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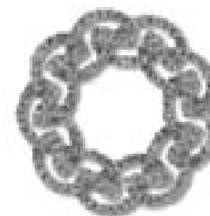

Standards for NHSScotland Chaplaincy Serices 2007

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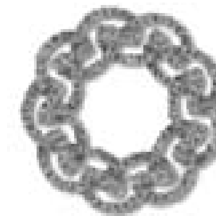

This work has been supported by NHS Education for Scotland

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CONTENTS

Contents
Working Group **2**

Introduction
Acknowledgements **3**

Audit
Definition of Terms **1**

Standard 1
Spiritual & Religious Care **2**

Standard 2
Access to Chaplaincy Services **4**

Standard 3
Partnership with Faith Communities and Belief Groups **5**

Standard 4
Staff Support **6**

Standard 5
Education, Training and Research **7**

Standard 6
Resources **9**

Standard 7
Chaplaincy to the Hospital or Unit **10**

References
Bibliography **11**

Self Assessment Tool **13-28**

INTRODUCTION

These standards have been developed following the recommendations of the NHS Quality Improvement Scotland Report of the Scoping Study Group on the Provision of Spiritual Care in NHSScotland (NHS QIS, 2005). The standards are presented to facilitate the audit of chaplaincy services, to ensure equality across services and to develop an integrated approach to the delivery of spiritual and religious care while at the same time being open the diversity of local services and needs. The standards are also designed to support those seeking to implement NHS HDL (2002) 76 Spiritual Care in NHSScotland, and to inform and provide an evidence base of good practice for the future development of National Standards for Spiritual and Religious Care in NHSScotland. The standards apply to chaplaincy services funded by NHS Boards.

It is acknowledged that Scotland has a rich and diverse heritage of culture, faiths and beliefs. While spiritual care is often referred to as a universal, the needs of faith communities or belief groups are specific and come within the equality and diversity agenda. It is the task of chaplaincy services and standards to address both of these areas. The intention of these standards is to be open to and inclusive of all individuals, in order to "respect the wide range of beliefs, lifestyles and cultural backgrounds found in the NHS and Scotland today" (NHS HDL (2002) 76, No 8). To facilitate that openness common terms have been developed and are described in the definition of terms, e.g. **faith communities** is used to describe those who see themselves adhering to a particular faith while **belief groups** is used to describe those who would recognise themselves holding individual or group beliefs such as a humanist. The working party recognise the differing understanding of terms and the communication difficulties that come with openness and inclusion, however, a key element in the provision of spiritual and religious care is to work through chaplaincy services to facilitate and support partnership with faith communities and belief groups (Standard 3).

These standards apply to all NHS services including acute, children and mental health. Where there is an issue of a patient's ability to communicate then the normal protocols would apply.

Essential to understanding the context of these Standards for NHS Chaplaincy Services is to recognise where they sit in the three tier process of National Standards, Service Standards and Competencies:

- National standards have yet to be developed and will set the criteria for what patients, carers, staff and volunteers can expect from Spiritual Care Services in NHSScotland (these could be developed by NHS Quality Improvement Scotland);
- Service standards set the criteria for how spiritual care services will be put into practice by the service primarily responsible for delivering spiritual care: Chaplaincy Services (these standards as supported by NHS Education for Scotland);
- Competencies in Spiritual Care which describe and assess the competence of individual health care professionals, including chaplains, to provide spiritual care (these would be developed by NHS Education for Scotland).

ACKNOWLEDGEMENTS

These standards have been adapted from the 2nd edition of the Association of Hospice and Palliative Care Chaplains Standards for Hospice and Palliative Care Chaplaincy (AHPCC, 2006). NHS Education for Scotland acknowledges with thanks the support and permission of the AHPCC to use and adapt these standards. NHS Education for Scotland also acknowledge the insight and experience from the three chaplaincy professional bodies: the Association of Hospice and Palliative Care Chaplains (AHPCC), the College of Health Care Chaplains (CHCC), and the Scottish Association of Chaplains in Healthcare (SACH).

AUDIT

An audit of chaplaincy services using the Standards for NHSScotland Chaplaincy Services should be carried out within 1 year of their introduction to provide a benchmark for chaplaincy services.

The Standards for NHSScotland Chaplaincy Services should be audited once in every 3 years (a number of standards may be audited each year as long as all are audited within a 3 year period).

To assist in the process of audit an assessment tool has been included with these standards.

DEFINITION OF TERMS

Belief group
Any group which has a cohesive system of values or beliefs but which does not self classify as a faith community.

Chaplain
A person who is appointed and recognised as part of the specialist spiritual care team within a health care setting. His or her job is to seek out and respond to those who are expressing spiritual and religious need by providing the appropriate care, or facilitating that care, through contacting, with the patient's permission, the representative of choice.

Chaplaincy service
The services provided by the individual or team of chaplains who are employed as specialist spiritual care providers/facilitators. Often this is known as the Department of Spiritual and Religious or Pastoral care. Such services seek to deliver or facilitate the appropriate spiritual or religious care to patients, carers and staff within NHS Scotland.

