

Active Listening Skills- Handout

“In true listening, we reach behind the words, see through them, to find the person who is being revealed. Listening is a search to find the treasure of the true person as revealed verbally and non-verbally. There is a semantic problem, of course. The words bear a different connotation for you than they do for me.

Consequently, I can never tell you what you have said, but only what I have heard.

I will have to rephrase what you have said, and check it out with you to make sure that what left your mind and heart arrived in my mind and heart intact and without distortion”...

John Powell

Non Verbal Communication

Non-verbal communication is the first communication we receive from and give to another person. Studies have found that the total impact of a message is about 7% verbal, 38% tone of voice and 55% non-verbal (body posture, gesture, eye contact, facial expression etc.)

Attending well involves being aware of our own non-verbal messages which could be creating barriers as well as attending carefully to the non-verbal clues a person is sending us. It is worth bearing the following in mind. Even if the person cannot actually see you, body language can be detected by sound, tone etc

- Avoid physical barriers between you and the other person and try and sit at equal height
- If the person is a wheelchair user try and find a seat that is equal in height to the wheelchair.
- Be sensitive to the space between the seats; different people will feel comfortable at different distances
- Keep your arms uncrossed (even with non- sighted people) and avoid fiddling or distracting movements
- Face the person and maintain a comfortable degree of eye contact, ensuring that this does not become a fixed stare. People with vision impairment can also tell if you are not facing them when you are talking to them.

- Sometimes it is helpful to use a light touch of the hand of someone who is visually impaired to indicate the distance you are sitting in relation to them.

Active Listening

The term 'active listening' underlines the fact that effective listening is far from a passive process. This active process demands that we first grasp what the person means and then communicate this to them. This demonstrates the helper's willingness and ability to understand the concerns of the other person. As Volunteers you are not expected to fulfil a counselling role with service users, and in such instances an appropriate referral may need to be made, but having listening skills is essential to developing a relationship of trust and support.

The skills of active listening are very different from the way we listen in everyday conversation. It means that we not only have to develop new skills, but we also have to unlearn old ones. These skills of active listening include:

- Paraphrasing
- Reflecting feelings
- Summarising
- Using questions
- Focusing

Before looking at these skills, we will look at some types of response that can get in the way of active listening. Here are some possible barriers:

- Thinking about your own experience "The same thing happened to me!" As Volunteers you are not there to talk about your own issues or problems
- Thinking about something quite different whilst the other person is talking
- Thinking about what to say back
- Feeling self-conscious or anxious in the situation
- Working out some advice to give, based on your own personal experience
- Judging the person, either positively or negatively: "Surely you didn't want to do that!" or "I think you were right to say that."

- Deep cultural issues
- Ignorance and prejudice

All of these responses get in the way of true listening. Listening to others therefore includes the following:

- STOPPING TALKING-you can't listen while you are talking
- DON'T GIVE UP TOO SOON-give person time to say what they want and don't interrupt
- CONCENTRATE ON WHAT THE PERSON IS SAYING-actively focus on words, ideas, feelings of the speaker
- LOOK AT THE OTHER PERSON-even without vision people can tell whether you are facing them or not
- GIVE SOME VERBAL RESPONSES- such as "Aha" or "Yes" but don't overdo it
- LEAVE YOUR ISSUES BEHIND- as they can prevent you from listening well
- GET RID OF DISTRACTIONS including pen and paper
- SHARE RESPONSIBILITY FOR COMMUNICATION-try to understand and if you don't ask for clarification
- REACT TO IDEAS, NOT TO PERSON-don't let your reaction to person influence your interpretation of what they say
- LISTEN TO HOW SOMETHING IS SAID-a person's attitudes and emotional reactions may be more important than what s/he says in so many words. Listen for personality, likes, dislikes
- ALLOW PEOPLE TIME AND SPACE TO THINK-avoid temptation to fill silence. If you have time constraint let person know in advance
- AVOID JUMPING TO ASSUMPTIONS-people don't always think, feel, use words in the same way as you do
- DON'T MAKE HASTY JUDGEMENTS-wait until you are in possession of all the facts
- RESIST FEELING THAT YOU HAVE TO SOLVE THE PROBLEM-if you are focused on finding answers then you are not listening

SKILLS OF ACTIVE LISTENING

1. Paraphrasing: This takes us back to school when we were told to 'put the following passage into your own words in order to show that you have understood what you have read'. It is a verbal skill that communicates to the other that we have not only heard but understood. They then have a chance to verify

the accuracy of what you have heard and understood. You select your own words to describe the other's experience. In doing this it is important that you do not add to or distort the other's meaning.

Example:

Person: *I am completely worn out- it's twice as difficult for me to get around now with physical disability and my family think I am feeling sorry for myself*

Volunteer: *You are exhausted trying to adjust to situation and your family don't seem to be able to understand*

Some possible introductory phrases for paraphrasing:

- So, what I hear you saying is...
- It sounds like you...
- If I understand you correctly...
- You are telling me that...

2. Reflecting: This is a very important listening tool as it mirrors the meaning and feeling of what has been said. Making an appropriate reflection involves not only identifying accurately the client's feelings but also selecting with sensitivity the appropriate time, tone of voice and words to convey this to the other. The aim of a reflection is to help the other feel understood, accepted and encouraged to share more of their feelings. It is also important to be tentative in the way in which s/he makes the reflection

Example:

Person: *I'm just wasting your time. There must be others who have much more serious problems than me.*

Volunteer: *You sound as if you are worried that your problems are not important enough.*

Person: *I'm always being left out. Because I can't get around as easily people have stopped asking me to go out.*

Volunteer: *You sound hurt about being excluded because of people's lack of understanding of how your disability has affected you*

or

I'm sensing you feel misunderstood and even more isolated because of this

FOCUSING: Useful for pointing person in right direction. One focusing technique that can be useful when the person is unable to express why they are upset, or is confused is to ask the person to use just one word to describe his/her problem. Then the person is asked to put the word in a phrase followed by a simple sentence that describes the problem.

Example:

Volunteer: Tell me in just one word or short phrase what you want?

Person: My family

Volunteer: All right your family. Now put that in a sentence and describe what you want,

Person: I want my family and my family life back

Other focusing techniques include stopping at something a person mentions repeatedly and gently asking them if they could tell you a little more about that please.

SUMMARISING: This can be useful in clarifying points made in a conversation or when a person gets stuck or goes off the point. It involves pulling together the main strands/points of a discussion and organising them so that they can be reviewed, confirmed or corrected (Moursund, 1990).

Guidelines

- Put together the key ideas and feelings into broad statements of the person's basic meanings
- Attend to the person's various themes and emotional overtones.
- Be brief and direct.
- Do not add to what the person has said, and avoid interpretations and evaluations.

Example: *May I just check that I have understood this correctly? You have told me of a few choices open to you. You could try ringing your sister-in law directly and telling her how you feel, approach your brother or give the situation more time to see what happens. What do you see as the advantages and disadvantages of each of these possibilities?*

Chaplaincy Mission Statement

Our mission is to provide spiritual care and comfort to the patients of Spectrum Health – Pennock, their families, and our staff so that all experience wholeness, wellness, and peace.

Vision Statement

We envision doing this as a part of a health care team which includes medical professionals, support staff, and spiritual leaders associated with the patients and families we serve. To this end we are to be guided by the following

Values

When a patient and family have an established relationship with a pastor, spiritual leader or church, we will work to nurture that relationship.

When a patient and family have no such relationship, we will assess the patient and family to determine their need or desire for spiritual support.

We will respect the patient's right to confidentiality.

We will respect a patient and/or families request to receive no spiritual support.

We will function as a supportive member of the healthcare team.

We will not impose any particular religious, theological, or spiritual beliefs or values on anyone.

Our dealings with patients and families will be highlighted by warm acceptance, patience, and concern for their well-being.

When conflicting interests or standards arise; the best interest of the patient shall govern all actions.

Beliefs

We believe that human life consists of three primary components – the physical, spiritual and emotional.

That wellness not only consists in the wellness of these components *but also* their harmony.

That distress in any of these components affects the others and may need to be addressed through medical or spiritual intervention.

That patients, families, and staff member may need our assistance in achieving wellness

That a chaplain, as a member of the health team, is uniquely qualified and entrusted with the duty to assist patients, families, and staff members with these needs

Area	Benchmark	Month	June	July	August	September
Census*						
P/C informed						
Sacraments						
Pt. Prayer						
Pt. Visit (M/S)						
Family visit (M/S)						
Pt. Visit (ICU)						
Family visit (ICU)						
Standards of Care						
Lit Request						
RPCC Req.						
Surg. Waiting Rm						
Rounds						
Defusings						
Debriefings						
Counseling						
Other						
Community Clergy						

CHAPLAINCY REPORT CARD

October November December January February March April May

Church Name	Denomination	Pastor's First, Last Name
Faith Bible Baptist Church	Baptist	Lee Owens
Memorial Presbyterian Church	Presbyterian	Dave Arnold

Church Directory Data Base

Church Address	Office Phone #	Home Phone #	Cell Phone
2494 Midway Dr Middleville MI	269-676-2201	269-676-4353	616-809-21
121 Lincoln Ave. Hastings, MI	269-445-1700	269-445-2975	803-908-27

#	Social Media	Flight
.31	FB, T, LI	2
'27	FB	1

Effective Hospital Visits

The hardest thing about hospital visitation is finding a parking spot!" jokes Kathryn Greene-McCreight, assistant priest at St. John's Episcopal Church in New Haven, Connecticut. But there's more to it than just parking and showing up. I asked experienced pastoral care people for their collective wisdom.

1. Pray before you arrive. Whether it's in your car, on the elevator, or just outside the room, ask God to work through you. "Anyone can visit a hospital," says Bruce Sonnenberg of Village Church in Irvine, California. "You're there as a representative of Jesus."

2. Understand HIPAA. The Health Insurance Portability and Accountability Act places severe restrictions on information that can be disclosed about a patient's medical record. "A patient will have a list of people who can know about his condition," explains Steve Murray, pastor of Trinity Baptist Church in Nashua, New Hampshire. "Get on that list."

Herb Flitton, a chaplain at North Dakota State Hospital in Jamestown, North Dakota, notes, "Most health professionals don't like HIPAA any more than clergy." To smooth your interactions with hospital staff:

- Identify yourself as a pastor.
- Ask for the room number of your parishioner—this implies you already know that the patient has been admitted, which is itself restricted information.
- If you receive resistance, ask the staff or receptionist to pass on a message that the patient contact you or approve you for the release of information.

3. Have a plan, but don't expect to use it. Know what you want to do when you visit. Don't get caught fumbling for a story or Bible verse or expecting the patient to direct the conversation. Balance that plan, with a healthy dose of discernment. If the patient is falling asleep, cut your story short.

4. Don't obstruct the flow. Pastor of First Presbyterian Church in Cambria, Wisconsin, Kristin Frederich recalls some timeless seminary advice: "Whatever you do, don't get in the way of plugs or tubes." Most hospital staffs are easy to work with once you introduce yourself, explain why you're there, and determine to let them do what they need to do.

The two most important elements

Offer to pray and to read Scripture. These are perhaps the two most important aspects of a visit. Even if the person has a weak or non-existent faith, prayer can be meaningful. Pastor Steve Murray recommends, "Ask for a favorite verse. If they have none, use an appropriate passage you selected ahead of time." Many pastors default to the Psalms, especially 23, 91, and 139. But if the patient says she can't handle one more verse about death, don't give her one.

5. Keep it short. Visit for ten minutes or so, less if the person is in discomfort. "People don't realize how exhausting it is to be a patient," offers Greene-McCreight. Between medicines, therapies, and other visitors, many patients are too tired to talk.

