

Standards of Practice for Professional Chaplains in Hospice and Palliative Care



OVERVIEW

Preamble: Chaplaincy care is grounded in initiating, developing, and deepening a mutual and empathic relationship with patients, families and staff. The development of genuine relationships is at the core of chaplaincy care and underpins, even enables, all dimensions of chaplaincy care. It is assumed that all of these Standards of Practice are addressed within the context of such relationships. While the fields of hospice and palliative care differ, it is recognized that both specialties of care are on a continuum that is complementary and collaborative. These Standards incorporate both the distinctions and the similarities of chaplaincy care within each specialty.

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, Access to Information and Documentation of Care: The chaplain, as member of the interdisciplinary team, assesses and enters information pertinent to 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: Team is an essential component of both hospice and palliative care, and the chaplain is a fully integrated member of the interdisciplinary team.

Standard 5, Ethical Practice: The chaplain will adhere 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/family members, medical record, interdisciplinary team members, larger health care team and local faith community 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, psycho-socially and spiritual/religiously competent patient- and family-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. For the purpose of this Standard of Practice, "organization" may refer to the hospital where palliative care is based, the hospital that serves as the base for the hospice or the freestanding hospice organization.

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 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 takes responsibility for continued professional development. The chaplain demonstrates a working knowledge of current theory and practice.

[Glossary, page 17.](#)

INTRODUCTION

HISTORY

From the beginning, people of faith have been instrumental in the establishment and development of the modern hospice and palliative care movement.¹ The first hospices are believed to have originated from the 11th century Catholic orders when the incurably ill were cared for in “hospices” dedicated to treatment by Crusaders.² In the early 14th century, the order of the Knights Hospitaller of St. John of Jerusalem opened the first hospice in Rhodes to provide refuge for travelers, and care for the ill and dying.³ The Daughters of Charity of Saint Vincent de Paul in France and the Women of the Calvary in New York, who opened the House of Calvary to care for poor women afflicted with cancer and similar diseases in 1899, continued this practice in the modern era.⁴ Later, the Irish Sisters of Charity opened St Joseph’s Hospice in London, England in 1902.⁵

In the 1950s Cicely Saunders, a devout Anglican nurse, and later social worker, physician and writer, began to develop many of the foundational principles of modern hospice care. Prior to World War II, Cicely Saunders had studied humanities. After the war began, she trained as a nurse, where she was introduced to the world of the suffering and the dying. In letters written in that time of her life, she spoke of patients having to “earn” their morphine, and often dying painful and lonely deaths.⁶ Her faith and the words of Psalm 37, “Commit thy way unto the Lord; trust also in him; and he shall bring it to pass,” fueled her commitment to provide better care for the sick and the dying.⁷

Cicely Saunders’ nursing career was cut short due to a back injury, and out of a desire to continue in patient care, she trained as a social worker. In 1948, she met a young Jewish man from Warsaw, David Tasma, who was in the hospital dying of inoperable cancer. Saunders and Tasma spent much time together before he died. Tasma’s suffering became Saunders’ classroom. Tasma’s spiritual, emotional and psychosocial pain became the foundation for Saunders’ revolutionary concept of “total pain.”⁸ Together they explored the needs of dying patients and began to envision a better kind of care for the suffering and dying.

During one visit recounted by Saunders, Tasma asked her for some words of comfort. Honoring his Jewish tradition, Saunders recited Psalm 23. Tasma asked if there was anything else she could say. When Saunders asked what else Tasma might want, he responded, “I want what is in your mind and in your heart.” This encounter became Saunders’ inspiration for St. Christopher’s Hospice, which opened in 1967 and became one of the key centers of the modern hospice and palliative care movement. Based on what she had learned from Tasma and others, the St. Christopher’s Hospice vision was to provide whole-person care from the “mind” and the “heart” by addressing not just the physical, but also the spiritual, emotional, existential, psychological and social components of suffering.

In the late 1960s, Cicely Saunders was also instrumental in the emerging field of medical ethics. She developed a professional relationship and rapport with Rev. Edward Shotter, who set up the London Medical Group, a forerunner of the Society for the Study of Medical Ethics, and later the Institute of Medical Ethics. From 1966 to 1989, he was director of studies at the London Medical Group, and then he was appointed dean of Rochester, a post he held until retirement in 2003.⁹

Around this same time, a movement was growing in North America. In 1969, based on conversations with dying patients, Elizabeth Kubler-Ross published her groundbreaking book *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families*. In 1971, the first coordinated hospice program in the United States was initiated by the Rev. Edward Dobihal, also the first chaplain to Grace New Haven Hospital (now Yale New Haven Hospital).¹⁰ He gathered a team of like-minded people and founded Hospice Inc., which was the beginning of a relationship with Florence Wald, Dean of the Yale School of Nursing.^{11,12} Working with physicians from Yale’s medical school, they established both a home-care program and a freestanding hospice facility (now named Connecticut Hospice) in Branford, CT in 1974.¹¹ In 1975, Balfour Mount first coined the term “palliative care”

¹ Aronson, Stanley M., *The Early Years of Hospice Care in Rhode Island*. Medicine and Health Rhode Island, 2005, 88(4). p. 108.

² Connor, Stephen R., *Hospice: Practice, Pitfalls, and Promise*. Taylor & Francis. 2005, p. 4.

³ Connor, p. 5.

⁴ <http://www.calvaryhospital.org/site/pp.asp?c=ktUJ9MPIS&b=3351797>, cited June 5, 2013.

⁵ Connor, p. 5.

⁶ Saunders, Cicely and Clark, David, *Cicely Saunders: Selected Writings 1958-2004*, Oxford: Oxford University Press, 2006, p.247.

