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A Training Program For Non-Chaplain and Volunteer Chaplains Conducting Spiritual Care At Feather River Hospital In Paradise, California

Brad B. Brown

Andrews University

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ABSTRACT

A TRAINING PROGRAM FOR NON-CHAPLAINS AND
VOLUNTEER CHAPLAINS CONDUCTING
SPIRITUAL CARE AT FEATHER RIVER
HOSPITAL IN PARADISE,
CALIFORNIA

by

Brad B. Brown

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ABSTRACT OF GRADUATE STUDENT RESEARCH

Project Document

Andrews University

Seventh-day Adventist Theological Seminary

Title: A TRAINING PROGRAM FOR NON-CHAPLAIN AND VOLUNTEER
CHAPLAINS CONDUCTING SPIRITUAL CARE AT FEATHER RIVER
HOSPITAL IN PARADISE, CALIFORNIA

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Problem

Responsibilities of chaplain services at Feather River Hospital (FRH) primarily include completing its mission of whole-person care by providing spiritual and emotional support to the patients and staff. However, the challenge of meeting this goal historically is due to insufficient funding to hire adequate staff chaplains to provide this service. Per conversation with fellow chaplains of other hospitals, this same staffing challenge in meeting the spiritual and emotional component of whole-person care is consistent. However, there is a potential solution. Staff and community volunteers with a spiritual

bent have shown interest in filling this gap of spiritual and emotional support, but proper training is essential to creating a consistent quality of care.

Method

A four-hour Mission Ambassador Training (MAT) was created and presented on three separate occasions, along with two abbreviated MATs for CNAs, between December 2014 and February 2015, for the FRH staff and volunteers. Also, a 30-minute Mission Ambassador Support Group (MASG) was created and implemented monthly from January 2015 through June 2015. The purpose was missional. The training included the learning components of linking theory to practice, fostering both internal and external spiritual and emotional awareness, providing resources, and building a collaborative team with chaplain services. It taught the competencies of roles and responsibilities of a Mission Ambassador volunteer (MA), historical context for spiritual and emotional support in a healthcare environment, recognition and support of spiritual and emotional issues, communication skills, bereavement, and teamwork. The project was evaluated for its diversity in staff participation, and by its participants and the community, using the quarterly National Research Corporation (NRC) survey, Gallup survey, Spiritual Climate survey, FRH standardized program evaluation survey, and the post-MAT support group attendees to determine the effectiveness of both the training and implementation on the staff, patients, and training participants.

Results

Twenty-two students enrolled in MAT: 8 from chaplain services and 14 from a variety of departments. Results from the NRC, Spiritual Climate, and Gallup were inconclusive. Education and Training Program Evaluation respondents and MAT Support Group surveys indicated the training was beneficial. MASG, on the other hand, was not deemed a success due to pragmatic reasons.

Conclusions

This project manuscript establishes that an efficient, accessible, competency-based, and mission-focused MAT for non-chaplain and chaplain volunteers may increase the support of the mission of FRH as well as patient satisfaction. This outcome suggests that extensive employment of this training curriculum could have positive missional impact on the entire Adventist Health organization. It may also have implications for other forms of non-chaplain and volunteer chaplain education.

Andrews University
Seventh-day Adventist Theological Seminary

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CALIFORNIA

A Project Document
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Ministry

by
Brad B. Brown
September 2016

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LIST OF ABBREVIATIONS

ACA: Affordable Care Act

AH: Adventist Health

AVP: Associate Vice President

CEU: Continued Education Unit

CNA: Certified Nurses' Assistant

FICA: Faith, Importance, Community, Assist

FRH: Feather River Hospital

HBOC: Hospital-based Outpatient Clinic

HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems

HIPAA: Health Insurance Portability and Accountability Act

MA: Mission Ambassador

MASG: Mission Ambassador Support Group

MAT: Mission Ambassador Training

NINER: Naming, Identifying, Normalizing, Exploring, Reflecting

NRC: National Research Corporation

PPACA: Patient Protection and Affordability Care Act

RN: Registered Nurse

SBNR: Spiritual But Not Religious

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CHAPTER 1

THE REQUISITE OF MISSION AMBASSADOR TRAINING

Introduction

With greater agitation and frequency today than possibly any other time in the history of healthcare, the focus of much literature, research, discussion, policies, and regulatory compliance has been about the missing link in whole-person care—spirituality. For instance, Puchalski and Ferrell’s (2010) self-describing book, *Making Health Care Whole: Integrating Spirituality into Patient Care*, was surprisingly not written by spiritual caregivers but by a nurse and a physician. In its pages, these healthcare professionals acknowledge the disconnect between the reality of their intimate connection with the spirituality in patients and the lack of expertise “to recognize or respond to spiritual reality, ... Our medical culture often limits the ways that we think, the ways that we see things” (p. xiii).

However, this lack of awareness in the spiritual landscape is changing. In fact, spiritual care in healthcare is a rapidly growing edge for best practice and thousands of dollars each year are spent attempting to capture the success or failure of a healthcare organization in meeting these patient experience standards.

The reason is that studies reveal the correlation between satisfied patients and staff and profitability due to the reimbursement guidelines (Spiegelman, 2012). Also, a

direct correlation has been shown between chaplain visits and patient satisfaction scores, leading to a realization of the benefits of spiritual care (Marin, Sharma, Sosunov, Egorova, Goldstein, & Handzo, 2015). Finally, studies have discovered a link between spiritual care and improved health (Lichter, 2013). These discoveries and more have triggered a recent change in curriculum for nursing and medical schools, resulting in many institutions now offering classes on spiritual care. This first chapter lays the foundation for a ministry project to create a stronger connection and support in a healthcare institution among these physical, emotional and spiritual realities.

Description of the Ministry Context

The context chosen for this ministry project was Feather River Hospital (FRH), a 101-bed acute care hospital, with multiple ancillary facilities, located in Northern California in the town of Paradise. It is part of Adventist Health (AH), a faith-based integrated healthcare delivery system, operated on a not-for-profit status, consisting of regional networks of 20 hospitals in California, Oregon, Washington, and Hawaii. Its headquarters are located in Roseville, California. The values and organizational success of Adventist Health originate from its Seventh-day Adventist Church heritage, which has believed in and taught the importance of prevention and care of the whole person: physical, mental, and spiritual. Adventist Health's mission, "To share God's love by providing physical, mental and spiritual healing," is based on the belief in the shared mission with Jesus Christ of bringing love and healing to its neighbors of all faiths.

FRH offers a wide-range of outpatient departments and services calculated to address the healthcare needs of Paradise and its surrounding communities. The services

range from birth (The Birth Day Place) to death (Paradise Hospice House) and include specialties like a Cancer Center offering state-of-the-art services, an Outpatient Surgery Center providing a variety of surgical procedures, as well as an expanding network of clinics offering a host of specialty services. These services continue to expand to meet the growing needs of healthcare in its community.

The following demographics offer a picture of the community which this hospital serves. The primary care area for the hospital is the town of Paradise with a population of 26,449 as of 2014 (United States Census Bureau, n.d.b.). The secondary care area is Butte County with a population of 224,241 (United States Census Bureau, n.d.a).

The major racial demographic of Butte County, Paradise, and the hospital staff is Caucasian. The town of Paradise reflects an aging population, having twice the state average of 65 and older. Also, Paradise and Butte County have a higher percentage of population living below the state average poverty level. Religiously speaking, most of the county is non-religious. Of those that profess, the largest number of adherents is Catholics (15%), followed by Protestants (10%). These demographics may help to explain why this hospital is one of only two in California which serves a majority of Medicare and low-income patients.

Chaplains have been a part of the whole-person care commitment of FRH for decades. Currently, the Chaplain Services Department offers on-call service 24/7 to the hospital, hospice, and the staff. Our chaplain staff includes two full-time employees, six on-call chaplains, two per diem positions, and 15 volunteer chaplains of various faiths. The hospital is the major employer of the town of Paradise, and, as of the end of 2012, its

staff comprised 1,209 employees, 160 physicians on medical staff, and 442 volunteers.

The author's role as director of chaplain services began in June 2012.

Statement of the Problem

FRH and chaplain services are constantly adjusting to meet the challenge of a changing healthcare environment. Responsibilities of chaplain services include providing spiritual and emotional support to the growing number and diversity of patients and staff at FRH, which require trained individuals to provide appropriate emotional and spiritual support for this diversity. Both financial and personnel deficiencies are major limiting factors to meeting the chaplain needs of FRH. Per conversations with fellow chaplains of sister hospitals, this same challenge in meeting the spiritual and emotional component of whole-person care is consistent. Chaplain Services has not been considered a revenue producing department, and with the Affordable Care Act (ACA) of 2010 (Wikipedia), reimbursement for services provided for FRH's primary patient care population has continued to shrink, causing concern over how many 'more for less' services the hospital can offer. However, due to the ACA including satisfaction standards of reimbursement, chaplain services should be considered as a revenue producing department. At this time, the realization of the financial benefit to the hospital for chaplain services has not translated into dollars and personnel.

Statement of the Task

The task of this project was to develop and implement a training program called Mission Ambassador Training (MAT) for the FRH staff and volunteer chaplains on

conducting spiritual and emotional care for our FRH community. This project was implemented at FRH through the chaplain services department. The project was evaluated for its diversity in staff participation and by its participants, hospital staff, and the community through the National Research Corporation (NRC) survey, the Gallup survey, Spiritual Climate survey, feedback from the FRH standardized Education and Training Program Evaluation, and Mission Ambassador Support Group (MASG) attendees to determine the effectiveness of both the training and implementation on the staff, patients, and training participants. Outcomes will be discussed in chapter 6.

Delimitations of the Project

This project is limited to the staff of FRH in Paradise, California. The participants include only those who voluntarily choose to sign up for this training program. Due to the narrow scope of this project, the reviewed literature was limited to missional church, chaplaincy, non-chaplain and volunteer chaplains, and hospital visitation. Training programs similar to MAT and other seminal works were reviewed as they relate to the creation of a MAT. The assessment tools for determining the effectiveness of this project were limited to those this researcher felt were most appropriate and timely to the scope of MAT.

Description of the Project Process

The project process involved creating a theological foundation, reviewing relevant contemporary literature, consulting with hospitals offering similar training programs, developing and implementing a spiritual care training program and a monthly follow-up

meeting, consulting relevant surveys to determine success of the program, and concluded with an evaluation and report of the results within a selected research methodology and protocol.

A theological foundation for this project includes (a) the Gospel in the New Testament, and the definition of ‘Good News’; (b) the New Testament impetus for evangelism which incorporates The Great Commission in Matthew 28:16-20 and the sheep and goats judgment of Matthew 25:31-46; (c) Christ’s evangelistic methodology, which includes Jesus incarnate, Jesus five-step methodology for evangelism, Jesus’ miracles and teachings, and reflects the compassion of Jesus for the suffering that motivated His healing ministry. Relevant contemporary literature was reviewed on the topics of missional churches, chaplaincy, spiritual care volunteers, and hospital visitation. Older seminal works were also reviewed. Other hospitals involved in similar training programs were consulted for relevant ideas and information.

A four-hour spiritual and emotional care seminar was developed and implemented to train non-chaplain and chaplain volunteers from the FRH staff. The MAT sessions are followed up by a monthly meeting with the trainees for a six-month period to determine the effectiveness of the training session and encourage implementation by the Mission Ambassadors (MAs).

To determine if patients and staff felt their spiritual and emotional needs are being met, the Spiritual Climate survey, the NRC survey, and the Gallup survey are assessed before and after the training; the Education and Training Program Evaluation survey results are reviewed post training. The completion date for this project was June 2015.

Definition of Terms

Hospital-based outpatient clinic (HBOC): “A clinic providing outpatient service” as listed on the hospital’s general acute-care license issued by the State Department of Public Health. The HBOC is a setting in which integrated and accessible primary and specialty healthcare services are provided by clinicians who must address a large majority of personal healthcare needs, develop a sustainable partnership with patients, and practice within the context of family and community. The clinic may be located on or off the main grounds of its hospital, but must be owned and operated by a hospital or system (California Hospital Organization).

Mission Ambassador (MA): Volunteer who has graduated from MAT and has chosen to be a part of the spiritual and emotional care for FRH’s staff, patients, and families.

Spiritual Climate survey: Offered to AH staff every 18 months to understand both the qualitative and quantitative perceptions of spirituality that contribute to a positive ‘spiritual climate’ in the workplace and provide actionable data to develop strategies towards the creation a positive spiritual climate in support of the AH mission. The higher the score, the higher the productivity, performance, emotional intelligence, job satisfaction, organizational commitment and loyalty, safety, team work, enhanced self-care and lower disruptive behavior.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): “A core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS survey items complement the data hospitals currently collect to

support improvements in internal customer services and quality related activities” (HCAHPS).

National Research Corporation (NRC): Primary company used to survey hospitals and is at the forefront of patient-centered care, assisting healthcare providers in measuring, improving quality and services by using “analytics that offer a rich understanding of customers’ experiences, preferences, risks, and behaviors, performing analyses that recognize a provider’s strengths and problem areas, and then uses the data to design specific, measurable improvement strategies” (NRC) to improve their HCAHPS goals which determine a hospital’s Medicare reimbursements.

Gallup surveys deliver analytics and advice to help leaders and organizations solve pressing problems by helping to maximize organizational performance through staff engagement. Gallup introduced the premier tool for measuring and managing staff, the Gallup Q12, which includes 12 actionable workplace elements with proven links to vital performance outcomes (Gallup, 2016).

Patient Protection and Affordable Care Act (PPACA): Commonly called the Affordable Care Act (ACA) or “Obamacare,” a United States federal statute signed into law by President Barack Obama on March 23, 2010. It represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. The ACA was enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and decreasing the overall costs of healthcare for individuals and the government. It introduced a variety of mechanisms—including mandates,

subsidies, and insurance exchanges—meant to increase coverage and affordability. The ACA similarly requires insurance companies to provide coverage for every applicant according to new minimum standards for eligibility and offer equal rates regardless of pre-existing conditions or gender. Further changes intended to lower costs and improve healthcare outcomes by moving the system towards quality over quantity through increased competition, regulation, and incentives to streamline the delivery of healthcare (Wikipedia, n.d.).

CHAPTER 2

A THEOLOGY OF NON-CHAPLAIN AND VOLUNTEER CHAPLAIN SPIRITUAL CARE

“Every religious and humanitarian tradition is grounded in a single idea: Love is about serving the other above the self” (Chapman, 2006, p. xvii). The key note in the proclamation of Christianity throughout the centuries has been grounded in this idea of love as well, and it has been called the gospel. Christians have left family and country, crossed land and sea, faced persecution and even death, to share the gospel. Some received a wage for their efforts, but many voluntarily gave of their time, means, and even their lives to share it. The gospel encompasses the redemptive activity of the Godhead on behalf of lost mankind through the life, death and resurrection of Jesus Christ. On acceptance of the gospel, converts are commissioned to share it, thus repeating the cycle. A theology of volunteer hospital spiritual care ministry is a natural part of this cycle of the proclamation of the gospel.

Chapter 2 will explore the following theological concepts as they relate to providing emotional and spiritual support to patients. First, the meaning of εὐαγγέλιον in the New Testament as the impetus for hospital spiritual care ministry will be explored. Second, a review of key New Testament rationale for evangelism will be analyzed.

Finally, Christ's methodology for evangelism as seen in His ministry on earth and set forth as an example for all Christians throughout the ages will be reviewed.

The Gospel in the New Testament

The gospel is the paramount message of the Bible and Christianity. John the Baptist preached the gospel (Matt 3:7-12). Jesus inaugurated His ministry with the proclamation that He had come to proclaim the gospel (Luke 4:18). Jesus taught repentance and conversion as an obligation of the recipients of the gospel (Matt 4:17; Mark 1:15). Christ communicated to His disciples the necessity and urgency of sharing the gospel to the entire planet (Matt 24:14; Mark 16:15). With all this agitation about the gospel, it begs the question of explaining the meaning of the gospel and why the obligation for its adherence to proclaim it to the world.

Εὐαγγέλιον: Good News

The Greek noun εὐαγγέλιον is a compound word, consisting of εὖ, "good," and ἀγγέλιον, "message," translated as "good news" or "the gospel." Originally this word meant a reward offered for good news brought by a messenger. Over time this word morphed to mean the content of the message brought. This word occurs in the Septuagint, with both the meaning of good news (2 Sam 18:20, 25, 27; 2 Kgs 7:9) and the classical definition of the reward offered for good news (2 Sam 4:10; 18:22). Adam and Eve originally in the Garden of Eden after sin were entrusted with the gospel by God (Gen 3:15). A few generations later, Abram also was entrusted with this message (Gen 12:3). The gospel message was continually expounded upon by subsequent Old Testament

writers, notably Isaiah (Isa 49, 60-62). Not surprisingly, Jesus Himself cites Isaiah 61:1, 2, in His hometown of Nazareth, during His Messiahship admission (Luke 4:18, 19). It should be dually noted, God does not change (Mal 3:6; Heb 13:8), and, by implication, the gospel in the Old Testament is not to be juxtaposed against the New Testament, as if God had somehow altered His method of dealing with humanity, but, in contrast, is the realization of God's original promise in the Old Testament to Adam and Eve (Matt 11:25).

The appearance of εὐαγγέλιον in the New Testament occurs 76 times in various noun forms. It is employed by both Jesus and the New Testament writers and bears a variety of meanings associated with the salvation made available through the life, death, and resurrection of Jesus Christ. It should be noted there are only two occurrences in the New Testament of the usage of this word which fall outside of this salvific meaning (Gal 1:6; 2 Cor 11:4). Even with its varied usage, a number of prevailing themes appear. The most common of these themes, as might be expected, is the gospel of Jesus Christ. This phrase or a close variant appears 16 times, mainly in the Pauline writings, revealing the principal theme of this message to Paul and by extension the entire New Testament (Mark 1:1; Rom 1:9, 16, 15:19, 29; 1 Cor 9:12, 18; 2 Cor 2:12, 4:4, 9:13, 10:14; Gal 1:7, Phil 1:27, 28; 1 Thess 3:2; 2 Thess 1:8). Mark also uses this phrase, the gospel of Jesus Christ, as the theme of his entire gospel in Mark 1:1 when he writes, "the beginning of the gospel of Jesus Christ, the Son of God, as it is written in the Prophets." This Christocentric gospel theme is perceived as so paramount that, if accepted, results in salvation (Rom 1:16), and, if rejected, eternal loss (2 Thess 1:8). White (1898) concurs

with this eternal gospel significance of salvation or damnation, based on acceptance or rejection, which Paul and Mark emphasize, when she writes,

Since the first gospel sermon was preached, when in Eden it was declared that the seed of the woman should bruise the serpent's head, Christ had been uplifted as the way, the truth, and the life. He was the way when Adam lived, when Abel presented to God the blood of the slain lamb, representing the blood of the Redeemer. Christ was the way by which patriarchs and prophets were saved. He is the way by which alone we can have access to God. (p. 664)

Another significant gospel theme in the New Testament is the gospel of the kingdom. All four occurrences are recorded in Matthew and Mark. Matthew uniquely connects healing with the gospel of the kingdom when he chronicles Jesus' travels around Galilee and all the cities and villages, teaching and preaching the gospel of the kingdom and healing sickness and disease (Matt 4:23, 9:35). Considering this connection to healing, it may not be so surprising to also discover Matthew's connection between the gospel message being preached to the entire world and the end of the world, a time of complete healing (Matt 24:14). Finally, Mark highlights this connective thread between the preaching of the gospel of the kingdom, the second advent of Christ, the stipulation of repentance, and faith in the gospel (Mark 1:14, 15).

The gospel of God is referenced seven times in the New Testament, six in the writings of Paul, and a single occurrence in Peter's epistle. Paul also calls the gospel of God the glorious gospel of the blessed God (1 Tim 1:11). The gospel of God perceived to be a holy calling (Rom 1:1), one to be ministered with sacredness (Rom 15:16; 1 Thess 2:8-9). Paul contends that the gospel of God is worth boldly proclaiming, even under much conflict (1 Thess 2:2). Peter connects judgment to the gospel for the believer and

the unbeliever by causing one to consider what judgment looks like for the obedient and disobedient (1 Pet 4:17).

The truth of the gospel for Paul is another key theme (Gal 2:5; Col 1:5), and Paul appeals to followers of Christ to live in such a manner the gospel of truth is not conflicted (Gal 2:14).

The word εὐαγγέλιον appears in reference to the gospel of peace (Eph 6:15), the mystery of the gospel (Eph 6:19), the fellowship in the gospel (Phil 1:5), the hope of the gospel (Col 1:23), the gospel of your salvation (Eph 1:13), and the gospel of the grace of God (Acts 20:24). In Revelation, John describes the gospel as the everlasting gospel to preach to those who dwell on the earth, which includes fearing God, giving glory to Him, and worshiping Him because judgment hour as has come (Rev 14:6).

Many have debated the meaning of Paul's statement calling the gospel "my gospel" (Rom 2:16, 16:25; 2 Tim 2:8, 9) and "our gospel" (2 Cor 4:3, 2 Cor 8:18; 1 Thess 1:5; 2 Thess 2:14). But this apparent confusion as to whose gospel Paul has been preaching can be cleared up by realizing Paul's source is not according to man, but came through the revelation of Jesus Christ (Gal 1:11, 12) and that he was approved by God to be entrusted with the gospel (1 Thess 2:4). Here, Paul is not preaching a different gospel, but instead is a recipient of a gospel from Jesus Christ and a conduit of its proclamation, closely aligning him with the gospel of Christ.

The significance of Christians preaching the εὐαγγέλιον to the world cannot be undervalued (Matt 26:13; Mark 13:10, 16:15; Gal 2:2). Luke and Paul explicitly affirm the importance of the gospel message reaching Jews and Gentiles (Acts 15:17; Gal 2:7).

Paul goes so far as to insist the Gentiles are fellow heirs and partakers of the promises of Christ (Eph 3:6). He sees every believer as commissioned to preach the gospel, but as a realist, he warns of sufferings associated with this gospel commission (2 Tim 1:8; Phil 1:12; Phlm 13). Paul names certain people or groups who have been part of his gospel ministry (Phil 2:22; 2 Cor 11:4) and instructs that the gospel ministers are to be materially supported for their spiritual work (1 Cor 9:14).

Paul predicts that some will refuse to obey the gospel (Rom 10:16; 2 Cor 4:4) and accepting and obeying will generate enemies (Rom 11:28). Nonetheless, Paul acknowledges recent converts begotten through the gospel (1 Cor 4:15) and brings to mind the end result of faith, the salvation which is theirs by holding fast to the gospel preached to them (1 Cor 15:1-3).

What compelled these disciples to leave the comfort of their homes and preach the gospel to the world? What gave a sense of urgency to their message? Whatever motivated the disciples should be the same impetus for volunteer hospital spiritual care ministry.

New Testament Impetus for Evangelism

There are different theological reasons Christ came to this earth. One of the most commonly accepted reasons is salvation. In the context of salvation, Christ tells us in Luke 19:10 that the Son of Man has come to seek and to save that which was lost, and that the lost or wicked go away into everlasting punishment, but the righteous into eternal life (Matt 25:46). The Great Commission and the judgment of Matthew 25:31-46 provide

the impetus and directive for gospel proclamation for all those who follow Christ, including volunteer hospital spiritual care ministry.

The Great Commission

After Christ's death and resurrection, but prior to His ascension, Christ revealed Himself to His disciples in Galilee and bequeathed to them their final directive, commonly identified in Christianity as the Great Commission. He told them in Matthew 28:18-20 that

all authority has been given to Me in heaven and on earth. Go therefore and make disciples of all the nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, teaching them to observe all things that I have commanded you; and lo, I am with you always, even to the end of the age.