6. Be sensitive, but not timid. "Don't avoid the pressing conversations about surgery or a serious diagnosis," says Flitton. Also, assess the depth of conversation. Ask yourself, *Is this a time to address fears? Is this a good time to be silent?* Sonnenberg recommends that when visiting patients, pastors "look into their eyes to see their heart, to see if they're tired or scared."

Greene-McCreight says "This is not the time to talk about all the bad news in the world. It's not the time to talk about yourself, either—which can come across as uncaring."

7. Lend a healing touch. Sonnenberg points out, "A pastor's touch can represent some of the only non-clinical contact a patient receives." Frederich calls this a direct extension of Jesus' ministry as he touched the sick and dying. Take a hand while praying or reading Scripture. Before you initiate any kind of touch, however, ask permission.

8. Don't rush out the door. Be sensitive to certain situations when it is best to stay longer—when the patient has few visitors, needs practical help, or clearly desires the counsel of a pastor. Feel free to sit in silence, too. "What you say isn't really important," counsels Frederich. "Your presence matters more than anything."

9. Remember the family. "A lot of people in the hospital need to do business with God," says Murray. But, he advises, "don't overlook the family that is waiting around." They often require similar pastoral care. Visit at least once while the family is there and share your desire to serve them, too.

Joint Commission Review Crosswalk for Chaplain Services

Commentary items are included in the “Hospital Plan for Chaplain Services Department,” “Chaplaincy Policies and Procedures,” and/or “Department Scope of Service” or in the Hospital P&P. Also found on the APC website.

Joint Commission Standards are cited with permission from the 2011 Joint Commission E-dition Release 3.0 for Hospitals

- Rev. 5.11 Stephen King, BCC, Network Liaison to The Joint Commission, APC Commission on Quality in Pastoral Services
- 9.08 Jon Overvold, BCC, Chair, APC Commission on Quality in Pastoral Services
- 6.05 Sue Wintz, BCC, former Chair, APC Commission on Quality in Pastoral Services

2011 Joint Commission Standard	Commentary/Chaplaincy	Needing Department Attention
<p>Rights and Responsibilities of the Individual RI.01.01.01 The hospital respects, promotes, and promotes patient rights.</p>	<p>Chaplaincy care is the responsibility of the Chaplaincy department. Chaplaincy follows the Common Code of Ethics.</p>	
<p>Elements of Performance</p> <ul style="list-style-type: none"> 2. The hospital informs the patient of his or her rights. (See also RI.01.01.03, EPs 1-3) 4. The hospital treats the patient in a dignified and respectful manner that supports his or her dignity. 5. The hospital respects the patient’s right to and need for effective communication. (See also RI.01.01.03, EP 1) 6. The hospital respects the patient’s cultural and personal values, beliefs, and preferences. 7. The hospital respects the patient’s right to privacy. (See also IM.02.01.01, EPs 1-5) 9. The hospital accommodates the patient’s right to religious and other spiritual services. 28. The hospital allows a family member, friend, or other individual to be present with the patient for 	<p>EP 28 and 29 are NEW.</p> <p>The chaplain helps the hospitals advocate for the rights of those significant in the lives of the patients.</p>	

<p>emotional support during the course of stay. Note 1: The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EPs 6-8.) Note 2: [Effective July 1, 2011, this will be part of the accreditation survey.] 29. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: [Effective July 1, 2011, this will be part of the accreditation survey.]</p>		
<p>RI. 01.01. 03 The hospital respects the patient's right to receive information in a manner he or she understands</p>	<p>Chaplains provide culturally sensitive, age appropriate, language specific, and spiritually/religiously appropriate care</p>	
<p>RI. 01.02.01 The hospital respects the patient's right to participate in decisions about his or her care, treatment, and services</p>	<p>Chaplains participate in patient/family centered care, palliative care, and ethics committee</p>	
<p>RI. 01.03.05 The hospital respects the patient's right to participate in decisions about his or her care, treatment, and services. Elements of Performance 1. The hospital reviews all research protocols and weighs the risks and benefits to the patient participating in the research.</p>	<p>Both IRB participation and IRB approval for research in which Chaplains are investigators or staff In conducting research, Chaplains follow all research ethics and regulations in order to protect the patient</p>	

<p>2. To help the patient determine whether or not to participate in research, investigation, or clinical trials, the hospital provides the patient with all of the following information:</p> <ul style="list-style-type: none"> - An explanation of the purpose of the research - The expected duration of the patient's participation - A clear description of the procedures to be followed - A statement of the potential benefits, risks, discomforts, and side effects - Alternative care, treatment, and services available to the patient that might prove advantageous to the patient <p>3. To help the patient determine whether or not to participate in research, investigation, or clinical trials, the hospital provides the patient with all of the following information:</p> <ul style="list-style-type: none"> - An explanation of the purpose of the research - The expected duration of the patient's participation - A clear description of the procedures to be followed - A statement of the potential benefits, risks, discomforts, and side effects - Alternative care, treatment, and services available to the patient that might prove advantageous to the patient <p>4. The hospital documents the following in the research consent form: That the patient received information to help determine whether or not to participate in the research, investigation, or clinical trials.</p> <p>5. The hospital documents the following in the research</p>		
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<p>consent form: That the patient was informed that refusing to participate in research, investigation, or clinical trials, or discontinuing participation at any time will not jeopardize his or her access to care, treatment, and services unrelated to the research.</p> <p>6. The hospital documents the following in the research consent form: The name of the person who provided the information and the date the form was signed.</p> <p>7. The research consent form describes the patient's right to privacy, confidentiality, and safety.</p>		
<p>RI. 01.05.01 The hospital addresses patient decisions about care, treatment, and services received at the end of life</p> <p>Elements of Performance</p> <p>10. Upon request, the hospital refers the patient to resources for assistance in formulating advance directives.</p>	<p>Chaplains explore the values of the patient, including advance directives, and both encourage the patient to communicate to the health care team and communicate themselves to the health care team as appropriate.</p> <p>Chaplains are one of the resources for assisting patients in formulating advance directives consistent with the patient's values and goals</p>	
<p>RI. 01.06.03 The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.</p>	<p>Chaplains are respectful, maintain appropriate boundaries, and honor the Common Code of Ethics</p>	
<p>PC.01.02.01 The hospital assesses and reassesses its patients.</p> <p>Elements of Performance:</p> <p>1. The hospital defines, in writing, the scope and content of screening, assessment, and reassessment</p>	<p>Screening, assessment, and reassessment are included in the comprehensive plan for chaplaincy care.</p>	

<p>information it collects</p> <ol style="list-style-type: none"> 2. The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. 4. Based on the patient's condition, information gathered in the initial assessment includes the following: <ul style="list-style-type: none"> - Physical, psychological, and social assessment - Nutrition and hydration status - Functional status - For patients who are receiving end-of-life care, the social, spiritual, and cultural variables that influence the patient's and family members' perception of grief 		
<p>PC. 01.02.03 The hospital assesses and reassesses the patient and his or her condition according to defined time frames</p>	<p>Time frame for initial assessments (and ideally reassessment) included in Chaplaincy scope of service documents</p>	
<p>PC. 01.02.05 Qualified staff or independent practitioners assess or reassess the patient</p>	<p>All practitioners can screen. Preferably a BCC (or supervisee) assesses or reassesses</p>	
<p>PC.01.02.07 The hospital assesses and manages the patient's pain.</p> <p>Elements of Performance:</p> <ol style="list-style-type: none"> 1. The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient's condition. (See also PC.01.02.01, EP 2; RI.01.01.01, EP 8) 2. The hospital uses methods to assess pain that are consistent with the patient's age, condition, and ability to understand. 3. The hospital reassesses and responds to the patient's 	<p>Chaplains may have a role in addressing pain</p>	

<p>pain, based on its reassessment criteria.</p> <p>4. The hospital either treats the patient’s pain or refers the patient for treatment.</p>		
<p>PC.01.02.11 The hospital assesses the needs of patients who receive psychosocial services for the treatment of alcoholism or other substance use disorders.</p> <p>Elements of Performance</p> <p>5. Based on the patient’s age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following:</p> <ul style="list-style-type: none"> - The patient’s religion and spiritual beliefs, values, and preferences - Living situation - Leisure and recreation activities - Military service history - Peer-group - Social factors - Ethnic and cultural factors - Financial status - Vocational or educational background - Legal history - Communication skills 	<p>Alcoholism or other substance abuse added to triggers for assessment in Scope of Practice and Plan of Care.</p>	
<p>PC. 01.02.13 The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.</p> <p>Elements of Performance</p> <p>3. Based on the patient’s age and needs, the assessment for patients receiving psychosocial services for the</p>	<p>Treatment of emotional or behavioral disorders added to triggers for assessment in Scope of Practice and Plan of Care.</p>	

<p>treatment of alcoholism or other substance use disorders includes the following:</p> <ul style="list-style-type: none"> - The patient’s religion and spiritual beliefs, values, and preferences - Living situation - Leisure and recreation activities - Military service history - Peer-group - Social factors - Ethnic and cultural factors - Financial status - Vocational or educational background - Legal history - Communication skills 		
<p>PC. 01.03.01 The hospital plans the patient’s care.</p> <p>Elements of Performance</p> <ol style="list-style-type: none"> 1. The hospital plans the patient’s care, treatment, and services based on needs identified by the patient’s assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2) 5. The written plan of care is based on the patient’s goals and the time frames, settings, and services required to meet those goals. 22. Based on the goals established in the patient’s plan of care, staff evaluate the patient’s progress. 23. The hospital revises plans and goals for care, treatment, and services based on the patient’s needs. (See also RC.02.01.01, EP 2) 	<p>Included in Chaplaincy’s Scope of Service</p>	
<p>PC. 02.01.05 The hospital provides interdisciplinary, collaborative care, treatment, and services.</p>	<p>Chaplaincy care is enhanced when provided in an interdisciplinary approach. Included</p>	

<p>Elements of Performance:</p> <p>1. Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner.</p>	<p>in Chaplaincy's Scope of Service</p>	
<p>PC. 02.01.21 The hospital effectively communicates with patients when providing care, treatment, and services. Note: This standard will not effect the accreditation decision at this time.</p> <p>Rationale:</p> <p>This standard emphasizes the importance of effective communication between patients and their providers of care, treatment, and services. Effective patient-provider communication is necessary for patient safety. Research shows that patients with communication problems are at an increased risk of experiencing preventable adverse events, * and that patients with limited English proficiency are more likely to experience adverse events than English speaking patients. ** ***</p> <p>Identifying the patient's oral and written communication needs is an essential step in determining how to facilitate the exchange of information with the patient during the care process. Patients may have hearing or visual needs, speak or read a language other than English, experience difficulty understanding health information, or be unable to speak due to their medical condition or treatment. Additionally, some communication needs may change during the course of care. Once the patient's</p>	<p>NEW</p>	