Clinical supervision
Clinical supervision brings practitioners and skilled supervisors together to reflect on practice. Supervision aims to identify solutions to problems, improve practice and increase understanding of professional issues (UKCC 1996).

Faith community
A recognisable group who share a belief system and usually undertake religious practices such as prayer, scripture reading, meditation, and communal acts of worship.

Spiritual and religious care
Religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community.

Spiritual care is usually given in a one to one relationship, is completely person centred and makes no assumptions about personal conviction of life orientation

Spiritual Care is not necessarily religious. Religious care, at its best is always spiritual (NHS HDL(2002) 76).

Standard 1

Spiritual & religious care

<table>
<tr><th>STANDARD STATEMENT</th><th>RATIONALE</th><th>CRITERIA</th></tr>
<tr><td>Patients and their carers have their spiritual and religious needs assessed and addressed.</td><td>Spiritual and religious care have been shown to be important to patients and are acknowledged to have a significant and beneficial impact on patient outcomes.

Spiritual and religious needs may be assessed and addressed by members of the healthcare team, which includes the chaplain, or with the patient's permission by contacting the patient's own faith representative.

Given that spiritual and religious needs can change from moment to moment, a process of continuous assessment enables healthcare professionals to be responsive to patients and their family/carer's needs.

Chaplains have an expertise in spiritual and religious care and using the security of their own belief system are enabled to discern and assess the varied spiritual and religious needs of all patients, and where appropriate, their carers: e.g. the parents of patients who are children and young people and the carers of adults with incapacity.

Patients should be protected from unwanted visits from spiritual and religious representatives or groups.

References
Everyone whether religious or not needs support and when confronting serious or life threatening illness or injury may have spiritual needs and welcome spiritual care as they seek to cope with suffering, loss, fear, loneliness, anxiety, uncertainty, impairment, despair, anger or guilt. Those associated with a faith community may derive help and comfort from their beliefs, from the rituals and ceremonies of their faith and the ministry of its leaders. The NHS must offer both spiritual and religious care with equal skill and enthusiasm.

Religious Care is given in the context of the shared beliefs, values, liturgies and lifestyle of a faith community.

Spiritual Care is usually given in a one to one relationship and is completely person centred and makes no assumptions about personal conviction or life orientation. Spiritual Care is not necessarily religious.

Religious Care, at its best, should always be spiritual (NHS HDL (2002) 76).

Spiritual issues have been shown to be important for patients with lung cancer or heart failure to the extent that the researchers express concern about healthcare professionals' lack of time and skills to address such issues (Murray et al 2004).

Spiritual care benefits from a process of continuous assessment. The key to such assessment is the knowledge skills and actions of the multidisciplinary team.

Chaplaincy often has its roots in religion however, for the generic chaplain their personal faith provides a base from where they can journey with people of different religious traditions and those who hold another life stance (Chaplin and Mitchell, 2005).</td><td>(a) Spiritual
1.a.1 Spiritual needs are assessed and addressed and may include the following:
• exploring the individual's sense of meaning and purpose in life;
• exploring attitudes, beliefs, ideas, values and concerns around life and death;
• affirming life and worth by encouraging reminiscing of the past;
• exploring the individual's hopes and fears regarding the present and future;
• exploring the individuals concerns about how their illness will affect others;
• exploring the 'WHY?' questions in relation to life, death, illness and suffering.
1.a.2 Liaise with local or national resources for spiritual support and with the patient's permission contact relevant groups/individuals.
(b) Religious
1.b.1 Religious needs are assessed and addressed and may include the following:
• ceremonies;
• meditation;
• prayer;
• rites;
• sacraments;
• worship.
1.b.2 With the patient's permission facilitate referrals to local faith groups and religious leaders.
(C) Protecting patients
1.c.1 Protect patients and their carers from unwanted visits from spiritual or religious groups and representatives.</td></tr>
</table>

Standard 2

Access to chaplaincy services

STANDARD STATEMENT	RATIONALE	CRITERIA
All patients and carers have information about and access to the chaplaincy service.	Effective healthcare requires a holistic approach to patient care including physical, psychological, social, and spiritual aspects of care. While all staff and volunteers have the potential to provide or facilitate spiritual care chaplains have a particular expertise in the spiritual, religious and cultural elements of patient care. **References** All health services should make provision so that proper personal consideration is shown to you, for example, by ensuring that your privacy, dignity and religious and cultural beliefs are respected (Patient's Charter, 1991). The task of spiritual assessment is a skilled task best undertaken by those who directly care for patients and their families. Staff who are aware of spiritual need should be proactive in offering spiritual care and accessing spiritual care services (NHS HDL (2002) 76). Chaplaincy should be a flexible service offering 24 hour cover. The role should not be confined to crises and emergencies. Chaplains have wide ranging experience and specialist knowledge which enables them to work with staff, patients, and carers in exploring areas of need (NAHAT, 1996).	2.1 All patients receive written information on admission containing details of the chaplaincy service available within the unit. 2.2 The written information contains an explanation of the chaplaincy service, examples of situations in which the chaplaincy service might be used and how contact with the chaplaincy service may be obtained. 2.3 The written information is supported by verbal explanation of access to the chaplaincy service during assessment. 2.4 The admission procedure ensures a check that written information is given. 2.5 There is a written protocol for referral to the chaplaincy service, including out of hours (Note: The protocol may provide for the referrals themselves to be verbal).