The phrase, the Great Commission, commonly used in Christianity, is not found in Scripture and has been uniquely associated with Matthew 28:16-20. It is also related to Luke 24:36-49, John 20:19-23, Acts 1:6-11, and Mark 16:14-20.

In the Great Commission of Matthew 28:16-20, English translations have normally placed the emphasis of the commission on the word "go." However, this emphasis has been incorrectly placed. Instead, Matthew emphasizes μαθητεύσατε, an imperative verb in its plural form, literally translated as "make disciples" or "disciple." The image of making disciples is of pupils patterning their life after the life and teachings of their teacher. Although Matthew places a greater emphasis on discipleship, baptizing, preaching, and going are necessary compassionate Christocentric gospel approaches.

Although the Great Commission of Matthew 28 is commonly recognized as the magnum opus, all four gospels carry a form of this commission. Though each version

varies, these other accounts record a similar encounter with Jesus and His disciples after the resurrection. In each instance, Jesus sends out His followers with specific directives. He uses commands such as go, teach, baptize, forgive, and make disciples.

The commission in Mark 16:14-20 includes a responsibility to preach the gospel to every creature. Luke, on the other hand, places a slightly different emphasis by focusing on the importance of preaching in Jerusalem before going to the world to fulfill the purpose of God in the Old Testament. Luke places as much meaning on this as the importance of Christ to suffer and to rise from the dead (Luke 24:46-48). John, on the other hand, makes known the progression of the commission by repeating Christ's words passed down from the Father to Christ to those commissioned, as the Father has sent Me, I also send you (John 20:21). The reception of the Holy Spirit acquaints us as to the source of power for this great mission, and the mention of forgiveness of sins focuses on the existential experience the gospel offers to meet the needs of sinful humanity (John 20:21-23). The territory to be evangelized with the gospel is surprisingly explicit in Acts 1:8. Everything recorded in Scripture bares significance, including the locations Luke mentioned. For instance, Jerusalem is the site of the crucifixion, implying a need for a gospel of forgiveness and salvation. Samaria, on the other hand, was the last place a Jew would consider as gospel territory because of the Samaritans' lack of worth. But Christ did not view worth in the same way as the Jews did; His message was for the whole world, including Samaria. Finally, in Christ's commission to the disciples to take the gospel to the ends of the earth, He opened the field of evangelism to include all forms of idol worship, pagan beliefs and practices, and immorality.

White (1898) notes,

In the commission to His disciples, Christ not only outlined their work, but gave them their message. Teach the people, He said, ‘to observe all things whatsoever I have commanded you.’ The disciples were to teach what Christ had taught. That which He had spoken, not only in person, but through all the prophets and teachers of the Old Testament, is here included. Human teaching is shut out ... the gospel is to be presented, not as a lifeless theory, but as a living force to change the life. God desires that the receivers of His grace shall be witnesses to its power. (p. 826)

The commission by Christ to preach the gospel to the ends of the earth applies especially to volunteer hospital spiritual care ministry. Mack (2003) marks the strong connection between volunteer hospital chaplain ministry and the commission to preach the gospel to everyone when he pens that hospital spiritual care ministers “to people of different races, sexual orientation, religion, economic background, social class, age, etc.” (p. ix).

Now that Christ provided a comprehensive commission to His disciples with specific details outlining their mission, the question remains, Are there New Testament consequences for either accepting or rejecting Christ’s commission?

Sheep and Goats Judgment

One of the most specific lists of Christian duty in the New Testament is found in the context of judgment. In Matthew 25:31-46, Christ portrays in detail to the disciples the impending judgment to occur at His Second Coming (Matt 25:31). Christ clarifies the parties involved in this judgment (Matt 25:32), which are symbolized by sheep and goats. Because both sheep and goats are clean animals (Lev 11) and used for temple sacrifices (Lev 23:18-19), Christ is revealing to His disciples the judgment at the Second Coming is for Israel or people of God. All who declare to be a Christ follower will be examined in this judgment to determine whether or not their works justify their claim (Matt 25:35-36,

42-43). This standard for judgment is a list of works, which include providing food for the hungry, water for the thirsty, housing for the stranger, clothing for the naked, and visitation to the sick and imprisoned (Matt 25:35-36, 42-43). These Christian obligations, if met, are credited by Christ as personally performed to Him. However, if unfulfilled, this inaction is credited as a personal rejection of Christ (Matt 25:40, 45). It is permissible for the defendants to contend with the Judge or Christ regarding the verdict (Matt 25:37-39, 44). The final verdict from this court case (this issue has eternal consequences (Matt 25:34, 42, 46). The verdict of not guilty results in heaven for the sheep having met Christ's standard. The verdict of guilty results in the sentence of everlasting punishment for the goats because of their failure to attain Christ's standard. The underlying issue involved in the goats' verdict of everlasting punishment is their failure to keep God's law, which, in reality, was a physical manifestation of their failure to love God and mankind. Matthew confirms this conclusion when he states that the ten commandments are summed up in two commandments, love God with all your heart and love your neighbor as yourself (Matt 22:37-39). Bonhoeffer (1954) asserts that this love for God is revealed through the ministries of hearing, helping, bearing, and proclaiming to our mankind (pp. 97-108). In other words, Bonhoeffer affirms that actions toward others reveal whether or not hearts are filled with love for God and humanity. Mack (2003) makes the connection between the revelation of God's love through actions and hospital spiritual care when he writes "the hospital chaplain must come into the presence of all patients as a channel of God's love and comfort" (p. ix).

To discover what can be done to fulfill the Great Commission and be found among the righteous at the sheep and goats judgment, it is important to understand and follow Christ's evangelistic methodology. Bonhoeffer's (2009) reminder is in line with the high calling of the gospel when he writes, "The church is the presence of Christ in the same way that Christ is the presence of God" (p. 138). Since Christ is the perfect example in all things (1 Pet 2:21-25), what can His followers learn from Christ's miracles and teachings as an example for them?

Christ's Evangelistic Methodology

To be a Christian is commonly understood to be a Christ follower. To follow Christ implies an understanding of what Christ is like. This is why Luke includes both Jesus' actions and teachings as important (Acts 1:1). Those who were His disciples while He was here on earth followed Him wherever He went. As was mentioned earlier, this is a shared journey between a teacher and pupil (Luke 10:38-42). This role does not necessitate ease. In fact, Christ Himself places a high standard on discipleship because it requires self-denial and a cross (Matt 16:24; Mark 8:34; Luke 9:23). What was Christ's methodology for evangelism?

As the anatomy and physiology professor would repeat to her students lost in the intricate details of the human body, "Don't forget the big picture!" To keep from being lost in the details of Christ's methodology for evangelism, the first focus will be on the big picture—the incarnation. Next, Christ's methods, acts or miracles, and teachings will be reviewed.

Jesus Incarnate

John writes “and the Word became flesh and dwelt among us, and we beheld His glory ... full of grace and truth” (John 1:14). He describes the methodology God used when coming from heaven to earth—He became one of us with us. God is a personal God. People could see Him, hear Him, and touch Him (John 1:29; Mark 12:37; Luke 8:46). White (1952) submits that one of the main reasons Christ came is to reveal this ideal as the only true standard for attainment; to show what every human being might become; what, through the indwelling of humanity by divinity, all who received Him would become—for this, Christ came to the world. He came to show how men are to be trained as befits the sons of God; how, on earth, they are to practice the principles and to live the life of heaven (p. 73).

White (1905) emphasizes the need to follow Christ’s incarnational example when she pens, “there is need of coming close to the people by personal effort” (p. 143). Hospital spiritual care is ripe with opportunities for coming close to people in their vulnerability and time of need.

Now that the incarnational import for a revelation of God’s character has been established as an example to follow for reaching humanity, Christ’s specific methodology will be reviewed.

Jesus’ Five-step Methodology for Evangelism

Probably the most comprehensive step-by-step process for evangelism states, Christ’s method alone will give true success in reaching the people. The Saviour mingled with men as one who desired their good. He showed His sympathy for them,

ministered to their needs, and won their confidence. Then He bade them, ‘Follow Me.’ (White, 1905, p. 143)

This statement encapsulates the methodology used by Jesus in His ministry to humanity.

The first step Christ commonly used in touching humanity was the ministry of mingling. Christ mingled with all classes of people in various situations (Matt 2:15; John 4:7-42; John 12:1-11) due to His impartial nature (Acts 10:34). This principle is also true for hospital spiritual caregivers. Kirkwood (2005) maintains the “one area where all must be treated on equal terms is in the healthcare field” (p. 2). Jesus Christ was purposeful in whatever He did, wherever He went, and with whom He mingled (John 4:34; John 6:38; Luke 19:10).

The second step or method Christ commonly used in touching humanity was sympathy. His mingling provided abundant opportunity for a personal revelation of His love for and interest in the welfare of people. Sympathy for Christ meant shared feelings or emotions. This included a wide range of emotions from weeping with those who weep to rejoicing with those who rejoice (1 Pet 2:24; Isa 53:4-5; Rom 12:15; John 11:35; Luke 7:11-17; Matt 9:36). Mack (2003) defines the function of hospital spiritual care ministry as one which provides spiritual counsel and emotional support to patients in all situations, and which often fills the role of a trusted friend or pastor to those without spiritual support. This role provides countless opportunities to journey with patients in their joy and pain (p. 25).

The third step frequently used by Christ was ministering to people’s needs. Paul writes, “And my God shall supply all your need according to His riches in glory by Christ Jesus” (Phil 4:19). Jesus came to minister to all the needs of humanity. It was not enough

for Christ to have compassion from afar. Christ acted on the needs He saw, with attendance to physical needs being the most prevalent. Christ spent more time on earth healing people than preaching the gospel. He healed people's infirmities (Matt 8:14-15; Luke 7:1-10; Matt 9:27-31, 5) and cared for their basic necessities (Matt 14:13-21; Matt 15:30-38). Christ also addressed the emotional and spiritual needs for love, acceptance, and forgiveness (John 4:4-26; Luke 7:36-50), which Plummer (2012) is convinced is the same role of hospital chaplaincy to offer 'a glimpse—and maybe more—of the relief that comes with forgiveness and grace' (p. 15). Following on from the last point, just as it was not enough for Jesus to have compassion from afar, His followers also must act to meet the needs of humanity.

White (1905) writes,

There is need of coming close to the people by personal effort. If less time were given to sermonizing, and more time were spent in personal ministry, greater results would be seen. The poor are to be relieved, the sick cared for, the sorrowing and the bereaved comforted, the ignorant instructed, the inexperienced counseled. We are to weep with those that weep, and rejoice with those that rejoice. Accompanied by the power of persuasion, the power of prayer, the power of the love of God, this work will not, cannot, be without fruit. (pp. 143-144)

The fourth step in Christ's process of reaching people was to win their confidence. Having confidence in someone requires faith or belief that that individual will act in a right, proper, or effective way. It is built on a relationship of trust or intimacy. It involves consistency through both words and actions. The way Christ won confidence was through the following steps already mentioned. He mingled with people, showed His sympathy for them, and ministered to their needs (Matt 4:23; Mark 1:32; Luke 4:40). Christ's actions revealed His heart of concern for their welfare. As a result,

people followed Him wherever He went (Mark 5:24; John 6:2). Kirkwood (2005) affirms that in chaplaincy the socio-religious needs of the patients should be addressed in a non-embarrassing way, as Christ did, demonstrating concern for the patient welfare while maintaining their trust (p. 2).

The final step in Christ's methodology for ministering to people was to call them to follow Him. The New Testament contains abundant examples of Christ's calling people. Jesus calls the little children to Him (Luke 18:16). Matthew mentions the calling of the disciples: "Follow Me, and I will make you fishers of men" (Matt 4:19). Christ invites all to come to Him (Matt 11:28-30). Christ clarifies what is involved in following Him: "If anyone desires to come after Me, let him deny himself, take up his cross daily, and follow Me" (Luke 9:23). Christ's calling is based on His mission: "For the Son of Man has come to seek and to save that which was lost" (Luke 19:10). Once confidence is gained, people are more receptive to follow the individual or instruction presented. The Holy Spirit is intimately involved in this process (John 16:8-14), convicting and prompting in thoughts and words. Mack (2003) describes the hospital chaplaincy role not as that of an evangelist in the common sense, but in the unique role of seeking to find where God is already working in the life of the patient and to be aware when the patient is ready to accept Christ (p. 23).

Jesus' Miracles

The miracles reviewed in this section are the supernatural activities Jesus performed during His ministry on this earth and recorded by the Gospel writers.

Buswell (1962) further defines biblical miracles as (a) extraordinary events, unexplainable in terms of ordinary natural forces; (b) events which cause the observers to postulate a super-human personal cause; and (c) an event which constitutes evidence or a sign of implications much greater than the event itself (p. 176).

It has been suggested by Van der Loos (1965) that Jesus miracles can be summarized into two primary categories: those affecting people and nature (pp. ix-xii). The category of miracles that affect people include miracles of healing or cures, miracles of exorcism, and miracles of resurrection.

The Bible writers emphasize the fact that the miracles of Jesus convey three essential messages about Him. First, they publicize that Jesus of Nazareth is approved by God by the miracles and wonders and signs He performed (Acts 2:22). Second, they witness that He was the expected One—the Messiah (Matt 11:2-6). Third, miracles carry a testimonial purpose with the intent people will believe that Jesus is the Christ, the Son of God, and, by believing, have life through His name (John 20:30-31).

A select number of Jesus miracles will be analyzed for their meaning and content according to the four following categories; miracles of healing or cure, resurrection miracles, miracles of exorcism, and nature miracles.

The first category is miracles of healing or cure. There are two types of healing miracles in the New Testament, physical healing (Matt 4:24, 10:8; Luke 5:17; John 4:47) and spiritual healing (Heb 12:3). The two primary Greek words for healing used in reference to Jesus miracles are *θεραπεύω* and *ἰάομαι*. In most instances when Christ healed someone, there was an implicit demand for faith to be exercised by the sufferer

(Matt 9:29; Mark 10:52; Luke 17:19), although exceptions exist (John 5:1-9). It is significant to remember Christ's healings or cures were never depicted as ordinary wonders; each one carried a meaning and a message. All the gospels are rooted in compassion and the apostle John establishes that the miracles are really signs (John 4:48). Not only is Jesus' healing ministry continued on through His apostles, but Paul considers this ministry part of the spiritual gifts bestowed by the Holy Spirit (1 Cor 12:9, 28, 30). A connection is also found in the entire Scriptures between the physical and spiritual meaning found in these healing acts (Num 12:1-15; John 12:40; 1 Pet 2:24).

The healing miracles of Jesus were directed toward the commonplace sickness and disease of the Middle Eastern town or village. The types of disease and sickness included blindness, deafness, dumbness, muteness, withered limbs, paralysis, and leprosy (John 4:43-54; Mark 1:40-45; Matt 9:1-8; Luke 6:6-11; Luke 5:25-34; Matt 9:27-31). Because Jesus' miracles carried both a theological and evangelistic message, Jesus' miracles of healing, sickness and sin are connected (Mark 2:17). Because of the uniformity in teaching in the Old and New Testament, this same message is found in the Old Testament (Isa 35:3-10). White (1898) writes that Jesus "taught that disease is the result of violating God's laws, both natural and spiritual. The great misery in the world would not exist did men but live in harmony with the Creator's plan" (p. 824).

In the miracle of healing Jesus performed on the paralyzed man (Mark 2:3-12), healing and forgiveness of sin are interchanged by Jesus, once again emphasizing the close association between sickness, sin, and restoration. Prior to the healing of the paralytic recorded in Matthew 9:1-8, Christ drew the man to Himself by His Spirit,

forgave his sins, providing him with a new life, and then healed him of his self-inflicted infirmity. The evangelistic message from this healing miracle is of Jesus' love and longing to restore the sinner completely, even while the sinner dwells in an unforgiven state.

The gospel of Mark records a tragic story of a woman unsuccessfully seeking healing from the physicians of her day from a chronic internal bleed for 12 years. Her life markedly changes when, by faith, she reaches out and touches Jesus' garments (Mark 5:25-34). The message of hope in this faith healing story is that reaching out to Jesus can bring both physical and spiritual healing. In the miracle story of the restoring of sight to a blind man named Bartimaeus from Jericho (Mark 10:46-52), the recipient throws off his garment and follows the call of the Great Physician. The gospel message is that if all who come to Jesus leave off their old coat or character, their eyes too will be opened, and they also can follow Jesus. Knowing Jesus for who He truly is brings forth a response of love.

The second category is resurrection miracles. The central message of resurrection miracles derives from their close connection between sickness and sin, asserting no matter how pervasive these may be, the power of Jesus can heal, forgive, and restore. The widow of Nain's son's resurrection (Luke 7:11-17) is the story of a mother who loved and needed her only son. This particular resurrection message is one of hope in a hopeless situation. It teaches that when Satan has apparently shattered all support, Jesus often is waiting to restore it. The needs of humanity are not beyond the notice or care of Jesus. The resurrection of Lazarus (John 11:1-45) is a portrayal of God that, for some, is uncomfortable because of the delay in Christ's response to the obvious need. The

message is that when what is lost seems beyond hope to have greater faith—in Whom to believe is to have eternal life (John 6:47). In the resurrection of the daughter of Jarius, a synagogue ruler (Mark 5:21-24, 35-43), is found a father with a hurting heart. Jarius loved his daughter, but unlike the Widow of Nain, she was not necessary for his financial survival. The resurrection of this girl by Jesus reminds us that God cares when hearts are broken and full of sadness.

The third category is miracles of exorcism or casting out demons. The dissimilarity found in this category of miracles is because Jesus is not dealing with the effects of sin but is in direct conflict with the supernatural world of evil. By performing these exorcisms, Jesus demonstrates a power greater than those who cause sin and misery. Miracles of exorcism point to the ultimate eradication of evil (1 Cor 15:24) as a result of Jesus' life, death, and resurrection.

Jesus commissioned His disciples to preach the gospel and cast out demons (Matt 10:8), presenting the intimate connection between both. In the miracle of Christ's exorcism of the demon-possessed man in the synagogue, the people in that community learned of the power of Jesus to heal and restore, and all the city came to Him for help and healing (Mark 1:21-39). The moral of this miracle is that when Jesus heals someone from sin, it is an invitation to everyone who hears of His power to come to Him and receive help and healing. In the miracle of Jesus healing the demon-possessed son (Mark 9:14-29) is taught the personal responsibility in having Satan cast out from someone's life and that the responsibility cannot be reassigned to God. Individually there is a part to play: just like it was necessary for the father to believe for his son's healing, it is true that

for anyone to have Satan exorcised from his or her life, trust and belief in Christ is a prerequisite (Heb 11:6).

The last category of miracles focuses on the natural world. Initially, what stands out about nature miracles is the reactionary effect they have on people: ““Who can this be, that even the winds and the sea obey Him?”” (Mark 4:35-41). The symbolic message hidden in this calming-of-the-storm miracle is that Jesus is with His people, the church, and, seemingly, His presence is not beneficial until one asks for help, at which point He stands up and calms the storms around them. Peace is offered as the blessing to all who ask and seek (Matt 7:7). Jesus shows His power over nature in the multiplication of food on different occasions for large crowds who had gathered and were hungry. The gospel message in these nature miracles is a self-revelation that Jesus alone is the source of all life—He is the bread of life (Mark 8:1-10; John 6:26-59). The miracle of Jesus walking on the water teaches that Jesus and His followers have victory over evil (Matt 14:22-33, Hilgert, 1966).

Jesus’ miracles demonstrate His power over sickness, death, demons, and nature. The gospel is in every miracle of Jesus and offers a global evangelistic invitation to come to Jesus, the supreme problem solver (Matt 11:28-30). Spiritual care ministries offer this same gospel message to come, see, and receive the good news of restoration, healing, forgiveness, hope, and new life.

Jesus’ Teachings

A study of Jesus’ life shows that He taught in a simple, clear language that demonstrated sympathy, tenderness, and earnestness. His illustrations were situational

and the associations familiar. Jesus showed respect for and ministered to all classes of people, presenting a best practice for life. Plummer (2012) asserts this approach is true for hospital spiritual care ministry, states it should “only want to see their clients whole and healthy—body, soul and spirit” (p. 15). Following are Jesus’ styles of teaching.

Jesus most frequently employed style of teaching was stories or parables. This frequency speaks to their importance and effectiveness. He chose this style for many reasons: difficult things are made understandable, ease of remembrance, a common medium of teaching, and as such were familiar to audiences, provided the freedom to teach controversial topics (Matt 18:12-14; 25:14-29; Luke 10:30-37), they fulfilled the Old Testament prophecy regarding Jesus (Ps 78:2; Matt 13:34-5), and provided a medium from which deeper study and understanding could be obtained (Mark 4:11-12).

White (1900) adds to this list:

In Christ’s parable teaching the same principle is seen as in His own mission to the world. That we might become acquainted with His divine character and life...men could learn of the unknown through the known; heavenly things were revealed through the earthly; God was made manifest in the likeness of men. So it was in Christ’s teaching: the unknown was illustrated by the known; divine truths by earthly things with which the people were most familiar. (p.17)

Another of Jesus’ teaching styles is the use of sermons or homilies. The Sermon on the Mount (Matt 5-7) is the quintessential example of all Jesus’ sermons. This sermon teaches the requirements for membership in the kingdom of heaven and how and what to pray for when addressing the Father (Matt 6:9-13; John 17). Jesus also taught using the method of discussion. An example is the young lawyer who came to Jesus to ask what he must do to obtain eternal life. Jesus countered with His own question (Luke 10:25-29), ultimately leading the questioner to deeper understandings of his own heart. Jesus

employed personal interviews. Some of Jesus' greatest truths were imparted during these private sessions. For example, the night interview with Nicodemus (John 3:1-21) contains profound teachings about the necessity of a new birth for salvation and the role of the Holy Spirit. The personal interview with the Samaritan woman at Jacob's well (John 4:6-26) exemplifies the power of personal evangelism. One encounter with Jesus resulted in an entire village flocking to hear Him speak, and for many, becoming Christ followers.

Jesus was also personable and used association to teach His disciples and friends. An example of this style of teaching is at the home of Martha (Luke 10:38-42). Jesus knew the value of practical experience and employed it as a method to teach His followers, sending them out on missionary journeys (Mark 6:7-13; Luke 10:1-24). Finally, Jesus taught by example or modeling. The close connection between Christ and His disciples for three and a half years allowed them to intimately study His life. Finally, Jesus challenges disciples of all times to do as He has done for them (John 13:1-15). As in the ministry of Jesus, hospital spiritual care ministry is also challenged to use varied methods of communication to meet the needs of individual patients. Mack (2003) mentions some of these same mediums when he stresses "to make your visits more effective and meaningful, you should collect, prepare, and properly use things such as Scripture verses, quotes, poems, and stories" (p. 24).

Summary and Conclusions

A development of a theology for non-chaplain and volunteer chaplain spiritual care ministry involves a review of the gospel in the New Testament, the impetus for proclamation of the gospel, and Christ, our great Example's methodology for gospel

proclamation. From this examination, principles were discovered from which a development of a theology and methodology for volunteer chaplain ministry has evolved with the potential of fulfilling Christ's prophetic declaration in John 14:12 that His followers will do even greater things than He did.

