Spiritual Care Volunteers
A Training Resource
The introduction of the National Standards for Spiritual Care Services within the NHS Wales in 2010 was a landmark moment for Healthcare Chaplaincy. The landscape for the provision of spiritual care in our hospitals has changed. The old model of predominately pastoral care and religious intervention has made way for a broader and more inclusive understanding of spiritual need and spiritual care. Spiritual well being is not only of relevance to patients who belong to a faith community but is an integral part of an NHS which prizes itself on the provision of person centred care. Attending to the inner realm of how a person thinks, feels and reacts to their health event is at the heart of Healthcare Chaplaincy work. Within this, NHS Wales recognises the valuable role which chaplaincy volunteers can play in helping patients cope with their hospitalisation.

This course provides the basis for understanding spiritual care within the context of a multi faith, multi cultural NHS. It identifies issues of entering the private world of patient care as it is carried out almost entirely within a much more public arena of the hospital ward. Issues come to life through group discussion, use of case studies, patient stories and the exchange of insight and personal reflection.

This training programme is the result of consultation and collaboration of chaplains working in NHS Wales.

Contributing chaplains:
Revd Eleanor Powell – Chair – Cwm Taf University Health Board
Revd Euryl Howell – Hwyel Dda Health Board
Revd David Roberts – Aneurin Bevan University Health Board
Revd Avril Dafydd-Lewis – Cardiff & the Vale University Health Board
Revd Trevor Williams – Cardiff & the Vale University Health Board
Revd Kathy Collins – Betsi Cadwaladr Health Board

It is recommended that all potential volunteers regardless of previous experience complete the entire 6 Modules before entering the recruitment process.

This basic course is only available online and it is hoped that tutors will find the material stimulating and helpful. It is also hoped that other NHS staff may be brought in to share in aspects of the training.
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Chaplaincy Spiritual Care Summary Chart
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DVD – What do you see? – Actress: Virginia McKenna (Most hospital libraries/training departments will have this)

DVD – No Regrets – Director: Amanda Waring [www.amandawaring.com](http://www.amandawaring.com)

Standards for Spiritual Care Services in the NHS in Wales 2010 – [www.cymru.gov.uk](http://www.cymru.gov.uk)

Spirituality in Nursing Care: a pocket guide – [www.rcn.org.uk](http://www.rcn.org.uk)

Multi-faith Resource for Healthcare staff, NHS Scotland – [www.nes.scot.nhs.uk/publications](http://www.nes.scot.nhs.uk/publications)

Association for Children’s Spirituality – [www.childrenspirituality.org](http://www.childrenspirituality.org)

Spirituality and Psychiatry Special Interest Group – [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
Patients, carers and relatives accessing healthcare in Wales need the support of a wide range of people to provide physical, psychological, emotional and spiritual care. It is essential that all individuals involved in providing this care have the knowledge and skills necessary so that people receive safe, high quality, compassionate care at all times. I am delighted therefore to see the introduction of this training resource for Spiritual Care Volunteers, which clearly sets out what the role entails and the standard everyone should aspire to in delivering this role.

Being a volunteer in our modern busy hospital environments can be a daunting prospect and having the right preparation should ensure that you, the Spiritual Care Volunteer, bring real comfort and support to patients at a distressing and sometimes uncertain time. It should also hopefully avoid some of the many pitfalls that this type of role presents, particularly in maintaining appropriate boundaries and knowing when to refer on to others.

Volunteering can be a hugely rewarding experience, knowing that your intervention has helped someone even if this is just a small way. Thank you for being so generous of your time and for giving kindness to others who are in need of spiritual support.

Professor Jean White
Chief Nursing Officer (Wales)/
Nurse Director NHS Wales
Session 1: Introducing Healthcare Chaplaincy

Purpose

To introduce the world of the hospital and the role which Chaplaincy plays in it.

To consider what the role of a Chaplaincy Volunteer is and what it is not.

Introduction

Welcome people to the session and invite them to introduce each other asking what it is that draws them into becoming a chaplaincy volunteer.

Poem – Ten Types of Hospital Visitor by Charles Causley to be read – a few minutes of silence to follow poem. See Appendix.

Chaplain comes from the Latin word for cloak. Use of the word grew from a story in the Western Christian tradition of St Martin meeting a man begging in the rain and without a cloak. If he had met the man’s need by simply giving his own cloak then Martin would have been in need, instead he tore his own cloak in two and shared - half for the beggar and half for himself. A Chaplain is one who shares support with those in the storms of life, especially illness.

Hospital comes from the mediaeval for hospice, a place of hospitality (food, shelter, medical care) for travellers. They were small in size and run by religious orders. Then in the 16th century following the dissolution of the monasteries many were closed down and those that survived did so as secular and municipal institutions. It wasn’t until some 200 years later, at the beginning of the 18th century, that hospitals as we know them began to be established. However they were largely charitable institutions funded by donations, wealthy benefactors and local authority grants. Many of these still had a strong religious influence both in management and in care. In 1948 with the formation of the National...
Session 1:
Introducing Healthcare Chaplaincy

Health Service these charitable institutions were in effect nationalised and thanks to the Archbishop of the day, Archbishop Fisher, the House of Lords ensured that spiritual care continued to have a place in these newly formulated institutions of care for the sick. The appointment of chaplains was seen to be the best way of ensuring that this continued.

Chaplaincy has a long and valued history in healthcare. In the early decades of the NHS Chaplains were relatively autonomous and were seen to have a primarily Christian religious role: prayer, sacraments, anointing etc. Chaplains equated the hospital to the parish; as a priest is to the parish so a chaplain is to the hospital. However, this is not the model of chaplaincy which is at work in hospitals today. Today Chaplaincy is part of mainstream life in NHS working in a multi-cultural, multi-faith society. We are managed not by our religious organisation but by hospital managers and our role is broader than just religious. (See Chaplaincy Service summary Chart in appendix)

However, although the NHS is now a secular institution of care it still believes there is a place for spiritual care within its life. It recognizes that people are more than physical beings of flesh and blood. It is not enough to know what an illness/trauma is in a medical sense; we also have to know what it means at a personal level so that we can help a person respond to their situation in as positive a way as possible. Thus the NHS believes that there is a spiritual dimension to illness and trauma. The inner realm of a person, their inner spirit sometimes becomes bruised and broken in life and never more so than when someone finds themselves in hospital. Patients often feel anxious, lonely, frightened or vulnerable. Life is not as certain as it once was. Their confidence in themselves, in life and sometimes in their God becomes shaken. Patients have lots of time to think and sometimes they need a listening ear and encouraging word to help them through. They need the ministry of human kindness. This is at the heart of chaplaincy spiritual care.

The work of Chaplains in the hospitals of NHS Wales is governed by the Standards for Spiritual Care Services in the NHS in Wales produced by the Welsh Government in 2010. Each Health Board has to adhere to these standards and to report annually to the Minister of Health on the standards.

"The majority of people, whether religious or not, need support systems in their life, especially in times of crisis. Most patients, carers and staff, especially those confronting
serious or life threatening illness or injury, will have spiritual needs and will welcome spiritual care. However the choice is always theirs. They may face ultimate questions of life and death and search for meaning in the experience of illness. They look for help to cope with their illness and with suffering, loss, fear, loneliness, anxiety, uncertainty, impairment, despair, anger and guilt.”

(Spiritual Care Standards para 6, page 9)

**Standards for Spiritual Care in NHS Wales 2010**

Remind participants of the Standards and the key considerations in terms of delivering spiritual care.

The Standards ensure that the spiritual/religious needs of the hospital population are given proper consideration. They specify that volunteers have a significant part to play in enhancing and strengthening the spiritual care service.

**Key considerations:**

1. Multi-faith Spiritual Care and the need to provide for everyone in a non-discriminatory way and with equal skill and enthusiasm
2. Patient confidentiality must be ensured
3. Patients should be protected from unwanted visits from spiritual and religious representatives or groups.
4. Spiritual Care Services should work in cooperation with a patient’s own faith community or belief group subject to the patient’s consent
5. Volunteers are recruited, trained and supervised according to local Health Board protocols.

**Understanding Spiritual Care in the NHS**

At the heart of Chaplaincy Spiritual Care is personhood and the work we do strives to embrace the fact that patients are more than people with a problem. Each person is a kaleidoscope rich with memories of the past, experiences of the present, hopes and fears...
Session 1: Introducing Healthcare Chaplaincy

for their future. Each is unique to them and within the Christian tradition we believe that each person matters to God. “We are more than Body, Brain and breath” (Eileen Shamy, The Spiritual Dimension of Care for people with Alzheimer’s Disease...)

We endeavor to relate to the patient first and foremost as a person. There are three aspects to the care we offer:

1. Pastoral
2. Spiritual
3. Religious

Understanding these aspects of care will be a central theme in the training course.

Pastoral Care

This is central to what we do. It is about caring for another person as a fellow human being. Pastoral care is the ministry of human kindness, being able to listen well, being thoughtful and helpful regarding the other person’s needs. It is about being able to listen if someone wants to talk. It is about being sensitive to their beliefs and concerns, about being supportive of their needs and offering encouragement in the face of difficulty. This is the primary work of chaplaincy volunteers.

Spiritual Care

While pastoral care is at the heart of what we do as Chaplains, our encounters with patients often take us into the realm of the spiritual. This happens as patients try to make sense of what is happening to them and come to terms with their situation. Illness and trauma can be a deeply meaningful human experience and sometimes it is a struggle to come to terms with its implications. Sometimes there may be a struggle to reconcile a particular view of God with what is happening to them. Deeply searching questions such as ‘Why me?’ ‘What have I done to deserve this?’ ‘Why is God allowing this to happen?’ can relentlessly whiz around a patient’s mind, disturbing sleep and deflating mood. Patients will often find it helpful to talk these things through with a Chaplain. What ever their view of God, regardless of whether they practice any particular faith, these kinds of questions often disturb a patients sense of peace and well being. The chaplain can help
to unravel these thoughts and help the person reach a more constructive view of their situation.

While this is not something volunteers would normally get directly involved in, it is expected that you will be aware of these issues and if you come across a patient who is clearly struggling with either their faith or what is happening to them then you would refer the patient to a Chaplain. However it is important that you obtain their consent before referring them to the chaplain for a visit.

Unlike ministers/faith leaders in the community we are here to offer spiritual support to all faiths and beliefs. We do this by listening, facilitating and when required signposting them to their own religious leaders.

**Religious Support**

If the person belongs to a faith community then it is likely that they would welcome support of a religious nature. They may not think to ask for someone to read scripture to them, or ask to visit the hospital chapel or multi faith room, or receive Holy Communion. The chaplaincy volunteer should ask the patient if they would like these things. The patient may like to listen to religious music or the Sunday service on the hospital radio. They may like a visit from their own faith leader. The Chaplain can facilitate this or ask an appropriate chaplaincy volunteer to help with this.