⁷ www.guardian.co.uk/news/2005/jul/16/guardianobituaries.health, accessed June 5, 2013.

⁸ Kearney, Michael, *A Place of Healing*, Louisiana: Spring Journal, 2009, p.5.

⁹ Reynolds, L.A., and E.M. Tansey, eds., *Medical Ethics Education in Britain, 1963-1993*, London: UK: Wellcome Trust Centre for the History of Medicine at UCL, 2007, p. 8, 77, 118. Available from: <http://eprints.ucl.ac.uk/14885>

¹⁰ Connor, p.5.

¹¹ Aronson, p.108.

to describe the inpatient hospital unit in The Royal Victoria Hospital in Montreal, Canada. Kubler-Ross, Mount, Dohi¹² and Wald were all influenced and inspired by Cicely Saunders and St. Christopher's Hospice. These hospice and palliative care pioneers all came from widely differing spiritual backgrounds. Yet all agreed from the start that spiritual, religious and existential care is an essential component of hospice and palliative care.

A group of concerned Rhode Islanders independently convened in 1974. This informal group called itself the Thanatology Associates in Rhode Island [TARI]. It consisted of Rev. Ken Wentzel, a Congregational minister; Ralph Redding MD; Michael Scala MD; Gene Knott PhD, a clinical psychologist; two nurses: Marion Humphrey, who later became the first staff nurse of Rhode Island Hospice Care, and Barbara Wright; and Rev. Charles Baldwin, chaplain to Brown University. The initial leadership of TARI was provided by Rev. Wentzel, who had just returned from a sabbatical leave in London, where he had worked as a visiting chaplain at St. Christopher's Hospice.¹³

Yet another group was gathering in Providence, RI, beginning in January of 1974. This small group met periodically at the home of Irving Kronenberg, then executive director of the Jewish Home for the Aged of Rhode Island. The team included Marilyn Schlossberg, a social worker; Rabbi Les Gutterman; Rev. Ray Gibson; Norma Kronenberg; Bruno Borenstein MD; and, again, Chaplain Charles Baldwin.¹⁴

Still another cluster of concerned people were meeting on the campus of Brown University, in late 1974, to explore the merit and feasibility of introducing hospice and palliative care concepts within the didactic curriculum of Brown's medical school. This group was lead again by Chaplain Baldwin, and Drs. Scala and Redding. They met regularly with Brown's dean of medicine to design and implement a weekly elective program for first- and second-year medical students. A series of seminars called "Death and Dying" was assembled with a volunteer faculty consisting of Drs. Scala, Redding, Cobb, McDuff, Borenstein and Aronson; as well as faith leaders, including Rev. Duane Parker, recently recruited to lead Interfaith Health Care Ministries, which would shortly become New England's largest hospital chaplaincy training program.¹⁵

On March 27, 1976, Hospice Care of Rhode Island was formally established, with the following incorporators: Chaplain Baldwin (as its first president), Rev. Ray Gibson, Ralph Redding MD, Irving Kronenberg and Marilyn Schlossberg. Joining them on the inaugural board of directors were: Sidney Cobb MD, Charles Edwards, Rev. George Frappier, Rabbi Leslie Gutterman, William Harvey, Margaret MacColl Johnson, Minerva King, Rev. Duane Parker, Jane Pretat, Eleanor Slater and Rev. Ken Wentzel.¹⁶

The involvement of chaplains and faith leaders in the beginnings of hospice and palliative care in North America, especially in United States, was clear. This may have been one of the reasons why the medical profession was often slow to accept hospice. Dr. Bruno Borenstein MD observed, "To most doctors, hospice represented a whimsical, pseudo-religious voluntaristic thing without real shape, without real substance or form."¹⁷ Within the first decade of the modern movement of hospice and palliative care, chaplains worked hard to change the view most physicians had toward this new approach to medicine at the end-of-life.

Hospice of the Bluegrass in Kentucky opened in 1978 and was an early leader in hiring professional chaplains, requiring a master of divinity degree and two units of clinical pastoral education (CPE), plus encouraging board certification. This was the first hospice to be accredited for CPE through the Association for Clinical Pastoral Education (ACPE), in 1993.

Hospice care became a part of the Medicare benefit in 1983. Hospice Conditions of Participation have always required that "a pastoral or other counselor" be included in the interdisciplinary group, and that spiritual counseling be provided to patients and families.¹⁸

The palliative care movement emerged out of the hospice movement in response to the need for alleviation of suffering and improved quality of life throughout the course of serious illness, not only in the final months of life. Palliative medicine was established as a subspecialty of general medicine in 1987. Like hospice, "palliative medicine is total care – of body, mind and spirit."¹⁹ The religious, spiritual and existential needs of patients are seen as

¹² Chaplain Dohi¹² spent a sabbatical in St. Christopher's Hospice in London serving there for six months as the spiritual care provider. Paradis, Lenora F., and S.B. Cummings. *The Evolution of Hospice in America Toward Organizational Homogeneity*. Journal of Health and Social Behavior, 1986, Vol. 27:373.

¹³ Aronson, p. 108.

¹⁴ Aronson, p. 108.

¹⁵ Aronson, p. 108.

¹⁶ Aronson, p. 108-109.

¹⁷ Aronson, p. 109.

¹⁸ (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/1983-Final-Rule.pdf>, accessed May 24, 2013).