A theology of volunteer hospital spiritual care ministry has been developed through an exploration of the word εὐαγγέλιον or gospel in the New Testament, examining the impetus for evangelism as revealed through the Great Commission and the sheep and goats judgment of Matthew 25:31-46, and examining Christ's personal methods for reaching humanity with His gospel. It has been discovered that εὐαγγέλιον, or gospel, with its varied themes, is to be proclaimed to the world by Christ's disciples, resulting in salvation to those who accept it and damnation to those who reject it. Because of these eternal consequences, Christ's commission is for His disciples throughout history; the breadth of the proclamation is worldwide. Christ's methods for proclaiming this gospel are provided as an example for His disciples to follow, including the importance of incarnational ministry. Christ mingled with people, showing sympathy for their situations. He ministered to their varied needs, resulting in confidence in Him. Finally, Christ called them to follow Him and reciprocate for what He had done for them. Christ's acts or miracles and His teachings provide His disciples specific examples and messages for proclaiming the gospel to the world. Binkewicz (2005) summarizes the work of hospital spiritual care ministry when he writes they

must be aware of any change. With eyes wide open and ears attentive to the voices of our patients, we sit silently, watching for the sign or signal that a patient is ready to discuss an important spiritual issue. If we approach them with our own agenda or seek our own will, we will fail on all levels. (p. 21)

Principles Applied to Volunteer Chaplain Ministry

The development and implementation of a more robust non-chaplain and volunteer chaplain ministry will be expanded in Chapter 4. The program will include recruiting and training additional volunteer hospital chaplains to provide a more diverse and specialized ministry for Feather River Hospital. The challenges to creating this ministry include the diversity of religious, social and spiritual backgrounds of the volunteer hospital chaplains, and the challenge of training this diverse group in Christ's methodology for ministering to the diversity of patients in our hospital. The results of this ministry will be a continuation of the calling Christ gave to His followers throughout the ages to fulfill the Great Commission.

CHAPTER 3

REVIEW OF LITERATURE RELATING TO THE MISSION AMBASSADOR TRAINING

Literature directly relating to Mission Ambassador Training (MAT) is limited. However, literature relating to the broader milieu of missional church, chaplaincy, spiritual care volunteers, and hospital visitation which can inform a curriculum for MAT is more readily available. A comprehensive literature review of each of these related themes would be unproductive and beyond the scope of this paper. However, each of these themes will be surveyed for content relating directly to a creation of a MAT curriculum. The preceding chapter articulates a theological foundation for the creation of a MAT through an understanding of the gospel, the commissioning by Christ to His followers, and through His exemplification of evangelism in His own ministry. While the following review of literature addresses these foundational subjects in a cursory way, its emphasis is on literature more directly relating to MAT curriculum. The literature considered for this project are those published between 2002 and 2012, with the occasional exception of a work considered extraordinarily valuable to this study, such as selected relevant dissertations and older seminal works.

The following categories form the heart of the literature reviewed. First, the foundational ideological concept of missional church offers a paradigm for a creative,

adaptive ministry amidst a changing landscape. Second, chaplaincy or spiritual care literature provides an understanding of the historical and contextual purpose, while offering a beacon for MAT. Third, works on spiritual care volunteers reveal components of effective training programs applicable to MAT curriculum. Fourth, writings on hospital visitation afford methodological comparisons for practical training.

This review assumes the principal competencies necessary for non-chaplain and chaplain volunteers are the same. Both serve in the same environment of Feather River Hospital (FRH), although some training will differ. The necessary non-chaplain and chaplain volunteer competencies that surface from relevant literature are interpersonal skills, listening skills, flexibility, teamwork, commitment, a compassionate heart, spiritual and emotional supportiveness, and intuitiveness. Elements of an educational approach and related considerations that emerge from this survey are the need for practical hospital-based training, a support group to encourage practical application of the training competencies, and the need to integrate learning with life experience.

Missional Church

The first type of reviewed literature was missional church. After serving for 15 years in a traditional role as parish clergy, the author's transition to hospital chaplaincy at times was flummoxing on both practical and philosophical levels. The roles of chaplain and parish clergy are, at the same time, similar and different. Both provide counseling and spiritual ministry to people in need, while the locale, method, and people may vary widely. The philosophical help needed by the author during this transition came in the form of missional church.

Hirsch (2006) claims the use of the terms missional and missional church were coined by a group of practitioners, missiologists, and theorists from North American known as the Gospel and Our Culture Network (GOCN) (pp. 81-82). However, in a classic work, Dubose (1983) appears to be the first person whose usage of missional falls within its current context (pp.14-15).

With the increased recent popularity of the missional movement, Stetzer (2014) rightly proposes that the definability of the word missional is virtually impossible. Simply stated, it means what people intend it to mean when they use it (Stetzer). Why is this true? Hirsch (2006), agreeing with Stetzer, assigns its fluidity to people looking for new and trendy tags to describe their activities, whether or not they are missional. Attempting to maintain the pure intent of the concept, he defines missional church as “a community of God’s people that defines itself, and organizes its life around, its real purpose of being an agent of God’s mission to the world” (p. 82). Others tend to agree (DeVries, 2007, pp. 8-12; Driscoll & Breshears, 2008, p. 218; Wright, 2006, p. 204).

Seventh-day Adventist Missional Perspective

With this definition of missional in mind, how does the Seventh-day Adventist church relate to missional? A short survey of its leaders and institutions demonstrates the fact missional is foundational to the churches past, present, and future as a movement. The earliest Seventh-day Adventist pioneers believed and preached the importance of its churches mission to the world. Church historian Knight (2004) writes, “The Sabbatharians through Bates began to see themselves as a prophetic movement rather than merely as another church. That self-understanding would eventually drive the Sabbatharians to

mission” (p. 148). White (1911), pioneer and messenger of God to the Seventh-day Adventist Church, confirms Bates understanding: “The church is God’s appointed agency for the salvation of men. It was organized for service and its mission is to carry the gospel to the world” (p. 9).

Today, number 12 of the church’s official statements of beliefs reads,

The church is the community of believers who confess Jesus Christ as Lord and Saviour. In continuity with the people of God in Old Testament times, we are called out from the world; ... for service to all mankind, and for the worldwide proclamation of the gospel. (Seventh-day Adventist Church, n.d.)

The Seventh-day Adventist Churches’ flagship theological seminary, Andrews University, teaches a Missional Church Cohort for its doctoral seminary students that describes missional church in these terms.

Missional church is a biblically formed 21st-century missionary movement of western culture. It defines the church as God’s sent people. It is a way of life that models the incarnational life of Jesus Christ who took the form of his creation to show humankind the Father (John 14:9-11). Just as Christ transcended culture to show us the Father, the missional church transcends culture to show lost people Jesus Christ through sharing life together. The result of the missional life is restoration of sinful people as we follow the ways of Christ through deeper understanding of truth (John 14:6). (“Andrews University,” n.d.)

Wilson, current president of the Seventh-day Adventist Church, in speaking at the 2014 Annual Council, confirms: “According to Bible prophecy, we are God’s prophetic movement proclaiming God’s prophetic message on God’s prophetic mission” (2014).

Burrill (1998), former North American Division Evangelism Institute director, contends, “Adventism professes to be a biblical movement, claiming that the Bible is their only rule of faith and practice. If so, then Adventism must have a mission theology and practice that his fully in harmony with the New Testament model” (p. 47).

Not only is the Seventh-day Adventist Church a missional movement from its inception, but it is still today necessary to maintain this focus on mission to fulfill its calling.

Church Barriers to Becoming Missional

Many missional church movement leaders contrast past successes with present realities. Roxburgh (2010) describes that living in this period like trying to find one's destination with outdated maps, requiring the church to make it up as it goes (p. x). Hirsch (2006) places the timeframe for this changing worldview and culture to within the last fifty years or so (p. 16). Some see this as a pivotal time period to either change and become relevant or remain the same and continue toward irrelevance in society (Guder & Barrett, 1998, p. 1; Hirsch & Ferguson, 2011, pp. 17-18). Bosch (1991), taking in the historical landscape of the Christian church, believes this period is not an anomaly. He believes, "the understanding and practice of mission have changed during almost twenty centuries of Christian mission history" and that the change was so profound that, historically, the mission models are almost unrecognizable. He believes the transformation will never come to an end and that today "we find ourselves, at the moment, in the midst of one of the most important shifts in the understanding and practice of Christian mission" (p. xv).

Missional Church Shift

This shift, commonly acknowledged by missional leaders is explained in a variety of ways, depending on perspective of the writer. For instance, Stetzer and Putman (2006) describe the missional movement shift as moving from

1. Programs to processes
2. Demographics to discernment
3. Models to missions
4. Attractional to incarnational
5. Uniformity to diversity
6. Professional to passionate
7. Seating to sending
8. Decisions to disciples
9. Additional to exponential
10. Monuments to movements (p. 48).

McNeal (2009), on the other hand, describes it as three shifts in thinking and behavior.

1. Internal to external in terms of ministry focus
2. Program development to people development in terms of core activity
3. Church-based to Kingdom-based in terms of leadership agenda (p. 10).

Missional leaders agree this shift has been traumatic to the Christian church in many ways. Cole (2005), looking through the mega church eyes, decrees the idea of “if you build it they will come” is no longer effective (p. xxvi). For McNeal (2003), it is not just the loss in the mega churches but the institutional churches as well, observing that they are “not leaving because they lost faith. They are leaving to preserve their faith” (p. 4). Cole (2005) concurs with this statement (p. xxii). But this is not a local North American problem. Hirsch and Ferguson (2011) write of the decline, marginalization, and in some locations, almost extinction of Christianity in the world. He believes what

happens in the U.S. context, in this time, will, in many ways, determine the shape and viability of Christianity in the West and beyond (p. 18).

Loss of Missional Potency

The explanations for this ineffectiveness of the church today vary from author to author. Some view it as the fault of the church for not fulfilling its Great Commission and is guilty of not keeping abreast of the times (Cole, 2005, p. 41; Hirsch, 2006, p. 16). Others view it as the fault of the world and culture (Guder & Barrett, 1998, p. 1; Newbigin, 1995, p. 2). Many feel that the only true solution to this complex bewilderment is to answer the basic questions, Why am I here? What am I supposed to be doing in this current culture and context? (Frost & Hirsch, 2003, p. 7; Wright, 2010, pp. 1-26). Since missional leaders agree that “if you built it, they probably *won't* come,” then what are some possible solutions for creating a missional church movement in this religious enigmatic world?

Missional Church Solution

The missional church movement sees the answer in a broad stroke by going into the world instead of expecting the world to come to Christianity. For some, like Cole (2005), the solution is to take the gospel to “where life happens and where society is formed ... restaurants, offices, homes university campuses, high school facilities, and beaches. We’ve had churches in meeting in bars, coffeehouses, parks, and locker rooms” (p. xxvi).

For others, like Halter and Smay (2008), it requires choosing the essentials and leaving behind the non-essentials. However, there is some reluctance when this happens even within the church and its leadership (pp. 23-28): “The key to reconstructing ‘ancient’ forms of church requires patience, savvy, wisdom, and love for everyone in the family” (p. 26).

Others, like Hirsch (2006), see the answer as connecting with the “Apostolic Genius (the primal missional potencies of the gospel and of God’s people).” He believes it lies dormant in all Christians and when tapped, causes them to be willing to do whatever necessary, including sharing resources, to become missionally effective (p. 22). However, the undergirding theme as the answer to this dilemma is unity. Hunsberger (1998), writing on Newbigin’s (1995) theology of cultural plurality, promotes unity as the answer to cultural relevancy. Cross-cultural mission for him is the importance of the church to embrace the dynamics of intercultural communication of gospel proclamation so that the gospel can be presented as relevant to each culture (pp. 25-33).

Breen and Absalom (2010) see unity as a direct response to God moving in the church and the church listening to His voice. For them, this Godly unity is when people from different places in the world, with different backgrounds, denominational affiliations, and socio-economic statuses all seem to be sensing the same thing independent of each other. It is as if all the barriers that would normally separate us are mysteriously broken down, and in one clarion moment, people who may not agree on a lot all share one thought, one big idea. We seem to be in that kind of moment right now (p. 12).

Deymaz (2007) agrees and narrows the scope of unity to the local church level by claiming it is the basic building block of any healthy multi-ethnic church (pp. 3-12). Bosch (1991) sums up the general feeling of this need: “It has become impossible to say ‘church’ or ‘mission’ without at the same time talking about one mission and one church” (p. 464). For him, this unity is non-negotiable (p. 464).

Chaplaincy

The second type of literature reviewed was chaplaincy. This focus was further narrowed to healthcare chaplaincy for the sake of brevity and applicability. The reason chaplaincy was chosen is because of its quintessential role as an idealistic model for providing spiritual care. This brief analysis will answer the following questions: What is a chaplain? What is his or her function? What can we adapt as a model for providing spiritual care for our non-chaplain and chaplain volunteers at FRH?

Traditionally, a chaplain is the minister in a specialized setting such as a priest, pastor, rabbi, imam, or lay representative of a worldview attached to a secular institution (such as a hospital, prison, military unit, police department, university, or private chapel). Although the word “chaplain” originally denoted a representative of the Christian faith, it is now also applied to men and women of other religions or philosophical traditions. Today, many lay individuals have also received professional training in chaplaincy and are now appointed as chaplains in a variety of institutions. The idea of “generic” and/or “multifaith” chaplaincy is becoming more popular, especially within healthcare and educational institutions (Religion Facts).

Historical Connection Between Chaplaincy and Healthcare

Historically, hospitals were established and operated by religious groups. For instance, people of various religious orders, whether Buddhist or Christian, provided care for the sick, based on the intrinsic value of the individual. It is recorded that in India, Buddhists monks established hospitals as far back as 200 BC, and in early Christianity, hospitals were established for the benefit of weary and sick travelers (Interchurch Council for Hospital Chaplaincy, n.d.).

The Middle Ages established a more intimate connection between the Catholic Church and “hospitals.” These hospitals ranged from monastic infirmaries to the segregated lazar houses for lepers. Unsurprisingly, priests operated many of these hospitals and physical and spiritual care were almost non-distinguishable.

The 18th century is known as the “age of hospitals” and many of the famous hospitals in England were founded during this period. From what can be ascertained, all of these hospitals founders were conscious of their duty to provide both physical and spiritual care to patients. Some hospitals were assigned a chaplain, while others were served by a local clergy; some were paid and others volunteered.

The 19th century continued to introduce general and specialized hospitals, of which many were charitable voluntary foundations. In England, acts of Parliament, such as the Lunacy Act of 1890, assured care for the sick, poor, destitute, and mentally ill and provided an Anglican chaplain to care for patients in every mental institution (Hospital/Health Care Chaplaincy, 2001).

Reasons for Chaplaincy

Why is there a need for chaplaincy when family members, friends, lay members and leaders of religious communities, and institutional staff members can offer basic spiritual care? Because chaplaincy is not intended to lesson but enrich and fill the specialized needs in an intense medical setting. Less than half of patients do not have an identifiable spiritual leader, and those who are active participants in a religious community often do not contact their faith community during hospitalization (VandeCreek & Burton, 2011, p. 6).

What can chaplaincy offer? Namely, spiritual and emotional care through listening and allowing patients to express their feelings. In his pioneering book, Belgum (1963) claimed that 75% of hospital patients manifesting physical illnesses have, at the root, emotional causes such as guilt (p. 54). Although profound for its time, today one of the largest investigations ever conducted, known as the Adverse Childhood Experiences (ACE), reveals associations between childhood maltreatment and future health and wellbeing, confirming Belgum's original findings. The parallel health benefit connection with chaplaincy came from the decreased physician visits as a result of patients simply divulging their adolescent trauma in a survey. Chaplaincy too offers a cathartic emotional opportunity for patients to divulge their adolescent or another life trauma allowing healing to occur. On a spiritual level, the same is true. Recent studies confirm that if people have a view of God as loving and forgiving, the human brain is altered: the prefrontal cortex continues to develop, especially in the anterior cingulate cortex, the amygdala is calmed, fear level decreases, confidence increases, and healing of the mind

and body occur (Jennings, 2013, p. 234). These are a few of the many benefits chaplaincy offers in a healthcare setting.

In a joint seminal work by five major chaplaincy associations (VandeCreek & Burton, 2001, pp. 11-17), the following shared benefits of the professional chaplain were created. These benefits for patients and families include supporting their individual religious and/or spiritual beliefs and practices, knowing the importance of religion or spirituality while coping with illness, helping them cope during illness, responding to spiritual distress, enhancing their coping strategies, caring for their families, and overall providing a higher level of patient and family satisfaction with the spiritual care.

The benefits for the healthcare staff are helping staff with stressful situations and coping with personal problems. The benefits for the healthcare organization consist of assisting the organization in meeting patient expectations, increasing the spiritual care available by providing spiritual education to the community, establishing and maintaining relationships with community clergy, helping mitigate potential litigious situations with patient/family dissatisfaction, helping reduce and prevent spiritual abuse, assisting patients and families in identifying values in end-of-life situations, are involved in developing the mission, value, and social justice statements, assist in fulfilling a variety of accreditation standards, and providing cost efficient spiritual care.

The community benefits are leadership and participation in community wellness programs, leadership of community support groups assisting with loss, illness or coping, leadership and participation in community responses to disaster, participation in a continuum of spiritual care, guidance and support various congregationally supported

programs, establishing educational programs for community clergy regarding visitation, maintaining active relationships with local clergy associations, and providing community education seminars on various topics. As can be seen, hospital chaplaincy plays a broad and important role in benefitting patients and families, staff, the organization, and the community.

But what specific religious/spiritual or non-religious interventions do chaplains offer in a healthcare setting? *The Journal of Health Care Chaplaincy* shared a report that analyzed data from 30,995 chaplain visits with families and patients as part of the New York Chaplaincy Study. From this study a categorization of the types of interventions chaplains make fell into what they termed religious or spiritual in nature or not specifically religious.

According to Marin, Sharma, Sosunov, Egorova, Goldstein, and Handzo (2015), who analyzed data from 30,995 chaplain visits with families and patients, there are two types of interventions in which chaplains engage: religious or spiritual in nature and not specifically religious. The eight non-religious interventions are crisis intervention, emotional enabling, ethical consultation/deliberation, life review, patient advocacy, counseling, bereavement, and empathetic listening.

The nine spiritual or religious interventions are hearing confession or amend, faith affirmation, theological development, performing a religious rite or ritual, providing a religious item, offering a blessing, praying, meditation, and other spiritual support.

As can be seen by this list of interventions, the role of the chaplain is diverse and complex as it stretches to meet the emotional and spiritual needs in a complex and changing world and healthcare environment.

Chaplaincy, a Growing Edge

According to Wright (2014), almost 70% of community hospitals surveyed in 2011 provided chaplaincy services, compared to 62% in 2003. Wright states that the cost of chaplaincy is increasing, as are its responsibilities. For example, the new emphasis on palliative care, which attempts to relieve stress, pain, and other symptoms associated with serious illness, has focused on the benefits of a chaplain. New guidelines from the National Consensus Project for Quality Palliative Care recommend that a board-certified, professional chaplain take a larger role in palliative care teams. According to the guidelines, spirituality is a “fundamental aspect of compassionate patient and family centered care.”

Numerous other changes in healthcare have caused chaplaincy to be viewed more as a discipline with a chaplain as the spiritual/pastor care expert integral to the interdisciplinary team. As a result, chaplains are now involved in measurement, quality improvement, and research that contribute to the overall patient health and outcomes. Chaplains now chart their care plan as well as articulate their role of pastoral care to the healthcare organization (“Board of Chaplaincy Certification,” n.d.). Either as a result or a by-product, education for hospital chaplains has become standardized, requiring a master’s or graduate theological degree, a total of 1,600 hours of clinical pastoral

education (CPE), and board certification (BCC) (Board of Chaplaincy Certification Incorporated).

Last but not least, one of the accrediting organization for hospitals, The Joint Commission, states that chaplaincy helps hospitals meet many of their accreditation standards in a variety of areas as the ethical advocate for the patient (“Joint Commission,” 2011).

Non-chaplain and Volunteer Chaplains

Because of the diversity of fields, which can include spiritual care volunteerism, it was necessary to limit the topic of spiritual care volunteers to healthcare. The literature uses various terms for non-chaplain and volunteer chaplains, such as spiritual care volunteers, associate chaplains, chaplain assistants, pastoral care volunteers, volunteer chaplains, depending on the local organization.

Non-chaplain or volunteer chaplains are generally people from interfaith communities who receive various levels of training, based on the organization they are associated, and are tasked with providing spiritual and emotional care. They play a support role for patients, their families, and staff and are trained to support people of any or no religious background. Normally they provide a listening ear, assist with spiritual concerns, mobilize spiritual resources as needed, and coordinate appropriate referral follow-ups with either staff or staff chaplains. Their pledge depends on the needs of the organization and their availability. For volunteers of an organization, their service can range from a few hours to several days per week. Staff who take on the role of spiritual support do so during their normal workday. Qualifications for spiritual care volunteers

differ from one organization to another. Often a vetting process includes an application, reference checking, interview, health check, and attendance at volunteer training and orientation sessions (“Regional One Health,” n.d.).

Prerequisites for Chaplain Associate Position

Organization-specific requirements range from minimal (FRH) to hospitals like Sutter Sacramento, which require one unit of Clinic Pastoral Education from an accredited center. Others may require ordination or official recognition as a spiritual leader from a faith community, and/or a collegiate or seminary theological education (Lexington Medical Center, 2016).

Many organizations believe volunteers must have the ability to establish rapport with others through effective listening skills, work as a team member and communicate relevant patient care information to appropriate healthcare staff, be willing to work with and meet the spiritual needs of people of all religious faith, age, gender, sexual orientation, race, and ethnic backgrounds, deal with the stressful nature of hospital work, be able to discern opinions from facts in patient documentation, and complete “age-specific” competencies.

The position generally also requires chaplain volunteers to be mobile within facilities, complete an annual TB test and initial background check, attend hospital and department specific orientation, and receive an annual performance review (Sutter Health, 2015).

Need for Non-chaplain and Chaplain Volunteers

Like chaplaincy, spiritual care volunteerism is also growing, with the realization of benefits still being discovered. “The chaplaincy program is an integral part of our holistic interdisciplinary team approach to treatment,” said Katie, who attends St. Gall in Colton (as cited in Solimine, 2005).

Solimine (2005) addresses the current dichotomy in healthcare. While the benefits of chaplain services are still being discovered, fewer hospitals are able to afford these services. Many larger hospitals, due to financial constraints, are looking to hospitals in smaller communities and smaller hospitals in larger communities, which only rarely have paid chaplain staff (Solimine). Locally this holds true. Enloe Medical Center in Chico, California, FRH’s primary healthcare competitor, has been able to reduce the cost of providing paid chaplaincy to meet the spiritual needs of their patients by using Spiritual Support Volunteers, a group of interfaith community members who provide spiritual and religious support services (VolunteerMatch.org, n.d.),

The good news is that many disciplines today see spiritual and emotional care as integral to the success of the patients, staff, and organization. Neurosurgeons like Levy (2011) have written about the power of prayer in their practice for patients and themselves. Expert authors on improving all aspects of a healthcare organization, like Studer, Robinson, and Cook (2010) and Lee (2004), highlight the necessity of supporting the emotional and physical needs of patients and the staff (Lee, pp. 59-62; Studer et al., pp. 45-68). Others see spiritual care as so integral whole person care of patients they

devoted entire volumes to this topic. Chapman's (2003, 2006) popular books are examples of this emphasis on "wholistic" care.

Role of Volunteer Chaplains

The specific responsibilities of a spiritual care volunteer can vary, depending on the healthcare organization. However, the basic role includes compassion, support, and sensitivity. Following are examples of some of the roles of volunteers. These include, but are not limited to, (a) compassionate and respectful support to help you draw on your spiritual, religious, cultural, and philosophical resources as you deal with the challenges of illness, treatment decisions, and the healing process, (b) spiritual care that preserves the dignity of each patient, (c) resources for patients and their families for making decisions about treatment, (d) on-call crisis support, (e) visits to assigned units on a consistent basis (special training required), (f) grief support, and (g) liaison with local faith communities ("Community Hospital of the Monterey Peninsula," 2016).

