

BMJ Open Volunteers as members of the stroke rehabilitation team: a qualitative case study

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ABSTRACT

Objectives Clinicians are facing increasing demands on their time, exacerbated by fiscal constraints and increasing patient complexity. Volunteers are an essential part of the many healthcare systems, and are one resource to support improved patient experience and a mechanism through which to address unmet needs. Hospitals rely on volunteers for a variety of tasks and services, but there are varying perceptions about volunteers' place within the healthcare team. This study aimed to understand the role of volunteers in stroke rehabilitation, as well as the barriers to volunteer engagement.

Design A qualitative case study was conducted to understand the engagement of volunteers in stroke rehabilitation services within a complex rehabilitation and continuing care hospital in Ontario, Canada.

Participants 28 clinicians, 10 hospital administrators and 22 volunteers participated in concurrent focus groups and interviews. Organisational documents pertaining to volunteer management were retrieved and analysed.

Results While there was support for volunteer engagement, with a wide range of potential activities for volunteers, several barriers to volunteer engagement were identified. These barriers relate to paid workforce/unionisation, patient safety and confidentiality, volunteer attendance and lack of collaboration between clinical and volunteer resource departments.

Conclusions An interprofessional approach, specifically emphasising and addressing issues related to key role clarity, may mediate these barriers. Clarity regarding the role of volunteers in hospital settings could support workforce planning and administration.

INTRODUCTION

Civic engagement in the provision of health services is common.¹ Volunteers have a long history of contributing to healthcare² and in that time hospitals have come to rely on the contributions of volunteers for a variety of programmes and services. The time and effort provided by volunteers allows hospitals to meet patient needs and have the potential to improve patient experience. Volunteer programmes have been shown to improve patient well-being and reduce social isolation.³ Volunteers have been shown to affect patient experience, as well as free up nurse

Strengths and limitations of this study

- Qualitative case study approach comprised of interviews and document analysis provides deep understanding of hospital volunteers in context which support rigour and credibility of our findings.
- This study provides insight into the various organisational perspectives on the role of volunteers in hospital practice and in inpatient rehabilitation specifically.
- Being a case study, the results reflect a particular time frame in one particular organisation, which may limit the transferability of our findings.
- Despite a focus on volunteers in stroke rehabilitation, volunteers worked in a variety of additional clinical areas which may have influenced experiences and perspectives.

time for other care activities.⁴ By providing administrative support, volunteers give providers more time to focus on clinical duties, which, in turn, reduces care costs and leads to care quality improvement.¹

The WHO defined health workers as 'all people engaged in actions whose primary intent is to enhance health' and includes volunteers in this definition.⁵ Despite this, health workforce planning and management has focused on regulated healthcare workers in paid roles.⁶ Although there has been some emerging literature to understand the role of hospital volunteerism, most of the current literature has focused on the role of volunteers in the context of palliative care and within the hospice setting. Within hospitals, volunteer leaders report that the value of volunteer programmes is often overlooked at the organisational level.^{2,6} There has been an increasing interest in calculating the economic value of volunteers across sectors in the United States. Reports by independent sector⁷ found that the financial value of 1 hour of volunteer work contributed to non-governmental organisations in 2017 was \$25.43. For hospitals specifically, Handy and Srinivasan¹ assessed the benefits and costs



that hospitals accrue by using volunteers, and found that hospitals derived, on average, \$6.84 in value for every dollar spent on volunteer services. While volunteer activities can improve patient experience and organisational efficiency, their contributions are often underutilised, unaccounted for or under-recognised.²

Stroke care is one clinical setting that has increasingly engaged volunteers. Stroke rehabilitation is a goal-oriented process aimed at enabling patients to reach optimal functional outcomes. Volunteers have taken on select roles and activities in this setting related to rehabilitation such as providing aid with mobility, psychosocial support (peer support), speech and language recovery as well as leisure programmes in an effort to facilitate this process.^{1 8-10} Despite active volunteer engagement within stroke recovery, much of that work is outside hospitals and in parallel to clinician-provided services. Clarifying the role of volunteers and better understanding their significance in relation to stroke rehabilitation teams may help realise the potential of volunteers and guide the development of further volunteer programmes. Such programmes may benefit both stroke rehabilitation patients and hospital staff without adding financial burden to the organisation. More specifically, literature discussing volunteers as members of the clinical team, as well as the barriers and facilitators to their inclusion, is limited. Therefore, the purpose of this study was to understand the role of hospital volunteers within the context of a stroke rehabilitation team, and any barriers to their participation.