Standard 3

Partnership with faith communities and belief groups

<table>
<tr><th>STANDARD STATEMENT</th><th>RATIONALE</th><th>CRITERIA</th></tr>
<tr><td>Chaplaincy services should work in partnership with faith community and belief groups to ensure the appropriate provision of religious and spiritual care for patients and their carers.</td>
<td>It is recognised that patients and carers who are members of faith communities and belief groups may have specific requirements which can only be provided by leaders from their own communities/groups, in particular rites and ceremonies (see Standard 1 Criteria 1.b.1).

Given that patient requests may come at short notice it is essential that there is a local referral protocol and that chaplaincy services maintain and review a directory of local and national faith representatives and belief group leaders with contact details.

Chaplains have a role in facilitating contact, maintaining links, and advising local faith communities and belief groups on healthcare matters relating to spiritual and religious care. Following discharge it is the faith community and belief group leaders who are most likely to provide support for their own members in the community.

References
Whole-time spiritual caregivers will normally be responsible for facilitating the ministry in hospital or other NHS facility of the religious leaders of faith communities who may seek assistance and advice (NHS HDL (2002) 76).

Providing spiritual care cannot be accomplished working in isolation and chaplains must be able to work effectively with other chaplains, health and social care professionals, ministers of religion and representatives of faith groups or communities (AHPCC, CHCC, SACH, 2005).</td>
<td>3.1 Chaplaincy services are an informed resource on spiritual and religious care for NHS staff and local faith community and belief group leaders.

3.2 Chaplaincy services will maintain links between the NHS and local faith community and belief group leaders e.g. through the spiritual care committee and training events.

3.3 A written protocol is in place for NHS staff to refer to local faith community leaders and belief group representatives. The protocol should include clear guidance stating that faith leaders can only be contacted with the permission of the patient or their family/carers.

3.4 A directory of contact numbers for representatives from local faith communities and belief groups is available in hospitals and units. The directory should include national contact numbers for smaller faith communities and belief groups, or numbers that are likely to change e.g. the representative lives in their own home.

3.5 The local directory should be regularly updated and the faith communities and belief groups consulted on its content and updating.

3.6 A manual outlining the principal beliefs and practices of the major faith communities and belief groups is available in all hospitals and units. It is recommended the NES manual A Multifaith Guide for Healthcare Staff is used. Where a local manual is also in use the relevant communities and belief groups should be consulted and this local manual should include:
• Religious/belief issues that have an impact on healthcare practice with suggested alternatives e.g. blood transfusions;
• Religious/belief needs that have implications for the patient's stay and well being e.g. diet, prayer, rites and ceremonies;
• What to do in the event of an unexpected death e.g. a summary of common practices, dos and don'ts;
• Information about actions or situations where it is important to be sensitive.

3.7 A written protocol for liaison and exchange of information with the identified representatives of faith communities and belief groups is in place. The protocol should respect patient confidentiality, adhere to the hospitals guidelines on the use of patient information, and protect patients from unwanted visits (see Standard 1 Criteria 1.c.1).</td></tr>
</table>

Standard 4

Staff support

STANDARD STATEMENT	RATIONALE	CRITERIA
As part of the hospital or unit's provision of support for staff and volunteers the chaplain offers personal and professional support.	It is recognised that working in a health care setting is stressful and may lead people to question their personal beliefs and philosophy including their understanding of life, death, illness, suffering and ethical issues. The complexity of issues can also cause professionals to question and reflect on their professional beliefs and to break new ground. Chaplaincy can offer an informed, confidential resource to enable individuals and groups to reflect on their beliefs, philosophy and practice. **References** …spiritual caregivers will normally be responsible for supporting staff through pastoral care, the ministry of presence and, where appropriate, counselling; in consultation with local voluntary services, selecting, training, supporting and supervising volunteers to work with the chaplain and elsewhere (NHS HDL (2002) 76).	4.1 The chaplaincy service builds working relationships with members of staff and volunteers. 4.2 The chaplaincy service responds to requests from members of staff and volunteers for personal and professional support. 4.3 The chaplaincy service responds to requests from members of staff and volunteers for spiritual and religious support. 4.4 With the staff member's permission the chaplaincy service facilitates referrals to other sources of support.