Some organizations may request their volunteer chaplains to make initial contact with new patients and be available for follow-up visits to listen, comfort, pray, administer sacraments, and provide crisis ministry. Others may only have them provide follow-up visits with patients who have already received an initial assessment.

Volunteer Benefits of Service

There are numerous benefits for volunteers. For many, the social benefits are the most important, but other benefits may also include annual flu vaccination, health

screenings, tuberculin test, Hepatitis B vaccination, luncheons, discounts to area-wide businesses, meals during volunteer shift, and specialized training.

Hospital Visitation

This literature was reviewed with an eye to volunteer spiritual care training programs. Hospital visitation has a long tradition in religious circles. Many times, members of churches have an expectation that a pastor, lay leader, or other church member will visit them in the hospital. Often patients are comforted by visits from family and friends. But are there any real health benefits to the patient? Epstein (2006) believes there are. He points to recent research that shows mirror neurons fire, based on human emotions, either one's own or others' emotional experiences. Patients mimic others sentiments which alters their mood. What this means for visitation is that during a visit from a cheerful loving friend or family member, mirror neurons cause similar positive feelings in the brain of the patient, raising their spirits and ultimately improving their health (Epstein, 2006).

Because of studies like these, many hospitals are changing their visiting policies, although most hospitals still restrict visitation hours for critically ill patients. New survey results reveal lifting such restrictions go a long way toward improving family satisfaction and patient well-being (Dallas, 2016).

Another cultural and religious shift known as "spiritual but not religious" (SBNR) has increased the need for spiritual care visitation for patients. According to a 2012 survey by the Pew Religion and Public Life Project, nearly a fifth of those polled said that they were not religiously affiliated, and nearly 37% of that group said they were

“spiritual” but not “religious.” The results indicate that fewer people are associated with a religious community, which leads to little or no outside spiritual support during hospitalization. Since basic human needs for emotional and spiritual support have not changed with the times, a volunteer chaplain or spiritual care ministry can fill in the gaps this change in religious culture has brought.

Because this deficit in spiritual and emotional care has been verified, hospital visitation programs are beginning to thrive and a variety of mostly religious organizations are developing them. For instance, Masonic lodges have created a hospital visitation program, seeing it as their major relief work, calling it their “finest public relations program ever undertaken by the Masonic fraternity.” They developed it for “Masons and Non-Masons alike, who now need someone to turn to for encouragement and to make life a little more pleasant” (“Masonic Service Association of Northern California,” n.d.).

The literature varies as to what various organizations’ motivation is for hospital visitation. According to the Masons, their motivation is public relations. Some religious groups see it as evangelistic, others altruistic. However, all see it as beneficial.

Basic Visitation Guidelines

The basic hospital spiritual care visitation guidelines are similar between most groups with slight variations, mainly dependent upon the motive for the visit. Following are three examples of visitation guidelines.

Christian

1. Pray before you arrive.

2. Understand HIPAA.
3. Have a plan, but don't expect to use it.
4. Don't obstruct the flow.
5. Keep it short.
6. Be sensitive but not timid.
7. Lend a healing touch.
8. Don't rush out the door.
9. Remember the family (Blumhofer, 2007).

Seventh-day Adventist

1. Identify yourself.
2. Don't be intrusive.
3. Be aware of sanitary rules.
4. Don't overstay your welcome.
5. Hospital ministry is a journey.
6. Assess the situation.
7. Listen.
8. Reassurance is usually not helpful.
9. Don't try to fix it.
10. Be aware of your nonverbal communication.
11. Use prayer carefully (McMillan, 2006).

Assembly of God

Do

1. Call first to determine patient availability for a visit.
2. Knock before entering a room and depend on the Lord to direct your visit.
3. Observe signs, notices, and precautions on patient's door.
4. If possible, sit where you can maintain comfortable eye contact with the patient.
5. Be cheerful, make pleasant conversation.
6. Shape the tone and substance of your conversation from cues offered by the patient.
7. Listen attentively by giving the patient your undivided attention.
8. Let the patient know he/she can talk about sensitive subjects.
9. Excuse yourself when the doctor enters the room unless requested to stay.
10. Share Scripture and ask patients if they have special needs as you prepare to pray.
11. Inform the Pastoral Care Department of your visit if possible.

Don't

1. Be insulted by a patient's words/attitudes or register shock at a patient's appearance.
2. Offer false optimism or participate in criticism about the doctor or treatment.
3. Touch equipment or sit on patient's bed.
4. Tell patient unpleasant news—including your troubles.
5. Whisper when talking to family members or medical staff.
6. Break hospital rules or violate confidentiality issues.

7. Awaken the patient unless nurse gives approval.
8. Help patients get out of bed or give food or drink without the nurse's approval.
9. Assume anything (Williams, n.d.).

What types of training programs are available to help volunteers meet the necessary educational criteria for providing spiritual and emotional care in a healthcare setting?

Volunteer Training Programs Similar to MAT

Expanding the reach of chaplaincy without undue financial burden is on every director's mind. Engaging volunteers, whether lay or clergy, can be the answer. However, for this approach to be successful, it is essential volunteers receive the necessary training, which should be developed and provided by a chaplain director.

A comparison of the table of contents from three volunteer training programs, similar to the one developed for FRH, provides a bird's eye view of what areas of education similar volunteer training programs emphasize.

Chaplaincy Care Volunteer Training Manual

1. Overview
2. Identifying spiritual distress
3. Communication and listening
4. Understanding the patient: Older adults and aging issues, individuals with visual impairments, and individuals with hearing impairments
5. Visitation

6. Cultural competency, spirituality, and religion
7. Death and grief
8. Confidentiality (Geevarghese & Robinson, n.d.)

Spiritual Care Volunteers: A Training Resource

1. Forward
2. Session 1 – Introducing Healthcare Chaplaincy
3. Session 2 – From Person to Patient and back again
4. Session 3 – Understanding Spiritual Care
5. Session 4 – Pastoral Care through attentive presence and listening
6. Session 5 – Introduction to Loss, Grief & Bereavement
7. Session 6 – On the Wards
8. Appendix
9. Supplementary material (Collins, Dafydd-Lewis, Howell, Powell, Roberts, & Williams, 2012, pp. 2-3).

Patient and Family Care Volunteer Training Manual

This third manual is for hospice volunteers.

1. Hospice Care General Information
2. Rules and Responsibilities of the Volunteer
3. Grief and Bereavement
4. Communication and Listening Psych-Social Issues
5. Infectious Disease and Infection Control

6. Transporting Patients and Families
7. The Admission Process—What You Need to Know
8. Safety Precautions and Concerns Protecting the Volunteer and Patient
9. Medical Aspects of Terminal Illness and Care
10. Spiritual Care
11. Cultural and Religious Traditions
12. HIPAA, Confidentiality and Documentation
13. Supplemental Readings
14. SHARE
15. Policies (Realin & Ruckstuhl, 2009)

Summary and Implications of Literary Findings

The following will address the learnings gleaned from the literature review of missional, chaplaincy, non-chaplain and hospital chaplain volunteers, and hospital visitation, questions for further research, as well as the implications from these findings for the MAT pilot project. As mentioned earlier, this review does not represent a comprehensive analysis of related literature but reflects topics most appropriate to MAT development.

Major Insights

The missional literature defined missional as “a community of God’s people that defines itself, and organizes its life around, its real purpose of being an agent of God’s mission to the world” (Hirsh, 2006, p. 82). For the Seventh-day Adventist Church, this

idea has been and continues to be central to its purpose and existence. The barriers to being missional include the lack of clear direction and irrelevancy of Christianity to the present. There has been and continues to be shifts in the missional movement which, if understood, help to explain the current realities compared to those of the past. Solutions to the missional church dilemma are summed up in the need to go into the world and bring Christ to the people in the places “where life happens and society is formed” (Cole, 2005, p. xxvi). For most missional leaders, this means a renewed sense of purpose and unity. MAT meets the missional criteria by going to where life happens in the healthcare setting and uniting with others in providing spiritual and emotional care.

Chaplaincy literature points to the quintessential role of chaplaincy as the ideal model for providing spiritual and emotional care, in both its historical and present setting. Chaplaincy enriches and fills the specialized needs in an intense medical setting, providing numerous benefits to patients and families, healthcare staff, the organization, and the community through interventions that include both a religious and non-religious role. The review confirmed that chaplaincy is a growing edge with integration into the healthcare setting seen more as one of the many disciplines, with the chaplain as the spiritual/pastor care expert confirming the need for chaplaincy and the uniqueness of the role it plays.

The literature reveals that non-chaplain and chaplain volunteers in the healthcare setting are people from interfaith communities that are tasked, like chaplaincy, with providing spiritual and emotional care in a support role for patients, families, and staff. Prerequisites, levels of responsibility, number of hours worked, duties, and qualifications

vary by organization. Like chaplaincy in general, the need for volunteers to fill the emotional and spiritual needs is growing due to its benefits to the volunteer and organization and financial benefits.

Hospital visitation literature was reviewed with an eye to curriculum similar to MAT. The literature connects the long tradition or expectation of hospital visitation in religious circles, health benefits resulting from these visits, reaction by healthcare organizations to this information, and the greater need for spiritual care as society becomes less religious and more spiritual. Additionally, hospital visitation programs are beginning to grow as a variety of mostly religious organizations develop them for motivational reasons. A review of basic hospital visitation guidelines from various organizations indicates they are fairly consistent in their instructions. These included being non-intrusive, intuitive to the situation and patient needs, following hospital protocol and HIPAA, and listening. MAT can assist in helping volunteers meet their goal of providing appropriate patient visitation. A brief review of the training programs similar to MAT show a fairly consistent list of competencies for meeting the emotional and spiritual needs of various healthcare organizations: an understanding of rules and responsibilities of the volunteer, use of interpersonal skills, understanding grief and bereavement, ability to communicate and listen, understanding confidentiality, cultural and religious traditions, and visitation. These main competencies guided the creation of those for MAT.

Questions for Further Research

While this literature review included a number of worthy literature topics, many questions remain. For instance, since hospital-based outpatient clinics (HBOC) are trending today as more services are moving from inpatient to outpatient, what will chaplain services look like in an HBOC setting? As more remote services are provided through TeleMedicine (using telecommunication and information technologies to offer clinical healthcare from a distance), could chaplaincy move in this direction as well to meet the growing outpatient demand and increase its area of support through video conferencing, phone calls, or Skype? What about a spiritual care consult where patients communicate their needs online, to chaplain services? How could MAT be adjusted to meet these and other changes in healthcare and grow as healthcare trends toward patient a focus on patient experience and accessibility?

CHAPTER 4

THE ROLLOUT OF THE MISSION AMBASSADOR TRAINING ON THE HOW-TO OF SPIRITUAL CARE FOR CHAPLAINS AND NON- CHAPLAIN VOLUNTEERS

Introduction

The Adventist Health (AH) corporation has a shared mission, vision, and set of values across its organization. Its mission is “to share God’s love by providing physical, mental and spiritual healing.” One of its values defines spiritual healing as the “compassionate healing ministry of Jesus.” The entire staff at Feather River Hospital (FRH) has signed their names pledging participation in this mission, vision, and values. Essentially, this means the entire FRH staff has committed to participate in the spiritual healing component of its mission. However, hospitals by their nature have a tendency to create departmental silos and not interdepartmental teams. This is true for the spiritual care department and medical care departments.

Nevertheless, changes are taking place within healthcare that will alter the silo approach. The National Research Corporation (NRC) has been at the forefront of patient-centered care, helping healthcare providers measure and improve quality and services. They project that for a coordinated healthcare delivery system to be successful,

financially and operationally, it must extend the patient-centered care approach to incorporate perspectives of the entire care experience, including spiritual care.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores will potentially affect a hospital's reputation in the community it serves, and are used in calculating a hospital's value-based purchasing payments going forward.

Chaplain Services Departments challenge was to create a spiritual care teamwork approach with all of the FRH staff. Mission Ambassador Training (MAT) was developed with shared team identity in mind—spiritual care is everyone's concern at FRH.

The purpose of this project was to develop and implement a training program for the FRH staff of chaplain and non-chaplain volunteers on how to provide emotional and spiritual support to the FRH community. From the previous chapters it can be ascertained that a spiritual care training program is in alignment theologically, theoretically, missionally, economically, and practically with FRH needs. The data, studies, and resources surveyed support this claim. The roll out of MAT and the test run are the benchmark to determine the effectiveness of the program. This chapter provides a profile of the ministry context for MAT as it relates to this project and how the intervention was developed and implemented. The rollout of this program began in July, 2014, and finished in June of 2015. This project was implemented at FRH in Paradise, California.

Ministry and MAT

The next section defines the ministry as it relates to MAT. The approach will be to draw attention to both the internal and external influences that affect FRH as relating to MAT.

Internal Influences

There are many internal factors that influence the need for MAT. To begin with, the desire of the hospital founders was to ensure FRH's long-term mission as an Adventist healthcare center over fifty years ago by entrusting FRH to the Northern California Conference of Seventh-day Adventist. FRH maintained this connection even when it joined Adventist Health in 1973. It also uniquely holds the designation as the only faith-based hospital in Butte County. To continue this rich heritage of FRH as a faith-based organization, a focus on whole person care must be continued through its mission, vision and values and its staff. This emphasis, along with the strong support for the mission from the FRH administration, continues to create a working atmosphere, which promotes faith and spirituality among the staff and is experienced by the patient population. Often when rounding, patients will mention the contrast between FRH's atmosphere and the surrounding hospitals. Many patients feel they are supported emotionally and spiritually by the staff and cared for as an individual. This atmosphere also contributes to attracting a higher percentage of a staff that affirms faith as important and desire to live out their faith within the workplace.

However, even though FRH is a Seventh-day Adventist hospital the staff is spiritually and religiously diverse. About a third of its physicians are Seventh-day Adventists, about a third are Church of Jesus Christ of Latter-day Saints, and about a third are a mixture of other spiritual and religious faiths. There is an even greater diversity within the staff, as only about 10% of the FRH staff are Seventh-day Adventist.

This calls for tact in maintaining the distinctiveness of the Seventh-day Adventist values while providing spiritual and emotional support to and within a diverse staff.

Another area of diversity is FRH's growing number of chaplain volunteers who come from varied Christian faith backgrounds. Having a diverse faith-based support group helps meet the faith diversity within our FRH community and falls in line with FRH's philosophy of openness to all people, regardless of their personal beliefs, as well as FRH's emphasis on partnering with members of other faiths to enhance the health of the community in which it serves. However, this diversity comes with its challenges.

Limited financial resources available to Chaplain Services Department to meet the spiritual and emotional needs of FRH staff and patients has contributed to a number of FRH ancillary facilities having little or no chaplain services support. The chaplain services department has attempted to fill some of these gaps with chaplain volunteers. Table 1 shows the number of chaplains supporting various FRH facilities and the amount of coverage provided.

Table 1 reveals a variety of vacancies in spiritual care at a number of strategic ancillary FRH facilities. FRH is intent on moving from a focus on inpatient to outpatient care, as are hospitals across the United States, creating an increased need for future spiritual care to outpatient clinics. The only way to support these locations is for either volunteer chaplains or training staff to become Mission Ambassadors (MA's).

Table 1

Chaplain Department Support for Feather River Hospital Facilities

	Chaplain	Volunteer chaplain	Literature distribution	Days/ week	Coverage	Other
FRH	FTE (1) Hourly (2) On call (3)		Literature (3)	7	24/7	Various
FRHC		Chaplain (1)		2	On call	Daily overhead prayers
OP surgery center		Literature (1)			On call	
Cancer center	(1)	Literature (1)		3	M-F	Various
Hospice	FTE (1)			7	24/7	
Skyway primary care		Literature (1)			Quarterly rounds	
Home health					Quarterly rounds	
<i>Note:</i> Parenthetical numbers = number of available chaplains.						

External Influences

There are a number of external influences which contribute directly and indirectly to the project of developing and implementing MAT.

The geographic location of FRH in the town of Paradise, California, according to an informal survey of retired patients, seems to be a major contributor to retirees moving to this community. According to the United States Census Bureau (n.d.a.), Butte County has about a 4% higher retiree population of 65 and older than the rest of the state. The town of Paradise exceeds this statistic with approximately half of its population 65 and older (United States Census Bureau, n.d.b). These statistics may directly contribute to both the patient population of FRH, the exceptionally high percentage of volunteer staff, and the age demographic of the volunteer chaplains (United States Census Bureau, n.d.b.).

Butte County is almost 82% Caucasian and the town of Paradise proper exceeds the county at 92% (United States Census Bureau, n.d.a.). The Association of Religious Data Archives (n.d.) indicates only about a third of the population of Butte County have any religious affiliation. These statistics reveal a homogeneous county in which most residents do not have religious support. The town of Paradise has a large Seventh-day Adventist Church with a membership of over 1,300. It shares a close, mutually supportive relationship with FRH which also plays a significant role in affecting the spiritual care of the Chaplain Services Department. Two of the pastors on staff at the church provide chaplain support to FRH, as do a number of members who volunteer with Chaplain Services Department.

Because FRH is the only hospital in Paradise and its largest employer, many in the community rely upon the hospital. Good will and support from the community is important to the success of both the community and the hospital.

The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or “Obamacare,” is a United States federal statute signed into law by President Barack Obama on March 23, 2010, and is probably one of the greatest influencers on the finances of FRH. The result of the ACA on healthcare providers is a more-for-less approach: the federal government is expecting more services for more people from healthcare providers for less money. The incentive to healthcare is the higher the patient satisfaction from HCAHPS scores, the greater the reimbursement from the federal government for services. As a result, healthcare providers, including FRH, are tightening their financial belt in preparation for an uncertain financial future.

Development of the Intervention Process

“Spiritual but not religious” (SBNR) is a popular phrase heard often from patients and the staff at FRH. In fact, a survey by the Pew Research Center (2012) reveals that about 20% of Americans describe themselves as unaffiliated. SBNR implies a belief in spirituality that rejects traditional organized religion as the only or most valuable method of advancing spiritual growth. This shift may be reflected by the fact that a number of our patients and staff see FRH as their church and the chaplain as their spiritual leader.

The transformation of culture moving from religious to spiritual aligns with the missional church movement which believes “the church exists to go into the cultures and nations of the earth and live sacrificially for the good of others” (Driscoll & Breshears, 2008, p. 218). This is a pivotal understanding in the provision of spiritual care to a community. Missional church leader Reggie McNeal (2009) believes this represents three different shifts in thinking and behavior from internal to external in terms of ministry focus, from program development to people development in terms of core activity, and from church-based to Kingdom-based in terms of leadership agenda (p. 10). The question that Frost and Hirsch (2003) ask about their missional context is the question asked in relation to developing MAT: “what has God called us to be and do in our current cultural context” (p. 7).

Soon after the author arrived at FRH as director of chaplain services, it became clear there was both a need and interest on the part of many of the FRH staff to participate in providing spiritual care to patients and fellow staff members. This information was gathered from informal conversations from the FRH staff and a

previously successful spiritual care training program offered to the FRH staff by a former chaplain services director. The development and implementation of MAT aligned with the mission, vision, and values of AH and FRH, Jesus' life and teachings, and the biblical model that all are called to be involved in supporting those in need (Matt 28:16-20 and Matt 25:31-46). It is also clear from the gospels that Jesus spent much of His time teaching by both words and actions (Acts 1:1). This example was important to incorporate in any type of spiritual care training program. The program needed to teach appropriate spiritual care and be broad enough and accessible enough so that anyone at FRH could be trained.

The Vision

A vision emerged to the author to develop a MAT which would be open to the entire FRH staff, reflect its mission, vision, and values, recent literature, and biblical principles, be accessible, as well as teach appropriate spiritual care within the context of FRH. To develop a spiritual care program of this magnitude within the AH and FRH organizations required approval, cooperation, and support of key administration and the staff: the hospital administrator (CEO), the AVP for Mission and Spiritual Care of AH, and the Chaplain Services Department staff. Conversations with these leaders and staff began in January 2013, with support and recommendations gained from all parties involved.

Beneficial to creating MAT is the previous attempts and successes of other spiritual care departments across the organization, including FRH. However, these programs did not align closely enough with the needs of FRH. The two major benefits of

reviewing these programs were (a) gaining feedback from previous programs as to successes and failures, and (b) realization there was already an awareness on the part of administration and the staff of the need for an accessible, cross-discipline spiritual care training program.

The development of MAT was both challenging and rewarding. The challenging part included the development of a training program that would provide a broad enough scope of information to cover the theoretical and practical basis for training non-chaplain and chaplain volunteers and narrow enough to not become overwhelmed in the milieu of information.

Recruiting Mission Ambassador Participants

Promotion for MAT involved working closely with the marketing department on a marketing plan. The marketing strategy developed for MAT included newsletter articles and announcements, a mass promotional email to the FRH staff, a brochure, verbal announcements at various FRH meetings, and personal invitations to potential candidates.

The registration took place through the Education and Training Department. Participants could either sign up on the HealthStream online education website for FRH or by calling the chaplain's department or the Education and Training Department. Participants were asked to provide contact information and signature of their department director.

Conditions for participation in MAT are completion of the registration form, approval by departmental director, and a personal desire to participate. The reason an emphasis is placed on intrinsic motivation in MAT is because studies have shown that if

participants do not have an internal desire to be a part of a change, this lack of motivation must be made up by relying on external incentives (Grenny, Patterson, Maxfield, McMillian, & Switzler, 2007, p. 84). Because MAT is about spirituality, it was felt that the motivation for participation needed to be internal and pleasurable or rewarding. All the applicants were accepted, based on their departmental director's approval.

Mission Ambassador Training Schedule

MAT consisted of four sessions and was offered in four-hour blocks of time. Each session included a theoretical and practical element. MAT was offered monthly, with the entire program covering the period of one year (July 2014-June 2015). At the conclusion, the data collected were evaluated.

Mission Ambassador Training Overview

Each MAT session began with introductions and participants were asked about their expectations. Next, an overview of the program was provided. The overview included introductions, a signup sheet, and an agreement document to participate in a doctoral study which had to be signed (Appendix A), handouts of presentation materials and resources, and a class schedule (Appendix B). Also included were an ice breaker question, definition of spiritual care, motivational stories, scientific data supporting the benefits of spiritual care, and illustrations of how patients have been benefited by spiritual care and how it connects with the mission, vision, and values of FRH. Next, the group explored their new role as mission ambassadors (MA) in the spiritual care of FRH

as compared to chaplains, pastors, or social workers, and possible challenges were discussed.

In Session 1, the group explored what spiritual and emotional distress is, how to identify it, how to offer spiritual and emotional support, including appropriate prayer, how and when to make referrals, and the importance of confidentiality. The MAs then role-played these skill sets with a variety of scenarios.

Session 2 covered the topics of communication and listening skills, including what it means to be an active or reflective listener. The participants filled out a questionnaire to rate their listening skills. This questionnaire was used to provide them with a personal guide on their strengths and weaknesses. The class then addressed ways for improving communication and listening skills such as the types of questions that can be asked, helpful phrases, non-verbal communication, attending, responding, and reflecting skills. This was followed by another role-play.

Session 3 covered the topic of understanding the patient. This included education and resources about what types of things to be aware of with patients, depending on their age, visual or hearing impairments, cultural competency, and spirituality and religion. This session also included a role-play.

Finally, session 4 explored the topics of grief and death, analyzing self-awareness of the MAs' emotions and thoughts on death, awareness of what death and the dying process may mean for the patient physically, emotionally, and spiritually, as well as exploring what the family may experience during the dying process. The group explored grief and mourning, the steps in the grief process, and grief recovery. Throughout this

session, the MAs explored healthy and appropriate ways to support the patients and family members through their journey of grief and death, including when and to whom to make referrals. Each MA was then provided with handouts and PowerPoints on the topic of grief and death for themselves and for the patients and families to help better understand and cope during this process of death and grief. The session included opportunities to role-play techniques for assisting people through grief and death. Lastly, the MAs were asked to fill out the Education and Training Program evaluation (Appendix C).