METHODS

A qualitative case study was conducted between January 2014 and July 2015. Qualitative case studies enable researchers to describe a phenomenon in context using various data sources.¹¹⁻¹³ Qualitative research is inductive, whereby researchers draw from naturalistic and constructivist perspectives to describe informants' perceptions

and experience of the world.¹⁴ Prior to data collection, all participants provided written informed consent.

Reflexivity

Consistent with qualitative research, we, as the research team, needed to consider the ways in which our interactions with participants might be influenced by our professional background, experiences and prior assumptions. All interviewers were clinicians and engaged in other research focused on volunteers in health settings. During study design, we developed propositional statements (table 1) which served two purposes: (i) helped bound the study, and (ii) helped us reflect on how our experiences and professional backgrounds contributed to what participants shared in the interviews and focus groups as well as our interpretation of study data.

Binding the case

The study was bound within a stroke rehabilitation programme of a community hospital located in a large Canadian city, comprised of 400 inpatient beds, approximately 60 of which are dedicated to neuro-rehabilitation. There is also an outpatient clinic that provides rehabilitation services, often to patients discharged from the inpatient programmes. The rehabilitation teams are comprised of physicians, nurses, therapists (occupational, physical and recreation), social workers, pharmacists, speech language pathologists, dietitians and spiritual care providers. A small group of hospital administrators manage the clinical units and an even smaller group oversee the operations of volunteer resources and the inpatient and outpatient rehabilitation services. The hospital as a whole had approximately 200 active volunteers at the time of the study, approximately 40 of whom were actively engaged on the stroke rehabilitation units.

Participants

Purposeful sampling was undertaken, specifically maximum variation sampling. The sampling strategy criteria were developed to ensure we recruited

Table 1 Propositional statements and sources

| Propositional statements | Source: (selected literature; does not reflect the full literature review) |
|---|--|
| Hospitals have large numbers of volunteers working in patient facing roles. | <i>Professional experience and literature:</i> Handy F, Srinivasan N. Valuing volunteers: an economic evaluation of the net benefits of hospital volunteers. <i>Nonprofit Volunt Sect Q</i> 2004;33:28–54. Fitzsimons B, Goodrich J, Bennett L, et al. Evaluation of King's College Hospital Volunteering service. The King's Fund 2014. |
| How hospitals engage volunteers in improving patient experience and outcomes is not well documented. | <i>Literature</i> Mundle C, Naylor C, Buck D. Volunteering in health and care in England: A summary of key literature: The King's Fund 2012. Garrison M, Wolf JA. The role of the volunteer in improving patient experience (internet) The Beryl Institute; 2016. |
| Hospital volunteer engagement is dependent on inclusion within clinical teams, but barriers to participation at team and organisational levels are not well documented. | <i>Professional Experience and Literature</i> Malby R BD, and Crilly T. Can Volunteering Help Create Better Health and Care? An evidence review. London, UK: London South Bank University 2017. |

participants from various clinical disciplines, organisation administrative roles and volunteers with firsthand experience regarding hospital volunteerism in stroke rehabilitation. Clinician participants were recruited from the stroke rehabilitation clinical units. Twenty eight clinicians agreed to participate, representing multiple disciplines: nursing, occupational therapy, recreation therapy, physiotherapy, speech language pathology, rehabilitation assistants, social work and unit clerks. Twenty-two hospital volunteers agreed to participate. In order to be eligible, volunteers had to have volunteered in the hospital for a minimum of 6 months, be over the age of 18 and actively volunteering on one of the stroke rehabilitation units. Ten hospital administrators with varying levels of responsibility for some component of the stroke rehabilitation programmes, including volunteer managers, clinical unit managers, programme directors, human resource representatives, discipline practice leaders also participated. Participant characteristics are not detailed. Some participant categories have only one or two individuals. Providing more detail about discipline, age, gender, or seniority/years of practice would compromise participant confidentiality.

