The FACT Spiritual History Tool

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In all likelihood, as an illness, disease or health problem progresses in severity, the patient and/or the patient's family will at some point experience an existential or spiritual crisis. One's sense of meaning and purpose and one's values and beliefs may be threatened, questioned or reevaluated in light of the health crisis. When this happens, a person often draws more deeply upon their own resources, both social and inner, which may include faith and spirituality. These existential or spiritual resources may or may not be adequate to help the person cope successfully. A healthcare clinician must determine when these resources are contributing to a healthy outcome and when they are not and then respond appropriately. A well-designed spiritual history tool helps the clinician make this determination.

An example of such a tool is the **FACT** Spiritual History Tool, which includes three questions (**F**aith, **A**vailability and **C**oping) plus an outcome (**T**reatment). Any properly trained healthcare practitioner can use the **FACT** Spiritual History Tool (see below for a quick reference sheet). This tool is most effective when used conversationally, instead of as a checklist.

Upon admission to most healthcare institutions, a spiritual screen is performed that often includes one or two questions aimed at determining a person's particular religion or faith and whether there are any specific spiritual, religious or cultural needs the hospital can address during hospitalization. This is NOT a spiritual history. A spiritual *history* seeks to understand how a person's spiritual life and history affect their ability to cope with their present healthcare crisis and is more involved than a spiritual *screening*. Information obtained during a spiritual screen rarely changes in the course of hospitalization, whereas the information gleaned through a spiritual history can change dramatically as diagnosis, prognosis and/or treatment plans change. It is important to monitor a patient's ability to utilize their spiritual resources to cope with their health crisis as changes occur—a person who can cope well with an aggressive treatment plan for cancer may not cope as well if the treatment plan changes to palliative care. A spiritual history tool must not only be able to account for a patient's ability to cope in the often swift-changing dynamics of modern healthcare today, but also provide options for follow up treatments.

When taking a spiritual history, regardless of the specific tool used, there are a few guidelines that one must follow. The first one is to show respect for the patient's expression of their faith or beliefs, even if yours are radically different. Your goal is never to impose your faith or system of beliefs on the patient. A second guideline is that a spiritual history is less concerned with *what* a person believes and more concerned with how the person's faith and/or beliefs *function* to help them cope positively with their illness crisis. Evaluating the nuances of what a patient believes should never be done except when the patient invites it, and even then it is best to leave that discussion for someone who has the proper training. A third guideline is the recognition that you are not taking the spiritual history in order to "fix" anything that might come up. If something comes up that makes you uncomfortable or that is outside your training, know to whom you can make a referral. A final guideline is to always remember that many of your patients utilize their faith to help them cope and that when you show an interest in

their faith, you are bringing them comfort and providing a therapeutic intervention. Even if patients do not utilize faith or spirituality to help them cope, if you are respectful of that and not judgmental, then you again provide comfort.

The **FACT** Spiritual History Tool can be used either as a formal and explicit checklist or as an informal and implicit checklist. When used as a formal and explicit checklist, it forms part of a larger, more in-depth assessment, such as a physician's history and physical, a nurse's admission assessment, or a professional chaplain's spiritual assessment. This formal and explicit use fits well with initial assessments. When used as an informal and implicit checklist, it functions as a guide around which a clinician can organize a conversation in order to obtain clinically relevant information pertaining to a patient's spiritual well-being. This informal and implicit use fits well within the ongoing relationship a clinician forms with a patient over the course of their hospitalization or illness process: as changes occur, the clinician can continue to reevaluate the patient's spiritual well-being by using what appears to be casual conversation.

Whether used formally or informally, the process is similar. Within the context of an initial assessment or the ongoing exchange inherent within developing a caring relationship, the clinician will ask what **F**aith, spiritual path or beliefs the patient practices, whether what they need in order to practice their faith is **A**vailable to them, and then how their faith and/or their practices are helping them **C**ope in their current situation. If the history reveals that the patient has everything he or she needs to practice their faith or to maintain their beliefs and that the patient is using these resources well to help him or her cope, then the clinician may simply encourage the patient to continue accordingly and then at a later time reassess if and when significant changes occur.

If in the course of taking the spiritual history the clinician discovers that the patient's spiritual resources are not available or are insufficient for coping well with their current healthcare situation, then the clinician has three options for follow-up **T**reatment. The first option is to provide a direct intervention on the spot, such as, for example, offering to pray with the patient. However, one must be *very* careful with this option. Choosing this option means the clinician has already established the following things: 1) that the patient and the clinician share a similar faith; 2) that the patient would welcome such an intervention; and 3) that the clinician would not be imposing his or her beliefs onto the patient. Due to the potential for crossing ethical and professional boundaries, choosing this option is not recommended unless there is a strong and well-established relationship between the clinician and patient. Even then, one must tread lightly.

The second and third treatment options for follow up are less problematic and therefore recommended. The second option is to suggest that the patient speak to their own faith leader about any spiritual concerns that surfaced during the spiritual history. This option is contingent upon the faith leader's availability and the patient's desire to address these concerns with their own faith leader.

The third option for treatment follow-up is to make a referral to the hospital chaplain. This option is most recommended, but contingent upon the institution having a professionally trained chaplain on their staff. The Board Certified Chaplain provides in-depth spiritual assessments, which begin with a patient's spiritual history and spiritual profile. Based on these the chaplain determines what outcomes the chaplain's care can contribute to the patient's overall healing and well-being. The chaplain, in conversation

with the patient, then designs a pastoral care plan that includes appropriate interventions and a way to measure effectiveness.

One caveat is in order when it comes to making a referral to the hospital chaplain: Do NOT ask the patient if they want to see the chaplain. When you ask them if they want to see a chaplain, you are in essence asking them to self-assess their need for spiritual support and you are assuming they understand the role of the chaplain on the healthcare team. Just as we do not ask them if they want to see a respiratory therapist, so we should not ask them if they want to see a chaplain. If you as the clinician assess they have spiritual needs, then put in the referral to the chaplain. Let the chaplain follow up on the appropriateness of the referral.

Faith or spirituality is a **fact** in the lives of many people. It is also a **fact** that many people use their faith or spirituality to help them cope with a health crisis and to help them make medical decisions. Finally, it is arguably a **fact** that a person's faith or spiritual practice affects their medical outcomes. The **FACT** Spiritual History Tool provides a quick and accurate determination of whether or not a person's current health crisis is affecting their spiritual well-being and then, based on that determination, it suggests a treatment plan.

The Acronym

F – **F**aith (and/or Beliefs, Spiritual Practices)
A – **A**ctive (and/or **A**vailability, **A**ccessibility, **A**pplicability)
C – **C**oping (and/or **C**omfort); **C**onflict (and/or **C**oncern)
T – **T**reatment Plan

Specific questions that may be asked to help discuss each element of the tool:

F: What is your **f**aith or belief?
Do you consider yourself spiritual or religious?
What things do you believe that give your life meaning and purpose?

A: Are you **a**ctive in your faith community?
Are you part of a religious or spiritual community?
Is support for your faith **a**vailable to you?
Do you have **a**ccess to what you need to **a**pply your faith (or your beliefs)?
Is there a person or a group whose presence and support you value at a time like this?