Religious support for the end of life is an important aspect of chaplaincy work and usually the domain of the chaplain although some chaplaincy departments do use specially trained volunteers to help with this work.

All three aspects of care: pastoral, spiritual and religious, are present in the work of chaplaincy. Through who we are, what we say, how we say it and what we do, we make visible the fullness of human kindness and the God who loves without limit.

**Any questions?**
The World of the Hospital

The purpose of this section is to help potential volunteers appreciate the different contexts for ministry between a religious institution/community group and a NHS organization and the consequent implications for work as a chaplaincy volunteer.

Describe your own Health Board, the hospital sites as appropriate, including specifics around when/how volunteers’ work.

Feedback

Together make a list of all the differences you can think about between a church/chapel/mosque/temple/faith community and a hospital community.

<table>
<thead>
<tr>
<th>FAITH COMMUNITY</th>
<th>HOSPITAL COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Faith in God</td>
<td>All Faiths represented</td>
</tr>
<tr>
<td>Predictable</td>
<td>Unpredictable</td>
</tr>
<tr>
<td>Religious organisation</td>
<td>Secular organisation</td>
</tr>
</tbody>
</table>
Session 1: Introducing Healthcare Chaplaincy

<table>
<thead>
<tr>
<th>Well and mobile</th>
<th>Not well, often bed bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>Dependant</td>
</tr>
<tr>
<td>Friends</td>
<td>Strangers, colleagues</td>
</tr>
<tr>
<td>Freedom and choice</td>
<td>Contained and controlled</td>
</tr>
<tr>
<td>Public/private</td>
<td>Private</td>
</tr>
<tr>
<td>Volunteers</td>
<td>Paid</td>
</tr>
</tbody>
</table>

Role of Chaplaincy Volunteer

We have covered something of what chaplaincy services are about, but to do it we need people like you. People who can offer sensitive pastoral care by visiting patients on the wards. People who are good listeners, who can spot whether a person is struggling spiritually or who could be supported through prayer, a religious rite such of Holy Communion. Or who would appreciate an appropriate prayer card or would value holding a cross for comfort in the quiet hours of the night. These are all expressions of pastoral care and the primary role for chaplaincy volunteers.

Ask a chaplaincy volunteer to tell their story of being a volunteer.

Distribute and discuss Chaplaincy Volunteer Role Profile

Any questions?
Session 1: Introducing Healthcare Chaplaincy

Summing up

In the context of the Hospital Community

Chaplains and Chaplaincy Volunteers offer:

- Acceptance without judgement
- Availability
- Compassionate listening
- Confidentiality
- Willingness to walk alongside difficult issues
- Religious support in some instances

Chaplains and Chaplaincy Volunteers do not offer:

- Easy answers to difficult questions
- Their own story
- Explicit Religious evangelism
- Judgement on someone’s life/decisions

Any questions?

What next?

Give out dates/times of training course stressing the need to complete the course before being eligible to become a chaplaincy volunteer. Explain your Health Board’s process for selection and recruitment including CRB check and references.

Application forms will be available at end of session.
Reflection

Go around the group asking each person to say in one sentence what is the most significant thing they have learned in this session.

Quiet time/music/prayer as appropriate to group.
Session 2:
From Person to Patient & back again

Purpose
To consider what it is like to be a Patient
To consider what it is like to be a Person

What is it like to be a Patient?
It is important to consider not just our own experience, if any, but also preconceptions that exist – from visiting in hospital or hearing from friends or from the media e.g. television programs like 'Casualty'.

Share any personal experience the group may have of being a patient in hospital.
Make a list together of the plus and minus aspects of being a patient in hospital.

Minus might include:
- Loss of identity: hospital gown, stranger among strangers, loss of personal space and privacy
- Loss of control: washing, toilet, sleep disruption
Loss of personal interaction: problem focused, medical conversation, staff talking about and over you, too sick to socialize

Loss of activity/occupation: nothing to do, boredom, lack of stimulus, TV, radio as distraction, restricted freedom of movement, effects of drugs

Loss of independence: intimate care done by others/witnessed by ward, loss of dignity, being fed by others, helped to walk

Emotional instability: fear, anxiety, grief, shock, despair, stress

Plus might include:

Relief: knowing what is wrong, treatment has started

Emotional: sense of peace, happy at successful treatment, recovery

Physical security: being cared for, receiving treatment, relief of symptoms

If you could choose one thing which would make all the difference to how a patient copes with their experience in hospital what would it be?
Session 2: From Person to Patient & back again

SPIRITUAL CARE VOLUNTEERS: A TRAINING RESOURCE

Together Time

With the group make a list of the top 5 things that are important for a hospital patient.

1. 
2. 
3. 
4. 
5. 

Talk Time

What does it mean to be a person?

The SEA view of Personhood. (Hughes 2001)

One recent view of understanding what it is to be a person is the SEA view.

SEA is an abbreviation of Situated Embodied Agent

Situated in that we are not islands nor discrete atoms. We are people who are interconnected and mutually dependent human beings. We are situated in families and
we have our own family history. We are also situated in a social and cultural context which we share with others. It is a context in which we contribute more or less depending on our individual circumstances.

**Embodied** in that we are physically embodied within our own skeletal fleshly selves. We cannot escape our own biology and the consequences of it. We get sick, parts of our body breakdown, get broken or damaged, but we are more than just bodies. Our body holds our mind, emotions, our senses and inner spirit or soul. It is our body which will show our mental, emotional and spiritual lives. “We are more than Body, Brain and breath” (C Benland 1988 in Eileen Shamy, A guide to the Spiritual Dimension of Care for People with Alzheimer’s disease and Related Dementia)

**Agent** in that we act in the world in which we live. We make decisions, do things, exert influence, we contribute, create, engage in activity for the benefit of ourselves and others.

**How do I see myself?**

Our self image is important because it determines our behaviour and our response to other people. Our interpersonal relationships depend on how aware we are of ourselves. Distribute the Reflective exercise in Appendix.

- Who am I?
- What are my strengths?
- What are my weaknesses?
- What is important in my life, my priorities?
- What influences me from my past?
- How do I respond to praise? To criticism?
• How do I say/show that I care?

Write a list of adjectives which describe you – this may include: physical features, personality characteristics, abilities, beliefs, moral values, or roles.

Look over your list and notice which things you consider desirable and while others may be less desirable.

Try to decide which things about yourself you value most and which you think other people value.

Any questions?

Share with the group how you felt about completing the sheet. Were there any surprises for you?

Watch the DVD – Who do you see? With Virginia Mckenna

The DVD brings into sharp relief the issues around Personhood and the Patient. This is a question we may ask of ourselves every time we visit a patient.
Session 2:
From Person to Patient & back again

As a group discuss your reactions to the DVD, trying to answer these questions:

- How do the members of staff see this patient?
- What does the Elsie think, feel about what is happening to her?
- How does Elsie see herself?
- How do you see Elsie?

What might be the pastoral, spiritual or religious needs of Elsie and how might they be met?

Pastoral needs:

- Spoken to as a person, kindly with understanding
- She has a name
- Important past needs recognition
- Respect
Session 2: From Person to Patient & back again

- Encouragement
- Affirmation and feeling valued as person
- Make her own choices
- Still counts, can still contribute
- Dignity
- Warmth of human kindness

**Spiritual needs:**
- Loved, valued as person with past, present and future
- Feel her life matters
- Hope
- Help to address inner questions, Who am I? What have I become?
- Move from feeling of loss and resignation to a sense of peace in the eve of her life, resolution
- Feel human/divine love in her loneliness

**Religious needs:**
- Peace through prayer, familiar scripture
- Reassurance of God’s continued care
- Remember the past through ritual of thanksgiving
- Inner strength of prayer and companionship of others who share her faith
- Sense she can still give in different way – frustration of relying on others to “pray for you”
Session 2:
From Person to Patient & back again

Going back to the list of 5 important things for a hospital patient. Are there any you would change?

Go around the group and ask each person what is the most important thing they have learned in this session and what will take away with them.

**Reflection**

Go back to the exercise **How do I see myself?** During the coming week, reflect on what you might bring of yourself to being a chaplaincy volunteer.
Session 3:
Understanding Spiritual Care

Purpose

To understand the role of Spiritual Healthcare in the NHS in Wales
To understand the difference between Spiritual, Religious and Cultural needs of patients in hospital.

The Goal

The goal is Health. What is health?

Feedback

"Health is a state of complete physical, mental and social (emotional & spiritual) well-being, not merely the absence of disease or infirmity.

Health is a fundamental human right." World Health Organization 1978
“Healthcare is an activity that enables people to re-establish a ‘whole’ that was broken...this means making new or broader connections to a reality that may have to include illness and suffering, the success or failure of treatment and even dying.” (Spiritual Care for Healthcare Professionals 2011, Gordon, Kelly & Michell)

Each member of the group is given a number of cards and asked to place each card on the appropriate heading: Spiritual, Religious, Cultural and Pastoral.

Cards might include:

<table>
<thead>
<tr>
<th>Diet</th>
<th>Belief</th>
<th>Attentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>Tearful</td>
<td>Books/newspaper</td>
</tr>
<tr>
<td>Modesty</td>
<td>Do not attempt Resuscitation</td>
<td>Encouraging</td>
</tr>
<tr>
<td>Values</td>
<td>Prayer beads</td>
<td>Internet</td>
</tr>
<tr>
<td>Compassion</td>
<td>Care by doctor of same gender</td>
<td>Reflective</td>
</tr>
<tr>
<td>Trust</td>
<td>Understanding</td>
<td>Telephone</td>
</tr>
<tr>
<td>Cross, Rosary</td>
<td>Thoughtful</td>
<td>Angels</td>
</tr>
<tr>
<td>Music</td>
<td>Receiving Blood products</td>
<td>Holy Books</td>
</tr>
<tr>
<td>Faith</td>
<td>Helpful</td>
<td>Hope</td>
</tr>
<tr>
<td>Kindness</td>
<td>Prayer</td>
<td></td>
</tr>
</tbody>
</table>
As a group discuss the cards under each heading. Are they in the right place? Could they be under more than one heading? Were some easy to place while others were more difficult?

**Spirituality**

*Standards for Spiritual Care for the NHS in Wales (Welsh Assembly Government 2010)*

This is underpinned by principles:

1. All patients should have their spiritual/religious needs assessed on admission and reviewed
2. Spiritual/religious/cultural needs addressed by appropriate staff
3. Staff should have support in their own spiritual/religious/cultural needs
4. Patients and their carers should be protected from unwanted visits from spiritual or religious groups and representatives.
What is Spiritual care?

