Standards of Practice for Professional Chaplains in Acute Care: Second Draft of the Consensus Document
November 1, 2009

In October 2008, the Commission on Quality in Pastoral Services of the Association of Professional Chaplains (APC) convened a work group to draft consensus standards of practice (SOPs) for chaplains in acute care. This was the first step in creating SOPs for chaplains in various settings in order to better communicate the work of chaplaincy and to serve as a basis for establishing best practices. The initial draft was published in PlainViews 6, no. 2 (Feb 18, 2009) and responses invited from the chaplaincy community. This second draft consensus document is followed by invited responses from various perspectives that the work group deemed important to the discussion. If you wish to add your voice, please e-mail the work group by Friday, December 4 (sop@professionalchaplains.org). The work group will consider those responses as well as the ones published in Chaplaincy Today to create a final consensus document that will be sent from the Commission on Quality in Pastoral Services to the APC Board of Directors for a decision on how to proceed. The Steering Committee of the Spiritual Care Collaborative affirmed the initial document earlier this year, and the APC Board of Directors affirmed this draft in September. The hope is that all cognate partners will affirm or adopt the final consensus document for professional chaplains in acute care settings and that it will serve as a model for chaplains in other settings. A work group of chaplains already is engaged in the process of creating long-term care SOPs. In this publication, the glossary appears as a separate document to enable the reader to open both and to move easily between them. Glossary words are highlighted on their first appearance.

Standards of Practice for Professional Chaplains in Acute Care Overview

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 actively and clearly 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, and abides by all applicable laws and regulations.

Standard 7 – Respect for Diversity: The chaplain actively 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 Good 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.

Standards of Practice for Professional Chaplains in Acute Care Document

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., churches, synagogues, and in specialized ministry, e.g., hospitals.²

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.³

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, 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.⁴

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 groups⁵ 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.⁶

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 APC 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 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.” 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 in the glossary, which accompanies this document, 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 (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.
- Current endorsement by a recognized religious faith group for ministry as a chaplain.
- Met competencies for chaplaincy as established by the Spiritual Care Collaborative.
- 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 his/her faith tradition every five years.
Scope of services
Chaplains provide a broad and diverse range of services including the following:

- 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.
- Offering rituals, prayer and sacraments.
- Contributing in ethics, e.g., through a primary chaplaincy relationship, participation on an ethics committee or consultation team, 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 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 included George Fitchett, Daniel Grossoehme, George Handzo, Martha Jacobs, David Johnson, Robert Kidd, Stephen King, Mark LaRocca-Pitts, Ted Lindquist, Jane Mather, Kimberly Murman, Floyd O’Bryan, Jon Overvold, Don Patterson, Brent Peery and Sue Wintz.

Preamble
Chaplaincy care is grounded in initiating, developing and deepening, and bringing to an appropriate close, a mutual and empathic relationship with the patient, family and/or staff. The development of a genuine relationship is at the core of chaplaincy care and underpins, even enables, all the other dimensions of chaplaincy care to occur. It is assumed that all of the standards are addressed within the context of such relationships.9

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 the following:

- 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**
- 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 able to instruct 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.

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 ongoing chaplaincy care.

• Reason for visit.

• 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 ongoing 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 ongoing 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 actively and clearly 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.
- Remains alert to patient referral opportunities that arise while providing chaplaincy care.
- Maintains candid, 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.
- Clearly communicates chaplaincy care interventions using the organization's approved interdisciplinary communication channels.
- Regularly 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. \(^{11}\)
**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**
- Respects 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 and abides by all applicable laws and regulations.

**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**
- Charts only what is appropriate for the care being received.
- Safeguards privacy when using clinical material for educational activities or publishing.
- Understands the ramifications of the laws 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.
- Clearly 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 may be at odds with the legal authorities, e.g., sanctuary/deportation issues.

**Standard 7: Respect for Diversity**
The chaplain actively 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 staff accomplishments, e.g., employment anniversaries, job promotions, educational graduations.

• Attends to staff needs through regularly 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 ongoing 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, provides a prophetic 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/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; regularly trains organizational staff on communications and religious/spiritual/cultural issues.
- Intermediate: Presents regularly at the certifying association’s yearly conference and other education events.
- Advanced: Writes for publications.

**Section 3: Maintaining Good 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.
• Regularly reports quality improvement initiatives and outcomes to the organization’s quality improvement program.

Examples
• Basic: Participates in a quality improvement project that is multidisciplinary. 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: Regularly 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 and/or other health care professionals on the role, value or impact of chaplaincy.
• Intermediate: Creates and executes quality improvement programs and disseminates the findings to the wider community, e.g., outside the chaplain’s own department, whether
through the organization’s quality improvement committee or through publication in chaplaincy or specialized journal.

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 Principal 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 editorial board as peer-reviewer for 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 his/her 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.
1 Adapted from Dan Murphy, an e-mail response to “Standards of Practice Responses,” “Standards of Practice for Professional Chaplains in Health Care Settings,” PlainViews 6, no. 2 (February 18, 2009). http://www.plainviews.org Accessed March 26, 2009.


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


8 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.

9 Murphy, “Standards of Practice Responses.”