Patient and public involvement

No patients were involved in the design, recruitment or conduct of this study.

Data collection

Data were collected through semi-structured interviews, focus groups and a review of organisational documents pertaining to volunteer management. An interview guide was developed prior to data collection based on our professional experiences, our previous research in this area which included a review of hospital volunteerism literature. There were separate interview guides for each participant group: staff (administrators and clinicians) and volunteers. Consistent with qualitative approaches,^{15 16} the interview guides were iterative, meaning that they served as starting points for the discussions, with questions revised or added as necessary to provide deep understanding of the phenomenon, and

ensure that knowledge gaps related to emerging categories were addressed. Questions elicited perspectives on: (i) the current and potential volunteer roles in stroke rehabilitation to address patient needs; (ii) the relationship of volunteers to the clinical team; and (iii) the barriers to engaging volunteers to fulfil the potential roles articulated by participants. Selected questions are outlined in [table 2](#).

Semi-structured interviews and focus groups were conducted concurrently. Seven focus groups were conducted: 4 with clinical team members (multidisciplinary) and 3 with volunteers who worked on the stroke rehabilitation units. Fifteen interviews were conducted: 10 with hospital administrators, 3 with clinicians and 2 with volunteers. Clinicians and volunteers were invited to participate in focus groups first, and if unable to attend were offered an interview. Focus groups were used to foster in-depth discussion and probing related to participants' experiences with and as volunteers, and their understanding of the volunteer role as a part of the stroke teams. Administrators were invited to participate in interviews as it would have been very difficult to coordinate schedules for a focus group. Moreover, each administrator spoke from a distinct position within the organisation, and interviews allowed for deeper exploration of the topic. Fifteen individuals participated in member-checking interviews: 4 clinicians, 3 volunteers and 8 administrators. Member-checking interviews allowed researchers to share their interpretations of the data, giving participants an opportunity to discuss and clarify, and provide any additional perspectives on the topic. All interviews and focus groups were audio recorded and transcribed verbatim.

Organisational documents pertaining to the recruitment and management of volunteers were retrieved from respective departments responsible for volunteer programmes. Information from the hospital volunteer programme web page and volunteer position postings were included. In addition, administrative documents provided by participants, including policies, recruitment and onboarding documents and performance

Table 2 Selected interview guide questions

| Staff (administrators and clinicians) | Volunteers |
|---|--|
| <p>Please tell me about your experiences with volunteers here at (hospital). <i>How are they engaged currently? What are some of the highlights and challenges?</i></p> <p>How do you see volunteers in relation to the stroke rehabilitation team?</p> <p>What patient needs are challenging to meet? <i>Which of these needs do you think volunteers require to support these needs? What limits volunteer engagement in these activities?</i></p> <p>Reflecting on your experiences with volunteers on the unit—what would ideal volunteerism look like? <i>How would it be different from what is going on now? What would have to happen to get there?</i></p> | <p>Please tell me about your experiences as a volunteer here at (hospital). <i>Tell me a bit about your work with patients? What are some of the highlights and challenges you've experienced?</i></p> <p>Please describe your experience working on the stroke rehabilitation unit. <i>How would you describe your relationship with the clinicians? What types of activities would you like to be doing at (hospital)?</i></p> <p>Reflecting on your experiences on this unit, what would ideal volunteerism look like? <i>How would it be different from what is going on now? What are the obstacles towards achieving it? What would have to happen to get there?</i></p> |

review procedures, were retrieved and included in data analysis.

Data analysis

Interview and focus group data were analysed using a qualitative content analysis approach consistent with qualitative descriptive studies¹⁶ in order to develop and present a description of the phenomenon of interest. Interviews and focus groups were transcribed verbatim and coded by two authors of this study (MLAN and RT) to ensure consensus on emerging codes and categories. Emergent descriptive categories were populated with data, and commonalities and discrepancies in participant responses were noted. The coding framework was refined based on additional emergent categories, and used to further analyse and interpret the transcripts. This iterative process continued as categories and constituent elements were developed, compared and contrasted between participant groups and until a coherent description of participants' perspectives was developed. Differing perspectives between groups, where shared, were represented in the results. Interviews and focus groups were conducted until data saturation was reached. A rich, detailed and straightforward description of the phenomenon in context was generated.^{14 16}

