Consensus is developing in the field of professional pastoral care around the several best practices. The discipline is becoming a multi-faith, referral service. Generally, it is no longer the case that particular clergy come in and visit all of the patients of their faith tradition. This model does not make efficient use of pastoral care resources and does not promote integration into the health care team which is so essential to the continuity of care and quality practice. In current best practice, chaplains are assigned to specific locations, generally selected for their strategic importance to the institution, and visit patients of all faiths selected according to specific protocols.

While there are no formal agreed upon practices adopted by industry groups, the following practices are increasingly accepted as representing the highest quality in professional pastoral care.

- **Based On a Plan with Outcomes.** Pastoral care services are based on a plan agreed to by institutional management and other stakeholders. This plan is key to the mission and strategic plan of the organization, lays out specific objectives and goals and is consistent with institutional culture. By example, if the institution has a trauma center, the pastoral care plan will have a focus on 24/7 availability and swift response to crises. In a community hospital, a focus will likely be on relationships to the local faith community.

- **Targeting of Pastoral Care.** Pastoral care resources are targeted to particular services or patient populations chosen for their strategic importance to the institution and/or the demonstrated impact of pastoral care on those patients and staff. This is preferred to having chaplains cover all parts of the hospital equally. Generally, the clinical services chosen have high volume and/or high acuity. Intensive care units often receive priority coverage along with cardiac and cancer units where spiritual issues related to mortality and meaning in life are common.

- **Protocol-based Referrals.** Except for units which are targeted for daily coverage because of the issues outlined above, pastoral care visits are generally initiated by protocol-based referrals. A major emphasis for many institutions is patient transition from one level of care to another within the system, as well as end of life care. These changes, whether they are from hospital to hospice, assisted living to long term care facility, regular medical unit to intensive care, or from curative treatment to palliative care, tend to raise religious/spiritual issues including meaning and hopefulness where pastoral care can make a contribution. Chaplains should generally be included in protocols covering codes, deaths, organ donation, radical change in prognosis, execution of advanced directives, and disasters. A clear protocol must be established for covering pastoral care needs outside of regular business hours. This protocol should spell out which situations will generate a pastoral care referral as well as how the chaplain on call is to be contacted.

- **Spiritual Screening and Assessment Processes.** There should be protocols for assessing and diagnosing spiritual distress in patients and families which contain algorithms for referral to pastoral care. The screening should, at minimum, evaluate how important religion and spirituality are to the patient’s coping, how well those coping strategies are working at the moment, and whether the patient has any immediate religious or spiritual needs that require pastoral care intervention. The success of the referral system depends on the ability and willingness of nonpastoral care clinical staff to reliably do spiritual screening. Staff needs training for this task and the protocols and infrastructure must be in place to transmit referrals reliably and efficiently. To this end, chaplains participate in the orientation of new clinical staff. Patients referred for pastoral care should have an in-depth spiritual assessment by the chaplain on the initial visit and periodically thereafter according to an agreed upon protocol.

- **Multifaith Ministry.** Professional chaplains are trained to minister to people of all faiths or no faith. This ministry is accomplished by being able to work within the patient’s own faith and belief system. Rather than imposing answers or solutions, the task of the chaplain is to assess the strengths and weaknesses of the patient’s own spiritual resources and
help the patient maximize those in the service of the patient's healing. The denomination of the chaplain will come into play when religious rituals are required. At this point, the chaplain needs to have available clergy of various faith groups to function in this capacity. This strategy is parallel to that used by mental health professionals who work with and strengthen the patient's existing coping mechanisms rather than impose a set of mechanisms which may be foreign to the patient and therefore not effective.

- **Staff Training & Support.** The impact of professional chaplains is broadened by having them provide training for staff on such topics as cultural awareness and sensitivity, listening skills, advanced directives, and spiritual issues. The training allows all staff to better serve patients' and families' emotional, spiritual and cultural needs. While the chaplains are the spiritual care specialists on the team, all clinical staff play a role in the assessment and delivery of spiritual care. By having chaplains on units that tend to be stressful for staff, the chaplains can provide immediate support for staff after particularly stressful incidents, thus reducing down time and improving staff efficiency.

- **Certification of Pastoral Care Staff.** All pastoral care staff should be certified according to the Common Standards for Professional Chaplains and agree to abide by the Common Code of Ethics for Chaplains and Pastoral Counselors. Basic requirements for certification include graduate theological education, 1,600 hours of Clinical Pastoral Education in an accredited program, endorsement for chaplaincy by a recognized faith group and an appearance before a peer review committee. The Common Code of Ethics is significant in that it prohibits proselytizing or in any way imposing one's own beliefs and practices on a patient. This limitation is consistent with the emphasis on working with the patient's own belief system. Volunteers and community clergy provide ministry in carefully defined roles under the supervision of the professional staff.

- **Contributions to Cost Enhancement.** While pastoral care should be primarily considered a contribution to the fulfillment of the institution's mission, it can make financial contributions as well. Intentional pastoral care of staff during times of professional and personal stress can contribute to reduction in staff down time and turnover. These interventions can be informal or can be formally incorporated into an Employee Assistance Program. In the latter case, chaplaincy staff should also have pastoral counseling training which is different from clinical pastoral education. Pastoral care staff often conduct memorial services where clinical staff can commemorate the death of a specific patient, a group of patients on a specific service, or a beloved colleague. While positioning chaplains as the primary organ requestors in the institution is somewhat controversial in that it removes chaplains from their neutral role in relationship to patients and families, it has been shown to significantly raise the organ recovery rate for the institution.

- **Participation in Ethics Processes.** Since ethical decisions for many patients involve religious beliefs, at least one chaplain should serve on the ethics committee. Given the concepts of multifaith ministry described above, it is not necessary to have all major religious groups represented. The chaplain should develop resources in the local religious community to provide assistance where necessary. In deciding on pastoral care involvement in the ethics processes, it should not be assumed that every chaplain has training in ethics by virtue of being clergy. Specific chaplains may need training in the basic principles of biomedical ethics as well as in the process of ethical consultation before being ready to assume this role.

- **Involvement in Disaster Preparedness.** The Pastoral Care Department should have a specific role in any institutional disaster plan. Often this role involves care of family members and/or being part of a general labor pool. The department should have a specific protocol for mobilizing its staff and possibly selected community clergy during normal business hours and off hours.

- **Quality Improvement.** The Pastoral Care Department should fully participate in the institutional quality assurance efforts to the same extent as similar departments. The department should have agreed upon goals for data collection, analysis and reporting.

- **Other Institutional Involvements.** Depending on the character and mission of the institution, chaplains can contribute in various other ways. In community hospitals, chaplains should be active in marketing and community outreach efforts aimed at the local religious community. In academic medical centers, chaplains should have a role in teaching and research. Chaplains should be recruited with the requisite skills and given appropriate training to fulfill these roles.

**References**