Standard 5

Education training and research

STANDARD STATEMENT	RATIONALE	CRITERIA
The chaplaincy service is committed to supporting the continuing professional development of chaplains and contributes to the healthcare team's professional education, training and research programmes.	Continuing Professional Development (CPD) within the Knowledge and Skills Framework enables chaplains to develop their capabilities and potential to fulfil their role within the healthcare team. Through CPD the chaplain will know what is expected of them, get feedback on their performance and will be able to identify and satisfy their development needs. Accessing individual or group clinical supervision which is focused on reflective practice is an integral part of CPD. Education and training of healthcare staff on the issues involved in the provision of spiritual and religious care, including the role of the chaplain, enhances confidence and knowledge, and can improve care for patients and their carers. Increasing expectations and new technologies, drugs and treatments can raise ethical questions for all healthcare professionals. Experienced chaplains can be an informed resource to support healthcare professionals, patients and carers in the discussion of ethical issues. The promotion of evidence based practice is enabled and supported by active participation in research. **References** The Board makes recommendations concerning professional education and training for chaplains at all levels and operates a scheme for awarding points in recognition of continuing professional education (CAAB, 2005). The NHS Knowledge and Skills Framework defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services (DoH 2004).	5.1 Chaplaincy services are committed to continuing professional development (CPD) within the Knowledge and Skills Framework and all chaplains keep an annual record / portfolio that evidence CPD. This can include: • Attendance or presentation at conferences; • Formal education (courses attended or taught); • Teaching delivered; • Articles and books written or reviewed; • Journal club; • Reflective practice, e.g. Clinical Supervision or Clinical Pastoral Education (CPE). 5.2 The chaplaincy service contributes to staff induction for new members of the healthcare team. 5.3 The chaplaincy service contributes to the healthcare team's education and training programme. Topics may include: • Spiritual and Religious Care; • The Role of the Chaplaincy Service and Chaplains; • Loss, Grief, and Bereavement; • Making a spiritual assessment; • Diversity issues relating to religion and belief. 5.4 The chaplaincy service makes recommendations for educational and training resources. e.g. recommendations for the unit's library, an appropriate course or attendance at a conference.

Standard 5

Education Training and Research

STANDARD STATEMENT	RATIONALE	CRITERIA
The chaplaincy service is committed to supporting the continuing professional development of chaplains and contributes to the healthcare team's professional education, training and research programmes.	Priorities in spiritual care include the training of different staff groups on the potential impact of the delivery of spiritual care to patients and their relatives, and the role staff groups may play in this (NHS QIS, 2005). Chaplains are a support system for those engaged with the ethical dilemmas which advancing technologies and heightened expectations bring at the beginning and end of life (NHS HDL (2002) 76). Fostering a research based culture is essential to support the promotion of evidence based practice (SYWDU 2003, 62 p18). Chaplains should become involved with research e.g. collaborate with existing research teams and develop and take the lead informing research questions and projects (Speck, 2005).	5.5 The chaplaincy service is available to the healthcare team as an informed resource for ethical issues and discussion e.g. serving on a local ethics committee, for consultation on individual cases, contributing to ethical debate and discussion (see also criteria 7.4). 5.6 The chaplaincy service initiates, supports, and contributes to research within the healthcare setting, within the areas of chaplaincy, and spiritual and religious care, e.g. local research projects, multi-site research projects and national research projects. 5.7 The chaplaincy service is aware of current research and best practice and considers and implements its findings.

Standard 6

Resources

<table>
<tr><th>STANDARD STATEMENT</th><th>RATIONALE</th><th>CRITERIA</th></tr>
<tr>
<td>The unit ensures the chaplaincy service is provided with the resources to fulfil service standards, job description, supervision and training needs.</td>
<td>To enable chaplains to fulfil their remit as a health care professional the resources required to meet the standards for chaplaincy services should be made available.

All employed members of the spiritual care team/chaplaincy department should receive an induction to the post and undertake introductory training as offered through NHS Education for Scotland (NES).

Members of the chaplaincy service require access to continuing professional development, education and training to enable, maintain and enhance their skills.

Professional organisations and specialist interest groups can provide advice, a source of experience and professional/personal development opportunities for individuals and units.

References
All NHS Organisations, wherever feasible, should have Quiet Room, Multi faith Sanctuary or Worship Space, a room for meeting and teaching (Information and Signage NHSHDL (2002) 76).

There should be a system for accurate documentation and referral for those who wish to request a visit from a chaplain or chosen faith representative. Patients and relatives will have access to a chapel or suitable room for private reflection, worship or religious observance (NAHAT, 1996).</td>
<td>(a) Chaplaincy services should have:
6.a.1 Access to quiet and private areas for confidential support of patients, carers, staff and volunteers.
6.a.2 Access to a chapel or prayer room acceptable for the religious observance of all faiths.
6.a.3 Access to patient information systems for providing and facilitating appropriate spiritual or religious care and recording information and interventions.
6.a.4 Access to office accommodation and administrative support.
6.a.5 Access to communication systems to facilitate internal communication and on-call cover. For example:
• Pager, mobile phone;
• Intranet;
• e-mail.
6.a.6 Sufficient hours to meet the spiritual and religious needs of patients, carers, staff and volunteers, including out of hours cover.

All chaplains have:
6.a.7 Received an induction to their post (new chaplains appointed 2007 on).
6.a.8. Undertaken introductory training with NES (new chaplains appointed 2007 on).
6.a.9 Regular appraisal (at least annually) to review professional development and training needs. Identified needs to be resourced.
6.a.10 Access to external professional supervision (see criteria 5.1).