<p>communication needs are identified, the hospital can determine the best way to promote two-way communication between the patient and his or her providers in a manner that meets the patient’s needs. This standard complements RI.01.01.01, EP 5 (patient right to and need for effective communication); RI.01.01.03, EP 2 (provision of language interpreting and translation services); and RI.01.01.03, EP 3 (meeting needs of patients with vision, speech, hearing, or cognitive impairments).</p> <p>Footnote *: Bartlett G, Blais R, Tamblyn R, Clermont RJ, MacGibbon B: Impact of patient communication problems on the risk of preventable adverse events in acute care settings. CMAJ 178(12):1555–1562, Jun. 3, 2008.</p> <p>Footnote **: Divi C, Koss RG, Schmaltz SP, Loeb JM: Language proficiency and adverse events in U.S. hospitals: A pilot study. Int J Qual Health Care 19(2):60–67, Apr. 2007.</p> <p>Footnote ***: Cohen AL, Rivara F, Marcuse EK, McPhillips H, Davis R: Are language barriers associated with serious medical events in hospitalized pediatric patients? Pediatrics 116(3):575–579, Sep. 2005.</p> <p>Elements of Performance:</p> <ol style="list-style-type: none"> 1. The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1) <p>Note 1: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication</p>		
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<p>boards, and translated or plain language materials. Note 2: This element of performance will not affect the accreditation decision at this time.</p> <p>2. The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. (See also RI.01.01.03, EPs 1-3) Note 1: This element of performance will not affect the accreditation decision at this time.</p>		
<p>PC. 02.02.03 The hospital makes food and nutrition products available to its patients.</p> <p>Elements of Performance: 9. When possible, the hospital accommodates the patient's cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.</p>	<p>Included in Chaplaincy's Scope of Service as a trigger for assessment</p>	
<p>PC.02.02.13 The patient's comfort and dignity receive priority during end-of-life care.</p> <p>Elements of Performance 1. To the extent possible, the hospital provides care and services that accommodate the patient's and his or her family's comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs. 2. The hospital provides staff with education about the unique needs of dying patients and their families.</p>	<p>Included in Chaplaincy's Scope of Service. Additional trigger for assessment</p>	
<p>PC.02.03.01 The hospital provides patient education and training based on each patient's needs and abilities.</p> <p>Elements of Performance:</p>	<p>Chaplains have an educational role in health care. Trigger for assessment. Included in Chaplaincy's Scope of Service.</p>	

<ol style="list-style-type: none"> 1. The hospital performs a learning needs assessment for each patient, which includes the patient’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication. 2. The hospital provides education and training to the patient based on his or her assessed needs. 5. The hospital coordinates the patient education and training provided by all disciplines involved in the patient’s care, treatment, and services. 		
<p>DISCHARGE OR TRANSFER PC.04.01.01 The hospital has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.</p>	<p>Included in Chaplaincy’s Scope of Service. Chaplaincy provides education and/or a plan for ongoing spiritual/religious care post-transfer or discharge as needed</p>	
<p>HOSPITAL PERFORMANCE IMPROVEMENT PI.01.01.01 The hospital collects data to monitor its performance.</p>	<p>Included in Chaplaincy’s Scope of Service—continuous quality improvement (CQI)</p>	
<p>PI.02.01.01 The hospital compiles and analyzes data.</p> <p>Elements of Performance</p> <ol style="list-style-type: none"> 1. The hospital compiles data in usable formats. 2. The hospital identifies the frequency for data analysis. 3. The hospital uses statistical tools and techniques to analyze and display data. 4. The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. 12. When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified 	<p>Included in Chaplaincy’s Plan for CQI.</p>	

<p>in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes.</p> <p>Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to work flow; competency assessment; credentialing; supervision of staff; and orientation, training, and education.</p>		
<p>PI.03.01.01 The hospital improves performance.</p> <p>Elements of Performance:</p> <ol style="list-style-type: none"> 1. Leaders prioritize the identified improvement opportunities. (See also PI.02.01.01, EP 8; MS.05.01.01, EPs 1-11) 2. The hospital takes action on improvement priorities. (See also MS.05.01.01, EPs 1-11) 3. The hospital evaluates actions to confirm that they resulted in improvements. (See also MS.05.01.01, EPs 1-11) 4. The hospital takes action when it does not achieve or sustain planned improvements. (See also MS.05.01.01, EPs 1-11) 	<p>Included in Chaplaincy’s Plan for CQI.</p>	
<p>PI 04.01.01 The hospital uses data from clinical/service screening indicators and human resource screening indicators to assess and continuously improve staffing effectiveness.</p>	<p>Included in Chaplaincy’s Plan for CQI.</p>	
<p>LEADERSHIP</p> <p>LD.03.02.01 The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.</p>	<p>Included in Chaplaincy’s Plan for CQI.</p>	

<p>Rationale: Data help hospitals make the right decisions. When decisions are supported by data, hospitals are more likely to move in directions that help them achieve their goals. Successful hospitals measure and analyze their performance. When data are analyzed and turned into information, this process helps hospitals see patterns and trends and understand the reasons for their performance. Many types of data are used to evaluate performance, including data on outcomes of care, performance on safety and quality initiatives, patient satisfaction, process variation, and staff perceptions.</p> <p>Introduction A hospital's culture reflects the beliefs, attitudes, and priorities of its members, and it influences the effectiveness of performance. Although there may be a dominant culture, in many larger hospitals diverse cultures exist that may or may not share the same values. In fact, diverse cultures can exist even in smaller hospitals. Hospital performance can be effective in either case. Successful hospitals will work to develop a culture of safety and quality.</p> <p>In a culture of safety and quality, all individuals are focused on maintaining excellence in performance. They accept the safety and quality of patient care, treatment, and services as personal responsibilities and work together to minimize any harm that might result from unsafe or poor quality of care, treatment, and services. Leaders</p>		
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<p>create this culture by demonstrating their commitment to safety and quality and by taking actions to achieve the desired state. In a culture of this kind, one finds teamwork, open discussions of concerns about safety and quality, and the encouragement of and reward for internal and external reporting of safety and quality issues. The focus of attention is on the performance of systems and processes instead of the individual, although reckless behavior and a blatant disregard for safety are not tolerated. Hospitals are committed to ongoing learning and have the flexibility to accommodate changes in technology, science, and the environment.</p> <p>Elements of Performance:</p> <p>5. The hospital uses data and information in decision making that supports the safety and quality of care, treatment, and services. (See also NR.02.01.01, EPs 3 and 6; PI.02.01.01, EP 8).</p>		
<p>LD.03.03.01 Leaders use hospital-wide planning to establish structures and processes that focus on safety and quality.</p>	<p>Chaplaincy participates in hospital CQI</p>	<p>Elements of Performance:</p>
<p>LD.03.06.01 Those who work in the hospital are focused upon improving safety and quality.</p>	<p>Chaplaincy participates in hospital CQI</p>	
<p>LD.04.01.05 The hospital effectively manages its programs, services, sites, or departments.</p> <p>Elements of Performance:</p> <ol style="list-style-type: none"> 1. Leaders of the program, service, site, or department oversee operations. 2. Programs, services, sites, or departments providing patient care are directed by one or more qualified 	<p>Responsibility and Accountability in Chaplaincy documents</p>	

<p>professionals or by a qualified licensed independent practitioner with clinical privileges.</p> <p>3. The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. (See also NR.01.01.01, EP 5)</p> <p>4. Staff are held accountable for their responsibilities.</p> <p>5. Leaders provide for the coordination of care, treatment, and services among the hospital's different programs, services, sites, or departments. (See also NR.01.01.01, EP 1)</p>		
<p>LD.04.01.07 The hospital has policies and procedures that guide and support patient care, treatment, and services.</p>	<p>Hospital plan includes Chaplaincy/chaplaincy care.</p>	
<p>LD.04.01.11 The hospital makes space and equipment available as needed for the provision of care, treatment and services.</p> <p>Elements of Performance:</p> <p>2. The arrangement and allocation of space supports safe, efficient, and effective care, treatment, and services.</p>		
<p>LD.04.03.07 Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.</p> <p>Elements of Performance:</p> <p>1. Variances in staff, setting, or payment source do not affect outcomes of care, treatment, and services in a negative way.</p> <p>2. Care, treatment, and services are consistent with the hospital's mission, vision, and goals.</p>	<p>Equity of care is a standard for Chaplaincy</p>	
<p>LD. 04.03.09 Care, treatment, and services provided</p>	<p>Some Chaplaincy services are through</p>	

<p>through contractual agreement are provided safely and effectively.</p> <p>Elements of Performance:</p> <ol style="list-style-type: none"> 1. The hospital describes, in writing, the nature and scope of services provided through contractual agreements. 4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services. 	<p>contractual agreements. Those services must also be safe and effective.</p>	
<p>LD.04.04.03 New or modified services or processes are well-designed.</p> <p>Elements of Performance:</p> <ol style="list-style-type: none"> 1. The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others. 2. The hospital's design of new or modified services or processes incorporates the results of performance improvement activities. 4. The hospital's design of new or modified services or processes incorporates evidence-based information in the decision-making process. Note: For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards. 7. Leaders involve staff and patients in the design of new or modified services or processes. 	<p>This might be part of a CQI approach.</p>	
<p>LD. 04.04.07 The hospital considers clinical practice</p>	<p>Chaplains participate in hospital and</p>	

<p>guidelines when designing or improving processes.</p> <p>Rationale: Clinical practice guidelines can improve the quality, utilization, and value of health care services. ... Sources of clinical practice guidelines include the Agency for Healthcare Research and Quality, the National Guideline Clearinghouse, and professional organizations.</p>	<p>departmental CQI.</p>	
<p>TRANSPLANT SAFETY TS.01.01.01 The hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs and tissues.</p> <p>Elements of Performance:</p> <ol style="list-style-type: none"> 5. Staff education includes training in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families of potential organ, tissue, or eye donors. 6. The hospital develops, in collaboration with the designated organ procurement organization, written procedures for notifying the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes. 7. The individual designated by the hospital to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor. <p>Note: A designated requestor is an individual who</p>	<p>Chaplain may function as or interact with Organ Procurement Organization Facilitator or Designated Family Communications Coordinator.</p>	

<p>has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation.</p>		
<p>HUMAN RESOURCES HR.01.02.01 The hospital defines staff qualifications.</p> <p>Elements of Performance: 1. The hospital defines staff qualifications specific to their job responsibilities. (See also IC.01.01.01, EP 3 and RI.01.01.03, EP 2)</p>	<p>Included in Staffing Plan; Definition of Board Certified Chaplain is included in Chaplaincy documents.</p>	
<p>HR.01.04.01 The hospital provides orientation to staff.</p> <p>Elements of Performance: 5. The hospital orients staff on the following: Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of this orientation is documented. 6. The hospital orients staff on the following: Patient rights, including ethical aspects of care, treatment, and services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented.</p>	<p>Chaplain is both educator and engages in education</p>	
<p>HR.01.05.03 Staff participate in ongoing education and training.</p>	<p>Chaplains must also continue to learn and grow.</p>	
<p>HR.01.06.01 Staff are competent to perform their responsibilities.</p> <p>Elements of Performance:</p>	<p>Chaplaincy defines and achieves competencies for service</p>	

<ol style="list-style-type: none"> 1. The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. 2. The hospital uses assessment methods to determine the individual's competence in the skills being assessed. Note: Methods may include test taking, return demonstration, or the use of simulation. 5. Staff competence is initially assessed and documented as part of orientation. 6. Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. 15. The hospital takes action when a staff member's competence does not meet expectations. 		
<p>RECORD OF CARE, TREATMENT AND SERVICES</p> <p>RC.02.02.01 The medical record contains information that reflects the patient's care, treatment, and services.</p> <p>Elements of Performance: (A summary follows)</p> <ul style="list-style-type: none"> • Documentation and findings of assessments and reassessments • The reason(s) for admission for care, treatment, and services • The goals of the treatment and the treatment plan • Progress notes made by authorized individuals • All reassessments and plan of care revisions, when indicated 	<p>Chaplains document in the medical record</p>	

<ul style="list-style-type: none"> • The response to care, treatment, and services provided • Advance directives 		
<p>INFORMATION MANAGEMENT IM.02.02.01 The hospital protects the privacy of health information.</p> <p>Elements of Performance: 4. The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. (See also RI.01.01.01, EP 7)</p>	Chaplaincy documents are clear about privacy in relationship to sharing health information, including with faith groups, and in terms of opening medical records	

The FACT Spiritual History Tool **Mark LaRocca-Pitts, PhD, BCC**

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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** – Faith (and/or Beliefs, Spiritual Practices)
- A** – Active (and/or Availability, Accessibility, Applicability)
- C** – Coping (and/or Comfort); Conflict (and/or Concern)
- T** – Treatment Plan

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

F: What is your faith or belief?