C: How are you **c**oping with your medical situation?
Is your faith (your beliefs) helping you **c**ope?
How is your faith (your beliefs) providing **c**omfort in light of your diagnosis?
Do any of your religious beliefs or spiritual practices **C**onflict with medical treatment?
Are there any particular **C**oncerns you have for us as your medical team?

T: **T**reatment Plan

1. Patient is coping well
    a. Support and encourage
    b. Reassess at a later date
2. Patient is coping poorly
    a. Depending on relationship and similarity in faith/beliefs, provide direct intervention: spiritual counseling, prayer, Sacred Scripture, etc.
    b. Encourage patient to address these concerns with their own faith leader

c. Make a referral to the hospital chaplain (Do not ask if the patient wants a referral—let the chaplain do his or her own assessment.)

General guidelines to remember when using FACT:

1. Faith is already a **FACT** affecting the lives and healthcare choices for many patients and most already utilize faith-based practices as complementary treatment modalities: healthcare professionals need to assess how it impacts their treatment choices.
2. A spiritual history is less about *what* a person believes and more about how their faith or belief *functions* as a coping mechanism.
3. Respect the privacy of patients with regard to their spirituality; do not impose your own beliefs.
4. Make referrals to professional chaplains, spiritual counselors, and community resources as appropriate.
5. Your own spirituality can positively affect the clinician-patient relationship. Remember: "Cure sometimes; relieve often; comfort always." Addressing spiritual concerns with your patients can provide comfort. In itself, it is a therapeutic intervention.

Short Bio:

Rev. Dr. Mark LaRocca-Pitts is a Board Certified Staff Chaplain at Athens Regional Medical Center and is endorsed by the United Methodist Church. Mark is an Adjunct Professor in the Religion Department at the University of Georgia and pastors a three-point rural UM charge. Mark currently serves the APC as a member of its Commission on Quality in Pastoral Services. He lives with his wife and twin eight year-olds in Athens, GA. Mark can be contacted at marklp@armc.org.

SPECTRUM HEALTH

Spectrum Health Pennock
Foundation & Volunteer Services
1009 W. Green St.
Hastings, MI 49058

Dear Volunteer Applicant:

Thank you for expressing an interesting in volunteering with Spectrum Health Pennock. If you enjoy helping others and would like to make an impact within the community, we may have the perfect opportunity for you!

The positions available for our volunteers are highly focused on patient and family centered care**.** The volunteers at Spectrum Health Pennock focus on placing the needs of others first and fulfilling a better patient experience for everyone through their own personal touch.

Please complete the volunteer application attached. Once your application is submitted, the following process will take place:

- A basic background and reference check
- A Tuberculosis (TB) test or proof of one completed within the last year. Spectrum Health Pennock is able to provide one at our Occupational Medicine Department at the State Street Center. After the TB skin test is administered, it is necessary to return to the clinic within 2-3 days for test results.
- Interview with Volunteer Services
- A short orientation session with the Volunteer Coordinator will also be required before you begin your volunteer work.

Please feel free to contact Sarah Staple, Volunteer Coordinator, at phone number (269) 945-1212 Ext. 1181 if you have any further questions. Thank you for your interest in our volunteer program at Spectrum Health Pennock and we will be in contact with you as we proceed.

Sincerely,

Sarah E. Staple
Volunteer Coordinator

SPECTRUM HEALTH

SPECTRUM HEALTH PENNOCK
VOLUNTEER SERVICES APPLICATION

APPLICANT FULL NAME: _____
(Last) (First) (Middle)

CURRENT ADDRESS: _____
(Street) (City) (State) (Zip)

PERMANENT ADDRESS: _____
(Street) (City) (State) (Zip)

HOME PHONE:(____) _____ CELL:(____) _____ WORK:(____) _____

BEST TIME TO CALL: _____ EMAIL: _____

BIRTHDATE: (M/D/YYYY) ___/___/_____ US CITIZEN? ☐ YES ☐ NO

ARE YOU AT LEAST 18 YEARS OF AGE? ☐ YES ☐ NO

PARENT/LEGAL GUARDIAN (if under 18 years of age): _____

PARENT/LEGAL GUARDIAN PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTRACT ADDRESS: _____

EMERGENCY CONTACT PHONE: _____ ☐ Cell ☐ Home ☐ Business

EDUCATION

Are you currently enrolled in a college or university program? ☐ YES ☐ NO

HIGH SCHOOL: _____
(Name) (City) (Grade Completed)

COLLEGE: _____
(Name) (Year Completed) (Major)

_____
(Name) (Year Completed) (Major)

OTHER SPECIAL TRAINING: _____

REFERENCES*: Two references are required. If you are under the age of 18, one reference must be a teacher. Past or present employer, teacher, counselor or clergy are acceptable. *Please do not list relatives*.

REFERENCE ONE: _____
(Name) (Relationship) (Phone)

ADDRESS: _____
(Street) (City) (State) (Zip)

SPECTRUM HEALTH

REFERENCE TWO:_____
(Name) (Relationship) (Phone)

ADDRESS:_____
(Street) (City) (State) (Zip)

**Your signature on the bottom of this application grants us permission to contact your references.*

Have you ever been convicted of a crime or misdemeanor? ☐ YES ☐ NO

If yes, please provide a date and brief description:

_____

_____

VOLUNTEER/EMPLOYMENT HISTORY: Are you currently seeking employment? ☐ YES ☐ NO

PRESENT EMPLOYER:_____

LOCATION:_____ ☐ FULL TIME ☐ PART TIME

DUTIES:_____

DATE WORKED/VOLUNTEERED: From_____ To_____

MANAGER/SUPERVISOR:_____

MAY WE CONTACT THEM? ☐ YES ☐ NO PHONE:_____

PREVIOUS EMPLOYER:_____

LOCATION:_____ ☐ FULL TIME ☐ PART TIME

DUTIES:_____

DATE WORKED/VOLUNTEERED: From_____ To _____

MANAGER/SUPERVISOR:_____

MAY WE CONTACT THEM? ☐ YES ☐ NO PHONE:_____

AVAILABILITY

☐ STUDENT VOLUNTEER, AVAILABLE THESE DATES:_____

☐ YEAR-ROUND VOLUNTEER, AVAILABLE THESE DATES:_____

MORNINGS: ☐ YES ☐ NO MON____ TUES____ WED____ THURS____ FRI_____
AFTERNOONS: ☐ YES ☐ NO MON____ TUES____ WED____ THURS____ FRI_____

PREFERRED VOLUNTEER LOCATION(S):

☐ MAIN CAMPUS ☐ HEALTH & WELLNESS CENTER

SIGNATURE:_____ **DATE:**_____

If volunteer is under age 18, signature of parent or legal guardian is required:

SIGNATURE:_____ **DATE:**_____

Standards of Practice for Professional Chaplains in Acute Care Settings

INTRODUCTION

Preamble: Chaplaincy care is grounded in initiating, developing and deepening, and bringing to an appropriate close, a mutual and empathic relationship with the patient, family, and/ or staff. The development of a genuine relationship is at the core of chaplaincy care and underpins, even enables, all the other dimensions of chaplaincy care to occur. It is assumed that all of the standards are addressed within the context of such relationships.[i]

Section 1: Chaplaincy Care with Patients and Families

Standard 1, Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.