During the trial and rollout period from July 2014 to June 2015, MAT was marketed about five months prior to the beginning of class. There were also monthly support groups held for the purpose of encouragement, problem solving, and team building.

Table 2 shows the MAT schedule during its one-year roll-out and pilot period. The schedule shows a five-month advertising campaign, followed by four MAT classes and six MA support group meetings.

The materials used during MAT sessions included a class schedule, PowerPoint presentations (Appendix D), video clips, the manual (Appendix E), the Loma Linda University Health System Health Care and Religious Beliefs booklet, and a variety of handouts. Other books, illustrations, and materials were provided as resources for further study.

Mission Ambassador Support Group

A Mission Ambassador Support Group (MASG) for the MAs was scheduled monthly and provides opportunity for emotional comfort, moral support, and appropriate sharing and feedback such as practical advice and tips for handling challenging situations. The main objectives of the support group were to create a sense that each person is not alone, they are a part of a team, there are resources and support available for them, and to offer encouragement for their role as an MA.

Data for Evaluation of MAT

Success for MAT was based on the following metrics.

1. Participation in and diversity of the FRH staff that volunteered to join MAT.
2. How well the staff's spiritual needs were met, according to results of the annual Gallup survey on employee engagement and the Spiritual Climate survey.
3. Patient experience responses to the NRC survey and its alignment with HCAHPS scores.
4. Participants' evaluations of the effectiveness of the class (provided by the Education and Training Program).
5. MA graduates' participation and feedback in the MASG.

This project used data from these categories to evaluate the overall effect MAT program is having on the hospital, patients, and staff.

Table 2

Mission Ambassador Training and Support Group Schedule

July 2014	Advertise MAT to FRH staff
August 2014	Advertise MAT to FRH staff
September 2014	Advertise MAT to FRH staff
October 2014	Advertise MAT to FRH staff
November 2014	Advertise MAT to FRH staff
December 2014	MAT group
December 2014	Abbreviated MAT
January 2015	MAT and support group
February 2015	MAT and support group
March 2015	Mission ambassador support group
April 2015	Mission ambassador support group
May 2015	Mission ambassador support group
June 2015	Mission ambassador support group

Chaplain and Non-chaplain Volunteer
Participation in MAT

An important measure of the success of MAT was the number of participants. Because of the extremely low patient and staff to chaplain ratio at FRH, the greater the number of MAs, the broader the influence of spiritual care and the greater mission alignment. The intent is not just numbers, but as MAT is offered in the future, that a greater number of FRH ancillary facilities and a broader diversity of departments will have MAs as part of their staff.

From December 2014 through February 2015, a total of 22 FRH employees participated in MAT and became MAs. Of the 22 participants, eight (36%) were chaplain volunteers and 14 (64%) were non-chaplain volunteers, most of whom were direct patient care (e.g., nurses, CNAs, imaging technicians). Of the 14 non-chaplain volunteers, six were CNAs who participated in the abbreviated two-hour MAT.

NRC Survey

The NRC Survey is administered for FRH through the mail from the National Research Corporation to a randomly selected sample of inpatients and patients who received care through a variety of outpatient ambulatory services. A maximum of one survey is administered per patient in the sample per year. An initial survey is sent out by the National Research Corporation and is followed about three weeks later with a second survey to non-respondents. All payer types are included and only acute care hospitals are surveyed. Exceptions to inclusion are under age 18, expired patients, most psychiatric cases, and hospice discharges. Sampling occurs at least monthly using a relatively small sample size. Surveys from this sample accumulate over 12 months and are made available to the public. The target number is at least 300 returned surveys per 12 months to achieve the desired statistical reliability. This averages out to 25 or more survey responses per month. A smaller sampling equals decreased reliability (National Research Corporation, n.d.a.). The rate of change is best compared annually, not monthly due to normal variations in data. A 2-5% change in the score either against itself or a desired benchmark is considered practically significant as determined by the creators of the metrics. This project analyzes the NRC survey sampling on a yearly summary.

HCAHPS data from the NRC surveys is a rollup of the following 8 dimensions: Cleanliness/quietness, Communication with nurses, Communication with doctors, Responsiveness of hospital staff, Communication about meds, Discharge information, Pain management, and Overall rating of the hospital and includes 61 questions (Appendix F). Because the NRC is the primary surveyor of hospitals, its survey results are important for measuring and improving quality and services to better meet patient needs, and because the government has tied patient satisfaction results to Medicare reimbursements.

Three questions were chosen from the survey based on their applicability for indicating potential influence and effectiveness of MAT: “Would you recommend this hospital to your friends and family?” (#22); “If you expressed a spiritual or religious need, did someone meet that need?” (#54); and “Using any number from number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?” (#21). Figure 1 shows a quarterly comparison for the last three years of these three survey question results, however, the following comparisons are based on annualized ratings (averages of the four quarterly ratings). “Overall rating of the hospital” decreased 3.8% from 76.7% in 2013 to 72.9% in 2014, and decreased again 0.4% between 2014 and 2015, ending at 72.5%. “Patient satisfaction with attention to spiritual needs” increased 1.2% from 84.9% in 2013 to 86.1% in 2014. Between 2014 and 2015, there was a 6.6% decrease from 86.1% to 79.5%. On the question of “Would recommend hospital to family,” from 2013 to 2014 there was a 3.5% decrease from 80.8% to 77.3%. From 2014 to 2015 there was a

decrease of 1.4% from 77.3% to 75.9% (Appendix G). Permission was given to use this data.

Figure 1. NRC percent trends on overall rating, recommendations, and spiritual care by quarter.

Spiritual Climate Survey Results

The purpose of the Spiritual Climate Survey is to understand both the qualitative and quantitative perceptions of spirituality at FRH that contribute to a positive spiritual climate in the workplace. It also provides actionable data to be used to develop strategies towards creating positive Spiritual Climate in support of the AH mission. The following work aspects are linked to a strong spiritual climate: higher productivity and performance, greater job satisfaction, safety, teamwork, organizational commitment and loyalty, higher emotional intelligence, less disruptive behavior, and enhanced self-care.

Spiritual Climate Survey questions rate how comfortable staff feel expressing spirituality in the workplace and whether or not they feel their views are supported, encouraged, and accepted. The five-question voluntary survey was conducted online through SurveyMonkey between January 15-31, 2015, and an email link was sent to all FRH staff. The questions were

1. I am encouraged to express spirituality in this work setting,
2. My spiritual views are respected in this work setting,
3. My spirituality has a comfortable home in this work setting,
4. A diverse set of spiritual views are accepted in this work setting, and
5. People in this work setting feel comfortable talking about God.

Responses to the survey and their scores were “agree strongly” (100), “agree slightly” (75), “neutral” (50), “disagree slightly” (25), “strongly disagree” (0), and “N/A” (0) (Appendix H).

The threshold of excellence was 80% or higher, which shows a strong consensus. Further improvement from 80% to 100% is not associated with the same enhancement of outcomes as improvement from 50% to 60%. Sixty percent or lower marks a high likelihood for substandard clinical and operational outcomes. Most causes of variability in employee perception are due to unit-level factors such as job tasks, managers, and local norms. Interventions also tend to be effective at unit level. Any two groupings likely exhibit some differences. Small differences in survey scores are often due to random chance, rather than to meaningful, systematic variation. A ten-point spread or more in an item or domain score was considered practically significant as determined by the creator

of the metrics, representing a shift in thought, behavior and culture. Any department with less than five employees or respondents was grouped together to provide a large enough sample size for an accurate analysis. Permission was given to use this data.

Figure 2 reflects all five questions from the Spiritual Climate survey and indicates that between 2011 and 2012 there was a 3% increase in satisfaction of the spiritual climate at FRH. Between 2012 and 2015, there was a 1.6% decrease in satisfaction of the spiritual climate at FRH (Appendix I).

Figure 2. Spiritual climate survey by year and percent of satisfaction.

Gallup Survey Results

Employees annually complete a Gallup survey which measures a number of factors involving employee engagement or how committed they are to their organization, role, manager and co-workers. Employee engagement has a direct correlation to customer ratings, profitability, productivity, turnover, safety incidents, shrinkage (theft), absenteeism, patient safety incidents, and quality (defects) (Gallup, n.d.).

The Gallup survey was conducted September 14-October 4, 2015 through an online questionnaire. An email was sent to all staff with a link to the Gallup survey. A comment section was also provided at the end of the survey. The main survey includes 12 simple questions and each organization can add any custom questions they feel appropriate for their organization which directly correlate to performance results.

Survey statements were rated “strongly agree” (5), “extremely satisfied” (4), “neutral” (3), “strongly disagree” (2), “extremely dissatisfied” (1), or “does not apply or don’t know” (0). Statement or dimension averages were based on a five-point scale, with “1” being the lowest possible average and “5” being the highest average. “Does Not Apply” or “Don’t Know” responses are 0 or not scored (Appendix J). A change in score is meaningful if the score changes 0.2 or more between survey periods, according to developers of the Gallup survey. Each workgroup is compared to other parts of the company. The higher the score, the more engaged staff were. This survey clearly highlights strengths and opportunities for improvement in employee engagement. There must be 100 employees participating to receive the full spectrum of responses. Respondents for 2014 ($n=839$) and 2015 ($n=885$) were sufficient to provide a full spectrum response.

Figure 3 shows an apparent overall increase in employee engagement from 2014 to 2015 in the three areas chosen as indicators for the success of MAT: “The organization cares about my spiritual well-being” (C03), “How satisfied are you with your organization as a place to work?” (Q00). “The mission or purpose of my organization makes me feel my job is important” (Q08). However, no question scored high enough to

be significant. There was a 0.07% increase in satisfaction with the statement “The organization cares about my spiritual needs,” a modest 0.02% increase in satisfaction

Figure 3. Percent of satisfaction in spiritual care, workplace, and mission.

with the statement “Satisfaction with organization as a place to work,” and 0.13% increase in satisfaction with the statement “The mission or purpose makes me feel my job is important,” (Appendix J).

Education and Training Program Evaluation

The first section of the evaluation was administered to all participants at the conclusion of class, allowing the participants to rate the class overall (Appendix C). These surveys were compiled and analyzed for significant trends.

Figure 4 reflects the MAT and CNA overall presentation rating of the classes. Of the 22 participants who responded to the question “How would you overall rate this presentation?,” 1 rated it “good,” 14 rated it “excellent,” and 7 provided no rating.

To the question of rating the speaker's knowledge of the subject, content and presentation, and questions and discussion, all (100%) rated the speaker's presentation as superior.

Figure 4. Overall presentation rating of MAT and CNA classes.

Comments about the speaker included “Very, very good! Thank you so much!,” “Thank you,” “Excellent in service on being an ambassador, clearly presented, great materials. There is a need for this training and I am very grateful to receive it. Thank you!,” “I would like to see prayer for staff,” “Brad’s presentation is and will be helpful going forward. He gave up plenty time to share and digest what we were hearing and seeing,” “Job well done!,” “Well prepared!,” “Very interactive,” and “Very informative. Took time to answer questions.”

On a scale of 1 (not helpful) to 4 (very beneficial), with an additional “not applicable” option, participants were asked about the teaching methods used in the class

and their effectiveness. Either all or most of the participants found all teaching methods very beneficial (Table 3).

Comments about teaching methods included “I would like to see this training for staff and being an ambassador for staff,” “Very helpful,” “Thank you! This class is very very helpful!!,” “Thank you. I really needed this class today. Amazing how some things

Table 3

MAT and CNA Participants’ Teaching Method Evaluation

Teaching method	A	(Not helpful) 1	2	3	(Very beneficial) 4
Lecture/discussion		0	0	0	21
Seminar		0	0	0	16
Group projects		0	0	0	18
Slides/overheads/PowerPoints		0	0	0	22
Handouts		0	0	0	22
Lighting/amenities/food		0	0	0	18
<i>Note:</i> Some participants did not respond to all questions.					

fall into place when you need them,” “Oranges, water, the host, YouTube videos great!,” “Best class I ever took at FRH! Wish it were eight hours. Very interesting and beneficial.”

Finally, participants were asked whether program objectives were clear and whether they were met (Figure 5). Twenty-one of the participants felt the objectives of

the program were clear and 19 felt the objectives had been met. There were no negative comments.

Under the comments section of whether or not the objects were clear and met, participants wrote “This is good to go over and over again! To refresh!,” “I really appreciated the information. Very good insight,” “Brad”s own life reflects his belief system and how he conducts himself. He is a wonderful example of Godly living.” Finally, feedback from those who responded to the questions as to whether or not the class had clear objectives and whether or not they were met was 100% in the affirmative.

MAT Support Group Evaluation

MASG participants were queried regarding strengths and weaknesses of MAT. MASG meetings took place once a month in 2015 on January 19 (four attendees), February 19 (two attendees), March 5 (one attendee), April 28 (two attendees), May 18 (one attendee), and June 18 (one attendee) in the FRH fireside lounge from 12:00 pm to 12:30 pm, for an average of two per meeting.

Feedback was positive. Some participants said they tried new tools learned in MAT and all felt higher levels of comfort with spiritual care interactions. Other comments reflected on the unpredictability of hospital schedules for most of the staff, a desire for more versatile ways for communicating, and a belief that supporting each other should be addressed. One suggestion was a weekly or monthly email to all MAs with tips or encouraging thoughts.

Conclusion

A collaborative cross-discipline approach to spiritual care at FRH through MAT could provide the greatest potential for effectively aligning the historical intent of its founders with the current wholistic mission, vision and values of AH and FRH “To share God’s love by providing physical, mental and spiritual healing.”

The other differences MAT could make are almost as significant: creating a sense of teamwork throughout the hospital, raising spiritual awareness of staff, increasing patient and employee satisfaction scores, more closely aligning FRH with Affordable Care Acts (ACAs) mandates for higher reimbursements, providing a greater diversity in spiritual care across all of FRH and its ancillary locations, using the diversity in the staff to support the diversity in the patient population and in FRH’s staff, a closer association with local faith communities, aligning with the predicted future as FRH moves to a more outpatient-centered approach to healthcare, moving closer to the missional approach of taking church to the people, and finally, more closely following Christ’s example and mandates of working with people where they are while teaching and living Christ.

MAT cannot resolve all the challenges that come with meeting the growing and diverse spiritual and emotional needs of a hospital staff and community. New methods for meeting these challenges will need to be explored as the world, healthcare, and society change. For instance, technological opportunities to meet some of the diverse spiritual care needs are already being examined, such as iPads for patients containing spiritual and emotional support videos. With a healthy imagination, a heart for service,

and the help of the Holy Spirit there really is no limit to opportunities that may be explored in providing spiritual care to a hospital's patients and its staff.

CHAPTER 5

THE MISSION AMBASSADOR TRAINING PROGRAM PILOT

Yogi Berra, the famous baseball coach once said, “In theory there is no difference between theory and practice. In practice there is.” This statement holds true for Mission Ambassador Training (MAT). The original intent of MAT was to create a pilot project that would train non-chaplain and chaplain volunteers to provide spiritual support to patients, their families and staff at FRH. Chapters 1 to 4 laid a foundation for the validity of MAT by presenting project alignment with missional need, theological reliability, scientific data, conceptual/comparative studies, and the context, development, and intervention of MAT. This chapter describes the chronological narrative of the implementation of MAT and, like Yogi Berra underscored, it will demonstrate the practicality of the theory.

MAT sessions were offered in December 2014 and finished on February 2015. During this time, by request, an abbreviated version for CNAs was created. The monthly support group for this training began in January 2015 and concluded in June 2015.

Birth of the Mission Ambassador Program

About a month before coming to Feather River Hospital (FRH), the outgoing Director of Chaplain Services and the author met for almost a week of orientation, during which he learned about a defunct voluntary eight-hour training workshop offered to FRH staff by the outgoing director's predecessor called Mission Ambassador Training (MAT) where participants learn how to provide spiritual and emotional support for other FRH staff and patients. After arriving at FRH, the author received numerous inquiries about reinstating this program.

Feedback from MAT graduates was especially helpful. Probably the most illuminating comment came from a nurse who said staff were usually too busy to spend any significant time with patients on spiritual or emotional matters even though many would like to. Her solution was to provide staff with efficient tools for either providing spiritual care or knowing when to place a referral to chaplain services for more in-depth assistance. Another common theme staff shared became foundational to MAT and was the basis for their motivation to work at FRH. Their desire was to be able live the mission of FRH in their jobs: "To share God's love by providing physical, mental and spiritual healing." However, the greatest obstacle for many who wished to do so but had not was a feeling of a lack of knowledge and expertise. The author also asked fellow FRH chaplains what a MAT might look like. Dr. Paul Crampton, AVP for Mission and Spiritual Care for Adventist Health, provided the author with helpful direction, as well as a volunteer training manual titled *Chaplaincy Care Volunteer Training*. The author's adviser, Dr. Jim Wibberding, had developed for his doctoral project a training program

titled *A Curriculum to Equip Lay Pastoral Candidates for Service in the Pennsylvania Conference*, and ideas from this dissertation were helpful. The author's professor for the Doctor of Ministry program, Dr. Michael Cauley, was especially astute at conceptually exploring what a program of this caliber might look like. Conversations with chaplains at Florida Hospital, another Adventist hospital system on the east coast, provided ideas and materials used by Florida Hospital in their hospice volunteer training.

The next step was to discuss the implementation of MAT with Kevin Erich, CEO of FRH. He found value in the program and gave permission to pursue its development and implementation. He made a valuable suggestion for making MAT more accessible to the entire staff by offering it as a four-hour in-service training. A project proposal for MAT was officially submitted on August 26, 2014. The proposal was accepted on September 24, 2014, and the project was cleared to launch on October 31, 2014, by the International Review Board (IRB), the research committee formally designated to approve, monitor, and review biomedical and behavioral research involving human subjects.

Philosophy and Methodology

The philosophy and methodology behind the development and implementation of MAT involved the following key areas. Admission criteria, marketing, course schedule, monthly support group, assignment categories, and variations to the original proposal.

Admission Criteria

FRH and Adventist Health pride themselves on their wholistic approach to healthcare as contained in its shared mission statement “to share God’s love by providing physical, mental and spiritual healing.” This mission stems from FRH being part of a faith-based organization rooted in the Seventh-day Adventist Christian heritage. This mission and heritage has lead FRH to encourage its staff to support each other and patients both emotionally and spiritually when needed. FRH’s wholistic approach to healthcare allows for a program like MAT to fit compatibly within the operations of its hospital. As a result, all FRH staff were invited to participate in the training. The admission criteria for MAT participants was simple and inclusive, based on the following criteria: a voluntary participant must be a part of the FRH staff, must have their department directors’ approval for participation, and complete the registration form either online through the FRH HealthStream Learning Center or call the Education and Training Department or Chaplain Services Department to register.

Marketing

FRH’s Marketing Department and Education and Training Department joined the Chaplain Services Department in marketing this program.

The Marketing Department, guided by the Education and Training Department, created a flyer which was sent to all FRH departmental directors as well as. The Marketing Department published this same announcement in the “Feather River Rapids” (Appendix K), FRH’s Monday morning internal email created by and sent from the Marketing Department highlighting all important upcoming FRH events. Finally, the

Marketing Department created messages for the time clock, computer screensavers (Appendix L), and Connect Calendar, FRH's internal employee calendar.

MAT classes were also promoted on the FRH HealthStream Learning Center, a web-based, self-paced software application covering most mandatory education courses. Promotion and registration for MAT began July 2014 through the Education and Training Department's HealthStream. The Marketing Department began promotion of MAT on December 1, 2014, through the Feather River Rapids. As mentioned, registration was either through the Chaplain Services Department or Education and Training's HealthStream or phone message.

Chaplain Services Department marketed MAT through verbal announcements made during meetings and emails and phone calls to chaplain staff and volunteers. A three-fold brochure about MAT was also created and distributed by chaplain services (Appendix M).

Course Schedule

MAT was designed to be taught in four modules covering a variety of topics. Three MATs were offered as part of this pilot project. Table 4 shows the dates, times, locations, and attendance for each MAT.

Table 4

Mission Ambassador Training Schedule and Attendance

Date	Time	Location	No. attendees
December 15, 2014	8:00 am-12:00 pm	FRH fireside lounge	6
January 12, 2015	8:00 am-12:00 pm	FRH fireside lounge	3
February 12, 2015	12:30 pm-4:30 pm	FRH fireside lounge	7

Each MAT began with a welcome and introduction followed by some basic formalities. These included a sign-in sheet provided by Education and Training Department, distribution of various handouts, a brief overview of these handouts including the MAT manual, and the Health Care and Religious Beliefs booklet produced by Loma Linda University Health System. Next, an explanation of Mission Ambassador Support Group (MASG) and an overview of what to expect during the class were given. The participants were then asked what expectations they might have for the class. This question created an opportunity for dialogue throughout the class and provided awareness as to the participants' expectations.

The rest of class time included the MAT manual, YouTube video clips inserted into PowerPoint slides, and 119 PowerPoint slides specifically designed for this class. The class was divided into four sections with the following objectives: (a) learn to apply our mission to a work setting, (b) learn to provide spiritual support, (c) learn to provide emotional support, and (d) learn to provide support through the bereavement process.

The first section (learn to apply our mission to a work setting) discussed the mission, vision and values of Adventist Health (AH), including a brief history of the Seventh-day Adventist Churches beliefs and their connection to AH's emphasis on whole person care. The class reviewed scientific studies in an attempt to answer the question "Is there a scientific connection between spirituality, religion, and healthcare?" The scientific data overwhelmingly pointed to a strong correlation. After validating the importance of spirituality and religion in a healthcare context, the next question asked was "How can you participate and be benefitted from this connection?" Participation was defined as (a) identify spiritual distress, (b) communicating with and listening to patients, (c) providing emotional and spiritual support through prayer, touch, and presence, and (d) making referrals to chaplain services.

The second section (learn to provide spiritual support), covered communication and listening skills. Following this, tips were given for identifying and responding to spiritual distress, and two case studies were discussed for their applicability. MAT participants were then taught about praying, including examples of styles and samples from a variety of faith groups. There was also a discussion on appropriate and inappropriate prayers, based on scenarios from different religions. The module concluded with an assignment to (a) choose a religious group they felt uncomfortable praying for and (b) write out a prayer for a person in that particular faith group based on information provided in MAT.

The third section (learn to provide emotional support) was a discussion on emotional support. Addressed were four types of emotions (mad, sad, glad, afraid),

approaches to providing emotional support, as well as tools for classifying, identifying and supporting three types of people: wanters, givers, seekers. A quiz provided an opportunity to put theory into practice. Last, an acronym for facilitating emotions called NINER was explained and demonstrated. NINER stands for Naming (mad, sad, glad, afraid), Identifying (clarifying which emotions is being felt), Normalizing (affirming the normality of their emotions), Exploring (encouraging further sharing of feelings), and Reflecting (summarizing back the conversation).

The final section (learn to provide support through the bereavement process) focused on the bereavement process. Sections from the MAT manual were discussed: Typical Grief Responses, Symptoms of Grief, Grief and Mourning, Grief—Expectations You Can Have for Yourself, Grief Recovery—Moving in The Right Direction, “What are Patients and Families Experiencing?,” Anticipatory Grief—A Patient’s Perspective, Children and Death, and Clichés to be Avoided.

The class briefly discussed how to visit a patient. Class concluded with how the referral process works for chaplain services and when to make referrals. A question and answer period was provided at the conclusion of each class.