In pairs discuss this question. One person could be ET (Extra Terrestrial) and know nothing at all about anything to do with spiritual care or religion and the other should try to explain what this kind of care is.

Royal College of Nursing 2012: Spirituality in Nursing Care:

Spiritual care is:

- maintaining hope and finding strength
- trusting in others
- searching for meaning and maintaining a sense of purpose
- forgiveness of self and others
- belief and faith in self, others, and for some this includes a belief in a deity/turning to a higher power. (AA use the term Higher Power with reference to support systems for alcohol abuse)
- peoples’ values, what is important to me.
- love and relationships as sources of support and purpose
- morality, what is right and wrong, just and fair
- creativity and self expression, a need to contribute, make a difference, make oneself understood, express one’s inner self.

Spiritual care is NOT:

- just about religious beliefs and practices
- about imposing your own beliefs and values on another
- using your position to convert
- a specialist activity
- the sole responsibility of the Chaplain.
Aspects of our Spiritual Side or common themes

- Striving to understand the world, making sense of the things we encounter.
- Awareness of God
- Life, the Universe and Everything. The world is often beyond of comprehension.
- Feelings and thoughts make up our common humanity. I wonder why...? Why me? Fairness principle, compassion,
- Being uplifted by music, landscape, art, exercise.

Great Spiritual Questions common to all humanity

Who made the world, the universe?

Is there a purpose in life?

What happens when someone dies?

Why do people suffer?

Thinking Time

Write, either individually or with someone else, a definition that starts *Spiritual care is* . .
Session 3:
Understanding Spiritual Care

Share together your definitions of spirituality, try to work out how many of the words from the first exercise would be included under your definition.

A point to remember

Spirituality is not just the feel good factor. Spirituality is often about asking hard questions knowing there are no easy answers.

Our spiritual side can often be as challenging as it is comforting.

Think of one example when you have been spiritually challenged and one example when you have been spiritually comforted and/or supported.

Share thoughts (optional)

Any Questions?
Session 3: Understanding Spiritual Care

Some people choose to express their spiritual needs through a specific religious belief. This may include a shared set of beliefs, faith, ritual, prayer and other customs.

Christian    Muslim    Hindu    Buddhist    Jehovah Witness

Make a list of religious needs that people may have while in hospital. Remember to include all the world faiths when you are thinking about this. How many of the words from the first exercise might come under this heading?

Give out paper resource on faith based spiritual, religious and cultural needs.


Share your list with the group.

Suggested answers, there will hopefully be more.

• Time and space to observe rituals, prayer and practices in privacy and with dignity
• Resources to continue or return to religious practice in healthcare setting
• Respect for everyone’s beliefs and traditions
• Rituals for death, birth, rites of passage
Culture

Culture is how we do and view things in our own group; our values and worldview based on shared history and language. Culture is the lens through which we look at the world.

Find a partner, someone you haven’t worked with before, and together make a list of the things about your own culture that are important and that you think might impact on your healthcare.

Share your lists with the group – they might include:

- Language
- Diet
- Modesty, privacy, clothing
- Names
- Attitude towards medical staff – medical systems
Expressions of grief

**Exercise** - *Testing our assumptions about people, the patients or staff we might encounter in hospital.*

You are going to be introduced to a patient. You will be given one piece of information about them at a time. Think about how your assumptions about the person change with the information you are given.

Introduce Mrs Y one detail at a time – asking between each step what picture the group has of her.

1. Mrs Y is in renal failure
2. She has 3 teenage children
3. She likes cooking
4. She speaks five languages
5. She has an Open University degree in Psychology
6. She is a member of our domestic staff
7. She is a Gujarati Hindu

*An additional Exercise if there is time*

Imagine you are in hospital in Pakistan. What would be your three greatest needs? Now substitute Orlando, Florida for the location of the hospital and list your three greatest needs.
Session 3:
Understanding Spiritual Care

Together Time

Going back to the first exercise are there any additional words you would put under the different headings.

Go around the group with each person asking for one thing they have learned in this session or one thing they will take away with them.

Reflection

Reflect on the differences between Spirituality, Religion and Culture. Think about what is important in your life, what gives you value.
Purpose

To introduce basic listening and communication skills, including non-verbal and body language signals.

Good communication is a core skill for all chaplaincy volunteers. It is through personal interaction with patients, carers and staff that Spiritual Care is delivered and received.

Communication in the context of Spiritual Care has two significant elements. The first is interpersonal skills e.g. attentive listening.

However, the second element is the more uncomfortable one, where we realise that the context for using our communication skills is bound up with what we would normally term the patient’s private life. (Spiritual Care for Healthcare Professionals by T. Gordon, E. Kelly and D. Mitchell 2011)

Self Awareness

All communication starts with being aware of who we are, who we would like to be. Our self-image is important, but how well do we know ourselves? This links closely with the work from the last session about personhood.
SESSION 4:
PASTORAL CARE THROUGH ATTENTIVE PRESENCE & LISTENING

S P I R I T U A L  C A R E  V O L U N T E E R S:
A TRAINING RESOURCE

Together Time

Look at the diagram below of the Communication Cake. With a partner discuss if you think this view of communication is correct. Can you think about a time when what someone said to you, the words, were not as important as how it was said. Can you think of an instance when how the person felt was reflected in their body language.
**Approaching the Patient**

- You are entering their world...beware and be aware!!
- Greeting: Introduce yourself and say you are a visitor from the Chaplaincy (ask permission if you sit down).
- Contextual factors: patient’s condition, ward atmosphere (busy, quiet, hectic, frantic), doctor’s rounds, meal/quiet/visiting time approaching
- Whether others at the bedside welcome you

**The Conversation**

- Try to avoid asking too many questions.
- Learn the difference between open and closed questions
  
  Open ‘how are things going for you today’

  Closed ‘did you enjoy your meal today?’

- Topics of conversation will range far and wide.
- Listen carefully to what the patient tells you
SESSION 4:
PASTORAL CARE THROUGH ATTENTIVE PRESENCE & LISTENING

- Let them share what they wish.
- Do not argue with a patient.
- Do not be shocked or disapprove of anything the patient may say.
- Avoid talking about your own illness or operations.
- If a patient asks questions you about their medical condition, explain that you are a volunteer and you do not know the answers to the questions. However, encourage the patient to ask a member of staff either medical or nursing the next time they visit.

Thinking Time

Attentive listening takes practice and in a hospital situation there are many obstacles to listening. As you approach each bed ask yourself these three questions:

What am I seeing?
What am I hearing?
What am I feeling?

On your own or with a partner write down what you think are some of the important indicators under the following headings:

Distress signals to listen for
- Emotional tone of voice
SESSION 4: PASTORAL CARE THROUGH ATTENTIVE PRESENCE & LISTENING

- Facial expressions
- Body language (i.e. gestures, positions, posture)
- Dress and appearance

Good ways to listen
- Relax
- Show you are interested
- Concentrate
- Respond non verbally (nod, smile, sympathetic noises)
- Allow the other person to steer the conversation.

Obstacles to listening
- Switching off
- Shortage of time
- Interrupting silences
- Noise

With the whole group share your lists and discuss how we can best become good listeners and overcome the obstacles to listening in hospital.
SESSION 4:

PASTORAL CARE THROUGH ATTENTIVE PRESENCE & LISTENING

What are we listening to?

1. Listen to a person’s **SPEECH**, paying attention to phrases that might indicate conflict, sadness or struggle.

2. Listen to a person’s **THINKING**, paying attention to important questions maybe about the future, concerns about family, home or job; anticipating test results or report on treatment.

3. Listen to a person’s **TONE OF VOICE, PITCH AND SPEED** – a depressed person will often speak at only one tone, while an anxious person may talk rapidly jumping from subject to subject.

4. Listen to a person’s **SILENCES** - this may sound like nonsense for how can a silence be heard? Yet there are many kinds of silence and each should be treated with respect. E.g. the silence of reflection, the silence of deafness, the silence of wanting to be left alone, the silence of brain damage. The old phrase *Silence is Golden* contains a great deal of truth. As listeners we should sit comfortably with each and every silence, reflecting on what is happening for this person and resist the urge to rush in with words.

5. Listen to a person’s **FEELINGS**, these may be expressed in words, in tears, in laughter, in silence and in a person’s body language.

Any questions?
SESSION 4:

PASTORAL CARE THROUGH ATTENTIVE PRESENCE & LISTENING

The Chinese calligraphy for ‘to listen’ shows what a complex skill listening is.
LISTENING EXERCISE

Using a case study from the Appendix or the DVD ‘What do you see?’ or a patient story from your own source, write down what you think the patient is saying about their situation? What signals are being communicated through what you see and what you hear and sometimes what you smell.

FEEDBACK

Share, in a group, what we heard each person saying and what signals were important for our listening and understanding the person.

EXERCISE TWO

Select one or two case studies from the appendix, divide group into pairs or small groups and discuss what the possible pastoral, spiritual and religious needs may be.

FEEDBACK
Go around the group and ask what the most important thing they have learned in this session or what is the most significant thing they will take away with them.

**Reflection**

In the week ahead ask the group to reflect individually on what their strengths and weakness in terms of listening skills.
Purpose

To begin to explore the range of feelings and reactions connected to different losses, including becoming a patient in hospital.

To understand that whenever we face loss, we experience grief. Our reactions are unique and individual; none of us experience grief in the same way. Not only are we different, but our losses are different. Facing illness, disability and of course death are all kinds of loss.

HEALTH WARNING: talk about loss, grief and bereavement may brings up feelings for us; be aware of our own bereavements and loss.

Encourage people to share as much, or as little, as they like about their own experience of loss.

Loss

As we go through life, we experience a wide variety of losses for which we grieve. It is not possible to go through life without suffering losses.

Examples: car keys, child in shop, pet

Ask the group to make a list of different types of losses.
Bereavement

Bereavement is another word used for loss. It is the fact of losing something or someone of value to us. It derives from the French, meaning to be robbed.

Usually applies to death but can be any loss however large or small.

Grief

Grief is our response to suffering a Loss or Bereavement which include:

- Feelings
- Physical reactions
- Mental confusion

Grief is UNIVERSAL, that is, some elements are common to us all.

Grief is INDIVIDUAL, that is, some elements reflect our own experience in life.

Times of emotional crisis and upset often involve some kind of loss. Most people grieve when they lose something or someone important to them.

Take some time to think about the losses you have experienced. What impact does loss have on someone's life?

Any Questions?
Were you uncomfortable thinking about loss? Patients may feel uncomfortable too, as a loss experience comes to the surface again.

