of *selection*). Second of all, for routinization of coordinating mechanisms to occur, these coordinating mechanisms should reflect and reinforce these same values and norms so that members of the organization will accept them and apply them in their daily routines. The four facets of coordinated volunteer work in Hospice Heuvelrug contribute to quality of care because these two requirements are met. For other professional care organizations to ensure a similar level of quality of care, then, they should not only look at the content of the four facets identified in this thesis, but also to these two requirements for their routinization: the existence of a shared basis of norms, values, and attitudes for providing good quality care, and the reflection and reinforcement of these norms and values in the coordinating mechanisms and routines present in the organization.

7.5.5 Conclusion

Using Flyvbjerg's logic of the 'power of example', a professional care organization was chosen in which the provision of high quality care and a heavy reliance on volunteers go hand in hand. Through an extensive case study, which made use of participant observation, interviews and document analysis, four facets of coordinated volunteer work were identified in Hospice Heuvelrug. Continuous learning, responsible action, working together and organizational membership were all found to play central roles in the coordination of volunteers and in ensuring that volunteers, in effect, provide good quality of care. For professional care organizations to ensure quality of care provided by volunteers, then, these four facets of coordinated volunteer work offer one alternative of how this might be achieved. Essential to these four facets being able to do so, however, is that the coordinating mechanisms (artifacts and interactions) belonging to them are routinized into the daily routines of members of the organization, including volunteers. For this to occur, people entering the organization as volunteers, nurses or in coordinating roles need to share the values and norms held by the organization on the subject of good quality care, and coordinating mechanisms (and existing routines, if any) need to be based on these very same values and norms.

Of course, as the main research question already suggests, the type of coordination suggested here is only one way professional care organizations might coordinate their volunteers if they want to ensure good quality of care. However, according to Mintzberg (1996, p. 82), it is a very desirable way to organize a professional care organization: “An organization without [normative] commitment is like a person without a soul: Skeleton, flesh, and blood may be able to consume and to excrete, but there is no life force. […] I believe this conclusion applies especially to client-oriented professional services, such as health care and education, which can never be better than the people who deliver them”. It is for professional care organizations themselves, then, to decide which type of coordination best suits their purposes. If they decide to learn from the example of Hospice Heuvelrug, they will have to bring in a lot of time, effort and commitment in order to bring the process to fruition. However, as Hospice Heuvelrug also shows, the results are actually worth it.

7.4 Implications

Although the main research question has been answered, the last part of this study, considering the academic and practical implications of this answer, still needs to be covered. Hopefully, the study will be of use to both academic and practical audiences. This paragraph shows in which ways this might be the case.

Research implications

First of all, this study has some implications for future research. Although Hospice Heuvelrug provides a good example of how a professional care organization might successfully coordinate their volunteers in terms of the effects on quality of care, it is only one case, and a very specific case at that. For that reason, no statements can be made on the extent to which the findings presented here are applicable to other professional care organizations such as nursing homes. Future research might therefore focus on comparing the coordination of volunteers in different professional care organizations, thus being able to make more confident statements about the effects of various types of coordination on quality of care. These comparative case studies could be shaped in various ways. One interesting option would be to compare different types of professional care organizations, such as a hospice, a nursing home and a hospital, in order to find out in what ways successful volunteer coordination differs between those different types of organizations. A second option, which might be more interesting, would be to identify one organization in which volunteers are successfully coordinated and quality of care is high, and another in which volunteer policy is failing. In that way, it would be possible to determine with more certainty which elements of volunteer coordination are important to ensuring quality of care and which elements are not. A combination of these two options would also be possible. Through these comparative analyses, academic research could further contribute to insights on using volunteers in professional care organizations. This would not only enhance academic knowledge on the topic, but would also be relevant to praxis.

Another implication for future research concerns the theoretical model presented in this study, which combines Mintzberg's coordinating mechanisms with two conceptual models from the routine literature. Although the model functions well as a means to interpret the empirical data in this study, it is by no means certain that this is the best conceptual rendition of the various interrelations. Especially the conceptualization of mutual adjustment and direct supervision as *interactions* as well as the role and place of normative commitment in the model deserve closer attention, since they rest most on the writer's own logic and least on existing literature. Hopefully, this study sparks a conceptual discussion on these aspects of the model, as well as on the relation between Mintzberg's coordinating mechanisms, routines, and the eventual relation to coordination more generally.