¹⁹ Derek Doyle, et al. *Oxford Textbook of Palliative Medicine*, 2nd ed, Oxford: Oxford University Press, 1998, p.6.

integral to the care of the whole person. As in hospice, palliative care is provided by an interdisciplinary team that ideally includes a physician, nurse, social worker and chaplain.²⁰

This focus on the spiritual aspect of suffering in the course of life-limiting illness is also reflected in the growing list of definitions of palliative care. In 1982, the World Health Organization defined palliative care as, “the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best quality of life for patients and families.”²¹

The inclusion of the “spiritual” domain as one of the eight essential domains of care in the *Clinical Practice Guidelines for Quality Palliative Care* in 2004 provided the impetus for the Consensus Conference on “Improving the Quality of Spiritual Care in Palliative Care” in 2009. The groundbreaking work of the Consensus Conference in defining spirituality as, “...the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred,”²² continued to open the way for spiritual care to be included as an essential component of quality palliative care.

In the most recent edition of the National Consensus Project for Quality Palliative Care Guidelines, palliative care is defined as, “...patient- and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs, and to facilitate patient autonomy, access to information and choice.”²³

Just as Dame Cicely Saunders and David Tasma discovered, the role of the hospice or palliative care spiritual care provider has always been grounded in a sacred encounter between persons. While our history in caring for the suffering and dying is far larger than any one movement, chaplains, as fully integrated members of the interdisciplinary team, have an essential role and unique opportunity in the rediscovery of whole-person care as expressed in hospice and palliative care. This calling is, and will be, one way among many we, as people of faith, serve and will continue to serve all those who suffer in body, mind and spirit.

PROJECT

In 2005, the Association for Professional Chaplains (APC) advanced the profession by developing [Standards of Practice for Professional Chaplains in Acute Care](#). Soon after the acute care standards were established, [Standards of Practice for Professional Chaplains in Long-Term Care](#) were developed.

In 2012, a group of hospice and palliative care chaplains was convened by the APC Quality in Chaplaincy Care Committee to develop standards of practice for professional chaplains working in hospice and palliative care. These standards of care reflect the consensus of chaplains in both settings in a unified document that reflects the uniqueness and commonalities of each setting.

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.”ⁱ 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 a process for assessing the spiritual/religious needs of patients.
- **Competency standards** define skills and training 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 assessments.

²⁰ *Clinical Practice Guidelines for Quality Palliative Care*, 3rd ed., National Consensus Project for Quality Palliative Care, 2013.

²¹ Doyle, p. 3

²² Christina Puchalski, et al., *Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference* (Journal of Palliative Medicine, Vol. 12, No. 10, 2009), p.887.

²³ *Clinical Practice Guidelines for Quality Palliative Care*, 3rd ed., National Consensus Project for Quality Palliative Care, 2013, p. 12.

- **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 complete 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, medical professionals and students in a health care setting.
- Throughout the standards, “chaplain” refers to a board certified chaplain serving in hospice and palliative care.
- The term “spiritual/religious” recognizes the differences inherent in the individual concepts but links the two for sake of ease in this document.
- Throughout these standards, when the term “spiritual/religious care” or “spiritual care” occurs, it is our intention that this term represents the more inclusive or complete concept of “spiritual/religious/existential care.” In places where all three terms appear, it is because their use makes sense in that context.

THE CREDENTIALS OF THE BOARD CERTIFIED CHAPLAIN

According to the [Common Standards for Professional Chaplaincy](#), any board certified chaplain will:

- Have a bachelor’s degree from a college or university that is appropriately accredited.
- Have 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.
- Have four units (1,600 hours) of clinical pastoral education (CPE) 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.
- Have endorsement by a recognized religious faith group for ministry as a chaplain.
- Have competencies for chaplaincy as established by the Common Standards for Professional Chaplaincy.
- Have accountability 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 his/her faith tradition every five years.
- Hospice & Palliative Care Speciality Certification. BCCI offers speciality certification beyond board certified chaplain (BCC) designation. With successful completion of the process, the designation for a person so certified is BCC-HPCC (board certified chaplain-hospice and palliative care certified).
<http://bcciprofessionalchaplains.org/palliative>

CONTEXT

Hospice and palliative care can differ in the settings where they are offered. While a hospice organization may function as a stand-alone set of services, palliative care is usually provided in a clinical inpatient or outpatient setting.

A number of factors distinguish the hospice and palliative care settings. These distinctions have a direct influence on the way in which chaplaincy care functions in each. For example, hospice care can be in the patient’s home, in a long-term care facility or in an inpatient setting, and incorporates palliative care principles during the final months of the trajectory of illness. The chaplain’s scope of practice in hospice care may include such services as facilitating a patient’s contact with his/her existing religious community or providing worship opportunities for patients no longer able to attend their houses of worship.

Since palliative care can be provided at any stage of disease, at the same time as curative or life-prolonging treatments, and in inpatient or outpatient settings, the palliative care chaplain may provide chaplaincy care to patients over the course of several months to years.

The chaplain's scope of practice in hospice and palliative care may include addressing religious, spiritual and existential pain and suffering related to a life-limiting diagnosis, assisting with advance care planning in light of one's values and beliefs, or facilitating conversations about one's hopes and fears.

In both the hospice and palliative care settings, there is the critical need for staff support due to the frequency of death and the cumulative impact of grief. Routinely addressing staff concerns related to bereavement will prevent the debilitating issues related to compounding.* Another important aspect of the chaplain's work may be to provide bereavement support for the patient's caregivers.

* *Compounding* is the term used in grief counseling to describe the results that can occur when a grieving person does not adequately deal with the trauma of an initial death before one or more additional deaths occur.

