Standards of Practice for Professional Chaplains in Long-term 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 resident, family and/or staff. The development of a genuine relationship is at the core of chaplaincy care and underpins, even enables, all the other dimensions of chaplaincy care to occur. It is assumed that all of the standards are addressed within the context of such relationships.[i]

Section 1: Chaplaincy Care with Residents and Families

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

Standard 2 – Delivery of Care: The chaplain develops and implements an individualized plan of care to promote resident well-being and continuity of care.

Standard 3 – Documentation of Care: The chaplain enters information into the resident's service record or medical record that is relevant to the resident'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 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 resident, 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 resident-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 of long-term care 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 up-to-date knowledge of current theory and practices and integrates such information into his/her own practice.

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INTRODUCTION

BACKGROUND

In 2008, in order to move professional chaplaincy toward Standards of Practice, the Association of Professional Chaplains' Commission on Quality in Pastoral Services brought together leaders in health care chaplaincy to work toward consensus about such standards. The first work group focused on the following:
- 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. The primary goal of the work group was to reach consensus about what standards of practice were most important at that time and to set those standards in front of the profession for further discussion. These standards were published in *Chaplaincy Today* 25, no. 2 (Autumn/Winter 2009) and accepted by the Association of Professional Chaplains in 2010. They should be referenced in conjunction with this long-term care document.

PROJECT

With the Standards of Practice for Professional Chaplain in Acute Care now developed, the goal was to develop standards for professional chaplains in long-term care. The acute care model informed this work and provided the catalyst for identifying and briefly explicating standards of practice for chaplaincy care in long-term care.

In order to move professional chaplaincy toward Standards of Practice for Long-term Care, the Association of Professional Chaplains' Commission on Quality in Pastoral Services brought together several leaders in chaplaincy care in long-term care to work toward consensus about such standards. These standards apply to a particular subset of chaplains: chaplains in long-term care. The work group focused on the following:
- Minimal but essential standards of practice.
- Standards for board certified chaplains in long-term care.

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."[ii] They describe a function, action or process that is directed toward the resident to contribute to the shared goal(s) of the resident and organizational care team. For example, a standard of practice might require that there is a process for assessing the spiritual/religious needs of residents.

- **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 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 at the end of this document, the following terms need clarification now:

- The term "resident" encompasses the resident *and* the situation, including family and staff.

- The term "staff," as in "staff care," means all staff, volunteers, doctors and students in a long-term care setting.

- Throughout the standards, "chaplain" refers to a professional board certified chaplain serving in a long-term care setting.

- The term "spiritual/religious" recognizes the differences inherent in the two individual concepts but links them for sake of ease in this document.

- The term "long-term care setting" refers to any of the following:
  - skilled nursing facility
  - adult day care center
  - assisted living facility
  - independent living community
  - subacute care
  - dementia care
  - continuing care retirement community (CCRC), which may include multiple levels of care, such as independent living, assisted living, skilled nursing care, dementia support care, rehabilitation and subacute care.

CONTEXT

A number of factors distinguish the long-term care setting from the acute care setting and have a direct influence on the way in which chaplaincy care functions in that setting. For example, long-term care is residential, which implies that these are the communities in which people live. Services offered are based upon the lifestyle preferences of the residents, and the kinds of programs and activities that have meaning to the residents. Depending on their situation, residents may be able to maintain involvement in their existing religious communities. This means the chaplain's scope of practice may include such things as facilitating a resident's contact with their existing religious community or providing worship opportunities for residents no longer able to attend their houses of worship.

Another factor that distinguishes long-term care from acute care is that not all settings for long-term care are based upon a medical model of care. Some facilities will operate under different licensing requirements and regulations, for example independent living and assisted living. In these settings, care planning and the provision of services may be organized by other models that do not include a medical record but use a "resident service file" instead. Skilled nursing facilities and subacute care facilities are based on the medical model and are regulated by state license and the federal requirements for Medicare/Medicaid reimbursement. The point to emphasize is that depending on the model in use, chaplaincy care departments will have slightly different roles and responsibilities.