Think together about the losses that becoming a patient in hospital can bring about:

<table>
<thead>
<tr>
<th>Home &amp; familiar surroundings</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living under hospital rules &amp; regulations</td>
<td>Food</td>
</tr>
<tr>
<td>Family, friends &amp; even pets</td>
<td>Freedom</td>
</tr>
<tr>
<td>Becoming a medical condition no longer a whole person</td>
<td>Reminder of other losses</td>
</tr>
<tr>
<td>Disability or chronic illness</td>
<td>End of Life</td>
</tr>
</tbody>
</table>

Listen to (or read) this poem describing grief. It could describe loss of any kind, and can sometimes overwhelm us spiritually. The feelings are the same for many people but each of us will deal with them differently.
SESSION 5:
INTRODUCTION TO LOSS, GRIEF & BEREAVEMENT

The Sea and the Beach by Tessa Wilkinson

The sea seems to illustrate pain and sorrow so well
It comes in and goes out
For a while it is there, overwhelming, covering everything
Then slowly the tide turns and it withdraws
For a while we can see the beauty of the shells, the seaweed
We can rejoice in the patterns in the sand
We can feel the corrugated ripples under our feet
Alive to what is around, and beyond
But then the tide turns and again it is all washed away, all overwhelmed
We feel like the crashing of the waves on rocks
Raw and out of control
Full of anger and rage
Battered and bruised
Tossed about like flotsam floating wherever we are thrown
There are so many questions. Why now? Why her? Why him?
But no answers
Then the sea calms and gently the waves lap the rocks
We are soothed and the inner turmoil is calmed
In time we can learn to move up the beach as the tide comes in
Out of its reach
Not to be overwhelmed
The pain is still there, but in control
We can recognise the pain
Revisiting the sadness
Acknowledging how much the person is missed
We learn to turn away and look to the future
Knowing the person will always be part of us
Always loved and always remembered.

Share with the group your response to the poem.
It is often difficult to be with someone who wants to talk about a loss and it is common to be overwhelmed with self consciousness. You don't know what to say or how to respond. The fear of "not knowing" can prevent you from giving the empathy and support that is most needed.

Remember:

**LAUGHTER and TEARS are both OK** - allow the patient to express intense feelings.

**DON'T FEEL SORRY FOR SOMEONE** - help them to preserve their dignity and pride. Empathy is not the same as sympathy or pity.

**LET THEM TALK ABOUT THEIR ILLNESS BUT ONLY IF THEY WANT TO** - talking helps someone work through their feelings.

**LET THEM BE SILENT IF THEY WANT TO** - presence alone can be comforting.

**KEEP YOUR VISITS SHORT** – being in hospital can be tiring.

**What can I say?**

Don’t try to lessen the loss with easy answers

Don’t feel that you must have something to say

**Phrases that DON’T help:**

- It is God’s will
SESSION 5:
INTRODUCTION TO LOSS, GRIEF & BEREAVEMENT

- I know how you feel
- Time will heal
- There must have been a reason

**Phrases that DO help: are “door openers”** which invite the person to talk about what is on their mind but be aware that what they say may be painful for them to talk about and hard for you to hear.

It is very important that we listen with:

- Empathy – recognise feelings in others; not judge but simply accept what you hear
- Respect – give value to someone’s feelings even if you find response/feelings hard
- Give value to what has been lost, even if it does not seem important to you

**Points to Remember**

- You can help and support someone experiencing loss but you cannot grieve for someone else.
- You can offer a listening ear or practical help but not take away pain
- Warmth – that comes through empathy, respect and attentive listening – even for a short time will be valued

It is important to accept that as a Chaplaincy volunteer you cannot change the patient’s sense of loss. Nothing that you say or do will take away pain. We can reassure, offer support and be with someone as they talk about loss but you cannot take away the grieving of loss.
SESSION 5: INTRODUCTION TO LOSS, GRIEF & BEREAVEMENT

Go around the group asking each person what is the most important thing they have learned in this session or what is the most significant thing they will take away with them.

Reflection

Acceptance is being able to remember without the pain that disables. All of our losses remain part of who we are – we carry them with us through our lives.

Reflect on your own experience of loss, grief and bereavement and how this session may have helped you understand your own experience better.
Purpose

To provide an understanding of the practical aspects of visiting patients on the hospital wards. This session is slightly different from the others in that some topics may be covered by other Health Board staff.

Confidentiality

In very general terms for the purposes of visiting in hospital as chaplaincy volunteers, the law amounts to this:

The very fact that a person is a patient is itself **private confidential information**.

It must remain confidential until the patient agrees otherwise. This includes not just the fact that a person is a patient in the hospital but any information about their condition or treatment.

The patient alone has the right to say who may be told what and when. People not professionally involved in the care of the patient do not have the right to know. This includes family, friends, employers, neighbours, clergy, ministers and fellow members of faith groups or the local church.

Any written information you keep on a referral sheet, for example, as basic as patient name/ward/request must remain in the Chaplaincy office and be destroyed through confidential waste when no longer needed.
SESSION 6:
ON THE WARDS

Understanding confidentiality - Do the following exercise.

Take an A4 sheet of paper.
Close your eyes.
Follow the instructions.
No questions are allowed.
Fold the sheet in half
Then fold it in half again
Then fold it in half yet again
Tear off the right hand corner
Turn the sheet over and tear off the left hand corner.

Open your eyes & it will be obvious that not everyone has the same finished project. Why?
Were the instructions easy to follow?
Why? Why not?
You all have the same instructions about confidentiality and the patient, yet you may be interpreting them differently from one another.

In brief:

Nobody outside the hospital has any right to know that a person is a patient here.
You must not share any information about a patient with anyone outside the Chaplaincy team.
Despite your best intentions in offering prayer for someone - it is best not to offer prayer for a patient, even anonymously, outside the Chaplaincy team - pray for people alone, with fellow lay visitors or hospital chaplains
Always work on the principle that if you break a confidence, it will come back to you, at some time.

Confidentiality – A Salutary Tale

Perhaps a few recent examples of local practice and professional standards, which have failed to be up to the highest expectations of the NHS, society and the law, will serve to highlight the pastoral implications of this problem.

Example 1
The economic recession of recent years has meant that many employers large and small are unwilling to employ those who they think may have a bad sickness record now or in the future. For example, when a manager of a small Midlands company attended a service at his local church and heard the prayers, using the full name, for a person in the town who was, in the words of the Bidding, “seriously ill and needing further major investigations,” he mentioned his genuine concerns for the sick person to the company personnel officer.
Rightly or wrongly the sick person came to the view that the only reason for having been made redundant in the down-sizing of the company a few months after his/her return to work, was that the company might have to pay for very expensive sickness payments in the changed arrangements of National Insurance, which would be financially to the company's disadvantage - a serious matter in the light of the recession.

When detailed inquiries were made, it became clear that the name had been put on the prayer list not at the request of the person concerned but in response to information given by a 'concerned member of the church' who had picked up the news while visiting her husband who happened to be on the same ward.

The prayers of the faithful greatly disadvantaged both patient and family in this case!

**Example 2**

Another example is that of a concerned minister.

Having been told of the serious illness of a lady's husband, and from the best possible motives, he made a home visit.

Regrettably the information had come not from the patient, but from a Chaplaincy lay visitor in the congregation.

This visitor had made an official visit to another patient in a distant hospital who happened to be in the same ward as the husband.

The visitor had recognised the husband/patient as a member of the congregation, and had gone straight back to tell the minister that this man was in hospital for cancer tests.

The fact that her husband was in hospital at all was news to the wife, and came as such a shock when the minister told her, that her already fragile mental and nervous condition gave way to a total breakdown leading to her immediate admission to the local acute psychiatric clinic.

It transpired that her husband, aware of his wife's delicate condition had arranged to go away on business for a couple of days' rather than worry her with the truth that he was to undergo preliminary cancer investigations.

In law he was entitled to expect that the fact that he was a patient was itself confidential information. He had the right, whatever others might think of his approach, to protect his wife in what seemed to him the best manner possible. His caution seems to have been justified by the fact that she required prolonged treatment following disclosure of his real situation. Thinking that the breach of confidentiality was made by the hospital, he began legal proceedings against the health authority, which he withdrew only when the true source of the breach was identified.
Both husband and wife are now alienated from all worshipping communities.

**Any Questions?**

As a group discuss your response to the following scenario:

A chaplaincy volunteer meets a patient, Mrs. A, on the ward who is a member of her church/faith group. On leaving the hospital the volunteer immediately telephones the minister/leader of the group and tells them that Mrs. A is in hospital, which ward she is on and her diagnosis so that she can be prayed for by the church/faith group.

**The Routine of visiting**

Before going onto the wards:

- Sign in the volunteers book in the Chaplaincy Office
- Make sure you are wearing your ID Badge
- Remember to make a note of the patients wishing to see a Chaplain, receive Religious care, for example Holy Communion or any other requests. A pocket note book is good for this. Some chaplaincy departments have their own process for recording referrals.
SESSION 6:  
ON THE WARDS

- Spend a few moments in prayerful preparation in the hospital chapel

Arriving on the Ward:

- Make sure that the ward is not closed for mealtimes, quiet times, doctors round or for infection control
- Use the antiseptic hand gel on entry and on leaving the ward
- Find the Ward Sister, or Staff Nurse in charge, and introduce yourself or tell them you are on the ward as part of the chaplaincy team.
- Ask if you may visit the patients on the ward and if there are any who would particularly value a visit or anyone who should not be disturbed.
- In side rooms be aware of any barrier nursing or infection control procedures which should be clearly signposted.
- Be thoughtful and polite to all staff on the ward as they go about doing their work.
- You are there as a guest and if asked to leave you should do so promptly.

Dos and Don’ts of Visiting

DO

- Look above the patient - at the name board – remembering that the nurse’s and/or consultant’s name may be there as well.
- Observe the patient’s bed space. Are there any indications of belonging to a faith/family? Are there any indications that the patient has ‘no’ visitors?
- Listen
- Empathise
  “Stand behind someone’s eyes and look out.”
- Ask permission before you come into their personal space, it may be the only control a patient has over this precious bed space
SESSION 6: ON THE WARDS

Spiritual Care Volunteers: A Training Resource

- **Pray**, if appropriate, but only with a person’s permission or ask if they would prefer for you to remember them in prayers in the Chapel. (it gives a choice)

- **Offer** the help of Chaplains

- **A touch of the hand or arm** may help to reassure.

**DON’T**

- **Take anything for granted** - If you’re not sure – ask

- **Argue** Even if the patient is wrong, or offensive. You can win the argument and lose the patient

- **Criticize** someone else’s religion, church, faith or belief system or lifestyle choice.

- **Diagnose**, or compare your illnesses

- **Lift** a patient

- **Touch** if arms/ hands are under the bedclothes.