SCOPE OF SERVICES

Hospice and palliative care chaplains provide a broad and diverse range of services, including the following:

- Completing an assessment and determination of an individualized 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, such as sacred texts, Shabbat candles, music, prayer rugs and rosaries.
- Offering or facilitating rituals, prayer, sacraments and legacy work.
- Contributing in ethical issues, such as through a primary chaplaincy relationship, participation on an ethics committee or consultation team and/or participation on an institutional review board.
- Helping identify and interpret *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 organization.
- Offering care and counsel to patients, their caregivers and staff regarding dynamic issues, including loss/grief, spiritual/religious/existential struggle, strengths, opportunities for change and transformation, ethical decision making, and difficult communication or interpersonal situations.
- Facilitating difficult conversations, including goals of care and advance care planning.
- Addressing signs and symptoms of non-physical pain and suffering.
- Providing leadership within the organization and within the broader field of chaplaincy.

ACCOUNTABILITY

This Standards of Practice for Professional Chaplains in Hospice and Palliative 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 Quality in Chaplaincy Care Committee, which is responsible for the work and to which this work group is accountable. This work group is composed of board certified chaplains from APC. Although brought together by an APC committee, 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 Ahmed Aquino, Karen Ballard, Miriam Dakin, Denise Hess, Terry Irish, Bonnie Meyer and Sue Nebel. Pat Appelhans served ex-officio.

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 spiritual assessment of a patient and family in hospice and palliative care settings involves relevant physical, psycho-social and spiritual/religious factors, including the needs, hopes and resources of the individual patient/family, keeping in mind the relationship between spirituality and religion. Spirituality is the overarching reality. Religion is spiritual but not all that is spiritual is necessarily religious. Assessing for spiritual care is appropriate, even when a patient or family does not identify with, or express interest in, religion.

A comprehensive spiritual assessment:

- Gathers and evaluates information about the spiritual/religious, emotional and social needs, hopes and resources of the patient or the situation.
- Identifies potential obstacles and/or risk factors for effective spiritual, religious and existential care.
- May employ a standardized instrument.

MEASUREMENT CRITERIA

- First assessment is completed within the required time frame (hospice – five days) and updated on a continuous basis.
- Documents patient/family encounters in medical record in format accessible to interdisciplinary team.²⁴ (See transdisciplinary team²⁵.)
- Acknowledges and respects patient's and family's beliefs, culture and values.
- Acknowledges and respects patient's and family's ethnicity and ensures effective communication by utilizing resources in their preferred language.

EXAMPLES

- Identifies spiritual crisis, with the possible use of one or two **spiritual screening** questions:
 1. "Would you say religion or spirituality is an important part of your life?"
 2. "How well would you say these resources are working for you at the present time?"²⁶
- Documents a **spiritual history** to better understand patient spiritual resources and needs, with the possible use of a tool such as:
 1. F.I.C.A. [**f**aith, **i**mportance/**i**nfluence, **c**ommunity, **a**ddress in caring for the patient] (Christina Puchalski, MD)
 2. SPIRIT [**s**piritual belief system, **p**ersonal spirituality, **i**ntegration, **r**ituals/**r**estrictions, **i**mplications and **t**erminal events] (T.A. Maugans)

²⁴ **Interdisciplinary team:** This APC-appointed *Standards of Practice for Hospice and Palliative Care* Task Team has chosen this term with deliberate care, recognizing that the term which is coming into popular use during the development of these *Standards* in 2013, and in all likelihood will become the accepted term used in the future to describe our collaborative work, will be **transdisciplinary team**.

²⁵ **Transdisciplinary team:** All members of the team work collaboratively to develop a shared team mission and goals, benefit from each other's unique skill set and role overlap, and have integrated responsibilities, training and leadership. (Otis-Green, S. et al (2009). An Overview of the ACE project – Advocating for Clinical Excellence: Interdisciplinary palliative care education. *Journal of Cancer Education*, 24(2), 120-126.)

²⁶ Adapted from Puchalski, CM. (2009). Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference. *Journal of Palliative Medicine*, 12(10), 891, 893.

- Completes a **spiritual assessment**. Unlike recording a spiritual history, a spiritual assessment requires the specialized training and listening skills of a board certified chaplain, and is not built on a set of questions. This more extensive process involves active listening as the patient tells the story and the chaplain summarizes what s/he learns about the needs and resources indicated by the patient.

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 other members of the interdisciplinary team. The plan of care is based on the needs, hopes and goals of the patient or situation identified in the chaplaincy assessment. The chaplain has the primary responsibility for providing spiritual, religious and existential care for the patient and family, and utilizes resources, such as community religious leaders, as appropriate.

MEASUREMENT CRITERIA

- Involves the patient, family and other team members in articulating desired outcomes, interventions, and a personalized care plan when possible and appropriate.
- Acknowledges and respects the patient's and family's beliefs, culture and values, and uses appropriate resources to ensure effective communication and interventions.
- Evaluates the care plan on an ongoing systematic basis.
- Modifies desired outcomes and interventions based on changes in the status or wishes of the patient/family.
- Provides information on the patient's spiritual/religious beliefs and practices to interdisciplinary team members and to other staff members in the organization.
- Documents patient/family encounters and changes in the care plan in the medical record in a format accessible to the interdisciplinary team members.

EXAMPLES

- Provides services such as prayer, compassionate presence, active listening, life review and rituals as requested or permitted by patient/family.
- Communicates with and supports the involvement of local faith leaders to provide appropriate care for patient and family.
- Assists with funerals or memorial services when requested by families.
- Provides information to the interdisciplinary team about cultural and religious beliefs that inform and influence the patient's and family's attitudes and responses to medical treatment.

STANDARD 3: ACCESS TO INFORMATION AND DOCUMENTATION OF CARE

The chaplain, as member of the interdisciplinary team, assesses and enters information pertinent to the patient's medical record that is relevant to the patient's medical, psycho-social and spiritual/religious goals of care.