Implications for professional care organizations

As a good example, Hospice Heuvelrug provides insights for professional care organizations on the facets of coordinated volunteer work that might be important in ensuring volunteers successfully contribute to quality of care. Naturally, the routines and coordinating mechanisms found in Hospice Heuvelrug will not all be applicable to other professional care organizations. After examining the four facets continuous learning, responsible action, working together and organizational membership and the specific routines belonging to these facets, professional care organizations themselves might relate them to their own organization and consider to what extent they might be useful in that context.

One important lesson they could learn from Hospice Heuvelrug, is that it is important to acknowledge and appreciate your volunteers, or 'seeing and appreciating' them, as the hospice members refer to it themselves. In that way, volunteers remain motivated and will probably remain volunteering for a longer period. Volunteers should feel part of the organization and the team in which they work, and it is thus important that paid staff also considers them as such. Only in that way can they effectively work together, and an environment of mutual respect and learning can be created. Finally, by giving volunteers responsibility and offering them continuous opportunity for learning, they feel taken seriously and will be better enabled to provide the quality of care required of them. All in all, providing good quality of care with the help of volunteers is a process with a strong normative character, and shaping this process takes a lot of effort.

Taking these and all the other numerous possible lessons which can be found in Chapters 6 and 7 of this thesis into account, it should be noted that although these might be useful, they are also based on a case study of an organization with a very unique character. As a hospice, De Heuvelrug has a very specific target group, working with whom appeals to a lot of possible volunteers. Compared to different professional care organizations such as nursing homes, hospices have a luxury position since they can select volunteers from a large group of motivated people. Of course, other professional care organizations might not be so lucky.

The same might be true for the other precondition identified as relevant for effective coordination in Hospice Heuvelrug: time. For many of the routines, principles and ways of working in the hospice, *time* is essential. Volunteers and nurses need to have time to provide care unhindered by the constant urge to hurry along; enough time is required, too, for the organization of volunteer coordination itself. Here, the universal saying ‘time is money’ becomes relevant. If professional care organization wish to apply the principles and insights presented in this study, they should take into account that a certain amount of time is needed, and that includes having enough personnel available, both on the work floor as well as possibly in the form of a separate (and paid) volunteer coordinator. For organizations lacking financial means, this might be difficult.

Finally, the types of tasks volunteers conduct in Hospice Heuvelrug might not be conceivable or even desirable for volunteers in other organizations. Whereas the hospice sector is traditionally largely supported by volunteers, this is not the case for many other professional care organizations. Involving volunteers in care-related tasks such as washing and dressing clients might in those organizations be considered as crowding out paid workers. Instead, volunteers may help provide breakfast and dinner to clients, organize games and other activities or take clients for a walk outside. In these cases, too, professional care organizations might benefit from applying the insights offered in this thesis. After all, quality of care is not just based on the effectiveness of knowledge-based care, but also on the effectiveness of interpersonal care, and on (relational) continuity. As long as volunteers take part in tasks that require direct contact and interaction with clients, their actions will have an influence on both these aspects of quality of care and the insights offered in this thesis will thus be of importance.

Implications for policymakers

Policymakers are currently working hard on the transition of the welfare state towards a participation society. This study only touches upon a small element of this transition, the heavier reliance on volunteers in the care- and welfare sector that will probably be the result. Its findings, however, are very relevant to policymakers. The transition to a participation society is accompanied by many budget cuts. The decentralization of long term care from central government to municipalities is an example. There, too, decentralization and budget cuts go hand in hand. This is not surprising, since downsizing the costs of the welfare state is one of the prime reasons for moving towards a participation society in the first place. It is the hope of many policymakers that citizens themselves will partly fill the gaps in care caused by these budget cuts. However, as this study shows, a successful use of volunteers in the provision of care requires thorough coordination in order for quality of care to be ensured. This coordination, in turn, requires time and money. Unfortunately for policymakers, therefore, leaving responsibility for care to citizens themselves does not necessarily lead to fewer costs, at least not when quality of care is expected to stay at the same level. What is more, professional expertise remains crucial to providing good quality care, especially when it comes to the effectiveness of knowledge-based care. Volunteers can aid nurses in a lot of care-related tasks, but certain tasks, such as the provision of medicine and the care of very ill clients, require the presence of a professional nurse. A heavier reliance on volunteers in professional care organizations can thus only go so far.