The organisational documents were analysed after the analysis of interview and focus group data, and treated like a respondent representing the organisation. Analysis of the included documents entailed an iterative process of skimming (superficial examination), reading (thorough examination) and interpretation.¹⁷ Data were extracted to provide insights and additional perspectives on themes identified through the interview and focus groups. Converging the data sources helped to promote a greater understanding of the phenomenon.¹¹

Rigour

We conducted the study as outsiders to the participant groups; therefore data collection occurred over several months, giving us prolonged exposure to the phenomenon within context. The integrity and trustworthiness of qualitative case study research were enhanced by incorporating a wide range of perspectives to prevent the viewpoint of one group from becoming the sole truth about a phenomenon.¹⁸ During data analysis, accounts from each group were compared with uncover similarities and differences with a main goal of identifying descriptive categories. Though main categories were highlighted, equal importance and attention were also given to identifying individuals' views and experiences, where shared. Rigour in qualitative research was also enhanced by ensuring authenticity, credibility, criticality and integrity.¹⁹ Consistent with qualitative case study research and to support authenticity, we engaged in triangulation through the document review, included in order to avoid a naive over-emphasis on interview data.²⁰ We wrote field notes after each interview and focus group analysis to ensure context was taken into account, and to reflect on any biases. Given

the iterative nature of qualitative research, every decision was critically appraised throughout the process.

RESULTS

Study participants provided extensive perspectives on the engagement of volunteers within stroke rehabilitation services, the activities they may fulfil and what barriers limit their participation. Online supplementary file 1 provides additional participant quotations for each data category presented below.

Volunteer activities

In considering the unmet or under-addressed needs of patients, clinical teams identified 39 potential roles and opportunities for volunteers that were distilled into five categories: rehabilitation support, education and information, assisting and escorting patients, personal needs assistance and unit administration—outlined in [table 3](#). These categories of activities align with the mandate of hospital volunteers outlined on the hospital web page, which stated volunteers are recruited to: (i) enhance the patient and family experience; (ii) improve patients' quality of life by helping them engage in activities; and (iii) become part of the staff support team, enhancing the work of the care team.

Inpatient clinicians and administrators were supportive of engaging volunteers in stroke rehabilitation. There were noted differences between the inpatient and outpatient programmes regarding the engagement of volunteers, and those differences are identified below.

I think that volunteers have opportunities to intervene in many different ways... For example, we have gym spaces that are closed for many hours of the day and on weekends. We limit access because we can't control patients going in who may not be safe. I think about opportunities to train volunteers to identify who is appropriate to come and go, to help them with equipment, to be in the environment for emergency response-type purposes. I think some of those are fantastic opportunities, and in alignment with our goals to have patients be self-managing. It gives [patients] access to things that are right there, and can be used. So there are activities where I think we absolutely can leverage volunteers. (Inpatient Clinician)

“Yeah. The volunteer can come to help us like talking with the patients, calming down the patients, or at mealtimes, assist the patients. It's a big help.” (Inpatient Clinician)

When asked to describe how those volunteers should be included within the team, an administrator participant emphatically said:

I think of [volunteers] almost as part of the health-care team on a unit, where the volunteer program is actually part of the core business of a program. When volunteers come in, we know they're starting at

Table 3 Potential volunteer activities

| Activity category | Identified activities |
|--|--|
| Rehabilitation support (augmenting therapy, psychosocial support and leisure activities) | <ul style="list-style-type: none"> ▶ Reinforcing therapy goals (individual-level activities, group activities augmenting therapy, gym supervision during 'off hours') ▶ Psychosocial support (men's and women's groups, caregiver support groups, friendly visits, peer/social support groups) ▶ Leisure (games, music, computer time, reading, letter writing) |
| Education and information | <ul style="list-style-type: none"> ▶ Education programmes (diabetes education programme, computer training) ▶ Hospital stay support (introduce hospital programmes, assist with way finding, unit and hospital tours and/or orientation) ▶ Discharge process support (discharge information, community information) |
| Supporting patients' instrumental activities of daily living | <ul style="list-style-type: none"> ▶ Helping patients orient and navigate within the hospital (therapy, outdoor space, stores within hospital) ▶ Assisting patients travel to destinations outside the hospital (banking, long-term care visits, outside appointments) ▶ Laundry assistance ▶ Shopping assistance (within hospital) |
| Unit administration | <ul style="list-style-type: none"> ▶ Welcoming and orienting patients and families ▶ Answering phones, filing support |

this time and they're finishing at this time, and that they're coming in, signing in. So we have a direct line of accountability. They're enhancing the already high functioning team, not a program off on their own that no one is aware of... They're part of the team. (Administrator)