INTERPRETATION

Access to information and 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 respects the organizational and regulatory guidelines with regard to confidentiality, while ensuring that the chaplain team and the whole health care team is aware of relevant spiritual/religious needs and concerns.

Access and notation of documentation should include, but are not limited to, the following:

Access:

- History and physical of patient (to learn about diagnosis, prognosis, psycho-social/spiritual history from MD/DO assessment).
- Progress notes.
- Nurse's notes.

- Social worker's notes.
- Case management's notes.
- Interdisciplinary plan of care.
- Advance directives.

Notation:

- Reason for encounter (i.e. request for total pain management, goals of care, compassionate extubation, centers for Medicare and Medicaid services, and Joint Commission requirements).
- Spiritual/religious preferences and desire for, or refusal of, ongoing chaplaincy care.
- Critical elements of spiritual/religious assessment.
- Patient/family-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

- Documents in the medical record the spiritual/religious screening and assessment, patient's ongoing spiritual/religious and ritual needs; chaplain's plan for meeting such needs (e.g. anointing, communion, Shabbat candles, faith leader visits), and the patient/family's wish to receive or terminate ongoing chaplaincy care.
- Documents in the medical record the chaplain's participation on the interdisciplinary team that may affect patient's plan of care.
- Indicates in the medical record the spiritual/religious resources and problems that affect the plan of care.

STANDARD 4: TEAMWORK AND COLLABORATION

Team is an essential component of both hospice and palliative care, and the chaplain is a fully integrated member of the interdisciplinary team.

INTERPRETATION

The chaplain provides the team with specialist level expertise in assessing and addressing the spiritual and existential needs of patients, family and staff. In order to accomplish this, the chaplain initiates and engages in clear, regular communication practices, and promotes collegial interactions that nurture a collaborative team environment of trust and respect.

MEASUREMENT CRITERIA

- Participates in interdisciplinary care team meetings, providing contributions to the plan of care to address the spiritual and existential needs of patients and their families facing life-limiting or terminal illness.
- Participates in patient/family conferences as a member of the team addressing the existential, spiritual and emotional concerns that are presented.
- Possesses knowledge of each discipline represented on the team.
- Able to articulate the purpose and value of each discipline to patient/family.
- Demonstrates an awareness of one's own scope of practice, and respect for each team member's expertise and scope of practice.
- Maintains clear boundaries while handling team role blurring with professionalism and maturity.
- Works collaboratively to incorporate fellow team members' contributions to patient/family plan of care, as appropriate, while advocating for the patient/family-identified goals of care.
- Maintains authentic, professional interpersonal relationships with the fellow team members.

- Responds promptly to team member referrals.
- Communicates chaplaincy care interventions using the organization's approved communication channels.
- Articulates and practices an understanding of group dynamics, process and development.

EXAMPLES

- Maintains accountability to interdisciplinary team members, remaining open to feedback and cultivating awareness of one's own strengths and weaknesses.
- Contributes consistently and meaningfully to interdisciplinary meetings, including sharing information derived from observations and assessments, and by documenting chaplaincy interventions using professional language understandable to other disciplines.
- Models, facilitates and participates in effective interdisciplinary team conflict resolution, and provides constructive feedback to fellow team members in order to enhance team function and effectiveness.
- Educates the interdisciplinary team about spiritual and existential issues, and appropriate care for those with life-limiting or terminal illness.

STANDARD 5: ETHICAL PRACTICE

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

INTERPRETATION

The chaplain is knowledgeable about the potential ethical and moral challenges in the care of persons with life-limiting illnesses and facilitates ethical decision making with patients and families, the interdisciplinary team, staff, and the community. The chaplain respects and advocates for plans of care that accurately reflect the patient or surrogate's stated beliefs, values, culture and preferences. The chaplain affirms the patient's right to self-determination, to forgo treatment, to informed consent (and assent for minors), and the relevant federal, state or faith community guidelines on medical decision making. The chaplain is knowledgeable about the process of assessing patient decision making capacity and state regulations regarding surrogate decision makers. 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

- Upholds the ethical principles of respect, justice, nonmaleficence and beneficence in their professional role with patients and families, the interdisciplinary team, staff and community.
- Is able to define "double-effect" and the role of intentions in ethical decision making.
- Is able to articulate the ethical issues surrounding the use of palliative sedation.
- Is aware of faith tradition directives regarding the provision, withholding or withdrawing of life-sustaining treatments while supporting patient or surrogate autonomy.
- Maintains clear boundaries around sexual, spiritual/religious, financial and/or cultural values.

EXAMPLES

- Participates in the process of ethical decision making and/or the ethics committee as appropriate to the setting, supporting various theological, spiritual and cultural values.
- Participates in continuing education events with a focus in ethical decision making, models the process of ethical decision making in the context of interdisciplinary team interactions, understands personal/professional limitations and seeks consultation when needed.
- Assists patients and families in identifying the benefits and burdens of specific medical interventions, and addresses the potential impact of the health care decisions on families and other stakeholders.
- Recognizes the unique vulnerability of unrepresented patients and/or those deemed to lack capacity, serving as their advocate when necessary.
- Articulates the ethical perspectives regarding natural death and physician-assisted dying, and relevant state laws where applicable.

STANDARD 6: CONFIDENTIALITY

The chaplain respects the confidentiality of information from all sources, including the patient/family members, medical record, interdisciplinary team members, larger health care team and local faith community members, in accordance with federal and state laws, regulations and rules.