One of the greatest distinguishing factors of the long-term care setting is that the chaplain often provides chaplaincy care to residents over the course of months or even years. The chaplain's relationships with residents may be marked by greater depth and understanding because the resident has been able to share his/her story with the chaplain over time. Not only the chaplain but also other staff and the residents themselves will have long-term relationships in a common community. Hence, an important aspect of the chaplain's work will be to provide opportunities for the community to mark the transitions of members entering and leaving the community and provide bereavement support as needed. In long-term care, the chaplain's role as spiritual leader for the whole community of the organization takes on greater importance.

The context of long term care varies greatly in the amount of resources committed to chaplaincy care when comparing organizations. Some organizations invest in robust chaplaincy services while other organizations rely on part-time chaplains or none at all. This document is intended to encourage chaplains who work in organizations with fewer resources and to help those organizations to aspire to a standard of care that will more fully addresses the spiritual needs of residents in their care.

THE CREDENTIALS OF THE BOARD CERTIFIED CHAPLAIN

According to the *Common Standards of 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 (1,600 hours) of *clinical pastoral education (CPE)* as accredited by the Association for Clinical Pastoral Education (ACPE), National Association of Catholic Chaplains (NACC) or the Canadian Association for *Spiritual Care* (CASC/ACSS); one of these units may be an equivalency.

- A minimum of one year full-time chaplaincy experience upon completion of four CPE units.

- Current endorsement by a recognized religious faith group for ministry as a chaplain.

- Demonstrated competency in areas of chaplaincy care, as outlined by the Common Standards for Professional Chaplaincy.[iii]

- Remain accountable to the endorsing faith group, employer and certifying body.

- Affirm and practice chaplaincy according to the *Common Code of Ethics*.

- Maintain membership in a certifying body by participating in a peer review every five years, documenting at least 50 hours of continuing education each year and providing documentation of endorsement with her/his 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 an individualized plan of care that contributes to the overall care of the resident 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 or facilitating rituals, prayer and sacraments.

- Contributing in ethics, e.g., through a primary chaplaincy relationship, participation on an ethics committee or consultation team, and/or participation on an institutional review board.

- Helping interpret and broker *cultures* and faith traditions that impact long-term care practice and decisions.

- Educating and consulting with the long-term 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 residents and staff regarding dynamic issues, e.g., loss/grief, spiritual/religious struggle, as well as strengths, opportunities for change and transformation, ethical decision making and difficult communication or interpersonal dynamic situations.

- Providing leadership within the organization and within the broader field of chaplaincy.

- Offering care and counsel to residents 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 Long-term 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 Commission on Quality in Pastoral Services of the Association of Professional Chaplains (APC), 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 (nonrepresentative) ties to the Association for Clinical Pastoral Education (ACPE), and the National Association of Jewish Chaplains (NAJC). In the revision process of this document the National Association of Catholic Chaplains provided written comment which contributed to this process. Thus, although brought together by an APC commission, this work group seeks to contribute to the wider profession of chaplaincy and is not writing for any particular organization. Participants in the work group included Leonard Blank, Heather Bumstead, Dale Carr, Scott Cartwright, Peter Yuichi Clark, John Fureman, Robbye Jarrell, Donald Koepke, Mark LaRocca-Pitts, Michele Micklewright, Margaret Muncie, Jon Overvold, Jackie Ward, David Wentroble, and Josh Zlochower.

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.[iv]

SECTION 1: CHAPLAINCY CARE WITH RESIDENTS AND FAMILIES

STANDARD 1: ASSESSMENT

Assessment: The chaplain gathers and evaluates relevant data pertinent to the resident'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 resident 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 resident 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 resident 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 resident.

- Involves the resident, family, other health care providers and the resident's local spiritual/religious community, as appropriate, in the assessment.

- Prioritizes data collection activities based on the resident's condition or anticipated needs of the resident 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.

- 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 an individualized plan of care to promote resident well-being and continuity of care.

INTERPRETATION

The chaplain develops and implements an individualized plan of care, in collaboration with the resident, the resident's family and 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 resident needs within their health care settings. Care will be based on a comprehensive assessment.

MEASUREMENT CRITERIA

- Involves the resident, 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 resident and the resident'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 resident or evaluation of the situation.

- Documents desired outcomes, interventions, plans and evaluations in a retrievable format accessible to the health care delivery team.

EXAMPLES

Independent Care and Assisted Living

- Delivery of care may entail ongoing contact between residents and their existing religious/spiritual community.