- Do you consider yourself spiritual or religious?
- What things do you believe that give your life meaning and purpose?

A: Are you active in your faith community?

- Are you part of a religious or spiritual community?
- Is support for your faith available to you?
- Do you have access to what you need to apply 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 coping with your medical situation?

- Is your faith (your beliefs) helping you cope?
- How is your faith (your beliefs) providing comfort in light of your diagnosis?
- Do any of your religious beliefs or spiritual practices Conflict with medical treatment?
- Are there any particular Concerns you have for us as your medical team?

T: Treatment 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:

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***Spectrum Health – Pennock
Hospital***
**HIPAA Confidentiality and
Privacy Training**
For Chaplaincy Staff

Introduction

HIPAA Confidentiality and Privacy

As employees of Spectrum Health - Pennock Hospital we promise to give patients the highest quality health care, and patients expect that we keep information about their health confidential, sharing it only with people who need the information to do their jobs. Confidentiality and patient privacy has been part of our **Code of Conduct, Standards of Behavior, State laws, and JCAHO standards for patient care.**

Under a new national law it will be illegal to violate this code. The ***Health Insurance Portability and Accountability Act*** or **HIPAA** for short, includes punishments for anyone caught violating patient privacy. Under HIPAA, the hope is that educated patients will be able to trust their providers and the organization in which they work. To build trust, HIPAA calls on health care workers and others with access to patient information (***covered entities***) to learn the rules for privacy and confidentiality and then live by them.

Confidentiality and privacy means that patients have the right to control who will see their protected, identifiable health information. This means that communication with or about patients involving patient health information will be private and limited to those who need the information to provide treatment, payment, or healthcare operations. Such communications may involve verbal discussion, written communication, or electronic communications. Only those people and computer processors with an authorized need to know will have access to protected information. Hospitals and healthcare organizations have always upheld strict privacy and confidentiality policies. Now with the passing of HIPAA a patient's right to have his or her health information kept private and secure/confidential became more than just an ethical obligation of physician's and hospital, it is now a law.

The U.S. government has begun to strengthen the laws protecting privacy and confidentiality in response to situations in which private medical information has ended up in the wrong hands. For example, in various states employers have fired good employees shortly after the company learned the employee tested positive for genetic illnesses that could lead to lost work time and increased insurance costs. Individual's health information has been used against them in divorce and custody proceedings, political elections, loan applications, and various other ways. Cases of misuse of health information have caused lawsuits. As the number of cases of health information being misused rises, Congress has taken action to ensure hospitals and healthcare providers protect health information privacy and confidentiality.

Overview: What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 is a multifaceted piece of legislation that covered these three areas: 1) Insurance portability, 2) Fraud enforcement (accountability) and 3) Administrative Simplification (reduction in health care costs). HIPAA was enacted to improve the efficiency and efficacy of the healthcare system. The first two components of HIPAA are already in effect, ***portability*** and ***accountability***.

Portability ensures that individuals moving from one health plan to another will have the continuity of coverage and will not be denied coverage under pre-existing clauses.

Accountability significantly increases the federal government's fraud enforcement authority in many different areas.

Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs.

Title II of HIPAA, the Administrative Simplification Provisions of the act require the Department of Health and Human Services to establish:

- National standards for electronic health care transactions
- National identifiers for providers, health plans and employers and
- The security and privacy of "individually identifiable health information" past present or future.

The third component **Administrative Simplification**, is arguably the most significant part of the legislation and will be the focus of this course. Since the implementation date was later than the previous two components, Administrative Simplification requirements received little attention. But today, two of the rules, privacy (which is finalized) and security (which was recently finalized), are generating much discussion and debate in the healthcare community. Concern centers on the administrative, technical, and policy changes that the rules required healthcare organization to make in order to protect their patient's privacy and confidentiality of patient health information (PHI).

The **Administrative Simplification** portion, specifically privacy and confidentiality will be the focus of this course. This portion of HIPAA deals in areas of: **Privacy, Security, Transaction standards**. This rule set national standards for the protection of health information, as applied to **three types of entities: health plans, health care clearing houses, and health care providers** who conduct certain health care transactions electronically.

The three major purposes for the privacy rules are:

- Protect patients' right by giving them access to their health information and control over making sure the records were used appropriately.
- Improve the quality of care by restoring trust in the health care system.
- Improve the efficiency and effectiveness of the way health care is delivered by creating a framework for privacy that build on efforts by states and health systems.

The new changes to **HIPAA will become effective Monday, April 14, 2003**. Once the law is in effect it will be illegal to violate this code. Under the **privacy rule**, finalized during August 2002, healthcare organizations across the country must train all employees in the basics of patient privacy and confidentiality by April 14, 2003. There are significant criminal and civil penalties and liability risks for noncompliance. This applies to all staff members, nurses, physicians, volunteers, and some contract workers at health care facilities. All must become aware of their role in protecting privacy of all patients. The Office for Civil Rights, in the Department of Health and Human Service (HHS), has been charged with enforcing the HIPAA privacy rule.

There are several provisions under HIPAA such as electronic signature, security, transaction, and standard code set, unique identifiers, and information shared between health plans. The **transaction standards and standard code sets** were the first ones to become final. The privacy rules was the second, and most recently, the **security** standard, finalized February 2003, will become effective in 2005. The **electronic signature standards** will also have a great impact on healthcare workers.

Who is covered by the privacy rule?

All healthcare organizations and providers including: hospitals, physician offices, health plans, employers, public health authorities, life insurers, clearing houses, billing agencies, information systems vendors, service organizations, universities. These are known as **covered entities** for HIPAA's privacy and security regulations and covered entities must comply with its regulations. Covered entities, such as the hospital must implement standards to protect and guard against the misuse of individually identifiable health information. Failure to timely implement these standards may, under certain circumstances, trigger the imposition of civil or criminal penalties.

Summary

The information provided will review the main points of the new regulation, identify **who must comply, what is covered, and discuss the legalities and their everyday applications in health care**. Strategies for compliance will also be also discussed. HIPAA requires organization to have detailed policies and procedures in place that dictates how patient information is to be used, when it can be disclosed, and how it should be disposed of. Some of these policies are new and/or are being revised.

Spectrum Health - Pennock Hospital is committed to protecting patient privacy and confidentiality and expects all employees to adhere to the privacy and confidentiality policies. When you fail to protect patient information and patient records by not following the hospital's privacy policy, it can have an impact on your ability to do your job, your status with the organization, and your license to practice. Be sure to read and become familiar with these policies as they become available. **If you are unsure or have any questions, see your supervisor or consult with the hospital's privacy officer.**

Employees are encouraged to **report violations or suspected abuse** to the hospital's **privacy officer** (Sherri Thrasher ext. 1399). You may report violations anonymously, if you wish, and should not fear retaliation for reporting a privacy violation. It is considered part of your job to report instances where you suspect the privacy or confidentiality policies are being broken.

HIPAA: Confidentiality and Privacy Summary Sheet

The **HIPAA privacy rule guarantees patients access to their medical records, gives them more control** over how their **protected health information** is **used and disclosed**, and **provides recourse** if their medical privacy is compromised. The rule also protects the confidentiality of medical records. Health care providers need to understand their responsibilities and rights under the federal privacy regulation to implement new policies and procedures without interfering with access to quality care.

This guide summarizes the HIPAA privacy rule, its implication, and steps to take to ensure compliance.

The HIPAA Privacy Rule

The privacy rule creates national standards to protect individuals' medical records and other personal health information. The rule:

- Gives patients more control over their health information.
- Set boundaries on the use and release of health records.
- Establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- Hold violators accountable with civil and criminal penalties if they violate patients' privacy rights.
- Takes into account public responsibility to disclose some forms of data to protect public health

Who Is Covered By the Privacy Rule?

Providers who conduct electronic transactions, health plans and clearinghouses are covered. If business associates receive or create **protected health information** to perform some function for a hospital, contracts must declare that those business associates will use the information only for the purposes that they were hired to perform, will safeguard the information from misuse and will help the covered entity comply with its HIPAA obligations. They are prohibited from using information in any way that would violate HIPAA.

Protected Health Information (PHI)

- HIPAA protections extend to any identifiable information related to the "past, present or future physical or mental health condition" of a person
- In any form or medium
- Only adequately "de-identified information" is exempt:
- Information that contains no direct identifiers
- It would be virtually impossible to identify from the indirect one that remain

Examples of protected health information include: zip codes, telephone numbers, fax numbers, e-mail addresses, pictures, dates of service, patient history, discharge summary, phone notes, inpatient progress notes, outpatients progress notes, census and allergies. The **Minimum Necessary Standard** states that when using or disclosing protected health information or when requesting protected health information from another covered entity, the provider must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. **"Incidental disclosures"** are not a violation of the privacy rule.

Who is authorized to see protected health information?

Healthcare providers who are directly involved in providing **treatment, payment, or involved with health operations** (TPO) are authorized to see access patient information.

Compliance Date for HIPAA Privacy Rule

The compliance date is **April 14, 2003**. An additional year is allowed for completion of existing contracts that have not expired by the compliance date. New or renewed contracts with business associates must incorporate the requirements into the contracts. HHS expects to issue an enforcement rule soon. The Office for Civil Rights is the enforcement authority.

What is Required of Providers (the hospital) to ensure privacy of patients?

- **Provide information to patients** about their **privacy rights** and how their information may be used.
- Adopt **clear, enforceable privacy procedures**.
- **Train employees** to understand the privacy procedures.
- Designate an individual to be responsible for seeing that the privacy procedures are adopted and followed.
 - This individual is known as the **Privacy Officer: Sherri Thrasher**
She is the Director of Performance Improvement at Spectrum Health - Pennock Hospital and can be reached at ext. 1399.
- **Secure patient records** containing individually identifiable health information so that they are not readily available to those who do not need them.
- Comply with the **minimum necessary** information requirements.

Provider (Hospital's) Responsibilities

- Ensure that patient information is not disclosed improperly.
- Allow patients access to examine their records.
- Allow patients to suggest changes to those records.
- Educate patients on privacy policies (how their data will be used).
- Give patients the right to revoke permission to use data.
- Notify patients of anyone who has seen their records.
- Provide a formal complaint process for patients.
- Allow patients to determine where communications are sent.
- Mitigate damage from inappropriate uses or disclosure.
- Respond within reasonable time and costs to patient requests.
- Maintain a permanent copy of the record (required by law) and appropriately manage it.

◆ HIPAA Rights Guaranteed to Patients

HIPAA provides rights to patients for their protected health information:

- **"access"** - to see, get copy of one's records

- **"amendment"**- to request corrections, statement of disagreement when errors are found
- **"accounting"** - of uses and disclosures of protected health information (patient may request a list of (some of) the entities to which/whom one's records has been disclosed)
- for especially sensitive information, can request extra protections and/or confidential communications
- to complain about, get resolution of, privacy problems

Provider Rights

- Use patient information for treatment, payment, and health care operations.
- Disclose information for treatment, payment and operations by other covered entities.
- Withhold part of the record if disclosure would result in patient harm.
- Disclose information to family members or other patient representatives, if patients cannot speak for themselves.

Fines and Penalties for Violating HIPAA Standards

Civil and criminal penalties for noncompliance include fines up to \$250,000 and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information.

HIPAA Sanctions

- **Civil**

\$100 each violation, up to \$25,000/person/year liability of knew, or reasonably should have known, and attempted cur

- **Criminal**

- "knowing"- up to \$50,000, 1 year in prison

- "under false pretenses"- \$100,00, 5 years in prison

- with "malice" or intent for "personal or commercial gain" - \$250,000, 10 years in prison

Other Sanctions

- Institutional reputation – loss of business, profits
- Employee suspension or termination
- Loss of license to practice
- Civil fines
- Criminal fines and imprisonment

Authorization for Use or Disclosure of Protected Health Information (PHI)

Authorization is not required for use or disclosure of PHI for treatment, payment and health care operations (TPO).