(b) Chaplains should:
6.b.1 Be a member of a professional chaplaincy association with a code of conduct and their professions ‘specialist interest group’ if there is one. e.g.
• Association of Hospice and Palliative Care Chaplains (AHPCC);
• College of Health Care Chaplains (CHCC);
• Scottish Association of Chaplains in Healthcare (SACH).
6.b.2 Have a recognised status within a mainstream faith community or belief group.</td>
</tr>
</table>

Standard 7

Chaplaincy to the hospital or unit

STANDARD STATEMENT	RATIONALE	CRITERIA
The chaplaincy service is a resource for the hospital or unit's major incident plan and other events that need a communal recognition and action.	Chaplaincy services have a significant contribution to make when a major incident has been declared, for example providing support to relatives and staff and offering spiritual and religious support to the injured or dying. Policies and procedures relating to major incidents should include the Chaplaincy service. Events in the hospital or unit, external events such as natural disasters, world events, or personal events such as the death of a member of staff can create individual or collective needs that the Chaplain is best placed to address, either through pastoral care or by holding a suitable communal ceremony. Where appropriate, consideration should be given to involving representatives of other faith communities and belief groups. Through regular staff contact the chaplain may have insight into significant factors affecting the morale of the unit. The morale of the unit can be enhanced by raising issues and concerns with managers without breaking individual confidences. Through links with local communities, patients, carers and staff, chaplains can have insight and experience that can be used as an experienced ethical resource to inform changes in healthcare services and provision. **References** Chaplains have a duty to care for the colleagues they work with. Those who are frequently exposed to high stress situations require support, comfort and counsel. If this is provided in a sensitive and timely manner, it can reduce the incidence of breakdown, absenteeism and low morale (NAHAT, 1996). In understanding the relationship of spirituality to healthcare, chaplains recognise that values, meaning and beliefs play an important role in the life and work of the healthcare organisation. This distinctive approach enables the chaplain to be a resource to the institution and provide insight into a wide range of issues (SYWDU, 2003).	7.1 The chaplaincy service is included in the hospital or unit's policies and procedures for responding to major incidents. For example: • The chaplaincy service is included in the call out list; • Members of the chaplaincy service are involved in emergency exercises; • Use of the chaplaincy centre; • Liaison with local faith communities and belief groups. **The chaplaincy service responds to:** 7.2 Events in the unit which are having an impact on staff and require a communal response or event. For example: • Death or illness in a member of staff; • Unusual patient or family events. 7.3 Events external to the unit which are having an impact on staff and require a communal response or event. For example: • National disasters; • World events; • Remembrance / anniversaries. 7.4 An awareness of issues or events affecting the morale or functioning of the unit which require management awareness to resolve. For example: • Managing change; • Communication. 7.5 Requests for consultation on ethical issues relating to restructuring, changes in buildings, local priorities and working practices. For example: • Restructuring of services; • Impact on patients, carers and staff; • Equality and diversity. (Also see criteria 5.5)

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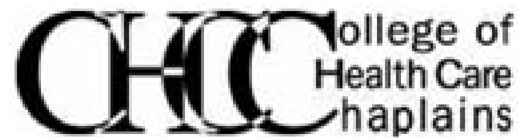
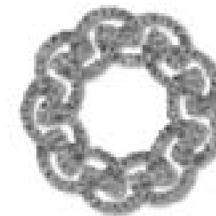
Self Assessment Tool





Scottish Association of Chaplains in Healthcare

Self Assessment Tool

INTRODUCTION

This assessment tool has been developed to assess and audit the Standards for NHSScotland Chaplaincy Services.

AUDIT

An audit of chaplaincy services using the Standards for NHSScotland Chaplaincy Services should be carried out within 1 year of their introduction to provide a benchmark for chaplaincy services.

The Standards for NHSScotland Chaplaincy Services should be audited once in every 3 years (a number of standards may be audit each year as long as all are audited within a 3 year period).

USING THE SELF ASSESSMENT TOOL

The self assessment tool has five columns, three of which require completion.

Criteria

This column is a duplicate of the chaplaincy standards Criteria column

Self assessment question

This column poses the audit questions

Answer and evidence

This column is for answers to the questions in the self assessment question column and the evidence to support the answer e.g. copies of documents and written protocols, results of surveys, policies and procedures etc.

Reviewer comments

This column allows a reviewer to comment on the answers and evidence

Met / not met

This column gives a choice of met or not met, however it may be that you wish to add to this by including partially met or working towards.

Standard 1

Spiritual & religious care

CRITERIA (Standard 1)		SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
(a)	**Spiritual**				
1.a.1	Spiritual needs are assessed and addressed and may include the following: • exploring the individual's sense of meaning and purpose in life; • exploring attitudes, beliefs, ideas, values and concerns around life and death; • affirming life and worth by encouraging reminiscing of the past; • exploring the individual's hopes and fears regarding the present and future; • exploring the individuals concerns about how their illness will affect others; • exploring the 'WHY?' questions in relation to life, death, illness and suffering.	How do you ensure that patients and those important to them have had the opportunity for their spiritual and religious needs to be assessed and addressed? (describe the process and how audited e.g. audit of patient information systems (notes or electronic), patient feedback etc.)			
1.a.2	Liaise with local and national resources for spiritual support and with the patient's permission contact relevant groups/individuals.	What systems are in place to liaise with local resources for spiritual support? (give details e.g. a directory of contact numbers for local/national organisations is available) (See also criteria 3.3)			