- **Evangelize**, you are not there to promote your beliefs

- **Sit** on the patient’s bed. Ask before pulling up a chair or stool.

- **Accept any money**. If asked to purchase goods by the patient, check with a senior member of staff first.

- **Give any food or drink** to a patient without permission from staff, even if they request it.

- **Wake** a patient up to talk to them unless staff suggest that you do so.

**When you are finished visiting**

- Come back to Chaplaincy Office

- Complete any paperwork for referrals

- Speak to one of the Chaplains if something occurred during your visit that you need to talk over

- Sign out of the volunteers book
Any Questions?

Choose a case study from the appendix to discuss with the group.

Infection control

It will be no surprise to know that hospitals are full of bugs: MRSA, Noro virus, CDif to name but a few so infection control is an essential part of hospital life. You need to be aware of how this affects you as a volunteer.

Hand Hygiene

You will be shown effective hand washing techniques as part of your volunteer induction but it is important to remember to clean your hands with soap/water or alcohol gel on entering/leaving each ward and between each patient visit when you have spent time at the bedside.

Barrier Nursing

Some patients with infections or weak immune systems are nursed with infection control precautions or barrier nursing. This is either to protect staff from the infections carried by the
patient or to protect the patient from acquiring any infection when their own immune system is weak. Volunteers are not expected to visit such patients and should refer them to a Chaplain if a visit is required.

**Closed Wards**

At different times of the year, especially in the winter months, wards may have several cases of Noro virus, sometimes called the “cruise ship virus”. This is a highly infectious virus which causes diarrhea and vomiting. It is short lived, about 48 hours, but easily transmitted and very unpleasant. When this happens wards will be closed to all but essential visitors. As a volunteer you should not visit any ward closed for this reason. If you should develop the Noro virus or any other illness with symptoms of diarrhea or vomiting you should not come to the hospital to visit until you are 48 hours clear of all symptoms.

**Your own health**

Do not come into hospital to visit patients if you are yourself unwell. Let the chaplain know that you will not be in that week.

**Any questions?**
Health and Safety

Hospitals are busy places full of people, equipment and potential hazards. It is your responsibility to be aware of your surroundings and to take common sense decisions to protect your own health and safety and that of others.

On the wards be aware of equipment around the patient beds which may include cabling, wires, bags etc. Do not interfere with any equipment, especially medical equipment. (it is ok to turn off the sound on the television but not the intravenous drip) Tell a member of the nursing staff if the patient you are visiting needs help with the bed or any other equipment.

Do not under any circumstances help a patient in or out of bed, to stand, walk or into a wheelchair – press the patient’s call buzzer or call a member of the nursing staff immediately, especially if there is imminent danger of the patient falling.

If you see a hazard on the ward, liquid spill for example, it is your duty to report it to the nursing/cleaning staff and ensure that it is dealt with.

Dress Code

There is an All Wales dress code for staff and volunteers visiting wards. You should observe the “bare above the elbows” rule by not wearing long sleeves or excessive jewelry which interferes with good hand hygiene. You should also wear footwear that is closed toed, low heeled and comfortable. There is a lot of walking in hospitals, wheeled equipment and bags of liquid which can present a hazard.

Any Questions?
Reflection

Ask each person what is the most important thing they have learned in this session or what is the most significant thing they will take away with them.

The next session is a final review and recap of the course before your interview and selection as a chaplaincy volunteer. Write down any questions you want to ask, anything that is not clear or where you need further training. Reflect also on how you feel about being a chaplaincy volunteer.
Poem – Ten Types of Hospital Visitor by Charles Causley

Reflective Exercise – How do I see myself?

Case Study 1 – Religious/Spiritual Enquiry

Case Study 2 – Pastoral/Spiritual Care

Case Study 3 – Pastoral, Spiritual & Religious Needs

Case Study 4 – Pastoral Care with Religious Support

Case Study 5 – Loss revisited

Case Study 6 – Spiritual Distress

Case Study 7 – Spiritual Care within a Neonatal Unit

Case Study 8 – Mental Health

Case Study 9 – Barriers to Spiritual care

Chaplaincy Spiritual Care Summary Chart

Faith Chart

Job Description
The first enters wearing the neon armour
Of virtue
Ceaselessly firing all-purpose smiles
At everyone present.
She destroys hope
In the breasts of the sick,
Who realise instantly
They are incapable of surmounting
Her ferocious goodwill.

Such courage she displays
In the face of human disaster!

Fortunately, she does not stay long.
After a speedy trip round the ward
In the manner of a nineteen-thirties destroyer
Showing the flag in the Mediterranean,
She returns home for a week,
With luck, longer,
Scorched by the heat of her own worthiness.

The second appears a melancholy splurge
Of theological colours,
Taps heavily about like a healthy vulture
Disturbing deep-frozen hope.

The patients gaze at him cautiously.
Most of them, as yet uncertain of their realities
Of heaven hell-fire, or eternal emptiness,
Play for safety
By accepting his intentions,
With just-concealed apathy,
Except the one old man, who cries
With newly sharpened hatred,

‘Shove off! Shove off!
‘Shove...shove...shove...shove...
Off!
Just you
Shove!’
The third skilfully deflates his weekly smiling victim
By telling him
How the lobelias are doing,
How many kittens the cat had,
How the slate came off the scullery roof,
And how no one has visited the patient for a fortnight
Because everybody
Had colds and feared to bring the jumpy germ
Into hospital.
The patient’s eyes
Ice over. He is uninterested
In lobelias, the cat, the slate, the germ.
Flat on his back, drip-fed, his face
The shade of a newly-dug-up Pharaoh,
Wearing his skeleton outside his skin,
Yet his wits as bright as a lighted candle,
He is concerned only with the here, the now,
And requires to speak
Of nothing but his present predicament.

It is not permitted.

The fourth attempts to cheer
His aged mother with light jokes
Menacing as shell-splinters,
‘They’ll soon have you jumping around
Like a gazelle’ he says.
‘Playing in the football team’.
Quite undeterred by the sight of kilos
Of plaster, chains, lifting gear.
A pair of lethally designed crutches,
‘You’ll be leap-frogging soon’ he says,
‘Swimming ten lengths of the baths’.
All these unlikely prophecies.
The old lady stares fearfully
At her sick, sick offspring
Thinking he has lost his reason-

Which, alas, seems to be the case.

The fifth, a giant from the fields
With suit smelling of milk and hay,
Shifts uneasily from one bullock foot
To another, as though to avoid
Settling permanently in the antiseptic landscape.
Occasionally he looses a scared glance,
Sideways, as though fearful of what intimacy
He may blunder on, or that the walls
Might suddenly close on him.

He carries flowers, held lightly in fingers
The size and shape of plantains,
Tenderly kisses his wife's cheeks
The brush of a child's lips-
Then balances, motionless, for thirty minutes
On the thin chair.

At the end of visiting time
He emerges breathless
Blinking with relief, into the safe light.

He does not appear to notice
The dusk.

The sixth visitor says little,
Breathes reassurance,
Smiles securely,
Carries no black passport of grapes
And visa of chocolate, has a clutch
Of clean washing,
Unobtrusively stows it
In the locker, searches out more.
Talks quietly to the Sister
Out of sight, out of earshot, of the patient,
Arrives punctually as a tide,
Does not stay for the whole hour.

Even when she has gone
The patient seems to sense her there:
An upholding
Presence.

The seventh visitor
Smells of bar-room after-shave,
Often finds his friend
Sound asleep: whether real or feigned
Is never determined.

He does not mind; prowls the ward
In search of second-class, lost-face patients
With no visitors
And who are pretending to doze
Or read paperbacks.
He probes relentlessly the nature
Of each complaint, and is swift with such
Dilutions of confidence as,
‘Ah, you’ll be worse
Before you’re better’.

Five minutes before the bell punctuates
Visiting time, his friend opens an alarm-clock eye.
The visitor checks his watch.
Market day. The Duck and Pheasant will be still open.

Courage must be refuelled.

The eighth visitor looks infinitely
More decayed, ill and infirm that any patient.
His face is an expressive grey.

He peers about with antediluvian eyes
As though from the other end
Of time.
He appears to have risen from the grave
To make this appearance,
There is a whiff of white flowers about him;
The crumpled look of a slightly used shroud.
Slowly he passes the patient
A bag of bullet-proof
Home- made biscuits,
A strong death-dealing cake
‘To have with your tea’
Or a bowl of fruit so weighty
It threatens to break
His glass fingers.

The Patient, encouraged beyond measure,
Thanks him with enthusiasm, not for
The oranges, the biscuits, the cakes,
But for the healing sight
Of someone patently worse
Than himself. He rounds the crisis-corner,
Begins a recovery.

The ninth visitor is life.

The tenth visitor
Is not usually named.

*Charles Causley, from Collected Poems 1951-1975, Macmillan, 1983*
Reflective Exercise

How do I see Myself?

Our self image is important because it determines our behaviour and our response to other people. Our interpersonal relationships depend on how aware we are of ourselves.

- Who am I?
- What are my strengths?
- What are my weaknesses?
- What is important in my life, my priorities?
- What influences me from my past?
- How do I respond to praise? To criticism?
- How do I say/show that I care?

Write a list of adjectives which describe you – this may include: physical features, personality characteristics, abilities, beliefs, moral values, or roles.

Look over your list and notice which things you consider desirable and while others may be less desirable.

Try to decide which things about yourself you value most and which you think other people value.
Case Study 1: 
Religious/Spiritual Enquiry

Chaplain on a routine visit to a ward came across a patient who was sitting up in bed reading a Gideon Bible. On introducing herself as the chaplain the patient started to engage in conversation.

“I am glad to meet you, I was wondering if there was a chaplain in the hospital? I picked up this bible from the locker and am finding it very interesting. I have always been fascinated by religion. I don’t go anywhere myself but I am interested in all the different religions of the world. I’ve got nothing else to do here and time is so long I thought I would read the bible from beginning to end.”

The chaplain enquired which part of the bible he was reading at the moment. The patient was reading the Psalms. He had read the first 4 Gospels and was getting confused by the inconsistencies in the accounts and so he thought he would read the Psalms.

The chaplain explained the possible reason for the inconsistencies emphasizing that the heart of the story was essentially the same. The patient understood the explanation and then proceeded to talk about the God who would send plagues on the people of Egypt. He could not accept a God who would do such a thing as it seemed so unreasonable.

How would you respond to such a patient?
Case Study 2:
Pastoral/Spiritual Care

Chaplain on routine visits to a Ward entered a 4 bed bay.