Individual authorization required from patient for:

- Marketing and fund-raising.
- Research-related treatment (unless waived by a n institutional review board).
- Psychotherapy notes.

- Employment determinations.
- State laws impact that may provide authorization for an individual.

Disclosures Not Requiring Authorization from Patient

These disclosures can occur without patient permission:

- Required by law: **public health** (reporting of diseases and conditions, suspicious deaths)
- Health oversight
- Medical devices reporting for injuries, breakdown or malfunction
- To report child abuse, neglect, domestic violence
- For law enforcement investigations
- For judicial or administrative proceedings
- To avert a serious, immediate threat to public safety
- For national security purposes
- Research (IRB approved)
- Decedents
- Worker's compensation
- Specialized governmental functions

Ways to Safeguard Protected Health Information (PHI)

Reasonable efforts for implementation of administrative, technical and physical safeguards are required:

- Verbal conversations precautions: Close doors when discussing treatments and administering procedures.
- Close curtains and speak softly in semi-private rooms when discussing treatments and administering procedures.
- Avoid discussion about patients in public areas such as elevators and cafeteria lines.
- Do not leave messaged on answering machine regarding patient conditions or test results.
- Avoid paging patients using information that could reveal their health problems.
- Secure storage and transportation of patient information.
- Display precautions (e.g., computer screens displayed away from public access)
- Posted or written patient information i.e., whiteboards kept away from public access areas).
- Log off computers when away from workstation.
- Telephone and facsimile precautions: When given patient information regarding condition on the phone limit responses to basic responses *stable* or *critical*.
- Verify the doctor is working on the patient's case; send to a registered fax number on record with the hospital. Send fax only when someone is there to receive it- do not leave in the fax machine for long periods of time.
- Shredding and disposal of PHI. PHI should be placed in closed receptacles, burned, or shredded- never leave in open garbage bins.

- Records are kept locked, only people with a need to see information about patients have access to them.

HIPAA Terminology

HIPAA

Health Insurance and Portability Act of 1996.

- HIPAA has two main goals:
 - making health insurance more portable when persons change employers
 - making the health system more accountable - especially reducing waste and fraud.

Administrative Simplification

- Provision promoting efficiency in the health care system particularly by more use of computers
- Four “rules” that set standards for collection, use and disclosure of health information:
 - Transactions and Code Sets Rule
 - Identifier Rule (unique Ids for providers, plans, employers and maybe, patients)
 - Security Rule (for electronic health information)
 - Privacy Rule (for all health information)

Covered Entities

HIPAA protections for put obligations on almost every organization that provides or pay for health care in the US:

- health plans (health insurers, HMOs, etc.)
- health care providers (that use electronic transactions)
- health information clearinghouses (businesses that specialize in health data processing)

HIPAA Obligations

Covered entities must have appropriate privacy and security policies, which include:

- role-based rules on information use
- training and sanctions to ensure that workforce practices follow policies

Workforce Education

- obligations for a covered entity actually fall on its “workforce” - includes every employee, and every volunteer
- Every member of covered entity’s workforce must be educated – “as necessary and appropriate” to do his/her job

Business Associates

Companies that handle health information on a covered entity's behalf are also

reached by HIPAA:

- covered entities must enter into contracts with all business associates
- limited obligation for covered entities to monitor business associates' practices

State Preemption

State laws that provide "more stringent" privacy protections remain in force:

- HIPAA provides a floor of protections for everyone
- State laws that are "more stringent" are not preempted by HIPAA
- State laws relating to public health and health system oversight also remain in Force

Notice of Privacy Practices

Every patient will receive a Notice from his or her "direct treatment providers" informing him or her of

- Access, correction, accounting, special protections and communications, and complaint processes
- The covered entity's obligations for
 - Appropriate privacy and security policies
 - Workforce training in those policies
 - Business associate monitoring

Acknowledgement of Notice

"direct treatment providers" must make an effort to get written acknowledgment of receipt of the notice from each patient:

- The notice must also be posted in a facility, and copies must be available
- Acknowledgement process provides an opportunity for patients to discuss privacy issues with providers

• Health plans must also issue such notices periodically

Treatment, Payment, Healthcare Operations (TPO)

Acknowledgement constitutes permission for a broad range of "routine" transactions:

- for any and all treatment needs
- to secure payment for that treatment
- for a very long list of other "health care operations"

"Consent" is not required from patient for TPO

Authorization

- Patients must sign a written authorizations for non-routine uses beyond TPO
 - Certain kinds of fundraising, research, marketing
- Authorizations specify who is receiving protected information, for what purpose, and for how long
- Stricter state laws may impose additional authorization (or consent) requirements

Agree or Object

- For a few kinds of routine practices, only an opportunity for oral agreement (or objection) is required including patient's name and condition in a facility's "directory information"
 - discussions of patient's condition with immediate family members

No opportunity to agree or object

- A large number of disclosures can occur without patient permission, just as now:
 - For public health (reporting of diseases and conditions)
 - To report child abuse, neglect, domestic violence
 - For law enforcement investigations
 - For judicial or administrative proceedings
 - To avert a serious, immediate threat to public safety
 - For national security purposes

Minimum Necessary

- Use and disclosure of patient's protected health information should be no more than necessary to get the job done:
 - The regulations acknowledge that "incidental; uses and disclosures" inevitably happen
 - All that is required is "reasonable" effort by health care workforce to achieve minimum necessary

Reasonable, appropriate security

- Attention to technical, physical and administrative measures:
 - Computer and communications protections, door locks and alarms, policies about information use
 - Protections need only be "reasonable" for the circumstances, given costs and current technology
 - Protections must also be appropriate to the kind and amount of information being protected

Complaints of Violations

- Any patient may complain to the institution's "privacy officer" or to the US Department of Health and Human Services (DHHS) Office of Civil Rights
 - Institutions must respond promptly and take appropriate action as needed
- Workforce members may complain to privacy officer or DHHS:
 - With reasonable good faith belief, and disclosing no more than necessary
 - No intimidating, retaliatory acts by covered entity

Privacy, Confidentiality, Data Security, and HIPAA Dilemmas

How would you handle these situations?

1. A family member calls and inquires about the condition of a relative. What do you do?
2. You are a healthcare provider caring for Mrs. Jones, a patient at Mercy Hospital. Dr. Max, a physician at Pennock Hospital asks you to see Mrs. Jones' chart. He is not her physician but her next-door neighbor and is concerned about her health. What do you do?
3. Big Daddy is a well-known entertainer and is a patient in the hospital for a few days before he dies of injuries sustained in an auto accident. All of your friends are begging you to find out more information about what happened to Big Daddy. Your position gives you access to patient's records in the hospital and it would be easy to find out everything everyone is curious about. Your friends tell you Big Daddy won't know or care, plus information will come out in the press in a few days any way. What should you do?
4. You attended a meeting to evaluate certain patients and their medical progress. A list of each patient's name, patient number, and diagnosis is given to everyone at the table for purposes of discussion. At the end of the hour everyone leaves but you notice that several copies of the patient list are still on the table. What do you do?
5. A nurse enters an order and refers to patient information in the computerized patient record and then leaves the computer terminal without logging off properly. You are working in the area and notice that the computer is on, but you assume the nurse is coming back in a minute. Meanwhile a patient wandering the hallway goes to the computer to review his friends' patient records. Who is responsible for the patient's lost privacy?
6. A student nurse arrive on your unit to review a patient's chart prior to his/her clinical rotation begins the next day. Would it be appropriate to allow access to the patient's medical record?
7. Dr. Anderson is discussing a patient's care with the nurse outside the patient's door. Another patient wondering the hall overhears the conversation. Dr. Anderson later discussed the case in the elevator with Dr. Smith. Everyone in the elevator hears the conversation. Has Dr. Anderson violated the privacy regulation?

8. You work in the hospital and notice some papers in a box that is to go in the shredding machine. Since Pennock has an Environmental Stewardship program, you decide to take it home to use for coloring paper for the kids and printer paper for the family computer. Is this the proper thing to do?
9. You work in a clinical lab. Dr. Brian's office calls to check lab results for a patient and is told the results would be ready late evening. Dr. Brian's office representative tells you to fax the information to them whenever it is ready and gives you the fax number. You have never dealt with Dr. Brian's office before. Should you send the fax?
10. You work in the hospital and decide to download some patient information so you can do some catch up work at home on your p.c. Is this O.K.?
11. A patient calls medical records and requests for a note in his medical record to be corrected. Who makes the decision on this issue?
12. A patient requests a copy of his health information access log, stating it is his right to have an accounting of all disclosures. Is he/she correct?
13. Mr. Smith writes Pennock Hospital requesting a copy of his wife's medical record. Mr. Smith does not include a written authorization from his wife. Are we obligated to supply the information?
14. A local sheriff or police department calls Pennock Hospital requesting information on a specific patient (e.g. address information). Can you give them this information?
15. A reviewer from XYZ Home Health Agency with proper ID comes to your floor and picks up a patient's medical record to review. Is this the appropriate process?
16. The infection control nurse wants to report all tuberculosis cases diagnosed in the hospital to the State Public Health Department. Is this permissible?
17. A man comes to your department and tells you he is here to work on the computer. He wants your password to log onto the computer. What should you do?

Post Test

1. The issue of portability deals with protecting healthcare coverage or employees who change jobs and allowing them to carry their existing plan with them to new jobs.

- a) True
- b) False

2. The privacy and data security portions of the HIPAA go into effect:

3. The proliferation of computers in medicine has

- a. Slowed down procedures
- b. Created new dangers for breaches of confidentiality
- c. Made it harder to access records
- d. Automatically made breaches of confidentiality less likely

4. The set of rules that provide administrative simplification by standardizing the codes and format used for exchange of medical data is referred to

- a) CPT
- b) Written notice
- c) ICDM-10
- d) Electronic transaction standard

5. In general, information about a patient can be shared

- a) When it is directly related to treatment
- b) Only when it is not related to treatment
- c) Only when the patient authorizes it specifically
- d) Only with other medical personnel

6. Data security issues that must be addressed by HIPAA implementation teams include:

- a) Data backup
- b) Access control
- c) Internal audits
- d) All of the above

7. The single most important key to administrative simplification is standardizing throughout the healthcare system a set of transactions standards and code sets.

- a) True
- b) False

8. One good rule to prevent unauthorized access to computer data is to:

- a) Never access medical data with a computer
- b) Always leave the computer on when you go away
- c) Make sure screens are visible to passers-by
- d) Black the screen or turn off the computer when you leave it

9. You can reveal information needed for medical research if :

- a) A physician requests it
- b) Your supervisor request it
- c) The patient authorizes it

d) You feel it is in the best interest of science

10. The general privacy rule now is that patients must be notified of the institution's privacy policies, and healthcare workers must always obtain a written acknowledgement of this.

- a) True
- b) False

11. In a hospital, the obligation to maintain confidentiality applies to:

- a) Medical information only
- b) Personal information only
- c) All medical and personal information
- d) Patients with HIV only

12. If you are sending patient information via e-mail, security is best maintained with:

- a) Password protection at both ends
- b) Encryption if it goes over the Internet
- c) Destroying any printouts or placing them in the patient's medical chart
- d) All of the above

13. One exception to confidentiality is _____.

- a) A gunshot wound
- b) When any doctor asks you for information, for any purpose
- c) A minor who is pregnant
- d) A celebrity who is already well known to the public

14. HIPAA overrides all state laws that define and regulate patient privacy.

- a) True
- b) False

15. Anyone caught selling private health care information can be fined up to _____ and sentenced

to up to _____ in prison.