In order to fully integrate volunteers into clinical teams however, participants noted that there needed to be explicit organisational structures and support stating 'Volunteers need to be supported in the program or a team. You can't just drop them in there and expect it all to go well' (*Inpatient Clinician*).

Furthermore, participants noted that volunteer programmes and roles should be developed based on clinical needs, and the volunteers should subsequently be matched with these roles. In addition, clinicians felt that volunteers' efforts should be directed to programmes and clinical areas with the greatest needs, as other health human resources would be allocated:

If we have 40 active volunteers, and there are programs that need to operate, then we have these 40 volunteers doing their work. But when we suddenly end up with a vacancy in a priority program, what's the opportunity to shift resources to have those volunteers meet that need? Is there a way that we could potentially prioritize volunteer roles and activities? Not the people but prioritized based on impact to patient care or patient programing. (Inpatient Clinician)

In contrast, a number of outpatient clinicians considered volunteers secondary to the core rehabilitation activities provided. A participant stated:

If we had to take volunteers in outpatient [rehabilitation unit], it would be better if they helped the

administrative staff rather than clinicians. (Outpatient Clinician)

These outpatient rehabilitation clinical team members were also less amenable to the idea of volunteers integrating into the clinical team, as two outpatient clinicians suggested, and other participants agreed:

My experience with volunteers is they are an addition. We cannot depend on them to run a program. They are just not dependable enough. So it's hard to build a relationship in terms of the volunteer when they're not here all the time or I don't know if they're even coming. (Outpatient Clinician)

Volunteers reported that they wanted to be considered part of the team, but noted that although they felt their efforts were appreciated, they 'could not go so far as saying that I feel like a member of the team' (*Volunteer*).

Barriers to volunteer engagement

Three predominant barriers to the meaningful engagement of volunteers were identified: (i) volunteers can't replace paid roles; (ii) volunteers are outside the circle of care; and (iii) volunteers are unreliable.

Barrier I: volunteers can't replace paid roles

Despite the desire to engage volunteers in enhancing patient experience, participants were concerned that volunteer activities would encroach on paid roles, particularly those housed in a collective bargaining agreement. An organisational policy requires that volunteer job descriptions be checked against existing labour agreements and policies before implementation. Managers across the organisation were particularly sensitive to the issue:

I'm open to any development of volunteer roles. The one thing I'd be aware of as manager is that I know

that they cannot be doing something that is currently being done by paid staff. (Administrator)

Both clinicians and volunteer participants believed that volunteer roles should augment the activities of clinical teams, and be designed to enhance the rehabilitation programmes, not replace clinicians:

I guess some fear that [the volunteer] will take someone's job. It is not about taking; it's about enhancing the patient experience. This ultimately enhances the staffs' experience. So if the staff can feel that volunteers are part of the team, it creates the culture that we're all here for the same purpose. And we all want the patients to have the best experience. (Inpatient Clinician)

"I guess the challenges in terms of in general, I would say that there's a fine line, again as I alluded to earlier, a fine line with because this is a unionized environment, there's a careful balance in terms of what is considered "union" work. And if it is then it's something that should not be performed by anyone other than a unionized member. So that in the past has caused us some challenges where the lines may have been blurred slightly, and in fact did result in us having to eliminate the volunteer role at one point." (Administrator)

Barrier II: volunteers are outside the 'circle of care'

Issues of confidentiality, liability and patient safety were commonly identified as barriers to volunteer engagement, with confidentiality prioritised. Clinicians were unsure how much patient information volunteers were allowed to receive, or what policies were in place to protect patient privacy specific to volunteers:

I'm assuming that they sign a confidentiality agreement. Confidentiality is a big issue with volunteers... you can't give them that much info about patients. The biggest barrier is liability. So that's not to say we're not happy to have them or we're not appreciative of them but there's always that confidentiality issue, there's always that safety issue because they're not trained personnel. (Inpatient Clinician)

Organisational policies dictated that volunteers undergo rigorous intake processes and hospital orientation; all volunteers receive a copy of the organisational code of ethics and sign a confidentiality agreement prior to their placement within the hospital. The confidentiality agreement states:

In order to protect the patients' right to privacy, I [the volunteer] agree and understand that as a volunteer, I must not read patient charts nor ask about personal information regarding patients. Any facts important to my volunteer assignment will be given to me. This and any other confidential information that I might learn about patients, their families and

staff, I will keep confidential and will not discuss with other people in or out of [HOSPITAL].

Although volunteers were aware that they should not have access to confidential patient information, they expressed frustration with the amount of information they received from clinicians, which limits their ability to participate:

Let us understand (the patient situation). I think that the volunteers really need to be part of the team. If you want the volunteer to be part of it, give us the tools to do our jobs. (Volunteer)

Barrier III: volunteers are not reliable

Participants across all groups noted the need for consistency in volunteer attendance. This was of particular concern especially when discussing the potential of volunteers offering stand-alone programmes or independent services for patients. A participant explained:

You need volunteers to be consistent. I would prefer either they come regularly or they don't come at all... As a staff member, you expect them to show up because you plan your day. You have to prioritize what you have to do. (Inpatient Clinician)

Some administrative participants were less concerned about volunteers' absenteeism, drawing the parallel to when clinicians are away from work; when a clinician is absent, the clinical unit carries on:

On a unit right now, we may have a speech language pathologist sick. Patient care continues... We do try to make sure that the normal routine of the floor continues irrespective of the person who wasn't present. And that would be my idea for a volunteer program. It can't be individual-specific. It's got to be part of the core value of the team of what we function as to enhance the patient's care. (Administrator)

Volunteers were aware of the importance of accountability and consistency. The volunteer agreement signed by all volunteers mandates once a week attendance for a minimum of 6 months. In addition, attendance was monitored by the volunteer resource department and the agreement notes that three absences without prior notification could be grounds for termination.

DISCUSSION

This study provides a description of stakeholders' perspectives about the inclusion of volunteers as members of the stroke rehabilitation team. Although study participants felt that volunteers should be considered members of the team, whose activities augment and extend the reach of clinicians, several barriers to volunteer inclusion were identified. Study results align with existing research on how hospitals have come to rely on volunteers for a variety of tasks and services, including direct patient

contact (eg, way finding, recreation programming), as well as 'behind the scenes' administrative or governance support.^{18 21} Specific to rehabilitation, participants noted that volunteers could be engaged in a range of activities, from working directly with patients, to providing administrative support to the clinical units that may help address unmet needs. This is seen in speech therapy provided to patients experiencing aphasia following a stroke. Speech language pathologists do not exist in many countries, and where this is the case, volunteers are trained to meet this need by providing targeted interventions aimed to improve stroke patients' communication functioning.⁹ What has been difficult to demonstrate however is that volunteer contributions create lasting improvements in the clinical outcomes and health status of the service recipients,^{3 22} an area warranting further research.

The increasing complexity of patients accessing stroke rehabilitation programmes has an impact on the amount and types of services that clinicians are able to provide on a routine basis.²³ This may result in a disconnect between the provider's desire to provide holistic and compassionate care, and the patient's perception of their provider as competent and caring.²⁴ Volunteers were identified as one way to help meet patients' needs; however barriers to their participation were readily identified. Barriers centred primarily on the relationship of volunteers to paid staff, access to confidential patient information and the reliability of volunteers to provide services.