Mission Ambassador Support Group

An on-going monthly meeting linking MAT with MASG is based on John Kotter’s (2012) eight errors in leading change: “neglecting to anchor changes firmly in the corporate culture” (p. 14). Because change takes time and habits do not form overnight, the support group was designed to support this change over the long term. The support group also met another need: encouragement of Mission Ambassadors (MAs).

Duhigg (2012) summarizes this need when he wrote, “Small wins fuel transformative changes by leveraging tiny advantages into patterns that convince people that bigger achievements are within reach” (p. 112). He also believes “small wins ... are a part of how keystone habits create widespread changes” (p. 112).

The purpose of a support group was to provide a forum for MAT graduates to both give and receive emotional and practical support and exchange information through this process of change. Each session provided opportunity to give the MAs a chance to share their wins and their challenges. The wins were celebrated and challenges were addressed. Each session included a short training session to emphasize one of the previously taught lessons or provide new information to participants. Because of busy schedules, a monthly meeting was considered reasonable.

Assignment Categories

Each participant was provided with an opportunity to participate in a number of key learning assignments. In-class assignments included both individual and cooperative learning components, utilizing individual and group quizzes, question and answer segments, and cooperative assignments among participants.

Post-class assignments included reading the Health Care and Religious Beliefs booklet and reading the sections of the Mission Ambassador Training Manual not covered during training. Each participant was also strongly encouraged to join MASG. MASG assignments included individual experiential updates regarding participants’ successes and challenges. Each participant was asked to fill out an Education and Training Department evaluation of MAT.

Variations to the Original Proposal

FRH's Education and Training Department requested a two-hour class be offered through Chaplain's Services Department for its Certified Nurses Assistances' (CNA) continued education units (CEU), focusing on how to care for others' spiritual needs. This two-hour CNA class was not part of the original MAT scheduled for this doctoral pilot and this class did not cover all MAT material due to its abbreviated timeframe. However, the intent and content of this class fell within the scope of MAT and therefore is included as a variation to the original two classes were held in the FRH computer training room on December 10, 2014, from 8:00am to 10:00am (four attendees) and from 3:00pm to 5:00 pm (two attendees). The abbreviated MAT followed the same objectives and format and covered the same material as the full training but included fewer illustrations and less information on each topic.

Evaluation of MAT Success

MAT's success was measured in six ways.

1. Participation and diversity of the FRH staff that volunteered to join MAT.
2. Results from the NRC survey's alignment of scores with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) goals.
3. Results from the annual Gallup survey of staff on engagement and satisfaction.
4. Results from the Spiritual Climate Survey of staff on the level of comfort, support and engagement they feel with regard to spiritual matters at work.
5. Results from the Education and Training Program survey of MAT participants' satisfaction with the training.

6. Feedback from MAT graduates during monthly MASGs.

Limitations, Variables, and Other Unknown Influencers

MAT is one program offered in a complex healthcare organization. A number of limitations, variables, and other influencers, both known and unknown, influence MAT, such as content, imposed, unknown.

Content Influencers

Since the primary instructor for MAT was also its creator, it would stand to reason that if someone else were to teach MAT, he or she might emphasize different material, based on what that person perceived as valuable. However, this variation may not be as influential because the intent of MAT is to start MAs on a lifelong journey of learning and growth in the areas of spiritual and emotional support.

Imposed Influencers

MAT was created to discover whether a broader, better equipped, and more formally organized spiritually and emotionally supportive staff at FRH would increase National Research Company (NRC) patient satisfaction scores. The results were inconclusive. Because of MAT's singular focus, other questions are left unaddressed. First, there was no on-the-job training with this program. Second, the timeframe for evaluation of its success was limited due to the author's project completion deadlines.

Unknown Influencers

When studying a subject there are influencers which affect a study without the researcher's awareness. This project is no exception. However, because they are unknown, the hope is that as the author continues to offer MAT to FRH staff in the future, these unknown influencers will become obvious, allowing for a clearer understanding of not only the effect of MAT but also what influencers are affecting it.

CHAPTER 6

MAT PROJECT EVALUATION AND LEARNINGS

This final chapter summarizes the Mission Ambassador Training (MAT) pilot project and provides the framework and learnings. This includes how the project was evaluated, how the data were interpreted, conclusions drawn, outcomes from MAT, and a recap of each chapter. Last, recommendations were considered for further research, as well as the future direction for MAT in an attempt to improve its effectiveness.

Summary of MAT

This MAT pilot project was an attempt at creating a training program at Feather River Hospital (FRH) in Paradise, California, for the non-chaplain and chaplain volunteer staff who wished to become ambassadors of the Adventist Health's (AHs) mission "To share God's love by providing physical, mental and spiritual healing."

A four-hour MAT class was created and offered three times, along with two abbreviated MATs for CNAs, between December 2014 and February 2015, to FRH staff of staff and volunteers. Also, a 30-minute Mission Ambassador Support Group (MASG) was offered monthly from January 2015 through June 2015. The purpose was missional. Training included linking theory to practice, fostering internal and external spiritual and emotional awareness, providing resources, and building a collaborative team with chaplain services. It explained the roles and responsibilities of a Mission Ambassador

(MA) volunteer, historical context for spiritual and emotional support in a healthcare environment, how to recognize and support spiritual and emotional issues, communication skills, bereavement, and teamwork. The foundational elements of the project also involved creating a theological framework, reviewing relevant contemporary literature, consulting with hospitals offering similar training programs, and reviewing relevant surveys and feedback to determine the success of MAT. It concluded with an evaluation and description of the results within a designated research methodology and protocol.

Method Used to Evaluate MAT Intervention

Data from the FRH departmental participation, National Research Corporation (NRC) surveys, Spiritual Climate surveys, Gallup surveys, Education and Training Program evaluations, and MASG were analyzed to determine the effectiveness of MAT.

Evaluation

Six methods were chosen for their alignment to MAT.

1. Diversity in staff participation. This evaluation divided participants into two categories: chaplain volunteers and non-chaplain volunteers.
2. Patient experience. NRC survey data were used to determine patient perception of their overall experience and how well their spiritual needs were being met. Survey questions covered the topics of “overall rating of the hospital,” “satisfaction with attention to spiritual needs,” and “would recommend hospital to family.”
3. Employee engagement. The Spiritual Climate survey informed FRH leadership

about the current spiritual climate of its staff. Topics covered how well the hospital was meeting their spiritual needs, if they were able to express their spirituality, and how accepted they felt their spirituality was at FRH. Studies show the more comfortable staff feel regarding their spirituality, the greater their engagement.

4. Employee engagement. The Gallup survey topics used also measured employee engagement. The statements used were “Mission or purpose makes me feel my job is important,” “Organization cares about my spiritual needs,” and “Satisfaction with organization as a place to work.”

5. Value of MAT. FRH’s standardized Education and Training Program evaluation was filled out by MAT participants at the end of each class. This evaluation provided feedback on the overall rating of the program, the presenter’s knowledge of subject, content, and his presentation and questions and discussion ability. The effectiveness of the teaching methods was analyzed, as well as the clarity of the objectives and whether these objectives were met. Comments could be made under each individual category.

6. Effectiveness of the training and implementation of MAT on the staff, patients, and training participants was evaluated by MASG.

Interpretation and Conclusions

A comparison of the departments represented by MAT participants revealed the following information. There were twice the number of participants from the FRH staff compared to chaplain volunteers. This does not indicate a lack of interest of individuals from the chaplain’s department, but is reflective of a smaller pool of individuals in the

chaplain's department in comparison to the larger pool of individuals from the general staff. Because the larger number of participants was non-chaplain volunteers, this indicates non-chaplain staff also perceived a benefit from MAT. Results indicate MAT achieved the goal of participation diversity.

Three statements were chosen from the NRC survey to determine if MAT influenced patient satisfaction in 2015. Three years of data were analyzed to determine trends from 2013 to 2015. The first statement, "Overall rating of the hospital," showed a significant downward trend between 2013 and 2014, but no significant trend between 2014 and 2015. The second statement, "Patient satisfaction with attention to spiritual needs," showed no significant change between 2013 and 2014, but did reveal a significant decrease between 2014 and 2015. The third statement, "Would recommend hospital to family," revealed a significant downward trend between 2013 and 2014, followed by no significant trend between 2014 and 2015.

Many factors that impact patient satisfaction. Most notably, in first quarter 2015, there was a nursing staff shortage which impacted staff and patient satisfaction scores. From 2013 to 2015, spiritual care provided to patients remained consistent, demonstrating chaplain support was not the reason for the downward trend in these three statements. This variation in data between fourth quarter 2014 and 2015 reveals the close alignment in perception by patients between spiritual and emotional care and how much influence non-chaplain staff have on patients' perception. Declining scores on the NRC surveys during the nursing staff shortage emphasize the necessity of an interdisciplinary

team approach at FRH to meet patient spiritual care needs. Nevertheless, because of this nursing shortage, the influence of MAT on patient satisfaction was not possible to isolate.

The Spiritual Climate survey, appraising the current workplace spiritual climate among staff, shows that changes of 2% or less between surveys at FRH between 2011 and 2015 were not significant for the purpose of this study. However, a 10% change in employee spiritual climate results would have been considered significant. It can be concluded that MAT did not have a measurable impact on the spiritual climate survey results.

The Gallup survey measuring staff engagement reveals an upward trend between 2014 and 2015 in scores on all three statements chosen as possible indicators of MAT influence: “How satisfied are you with your organization as a place to work?” “The mission or purpose of my organization makes me feel my job is important,” and “The organization cares about my spiritual well-being.” The largest increase was seen in “Mission or purpose makes me feel my job is important” (0.13%), but this was still below the 0.2% meaningful score change. A perceived upward trend is seen in the responses to all three statements. An investigation of trends in the next two or three years would more clearly indicate the impact of MAT on staff engagement.

The Education and Training Program evaluation assessed the MAT presentation and perceived benefit of participants. Of the respondents, 64% indicated the overall presentation was excellent, 5% rated the presentation as good, and no respondents rated the presentation as poor or fair. The remaining 31% of respondents left no comment. Overwhelmingly, the participants indicated the presentation was excellent.

On a scale of 1 to 5, 100% of respondents viewed the speaker as “superior” in the areas of “knowledge of the subject,” “content and presentation,” and “questions and discussion.” Comments reflected the same conclusions.

The teaching method was evaluated on a scale of 1 (“not helpful”), 2 (“not very helpful”), 3 (“somewhat beneficial”), and 4 (“very beneficial”). A “not applicable” option was also available. Of the 22 participants, a few did not respond to all questions. A majority (95%) of participants rated “Lecture/Discussion” as “very beneficial” and 5% did not respond. Of the participants, 73% rated “Seminar” as “very beneficial,” 5% rated it as “somewhat beneficial,” and 22% did not respond. “Group Projects” was rated “very beneficial” by 82% of participants, 5% rated it as “somewhat beneficial,” and 8% did not respond. All participants rated the “Slides/Overheads/PowerPoints” and “Handouts” as “very beneficial.” Of the participants, 82% rated “Lighting/Amenities/Food” as “very beneficial,” 5% rated it as “somewhat beneficial,” and 23% did not respond. In conclusion, the results and comments from the evaluation of the teaching methods indicate no changes need to be made to MAT.

Participants were asked whether the objectives of the program were clear and if they were met. Overwhelmingly, responses were positive to both questions; no participants responded negatively. These results show MAT successfully fulfilled its objective.

MASG had low attendance, with an average of two MAs (10%) attending each of the six group meetings. Participant comments revealed that after putting the program into practice, they felt more empowered to provide spiritual care. The primary reason given

for the low attendance was the challenge of fitting another meeting into an already demanding work schedule. Although MAT was considered a success by participants, MASG was not considered pragmatic.

In summary, it was not apparent whether MAT had a significant impact on patients and the general workforce. However, a significant impact was made by MAT on the chaplain and non-chaplain volunteer staff that participated. The support group on the other hand was not deemed a success due to pragmatic reasons.

Outcomes

Generally, MAT successfully enhanced chaplain services and FRH by adding trained non-chaplain and chaplain volunteers to the spiritual care team to provide additional spiritual and emotional care for FRH staff and patients. MAT helped to recognize the important role chaplaincy plays, as well as creating a larger sensitivity to the emotional and spiritual needs at FRH. Since the implementation of MAT on a quarterly basis at FRH, program participation has continued to grow. The program has also been advertised to AH chaplains and its administration. As a result, a number of AH hospitals have requested MAT curriculum and some have begun to implement this program in their hospitals at various levels. Most importantly, MAT improved the capacity of the Chaplain Services Department at FRH to provide broader and more effective spiritual and emotional support to patients and staff.

Adventist Health's AVP for Mission and Spiritual Care, Paul Crampton, indicated the practicability for a program like MAT in the AH system to help bolster patient satisfaction and wellness (personal communication, March 19, 2013). Also, according to

an article submitted to the *American Journal of Quality* (Bokovoy, Chapwick, Crampton, Doram, Profit, B. Sexton, & J. Sexton, 2015), findings from a Spiritual Climate survey administered at AH hospitals revealed “clinical areas high on spiritual climate had respondents that reported lower burnout, lower intentions to leave, and lower rates of disruptive behaviors.”

Conclusions

For FRH, an accessible, competency-based, practical and missional focused MAT for non-chaplain and chaplain volunteers increased non-chaplain and volunteer chaplain participation in the organization’s mission of providing wholistic care. This study establishes that MAT supports the mission of FRH, as well as staff alignment and patient satisfaction. This conclusion suggests that widespread employment of this proposed training curriculum would have positive missional impact on the entire AH organization. As a result, other AH hospitals were encouraged to adapt MAT to their specific environments, following the recommended steps and preserving curriculum fundamentals. The greatest learning from this MAT pilot project was that when chaplaincy trains and supports non-chaplain and volunteer chaplains as part of a spiritual care team, the possibilities for missional impact, emotionally and spiritually, on a healthcare community is unlimited. MAT may also have implications for other forms of non-chaplain and volunteer chaplain educational opportunities. Finally, many topics of MAT curriculum application and impact are worthy of further exploration.

Recommendations for Further Research

Limitations to this study include not investigating a number of areas such as to what extent MAs use MAT materials and how “user friendly” they were. These areas could be essential to a thorough understanding of non-chaplain and volunteer chaplain development. The main emphasis has been validation of MAT for non-chaplain and volunteer chaplains and to evaluate the usefulness of an accessible, mission-focused, and competency-based program for non-chaplain and volunteer chaplain training. Further exploration of post pilot project modifications and uncharted territory is warranted.

MAT Modifications Post-Pilot Project

After the initial MAT pilot was completed, several changes were made to improve the benefits for MAT trainees. One of those changes was the addition of a co-instructor. The current co-instructor is a registered nurse (RN) who actively participates in spiritual care at FRH, bringing with her not only a strong missional focus but also a medical perspective on spiritual and emotional care in the workplace. This addition balanced the medical and non-medical approach to spiritual and emotional care making the class more applicable to a broader number of participants.

The second change was a stronger emphasis on the practical verses the theoretical during the four-hour class. For instance, discussion on the historical connection and scientific benefits, grief, and most of the YouTube video clips was shortened, and the personality types of wanters, givers, and seekers were no longer taught. Remaining time was used for group discussion on case studies and personal reflection using the handout

materials. A “FICA” (faith and belief, importance, community, assist) spiritual assessment was added to guide spiritual conversation (Appendix N). This tool was presented as the standard for spirituality and religious conversations and support.

A third change was to offer RNs and CNAs four CEUs, through the Education and Training Department, to assist them in meeting their yearly state requirement for licensing.

A fourth change, made by the Education and Training Department, was to require MAT as part of the curriculum for the Versant, a RN new graduate residency program required by FRH.

The fifth change was to give each participant a small gold-colored label pin with a pair of praying hands at the completion of MAT, which they could display on their name badge to indicate completion of MAT and a willingness to participate as MAs in their department.

The ultimate effect of these five changes has not been measured. However, anecdotal results are encouraging.

Uncharted Territory

There are more challenges and opportunities for non-chaplain and chaplain volunteer growth that deserve attention. Although the outcomes of this study highlight the success of MAT on healthcare at FRH, knowledge is still power and additional education may enhance the success of the program. Following are nine opportunities for exploration.

A four-hour class covering chaplaincy competencies does not necessarily result in proficient spiritual care volunteers. It does, however, provide an awareness of and framework for the acquisition of these skills and should be further developed. A variety of education programs I Clinic Pastoral Education (CPE) or an advanced MAT could be developed to provide advancement in knowledge and proficiency in each competency.

Second, a broader marketing of MAT could lead to higher levels of participation and long-term support for the program.

Third, despite the lack of participation in MASG, the creation of a support system to encourage sustainability of MAT is deemed necessary. This support system would be more flexible to meet the varied staff work schedules. Possibilities could include regular emails and phone calls, and individual- or department-specific meetings with MAs to bolster participation and support.

Fourth, a comparative exploration of the effectiveness of chaplaincy specific competencies to other approaches of spiritual and emotional support to derive effectiveness could be helpful.

Fifth, an AH-wide post-pilot project already being explored is field testing MAT in a variety of healthcare settings. The diversity from this field test might be beneficial in assessing the effectiveness of MAT as developed to determine if adjustments may need to be made depending on the site implementation.

Sixth, integration of MAT into programs like General Employee Orientation for new employees was not considered. Further exploration with the Education and Training

Department and the administration could provide guidance as to the availability and support for this alignment idea.

Seventh, this pilot project does not compare the development of MAs to volunteers in other programs. This understanding of the differences in training and job description could determine whether future changes in MAT are needed in the application of this training in different contexts.

Eighth, the benefits of continued education on the core competencies for chaplaincy to the MA and the organization were not considered. This may lead to greater existential reward for the volunteers and greater implementation of the competencies by the participants.

Ninth, coaching is currently part of the training for chaplain volunteers but not for non-chaplain volunteers. Coaching non-chaplain volunteers may result in higher confidence and commitment to the program's mission.

Additional investigation into these nine areas of improvement will improve non-chaplain and chaplain volunteer success at FRH and AH. The results of this investigation should lead to closer alignment with FRH's and AH's mission of wholistic healthcare, "To share God's love by providing physical, mental and spiritual healing."

APPENDIX

APPENDIX A

INFORMED CONSENT FORM

**Project Title: Training Program for Non-Chaplain and Volunteer Chaplains
Conducting Spiritual Care at Feather River Hospital, Paradise California**

I state that I am 18 years of age or older and wish to participate in a program of research being conducted by Brad Brown at Feather River Hospital, Paradise California for his Doctor of Ministry program through Andrews University, Berrien Springs, Michigan.

The purpose of the research is to study if a spiritual care training program offered to the Feather River Hospital workforce has a correlation on the NRC and PRC scores. Volunteers from the Feather River Hospital workforce will participate in a one day four hour training session conducted on spiritual care and then encouraged to use the skill set they develop in the workplace setting. The PRC and NRC scores will be assessed for any correlations.

Each participant's information will be kept in confidence. Only the names of the participants will be kept on file for the purpose of tracking the number of participants in the spiritual care training from each department and the total number of participants from Feather River Hospital.

I understand that the experiment is designed to improve my skill set for providing spiritual care to those associated with Feather River Hospital.

I understand that I am free to ask questions or to withdraw from participation at any time without penalty.

If you require further information, please contact me at the Chaplain Services Department, Feather River Hospital, 5974 Pentz Rd, Paradise, CA 95969 and/or call (530) 876-7102.

Yours sincerely,

Brad Brown, Director of Chaplain Services, Feather River Hospital

I, _____, have read the above information on the study. I understand the purpose of this study which has been explained in the information above and understand that my participation is voluntary. I hereby consent to be involved in this research study.

Signature of Participant _____ Date _____
Signature of Witness _____ Date _____

APPENDIX B

MAT CLASS SCHEDULE

Mission Ambassador Training Schedule

0800-0820	Introductions
0820-0835	Adventist History of Healthcare
0835-0845	Science, Religion and Healthcare
0845-0905	What Spiritual Care Is/ Is not
	Patient's Spiritual Rights
	Discussion
0905-0920	Communication/Listening
0920-0935	Exercise
0935-0955	Spiritual Distress
0955-1005	BREAK
1005-1015	FICA
1015-1030	Exercise
1030-1050	Religion and Culture
1050-1105	Prayer
1105-1115	Providing Emotional Support
1115-1125	WaGS
1125-1135	NINER
1135-1145	Review Grief Materials
	How to Make Chaplain Referrals
	Conclusion

APPENDIX C

EDUCATION AND TRAINING PROGRAM EVALUATION

Education & Training Program Evaluation

Title of Course/Topic: _____ Date: _____

How would you overall rate this presentation (please circle): POOR FAIR GOOD EXCELLENT

SPEAKER	Knowledge of Subject					Content & Presentation					Questions & Discussion				
	Poor				Superior	Poor				Superior	Poor				Superior
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Comments: _____

TEACHING METHOD	NA	Not Helpful 1	2	3	Very Beneficial 4
Lecture/Discussion					
Seminar					
Group Projects					
Slides/Overheads/Power Point					
Handouts					
Lighting/Amenities/Food					

Comments: _____

Were the objectives of this program clear? Yes _____ No _____ Were they met? Yes _____ No _____

Please Comment: _____

How did you learn about this program? Brochure/Flier _____ Currents _____ Education Hotline _____
Other _____

I would like to attend future symposiums on the following topics: _____

Participant Name (Optional): _____

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APPENDIX D

POWERPOINT PRESENTATION

4/13/2016

Objectives

- The Mission Ambassador Training will help you:
- Learn to apply our mission to your work setting.
- Learn to provide spiritual support to peers.
- Learn to pray with patients appropriately.
- Learn about different cultures and beliefs.

- The Mission Ambassador Training:
- Sign-in Sheet
- Mission Ambassador Training Manual
- LLU Health Systems Health Care & Religious Beliefs
- Didactic
- From Theory to Practice
- Handouts
- Monthly MA Support Group
- Dates: 1/19/15; 2/19/15; 3/5/15
- Time: 12:00 pm – 12:30 pm
- Location: Fireside Lounge
- Breaks

Introduction and Overview

Mission Ambassador

- The title "Mission Ambassador" comes from two words. An Ambassador is a person who acts as a representative or promoter of a specified activity, or in our case, the mission of Feather River Hospital which is to "share God's love by providing physical, mental and spiritual healing."
- As a part of the ministry team, you will have the opportunity to help meet physical, emotional, social, and spiritual needs.

AH Mission, Vision and Values

- **Mission**
 - To share God's love by providing physical, mental and spiritual healing.
- **Vision**
 - Feather River Hospital will be a recognized leader in mission focus, quality care and fiscal strength.

AH Mission, Vision and Values

•Values

- At Feather River Hospital, we value:
 - The compassionate healing ministry of Jesus;
 - Human dignity and individuality;
 - Absolute integrity in all relationships and dealings;
 - Excellence in clinical and service quality;
 - Responsible resource management in serving our communities;
 - The health care heritage of the Seventh-day Adventist Church, and;
 - Each other as members of a caring family.

History of Seventh-day Adventist Beliefs & Health Care

AH Healthcare Heritage

- Adventist Health's heritage dates back to 1866 when the first Seventh-day Adventist health care facility opened in Battle Creek, Michigan. There, pioneers promoted the "radical" concepts of proper nutrition, exercise and sanitation in a facility devoted not just to the healing arts but also to the prevention of disease. They called it a sanitarium, a place where patients and their families could learn to be well.

AH Healthcare Heritage cont.

- More than a century after Battle Creek, the health care system sponsored by the Seventh-day Adventist Church operates 160 hospitals and nearly 500 clinics, nursing homes and dispensaries worldwide. From Michigan to California and throughout the West, this early vision to treat the whole person—mind, body and spirit—is the foundation for their approach to health care.