There were three patients in the bay. One bed space, although occupied, the patient was not present. The Chaplain introduced herself to the patients in the bay. Two patients, probably in their 50s, were awake and sitting up on their beds. Both smiled and returned the greeting. The chaplain moved to the bedside of the first patient and spent some time listening to the patient’s concerns about her situation and lack of progress in terms of diagnosis and treatment. After some words of encouragement the chaplain left the bedside. As she did so she noticed that the patient diagonally opposite had now closed her eyes and appeared to be resting. Her arms were folded in front of her and her legs were crossed. The chaplain then walked towards the third patient; a frail elderly lady whom the Chaplain had observed on entering the ward appeared to be sleeping in her chair. She had her head in her hands and was leaning forward in her chair, it was difficult to tell if she was sleeping or simply resting her eyes.

The Chaplain went over, knelt down by her chair and gently touched her hand. The lady raised her head and opened her eyes. She looked sad and downhearted. The Chaplain introduced herself and enquired how things were with her today. She responded by saying she was fed up and would be glad to get out of the place. From the conversation it was clear that this patient had been upset by the attitude of some staff towards her. “They don’t listen to me”, she said, “They are trying to make me walk. I can’t walk without someone supporting me, I’ve just had a hip replacement. I can’t do it anymore.”

Where would you take this conversation?

On leaving the bay, the Chaplain noticed that the fourth patient had returned, she was also an elderly lady. She was dressed in a dressing gown and was sitting gazing at the floor. The Chaplain went over to her, knelt by her chair and gently touched her hand, she raised her head and immediately recognized the Chaplain from a previous stay in hospital. She smiled, shook the Chaplain’s hand and said how glad she was to see her. Conversation flowed freely as she told the Chaplain why she was in hospital and how fed up she was that no one was telling her what was happening. She had been waiting 6 days for a scan. She was trying to help herself by sitting more upright so that she can breathe more easily. “There is nothing wrong with my mind” she said, “I want to know what they are thinking, I want to know everything. I don’t like not being told anything.”

Where would you take this conversation?
Towards the end of the conversation the Chaplain remembered that this patient may have received Holy Communion on her last visit. She offered it again and the patient responded positively saying she would appreciate it as she is in need of a bit of help.

What communication skills was the Chaplain using in this ward visit
Case Study 3:
Pastoral, Spiritual & Religious Needs

Elderly patient on cardiac ward. Chaplain introduced their self.

Chaplain "Hello, I'm *x* the hospital chaplain."

Patient "Oh, how lovely, I've been wanting to talk to a minister. What religion are you?"

Chaplain "I'm a bit of everything really, I was brought up in the Congregational Church..."

Patient "Oh I thought that was a Chapel?"

Chaplain "Yes it is a Chapel, but officially it's just called a Congregational church. We call it Bethesda Chapel, I was brought up going there but I was ordained an Anglican."

Chaplain "I'm a Baptist, always been a Baptist. My husband is a Baptist too, he was baptised, completed covered in water. I never had that but I always went to the Baptist Chapel in our village.

There is something that is worrying me, I wonder if you can help me with it?

My husband died a few years ago and I do so miss him. I know he is with God, he was a good man. But this is what worries me, will I go to be with him when I die as I haven't been baptised. I couldn't bare to think that I wouldn't be able to join him."

Discuss the three questions:

What are the pastoral needs?

What are the spiritual needs?

What are the religious needs?
A verbatim account of a chaplaincy visit

Patient known to chaplain and had visited her frequently during her numerous stays in hospital.

As the chaplain approached her cubicle the doctors were just leaving, nurses looked grave. The doctor asked the nurse who was her next of kin and that they should be called. The chaplain realised that something serious was now going on for M.

**Chaplain** 'Hello M'

Patient opened her eyes and smiled and said hello,

**Patient** 'I've been waiting to see you. I want to talk to you.'

Patient looked peaceful. She had an oxygen mask over her face.

Chaplain held the patient’s hand and said,

**Chaplain** 'How are you doing today?'

**Patient** 'I am feeling hopeless. 'I've been knocked about such a lot, I feel hopeless.'

With that the nurse came in and started to prepare her for another procedure. She put up a drip and left.

Chaplain approached the bedside again but due to the patient’s position it wasn’t obvious which was the better side to stand and so she asked her. She noticed spots of blood on the floor. With that a domestic came in and mopped it up.

**Patient** 'At the bottom of the bed she said. I can see you there.'

**Chaplain** 'You wanted to talk to me M'

**Patient** 'Yes, I don’t know what’s happening to me, I’ve had blood transfusion and this thing down my throat. But I trust him.'
Case Study 4:
Pastoral Care with Religious Support

Chaplain ‘Yes you know that God will look after you. He will take great care of you. There is nothing that is going to happen to you that isn’t already in God’s hands.’

Patient ‘Yes I know that. I’ve had a good life. God has been good to me. I pray all the time. But I am so tired.’

Chaplain ‘M. I want you to know that when you become too tired to pray there are many others who will and are praying for you.’

‘M, of all the scripture that you know, which brings you most comfort now?’

Patient ‘Praise the Lord Oh my soul and forget not all his benefits....’

Chaplain ‘Yes that is lovely. Let me read it for you.’ Chaplain reads it. ‘One of my favourites is John 14.’

M started to recite it.

Patient ‘Let not your hearts be troubled, trust in God trust also in me, In my father’s house are many dwelling places....’

‘I think I want to go there now. I am ready if God wants me.’

Chaplain ‘Yes M God may be getting your room ready. When it’s ready he will come and collect you and it will be alright. He will take you by the hand and lead you through.’

Patient ‘The music, that was your idea. Thank you, others have loved it too. They have benefited from it.’

With that the nurse and porter came into the room to collect her.

Chaplain ‘I’ll come and see you when you come back. Don’t worry, you will be alright.’

**********************************************************************

For Discussion

What were the pastoral, spiritual and religious considerations of this visit?
Chaplain visits a cardiac ward. She knocks on the open door of a cubicle and enters.

**Chaplain:** *Good morning! May I come in?*

The patient puts down her magazine and invites the Chaplain in.

**Chaplain:** *My name is X, and I am the hospital chaplain.*

Patient returns the greeting and smiles.

**Chaplain:** *I've come to visit the ward this morning...to talk to patients and offer a bit of support during their stay in hospital.*

Patient invites the Chaplain to sit on the side of the bed.

**Chaplain:** *Thank you that is kind of you. How are you feeling today?*

**Patient:** *I feel alright actually. I'm here because of my heart, its gone haywire again, they are trying to settle it down. I've had blood pressure problems for years and sometimes it goes all irregular on me and I have to come in.*

**Chaplain:** *Can that be done with medication or will you need surgery?*

**Patient:** *Hopefully not..I'm on medication and it seems to be working.*

**Chaplain:** *That's good. Hopefully it wont be too long before you can go home. Do you have anyone at home to keep an eye on you?*

**Patient:** *No I’m a widow. I lost my husband over 20 years ago. One minute I was talking to him the next he was gone, it was one of these embolism things. There was nothing anyone could have done. It was a big shock. My son was only two at the time he’s grown up now with children of his own.  

**Chaplain:** *Do you see him much?*

**Patient:** *Yes, quite often, particularly the grandchildren. They keep me going, I’ve lots of sisters though, we are all very close, although I lost one sister three years ago. I miss her very much.*

Tears begin to flow down the patient’s cheek
Case Study 5: 
Loss Revisited

Chaplain: I’m very sorry to hear that. You’ve been through a lot and had some very difficult times. Loosing a sibling must be very hard.

Patient: Yes it was. She suffered such a lot. It only took three months. It was awful.

Pause

Patient: It’s the suffering I find really difficult. You feel so helpless.

Chaplain: Yes it is very hard to watch. You do feel so helpless.

Patient: Yes you do feel helpless. There is nothing anyone could do, it was so rapid, by the time she knew she was ill, the Cancer had spread everywhere. It was one of these silent Cancers. They said it was a very rare one. 1 in 1000. If that’s rare... patient raised her eyebrows and made a gesture with her face and arms...it makes you worry about the rest.

Chaplain: What was your sister’s name?

Patient: Rose.

Chaplain: Did Rose have to stay in hospital for these three months or was she able to go home?

Patient: She had to stay in hospital. It was all so rapid, she never got to go home.

Chaplain: I am so sorry. It must have been so hard, but it was good that you were able to stay with her as much as you could. I am sure that would have helped her a lot. What was the most difficult thing about it all for you?

Patient: The way she suffered, it was so quick.

Chaplain: Sometimes people can feel robbed when Cancer takes people as quickly as that.

Patient: Yes robbed. I do feel robbed. That’s a good way of putting it. I miss her so much, we used to go on holiday together.

***************************

Where would you take this conversation?
Case Study 5: Loss Revisited

What may be the pastoral, spiritual and religious needs of this patient and how may they be addressed?

This patient needed to talk about the loss of her sister. You may like to use this story for a period theological reflection on how you understand suffering and its impact on us as human beings and its relationship with our faith.
Case Study 6: Spiritual Distress

Mr B. had been admitted to the Rehabilitation ward of the community hospital following transfer from the district hospital since having a stroke in the spring of this year. He had been left with a paralysis of his left arm and leg, his speech had been unaffected. He was placed on a rehabilitation programme working with both physiotherapists and occupational therapists.

Prior to his illness this gentleman had been the head of his household. He has three children, one of whom he is very close to, the other daughters he has not bothered with for many years even though they live close to one another. He has always had a special relationship with his granddaughter who has just started college.

After several months of therapy Mr B was able to lift his affected arm slightly but could only stand with the aid of a hoist, on occasions he could transfer from one chair to another. He encountered other medical issues which hindered his recovery. Throughout his recovery he remained positive and believed that he would eventually return home.

Following a multidisciplinary meeting it was felt that Mr B had reached his potential and that intensive physiotherapy would be withdrawn. It was also suggested that Mr B’s family should look for a nursing home for their father; it was obvious that he needed constant care and the family did not feel that they could provide that care.

Mr B has become very distressed over this to the point of being bitter towards his family. He feels that he had been the mainstay of the household and had put his family before himself for years. He states that it was because of his financial input they were able to enjoy a reasonable standard of living.

He is now asking these questions--------

“Why me-------- I have led a good life, did not go out drinking every night, worked all my life, never got into debt.” etc.

“It is not fair, I have never done wrong to anyone and I am like this and they are enjoying life.”

“Life is unfair.”

“I pray every night that God will take me I don’t want to live like this.”
Case Study 6:
Spiritual Distress

For discussion
What may be the pastoral and spiritual needs of this patient and how may you address them?
Case Study 7: Spiritual Care within a Neonatal Unit

Definition

Spiritual care is that which enhances the human spirit as it faces the challenges of pain, weakness and diminishing life.