Standard 2, Delivery of Care: The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.

Standard 3, Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.

Standard 4, Teamwork and Collaboration: The chaplain collaborates with the organization's interdisciplinary care team.

Standard 5, Ethical Practice: The chaplain adheres to the *Common Code of Ethics,* which guides decision making and professional behavior.

Standard 6, Confidentiality: The chaplain respects the confidentiality of information from all sources, including the patient, medical record, other team members, and family members in accordance with federal and state laws, regulations, and rules.

Standard 7, Respect for Diversity: The chaplain models and collaborates with the organization and its interdisciplinary team in respecting and providing culturally competent patient-centered care.

Section 2: Chaplaincy Care for Staff and Organization

Standard 8, Care for Staff: The chaplain provides timely and sensitive chaplaincy care to the organization's staff via individual and group interactions.

Standard 9, Care for the Organization: The chaplain provides chaplaincy care to the organization in ways consonant with the organization's values and mission statement.

Standard 10, Chaplain as Leader: The chaplain provides leadership in the professional practice setting and the profession.

Section 3: Maintaining Competent Chaplaincy Care

Standard 11, Continuous Quality Improvement: The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.

Standard 12, Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.

Standard 13, Knowledge and Continuing Education: The chaplain assumes responsibility for continued professional development, demonstrates a working and current knowledge of current theory and practice, and integrates such information into practice.

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December 15, 2009

INTRODUCTION

HISTORY

Representatives of diverse faith traditions have provided spiritual and religious care to the sick for centuries. In the United States, modern health care chaplaincy began with a new form of education in the 1920s with theological students working and learning in a health care setting. It began under the leadership of Anton Boisen at Worcester State Hospital in Massachusetts. Boisen was inspired by Richard Cabot, a physician at Massachusetts General Hospital and faculty member at Harvard Medical School. This new educational movement grew rapidly in both psychiatric and general hospitals through what came to be called clinical pastoral education (CPE). CPE educated clergy and laity to work in general ministry, e.g., in churches and synagogues, and in specialized ministry, e.g., hospitals.[ii]

Up until the 1920s, hospitals usually invited retired clergy to provide chaplaincy services. The first clinically trained chaplain to be appointed to a general hospital was Austin P. Guiles at Massachusetts General Hospital in 1930. In 1933, Russell Dicks succeeded Guiles as chaplain and CPE supervisor. Dicks was later employed at Presbyterian Hospital in Chicago, which was a member of the relatively young American Protestant Hospital Association (APHA). He gave a lecture at their annual meeting in 1939 entitled, "The Work of the Chaplain in a General Hospital." This speech influenced the APHA to appoint a committee to write standards for chaplaincy and to appoint Dicks as chair. The standards were adopted at the 1940 APHA annual meeting.[iii]

These standards included minimum standards for chaplains as well as hospitals' aspirations for their chaplains. The standards for chaplains were that the chaplain should

- be accountable to the hospital administrator;
- cooperate with the hospital staff;
- have a rational plan for selecting patients;
- keep records, e.g., notes recorded in the medical record, simple records to refresh the memory of the chaplain on patients seen, and detailed notes on more difficult situations for the chaplain's learning;
- be appropriately seminary educated with at least one unit of CPE.

Hospitals should aspire to have chaplains who

- provide worship that is interdenominational and appropriate to the context;
- are selected by the hospitals but with input from the appropriate faith communities;
- provide a breadth of services to patients, families, staff, and the organization.[iv]

Over the years these initial standards were revised. As the chaplaincy groups matured they established standards for becoming certified as chaplains. In 2004, major North America pastoral care, counseling, and education groups[v] met as the Council on Collaboration, forerunner of the Spiritual Care Collaborative, and affirmed the foundational documents that included *Common Standards for Professional Chaplaincy,* which are "*competency* standards for certification," and a *Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Student*s.[vi]

PROJECT

Although chaplains have common standards for certification and a common code of ethics, they have no standards of practice. There has been much conversation about standards of practice for chaplains but little formal progress. Others with whom chaplains serve and communicate, e.g., doctors, nurses, those from other disciplines in health care settings, have standards of practice. Having standards of practice would help chaplains communicate with others about chaplaincy and assist chaplains in discussions with other chaplains.

In order to move professional chaplaincy toward standards of practice, the Association of Professional Chaplains' Commission on Quality in Pastoral Services brought together several leaders in health care chaplaincy to work toward consensus about such standards. This is applicable to a particular subset of chaplains, chaplains in acute care. The work group focused upon

- Minimal but essential standards of practice.
- Standards for board certified chaplains in acute care.

Models in social work and nursing, as well as models in Australian and Canadian chaplaincy, informed this work and provided catalysts for identifying and briefly explicating standards of practice within health care chaplaincy in acute care settings. The work group encourages chaplains serving in contexts other than acute care to utilize and adapt these standards for their own contexts. Organizational context will shape how the individual chaplain addresses all the standards.

DISTINCTIONS IN TERMINOLOGY

In order to provide clarity, the following definitions of "standards of practice," "competency standards," "scope of practice," and "best practice" are offered.

- Standards of Practice are authoritative statements that describe broad responsibilities for which practitioners are accountable, "reflect the values and priorities of the profession," and "provide direction for professional … practice and a framework for the evaluation of practice."[vii] They describe a function, action, or process that is directed toward the patient to contribute to the shared goal(s) of the patient and health care team. For example, a Standard of Practice may require that there is a process for assessing the spiritual/religious needs of patients.
- Competency standards define what skills and training are required for the provider of care, i.e., the chaplain. For example, competencies will state what the requirements are for the chaplain to have the credentials to do the spiritual/religious assessment.
- Scope of Practice refers to the expression of the standard of practice in the chaplain's individual context. For example, the scope of practice states where, when, and how a chaplain in a particular health care organization carries out his/her assessments.
- Best practice refers to a technique, method, or process that is more effective at delivering a particular outcome or a better outcome than another technique, method, or process. Best practices are demonstrated by becoming more efficient or more effective. They reflect a means of exceeding the minimal standard of practice. For example, a spiritual/religious assessment best practice will offer a more effective method for chaplains to do their assessments.

Although many terms are defined at the end of this document in the "Glossary," a few terms need clarification now.

- The term "patient" encompasses the patient *and* the situation, including family and staff.
- The term "staff," e.g., "staff care," means all staff, volunteers, doctors, and students in a health care setting.
- Throughout the standards, "chaplain" refers to a board certified chaplain serving in acute care.
- The term "spiritual/religious" recognizes the differences inherent in the two individual concepts but links them for sake of ease in this document.