Standard 1

Spiritual & religious care

CRITERIA (Standard 1)		SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
(b)	**Religious**				
1.b.1	Religious needs are assessed and addressed and may include the following: • ceremonies; • meditation; • prayer; • rites; • sacraments; • worship.	How do you ensure that patients and those important to them have had the opportunity for their religious needs to be assessed and addressed? (e.g. audit of patient information systems (notes or electronic), patient feedback etc.)			
1.b.2	With the patient's permission facilitate referrals to local faith groups and religious leaders.	What systems are in place to refer to local faith groups and religious leaders? (give details, e.g. a directory of contact numbers for local/national organisations is available) (See also criteria 3.3)			
(c)	**Protecting patients**				
1.c.1.	Protect patients and their carers from unwanted visits from spiritual or religious groups and representatives.	How are patients protected from unwanted visits spiritual or religious groups or representatives? (e.g. is there a written protocol for the chaplain/staff member to contact/inform representatives/faith leaders of the patient's decision? See criteria 3.6)			

Standard 2

Access to chaplaincy services.

CRITERIA (Standard 2)	SELF ASSESSMENT QUESTION	ANSWER AND EVIDEBCE	REVIEWER COMMENTS	MET/ NOT MET
2.1 All patients receive written information on admission containing details of the chaplaincy service available within the unit.	Do patients receive written information on the chaplaincy service? (attach a copy as evidence)			
2.2 The written information contains an explanation of the chaplaincy service, examples of situations in which the chaplaincy service might be used and how contact with the chaplaincy service may be obtained.	Does the information: a. give examples of when to contact chaplaincy services? (please give page/paragraph) b. examples of situations in which the chaplaincy service might be used? (please give page/paragraph) c. explain how to contact the chaplain? (please give page/paragraph)			
2.3 The written information is supported by verbal explanation of access to the chaplaincy service during assessment.	Is the booklet supported by oral explanation? (give details)			
2.4 The admission procedure ensures a check that written information is given.	What procedure is in place to check information is given?			
2.5 There is a written protocol for referral to the chaplaincy service, including out of hours. (Note: The protocol may provide for the referrals themselves to be verbal)	Is there a written protocol? (Please attach a copy of the protocol as evidence) Where is the written protocol held? (should be an area accessible to staff e.g. wards, patient notes, local computer network, local services manual etc.)			

Standard 3

Partnership with faith communities and belief groups

CRITERIA (Standard 3)	SELF ASSESSMENT QUESTION	ANSWER	REVIEWER COMMENTS	MET/ NOT MET
3.1 Chaplaincy services are an informed resource on spiritual and religious care for NHS staff and local faith community and belief group leaders.	In what ways do your chaplaincy services act as a resource to staff? (give details)			
	In what ways do your chaplaincy services act as a resource to local faith community and belief group leaders? (give details)			
3.2 Chaplaincy services will maintain links between the NHS and local faith community and belief group leaders e.g. through the spiritual care committee and training events.	In what ways do your chaplaincy services maintain links with local faith communities and belief groups? (give details)			
3.3 A written protocol is in place for NHS staff to refer to local faith community leaders and belief group representatives. The protocol should include clear guidance stating that faith community leaders and belief group representatives can only be contacted with the permission of the patient or their family/carers.	Is there a written protocol for NHS staff to refer to local faith community leaders and belief group representatives? (please attach a copy of the protocol as evidence)			
	Does the protocol give clear guidance on receiving the patient's permission before contacting faith community leaders and belief group representatives? (please give page/paragraph)			
3.4 A directory of contact numbers for representatives from local faith communities and belief groups is available in hospitals and units. The directory should include national contact numbers for smaller faith communities and belief groups, or numbers that are likely to change e.g. the representative lives in their own home.	Is there a directory of contact numbers for representatives from local faith communities and belief groups? (please attach a copy of the directory as evidence)			
	Does the directory include national contact numbers for contacts that might change? (give details)			
	Where is the directory held? (e.g. in wards, on intranet)			
	How do staff access the directory, including out of hours?			

Standard 3

Partnership with faith communities and belief groups

CRITERIA (Standard 3)	SELF ASSESSMENT QUESTION	ANSWER	REVIEWER COMMENTS	MET/ NOT MET
3.5 The local directory should be regularly updated and the faith communities and belief groups consulted on its content and updating.	When was the directory last updated?			
	How did you consult with local faith communities and belief groups? (give details)			
3.6 A manual outlining the principal beliefs and practices of the major faith communities and belief groups is available in all hospitals and units. It is recommended the NES manual A Multifaith Guide for Healthcare Staff is used. Where a local manual is also in use the local manual should include: • Religious/belief issues that have an impact on healthcare practice with suggested alternatives e.g. blood transfusions; • Religious/belief needs that have implications for the patients stay and well being e.g. diet, prayer, rites and ceremonies; • What to do in the event of an unexpected death e.g. a summary of common practices, dos and don'ts; • Information about actions or situations where it is important to be sensitive.	Are copies of the NES manual A Multifaith Guide for Healthcare Staff in use? (give details)			
	Is there a local manual outlining the principal beliefs and practices of the major faith communities and belief groups available? (please attach a copy of the manual as evidence)			
	Does the local manual outline religious/belief issues that can impact on healthcare practices for each religion/belief? (please give page/paragraph number)			
	Does the local manual outline religious/belief needs that have implications for the patient's wellbeing for each religion/belief? (please give page/paragraph number)			
	Does the local manual have a section on what to do in the event of an unexpected death for each religion/belief? (please give page/paragraph number)			
	Does the local manual contain information about actions or situations where sensitivity is important for each religion/belief? (please give page/paragraph number)			