The barriers align with foundational elements of collaborative practice: trust, communication, role clarity, cooperation and shared decision-making.^{25 26} Study participants shared two views on volunteer engagement. While they noted that volunteer roles could not infringe on paid roles, they also viewed volunteer services as an augmentation of staff functions, not a replacement for them. This is also consistent with the literature around the place and role of volunteers in unionised environments. Unionisation is a recognised barrier to volunteer engagement, and even the perception of infringement on paid roles can lead to friction.^{27 28} Despite the concern of volunteer labour infringing on paid roles, Handy *et al*²⁹ found that this replacement was limited in healthcare, likely due to laws and liability issues. A lack of understanding of professional roles and responsibilities makes it difficult to develop meaningful relationships; role clarity is essential for effective interprofessional collaboration.^{26 30–32} Prioritising role clarity for volunteers may reduce or eliminate the barriers, and may actually foster volunteer inclusion on clinical teams by clarifying the relationship of volunteers to paid staff, and delineating what activities are within each team members' purview. Clinicians hesitated to rely on volunteers for essential programme delivery, citing poor volunteer attendance despite organisational policies indicating that poor attendance would result in termination. Role clarity may improve volunteer attendance. If volunteers were engaged in clearly delineated and valued roles, volunteer attendance may be improved, as the provision of meaningful roles that

support core business is a recognised volunteer retention strategy.^{33 34} This, in turn, could address clinical team members' concerns about accountability and help to build the trust required for collaboration. Given the stated amenability for volunteers to be part of the stroke rehabilitation team, additional research focused on the nature of the barriers required. Understanding the nature of the barriers, whether they are structural, institutional, cultural or personal, could support the development of strategies to reduce and remove them to support volunteer optimisation.

Given study results, the apparently simple solution would be formally recognising volunteers as members of the team, engaging them in activities aligned with supporting improved patient experiences and outcomes. However, despite the stated amenability and apparent need, the hospital under study had not created roles for volunteers aligned with 'core business'. This encourages us to think critically as to why volunteers were neither included as part of the team, nor seen as a health human resource, and how this relates to the cultural context within which healthcare delivery resides. A seminal paper by Hall³⁵ notes that professionalisation, or the way in which healthcare professionals are educated, socialised and practice exclusionary closure to other disciplines, is a barrier to collaborative practice. Perhaps, in the same way that health professionals become professionalised and begin to regulate and monitor the type and number of entrants, interprofessional teams also become a 'guild', and begin to protect team composition and activities. As it stands, volunteers cannot take on work deemed 'essential', as such work is subsumed within the role of a paid profession. We have been socialised that volunteers are a nice to have, and until we consider the potential of volunteers as health human resources, as has been suggested elsewhere,³⁶ they can never be a need to have.

Limitations

Despite moving to an interprofessional model of care, clinical programmes remain medicine-focused. Although physicians received the recruitment materials, none chose to participate, and given the arms-length reach required by ethics, the reason behind their decision not to participate is unknown. The physician perspective may have added other views on the role and potential of volunteers in stroke rehabilitation. Representatives of the collective bargaining unit also chose not to participate, and they may have contributed to or clarified the topic of unionisation as a barrier. Second, some of the volunteer participants provided services on clinical units in addition to the stroke rehabilitation units, and may have been volunteers at other hospitals or health organisations. Therefore, their perspectives may have been shaped by their work on other clinical units and in other organisations. Finally, qualitative case study design has allowed for a deep understanding of volunteerism in the context of stroke rehabilitation during the time the study was conducted. However, this is a 'snapshot' of the phenomenon in its context at

a particular time, and any change to the context or the time may alter the data and findings.

CONCLUSION

Recognising and mediating the barriers that hinder volunteer engagement will enable the development of substantive patient-oriented volunteer programmes. Taken together, the identified barriers impede volunteers' ability to participate as members of the clinical teams. But officially recognising volunteers as members of the team, and developing roles/responsibilities aligned with clinical goals would directly address the barriers identified and would allow for the hospital to fulfil its aim of engaging volunteers to help improve patient experiences and outcomes. Overall, the interpretation of the results of this study suggests that until volunteers are viewed as a collaborative member of the healthcare team they may continue to be underutilised.

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Contributors Activities undertaken by the authors were as follows: MLAN conceptualised and designed the study, analysed and interpreted the data, wrote and critically revised the manuscript and approved final manuscript as submitted. RT carried out data collection processes, managed data, analysed the data and wrote and critically revised the manuscript with MLAN. JY wrote and critically revised the manuscript.

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Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. Individuals interested in accessing the data should contact the corresponding author.

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