THE CREDENTIALS OF THE BOARD CERTIFIED CHAPLAIN

According to the *Common Standards for Professional Chaplaincy*, any board certified chaplain will have the following basic qualifications and accountabilities:

- Obtained a bachelor's degree from a college or university that is appropriately accredited.
- Obtained an appropriately accredited master's degree in theological studies or its equivalent.
- Be ordained, commissioned, or similarly recognized by an appropriate religious authority according to the standard practice and policy of that authority.
- Completed four units (1600 hours) of Clinical Pastoral Education as accredited by the Association for Clinical Pastoral Education (ACPE), the United States Conference of Catholic Bishops Commission on Certification and Accreditation, or the Canadian Association for Pastoral Practice and Education (CAPPE/ACPEP); one of these units may be an equivalency.
- Current endorsement by a recognized religious faith group for ministry as a chaplain.
- Met competencies for chaplaincy as established by the Spiritual Care Collaborative.[viii]
- Remain accountable to the endorsing faith group, employer, and certifying body.
- Affirm and practice chaplaincy according to the *Common Code of Ethics.*
- Maintain membership in a certifying body by participating in a peer review every five years, documenting at least 50 hours of continuing education each year, and providing documentation of endorsement with her or his faith tradition every five years.

SCOPE OF SERVICES

Chaplains provide a broad and diverse range of services including:

- An assessment and determination of a plan of care that contributes to the overall care of the patient that is measurable and documented.
- Participating in interdisciplinary teamwork and collaboration.
- Providing spiritual/religious resources, e.g., sacred texts, Shabbat candles, music, prayer rugs, rosaries, etc.).
- Offering rituals, prayer, and sacraments.

- Contributing in ethics, e.g., through a primary chaplaincy relationship, participation on an ethics committee or consultation team, and/or participation on an institutional review board.
- Helping interpret and broker cultures and faith traditions that impact health care practice and decisions.
- Educating and consulting with the health care staff and the broader community
- Building relationships with local faith communities and their leaders on behalf of the health care organization.
- Offering care and counsel to patients and staff regarding dynamic issues, e.g., loss/grief, spiritual/religious struggle as well as strengths, opportunities for change and transformation, ethical decision making, difficult communication or interpersonal dynamic situations.
- Providing leadership within the health care organization and within the broader field of chaplaincy.

ACCOUNTABILITY

This Standards of Practice for Professional Chaplains in Acute Care document is a fluid document that will change as health care chaplaincy continues to mature and as situations change. It is a project of the APC Commission on Quality in Pastoral Services, which is responsible for the work and to which this work group is accountable. This work group is largely composed of board certified chaplains from the APC but also includes those with (non-representative) ties to the Association for Clinical Pastoral Education (ACPE) and the National Association of Catholic Chaplains (NACC). Thus, although brought together by an APC Commission, this work group is not writing for any particular organization but seeks to contribute to the wider profession of chaplaincy. Participants in the Work Group included George Fitchett, Daniel Grossoehme, George Handzo, Martha Jacobs, David Johnson, Robert Kidd, Stephen King, Mark LaRocca-Pitts, Ted Lindquist, Jane Mather, Kimberly Murman, Floyd O'Bryan, Jon Overvold, Don Patterson, Brent Peery and Sue Wintz.

PREAMBLE

Chaplaincy care is grounded in initiating, developing and deepening, and bringing to an appropriate close, a mutual and empathic relationship with the patient, family, and/ or staff. The development of a genuine relationship is at the core of chaplaincy care and underpins, even enables, all the other dimensions of chaplaincy care to occur. It is assumed that all of the standards are addressed within the context of such relationships.[ix]

SECTION 1: CHAPLAINCY CARE WITH PATIENTS AND FAMILIES

STANDARD 1: ASSESSMENT

Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.

INTERPRETATION

Assessment is a fundamental process of chaplaincy practice. Provision of effective care requires that chaplains assess and reassess patient needs and modify plans of care accordingly. A chaplaincy assessment in health care settings involves relevant biomedical, psycho-social, and spiritual/religious factors, including the needs, hopes, and resources of the individual patient and/or family.

A comprehensive chaplaincy assessment process includes:

- Gathering and evaluating information about the spiritual/religious, emotional and social needs, hopes, and resources of the patient or the situation
- Prioritizing care for those whose needs appear to outweigh their resources

MEASUREMENT CRITERIA

- Gathers data in an intentional, systematic, and ongoing process with the assent of the patient.
- Involves the patient, family, other health care providers, and the patient's local spiritual/religious community, as appropriate, in the assessment.
- Prioritizes data collection activities based on the patient's condition or anticipated needs of the patient or situation.
- Uses appropriate assessment techniques and instruments in collecting pertinent data.
- Synthesizes and evaluates available data, information, and knowledge relevant to the situation to identify patterns and variances.
- Documents relevant data and plans of care in a retrievable format accessible to the health care delivery team.

EXAMPLES[x]

- Basic: Demonstrates familiarity with one accepted model for spiritual/religious assessment and makes use of that model in his/her chaplaincy practice as appropriate.
- Intermediate: Demonstrates familiarity with several published models for spiritual/religious assessment and is able to select an appropriate model for specific cases within his/her chaplaincy practice.
- Advanced: Demonstrates familiarity with several published models for spiritual/religious assessment and is able to teach others in their use.

STANDARD 2: DELIVERY OF CARE

The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.

INTERPRETATION

The chaplain develops and implements a plan of care, in collaboration with the patient, the patient's family, and with other members of the health care team. It includes interventions provided to achieve desired outcomes identified during assessment. Chaplains are able to adapt practice techniques to best meet patient needs within their health care setting. Care will be based on a comprehensive assessment.

MEASUREMENT CRITERIA

- Involves the patient, family, and other health care providers in formulating desired outcomes, interventions, and personalized care plans when possible and appropriate.
- Defines desired outcomes, interventions, and plans in terms of the patient and the patient's values, spiritual/religious practices and beliefs, ethical considerations, environment, and/or situation.
- Identifies desired outcomes, interventions, and plans to provide direction for continuity of care.
- Conducts a systematic and ongoing evaluation of the outcomes in relation to the interventions prescribed by the plan.
- Modifies desired outcomes, interventions, and plans based on changes in the status of the patient or evaluation of the situation.
- Documents desired outcomes, interventions, plans, and evaluations in a retrievable format accessible to the health care delivery team.

EXAMPLES

- Develops chaplaincy care pathways or uses published ones to deliver consistent care.
- Uses an outcome-oriented plan of care as found, for example, in *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy*.[xi]

STANDARD 3: DOCUMENTATION OF CARE

The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.

INTERPRETATION

Documentation related to the chaplain's interaction with patient, family, and/or staff is pertinent to the overall plan of care and therefore accessible to other members of the health care team. The format, language, and content of a chaplain's documentation respect the organizational and regulatory guidelines with regard to confidentiality while ensuring that the health care team is aware of relevant spiritual/religious needs and concerns.

Documentation should include but is not limited to the following:

- Spiritual/religious preference and desire for or refusal of on-going chaplaincy care.
- Reason for encounter.
- Critical elements of spiritual/religious assessment .
- Patient's desired outcome with regard to care plan.
- Chaplain's plan of care relevant to patient/family goals.
- Indication of referrals made by chaplain on behalf of patient/family.
- Relevant outcomes resulting from chaplain's intervention.

MEASUREMENT CRITERIA

- Documentation is readily accessible to all disciplines.
- Information included reflects assessment and delivery of care as well as appropriate privacy/confidentiality.