INTERPRETATION

For the chaplain, the primary focus of care is the patient/family. Each patient has the right to privacy, confidentiality, autonomy and self-determination with regard to his/her health care information within the limits of federal and state laws. The chaplain respects the patient or surrogate's directions regarding information sharing. Confidential patient information is shared with the patient's family members, interdisciplinary team and larger health care team only as is appropriate, necessary and lawful. These obligations do not end with the patient's death.

MEASUREMENT CRITERIA

- Determines with whom communication of confidential information is appropriate.
- Documents only what is appropriate for the care being received.
- Protects confidential patient information sharing as patient moves across settings.
- Conducts and advocates for patient/family care conferences with patient knowledge and participation whenever possible.
- Educates staff on patient confidentiality.
- Communicates the patient's confidentiality needs with health care team.
- Adheres to state and federal guidelines regarding confidentiality for adolescents.
- Safeguards privacy when using clinical material for educational activities or publishing.
- Understands 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

- Shares information with patient's family/friends/community in accordance with the expressed wishes of the patient/surrogate when appropriate.
- Allows the patient to determine what health care information s/he does and does not wish to know.
- Understands the issues of the pastoral confession vs. confidentiality by appropriate state law, informing a patient what is and is not reportable to authorities when a confidential conversation is desired.
- Understands the ramifications of a decision to keep confidential information that could be at odds with the legal authorities, such as 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, psycho-socially and spiritual/religiously competent patient- and family-centered care.

INTERPRETATION

The chaplain includes in his/her assessment the identification of cultural, psycho-social and spiritual/religious issues, beliefs and values of the patient/family that impact the patient/family's goals of care. The chaplain provides education to the interdisciplinary team regarding self-awareness of one's own cultural values, beliefs and assumptions. This education influences attitudes and behaviors that affect care and enables the team members to serve persons of different backgrounds more compassionately and effectively.

MEASUREMENT CRITERIA

- Demonstrates a thorough knowledge and understanding of cultural, psycho-social and spiritual/religious diversity.
- Defines and incorporates desired outcomes, interventions and plans into the assessment and goals of care, in terms of the patient/family's cultural, psycho-social and spiritual/religious practices and beliefs, ethical considerations, environment, and/or situation.
- Identifies and respects spiritual/religious and/or cultural values.
- Advocates for, and responds to, identified needs while maintaining his/her own authenticity.

EXAMPLES

- Facilitates and supports a diversity of meaningful cultural and religious rituals and practices.
- Provides education to interdisciplinary staff in cultural, psycho-social and spiritual/religious diversity.
- Functions as a cultural, psycho-social and spiritual/religious advocate for the organization.

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 interventions.

INTERPRETATION

Chaplaincy care to organization staff is an important function of chaplains in addition to their primary focus on patient and family care. Comprehensive staff care involves a wide range of chaplaincy services available to all health care team members within the organization. The goal is to empower each professional to attend to such fundamental issues as existential transcendence, relatedness, meaning, purpose and wholeness.

There are a variety of staff care services with varying complexities:

- At a basic level, these could include such things as one-on-one supportive conversations and the provision of public worship opportunities.
- At a more complex level, these could include such things as formal counseling, and grief and loss support.

MEASUREMENT CRITERIA

- Provide support to staff through interventions such as active listening, emotional affirmation and conversation.
- Proactively offer spiritually/religiously inclusive rituals and other opportunities that help staff members realize their purpose, find meaning, and appreciate their relatedness to one another and the transcendent.
- Refer individuals to the organization's employee assistance program or external resources when appropriate.
- Provide timely, collaborative peer-support activities during high-stress or emergency situations.
- Encourage professional growth that addresses spiritual development, especially as it relates to the health care professional's sense of calling to his/her profession, the basis of relationship-centered care and provision of compassionate care.²⁷
- Offers calm and calming presence in the midst of crisis and stress.

EXAMPLES

- Offers informal one-on-one support to staff members, including family/work-related stresses, by promoting attention to self-care, personal reflection and stress management.
- Celebrates staff accomplishments, such as employment anniversaries, job promotions and educational graduations.

²⁷ Adapted from Puchalski, CM. (2009). Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference. *Journal of Palliative Medicine*, 12(10), 901.

- Attends to staff needs through scheduled public opportunities and memorial rituals.
- Provides opportunities for health care professionals to discuss spiritual and ethical conflicts, moral distress, and other issues encountered in working with patients and each other.
- Facilitates group support through counseling/debriefing sessions and providing specialized interventions, such as Critical Incident Stress Management and Psychological First Aid, when appropriate and if qualified in the specialized intervention.

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. For the purpose of this standard of practice, "organization" may refer to the hospital where palliative care is based, the hospital which serves as the base for the hospice, or the freestanding hospice organization.

INTERPRETATION

Chaplains are alert to potential means of expressing and living out their organization's mission and values from a holistic perspective. 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. Chaplains are also integrally involved in promoting the goals and objectives of palliative care and/or hospice. Chaplains who are in management or who also have mission leadership responsibilities may have additional duties in the care of the organization, consistent with their role in the organization.

MEASUREMENT CRITERIA

- Maintains professional and ongoing interpersonal relationships with organizational leaders and the team members, who function in a very egalitarian way.
- 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/hospice 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.
- Advocates for adequate staffing to meet the spiritual needs of patients, families and staff in compliance with the requirements of The Centers for Medicare and Medicaid Services (CMS) in the provision of spiritual care as a core element of the Medicare hospice benefit and to accomplish the comprehensive assessment of the spiritual aspects of care as recommended by the National Quality Forum.^{28,29}
- Assists in creating an organizational palliative care culture across the continuum of care.
- Advocates for policies that respect the organization's staff.