- a) \$500,000; 15 years
- b) \$25,000; 5 years
- c) \$100,000; 10 years
- d) \$250,000; 10 years

16. Facilities will no longer be able to post _____ anyplace where visitors might see them. This includes door tags and whiteboards at the nurses' station that are in public view.

- a) Patient's full names
- b) Shift start and end times
- c) Patient's room numbers
- d) Patient's ID numbers

17. There must now be a system in place to record the name of every person who views a patient's record.

- a) True
- b) False

18. Which organization has been charged with enforcing HIPAA's Privacy Regulation?

- a) JCAHO
- b) The Office for Civil Rights
- c) The Health Financing Administration
- d) FBI

19. When is the patient's authorization to release information required?

- a) In most cases, when patient information is going to be shared with anyone for reasons other than treatment, payment of healthcare operations
- b) Upon admission to a hospital
- c) When information is to be shared among two or more clinicians
- d) When patient information is used for billing a private insurer

20. If you suspect someone is violating the organizations' privacy policy, you should

- a) confront the individual involved and remind him or her of the rules
- b) watch the individual involved until you have gathered evidence against him or her
- c) report your suspicions to the organization's privacy or complaint officer, as outlined in the hospital's policy

21. Under HIPAA, what is an example of a "healthcare operation"?

- a) Some fundraising activities
- b) Medical record reviews
- c) Billing
- d) Accreditation surveys

22. If you are working elsewhere in the hospital when you hear that a neighbor has just arrived in the ER for treatment after a car crash. You should

- a) contact the neighbor's spouse to alert him or her about the accident
- b) do nothing and pretend you don't know about it
- c) tell the charge nurse in the ER that you know how to reach the patient's spouse and offer the information if it's needed

Answers to Privacy, Confidentiality, DataSecurity, and HIPAA Dilemmas

1. Respond with basic acknowledgements by stating the patient is in stable or critical condition.
2. Politely tell him "I'm sorry that information is confidential and cannot be shared."
3. Tell them the information is confidential and we cannot share with individuals not involved in the patient's case. Disclosing that information could cost you your job, open the hospital to liability, sanction, and fines.
4. Destroy/dispose of the papers in the appropriate manner, and remind your co-workers who attended the meeting that they are dealing with protected confidential information and everyone has to be extremely careful so that patient information is not left unsecured or accessible to others.
5. The nurse and the employee observing the situation, and ultimately the Hospital. These situations should be reported to the department manager.
6. Yes, after verifying the student's identity from their student picture I.D. They may view the medical record, take notes for school assignments (care plan, etc.) as long as there is no individual identifiable patient information with these notes. They may not under any circumstances make a copy of any portion of the chart.
7. Yes. Discussing patients and disclosing protected health information in an open area where others can easily hear is a violation of patient's privacy rights.
8. Any documents that contain patient information should not be removed from the hospital- unless authorized to do so. All private and confidential information should be destroyed appropriately.
9. Verify that the doctor is working on the patient's case; see that his office has a registered fax number on record with the hospital. Both are needed to send a fax. Also faxes should be sent when someone is there to receive it- it should not be left to stay in the fax machine for long periods of time.
10. Any documents that contain patient information should not be removed from the hospital- unless authorized to do so.
11. The Privacy Officer is the only individual authorized to make this decision.
12. Mercy Hospital does not have to provide a complete listing of every employee who uses the information for performance of their official duties i.e., routine uses for treatment, payment, and health care operations. The patient must submit their request in writing. The request should be referred to Mercy's Privacy Officer.
13. The hospital cannot provide the spouse a copy of the medical record without written authorization from the patient (except in rare circumstances). All exceptions must be approved by Mercy's Privacy Officer.
14. The sheriff/police office should be referred to the Privacy Officer. The hospital may disclose limited individually identifiable information to a law enforcement agency for the purpose of locating criminals in response to a written request from the law enforcement agency.
15. No, the reviewer must present a "pass" obtained in Case Management identifying the name of the patient they are to review. The reviewer must ask the unit secretary for the patient's chart.
16. Yes, State law requires the reporting of communicable diseases- this is considered a beneficial disclosure.
17. Do not give or share your password with anyone. You should also know the identify of anyone coming into your area. Ask questions and follow up with appropriate department to determine if the person is authorized to be in your area.

Pennock Hospital Volunteer Chaplain DOCUMENTATION

Patient Name:				
Church:				
Pastor to be Notified:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Communion ____ Baptism ____ L/R/PC ____				
Volunteer Chaplain Signature:				

<u>Spiritual Care</u>	<u>Spiritual Issues Noted</u>
Initial Visit Date	Anger
Prayer With Visit	Hopelessness
Family/Significant Other	Connection to God
Follow Up Visit	Divorce
Crisis Visit	Discouragement
Referred to Own Clergy	Stress
Reconnected to Church	Worry
<u>Summary Statement</u>	Guilt
	Low Self Esteem
	Bitterness
	Grief/Loss
	Forgiveness
	Conflict
	Death/Dying
	Insecurity
	Restoration to Church
	Family Dynamics

Protocols for Weekend Volunteer Chaplain Team

Weekend Schedule Management

The weekend schedule is constructed so that everyone has an equal role in fulfilling weekend chaplaincy duties throughout the year. The schedules are posted, by e-mail to the pastor (or church's) e-mail address and a reminder schedule is posted quarterly with "*The Samaritan*" newsletter which is e-mailed to all pastors. If there is a conflict within the schedule the following procedure should be used

1. Make contact with another volunteer team member and seek to make a switch between yourself and that team member to fulfill your obligation. When that is done then...
2. Contact the hospital chaplain's office (x 1548) to insure that the change is made in the hospital computer system for that weekend.

If the conflict is an emergent need (death in the family, illness etc.) call the hospital chaplain immediately and the chaplain will provide the emergency coverage for your absence or assist you in finding a member to cover weekend duties for you.

At no time can or should you refuse to fulfill your obligation for duty on an assigned weekend without the hospital chaplain knowing this. A report of such activity made to the chaplain will result in

- **an initial conference for the first offense;**
- **a staff conference with a director for the second offense; and**
- **termination from the volunteer program for the third offense**

Our presence for the families, patients, and staff is a necessity and we have been tasked with providing the best spiritual care possible for those people in crisis.

Response Time

Response time is a variable that we cannot always control. The distance one lives from the hospital and what one is doing at the time of the call are large factors in this. However, it would be helpful to the staff, patients, and families if you could give the person making the call a general estimate of when you can make it to the hospital to meet with the patient and family. This allows staff to know that the need is going to be covered and the patient and family a time to relax knowing that your help is on the way.

Mediating Concerns

At some time or another all of us will have concerns on a variety of different issues. I practice an “open door” policy when dealing with those concerns. If you do have one, please make it known to me by email or telephone call and don’t allow it to sit and fester, robbing you of the blessing of serving as a volunteer chaplain.

If your concern merits the need to talk to a director or a higher administrator, please allow me to make that contact and discuss it with them. If it is believed to be necessary, we will arrange a meeting between the appropriate director or administrator, me and you to discuss the matter.

While you may feel that direct contact is the best approach, the results may not be. Most of the directors and administrators that I work with expect a process of dealing with issues that starts with discussions between us before we involve them. If that process is not followed the issues, though valid, may be bumped back to a discussion between us and cause frustration within the process.

Reporting Critical Information

As chaplains we are, at times, presented with information by a patient or family member that can be deemed critical information. This information can include *but not be limited to*, expressions of suicide or suicide ideation, harm to others, recent or ongoing substance abuse, and abuse of a minor or elder.

Since you are considered part of the response team at the hospital, you should consider yourselves first reporters as well. This means, should any of the above issues be mentioned in conversation with a patient or family member, you need to do three things:

1. Identify yourself as a first reporter and state that because of the patient’s or family members disclosure you must now report what was said to another authority. Nurses, Social workers and I serve as that authority as we will have to report it to the appropriate departments (Adult Protective Services/Child Protective Services, Mental Health Authorities, etc.)
2. You **cannot and must not** disregard what the patient or family member has said by believing that the “silence of the confessional” overrides your duty to report. It does not and it puts yourself and the hospital at great liability if you do. You cannot disregard what the patient says even if they are suffering from dementia, Alzheimer’s disease, under the action of medicine or engaged in substance abuse. None of these conditions overrides your need to report.
3. You may be interviewed by me, administrators and/or legal counsel to establish the environment under which the statements were made and witnesses to the event.

4. Under no circumstances are you to engage the patient or family member in any additional conversation of the matter. Trying to engage in pastoral counseling given these situations may be detrimental and should be left to mental health professionals.
5. **If the patient or family member has a mental health history** this should already be known to staff. However, your report may increase the chances that the patient or family member receives the appropriate intervention from a mental health professional as early as possible.

These protocols are not exhaustive in scope but are designed to cover many of the basic issues that could be expected in a weekend volunteer chaplaincy situation. If an event occurs that falls outside the protocols above, please either call or e-mail me so that I can give you direction and then find an opportunity to debrief the issue to find an appropriate solution.

Sincerely,

Rev. Tod Clark, M.Div. BCPC
Assistant Chaplain
Spectrum Health – Pennock Hospital

Quarter Number, Year Chaplaincy Report

Month 1

Month 2

Month 3

Patient Census:

Pastor's Informed

Sacraments Arranged

Patients Prayed with

Med/Surg Patient Visits

Med/Surg Patients Missed

Med/Surg visits on 1st day of admission

Med/Surg families visited

ICU Patients visited

ICU visits on 1st day of admission

ICU Families visited

FBC Patient visits

FBC Families visited

Literature requests

Rosary-Prayer Card-Crucifix

ER Trauma visits

ER Waiting room visits

Surgical waiting Room visits

Interdisciplinary Rounds

Meeting w/ Pastors

Defusings

CISM Debrief

Code Debrief

Recruitment and Training Cycle

Volunteer Chaplaincy at Spectrum Health - Pennock

Recruitment

- Personal invitation
- Recruitment folder
 - Mission/Vision/Values statements
 - Volunteer application + statement of faith
 - Copy of Newsletter
 - Copy of volunteer schedule

Level 1 Training:

- Pastoral visitation
- Effective listening
- HIPPA
- Caring for Patients and Families in Crisis I
- Effective Reports I

Level 2 Training

- Effective Listening II
- HIPPA II
- Caring for Patients and Families in Crisis II
- Hospice and Palliative Care



Samaritan Newsletter

Edition 2 Volume 1

October 7, 2016

Volunteer Chaplain Schedule

Aug. 20-22 Chaplain Tod
Clark 616-819-0556

Aug. 27-29 Chaplain Tod
Clark 616-819-0556

Sept. 3-5 Rev. Danny
Quantstrom 816-810-0124

Sept. 10-12 Rev. Mark Payne
517-977-5678

Sept. 17-19 Rev. Steve
Olmstead 269-420-0354

Sept 24-26 Rev. David
Burgett 269-804-9642

Oct. 1-3 Deacon Jim Mellen
269-838-3078

Oct. 8-10 Rev. Ron Watterly
269-908-2669/269-623-3505

Oct. 15-17 Rev. Phil Reynolds
269-953-4379

Oct. 22-24 Rev. Peggy
Hopkins 734-787-7712

Oct. 29-31 Chaplain Tod
Clark 616-819-0556

MAJOR NEWS: PENNOCK FOUNDATION TO RENOVATE HOSPITAL CHAPEL

On July 21st, I was contacted by Janine Dalman who oversees the Pennock Foundation's board and informed that the Board would like to make the renovation of the hospital chapel its main priority for this next year. The board understands the need for spiritual of families in crisis.