EXAMPLES

- Documentation in medical record of spiritual/religious screening and assessment.
- Documentation in medical record indicating patient's on-going spiritual/religious and ritual needs and the plan for meeting such needs, e.g., anointing, communion, Sabbath candles, clergy visits.
- Documentation in medical record indicating spiritual/religious struggle issues that affect the plan of care.
- Documentation in medical record indicating the patient's wish to receive or terminate on-going chaplaincy care.
- Documentation in medical record indicating chaplain's participation on interdisciplinary teams affecting patient's plan of care.

STANDARD 4: TEAMWORK AND COLLABORATION

The chaplain collaborates with the organization's interdisciplinary care team.

INTERPRETATION

Patient and family chaplaincy care is a complex endeavor that necessitates the chaplain's effective integration within the wider care team. Such integration requires the chaplain's commitment to clear, regular communication patterns, as well as dedication to collegial, collaborative interaction.

MEASUREMENT CRITERIA

- Possesses a thorough knowledge of the services represented on the interdisciplinary care team.
- Alert to patient referral opportunities that arise while providing chaplaincy care.
- Maintains professional interpersonal relationships with the interdisciplinary care team members.
- Participates as fully as possible in the organization's interdisciplinary care team meetings.
- Works collaboratively to implement the interdisciplinary care team's plan, ensuring that the patient's wishes and wholeness remain primary.
- Promptly responds to interdisciplinary care team member referrals.
- Communicates chaplaincy care interventions using the organization's approved interdisciplinary communication channels.
- Educates staff regarding the role of chaplaincy care.

EXAMPLES

- Maintains solid interpersonal relationships within the interdisciplinary team.
- Contributes consistently and meaningfully to interdisciplinary meetings, including sharing information derived from skillful assessment.
- Documents chaplaincy interactions using professional language through means readily accessible to other care team members.

STANDARD 5: ETHICAL PRACTICE

The chaplain will adhere to the *Common Code of Ethics,* which guides decision-making and professional behavior.[xii]

INTERPRETATION

The chaplain understands the multiple levels of relationship that are established in the process of providing care to patients, family members, and staff. This care is frequently provided in a context of cultural, spiritual, and theological differences when individuals are often at a vulnerable point in their lives. An understanding of professional boundaries and ethical relationships is of utmost importance.

MEASUREMENT CRITERIA

- Protects the confidential relationships with those under her/his care.
- Maintains clear boundaries for sexual, spiritual/religious, financial, and/or cultural values.

EXAMPLES

- Is respectful of various theological and religious values.
- Participates in continuing education events with a focus in ethical decision making.
- Understands personal/professional limitations and seeks consultation when needed.

STANDARD 6: CONFIDENTIALITY

The chaplain respects the confidentiality of information from all sources, including the patient, medical record, other team members, and family members in accordance with federal and state laws, regulations, and rules.

INTERPRETATION

An understanding of the use of information, which has been given to a chaplain by the individual who is receiving care, is important. Knowing and deciding what information to keep to oneself; what to share with other staff members, state or regulatory agencies and/or what to publish as clinical vignettes mark various degrees of confidentiality.

MEASUREMENT CRITERIA

- Charting only what is appropriate for the care being received.
- Safeguarding privacy when using clinical material for educational activities or publishing.
- Understanding the ramifications of the laws, rules, and regulations regarding confidentiality within the state where one practices.
- Maintains the confidentiality of anyone who is a subject in a research project and uses appropriate informed consent with such a research project.

EXAMPLES

- Understands the issues of the "pastoral confession" vs. confidentiality by appropriate state law.
- Communicates what is and is not reportable to authorities when a confidential conversation is desired.
- Understands the ramification of a decision to keep confidential information that could be at odds with the legal authorities, e.g., sanctuary/deportation issues.

STANDARD 7: RESPECT FOR DIVERSITY

The chaplain models and collaborates with the organization and its interdisciplinary team in respecting and providing culturally competent patient-centered care.

INTERPRETATION

The chaplain includes in her/his assessment the identification of cultural and spiritual/religious issues, beliefs, and values of the patient and/or family that may impact the plan of care. The chaplain assists the interdisciplinary team, through practice and education, in incorporating issues of diversity into the patient's plan of care.

MEASUREMENT CRITERIA

- Demonstrates a thorough knowledge and understanding of cultural and spiritual/religious diversity.
- Defines and incorporates desired outcomes, interventions, and plans into the assessment and plan of care in terms of the patient's/family's culture, spiritual/religious practices and beliefs, ethical considerations, environment, and/or situation.
- Identifies and respects spiritual/religious and/or cultural values; assists in identifying and responding to identified needs and boundaries.

EXAMPLES

- Functions as a cultural broker for the organization.
- Provides education to interdisciplinary staff in cultural and spiritual/religious diversity.

SECTION 2: CHAPLAINCY CARE FOR STAFF AND ORGANIZATION

STANDARD 8: CARE FOR STAFF

The chaplain provides timely and sensitive chaplaincy care to the organization's staff via individual and group interactions.

INTERPRETATION

Though patient and family chaplaincy care is the primary focus of chaplains, the chaplaincy care provided to organizational staff is of critical importance.

Staff care involves a wide range of chaplaincy services for all health care team members within the organization. These services vary in their complexity. At a basic level, that includes such things as one-on-one supportive conversations with staff as well as provision of public worship opportunities. At a more complex level, staff care includes such things as Critical Incident Stress Management or Psychological First Aid interventions and formal counseling, all of which require specialized training.

MEASUREMENT CRITERIA

- Provides supportive conversations with staff.
- Provides chaplaincy care to the organization's staff through spiritually/religiously inclusive, non-coercive interactions.
- Proactively offers group rituals, particularly after emotionally significant events.
- Refers to and receives referrals from the organization's Employee Assistance Program where appropriate.
- Provides timely collaborative peer support activities during times of critical incidents.

EXAMPLES

- Offers informal one-on-one support with staff members.
- Celebrates of staff accomplishments (employment anniversaries, job promotions, educational graduations, etc.).
- Attends to staff needs through scheduled public opportunities.
- Provides memorial rituals for staff, especially after unexpected deaths.
- Conducts formal one-on-one counseling sessions, group work, and critical incident responses; gives attention to grief issues and family/work-related stresses.

STANDARD 9: CARE FOR THE ORGANIZATION

The chaplain provides chaplaincy care to the organization in ways consonant with the organization's values and mission statement.

INTERPRETATION

Chaplains are alert to potential means of expressing their organization's spiritual aspirations. At the same time, chaplains are sensitive to their organization's cultural and spiritual/religious diversity. While respecting this diversity, chaplains are creative and proactive in implementing initiatives that honor and champion the spiritual/religious aspects of their organization's mission.

MEASUREMENT CRITERIA

- Maintains professional and on-going interpersonal relationships with organizational leaders.
- Plans and implements corporate, spiritually based rituals consistent with the organization's mission statement and community needs.
- Creates and maintains adequate public sacred spaces in collaboration with hospital leaders.
- Supports the design and placement of public religious symbols in ways that are consonant with the organization's spiritual/religious heritage.
- Assists in leading the organization's inspirational community observances.
- Offers public relations guidance to highlight sacred components of healing.
- When possible, the chaplain provides a voice to create and implement policies that respect the organization's staff and patients.