- One-to-one contact between the chaplain and the resident for spiritual/religious assessment may assist residents in accessing religious/spiritual resources inside and outside the residential setting as needed.

- Group activities such as worship, Bible study, grief support, storytelling, or music may be offered.

- Documentation may or may not be available in these settings; however, the chaplain should use the records that are available.

Skilled Nursing Facilities

- The chaplain provides one-to-one care that includes spiritual/religious assessments, development of an individualized plan of care and interventions based upon that plan of care.

- The plan of care may include one-to-one visits with the chaplain, communal worship and programs with other residents.

- The chaplain also may be a liaison for community clergy to assist in the clergy/resident relationship.

- As a member of the interdisciplinary team, the chaplain ensures that the resident's spiritual/religious needs are addressed and integrated into the plan of care.

- The chaplain also provides documentation in the resident's chart.

- The chaplain may be utilized for end-of-life planning, advanced directives and end-of-life care. The chaplain provides support to the resident, family and staff during these times of loss. Some facilities may provide some form of aftercare, such as memorial services and support groups.

- The number of tasks the chaplain may be involved in may vary from facility to facility.

Subacute Care Units

- The chaplain provides one-to-one care either by self-initiative or by referral. This may include a spiritual assessment and development of an individualized plan of care.

- The chaplain role also may include facilitating or coordinating worship services, prayer groups, religious and/or spiritual practices as well as helping the residents remain connected to their faith communities.

The chaplain may use an outcome-oriented plan of care. See Larry VandeCreek and Arthur M. Lucas, eds., *The Discipline for Pastoral Care Giving: Foundation for Outcome Oriented Chaplaincy* (New York, London, Oxford: The Haworth Pastoral Press, 2001).

STANDARD 3: DOCUMENTATION OF CARE

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

INTERPRETATION

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

In facilities not using a medical model, documentation should include, but is not limited to, the following:

- Spiritual/religious preference.

- Relevant information obtained from spiritual screen.

- Resident's involvement in spiritual care activities.

- Referrals to chaplain for spiritual assessment and intervention.

In facilities using a medical model, 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.

- Resident's desired care plan outcome.

- Chaplain's individualized plan of care, relevant to the resident/family goals.

- Indication of referrals made by chaplain on behalf of the resident/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

Independent and Assisted Living Facilities

> Information gathered by a spiritual screen may be summarized by the chaplain or his/her designee in the **resident** service record. This documentation would include the resident's preferences for particular religious, cultural or spiritual activities. Because **resident** service records do not have the same confidentiality protection standards as medical records, the chaplain must ensure that the resident's confidentiality is maintained with respect to personal information.

Facilities that Use a Medical Record

- Documentation in the medical record of spiritual/religious screening and assessment.

- Documentation in the medical record indicating resident's ongoing spiritual/religious and ritual needs and the plan for meeting such needs, e.g., anointing, communion, Shabbat candles, clergy visits.

- Documentation in medical record indicating spiritual/religious struggle issues that affect the individualized plan of care.

- Documentation in medical record indicating the resident's wish to receive or terminate ongoing chaplaincy care.

- Documentation in medical record indicating chaplain's participation on interdisciplinary teams affecting resident's individualized plan of care.

STANDARD 4: TEAMWORK AND COLLABORATION

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

INTERPRETATION

Resident 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 resident 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 resident's wishes and wholeness remain priorities.

- 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.

INTERPRETATION

The chaplain understands the multiple levels of relationships that are established in the process of providing care to residents, 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/religious values and cultural differences.

- 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 resident, medical record, other team members and family members, and abides by all applicable laws and regulations.

INTERPRETATION

An understanding of the resident's expectations of the chaplain as a religious/spiritual professional and how the chaplain intends information shared by the resident/family to be used is important. Being able to know and decide what to keep to oneself; share with other staff members, state or regulatory agencies; or publish as clinical vignettes mark various degrees of confidentiality.

MEASUREMENT CRITERIA

- Documents only what is appropriate for the care being received.

- Protects privacy when using clinical material for educational activities or published work.

- Understands the ramifications of the laws regarding confidentiality within the state where he or she 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" versus confidentiality by appropriate state law.

- Clearly communicates 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, 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 resident-centered care.

INTERPRETATION

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

MEASUREMENT CRITERIA

- Demonstrates a working knowledge and understanding of cultural and spiritual/religious diversity.