Baby Sophie

Baby Sophie was born with significant Downs Syndrome features. She was delivered at 36 weeks. The parents were warned that there was a possibility of heart defects and that the baby would have to go to SCBU immediately. Baby Sophie clung to life, heavily dependent on the life support technologies of NICU. Mum sat beside her cot repeating over and over again her decision not to have the amniocentesis test, she felt helpless and yet could not leave Sophie, not even for a moment. Dad didn’t visit very often, the parents had three other children, all under 10. Both parents worked, Dad a long distance lorry driver, mum a classroom assistant.

For Discussion

1. What might be the spiritual/psychospiritual issues?

2. What spiritual support might the mother/parent/family need?

3. In what ways might spiritual care be given?
Case Study 8: Mental Health

This story has to be told by a Chaplain, it will become obvious why the patient could not write their own account. You will be asked to consider some of the details at the end and to consider some of the ethical and theological purposes for the Chaplaincy involvement with this lady.

I first met Mrs J in the early 1990s in an EMI Home in a South Wales Valley where she had been placed after being sectioned in a mental health hospital. It was soon realised that Mrs J would not get any better. Mrs J had been a regular Church attendee and had taken an active part in the life of the Church, never missing Sunday Services.

Background

Mrs J had been a dinner lady in a local school, where she left her handbag in the Headteacher’s office each day. At the end of a shift one day Mrs J went to the office to collect her bag, only to find it was missing. A search of the school was to no avail and Mrs J left the school for home. No one knows what happened on that journey to her home, except when she arrived at the house, all she could and would say was, 'handbag stolen, handbag stolen'. She repeated these words over and over again, to everyone’s confusion. That night she was sectioned under the Mental Health Act, following this she was transferred to the EMI Home.

All Mrs J said throughout the day, (7 years) after the incident with the handbag was 'handbag stolen', she had no conversation and could not rest, always walking round the home from one room to another, in a very disturbed and anxious mood.

I was asked to give Mrs J Communion and I wondered what her response would be. The small candles were lit. Mrs J refused to hold a Prayer Book, but her face showed some recognition as to what she was going to be doing, though all her responses to being asked if she would like communion were 'handbag stolen, handbag stolen,'.

The Host was visible, lying on a pix and we began, ‘In the name of the Father and of the Son and of the Holy Spirit’, to which there was a response Amen.

Then the prayer began 'Almighty God, unto whom’ and Mrs J said all the words, word perfect without a prayer book and, when the service came to the Confession, again she joined in with the correct words. However, when the Collect was read and the Gospel, Mrs J went into her well rehearsed, 'handbag stolen, handbag stolen’. When the familiar words
of the service resumed, with the Lord’s Prayer, Mrs J said the words perfectly, without error. She received the Host and the Service concluded with the Blessing as soon as the words were said, ‘let us go forth in peace’, Mrs J returned to her usual phrase of ‘handbag stolen, handbag stolen...’.

During the service there was a window of lucidity, which closed during and after the service, when unfamiliar words were spoken. Yet when Mrs J heard those words which she had said since her childhood, and when she extended her hands to receive the Sacrament, she was back to her childhood days and the security of her Faith.

**Thoughts**

What could be included in Worship Services to help people like Mrs J to reconnect with that part of life which had meaning and purpose for them? What are the theological and ethical issues involved in Mrs J’s story in relation to her spiritual care? Are there any theological /psychological explanations that could be given for Mrs J’s behaviour?
Mr P was a gentleman who had been employed in heavy industry and had been actively involved in local politics throughout his life. He spoke out for different causes and as he said, ‘I made enemies as I spoke the truth’.

He was a gentleman who frowned on any religious presence and yet one Christmas he attended the Carol Service in the hospital he had been attending. On leaving the Service he stuck his thumbs up in acknowledgement that he had enjoyed the service. Mr P did enjoy a good chat and held forthright views on a range of subjects.

Reflections

How could one present Chaplaincy in a positive way to a person such as Mr P? What resources could be employed in providing Spiritual Care for Mr P? How does one go about removing any barriers between patient and Chaplain?
Chaplaincy teams offer to patients, staff, relatives and visitors of all faiths and none:-

**A Welcome, Hospitality, Care, Teaching, Prayer, Worship, Information, Discussion, Conversation, Respect**
MULTI FAITH PRACTICES Healthcare staff should offer respect, dignity in a holistic manner that encompasses values and beliefs of the individual. This resource is a guidance on customs and observations to enable staff to facilitate a practice of best care. It is general, and many variations exist within communities/faiths – this summary serves to heighten awareness of offering sensitivity. Further help and support can be given by the Chaplaincy Departments. A more comprehensive document is under preparation. Speaking to patient and family about individual requirements is encouraged.

<table>
<thead>
<tr>
<th>Faith or culture</th>
<th>Symbol</th>
<th>General Faith Need / Dress</th>
<th>Medical Treatment</th>
<th>Gender/Privacy/Dignity</th>
<th>Dietary preference</th>
<th>Dying</th>
<th>Customs/observances at death</th>
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</thead>
<tbody>
<tr>
<td>Atheist</td>
<td>![Symbol]</td>
<td>None</td>
<td>None. Appreciate dialogue and discussion</td>
<td>No preference to male/female. No aversion to touch</td>
<td>None</td>
<td>Appreciate family presence and quiet</td>
<td>Burial or cremation</td>
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<tr>
<td>Agnostic</td>
<td>![Symbol]</td>
<td>None</td>
<td>No specific requirements or objections</td>
<td>As for Atheist</td>
<td>None</td>
<td>Family and friends</td>
<td>No special rituals. Burial or cremation</td>
</tr>
<tr>
<td>Baha’i</td>
<td>![Symbol]</td>
<td>Ethnical / cultural diversity</td>
<td>No specific requirements or objections</td>
<td>No objection to opposite sex examination.. Touch acceptable.</td>
<td>Fasting – Holy Season 2 – 20 March. Exempt for over 70’s, sickness and pregnancy. Most don’t drink alcohol, accepted in prescribed medicines.</td>
<td>Accept family or friend reading Baha’i scripture. Believe in after-life</td>
<td>Wash and wrap body in white cotton/silk sheet. No embalming, placed in a durable coffin and buried within an hour’s travelling from place of death. Special prayer is said at death. Holy Day nine in the year</td>
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<tr>
<td>Buddhist</td>
<td>![Symbol]</td>
<td>Peaceful environment. Variable practice</td>
<td>None</td>
<td>Treatments, medical examinations and comfort by either sex. Monks and nuns prefer same sex intention.</td>
<td>Often vegetarian and vegan. Salads, rice, fruit</td>
<td>Quite or time with another Buddhist who chant sacred texts. Want to keep a clear mind when terminally ill. Believe in Rebirth/reincarnation</td>
<td>Treat corpse as body as many Buddhists believe that soul does not leave body immediately after death. Move as soon as possible. Body can be handles by non-Buddhists Holy Day Sunday</td>
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<td>Chinese Could be Taoists/ Christians/ Buddhist/ Confucian</td>
<td>🍒</td>
<td>Different cultures and backgrounds Informal dress – shirt/blouse and trousers/slacks</td>
<td>Injections preferred to pills</td>
<td>Women preferred to be treated by women</td>
<td>No cow’s milk. Rice, fresh vegetables. Little meat</td>
<td>Family gather at bedside – don’t want to be left alone. After life depends on faith but all respect their ancestors</td>
<td>Undertakers to handle body, normally embalmed and dressed in best clothes. Grief is expressed loudly and mourners wear white</td>
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<td>Christian Include Orthodox Holy Book Bible</td>
<td>🙏</td>
<td>Varied. Observe seasons as Christmas and Easter. Check with Chaplaincy</td>
<td>Jehovah’s witness have thoughts on transfusion.</td>
<td>Normally no objections</td>
<td>Own preferences such as vegetarians/alcohol. Preference to fish on Fridays</td>
<td>Some value prayers/scripture/quiet Sacraments for some Holy Communion /anointing Believe in the resurrection</td>
<td>Either burial or cremation – family advice. Holy Day Sunday</td>
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<tr>
<td>Hindu Holy Book Vedas</td>
<td>🌞</td>
<td>Jewellery for women is sacred. Punjabi women wear baggy trouser (Sharwar) Asian women wear Dupatta – material draped round body</td>
<td>No special requirements Some prefer Ayurvedic medicine</td>
<td>Some prefer same sex care Shaking hands, hugging in public uncommon. Avoid direct eye contact – sign of disrespect Long gowns</td>
<td>No beef. Some strictly vegetarian and avoid animal fat, fish and eggs. Salads milk products fine</td>
<td>Fatally ill Hindus want a rosary (mala) Dying person may prefer someone of same sex. Believe in reincarnation Sanskrit is language of sacred texts</td>
<td>Body undressed and washed by someone of same sex. No removal of jewellery. Hindu’s placed together head facing north and feet south, arms at side and legs straight No weekly Holy Day</td>
</tr>
<tr>
<td>Humanist Special Book Humanist Manifesto</td>
<td>🌋</td>
<td>Emphasis is on the here and now, tolerance and respect</td>
<td>None some promote legal voluntary euthanasia</td>
<td>No gender issues.</td>
<td>Some may be vegetarian or vegan</td>
<td>Family or close friends present. No reference to God or afterlife</td>
<td>A non-religious celebration of life</td>
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<tr>
<td>Jain Holy Book Kalpa Sutra</td>
<td>🌿</td>
<td>Strong belief of a need for personal responsibility Religious leaders are monks – travel on foot</td>
<td>Accept transfusion and organ transplants if not at another’s expense. Against abortion.</td>
<td>Women would prefer treatment from women.</td>
<td>Strong vegetarians. No alcohol, meat, fish, poultry or eggs, mushrooms. Milk ok. Some avoid root vegetables. Water boiled, cooled and filtered best. May like curtains closed.</td>
<td>Mental detachment from all desires concentration on inner self. Believe in reincarnation</td>
<td>Bodies are always cremated apart from infants Holy Days (eighth &amp; fourteenth days of the moon cycle)</td>
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<td>Jewish</td>
<td><img src="symbol" alt="Judaic Star" /></td>
<td>3 daily prayers, morning pm and evening. NO Rabbi required. Men wear a cap KAPPAH. Some men wear wigs. Orthodox grow a beard</td>
<td>In most instances religious observations are not enforced during illness. Orthodox prefer same sex care.</td>
<td>Some Jews prefer contact to be restricted to family. However, the need to save life will take precedent</td>
<td>Jewish food laws (Kashrut). Permitted foods marked with KOSHER seal (special slaughter) No pork or shell fish. Prefer milk and meat is kept separate</td>
<td>Company for the dying is encouraged. Dying person not to be touched or moved. They wish to recite the Shema (Kaddish) ‘Hear, O Israel, The Lord is our God, the Lord is One (Deut6.4) Believe in after life. Leave drains tubes in</td>
<td>NOTIFY (Jewish Burial Society) The Chavra The Chevra Kadisha immediately after death. The eyes to be closed and jaws tied. Body washed and wrapped in a plain white sheet, placed feet towards door. Some request to sit near mortuary. <strong>Holy Day</strong> Friday</td>
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<td><img src="symbol" alt="Mormon Temple" /></td>
<td>Advocate self denial. Active members know how to contact their Bishop. Wear a secret undergarment</td>
<td>Organ transplants accepted but family need counselling</td>
<td>Respect for the special undergarment. Often removed by them before hospitalisation. Can be removed in emergency</td>
<td>Strict health code for tea, coffee or alcohol NO stimulants such as tobacco. Eat meat sparingly. Hot chocolate and chocolate drinks acceptable</td>
<td>Expect visits from members of local church. Anointing, laying on of hands and sacrament (bread and water) may be brought in. Will need ward privacy for service</td>
<td>Burial preferred to cremation. No specific rites but deceased is washed and dressed in shroud. If they have worn secret garment replaced after washing. <strong>Holy Day</strong> Sunday</td>
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<td>Muslim (Islam)</td>
<td><img src="symbol" alt="Islamic Flag" /></td>
<td>They submit to the will of God. Teaching of the Holy Koran, provides guidance, Prayers dawn, noon, mid afternoon, sunset at night – must wash before. Want to face Mecca (SE)</td>
<td>Emphasis on cleanliness. Shower preferred. Bed wash from water poured from a jug Interventions such as organ Transplants should be discussed with family.</td>
<td>Medical staff of any religion is acceptable. Both sexes prefer to be treated by members of the same sex. Some relax fasting at illness</td>
<td>Fasting during Ramadan all healthy over 12. No pork or alcohol. Meat HALAL. Kosher food is acceptable. Vegetarian food and fruit permissible</td>
<td>When dying the face should be turned to face Mecca (South East in UK). A dying Muslim needs to recite or hear (in Arabic) ‘There is no God but The God, and Mohammad is His prophet’. It can be said in English for them. Believe in after life. Life and death is faced in acceptance to Allah’s (God’s) will</td>
<td>Muslim bodies should be kept together is a designated area – men and women separate. Usually man tends a male and woman a female. Body should be laid on a clean surface, covered with a plain cloth with head on right shoulder and facing Mecca. Next of kin arranges funeral, which should take place soon. <strong>Holy day</strong> Friday</td>
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<tr>
<td><strong>Pagan</strong></td>
<td><img src="image" alt="Caduceus" /></td>
<td>No specific obligations. Wear symbolic jewellery that relates to spiritual path</td>
<td>No preferences although alternative treatments are preferred</td>
<td>Pagans are relaxed about medical examinations. Care if jewellery is removed for medical reasons</td>
<td>Most eat meat and accept alcohol. Many are vegetarian and some vegans. Fasts are for personal reasons</td>
<td>Most believe in reincarnation, accept dying as part of the cycle of life.</td>
<td>‘Last rites’ by pagan members to help spirit to go peacefully. Emphasis is on joyfulness for the departed as they pass to a new life</td>
</tr>
<tr>
<td><strong>Special Book</strong></td>
<td><img src="image" alt="Book of Shadows" /></td>
<td>No specific obligations. Wear symbolic jewellery that relates to spiritual path</td>
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<tr>
<td><strong>Rastafarian</strong></td>
<td><img src="image" alt="Hairstyle" /></td>
<td>Hairstyle (dreadlocks) symbol of faith.. Women dress modestly and to not wish to wear clothes by others</td>
<td>NO cutting of hair Smoke marijuana as an aid to meditation</td>
<td>NO pork, pork products or shellfish. Most are vegetarian and do not take stimulants – tea, coffee, alcohol.</td>
<td>Person will want to pray, supported by friends or family. No religious clergy</td>
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<td>A gathering is arranged – and drumming, singing, reading and praises given. <strong>Holy day</strong> some consider Saturday</td>
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<tr>
<td><strong>Book</strong></td>
<td><img src="image" alt="The Holy Piby" /></td>
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<tr>
<td><strong>Sikh</strong></td>
<td><img src="image" alt="Guru Granth Sahib" /></td>
<td>Some prefer Ayurvedic medicine. No to cutting or removing body hair. If necessary retain and give to another Sikh for disposal</td>
<td>Men and women prefer same sex carers. Religion of staff not relevant. All are equal although culture is for female to be subservient in public. Wash in running water</td>
<td>Most are vegetarian or vegans. Forbidden to eat Halal, Kosher or beef. No eggs. The use of alcohol and tobacco forbidden. No specific fasting</td>
<td>Dying person may want access to Sikh scripture. Holy Book Guru Granth Sahib). Service of a Sikh priest if possible (granthi). Believe in reincarnation</td>
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<td>Healthcare staff can do last rites. Family to view before removal to mortuary. Straighten limbs, place arms side of body. 5’Ks to be left on body. Expressing grief discouraged. Cremation of the body <strong>Holy day</strong> Sunday</td>
</tr>
<tr>
<td><strong>Holy Book</strong></td>
<td><img src="image" alt="The Avesta" /></td>
<td>Require 2 items of clothing. A white sacred shirt (Sudreh) and Kushti a sacred cord.</td>
<td>Running water essential. No Post mortem unless a legal requirement. Consult on blood transfusion.</td>
<td>Wash before prayers in privacy/prayer room. Day divided into 5. Some objections to organ donation</td>
<td>Some avoid beef and pork, some vegetarians</td>
<td>They believe corpses are polluting and wish to dispose of bodies as soon as possible, delays need to be explained. Prepared by family or funeral director. Burial or cremation</td>
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</tbody>
</table>