EXAMPLES

- Cultivates personal relationships with hospital leaders through regular and intentional face-to-face interactions.
- Designs and utilizes appropriate public relations materials that highlight spiritual components of the organization's mission.
- Designs and maintains mission-appropriate sacred spaces that meet the spiritual/religious needs of patients, families, and staff.
- Creates and leads corporate spiritual/religious rituals that undergird transcendent aspects of the organizations' mission, e.g., National Organ/Tissue Donor Awareness Day, National Day of Prayer, World Communion Day.

STANDARD 10: CHAPLAIN AS LEADER

The chaplain provides leadership in the professional practice setting and the profession.

INTERPRETATION

As the chaplain in the practice setting, the chaplain will take leadership within that setting on issues related to spiritual/religious/cultural care and observance. The chaplain will also have an obligation to help advance the profession of chaplaincy through providing education, supporting colleagues, and participating in his or her certifying organization.

MEASUREMENT CRITERIA

- Serves in key roles in the work setting by participating in or leading committees, councils, and administrative teams.
- Contributes to key organizational initiatives that draw on the knowledge and skills of the professional chaplain such as cultural competence training, customer and staff retention, and communications training.
- Mentors colleagues and writes for publication.
- Promotes advancement of the profession through active participation in his or her certifying association.
- Advocates that the size of the chaplaincy staff is aligned with the scope and complexity of the organization and the nature of chaplaincy care needs are related to the complexity of the medical care needs of the organization.

EXAMPLES

- Basic: Serves on organizational committees such as Ethics, Customer Satisfaction, Institutional Review Board, and service-based projects; trains organizational staff on communications and religious/spiritual/cultural issues.
- Intermediate: Presents at the certifying association's yearly conference and other education events.
- Advanced: Writes for publications.

SECTION 3: MAINTAINING COMPETENT CHAPLAINCY CARE

STANDARD 11: CONTINUOUS QUALITY IMPROVEMENT

The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.

INTERPRETATION

All health care organizations have programs for continuous quality improvement and the chaplain participates in programs that are relevant to chaplaincy care. The chaplain contributes to the organization's quality initiatives with other members of the interdisciplinary team. Using current, established quality improvement methodologies and with the support of the organization's quality department, the chaplain identifies processes in the delivery of chaplaincy care for ongoing review and improvement.

MEASUREMENT CRITERIA

- Collects relevant data to monitor quality and effectiveness of chaplaincy care services.
- Develops and implements an annual plan for chaplaincy care quality improvement.
- Participates in the quality improvement program of the health care organization.
- Participates on interdisciplinary teams to monitor opportunities for quality improvement in the clinical setting.
- Uses the results of quality improvement activities to initiate change in methods of delivering chaplaincy care.
- Reports quality improvement initiatives and outcomes to the organization's quality improvement program.

EXAMPLES

- Basic: The chaplain participates in a quality improvement project that is multi-disciplinary. The chaplain is not responsible for the whole project but contributes alongside other team members.
- Intermediate: A chaplaincy department develops an annual plan for continuous quality improvement. Results are reported to the organization's quality improvement leadership.
- Advanced: In large health systems, projects are developed and implemented across the system to improve chaplaincy care. Hospitals within a system benchmark results and foster an ongoing process of quality improvement.

STANDARD 12: RESEARCH

The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.

INTERPRETATION

Chaplaincy care has for many years been provided based on the concept of "presence" and non-directive active listening and on the chaplain's sense that her/his offerings are effective (sometimes based on direct feedback from families, patients or staff). However, other health care disciplines, over the past ten years, reviewed their practices and have begun to base their practices on research evidence. Increasingly, chaplains have been asked to demonstrate that they, too, practice out of a research base, and explicitly make a contribution to health care. Chaplaincy care is amenable to research in many ways; its practitioners should be sufficiently familiar with existing evidence to present it to their health care colleagues from other disciplines, read and reflect on new research's potential to change their practice and be willing and able to integrate that which is better for patients, families, and/or staff. In some cases, where the chaplain has sufficient skills and support, this will also mean participating in or creating research efforts to improve chaplaincy care.

MEASUREMENT CRITERIA

- Demonstrates familiarity with published research findings that inform clinical practice through reading professional journals and other materials.
- Critically evaluates new research for its potential to improve clinical practice and integrates new knowledge into clinical practice.
- Contributes through collaboration with other researchers of various disciplines, or if appropriate, initiates research projects intended to improve clinical practice and publishes the findings.

EXAMPLES

- Basic: Reads and discusses research articles in professional journals, e.g., *The Journal of Pastoral Care & Counseling; Mental Health, Religion & Culture; New England Journal of Medicine,* and considers implications for practice.

  Uses published research to educate administrators or other health care professionals on the role, value, or impact of chaplaincy.

- Intermediate: Creates and executes research and disseminates the findings to the wider community.

  Serves on organization's Institutional Review Board (IRB).

  Collaborates with researchers in other disciplines (or with other chaplains) in research projects designed for publication in peer-reviewed journals.

- Advanced: Functions as either Principle or Co-Investigator in one or more peer-reviewed research studies that are published in peer-reviewed journals or presented as an abstract/paper at conferences.

  Serves on an editorial board as peer-reviewer for a professional journal.

STANDARD 13: KNOWLEDGE AND CONTINUING EDUCATION

The chaplain assumes responsibility for continued professional development, demonstrates a working and current knowledge of current theory and practice, and integrates such information into practice.

INTERPRETATION

In order to meet the needs of the patients in the chaplain's area of ministry, the chaplain continues to grow and develop professionally and spiritually/religiously to meet the changing needs of the profession, his/her practice, and/or the organization's needs.

MEASUREMENT CRITERIA

Relevant continuing education is accountable

- within the *Common Standards for Professional Chaplaincy* and any applicable organizational, state, and/or federal requirements that guide the profession,
- to the function, specialty, and/or the strategic initiatives of the organization in which they are employed,
- to current theory/practice which may be found by reading and reviewing current peer-reviewed literature, such as the *Journal of Pastoral Care and Counseling*, advanced medical journals, the *Hastings Center Report*, and the *Oates Journal*. Of interest would also be new research vehicles and books that advance the practice of chaplaincy care.

EXAMPLES

The chaplain may be guided by

- his/her needs, interests, and/or performance evaluation, including professional and personal goals/objectives for the year,
- outcomes, reflections, and feedback from the five year Maintenance of Membership Peer Review that factor into the chaplain's professional development plan,
- areas of growing importance to the field, such as quality improvement, research, and data collection,
- the need to continually learn and implement self-care practices to bring balance to his/her life through healthy habits, e.g., nutrition, rest, relationships, exercise, spirituality.