Standard 3

Partnership with faith communities and belief groups

CRITERIA (Standard 3)	SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
	Were local faith communities and belief groups consulted when preparing the manual? (give details)			
	When was the local manual last updated and were local faith communities and belief groups consulted? (give details)			
	Where is the manual(s) held? (e.g. on the wards)			
	How do staff access the manual(s), including out of hours?			
3.7 A written protocol for liaison and exchange of information with the identified representatives of faith communities and belief groups is in place. The protocol should respect patient confidentiality, adhere to the hospitals guidelines on the use of patient information, and protect patients from unwanted visits (see Standard 1 Criteria 1.c.1).	Is there a written protocol for liaison and exchange of information with identified faith community leaders/belief group representatives? (please attach a copy of the protocol as evidence)			
	In what ways does the protocol adhere to the hospital guidelines on the use of patient information? e.g. data protection, Caldicott guardians etc.			
	In what ways does the protocol protect patients from unwanted visits? (see also criteria 1.c.1)			

Standard 4

Staff support

CRITERIA (Standard 4)	SELF ASSESSMENT QUESTION	ANSWER	REVIEWER COMMENTS	MET/ NOT MET
4.1 The chaplaincy service builds working relationships with members of staff and volunteers.	In what ways does the chaplaincy service seek to build relations with staff and volunteers? (give details e.g. include initiatives or practice to encourage relations with particular staff/volunteer groups)			
	Is there evidence of good working relationships? (give details, e.g. staff/volunteer survey?)			
4.2 The chaplaincy service responds to requests from members of staff and volunteers for personal and professional support.	In what ways does the chaplaincy service provide personal and professional staff support? (give details)			
	Are incidences (not content) of support recorded? (e.g. a diary/log noting the time spent and whether professional or personal. No name or content need be recorded, preserving confidentiality)			
4.3 The chaplaincy service responds to requests from members of staff and volunteers for spiritual and religious support	In what ways does the chaplaincy service provide spiritual and religious staff support?			
	Are incidences (not content) of support recorded? (e.g. a diary/log noting the time spent and whether spiritual or religious. No name or content need be recorded, preserving confidentiality)			
4.4 With the staff member's permission the chaplaincy service facilitates referrals to other sources of support.	How does the chaplaincy service facilitate referrals to other sources of support (give details e.g list resources referred to or resources available and referral procedure)			

Standard 5

Education, training and research

CRITERIA (Standard 5)	SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
5.1 The chaplaincy service is committed to continuing professional development (CPD) within the Knowledge and Skills Framework and all chaplains keep an annual record / portfolio that evidences CPD. This can include: • Attendance or presentation at conferences; • Formal education (courses attended or taught); • Teaching delivered; • Articles and books written or reviewed; • Journal club; • Reflective practice, e.g. Clinical Supervision or Clinical Pastoral Education (CPE).	Do all chaplains have an up to date record / portfolio of CPD activity? (give details, e.g. a summary of areas of activity and objectives from Knowledge and Skills framework)			
	When required for registration Have all chaplains achieved the required level of CPD to maintain registration as a healthcare chaplain? (give details e.g. the number of points required and achieved)			
	How does the chaplaincy service:			
5.2 The Chaplaincy service contributes to staff induction for new members of the healthcare team.	• contribute to staff induction? (give details)			
5.3 The chaplaincy service contributes to the healthcare team's education and training programme. Topics may include: • Spiritual and Religious Care; • The Role of the Chaplaincy Service and Chaplains; • Loss, Grief, and Bereavement; • Making a spiritual assessment. • Diversity issues relating to religion and belief	• contribute to the healthcare team's education programme? (give details)			
	• contribute to the healthcare team's training programme? (give details)			

Standard 5

Education, training and research

CRITERIA (Standard 5)		SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
		How does the chaplaincy service:			
5.4	The chaplaincy service makes recommendations for educational and training resources. e.g. recommendations for the unit's library, an appropriate course or attendance at a conference.	• Make recommendations for educational and training resources? (give details)			
5.5	The chaplaincy service is available to the healthcare team as an informed resource for ethical issues and discussion. e.g. serving on a local ethics committee, for consultation on individual cases, contributing to ethical debate and discussion (see also criteria 7.4).	• Serve as an informed resource for ethical issues and discussion? (give details)			
5.6	The chaplaincy service initiates, supports and contributes to research within the healthcare setting, within the areas of chaplaincy, and spiritual and religious care e.g. local research projects, multi-site research projects and national research projects.	• Initiate, support and contribute to research within the unit? (give details)			
		• Initiate, support and contribute to research within chaplaincy, spiritual and religious care? (give details)			
5.7	The chaplaincy service is aware of current research and best practice and considers and implements its findings.	In what ways does the chaplaincy service ensure it is aware of current research and best practice? (give details e.g. access to the Scottish Journal of Healthcare Chaplaincy and the Journal of Health Care Chaplaincy)			
		How does the chaplaincy service consider and implement current research and best practice findings? (give details)			