Adventists & Healthy Lifestyle

- Historical church teachings focused on the whole person, worship, diet & exercise.
- Emphasis is placed on abstaining from tobacco, alcohol & illicit drug use.
- Emphasis is placed on eating fresh fruit, vegetables, water, and little or no meat products (only clean meat).
- People of all ages are encouraged to exercise on a regular basis & have healthy social lives.
- Worship, prayer and meditation are viewed as daily activities and spiritual growth.

Western Health Reform Institute (1866)

Battle Creek Sanitarium (Today)

Battle Creek Sanitarium

Whole Person Care

- A commitment to giving excellent care- body, mind and spirit.
- Care with compassion and love.
- Care with respect and dignity.
- Care with sympathy and kindness.
- Care that is inclusive.

Care that is culturally competent & sensitive to any individual's spiritual expressions, gender roles & beliefs about birth, healing, death & afterlife.

Is there a Scientific connection between Spirituality, Religion and Healthcare?

Medicine and Faith in 1910: Immeasurable?

"Nothing in life is more wonderful than faith -- the one great moving force which we can neither weigh in the balance nor test in the crucible... mysterious, indefinable, known only by its effects, faith pours out an unending stream of energy while abating neither jot nor tittle of its potency."

Sir William Osler (1910). "The faith that heals," *British Medical Journal*, 1:1470-72.

Are Religion and Science Mutually Exclusive?

"Religion and science are mutually exclusive realms of thought whose presentation in the same context leads to misunderstanding of BOTH scientific theory and religious belief."

National Academy of Science (1984). "Science and creationism: A view from the National Academy of Science."

Science & Spirituality Contradictions

Spirituality

- Metaphysical Realities
- Inexact
- Abstract
- Intuitive
- Ultimate

Science

- Physical Data
- Seeks Precision
- Concrete
- Methodological
- Penultimate

The Scientific Method

- Demonstrates trends
- Shows relationships between variables
- May account for causality
- Is limited to sense data
- Cannot predict an individual's specific outcome
- Cannot prove spiritual truths

Religion Defined

A quest for the Sacred or Ultimate Reality involving the means, methods, rituals or prescribed behaviors receiving validation and/or support from an identifiable group

Spirituality Defined

The feelings, thoughts, experiences, and behaviors that arise from a search for the Sacred, meaning, or of being a part of something greater than oneself.

"One might be tempted to ask why, in a 'post-Christian', materialistic and technologically oriented society, mental health professionals should take seriously the therapeutic implications of something as apparently ethereal and 'unscientific' as spirituality. Surely, one might argue, in an age of science, reason, pharmacology and therapy such an intangible human quality as spirituality cannot hold a central place within the therapeutic complexities of contemporary mental health care practices."

Spirituality and Mental Health Care: Rediscovering a Forgotten Dimension by John Swinton

"Our prior research shows that the mental health of people recovering from different medical conditions, such as cancer, stroke, spinal cord injury and traumatic brain injury, appears to be related significantly to positive spiritual beliefs and especially congregational support and spiritual interventions. Spiritual beliefs may be a coping device to help individuals deal emotionally with stress."

Medical News Today, August 23, 2012

"Science without religion is lame; religion without science is blind."

Albert Einstein

Religion and spirituality are "among the most important factors that structure human experience, beliefs, values, behavior, and illness patterns."

Lukoff D, et al. *Journal of Nervous and Mental Disease* 1992; 180:673-682.

Science & Spirituality: The Perfect Marriage

- Perfect Marriage defined as:
- The union of two entities
- Each with intact identities
- Fully capable of standing alone
- Joining with each other because each benefits from the union
- But each maintaining a discreet identity in the process

Studies Reveal Patients Desire for Spiritual Support

Research suggests that patients struggling with serious illnesses want spiritual interactions with their physicians. Some doctors wrestle with how to react. Physicians are accustomed to fielding many challenging questions from patients, but there is one query that they may find especially flummoxing, considering the delicate terrain it requires them to traverse. The question: "Doctor, will you pray with me?" It's not a far-fetched scenario. About two-thirds of patients believe doctors should know about their spiritual beliefs... One in five patients likes the idea of praying with the doctor during a routine office visit, while nearly 30% want to do so during a hospital stay, the study found. Half of patients would want to pray with the doctor in a near-death scenario. About 75% of physicians say patients sometimes or often mention spiritual issues such as God, prayer, meditation or the Bible, said an April 9, 2007, article in *Archives of Internal Medicine*. amednews.com

For Dr. Larimore, it is the deeper connections with patients facilitated by prayer that make an impression. In early June, a patient undergoing a family trauma came in with elevated blood pressure. After a drink of water, a visit with a nurse and a prayer, the woman's diastolic blood pressure dropped about 20 points. "Was there a cause and effect? I don't know," Dr. Larimore said. "But I could tell by the tears in her eyes that the experience touched her."

amednews.com

Recent international and Australian surveys have shown that there is a need to incorporate the spiritual and religious dimension of patients into their management. By keeping patients' beliefs, spiritual/religious needs and supports separate from their care, we are potentially ignoring an important element that may be at the core of patients' coping and support systems and may be integral to their wellbeing and recovery. A consensus panel of the American College of Physicians has suggested four simple questions that physicians could ask patients when taking a spiritual history.... In considering the spiritual dimension of the patient, the clinician is sending an important message that he or she is concerned with the whole person. This enhances the patient-physician relationship and is likely to increase the therapeutic impact of interventions. Doctors, health care professionals and mental health clinicians should be required to learn about the ways in which religion and culture can influence patients' needs and recovery.

Dept. of Clinical Trials, Northern Psychiatry Research Centre, University of Melbourne

How can you participate and be benefited from the integration?

1. Identify Spiritual Distress
2. Communicate and Listen to the Patient
3. Provide Emotional and Spiritual Support to Patients: Prayer, Touch, etc.
4. Make referrals to Chaplain Services.

What Spiritual Care Is and Is Not?

Spiritual Care is Not:

- Forcing your religious beliefs on someone else.
- Having an agenda ahead of time.
- Correcting their religious/spiritual beliefs.
- Imposing prayer on patients.
- Sharing more than your asking (because you have an agenda).

Communication & Listening

Listening Skills Quiz:

1. Take a couple minutes and complete the quiz on p. 81.
2. Rate yourself on a scale of 1 to 10, 1 being a terrible listener and 10 being an excellent listener.
3. Share with the class why ranked yourself the way you did.

Communication & Listening

DO	Listening Skills	DON'T
• Always orient yourself toward the patient and make sure you are on the same level		• Be optimistic to a fault
• If sitting, lean forward slightly in your chair and avoid slouching		• Badger with questions
• Attempt to maintain appropriate eye contact and show interest		• Dictate action
• Always maintain your sincerity and express empathy		• Monopolize the conversation (own agenda)
• Accept their feelings regardless		• Tune out the speaker (computer, talking to coworker, etc)
• Listen for causes to the problem and help them associate cause and effect and work toward a solution.		• Fill in the pauses
• Remember they are real people not tasks to be accomplished.		• Tell the speaker how they should feel or what they should do, etc
		• Provide unsolicited advice
		• Pass judgment too quickly

Listening Skills Applied:

1. Find a partner, take a couple minutes taking turns sharing about an event that was meaningful to you.
2. The listener will practice using the “Helpful Phrases” on pages 78-80 of the MA Training Manual during the conversation.
3. Ask your partner to react to how they felt about your listening.

Spiritual Distress: Tips for Making Referrals

Areas of Inquiry	Possible Indicators of Spiritual Distress	Possible Questions
Permission for Referral	Referral may be made to the chaplain/clergy Chaplain's Office: <ul style="list-style-type: none"> Computer Generated "Spiritual Care Consult" Ext. 7102 Operator: 0 Page: Calendars in Work Stations 	Would you like to speak with someone about your spiritual concerns?

Case Scenario #1

Mr. B is a 60 year old African American with a history of prostate cancer. He has recently moved to your city with his wife of 38 years. They seem very close. They have 2 adult daughters who live in the local area.

Mr. B does not claim to have a spiritual practice. His wife and daughters have a long history as practicing Jehovah's Witnesses. Mr. B says he attends worship services on occasion.

At this time Mr. B has had severe pain, and episodes of vomiting. He has been unable to eat in several days. On one occasion he had severe diarrhea with copious bleeding. His wife saw the blood and became very upset. When she took him to the emergency room the physician told him that if his blood count was found to be too low he might need a transfusion.

*What spiritual questions might you consider?

*What questions would be of most benefit to obtain a spiritual assessment?

Case Scenario #2

Mrs. L is 72 years old, is Mexican, widowed and is a lifelong Catholic. She has been admitted because of a flare up with her COPD and has also been diagnosed with CHF. The patient has smoked for 52 years. The patient has been house bound for the last 2 months and does not have any relatives living in the area. The patient has been placed on comfort care and will be transferred to hospice.

*What spiritual questions might you consider?

*What questions would be of most benefit to obtain a spiritual assessment?

Religion and Culture

"Health Care and Religious Beliefs"

see Loma Linda University Health System booklet

"Recognizing Your Patients' Spiritual Needs"

see Mission Ambassador Training Manual, pps. 36-52

Prayer

Styles of Prayers

- Extemporaneous (no preparation) Prayer
- Prayer Recital-
- Psalms
- [Mantras- Buddhist & Hindu](#)
- Posturing- sit, stand, kneel etc.
- Verbiage- extra words, etc.
- "Prayer Talk"

Praying with the Patient

- When offering to pray with a patient, here are some helpful ideas:
- Ask the patient: Is prayer meaningful to you? If they reply with an affirmative, you may then ask, "Would you like me to pray with you?"
- Ask the patient if there is anything specific they would like to pray about
- You can ask the patient if they would like to lead in the prayer or have you pray for them.
- *Go with your intuition, sometimes its obvious in the conversation that prayer would not be meaningful to this patient so it may not be appropriate to even ask.
- *Remember, many patients will not want prayer but your presence is to them a "Sacred Presence"

Tips for Praying with Different Religions

- Orthodox Jewish: Amen
- Jehovah Witness: Jehovah
- Buddhist: Amen or none
- Islam: Allah or Amen ([Fajr Prayer](#))
- Etc.

Non-denominational Prayers

Sometimes a short prayer is the best. In her book, *Traveling mercies: Some thoughts on faith* (2000) Lamont argues that the two most common prayers are "Please, please, please..." and "Thank you, Thank you, Thank you..." Patients and nurses who wish can add "God" or "Lord" to the beginning of any of these prayers, or "In Jesus' name we pray" to the end. A calming prayer is "Calm my fears and anxieties as I go through this day." Some wish to say a prayer in the morning. One is "This is another day, O Lord. I do not know what the day will bring, but help me be ready to face the day." A similar prayer is "Please give me strength and courage to get through this day." Or "Help me Lord to be loving and kind to all I meet today." A prayer for both the patient and nurse is "God of compassion, source of life and health, give strength and new abilities to (insert name) and give your power of healing for those who minister to (insert name) needs." One nurse was often asked by the patients she cared for to pray with them. She has found that "Lord, please give (insert name) what he/she needs today" is very calming. Some say the prayer that never fails is, "Thy will be done."

Islamic Healing Prayer

Beloved Lord, Almighty God,
Through the Rays of the Sun,
Through the Waves of the Air,
Through the All Pervading Life in Space;
Purify and Revivify Us
And we pray, heal our bodies, hearts, and souls.
Amen

Navajo Indian Prayer for Healing

In the house made of dawn,
On the trail of dawn,
His feet, my feet, restore.
His limbs, my limbs, restore
His body, my body, restore,
His voice, my voice, restore,
With beauty before him, with beauty before me.
In the house of evening light,
On the trail of evening light,
Thank you for this day.

(This Navajo Indian prayer of healing or for those who believe in an Earth Mother, or are agnostic or atheist but still wish to take a moment to reflect on their place in the universe, and find peace in the beauty of the day as they begin or end their day.)

Tibetan Buddhist Phowa Prayer

Through your blessing, grace, and guidance,
through the power of the light that streams from you
May all my negative kama, destructive emotions,
Obscurations and blockages be purified and removed
May I know myself forgiven
for all the harm I may have thought and done.
May I accomplish all that I need to today,
And through the triumph of my disability,
May I be able to benefit all other beings, living or dead.

(Or)

Through your blessing, grace, and guidance, please release me
from my negative thoughts and destructive emotions.
May I know myself forgiven for all the harm I may have
thought and done. May I accomplish all that I need to today,
and embrace my disability to the benefit of others.

"The Mi Sheberakh"

a traditional Jewish healing prayer
(shortened version)

May the one who blessed our ancestors ---

Abraham, Isaac, Jacob, Sarah, Rebecca, Rachel and Leah

Bless and heal the one who is disabled and sick
___ (insert name) ___

May the holy Blessed One, overflow with
compassion upon him/her

To restore, to heal, to strengthen, to enliven
___ (insert name) ___

The One will send him/her speedily, healing of the
soul and body.

Let us all say; Amen.

Prayer for Health

"God of Health and Wholeness
We gather this morning to pray
For our dear friend (insert name)
as we desire for him/her to be restored
to the balance of good health
We pray for a successful surgery and for the
Medical Staff who will be working with him/her
So that, he/she may fully recover,
And return with renewed zeal
To the daily life that we share."

This blessing before surgery was obtained from the Catholic Health Association of the United States (chausa.org). It can be modified for any procedure a patient is to undergo, and can be used by people of several faiths.

"Our Father" or "Lord's Prayer"

Our Father, who art in heaven. Hallowed be thy name.
Thy kingdom come, Thy will be done, on earth, as it is in
heaven. Give us this day, our daily bread. And forgive our
trespasses, as we forgive those who trespass against us.
Lead us not into temptation, but deliver us from evil. For
Thine is the power, and the glory, forever, and ever.
Amen.

"Serenity Prayer"

"God grant me the courage to change the things I can, to
accept the things I cannot change, and the wisdom to
know the difference."

Prayers for Forgiveness

Patients may request a prayer for forgiveness, or a
prayer to forgive someone else. Both the "Our Father"
and the Buddhist prayers in the preceding paragraphs
ask for forgiveness. The following short prayer also
may be effective in helping a patient forgive someone
else. "Lord, ___ (insert name) ___ treated me badly, they
___ (briefly state what they did) ___, and I forgive them."
Encourage patients and families to say this prayer
every time the wrong doing comes into their head.
They may find they are no longer obsessed with
negative thoughts.

Prayers for Sleep and Pain Relief

- The following prayer was written for patients who ask to pray to be released from pain: "Dear Lord, I am facing this pain situation and it makes it difficult to work towards recovery. I don't know what it takes to bear this pain. Be near me in my time of weakness and pain. Give me the strength and courage to do what I need to do. Help me believe I can find comfort and rest. Thank you for your abundant grace. Amen."
- The following can be said with patients who ask for a prayer to help them sleep. "Heavenly Father, grant __ (insert name) __ the gift of sleep for the refreshing of __ (insert name) __ body and soul."

Prayer Prompts

Lord, __ (insert name) __ is facing __ (describe the situation) __

Trying to handle this alone makes __ (insert name) __ feel overwhelmed (express fears/weaknesses)

Give __ (insert name) __ your strength, joy, patience, and wisdom to face __ (the situation) __

Thank you, God for the abundant grace You provide for __ (insert name) __. Amen

Prayer Assignment:

1. Pick 1 Religious Group and Write out a Short Prayer for a Patient of that Religion.
2. Share your prayer with the class for feedback.

Providing Emotional & Spiritual Support

The Pit

Stage 1: Onlooker
"Sucks to Be You"

The Pit

Stage 2: Bystander
"Sucks to Be You"

Alone Again (naturally) by Gilbert O'Sullivan

- In a little while from now
- If I'm not feeling any less sour
- I promised myself to treat myself
- And visit a nearby tower
- And climbing to the top
- Will throw myself off
- In an effort to make it clear to who
- Ever what it's like when you're shattered
- Left standing in the lurch, at a church
- Where people are saying
- My God that's tough, she stood him up
- No point in us remaining
- May as well go home
- As I did on my own
- Alone again, naturally
- To think that only yesterday
- I was cheerful, bright and gay
- Looking forward to, but who wouldn't do
- The role I was about to play
- But as if to knock me down
- Reality came around
- And without so much as a mere touch
- Cut me into little pieces
- Leaving me to doubt
- Talk about God and His mercy
- For if He really does exist
- Why did He desert me

- In my hour of need?
- I truly am indeed
- Alone again, naturally
- It seems to me that
- There are more hearts
- Broken in the world
- That can't be mended
- Left unattended
- What do we do? What do we do?
- Alone again naturally
- Now looking back over the years
- And what ever else that appears
- I remember I cried when my father died
- Never wishing to hide the tears
- And at sixty five years old
- My mother, God rest her soul
- Couldn't understand, why the only man
- She had ever loved had been taken
- Leaving her to start with a heart
- So badly broken
- Despite encouragement from me
- No words were ever spoken
- And when she passed away
- I cried and cried all day
- Alone again, naturally
- Alone again, naturally

Questions asked by Giver?

- Am I really that important?
- Has my life had meaning?
- What did I do wrong to cause my illness?
- I deserved this, didn't I?
- Signs of the Giver...
- Main Emotion: Sad
- Minimize their importance.
- "Don't worry about me, I'm sure there is somebody worse off than can use your help."
- "I have a little pain, but I can wait until you have time."
- Blame themselves for their illness
- "I must have done something to get Cancer. God must be punishing me."

Needs of the Giver

- To know they are loved.
- To know their life has had meaning.
- To know that they will not be forgotten.
- To share their love with others.
- Self Worth
- Empowerment
- Affirmation
- How to approach the Giver
- Touch
- Saying thank you for their time shared
- Asking for advice or suggestions
- Sharing/hearing personal stories
- Simply reminding them that they are loved
- Validation

Wanter

"Ball and Chain" by Social Distortion

- Well it's been ten years and a thousand tears
- And look at the mess I'm in
- A broken nose and a broken heart,
- An empty bottle of gin
- Well I sit and I pray
- In my broken down Chevrolet
- While I'm singin' to myself
- There's got to be another way
- Chorus
- Take away, take away
- Take away this ball and chain
- Well I'm lonely and I'm tied
- And I can't take any more pain
- Take away, take away
- Never to return again
- Take away, take away
- Take away
- Take away this ball and chain
- Well I've searched and I've searched to find the perfect life
- A brand new car and a brand new suit
- I even got me a little wife
- But wherever I have gone I was sure to find myself there
- You can run all your life but not go anywhere
- Chorus
- Well I'll pass the bar on the way to my dingy hotel room I spent all my money
- I've been drinkin' since half past noon
- Well I'll wake there in the mornin'
- Or maybe in the county jail times are hard getting harder
- I'm born to lose and destined to fail
- Chorus

• Signs of a Wanter

- Main emotion: Mad
- Does not feel heard.
- Blames others for illness (i.e. MD's, HMO, family, companies, God, etc.)
- Has few visitors, estranged family, damaged relationships.
- Failure to recognize others are also in need of care.
- Distrusts caregivers.

• Questions asked by Wanters

- Why didn't somebody catch this before?
- Why won't anybody listen to my concerns?
- Don't they know how sick I am?

• Needs of a Wanter

- Need to recognize that they are not alone in their feelings.
- May need reconciliation with relationships that have been damaged.
- Need to recognize their own sense of responsibility and accountability.
- To be spoken to honestly by a trusted individual
- Community

• How to approach the Wanter

- Listen and reiterate what has been said.
- Offer gentle reminders that there are others that also need support.
- Be direct and honest. That is what they are really wanting.
- Create firm, but fair boundaries.
- Involve other professions such as Social Work and Chaplaincy to offer a realistic vision and help create a new community.

• Is there any hope for the Wanter?

- Wanters tend to open up to the care around them when they accept the reality of their illness. This is the opportunity for the patient to recognize that they are not alone and have a loving, caring health-care team to be with them.

“All By Myself” by Erik Camen

• When I was young	• All by myself, Don't want to be all by myself anymore
• I never needed anyone	• And making love was just for fun
• Those days are gone	• All by myself, Don't want to live all by myself anymore
• Living alone	• When I was young
• I think of all the friends I've known	• I never needed anyone
• But when I dial the telephone	• And making love was just for fun
• Nobody's home	• Those days are gone
• All by myself	• All by myself
• Don't want to be all by myself anymore	• Don't want to be all by myself anymore
• All by myself	• All by myself
• Don't want to live all by myself anymore	• Don't want to live all by myself anymore
• Hard to be sure	• Chorus
• Sometimes I feel so insecure	
• And love so distant and obscure	
• Remains the cure	

• Who is the Seeker

- The Seeker is somebody that views their life as meaningful, feels they have good connections with a community, but are feeling lost nonetheless.

• Signs of a Seeker

- Main emotion: Afraid
- Pensive
- Shares advice freely but also shares that “something is missing.”
- Looks to caregivers for answers.
- Strong family connections, though patient may feel things are unresolved.
- May be questioning of God's will

• Questions asked by the Seeker

- Why am I still here?
- Is there something I need to be doing?
- God must want me on earth for something, right?
- Is this normal?

• Needs of a Seeker

- The Seeker needs somebody to journey with them. Though they ask questions, they don't want answers. They merely want to know that it is okay to ask.

• How to approach Seeker...

- Ask reflective questions. “It sounds like you are feeling a lack of purpose. What do you feel you have left to do?”
- In end of life cases, reassure them that their life is complete and it is OK to die.
- Let them know that their questions are normal.
- Encourage them to share their stories and share their experiences.
- Explore how they managed during other times of “Seeking.”
- Co-journey with them, help them discover the purpose they are seeking.

Quiz

Name the type of patient: Wanter, Giver, Seeker.

1. The patient is a 56 year old Caucasian male, married, 2 kids, has been an inpatient for 1 week. Patients wife has visited 5 of the days but no other visitors have come. Patients room is bare with no flowers or cards. Admitting diagnosis is cardiac ischemia. Patient is angry with the cardiologist for not diagnosing him sooner. Patient is also complaining about his wife not visiting him enough.

Quiz

Name the type of patient: Wanter, Giver, Seeker.

2. The patient is a 76 year old Asian female, widowed, and has 3 children one of whom she lives with. LOS is 4 days. Admitting diagnosis is a bowel obstruction. Patients room has lots of flowers and cards and patient has had a number of visitors. The patients nurse comments on how the patient never complains and is complaint and easy going. Patient mentions to you how she feels bad about taking up space in the hospital when she would be fine at home.

Quiz

Name the type of patient: Wanter, Giver, Seeker.

3. The patient is a 34 year old Hispanic male, has a SO with whom they share a 6 month old baby boy. Admitting diagnosis is pancreatitis. Patient has had numerous visits by friends and family. Patients chart reveals they are Catholic but in conversation the patient shares they have not attended mass in 18 years. Patient has asked numerous questions to staff about their health and future. Patient wants to talk to you about troubles in their life and things they are worried about but seems uncertain about the answers he gets from you.