On August 24th and September 23rd a focus group of people, local clergy and others, advised the architects on what type of space we will eventually build. There are several elements that have already been decided. The space will reflect a non-denominational presence and be equally open to a variety of spiritual practices, from prayer to meditation. It will be a larger space with the possibility of accommodating ritual services.

From that set of meetings the architects reported back their recommendation to move the chapel from its current location and to one located in the atrium of the patient registration area. The northern part of that area, nearest the eligibility office, would be portioned into a chapel with flexible seating, areas for prayer and meditation, a resource wall, and access to the outside "healing garden".

Concerns were raised and ideas refined about the space and the architects were advised to bring back final plans with cost figures and final recommendations on furnishings and finishes. This space will firmly ground spiritual care into the life and culture of Spectrum Health – Pennock and idea of "community wellness" and "spectrum pledge here."

Now it is up to us, as local clergy to support this effort. Your best ways to assist are:

Resources: I found the following resources helpful when dealing with end of life discussions with family and grief issues for those family members taken in a tragedy: They include:

- *Where is God when It Hurts* – Philip Yancey
- *When God Doesn't Make Sense* – James Dobson
- *Walking with God through Pain and Suffering* – Timothy Keller
- *Caring for Those in Crisis* – Kenneth Mottram
- *A Grace Disguised* – Jerry Sittser

YouTube is also a wonderful compilation of videos that can assist families on their own terms to deal with the death of a loved one. A few of my favorites are:

- Lauren Daigle: Trusting God in the Midst of Grief
- Grieving a Loss
- Louie Giglio: Stunned by God
- Ravi Zacharias – The Problem of Suffering and the Goodness of God
- Bill Johnson – How to Deal with Loss
- John MacArthur: Why does God Allow Pain and Suffering
- The Loud Absence: Where is God in Suffering

Announcements:

Now that I have had some time to assist with the transition of Pennock to Spectrum Health – Pennock, I feel I can focus now on growing our volunteer chaplaincy base and our outreach to other churches. Therefore, I would like your input on how you would like to proceed. Prior to the alliance with Spectrum Health, chaplain volunteers were meeting once a quarter for a program and schedule check. Do we wish to keep that schedule up or is it time to develop a new one? Let me know at tod.clark@spectrumhealth.org

Also, how can we better train local pastors that may wish to just increase their skills in the pastoral care area? Because I have a number of units of clinical pastoral education (CPE) I forget that there are any pastors that don't have this background but want to be better pastoral care givers. What is the best way to engage our local pastors? I don't know, but I am willing to listen and assist where I can to help those who want the training get the training in a way that makes sense for them. Let me know at tod.clark@spectrumhealth.org

That's it for this edition of the Samritan's Newsletter. I will see you around town but until late October, have a wonderful fall kick off to your church programs and God's grace on your ministry!!

Blessings,
Chaplain Tod Clark, M.Div.
Spectrum Health - Pennock

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 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)

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:** _____

CODE BLACK CHAPLAIN DISASTER RESPONSE POLICY

Spectrum Health – Pennock Hospital

TITLE: CODE BLACK, INTERNAL OR EXTERNAL MANUAL:
DISASTER RESPONSE POLICY

SECTION: Chapter 8 Code Black
Policy #: EC07.1

POLICY: Spectrum Health - Pennock Hospital's Emergency Operations Plan establishes and maintains a disaster response policy which includes a modified Hospital Emergency Incident Command System (HICS) to effectively respond to a disaster. A disaster situation is an uncontrollable and unexpected event that has the potential to disrupt patient care and treatment. The HICS will be utilized to provide continuity between the hospital and area emergency responders and defines responsibilities and reporting channels for those persons in charge of the disaster.

PURPOSE: The Code Black Policy is the means for preparing for and anticipating positive outcomes in actual disaster scenarios or simulated emergency situations.

SUBSECTION 1

TITLE: CODE BLACK PROTOCOL FOR CHAPLAINS

POLICY: As Spectrum Health - Pennock Hospital's Emergency Operations Plan establishes and maintains a disaster response which includes a HICS system, it is incumbent upon the volunteer chaplain corps to understand and respond immediately and precisely in the case when a MCI (mass casualty incident) or disaster should strike.

PURPOSE: The Code Black Protocol for Chaplains is designed to prepare and anticipate outcomes in the event of an MCI or disaster scenario or event.

PROCEDURE:

In the event that a Code Black is instituted at Pennock Hospital, the following steps in the order cited will be taken PRIOR to the notification of any members of

the volunteer chaplain corps

- The site of the Family Outreach Center will be converted, if possible. The site selected for this at the hospital is the Pennock Café proper and the Village View, Parkside, Deck side and West Creek Rooms that are at the rear of the Café. This will allow us the maximum space necessary to interact and provide emotional first aid for community members. If this area is compromised and determined to be unusable, the Incident Command Leader (ICL) will select an alternative site for the Family Outreach Center to use.
- The Supervisors of the Family Outreach Center will be on-site. The supervisors that have been chosen are the Chaplain and the head of social work. They will be assisted by any discharge planning staff that is available.
- A communication link will be established from the incident command center to each supervisor so that conditions can be monitored.

After these initial three steps have been completed the following steps will be undertaken:

- The chaplain supervisor will contact Level 1 chaplain responders to assist in the triage and care of community members. Level 1 responders have been designated as:
 - Pastor, 1st United Methodist Church
 - Pastor, 1st Presbyterian Church
 - Pastor, 1st Baptist Church of Hastings
 - Pastor, Hope United Methodist Church
 - Pastor, Emmanuel Episcopal Church
 - Pastor, Hastings Church of the Nazarene
 - Pastor, Grace Lutheran Church
 - Priest, St. Rose of Lima Parish
 - Minister of Pastoral Care, TVC
 - Chaplain, Mission of Praise Ministry

The criteria for this designation are the proximity of these pastors to the hospital and the possibility for them to quickly assist at the hospital in case of an MCI or natural disaster.

- Upon receiving a Code Black call from the Chaplain supervisor, Level 1 responders will assemble at the Pennock Café for a briefing ½ hour later. At this time please bring the following things with you
 - Your ID badge - NOBODY gets into or out of the hospital during a Code Black without their badge
 - A **small** bug-out bag – You may be staying a while (even

overnight) to help before going home

- A Bible
 - A listening ear
- At the initial briefing, you will be broken up into teams of two to cover all the rooms and assist with the processing of incoming community members. We will also cover the following:
 - The size of the MCI/disaster as we understand it at that point
 - The number of community members we can be expected to deal with in the aftermath of the MCI/disaster.
 - The instructions for “flagging” community members exhibiting possible mental health issues that need assessment.

The supervisors will rotate you and get you fed on a schedule that they receive from the HICS.

- Should the MCI or disaster be significant, the chaplain supervisor, in consultation with the social worker, will call in second and third level responders to assist with the triage and emotional first aid of community members. The second and third level responders are so designated by the fact that they are removed from the hospital by distances that may make their participation not as easy in the midst of an MCI or natural disaster. They also will be briefed and teamed in the same manner as 1st responders and used to allow 1st responders rest and recovery periods.

Second Level Responders are:

- Pastor, Pleasantview Family Church – Dowling
- Pastor, 1st Congregational Church – Vermontville
- Pastor, 1st Congregational Church (UCC) – Lake Odessa
- Pastor, 1st Free Methodist Church Hastings
- Pastor, 1st Nazarene Church – Nashville
- Pastor, Hastings Apostolic Church
- Vicar, St Andrews and Mathias Church – Yankee Springs
- Pastor, Kilpatrick United Brethren Church - Hastings
- Pastor, McCollum United Brethren Church – Delton
- Pastor, 1st Baptist Church – Middleville
- Pastor, Middleville UMC - Middleville

Third Level Responders are:

- Pastor, Central UMC – Lake Odessa
- Pastor, Cedar Creek Bible Church – Delton
- Pastor, Vermontville Bible Church – Vermontville
- Pastor, Grace Brethren Church – Hastings
- Pastor, Zion Lutheran Church – Woodland
- Pastor, Grace Community Church – Nashville

- Pastor, Nashville Baptist Church – Nashville
 - Pastor, Woodgrove Parish
 - Pastor, Faith Bible Church – Lake Odessa
 - Pastor, Living Gospel Church – Hastings
 - Pastor – Living Waters Church – Hastings
-

PROCEDURES FOR MINISTRY ON SITE

The chaplain corps has been tasked with providing “emotional first aid” to family members primarily and then staff and first responders that seek attention. In order to accomplish this task, we need to be very good in several areas of support. They are:

- **Information gathering and dissemination**
- **Psychological triage**
- **Comfort Care**
- **Event Processing**

A. Information Gathering and Dissemination

Discussions with care teams associated with the Aurora, CO massacre and other MCI’s suggest that this area is the one that is most overlooked. The amount of information coming to care providers to deal with in a competent manner is staggering. Therefore, the first thing that is needed is to “chunk” this information into groups

- **Group A – Name of patient, family and head count**
- **Group B – Triage Group number**
- **Group C – Managing Information dissemination**
 - a. **How**
 - b. **Where**
 - c. **When**
 - d. **How much**

B. Psychological Triage

By the term psychological triage, we mean the ability to minister in a chaotic environment from those who need it most to those who need it less. This type of decision making is done sometimes on the fly but should take into account the following issues.

- **Condition of the patient**
- **Proximity to the event**
- **Presence/Lack of psychological expression**
- **Possibility of deeper issues**
- **Overt Psychological pain or distress**

Each of these areas need to be determined by a team approach and then continually assessed as the event unfolds. Why do we need to look at these areas primarily?

- A patient's condition will give information on what we may have to help the family with in the future
- Proximity to the event will tell us the exposure of the person/family and what they will need to process. A person who was an eyewitness will need to process more than one who was exposed to it on TV.
- Presence or Lack of psychological expression gives us a measure of how a person is processing the event. Sometimes overt displays are a good thing as opposed to a flat affect dazed appearance which could mean total psychological shutdown
- Possibility of deeper issues allows us to determine when the issues being processed are above the comfort care level and need the intervention of a trained professional
- Overt psychological pain and distress again allows us to pass the person along to trained professionals who can administer more than comfort care.

C. Comfort Care

This is among the hardest things to accomplish because of the chaotic situation AND the differing needs of the people we will be serving. At the minimum we need to do the following:

- **Talk to as many people as we can:** Welcome them, tell them we will be taking care of them as they wait news of their loved one. Show them where they can sit with family. These people are going to be in shock, so be ready to repeat this information many times.
- **Tend to their immediate needs** – do they need a blanket, food, drinks, a place to lie down? We will have places to access these things which will be covered in your initial briefing but make sure our guests have what they need when they need it.
- **Pay close attention to our seniors and to children:** They will be our most critical groups. A senior can go from being a family member to a patient in a second. Make sure that you are ministering to those. Children will have many questions. Any that you can answer honestly and with care will help the stress level of the entire family.
- **Be prepared to listen:** People will want to talk A LOT. Offer a listening ear. If they request prayer, pray with them. If you feel that a family may wish to have prayer, ask first
- **If information shows the patient has died, contact your leader (me) and be available afterwards. DO NOT MAKE A DEATH NOTIFICATION TO THE FAMILY ON YOUR OWN.**

D. In The Event We Have to Move

First, we will brief you on the move, prior to engaging in one so that the move can be accomplished swiftly but safely. The likely scenario will be a move due to structural instability of the building in a natural disaster. We would then move to tents in the parking lot. In case we overflow with families in a non-natural disaster MCI, we would likely be accessing the large conference room in the conference center for more room.

E. Debriefing

The idea of debriefing is two-fold. The first issue is that those that served as counselors have an opportunity to explore the feelings and reactions they had to the event. This is beneficial in keeping the psychological health of those that serve in a good place but it also allows the counselors to emot and relieve the stress over events and reactions that can lead to long-term psychological issues, PTSD primarily.