- Defines and incorporates desired outcomes and interventions into the assessment and individualized plan of care, in terms of the resident's/family's culture, spiritual/religious practices and beliefs, ethical considerations, ability/disability, sexual orientation, environment and/or situation.

- Identifies and respects spiritual/religious and/or cultural values; assists in identifying and responding to identified needs and boundaries.

EXAMPLES

- Provides a variety of spiritual/religious resources that reflect the diversity of the population served, e.g., prayer rugs, beads, sacred texts in translation and/or original languages as appropriate; provides sacred space that allows for varied configurations, e.g., seated, standing, kneeling, and use of symbols.

- Interprets and mediates when a resident's cultural and/or spiritual practices have an impact on long-term care practice and decisions.

- Functions as a cultural broker for the organization.

- Provides education to interdisciplinary staff in cultural and spiritual/religious diversity.

- Provides education in cultural and spiritual/religious diversity to all members of the residential community as it affects community life.

SECTION 2: CHAPLAINCY CARE FOR STAFF AND ORGANIZATION

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STANDARD 8: CARE FOR STAFF

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

INTERPRETATION

Though resident 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, this includes one-on-one supportive conversations with staff as well as provision of public worship opportunities. At a more complex level, staff care includes Critical Incident Stress Management or Psychological First Aid interventions and formal counseling, which require specialized training.

MEASUREMENT CRITERIA

- Provides supportive conversations with staff.

- Provides chaplaincy care to the organization's staff through spiritually/religiously inclusive, noncoercive 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 and after critical incidents.

EXAMPLES

- Engages in informal one-on-one support with staff members.

- Celebrates staff accomplishments, e.g., employment anniversaries, job promotions, academic 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.

- Provides continuing education, training or support related to grief/bereavement, stress, burnout or compassion fatigue.

- Administers rites and sacraments within ecclesiastical authorization as requested by staff.

- Develops programs for spiritual growth of staff, e.g., daily devotions, study of sacred texts, book study, brief retreat models, spiritual direction.

- Provides opportunities for staff to participate in volunteer charitable programs, e.g., Abider Ministry for the Dying, Alzheimer's Memory Walk, local United Way projects, food pantry support.

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STANDARD 9: CARE FOR THE ORGANIZATION

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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 organization 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 organization 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 residents.

EXAMPLES

- Cultivates personal relationships with organization 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 or quiet places that meet the spiritual/religious needs of residents, families and staff.

- Creates, coordinates or leads corporate spiritual/religious rituals that undergird transcendent aspects of the organization's mission or community observances.

STANDARD 10: CHAPLAIN AS LEADER

The chaplain provides leadership in the professional practice setting of long-term care 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.

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.

EXAMPLES

- Serves on organizational committees, e.g., ethics, customer satisfaction, institutional review board, service-based projects.

- Regularly trains organizational staff on religious/spiritual/cultural issues and communications.

- Presents regularly at the certifying organization's annual conference and other educational events; writes for professional publications.

SECTION 3: MAINTAINING GOOD CHAPLAINCY CARE

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STANDARD 11: CONTINUOUS QUALITY IMPROVEMENT

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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 the 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 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

- Participates in a quality improvement project that is multidisciplinary. The chaplain is not responsible for the whole project but contributes alongside other team members.
- Develops an annual chaplaincy department plan for continuous quality improvement. Results are reported to the organization's quality improvement leadership.
- In large organizations, develops and implements projects across the organization to improve chaplaincy care.

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STANDARD 12: RESEARCH

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

INTERPRETATION

For many years, chaplaincy care has 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, which sometimes is based on direct feedback from families, residents or staff. In contrast, other health care disciplines have reviewed their practices and have begun to base these on research evidence. Increasingly, chaplains are being asked to demonstrate that they also 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. Chaplains need to read and reflect on new research's potential to change the practice and to be willing and able to integrate that which is beneficial to residents, 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 by 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.

- Regularly reads and discusses research articles in professional journals, e.g., *Journal of Pastoral Care & Counseling, Mental Health, Religion & Culture, New England Journal of Medicine, The Journal of Religious Gerontology, The Journal of Palliative Care Nursing,* and considers implications for practice.

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

- 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 a chaplaincy or other 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.

