Glossary – SOP Long-term Chaplaincy Care

activities of daily living (ADL). Six basic personal care activities: eating, toileting, dressing, bathing, transferring and continence. The ability of someone to perform ADLs may help a professional assess an individual’s self-maintenance. Often ADLs are used as the criteria for payment by government and third party payers. ([Working with Seniors: Health, Financial and Social Issues](Society of Senior Advisors, 2005))

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

adult day care: Care provided at a community-based center for adults who need assistance or supervision during the day but do not need care around the clock. A primary focus of adult day care is on socialization and activities which are mentally and physically stimulating and may include help with personal care. ([Working with Seniors: Health, Financial and Social Issues](Society of Senior Advisors, 2005))

assent. Reflects the resident’s agreement with care rather than authorization.

assisted living facility: Residential housing meant for seniors with physical or cognitive impairments that make it difficult for them to perform an average of two ADLs without assistance. ([Working with Seniors: Health, Financial and Social Issues](Society of Senior Advisors, 2005))

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

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

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

clinical pathways. Clinical pathways are known by a variety of terms, e.g, pathways, clinical protocols, parameters, templates, benchmarks. The term speaks to a continuum of care that identifies structures, caregivers and processes that intervene at critical points to efficiently treat the patient and achieve a defined outcome. Pathways may be developed for medical conditions, specific patient groups or actual services such as chaplaincy care. Clinical pathways are essentially care maps that prescribe treatment for a particular patient. Often, they are used to coordinate care between different health care disciplines and to monitor the costs of care. However, they also are useful in mapping the contributions of a particular discipline to the care team and prescribing that discipline’s “branch” of the overall care tree. Increasingly, if a discipline is not represented on a given care map, it is not included in that patient’s care.
Common Code of Ethics. Gives expression to the basic values and standards of the profession, guides decision making and professional behavior, provides a mechanism for professional accountability, and informs the public as to what they should expect from professionals. (http://www.spiritualcarecollaborative.org/docs/common-code-ethics.pdf accessed January 14, 2009.)

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

continuing care retirement community (CCRC): Also known as life care communities, they provide a type of combined health, housing and social care insurance for the older adult. The individual signs a contract and agrees to pay an entrance fee and a monthly service fee in exchange for a living unit, health care and a lifetime of skilled nursing care, as needed. Many individuals age in place in a CCRC. (Working with Seniors: Health, Financial and Social Issues [Society of Senior Advisors, 2005].)

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

cultural broker. An individual who bridges, links or mediates between groups or persons of different cultural backgrounds for the purpose of reducing conflicts, producing change, or advocating on behalf of a cultural group or person. Cultural brokers also may be medical professionals who draw upon cultural and health science knowledge and skills to negotiate with the patient and health system toward an effective outcome. (Amy Wilson-Stronks, Karen K. Lee, Christina L. Cordero, April L. Kopp and Erica Galvez, One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations [The Joint Commission, 2008], 57 http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf accessed February 9, 2009.)

culture. “Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.” (Amy Wilson-Stronks, Karen K. Lee, Christina L. Cordero, April L. Kopp and Erica Galvez, One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations [The Joint Commission, 2008], 57 http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf accessed February 9, 2009.)

dementia care. Care specifically for the person with progressive cognitive impairment, e.g., Alzheimer’s disease.

deraad. An official declaration by a recognized faith community/tradition that a person meets its standards to serve in a specialized ministry setting of chaplaincy, counseling or clinical education.

evaluation. The comparison of a clinical practice—real or potential—against some standard, which could be an identified “best practice”; the current practice or a clinical outcome.

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

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

interdisciplinary. An approach to care that involves two or more disciplines (professions) collaborating to plan, care, treat or provide services to an individual resident and/or family. Examples include social work, nursing, medicine and chaplaincy care.
independent living: Living accommodations for seniors who are independent and ambulatory but may have minor physical impairments and health problems. These independent accommodations may be in an apartment complex or small patio homes/cottages on small lots. Some communities will have a mix of these buildings. The minimum age requirement for entry into such communities is normally 55. (Working with Seniors: Health, Financial and Social Issues [Society of Senior Advisors, 2005])

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

pastoral care. The offer of spiritual presence to people who are in need and/or experiencing pain/suffering. Pastoral care may form part of the care provided by a chaplain. See chaplaincy care.

peer review. A process intended to be a collegial and reflective view of one’s chaplaincy care practice, ministry, service and/or professional development. The review is intended to stimulate personal and professional growth through conference interaction with one’s peers.

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

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

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

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

religious. See religion.

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

resident. A generic term referring to a patient/resident/client/tenant/participant and/or family unit who receives care, treatment and/or services. Terms may vary depending on type of facility or geographic location.

skilled nursing care: Daily nursing and rehabilitative care that may be performed only by or under the supervision of skilled medical personnel. This care is usually needed 24 hours a day, must be ordered by a physician and must follow a plan of care. Individuals usually receive skilled care in a nursing care facility but also may receive it in locations such as the home under physicians’ orders and licensed medical supervision. (Working with Seniors: Health, Financial and Social Issues [Society of Senior Advisors, 2005])

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

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

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

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

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

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

spiritual/religious struggle. A situation which may develop when individuals are unable to make sense of stressful events in light of their spiritual/religious worldviews. Research has shown that elements of spiritual/religious struggle which have a negative impact on health include various aspects of one’s relationship to God, e.g., feelings of anger, abandonment punishment, as well as questioning God’s love. Spiritual/religious struggle also may arise from the individual’s experiencing hurt/betrayal at the hands of one’s congregation and/or religious authority figures. Additional research is needed to help us develop a comprehensive definition of spiritual/religious struggle. (See G. Fitchett, P. E. Murphy, J. Kim, J. L. Gibbons, J. R. Cameron and J. A. Davis, “Religious struggle: Prevalence, correlates and mental health risks in diabetic, congestive heart failure and oncology patients,” *International Journal of Psychiatry in Medicine* 34, no. 2 [2004], 179-96; K. I. Pargament, B. W. Smith, H. G. Koenig and L. Perez, "Patterns of positive and negative religious coping with major life stressors” *Journal for the Scientific Study of Religion* 37 [1998], 710-24; K. I. Pargament, H. G. Koenig, N. Tarakeshwar and J. Hahn, “Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: a two-year longitudinal study,” *Journal of Health Psychology* 9, no. 6 [2004], 713-30.)

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

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

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

**subacute care:** Comprehensive inpatient care designed for someone who has had an acute illness, injury or exacerbation of a disease process. It is goal-oriented treatment rendered immediately after or instead of acute hospitalization to treat one or more specific, active, complex medical conditions or to administer one or more technically complex treatments in the context of a person's underlying long-term conditions and overall situation.