The move towards a participation society seems inevitable. However, for quality of care to be ensured, policymakers should refrain from viewing the use of volunteers in care provision as a 'cheap' alternative that solves problems caused by budget cuts. Rather, they should view it as a promising but time- and money intensive project that requires a lot of effort (cf. Putters, in Kamerman, 2014 17 June). If they are willing to make the investment, however, the case presented in this thesis shows that this might result in high-quality care in a homely, caring atmosphere.

7.5 Concluding remarks

In a phronetic study (cf. Flyvbjerg, 2001), which this study aims to be, three questions are answered: where are we going; is this desirable; and what should be done? It is clear where we are going: the Dutch welfare state is changing. More and more, it is transforming into a participation society, in which citizens are expected to take more responsibility for their own and each other's welfare. New laws are introduced which emphasize the importance of informal caregivers and volunteers. In combination with budget cuts, these new laws will most likely lead to a heavier reliance on volunteers in the provision of care to their fellow citizens. It is also clear that this development is not necessarily desirable: it contains risks for the quality of care provided. This study's main contribution lies in providing an answer to *what should be done.* On the level of professional care organizations, it shows one way in which volunteer coordination can be shaped in order to ensure quality of care. By doing so, the study contributes to a societal discussion on what is necessary to turn the participation society into a success. It does not claim to provide all the answers, but some important conclusions can be drawn nonetheless.

First of all, involving volunteers in the provision of quality care to vulnerable clients is doable. Hospice Heuvelrug has successfully been doing so since its establishment 15 years ago. Good news for the proponents of the participation society, because it proves that a heavier reliance on volunteers than is presently the case in most professional care organizations is in fact possible.

However, and this brings us to the second and main conclusion of this thesis, effectively involving volunteers in the provision of quality care does not emerge by itself. It takes thorough coordination, which in turn requires time, money, and a lot of motivation. Policymakers need to be hesitant in their claims that a participation society can solve budget problems of central government. Increased participation, at least if it takes the form of a larger involvement of volunteers in professional care organizations, costs more rather than less money, at least if the intention is that volunteers contribute to rather than endanger quality of care. Moreover, neither governments nor professional care organizations should assume that volunteers can be left alone to fill the gaps caused by retreating government and professionals. Rather, it is the responsibility of government and professional care organizations to actively create an environment that enables these volunteers to do so. Only then can volunteers effectively contribute to quality of care, which I assume is the final goal in everyone’s mind. As it turns out, active citizenship not only requires active citizens, but active government and professional organizations, too.

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Appendix 1 – Interview Topic List (in Dutch)

Topiclijst

1. Kan je wat vertellen over jezelf?
    a. Hoe ben je bij het hospice terecht gekomen? (incl. carrière ervoor/ernaast)
    b. Hoe lang al bij hospice
    c. Werkzaamheden bij het hospice
    d. Leeftijd/geslacht

2. De heuvelrug staat bekend als een high-care hospice. Kwaliteit van zorg is dus erg belangrijk.
    a. Wat houdt kwaliteit van zorg op dit hospice eigenlijk in?
    b. Hoe komt goede zorg hier tot stand?
    c. Concrete voorbeelden: op de werkvloer

3. Op het hospice werken zowel verpleegkundigen als vrijwilligers. Kan je wat vertellen over hoe je als *verpleegkundige/vrijwilliger/coördinator* ervaart dat die samenwerking gaat?
    a. Rolverdeling
    b. Relatie met kwaliteit van zorg
    c. Concrete voorbeelden: op de werkvloer

4. Wat draagt er toe bij dat vrijwilligers hun werk goed kunnen doen/dat vrijwilligers goede zorg kunnen bieden?
    a. Coördinatie → Hoe wordt de inzet van vrijwilligers gecoördineerd op zo'n manier dat ze goed kunnen bijdragen aan de zorg?
    b. Opleiding
    c. Aanmelding
    d. *Processen op de werkvloer* → Wat gebeurt er op de werkvloer precies, tijdens een dienst zelf, om de vrijwilliger goede zorg te doen laten verlenen?
    e. Binding met de organisatie?

5. We hebben het al een beetje gehad over de coördinatie van vrijwilligers. Met het zicht op de toekomst, wat denk je dat wat dit betreft de sterke punten zijn in Hospice Heuvelrug? En wat kan er nog beter?

6. Zijn er nog onderwerpen waar we het niet over hebben gehad die volgens jou belangrijk zijn?