*Authored by Revd Euryl Howells, Senior Chaplain to the Hywel Dda Health Board May, 2011*
Role DETAILS

Role Title: Pastoral Care Volunteer

Hours: TBC

CPG/Corp Dept: Pastoral Care

Base: TBC

ORGANISATIONAL ARRANGEMENTS

Accountable to: Pastoral Care Manager/Pastoral Care Chaplain

Reporting to: Nominated Pastoral Care Chaplain

Role PURPOSE

A Pastoral Care Volunteer in a healthcare context is a trained volunteer who can support the professional pastoral care or Chaplaincy programme in a hospital or other healthcare facility.

They are not trained to assess spiritual needs or to provide high-level pastoral ministry, but rather to work under the direction of professional pastoral care or chaplaincy staff to provide more follow-up, everyday care, where this has been identified as appropriate through an assessment.

- To provide pastoral care to patients, families and significant others.
- To contribute to a supportive atmosphere conducive to spiritual, emotional and physical healing under the supervision of the Pastoral Care Chaplains.
• To identify and refer complex or complicated spiritual needs to Chaplains for follow-up.

Duties and Responsibilities

To carry out the following duties as directed by the Pastoral Care Manager and Pastoral Care Chaplain:

• Provide pastoral presence, spiritual care, befriending to patients, families, significant others in agreed areas of organisation, as directed by the Chaplain.

• Listen to the patient/family/ significant other to identify their needs.

• Respond appropriately to requests for religious/faith-based care and refer on to Chaplains.

• To provide consistency with arranged times of visits, and provide suitable notice of any variation or absence.

• Respect the religious/faith belief system of the patient/visitors/staff/other volunteers.

• If you are aware that a patient’s needs are beyond your capacity to respond at the time, or you have concerns about someone, refer to the Pastoral Care Chaplain or other team members for assistance as soon as possible.

• If you have any immediate concerns about the health of a patient refer to medical staff as soon as possible.

• Ensure identification badge is worn at all times.

• Maintain clear records of pastoral visits (including sign in and out), and communicate effectively with pastoral care team members.

• Observe all rules of privacy and confidentiality, including matters relating to hospital confidentiality in general and patient/family confidentiality in particular.

• Return any patient lists prior to daily departure.

• Participate in in-service training/other and regular supervision sessions.

• Pay attention to care of the self and report to the Chaplain any concerns that may affect care given to others.
GENERAL REQUIREMENTS

This post is subject to the Terms and Conditions within the Volunteer Policy of the Betsi Cadwaladr University Local Health Board.

Competence

You are responsible for limiting your actions to those which you feel competent to undertake. If you have doubts about your competence during the course of your duties, you should immediately speak to your local hospital chaplain or the Pastoral Care Manager.

Registered Health Professional

All volunteers of the Trust who are required to register with a professional body, to enable them to practice within their profession, are required to comply with their code of conduct and requirements of their professional registration. e.g., where applicable, CHCC/AHPCC/UKBHC/SACH code of conducts and lone worker policies.

Supervision

Where the appropriate professional organisation details a requirement in relation to supervision, it is the responsibility of the post holder to ensure compliance with this requirement. If you are in any doubt about the existence of such a requirement speak to the Pastoral Care Manager.

Risk Management

It is a standard element of the role and responsibility of all volunteers of the Local Health Board that they fulfill a proactive role towards the management of risk in all of their actions. This entails the risk assessment of all situations, the taking of appropriate actions and reporting of all incidents, near misses and hazards.

Records Management

As a volunteer of the Local Health Board, you are legally responsible for all records that you gather, create or use as part of your role within the Local Health Board (including patient health, financial, personal and administrative), whether paper based or on computer. All such records are considered public records, and you have a legal duty of confidence to service users (even after a volunteer has left the Local Health Board).

You should consult the Chaplain or the Pastoral Care Manager if you have any doubt as to the correct management of records for which you work.
Health and Safety Requirements

All volunteers have a duty of care for their own personal safety and that of others who may be affected by their acts or omissions. Volunteers are required to co-operate with management to enable the Local Health Board to meet its own legal duties and to report any hazardous situations or defective equipment.

Confidentiality

All volunteers of the Local Health Board are required to maintain confidentiality of members of the public (patients and service users) and members of staff in accordance with Local Health Board policies.

Flexibility Statement

This is a generic role description and therefore should be considered as an outline of the role and functions you are expected to carry out. It is not intended to describe all specific tasks.

This role description is intended to indicate the main areas of work for the post holder and may be subject to periodic review and amendment in the light of service development. Any review will be undertaken in conjunction with the post holder.

Date Prepared: 21.09.12

Prepared By: Wynne Roberts, Jane Marshall and Gary Windon

Agreed By:

Volunteer’s Name and Signature:

Date:

Pastoral Care Manager’s Name and Signature:

Date:

Date Reviewed:
BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD
ROLE DESCRIPTION

Role Title: Pastoral Care Volunteer – Faith Based

Hours: TBC

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Base: TBC

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• To see a patient/family in response to a request from the Chaplains to provide prayer/ritual or other Faith based care as appropriate.

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