A second benefit of the debriefing period is for those who are in the leadership and management of the volunteer counselors an opportunity to fine tune and rethink the procedures and protocols that are already being used. These refinements may make us more efficient and could produce less stress in future crises.

The preferred manner of debriefing should follow the CISM (Critical Incident Stress Management) model. Most public institutions and non-profits use this model in their debriefing because it is easy to lead and easy to follow. This does not mean that the issues themselves are easy to deal with. Considering that we are a hospital, it would be a good standard to have at least two persons on staff with this capability – the chaplain and the social worker would be the obvious choices.

The debriefing should also take place within a week or two and no more than a month after the event to insure that counselors are taken care of early on. This session may lead to other sessions or individualized counseling for team members should that be evidenced.

In any case, the debriefing sessions should be used to engage and normalize emotions, determine what happened both positively and negatively and support each other on a path of reclaiming wholeness, whatever that looks like for each member.

Spiritual Demography

Catholic Baptist Methodist Reformed Wesleyan Brethren

Number of Congregations
Membership
Aver. Sunday Attendance
Aver. Member age
Ratio members to attendance
% Comparative Strength

Characteristics
Medicine
Wellness/Health
Death/Dying
Questioning
Original Sin
Commandments

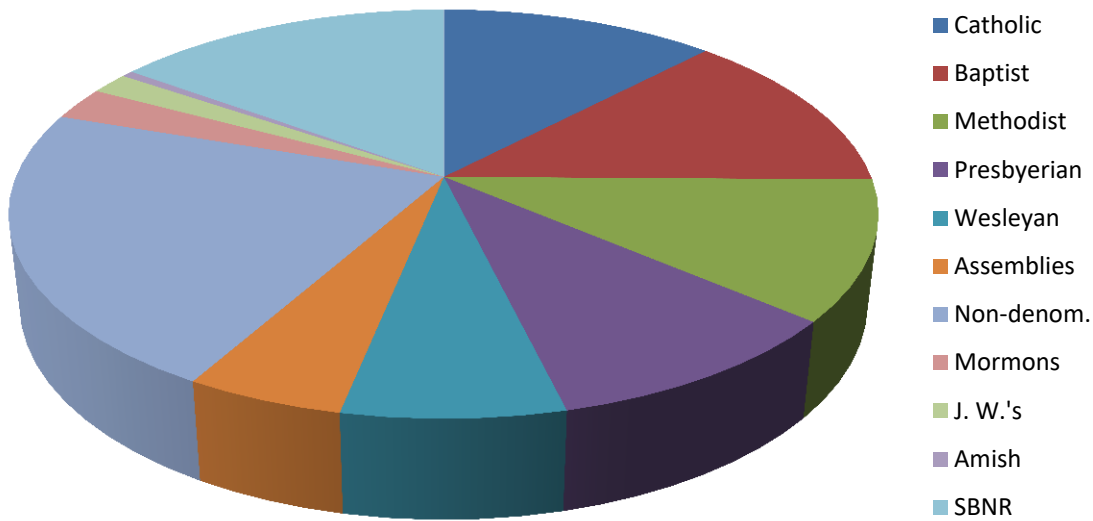
Leadership
Full Time Pastor
Part Time Pastor
Deacon Board
Small Groups
Adult SS
Child SS
Youth Ministry

Worksheet - Area

UB Lutheran Evangelical Non-denor LDS Amish JW Native American

Wiccan

Spiritual Demography - Barry County



Process used to assemble demographic analysis

- Church contact
 - a. Church Name
 - b. Address
 - c. Telephone number
 - d. Name of spiritual leader (pastor, reverend, minister, etc.)
 - e. Number of members
 - f. Average Sunday service attendance
 - g. Average member age
 - h. Major ministries
- Analysis
 - a. Growth/decline markers (average member age; ratio of members to average attendance)
 - b. Major ministries
 - c. Outliers?
 - d. Comparative strength assessment (% of each denomination + Non-denominational + localized faith groups (Mormons, J.W., Amish) + SBNR)
- Assembly
 - a. Creating groups for illustration
 - i. Who merits a group and why?
 - b. Color coding
 - c. Importing to a spreadsheet program

Standards of Practice

Chaplains in an Acute Care Setting

Short Form Description

Established by the SCC and JACHO

Date of Signature: 2/1/2012

Date of Implementation 1/1/2013

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

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/psych/social/spiritual/religious health

Volunteer Chaplain "Need to Know"

Volunteer chaplains are not exempt from collecting data and reporting it to the staff chaplain for their processing. The minimal information that a volunteer chaplain should collect is:

- Name of patient, residence address, phone number
- Reason for interaction: "Crisis visit" will suffice
- Any spiritual issues explored
- Clergy notification on patient's behalf
- Presence/absence of significant others and/or family support
- Use of prayer/reading of scripture

How to do the above:

- **Procedure A: Telephone my extension @ 945-1212 and punch in ext 1548. READ SLOWLY the information that you have and you're finished**
- **Procedure B: E-mail me your information to todc@pennockhealth.com**

Standard 2-4 focus on issues of importance to the job of the staff chaplain only

Standard 5: Ethical Conduct

The chaplain will adhere to the *Common Code of Ethics* which guides decision-making and professional behavior

The Chaplain understands the multi-level relationship that they have with a patient and family. They are also cognizant of the fact that this relationship can take place in an environment of cultural, spiritual and theological difference during a vulnerable point in the patient's life. Therefore, understanding the boundaries of professional conduct is of utmost importance.

Volunteer Chaplain "Need to Know"

Volunteer chaplains need to conduct themselves as they would in their day-to-day witness for Christ and include two important points:

- Respect for various theological and religious values
- Protect the confidentiality of the relationships that you are caring for

This last consideration leads to our discussion of Standard 6: Confidentiality

Standard 6: Confidentiality

The chaplain is to respect the confidentiality of all information from all sources, including patients, other team members and family in accordance with state laws and regulations.

Volunteer Chaplain "Need to Know"

The volunteer chaplain needs to understand the following in regards to confidentiality

- HIPPA (Health Information Protection and Portability Act) so that we all chart only what is appropriate for the care being received.
- Understand the issues of "pastoral confession" vs. confidentiality by appropriate state law. In Michigan we expect that a chaplain (volunteer or staff) would report to the appropriate medical personnel indications that the patient had serious intentions to harm themselves or others or that a patient's family members may be engaging in child/elder abuse. Also activities that are considered illegal by state statute (drug trafficking, etc.) are necessarily reportable. "Pastoral confession" does not exempt these reports by the chaplain/volunteer chaplain.
- Communicates this information when a patient desires a confidential conversation with you

These are the standards of the new document that apply directly to you in your position as a volunteer chaplain. A great many more standards apply to me as the hospital staff chaplain. Yet those that do apply to you will make a difference on how you will undertake your role. As a result of this set of standards you will be asked to:

- Gather more information and report it to me for documentation
- Engage in the highest of ethical conduct, which will include implementing HIPPA compliance in your oral and written communication about patients and their families while on call.
- Understand that you will need to report certain pastoral confessions to the appropriate medical staff. These include suicidal thoughts, homicidal thoughts, child/elder abuse, and illegal activities.

Standard 7: Respect for Diversity

It is up to us as chaplains to model for the members of the hospital staff what is included in ministry to those who may have spiritual and religious affiliations and or beliefs that are different from our own. While we understand that all people are made unique in God's sight , to enter into a productive and assistive dialogue with someone from another faith tradition can be difficult.

Volunteer Chaplain "Need to Know"

I ask that, as a volunteer chaplain, you engage with our patients with these three issues in mind

1. The patient, patient's family and medical staff has unique and distinct belief systems and worldviews with regard to spirituality. It is our mandate to help them reconnect with those beliefs during times of crisis, NOT proselytize for our own set of beliefs or worldview.
2. Engagement with families and patients in crisis is never easy. Many may not know how to describe what they believe or feel intimidated in trying to do so to a minister. Therefore we must make the atmosphere as conducive as possible for that conversation, which may entail no conversation regarding any spiritual issues and plenty of care-giving and care-showing .
3. In order to respond appropriately to the needs of patients, families and staff members, we, as chaplains, need to sensitively tune our own responses so that we can explore matters of faith with these people in crisis and give them hope and peace for the journey they are on.

Standards 8-15 deal exclusively with the interactions of a staff chaplain with the medical care team.

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.¹

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.

[Glossary, page 13](#)

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.ⁱ

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 Students*.^{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 Grosseohme, 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-Stonks, 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-Stonks, 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.)

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).

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- 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.

Training List and Schec

Clergy Name

Level 1 Training

Pastoral Visitation I
Effective Listening I
HIPPA for Clergy
Caring for Patients and Families I
Effrective Reports I

Level 2 Training

Effective Listening II
Caring for Patients and Families II
Geriatric spirituality
Caring for Children in Crisis
Life Care

Advanced Training

Stress and Trauma Care
Chaplaincy - Mental Health
Chaplaincy - Substance Abuse
Chaplaincy - Veterans
Diagnosis Chaplaincy

Rule Data Base

Title: Volunteer Chaplain
Reports to: Lead Chaplain

Primary Location: Spectrum Health – Pennock Hospital

Class: Non-Exempt

Supervises: None Effective Date: 1/25/2012

Position Summary:

The Chaplain is responsible to assist the Pastoral Care Coordinator in the coordination, planning and provision of spiritual support and counseling services to patients, families, and caregivers in keeping with their belief systems. In addition this position acts as a liaison between local clergy and the interdisciplinary team.

Qualifications:

1. Education: Bachelor's degree from an accredited institution in theology, divinity, religion or equivalent required.
2. Experience: Professional pastoral counseling in healthcare, home care, hospice or palliative care setting required.

Essential Duties & Responsibilities:

1. Assesses and identifies the patient/family/caregiver spiritual status and needs.
2. Provides pastoral and spiritual care services to patients/families/caregivers.
3. Collaborates with spiritual colleagues as appropriate.
4. Demonstrates continued professional growth and development through participation in education programs and review of current literature.
5. Adheres to all Agency, state and federal policies and procedures, laws, and regulations which are relevant to job responsibilities.
6. Maintains confidentiality of business and health information in accordance with HIPAA and state regulations, and HSM policies.

Other Job Functions:

The following is a list of responsibilities of this position, but is not intended to cover other related duties that this position may be required to perform from time to time.

1. Performs specific assignments for hospital as required.
2. Demonstrates flexibility, versatility and a positive attitude in integrating additional duties.
3. Interacts in a manner, which is professional, respectful, positive, helpful, which promotes trust.
4. Represents Spectrum Health – Pennock Hospital to the community in a positive manner.
5. Demonstrates effective listening skills when communicating with others.
6. Utilizes proper body mechanics and safe working techniques.
7. Reports unsafe environments/practices to supervisor in a timely manner.
8. Attends mandatory meetings and inservices, unless excused in advance by the supervisor.
9. Portrays a positive attitude towards the hospital by supporting its mission, vision, values, policies and procedures.

Required Skills, Abilities & Knowledge:

1. Appreciation of religious values, beliefs, lifestyles, cultures, rituals, and practices, allowing for open and flexible communication with people of all faiths, and those of none.
2. Compassion for the acute, chronically or terminally ill and understanding of ministry to them and their families.
3. Strong interpersonal and communication skills (verbal and written).
4. Ability to demonstrate sound theological and pastoral knowledge and skill base.
5. Knowledge of community resources, particularly spiritual/religious.
6. Respect and understanding of theological and moral values contrary to one's own.
7. Ability to relate to patients/families/caregivers in an open, empathetic and supportive manner while maintaining personal and professional boundaries.

Employee's Signature _____ **Date** _____