EXAMPLES

- Cultivates personal relationships with hospital/hospice leaders through regular and intentional face-to-face interactions.
- Designs and maintains mission-appropriate sacred spaces that meet the spiritual/religious needs of patients, families and staff for facility-based palliative care and/or hospice.
- Creates and leads corporate spiritual/religious rituals that undergird transcendent aspects of the organization's mission, such as National Day of Prayer, World Communion Day, Cancer Awareness Programs and other disease-specific awareness days that relate to hospice and palliative care.

²⁸ Hospice Conditions of Participation (2008), Standard 418.56(a)(1)

²⁹ http://www.qualityforum.org/Publications/2012/06/Performance_Measurement_Coordination_Strategy_for_Hospice_and_Palliative_Care.aspx

- Designs and utilizes appropriate public relations materials that highlight spiritual components of the organization's mission.
- Advocates for policies for a staffing ratio of a hospice caseload of 40 patients per chaplain with an average of 15-25 visits per week and for interdisciplinary palliative care teams, in all settings, to include spiritual care professionals.³⁰

STANDARD 10: CHAPLAIN AS LEADER

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

INTERPRETATION

The chaplain takes leadership on issues related to spiritual/religious/cultural care and observance. The chaplain also has an obligation to advance the profession of chaplaincy by providing education, supporting colleagues and participating in his/her certifying organization. The chaplain functions as a model of taking time and energy to cultivate his/her interior life that serves as the foundation for leadership.

MEASUREMENT CRITERIA

- Serves in key roles in the work setting by participating in or leading committees, councils and/or 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.
- Liaises with community religious leaders.
- Mentors colleagues and writes for publication.
- Promotes advancement of the profession through active participation in his/her certifying organization.
- Advocates for a chaplaincy staff size that is aligned with the scope and complexity of the organization as well as the nature of chaplaincy care needs as they relate to the complexity of the medical care needs of the organization.
- May participate in hiring and orienting new staff, and conducts ongoing in-services for staff of all disciplines regarding interdisciplinary spiritual care assessment, intervention and documentation, and the role of the chaplain in the team.
- Coordinates the spiritual and religious care for patients and family members, as assigned.
- Informs, interprets and articulates the organization's policies and procedures regarding spiritual care.
- Assists the organization in policy review, and assures that changes and advances in chaplaincy care practice are considered in related policy and procedure changes.
- Speaks to religious and community groups for general community relations and educational programs.

EXAMPLES

- Serves on organizational committees, such as ethics, customer satisfaction, institutional review board and service-based projects.
- Educates organizational staff on religious/spiritual/cultural issues and communications, and other hospice/palliative care topics.
- Presents at the certifying organization's annual conference and other educational events, and writes for professional publications.

³⁰ Standard PCPM.7, JCO requirement: (from p 96-97 in the 2013 manual for palliative care team certification)

STANDARD 11: CONTINUOUS QUALITY IMPROVEMENT

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

INTERPRETATION

The chaplain participates in programs and opportunities of quality improvement that are relevant to chaplaincy and hospice/palliative care. The chaplain identifies areas for improvements through ongoing reviews. The chaplain, with other members of the interdisciplinary team, contributes to the organization's quality initiatives and best practices.

MEASUREMENT CRITERIA

- Participates in the collection of relevant data to monitor quality and effectiveness of chaplaincy.
- Develops and implements an ongoing plan for chaplaincy care quality improvement.
- Participates on the hospice/palliative care quality improvement and/or best practices team of the health care organization.
- Reports quality improvement initiatives and outcomes to the organization's quality improvement program and/or best practice team.
- Participates on interdisciplinary teams to monitor opportunities for quality improvement.
- Uses the results of quality improvement activities to initiate change in methods of delivering chaplaincy care.

EXAMPLES

- Participates in the use of a patient/family satisfaction survey with questions that will provide measurable data related to the quality of chaplaincy care.
- Participates in the selection, development and implementation of chaplaincy care quality improvement projects.
- Participates in evaluating the success of such quality improvement projects.

STANDARD 12: RESEARCH

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

INTERPRETATION

Increasingly, chaplains are demonstrating that they practice out of a research base, as illustrated by the growing body of evidence-based research in our field.

MEASUREMENT CRITERIA

- Demonstrates familiarity with published research findings that inform clinical practice through reading professional journals and other materials.
- Maintains current knowledge of research literature in the field of hospice and palliative care.
- Participates in research projects when possible that improve patient and family spiritual care, and advances the discipline of chaplaincy care.
- 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.
- Follows research guidelines and applicable laws, and strives to protect the dignity, privacy and well-being of all participants.

EXAMPLES

- Reads and discusses research articles in professional journals, such as the *Journal of Health Care Chaplaincy*, *Journal of Pastoral Care & Counseling*, *Journal of Pain and Symptom Management*, *New England Journal of Medicine* and the *Journal of Palliative Care*; considers implications for practice; and uses published research to educate administrators and/or other health care professionals on the role, value or impact of chaplaincy.

- Creates and executes quality improvement programs and disseminates the findings to the wider community outside the chaplain's own department, whether through the organization's quality improvement committee or through publication in a chaplaincy or specialized journal; may serve on the organization's institutional review board (IRB); may collaborate with researchers in other disciplines (or with other chaplains) in research projects designed for publication in peer-reviewed journals.
- May function as either principal or co-investigator in one or more peer-reviewed research studies that are published in peer-reviewed journals or presented as abstracts/papers at conferences.

STANDARD 13: KNOWLEDGE AND CONTINUING EDUCATION

The chaplain takes responsibility for continued professional development. The chaplain demonstrates a working knowledge of current theory and practice.