GLOSSARY

acute care setting. Where care is provided to patients with shorter term physical and psychological needs. It is usually a hospital but may include ambulatory, emergency, rehabilitation, and palliative care settings; distinguished from long-term care or home hospice.

assent. Reflects the patient's agreement with care rather than authorization.

board certified chaplain. A chaplain who has met all of the requirements of the Common Standards (See http://www.spiritualcarecollaborative.org/docs/common-standards-professional-chaplaincy.pdf, accessed January 14, 2009.)

chaplaincy care. Care provided by a board certified chaplain or by a student in an accredited clinical pastoral education program, e.g., ACPE. Examples of such care include emotional, spiritual, religious, pastoral, ethical, and/or existential care. (See Brent Peery, "What's in a Name?", *PlainViews*, Volume 6, No. 2 [February 18, 2009]. www.plainviews.org)

clinical pastoral education. "Clinical Pastoral Education is interfaith professional education for ministry. It brings theological students and ministers of all faiths (pastors, priests, rabbis, imams and others) into supervised encounter with persons in crisis. Out of an intense involvement with persons in need, and the feedback from peers and teachers, students develop new awareness of themselves as persons and of the needs of those to whom they minister. From theological reflection on specific human situations, they gain a new understanding of ministry. Within the interdisciplinary team process of helping persons, they develop skills in interpersonal and interprofessional relationships." (http://www.acpe.edu/faq.htm#faq1, accessed January 31, 2009.)

clinical pathways. Clinical pathways are known by a variety of terms, such as pathways, clinical protocols, parameters, templates, and benchmarks. The term speaks to a continuum of care that identifies structures, caregivers, and processes that intervene at critical points to efficiently treat the patient and achieve a defined outcome. Pathways can be developed for medical conditions, specific patient groups, or actual services such as chaplaincy care. Clinical pathways are essentially care maps that prescribe treatment for a particular patient. Often, they are used to coordinate care between different health care disciplines and to monitor the costs of care. However, they are also useful in mapping the contributions of a particular discipline to the care team and prescribing that discipline's "branch" of the overall care tree. Increasingly, if a discipline is not represented on a given care map, it is not included in that patient's care.

Common Code of Ethics. Gives expression to the basic values and standards of the profession, guides decision making and professional behavior, provides a mechanism for professional accountability, and informs the public as to what they should expect from professionals. (http://www.spiritualcarecollaborative.org/docs/common-code-ethics.pdf, accessed January 14, 2009.)

competency. Possession of required skill, knowledge, and/or qualifications.

continuous quality improvement. A management philosophy that emphasizes an ongoing effort to improve the effectiveness and efficiency of processes and products. It began in manufacturing, was brought to prominence by the Toyota Production System, and is now almost universally practiced in health care as a way of driving up satisfaction and driving down cost. The central goals are to improve efficiency and effectiveness. Examples include Six Sigma, Plan-Do-Check-Act, and DMAIC Methodology.

cultural broker. "An individual who bridges, links, or mediates between groups or persons of different cultural backgrounds for the purpose of reducing conflicts, producing change, or advocating on behalf of a cultural group or person. Cultural brokers can also be medical professionals who draw upon cultural and health science knowledge and skills to negotiate with the patient and health system toward an effective outcome" (Amy Wilson-Stronks, Karen K. Lee, Christina L. Cordero, April L. Kopp, and Erica Galvez, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations* [The Joint Commission, 2008], 57. http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf, accessed February 9, 2009.)

culture. "Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" (Amy Wilson-Stronks, Karen K. Lee, Christina L. Cordero, April L. Kopp, and Erica Galvez, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations* [The Joint Commission, 2008], 57. http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf, accessed February 9, 2009.)

endorsement. "An official declaration by a recognized faith community/tradition that a person meets its standards to serve in a specialized ministry setting of chaplaincy, counseling, or clinical education." (From, DRAFT: A Covenant between Religious Endorsing Bodies and Pastoral Care Certifying Bodies. Revised November 7, 2008.)

evaluation. The comparison of a clinical practice (real or potential) against some standard, which could be an identified "best practice," the current practice, or a clinical outcome.

evidence-based. The integration of the best research and available clinical evidence with one's clinical expertise and knowledge of patient/family values in order to facilitate clinical decision-making. This normally follows a five step process consisting of (1) development of a clinical question (2) a literature search for evidence of efficacy (3) critical appraisal of article(s), (4) summary of evidence found and determination of adequacy, and (5) development of a care recommendation.

family. Refers to family members, loved ones, and/or significant others of the patient.

interdisciplinary. An approach to care that involves two or more disciplines (professions) collaborating to plan, care, treat, or provide services to an individual patient and/or family. Examples include social work, nursing, medicine, and chaplaincy care.

intervention. Any act, with or without words, originating in the chaplain's discipline, offered or intended for another's healing or well-being.

pastoral care. Coming out of the Christian tradition, "pastoral care developed within the socially contracted context of a religious or faith community wherein the "pastor" or faith leader is the community's designated leader who oversees the faith and welfare of the community and wherein the community submits to or acknowledges the leader's overseeing. The "faith" they share is a mutually received and agreed upon system of beliefs, actions, and values. The faith leader's care for his or her community is worked out within a dialectical relationship between the person's unique needs, on the one hand, and the established norms of the faith community, as represented by the pastor, on the other" (Mark LaRocca-Pitts, "Agape Care: A Pastoral and Spiritual Care Continuum," *PlainViews*, vol. 3, #2 [February 15, 2006]. Pastoral care may form part of the care provided by a chaplain. See "chaplaincy care."

patient. A generic term referring to a patient/resident/client and/or family as a unit who receive care, treatment, and/or services.

peer review. A process intended to be a collegial and reflective view of one's chaplaincy care practice, ministry, service, and/or professional development. In the context of one's peers, the review is intended to stimulate personal and professional growth.

plan. A detailed method that identifies needs, lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, protocols, practice guidelines, interventions, clinical pathways, and desired outcomes.

principal investigator. The individual judged by that person's organization to have the appropriate level of authority and responsibility to direct a project or program, including financial responsibility (if appropriate, e.g., funded research projects) and who bears final responsibility for the findings. This individual is normally the senior author of the final report or article when there are multiple investigators.

relevant data. Information pertinent to assessing, providing, and assessing care and often used in continuous quality improvement.

religion. "An organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) foster an understanding of one's relationship and responsibility to others in living together in a community" (Harold G. Koenig, Michael E. McCullough, and David B. Larson, *Handbook of Religion and Health* [New York: Oxford University Press, 2001], 18.)

religious. See religion.

research. A systematic investigation, including development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. (Adapted from Department of Health and Human Services (2005). Protection of Human Subjects. US Federal Code, Title 46, Subpart D, Section 102.)

spirit. Spirit, as the transcending part of the tripartite human (i.e., body, mind, and spirit), enables a person to connect with self, others, time, place, ideas, nature, and the Divine. Connecting is spiritual, which gives rise to relationships from which a person derives their sense of meaning and purpose. (Mark LaRocca-Pitts, "Spiritual Care Means *Spiritual*," *PlainViews*, Volume 6, No. 2 [February 18, 2009], www.plainviews.org.)

spiritual. See spirit and spirituality.

spiritual care. "Interventions, individual or communal, that facilitate the ability to express the integration of the body, mind, and spirit to achieve wholeness, health, and a sense of connection to self, others, and[/or] a higher power." (American Nurses Association, & Health Ministries Association. (2005). Faith and community nursing: Scope and standards of practice. Silver Spring, MD: American Nurses Association.) Spiritual care forms part of the care provided by a chaplain. See "chaplaincy care."