- Functions as either *principal or co-investigator* in one or more peer-reviewed research studies that are published in peer-reviewed journals and/or presented as an abstract/paper at conferences.

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

STANDARD 13: KNOWLEDGE AND CONTINUING EDUCATION

The chaplain assumes responsibility for continued professional development, demonstrates a working and up-to-date knowledge of current theory and practices, and integrates such information into his/her own practice.

INTERPRETATION

In order to meet the needs of the residents 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 as follows:

- 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 the chaplain is employed.

- To current theory/practice which may be found by reading and reviewing current peer-reviewed literature, e.g., *Journal of Pastoral Care and Counseling*, advanced medical journals, the *Hastings Center Report, Journal of Health Care Chaplaincy, Future Age, The Journal of Religious Gerontology, Generations: Journal of the American Society on Aging, The Hospice Journal: Physical, Psychosocial and Pastoral Care of the Dying, Oates Journal,* as well as new research vehicles and books that advance the practice of chaplaincy care.

EXAMPLES

The chaplain may be guided by the following:

- His/her needs, interests and/or performance evaluation, including professional and personal goals/objectives for the year.

- Workshops and professional conferences on the local, regional and national level that meet standards for continuing education for organizations that adhere to the Common Standards for Professional Chaplaincy.

- 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, e.g., quality improvement, research, 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.

activities of daily living. Six basic personal care activities: eating, toileting, dressing, bathing, transferring and continence. The ability of someone to perform ADL's can help a professional assess their personal self-maintenance. Often ADL's 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. This care may include help with personal care 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. (*Working with Seniors: Health, Financial, and Social Issues* [Society of Senior Advisors, 2005.)

assent. Reflects the patient'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 **ADL**'s 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.professonalchaplains.org/common_stds*, accessed January 14, 2009.)

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

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

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

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

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

continuing care retirement community: (Life care communities) Communities that provide a type of combined health, housing and social care insurance of an older adult. A person 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, if needed, as the individual's needs change over time. 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, was brought to prominence by the Toyota Production System and 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 can also be medical professionals who draw upon cultural and health science knowledge and skills to negotiate

with the patient and health system toward an effective outcome." (Amy Wilson-Stronks, Karen K. Lee, Christina L. Cordero, April L. Kopp, and Erica Galvez, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations* [The Joint Commission, 2008], 57. *http://www.jointcommission.org/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 like Alzheimer's.

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

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

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

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

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

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, small patio homes or cottages on small lots, and 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, offered or intended for another's healing or well-being.

pastoral care. Pastoral care is the offer of spiritual presence with people who are in need, pain or 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. In the context of one's peers, the review is intended to stimulate personal and professional growth.

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

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

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

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

religious. See religion.

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

resident. A generic term referring to a patient/resident/client/tenant/participant and/or family as a unit who receive 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 can 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 get skilled care in a nursing care facility but may also receive it in other places such as the home under physician's orders and licensed medical supervision. (*Working with Seniors: Health, Financial, and   Social   Issues* [Society of Senior Advisors, 2005])

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

spiritual. See spirit and spirituality.

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

Spiritual Care Collaborative. The Spiritual Care Collaborative was an international group of professional organizations actively collaborating to advance excellence in professional pastoral and spiritual care, counseling, education and research." Participating organizations included the American Association of Pastoral Counselors, the Association of Clinical Pastoral Education, the Canadian Association for Spiritual Care, the National Association of Catholic Chaplains, and the National Association of Jewish Chaplains.

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

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

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

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

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

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

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

subacute care: Care that is comprehensive inpatient care designed for someone who has had as 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.(*http://aspe.hhs.gov/daltcp/reports/scltrves.htm* Accessed November 17, 2010)

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[i] Adapted from Dan Murphy, an e-mail response to "Standards of practice for professional chaplains in health care settings," *PlainViews* 6, no. 2 (February 18, 2009) *www.plainviews.org* accessed March 26, 2009.

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

[iii] There are four areas of competency. **Theory of Pastoral Care** includes theology, psychological/sociological disciplines, group dynamics, ethics and emotional/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, provide appropriate public worship and 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 Common Standards for Professional Chaplaincy, *http://www.professonalchaplains.org/common_stds,* accessed November 17, 2010.

[iv] Murphy, "Standards of practice."