Standard 6

Resources

CRITERIA (Standard 6)	SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
(a) Chaplaincy services should have: 6.a.1 Access to quiet and private areas for confidential support of patients, carers, staff and volunteers.	**Do the chaplaincy services:** • Have access to quiet and private areas for confidential support?			
6.a.2 Access to a chapel or prayer room acceptable for the religious observance of all faiths.	• Have access to chapel or prayer room? (please describe).			
	• How do you ensure the chapel or prayer room is acceptable to all faiths? (give details)			
6.a.3 Access to patient information systems for providing and facilitating appropriate spiritual or religious care and recording information and interventions.	• Have access to the patient information systems?			
	• Record interventions in the patient information systems?			
6.a.4 Access to office accommodation and administrative support.	• Have access to office accommodation? (give details) • Have administrative support? (give details)			
6.a.5 Access to communication systems to facilitate internal communication and on-call cover. For example: • Pager, mobile phone; • Intranet; • e-mail.	• Have access to communication systems to facilitate internal communication? (give details)			
	• Have access to communication systems to facilitate on-call cover? (give details)			

Standard 6

Resources

CRITERIA (Standard 6)	SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
6.a.6 Sufficient hours to meet the spiritual and religious needs of patients, carers, staff and volunteers including out of hours cover.	Are the hours sufficient to meet the needs of patient's carers, staff and volunteers? (give details/evidence e.g. needs unable to be met)			
	What is your chaplaincy service out of hours cover commitment? (give details)			
	How does your chaplaincy service meet the out of hours cover commitment? (give details/evidence)			
Chaplains have:				
6.a.7 Received an induction to their post (new chaplains appointed 2007 on).	Have all new chaplains received an induction?			
6.a.8. Undertaken introductory training with NES (new chaplains appointed 2007 on).	Have all new chaplains undertaken introductory training?			
6.a.9 Regular appraisal (at least annually) to review professional development and training needs. Identified needs to be resourced.	Have all chaplains received an annual appraisal within the last year?			
	Have all chaplains had their training needs identified? (give details)			
	Have resource implications identified and agreed? (give details)			
6.a.10 Access to external professional supervision (see criteria 5.1).	Does the chaplain have external supervision? (give details e.g. clinical supervision every 4-6 weeks or CPE)			

Standard 6

Resources

CRITERIA (Standard 6)	SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
(b) **Chaplains should:**				
6.b.1 Be a member of a professional chaplaincy associations and their professions 'specialist interest group' if there is one.	Are all chaplains a member of a professional chaplaincy association and specialist interest group? (Give details e.g. AHPCC, CHCC, SACH)			
e.g. • Association of Hospice and Palliative Care Chaplains (AHPCC) • College of Health Care Chaplains (CHCC) • Scottish Association of Chaplains in Healthcare (SACH)	Is the membership confirmed? (e.g. a current letter/card confirming membership)			
6.b.2 Have a recognised status within a mainstream faith community or belief group.	Do all chaplains have a recognised status with a mainstream faith community or belief group? (give details)			

Standard 7

Chaplaincy to the hospital or unit

CRITERIA (Standard 7)	SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
7.1 The chaplaincy service is included in the hospital or unit's policies and procedures for responding to major incidents. For example • The chaplaincy service is included in the call out list • Members of the chaplaincy service are involved in emergency exercises • Use of the chaplaincy centre • Liaison with local faith communities and belief groups	How is the chaplaincy service included in the hospital or unit's major incident procedure? (give details e.g. outline the role of the chaplaincy service, e.g. its inclusion in the call out list, and include a copy relevant section of the policy/procedure manual)			
The chaplaincy service responds to:	**How does the chaplaincy service respond to:**			
7.2 Events in the unit which are having an impact on staff and require a communal response or event. For example: • Death or illness in a member of staff; • Unusual patient or family events.	• events in the unit? (give details: No name or personal content need be evidenced to preserve confidentiality)			
7.3 Events external to the unit which are having an impact on staff and require a communal response or event. For example: • National disasters; • World events; • Remembrance / anniversaries.	• external events? (give details)			

Standard 7

Chaplaincy to the hospital or unit

CRITERIA (Standard6)	SELF ASSESSMENT QUESTION	ANSWER AND EVIDENCE	REVIEWER COMMENTS	MET/ NOT MET
7.4 An awareness of issues or events affecting the morale or functioning of the unit which require management awareness to resolve. For example: • Managing change; • Communication.	• matters or events affecting morale or functioning of the unit? (e.g. an advocacy role representing staff or management concerns without breaking confidence)			
7.5 Requests for consultation on ethical issues relating to restructuring, changes in buildings, local priorities and working practices. For example: • Restructuring of services; • Impact on patients, carers and staff; • Equality and diversity; **(Also see criteria 5.5)**	• requests for consultation? (give details)			