Spiritual Care Collaborative. "The Spiritual Care Collaborative is an international group of professional organizations collaborating to advance excellence in professional pastoral and spiritual care, counseling, education and research." Participating organizations include the American Association of Pastoral Counselors, the Association of Clinical Pastoral Education, the Association of Professional Chaplains, the Canadian Association of Pastoral Practice and Education, the National Association of Catholic Chaplains, and the National Association of Jewish Chaplains. (http://www.spiritualcarecollaborative.org/mission.asp, accessed February 9, 2009.)

spiritual/religious assessment. Spiritual/religious assessment refers to a more extensive [in-depth, on-going] process of active listening to a patient's story as it unfolds in a relationship with a professional chaplain and summarizing the needs and resources that emerge in that process. The summary includes a spiritual care plan with expected outcomes which should be communicated to the rest of the treatment team. (See George Fitchett and Andrea L. Canada, "The Role of Religion/Spirituality in Coping with Cancer: Evidence, Assessment, and Intervention," in *Psycho-oncology*, 2nd ed., ed. Jimmie C. Holland [New York: Oxford University Press, forthcoming].)

spiritual/religious history. Spiritual/religious history-taking is the process of interviewing a patient, asking them questions about their life, in order to come to a better understanding of their needs and resources. The history questions are usually asked in the context of a comprehensive examination, by the clinician who is primarily responsible for providing direct care or referrals to specialists such as professional chaplains. (See George Fitchett and Andrea L. Canada, "The Role of Religion/Spirituality in Coping with Cancer: Evidence, Assessment, and Intervention," in *Psycho-oncology*, 2nd ed., ed. Jimmie C. Holland [New York: Oxford University Press, forthcoming].)

spiritual/religious screening. Spiritual/religious screening or triage is a quick determination of whether a person is experiencing a serious spiritual/religious crisis and therefore needs an immediate referral to a professional chaplain. Good models of spiritual/religious screening employ a few, simple questions, which can be asked by any health care professional in the course of an overall screening. (See George Fitchett and Andrea L. Canada, "The Role of Religion/Spirituality in Coping with Cancer: Evidence, Assessment, and Intervention," in *Psycho-oncology*, 2nd ed., ed. Jimmie C. Holland [New York: Oxford University Press, forthcoming].)

spiritual/religious struggle. Spiritual/religious struggle may develop for some people when they are unable to make sense of stressful events in light of their spiritual/religious worldview. Research has shown that elements of spiritual/religious struggle have a negative impact on health including anger with God, feeling abandoned by God, and questioning God's love for oneself. Other elements of spiritual/religious struggle include feeling punished by God, and feeling hurt or betrayed by one's congregation or by religious authority figures. Additional research is needed to help us develop a comprehensive definition of spiritual/religious struggle. (See G. Fitchett, P. E. Murphy, J. Kim, J. L. Gibbons, J. R. Cameron, and J. A. Davis. "Religious Struggle: Prevalence, Correlates and Mental Health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients," *International Journal of Psychiatry in Medicine* 34, no. 2 [2004], 179-196; K. I. Pargament, B. W. Smith, H. G. Koenig, and L. Perez, "Patterns of Positive and Negative Religious Coping with Major Life Stressors" *Journal for the Scientific Study of Religion* 37 [1998], 710-724; K. I. Pargament, H. G. Koenig, N. Tarakeshwar, and J. Hahn, "Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: a two-year longitudinal study" *Journal of Health Psychology* 9, no. 6 [2004], 713-730.)

spirituality. "The personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community" (Harold G. Koenig, Michael E. McCullough, and David B. Larson, *Handbook of Religion and Health* [New York: Oxford University Press, 2001], 18).

staff. All people who provide care, treatment, and services in the organization, including those receiving pay, volunteers, and health profession students.

standard. "Standards are authoritative statements by which the [chaplaincy] profession describes the responsibilities for which its practitioners are accountable. Consequently, standards reflect the values and priorities of the profession. Standards provide direction for professional [chaplaincy] practice and a framework for the evaluation of practice. Written in measurable terms, standards also define the [chaplaincy] profession's accountability to the public and the … outcomes for which [chaplains] are responsible." (American Nurses Association, *Nursing: Scope and Standards of Practice* (Silver Springs, MD: American Nurses Association, 2004), 77.)

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[i] Adapted from Dan Murphy, an e-mail response to "Standards of Practice Responses," "Standards of Practice for Professional Chaplains in Health Care Settings," *PlainViews*, Volume 6, No. 2 (February 18, 2009). http://www.plainviews.org. Accessed March 26, 2009.

[ii] Stephen D. W. King, *Trust the Process: A History of Clinical Pastoral Education as Theological Education* (Lanham, MD: University Press of America, 2007).

[iii] W. R. Monfalcone, "General Hospital Chaplaincy," in R. Hunter (Ed), *Dictionary of Pastoral Care and Counseling*, expanded edition, (Nashville, TN: Abingdon Press, 2005), 456-57; John Rea Thomas and Mark LaRocca-Pitts, *Compassion, Commitment & Consistence: The Rise of Professional Chaplaincy* (The Association of Professional Chaplains, 2006), 2.

[iv] Russell Dicks, "Standards for the Work of the Chaplain in the General Hospital," *Hospitals* (November 1940). Reprinted in *The Caregiver Journal* 12 (1996): 2-5, and in John Rea Thomas and Mark LaRocca-Pitts, *Compassion, Commitment & Consistence: The Rise of Professional Chaplaincy* (The Association of Professional Chaplains: 2006), Appendix A.

[v] American Association of Pastoral Counselors (AAPC), Association of Professional Chaplains (APC), Association of Clinical Pastoral Education (ACPE), Canadian Association for Pastoral Practice and Education (CAPPE/ACPEP, National Association of Catholic Chaplains (NACC), and the National Association of Jewish Chaplains (NAJC).

[vi] http://www.spiritualcarecollaborative.org/standards.asp. Accessed November 19, 2008.

[vii] American Nurses Association, *Nursing: Scope and Standards of Practice* (Silver Springs, MD: American Nurses Association, 2004), 77.

[viii] Theory of Pastoral Care includes theology, psychological and sociological disciplines, group dynamics, ethics, and emotional and spiritual dimensions of human development. Identity and Conduct includes respect for the other; appropriate boundaries; self-awareness in respect to one's strengths and limitations; the impact of one's attitudes, values, and assumptions; self-care; communication skills; professionalism; advocacy; and ethical behavior. Pastoral practice includes the ability to form deep relationships, provide effective care, manage crises, provide care in grief and loss, utilize spiritual assessments, provide appropriate spiritual/religious resources, and provide appropriate public worship, facilitate theological reflection. Professionalism includes the ability to integrate chaplaincy care into the life of the organization, establish and maintain interdisciplinary relationships, understand organizational culture and systems, promote ethical decision-making, document chaplaincy work appropriately, and form appropriate collaborative relationships with local faith communities and their leaders. See http://www.spiritualcarecollaborative.org/docs/common-standards-professional-chaplaincy.pdf. Accessed November 19, 2008.

[ix] Murphy, "Standards of Practice Responses."

[x] Throughout the document, examples are illustrative and not prescriptive.

[xi] Larry VandeCreek and Arthur M. Lucas, eds., *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy* (New York, London, Oxford: The Haworth Pastoral Press, 2001).

[xii] http://www.spiritualcarecollaborative.org/standards.asp. Accessed November 19, 2008.