INTERPRETATION

The professional chaplain is expected to continue to grow and develop professionally and spiritually/religiously in his/her own leadership skills, and the organization's professional and educational needs. Relevant continuing education is required within the Common Standards for Professional Chaplaincy, and any applicable hospice and palliative care organizational requirements.

MEASUREMENT CRITERIA

Relevant continuing education includes:

- That which supports function and/or the strategic hospice and palliative care initiatives of the organization in which chaplains are employed.
- Initiation and contribution to research projects of palliative and spiritual care.
- Preparation and presentation of information for the purpose of educating team members and the community.

EXAMPLES

The chaplain may be guided by:

- His/her needs interests and/or performance evaluation, including professional and personal goals/objectives for the year and outcomes.
- Reflections and feedback from the five-year Maintenance of Certification 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, including nutrition, rest, relationships, exercise and spirituality.
- The needs of the interdisciplinary team and institution for training on such topics as spiritual/religious care, role of the chaplain, hospice and palliative care, ethics, grief and bereavement.
- Current theory/practice found by reading and reviewing current hospice/palliative care, interdisciplinary peer-reviewed literature, such as the *Journal of Health Care Chaplaincy*, *Journal of Pastoral Care and Counseling*, *American Journal of Pastoral Counseling*, *Hastings Center Report*, *Oates Journal*, *Journal of Palliative Medicine*, *American Journal of Hospice and Palliative Care Medicine*, *Journal of Pain and Symptom Management*, and other advanced medical journals.
- Attendance at regional and national organizational meetings.

GLOSSARY

Board certified chaplain: A chaplain who has met all of the requirements of the Common Standards for Professional Chaplaincy (<http://www.professionalchaplains.org>).

Chaplaincy care: Care provided by a board certified chaplain, or by a student in an accredited CPE program, e.g., Association for Clinical Pastoral Education (CPE). Examples of such care include emotional, spiritual, religious, pastoral, ethical and/or existential care. (See Brent Peery, "What's in a Name?" *PlainViews*, Vol. 6, No. 2 [February 18, 2009], www.plainviews.org.)

Clinical pastoral education (CPE): "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 July 24, 2013).

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.professionalchaplains.org>).

Competency: Possession of required skill, knowledge and/or qualifications.

Continuum of care: An integrated system of care that guides and follows patients over time through a comprehensive array of health services spanning all levels and intensity of care.

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." (<http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf>, accessed July 24, 2013).

Endorsement: A demonstrated connection to a recognized religious community. ("Professional Chaplaincy: Its Role and Importance in Healthcare," edited by L. VandeCreek and L. Burton, 2001).

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 clinical question (2) a literature search for evidence of efficacy (3) critical appraisal of article(s), (4) summary of evidence found and (5) development of a care recommendation.

Existential care: Attending to the spiritual distress and/or disruption of one's beliefs or value system. (See <http://nurseslearning.com/courses/hpna/CPF SpiritualExistential/ZS14ECPF SpiritualCare.pdf>, accessed July 24, 2013.)

Family: Family is defined by the patient and generally refers to family members, partners, loved ones and/or significant others of the patient.

Hospice: Considered the model for quality compassionate care for people facing a life-limiting illness, hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones, as well. Hospice focuses on caring, not curing. In most cases, care is provided in the patient's home but may also be provided in freestanding hospice centers, hospitals, nursing homes and other long-term-care facilities. Hospice services are available to patients with any terminal illness or of any age, religion or race. <http://www.nhpco.org/about/hospice-care>.

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, but are not limited to, 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.

Palliative care: Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain and stress of a serious illness – whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. It is provided by a team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness, and can be provided along with curative treatment. <http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc>.

Palliative sedation: "The monitored use of medications to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and health-care providers." (Cherny NI, Radbruch L; Board of the European Association for Palliative Care. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. *Palliative Medicine* 2009;23:581–593.)

Peer review: A collegial process for reflection and evaluation of a chaplain's practice of care, service and/or professional development. Its purpose is to stimulate personal and professional growth.

Plan of care: A plan developed by the interdisciplinary team, based on the needs, hopes and goals of patient and family.

Quality improvement: Organizational program that monitors quality of care given by its staff. Creates and implements plans to improve quality of staff performance and patient care, and evaluates outcomes.

Religion: An organized and stated set of beliefs about a higher power, connections between human beings and that power, and guidelines for human actions and relationships. The use of symbols, rituals and prayer is part of many organized religions.

Self-determination: A patient's ability and right to make decisions about his/her care.

Spiritual assessment: Collection and evaluation of the needs, goals and resources of a patient (and, where relevant, of the family) using a standardized instrument. The information is used in creating the plan of care for the patient.

Spiritual care: Interventions that facilitate and support reflection and action on personal issues, such as meaning, relationships, hope, illness, suffering and reconciliation/closure.

Spiritual distress: The "impaired ability to experience and integrate meaning and purpose in life through a person's connectedness with self, others, art, music, literature, nature or a power greater than oneself." ("Interdisciplinary Spiritual Care for Seriously Ill and Dying Patients: A Collaborative Model," Christina M. Puchalski MD FACP, Beverly Lunsford PhD RN, Mary H. Harris MSW LICSW, Rabbi Tamara Miller MA, Washington, DC, *Palliative & Supportive Care*, Vol. 12 No. 5 September/October 2006, 398-416).

Spirituality: "Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred." (*Journal of Palliative Medicine* Vol. 12, No. 10, 2009 "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference.")

Surrogate decision-maker: Person designated to make decisions about care for a patient when the patient is unable to do so and has not designated a specific decision-maker in these circumstances. Surrogate decision-makers are determined by state laws.