Emotions

Only 4 Kinds of Emotions: Sad, Glad, Mad, Afraid

NINER

4 Kinds of Emotions: Mad, Sad, Glad, Afraid

Name- "You're scared of dying" (State the facts)
Identify- "So you're scared?" (Restate the same feeling)
Normalize- "That seems normal" (Empathize)
Explore- "Tell me what it's like for you being scared" (Dig Deeper)
Reflect- "So I hear you saying you're scared when you think of dying..." (Restate everything that happened)

Grief: Understanding the Bereavement Process

[YOUTUBE](#)
[The Grieving Process:](#)
[Coping with Death](#)

[YOUTUBE](#)
[The Five Stages of Grief](#)

“What Are Patients and
Families Experiencing?”
see Mission Ambassador Training
Manual, pp. 101

“Anticipatory Grief—A
Patients Perspective”
see Mission Ambassador Training
Manual, pp. 102

“Empathy”
see Mission Ambassador Training
Manual, pp. 85-88

“Typical Physical,
Behavioral, Cognitive, and
Emotional Responses
During Grief”
see Mission Ambassador Training
Manual, pp. 88-89

“Grief and Mourning”

see Mission Ambassador Training
Manual, p. 91

**“12 Steps in the Grief
Process”**

see Mission Ambassador Training
Manual, pp. 92-93

**“Grief—Expectations You
Can Have for Yourself”**

see Mission Ambassador Training
Manual, p. 94

**“Recognizing Your
Patients’ Spiritual Needs”**

see Mission Ambassador Training
Manual, pp. 36-52
see LLUCH Health Care and Religious
Beliefs

**“Grief Recovery—Moving
in the Right Direction”**

see Mission Ambassador Training
Manual, p. 95

**“Suggestions for Helping
Yourself Through Grief”**

see Mission Ambassador Training
Manual, p. 100

“Children and Death”

see Mission Ambassador Training Manual, pp. 103-113

Patient Visitation: “How to Make a Visit”

Basic Outline of a Visit

- Prior to Visit
 - Pray & Relax (can help clear mind and set aside personal issues)
- Introduction
 - I-CARE
 - “May I enter?” “May I sit down?”
- Set the tone of the visit by clearly indicating that the focus of the conversation will be on the patient: “How are you?” “Can I help you with anything today?”
- Touch patient as appropriate- hand, shoulder.
- Visit
 - Listen
 - Try to identify any major issues & feelings that may be presented by the patient or come up in conversation

Basic Outline of a Visit cont.

- Reflect back to the patient.
- Re-state to the patient what you think they might be expressing to ensure that you have interpreted the conversation correctly.
- Question the patient further for clarification.
- Allow room for silence.
- Pray if patient wishes
 - “Would prayer be meaningful to you?”
 - “Do you have a faith or religion?”
 - “Would you like to lead the prayer?”
- Use most important facts and feelings from your conversation in the prayer if you are leading.
- Conclusion of Visit
 - Leave the patient without making promises

Referral to Chaplain Service

Why might you call a chaplain?

Call a chaplain for:

- Patient or family request.
- Prior to a life - altering surgery.
- Terminal diagnosis.
- End-of-life decisions.
- Clinical emergencies such as Code Blue.
- Patient/family request
- Patient in isolation 7 or more days
- Multiple family members as patients
- Fetal demise or low birth weight babies
- Transfer of patient to higher level of care
- Patient under 16 years old without an attentive adult

Spiritual Rights For Patients

Each patient has the right to:

- Refuse spiritual care.
- Request notification or a representative from *their* clergy/church/mosque/synagogue of choice.
- Practice one's own spiritual expression that does not impede patient care, safety or infection control standards of the hospital and may not involve others against their will.

How to Contact Chaplain Services:

- Report all patient/family requests
- Via: PBX, phone message, computer generated
- Chaplain office: ext 7102; dial "0"
- Calling from the community: 872-7102
- Office Days: Mon.-Fri.
 - If chaplain does not answer the phone, please page chaplain on call.
- On Call Chaplain available 24/7

Chaplain Calendars are located:

- PBX Operator
- Nursing Stations
- Intensive Care & Emergency Care Units

Objectives

- The Mission Ambassador Training will help you:
- Learn to apply our mission to your work setting.
- Learn to provide spiritual support to peers.
- Learn to pray with patients appropriately.
- Learn about different cultures and beliefs.

Always remember to follow the "Golden Rule."

QUESTIONS?

Please Fill out the
CLASS EVALUATION FORM

APPENDIX E

MISSION AMBASSADOR TRAINING MANUAL

Mission Ambassador Volunteer Training Manual

MISSION AMBASSADOR

Volunteer Training Manual

FEATHER RIVER HOSPITAL
Paradise, California

An Adventist Health Affiliate

ACKNOWLEDGEMENTS

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CHAPLAIN SERVICES MISSION AMBASSADORVOLUNTEER CHECK-

OFF LIST

FEATHER RIVER HOSPITAL

NAME _____

VOLUNTEER/ORIENTATION	SIGN-OFF	DATE
Introduction to the Hospital		
Volunteer Role & Responsibilities		
Confidentiality		
Concepts of Death, Dying, Grief		
Communication Skills		
The Bereavement Process		
Spiritual Issues		
Psychosocial Issues		
ADMINISTRATIVE		
Hospital Staff and Volunteers		
Chaplain Department Structure		
Hospital Policies		
Communications – Beeper, Cellular Phones		
Customers, Who Are		

FEATHER RIVER HOSPITAL MISSION AMBASSADOR VOLUNTEER ORIENTATION PROGRAM

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Feather River Hospital
Mission Ambassador Volunteer Training

Module 1 – Introduction and Mission Ambassador Volunteer Role and Responsibility

Learning Objectives:

By the end of the session volunteers will:

1. WELCOME
2. What is a Mission Ambassador Volunteer?
3. Guidelines
4. The History of Adventist Health
5. The History of Feather River Hospital
6. Mission of Adventist Health
7. Emphasis on physical, mental & spiritual needs
8. Healthcare interdisciplinary team and services provided
9. Feather River Hospital
10. Identify the various roles he/she can provide as a volunteer
11. Have an understanding of the many ways a volunteer can provide support to patients and families
12. Discuss the importance of confidentiality and patient rights
13. Have an understanding of the volunteer job description
14. Identify the needs for dress code and ID badges
15. Gain an understanding of documentation expectations
16. Have knowledge of available resources

NOTES:

Welcome!

You have just entered into a new and exciting dimension of volunteer service. Serving hospital patients in their time of crisis, diagnosis, pain and distress can be very rewarding. Feather River Hospital is committed to serving the spiritual needs of the patients who entrust their care to the hospital.

Volunteers are very important to the pastoral care effort. With your support, many lives will be touched and special assistance will be provided to our patients. We are glad that you will become a part of the healing team in this hospital and we look forward to the contributions you will make to this ministry.

In general, to minister is to render selfless and personal service to those in need, with special focus on religion and spirituality. Your service will offer personal emotional support and spiritual encouragement to patients and their families. Yours will be both a challenging and a rewarding experience. Thank you for giving your time to this important work.

This manual is designed to give you an overview of what you may expect as a Mission Ambassador Volunteer, some guidelines you need to follow and some practical training skills for working with patients.

What is a Mission Ambassador Volunteer?

A simple question? Maybe not. It would be a simple question if a volunteer was simply one who is not paid for the work he or she does. But that might lead us to conclude that a volunteer is not as important as a paid employee. That simply is not the case! Volunteers are essential to an organization like this. While volunteers receive no monetary benefits and do not seek special recognition or praise, there will be great personal satisfaction as you touch lives and extend care and compassion to those in need.

The title “Mission Ambassador” comes from two words. An Ambassador is a person who acts as a representative or promoter of a specified activity, or in our case, the mission of Feather River Hospital which is to “share God’s love by providing physical, mental and spiritual healing.”

As a part of the ministry team, you will have the opportunity to help meet physical, emotional, social, and spiritual needs.

The word “volunteer” comes from the Latin word ‘volo’ meaning, “I will.” Your volunteering shows that you are truly an “I will” person. Often a paid employee is “willed” to do something by their employer. You, on the other hand, are offering an invaluable service with a willing spirit. We are glad you are here!

Mission Ambassador Volunteers bring a different dimension and excitement into the hospital. This is done out of a deep caring for people and a desire to share with others. You bring special skills, talents and vision. You will become part of a team made up of volunteers, chaplain services staff, patients, family members and medical/support staff. Your presence will become a source of daily help, affirmation and assistance to all members of the team.

Ask Yourself?

What benefits would you like to gain from volunteering here? How would you like to make a difference at this hospital? What type of recognition (if any) might you seek from this job?

About Chaplaincy

The Chaplain Services Department at Feather River Hospital has a strong tradition of offering interfaith spiritual support for its patients, families and staff.

WHAT IS A CHAPLAIN?

As a part of the hospital team, the Chaplain is someone, lay or ordained, who provides spiritual support and pastoral care to patients, family and friends. Feather River Hospital employs chaplains with CPE training with a goal of having them Board Certified with the Association of Professional Chaplains, or other professional certifying body. The Chaplain's unique training helps in providing spiritual care that represents a wide range of religious traditions. In addition to staff chaplains, representatives from the local clergy and lay persons who volunteer to help us provide spiritual care to our patients.

WHAT DO CHAPLAINS DO?

The role of the Chaplain is varied. Religious beliefs are not imposed upon our patients. Chaplains listen and endeavor to help patients cope with the questions raised by their illness, encouraging them to talk about their concerns and discover their own meaningful answers.

Sometimes patients need to vent their feelings to someone with an empathetic ear. Feelings of anxiety, anger, frustration and sadness are normal.

On other occasions, the Chaplain's role is to help the family and other caregivers become more sensitive and responsive to the patient's needs, enabling them to be more caring, supportive and understanding. If patients wish, we will read to them and/or offer prayers appropriate to their faith tradition. If patients are affiliated with a local religious organization, the Chaplain may play a supportive role and help communicate the patient's needs to his/her local clergy.

Our primary purpose is to provide patients with someone who is fully present and authentically caring, helping patients, and their loved ones, during this tumultuous time of their life to maintain dignity, grace and choice.

WHEN DO PEOPLE SEEK A CHAPLAIN?

People call on Chaplains for a multitude of reasons. Some of the most common reasons include:

- For encouragement and hope
- To find meaning and purpose
- To help you feel you are not alone
- Comfort
- Companionship and friendship
- Reconciliation
- When feeling helpless
- To help create a connection with the divine
- When needing the comfort of prayer
- When struggling with life
- When seeking solace through sacred writings
- When making important decisions
- When facing ethical dilemmas
- To perform sacred rituals

About Our Hospital

Adventist Health Adventist Health's heritage dates back to 1866 when the first Seventh-day Adventist health care facility opened in Battle Creek, Michigan. There, pioneers promoted the "radical" concepts of proper nutrition, exercise and sanitation in a facility devoted not just to the healing arts but also to the prevention of disease. They called it a sanitarium, a place where patients and their families could learn to be well.

More than a century after Battle Creek, the health care system sponsored by the Seventh-day Adventist Church operates 160 hospitals and nearly 500 clinics, nursing homes and dispensaries worldwide. From Michigan to California and throughout the West, this early vision to treat the whole person—mind, body and spirit—is the foundation for their approach to health care.

Originally, Adventist hospitals were governed by regional church leadership. As health care became more complex, however, the need arose for more time and specialized expertise than church administrators could give. In the 1970s the Seventh-day Adventist Church authorized centralized control and operations of its health care institutions at the Union (multi-state) level.

One-year later, regional divisions formed corresponding to the church's infrastructure. These divisions were known in the North Pacific Union as Northwest Medical Foundation and in the Pacific Union as Adventist Health Services. In 1980, the two western entities joined to form Adventist Health System/West, now known simply as Adventist Health.

Today, Adventist Health is a not-for-profit, faith-based health system operating in California, Hawaii, Oregon and Washington. Founded on the Seventh-day Adventist principles of Christian health care, Adventist Health comprises 20 hospitals with nearly 3,000 beds, nearly 19,000 employees, many clinics and outpatient facilities. It operates the largest system of rural health clinics in California, 15 home care agencies and three joint-venture retirement centers.

Feather River Hospital

Heritage We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths.

Every individual, regardless of his/her personal beliefs, is welcome in our facilities. We are also eager to partner with members of other faiths to enhance the health of the communities we serve.

History In 1946, Dr. Merritt C. Horning envisioned building a "total health center" in Paradise, California. Dr. Horning shared this vision with three of his colleagues: Dr. Dean Hoiland, Dr. C.C. Landis and Dr. Glenn Blackwelder. These men, along with other community leaders, purchased 35 acres from Paradise Irrigation District for the price of back taxes – \$3,500. Within the next few years, additional acreage was acquired

throughout several purchases, eventually totaling 182 acres. Labor and building materials were largely acquired through donations and volunteers.

Construction was scheduled to begin in April 1948, however, at the time funding was not available to build surgical and obstetrical units. When applying to the State of California for an operating license, the hospital board learned that the hospital did not qualify for a license unless it had a surgical unit. Dr. Horning contacted a friend, the state director of public health, and soon a new hospital classification was created to accommodate the project. Within days, Feather River received a license to operate as an acute medical facility containing 18 beds and officially opened in 1950.

Feather River has experienced three “firsts” in their geographical region. It was the only hospital in the area to train nurse assistants; they pioneered the teen volunteer program of candystripers and handystripers, and the facility was the first public building in Butte County to prohibit smoking.

In 1952, a surgery unit was added and by the end of the decade, a new wing also had been completed. More space was soon needed, so in 1964 a new food service department and a physician’s office building was added. Four years later, in 1968, the construction of a new 150-bed hospital was completed. This facility is located uphill from the original building which now houses the hospital’s Health Center.

The hospital founders and trustees desired to ensure the facility’s long-term mission as an Adventist health care center and so in 1960 they entrusted the hospital to the Northern California Conference of Seventh-day Adventists. On January 8, 1973, Feather River joined Adventist Health and became Adventist Health/Feather River Hospital.

2008: Feather River Health Clinic on Skyway opens, housing services once offered at the Rural Health Clinic on the Hospital campus. The outpatient pharmacy is also relocated here implementing drive-thru services and a prescription filling robot.

2006: Opening of the new Sleep Medicine building on Peach Lane. Site announced for the new Rural Health Clinic on Skyway.

2005: The hospital receives a Bronze Award from the California Awards for Performance Excellence.

2004: Feather River Hospital is one of Solucient's Top 100 hospitals for quality.

2003: Cancer Center opens with state-of-the-art radiation and medical oncology services. Hospice House also opens with the first in-patient hospice facility in Butte County providing 24-hour nursing care in a home-like environment. The 7,200 square-foot building includes six private rooms and other common areas typical of a home setting, with adjoining administrative offices.

1994: The Birth Day Place opens.

1980: Ground breaking for new wing, north side of hospital, adjacent to present ER.

1972: Six bed Intensive Coronary Care Unit established.

1964: Completion of new kitchen at original hospital. New physician's office building completed.

1959: New addition--five room plus two rooms for doctor and office.

1950: Opening of new 15-bed sanitarium building at the current Canyon View Clinic site.

ADVENTIST HEALTH'S MISSION STATEMENT

To share God's love by providing physical, mental and spiritual healing.

OUR VISION

Adventist Health will be a recognized leader in mission focus, quality care and fiscal strength.

OUR VALUES

- Compassion- The compassionate, healing ministry of Jesus
- Respect- Human dignity and individuality
- Integrity- Absolute integrity in all relationships and dealings
- Quality- Excellence in clinical and service quality
- Stewardship- Responsible resource management in serving our communities
- Wholeness- The health care heritage of the Seventh-day Adventist Church
- Family- Each other as members of a caring family

Being Not-for-profit

Being a not for profit organization means that Feather River Hospital does not earn profits for its owners. All of the money earned by or donated to a not for profit organization is used in pursuing the organization's objectives.

We Give Back To Our Communities

Feather River Hospital is committed to giving back to Paradise and surrounding communities. Feather River Hospital supports community benefit activities like:

- Lifeline Emergency Response System
- Meals on Wheels
- Health Foundation
- Give a Gift
- Volunteer Services
- Community Health Needs Assessment

Hospital Guidelines

The Administration of the hospital has specific guidelines for its volunteers such as identification, a background check, and medical screening.

Identification: Proper identification must be worn at all times. Items of identification include a name badge. The name badge will serve patients by identifying you before you even begin speaking.

Background Check: All employees and volunteers of Feather River Hospital are required to have a criminal background check to assure that our patients and families are as safe as possible.

Medical Screening: Volunteers are required to provide a brief medical history, as well as receive a TB test. This is a routine procedure to help assure your safety and the safety of the patients.

Solving Special Problems

You may encounter some problems. Talk with the chaplain. The chaplain should know whom to contact in special cases. In the event of a medical emergency, contact the nurses' station immediately. The chaplain can assist with spiritual and counseling needs. You should never try to solve medical care issues.

Adventist Health is an integrated delivery system, combining Health Plans, Physicians, and Hospitals & Health Services. The delivery of care is provided through interdisciplinary teams made up of physicians, nurses, social workers, care managers, and all other disciplines required for quality health care.

What Responsibility Does the Hospital Have Towards Me?

THE HOSPITAL IS EXPECTED TO:

- Treat you as a co-worker and member of the hospital family.
- Listen to and respect your opinions.
- Understand your personal needs.
- Provide you with sufficient information about the organization.
- Train you for your role as a hospital Pastoral Care volunteer.
- Provide ongoing educational enrichment opportunities.
- Give you an appropriate assignment.
- Give you guidance and direction for the performance of your role.
- Provide you with a variety of experiences.
- Constructively evaluate your performance regularly.
- PROVIDE YOU WITH SUPPORT AND ACKNOWLEDGEMENT.

What Responsibility Do I Have Towards the Hospital?

MISSION AMBASSADOR VOLUNTEERS ARE EXPECTED TO (if you are a FRH volunteer):

- Attending volunteer training.
- Understand and support the hospital goals.
- Participate in appropriate team conferences.
- Accept the guidance of your leader/coordinator.
- Advise your coordinator of any change in your volunteer status.
- Communicate your personal concerns and needs to your leader/coordinator.
- Be responsible for the required paperwork and fulfill your commitments.
- Communicate openly and freely with the hospital team.
- Listen to your co-workers and respect their opinions.
- Provide your own transportation.
- Be prompt and reliable.
- Follow the hospital standards of conduct.
- Experience tremendous personal growth and satisfaction from your hospital volunteering.
- Adhere to the policies and procedures of the FRH and the Chaplain Services Department
- Enjoy your hospital experience.

FRH MISSION AMBASSADOR VOLUNTEER POSITION DESCRIPTION

JOB SUMMARY: Responsible for providing spiritual and emotional care per training to hospital patients and families, and the FRH workforce to make referrals to a chaplain when the care needed goes beyond the scope of training.

REPORTS TO: Director of Chaplain Services

GENERAL DUTIES AND RESPONSIBILITIES

SERVICE	Mission Ambassador Volunteers will provide spiritual and emotional care to patients as appropriate. Volunteers may offer prayers with the patient at the patient's request and make referrals as needed to the chaplain on duty. Mission Ambassadors have completed the training program and have a heart for providing emotional and spiritual support to patients.
DOCUMENTATION	Maintains appropriate records of visits as appropriate, including making any necessary referrals to the chaplain on duty.
COMMUNICATION	Utilizes effective communication skills in a timely, concise, clear and positive manner.
CONTINUING	Participates as available in monthly Mission Ambassador support group.
EDUCATION	
CONFIDENTIALITY	Demonstrates confidentiality and sensitivity to patient and family rights according to FRH policy.
PATIENT/FAMILY	Takes ownership for meeting patient/family needs and resolves
RELATIONS	concerns/issues appropriately.
QUALIFICATIONS:	Must be at least 18 years of age. Complete hospital General Employee Orientation and volunteer training with Chaplain Services Department volunteer coordinator and an annual TB test. Demonstrate ability to work as a team member and have a nonjudgmental attitude. Must be willing to work with and meet the spiritual needs of people of all faiths. Ability to deal with the stressful nature of hospital work.

QUALIFICATIONS

Must be at least 18 years of age. Complete hospital General Employee Orientation and an annual TB test. Demonstrate ability to work as a team member and have a nonjudgmental attitude. Must be willing to work with and meet the spiritual needs of people of all faiths. Ability to deal with the stressful nature of hospital work.

What Are My Limitations of Care?

- As a Mission Ambassador, you do not offer medical advice to a patient or their family unless you are also a FRH staff member assigned to providing care for this patient. When medical questions arise, refer the patient or primary care person to the nurse or other medical care team members.
- Be aware regarding following up with patients. It is natural to want to follow up with a patient you have connected with, but without proper boundaries burnout can occur very quickly.

Guidelines for Visiting

- Don't visit with a set agenda of things you want to discuss. Allow the person to begin, to let you know how he/she feels at the time and what he/she is ready to share with you.
- Don't bring up emotionally charged topics that may create anxiety, yet don't shy away from topics the person wishes to discuss. There is a fine line between the two situations that takes some experience to recognize. Try not to let your own uncertainty or lack of confidence cause YOU to retreat from what the person wants to communicate.
- Avoid using ready-made clichés, biblical quotations or easy answers. They may cause a person to end a needed discussion rather than continue it.
- Don't leave before the person has "closed" again. Allow the person time to put things back together after a significant disclosure.
- As helpers, we can aid or hinder the mourning process. If we shorten it, it may remain unresolved, only to erupt later. Our goal is to help mourning proceed at its normal pace, not to hurry it along.
- Don't create long-term dependencies. Don't be possessive. Mourning is a transitional period in a person's life, a time when special care can often provide the help needed. **It is necessary to recognize when to pull back and to allow the person to move on.**
- **Many people feel helpless in working with the bereaved. You cannot bring back the deceased, and this feeling of not meeting the bereaved person's need sometimes leads to a feeling of helplessness or uselessness. You can, however, offer your presence and support.**
- Remember: bereavement, grief and mourning are normal responses. Too often, people in our society can't tolerate the feelings that accompany them, and consequently avoid the bereaved individual or try to deny the process he/she is experiencing. Through Chaplain Services and Mission Ambassador Volunteers we can provide support and listening that society frequently denies. This can be a most important service.

EMOTIONAL SUPPORT

- Provide hope, encouragement, friendliness and spiritual care as appropriately needed.
- Serve as a willing, sensitive listener.
- Provide encouragement to patient and family members.
- Be aware of the feelings both patient and family will be experiencing by trying to put yourself in their position.
- Remember unreasonable anger is not aimed at you but may be a reaction some people have to their circumstances.
- Enjoy hearing stories and memories, or share a joke.
- Discuss their deeper thoughts, if you are asked to, by letting the patient or family member express their feelings.
- Listen to what is being said and what is being expressed behind the words.
- Think of ways to make your visit quality time for the patient and family.

ROLE OF THE MISSION AMBASSADOR VOLUNTEER

The first visit is always hard. “Will they like me?” “Will I be able to help?” “What will I do?” These questions are natural. Just remember at these times that you have been selected to serve as a team member because people experienced in the field have confidence in you. Just “plunge in,” taking with you an attitude of openness and receptiveness to the needs of the patient/family to whom you have been assigned. They will let you know what they need, and you, in turn, will let them know what you can offer. The relationship unfolds step by step in a very natural way.

Here are some guidelines that may help:

1. **GENUINENESS** – BE YOURSELF. Aside from modifications in behavior to assure the comfort of the patient; i.e., quietness, less talking and more listening, conscious attentiveness, etc., the volunteer should relate with the same ‘personality’ he/she displays in other situations. People who are ill appreciate being treated naturally, and in this way are reassured that their illness has not set them apart any more than in the obvious ways. Relate to the patient, not to the illness.

This holds true for family members as well. The volunteer role is that of friend and supporter, not expert or authority. You are not expected to know all the answers. It does not take long to clarify for the family that the nurse and physician can best answer medical and technical questions, and that you are there to provide other nontechnical support.

2. **COMMUNICATION WITH THE NURSE** – The importance of clear communication between nurses, social workers and volunteers cannot be overemphasized. The two of you can be of great help to one another and to the patient/family by maintaining contact and keeping one another current with what is going on. Don’t be afraid to take the initiative in establishing this relationship; it is important to break the ice early so that a strong bond can be established before the patient/family’s situation comes to a crisis. Clarify mutual expectations with one another at the start.
3. **COMMUNICATION WITH THE FAMILY** – It is your responsibility to state clearly to the family what you can and cannot offer. This will prevent awkward and possibly painful misunderstandings at another time. It is helpful to ensure you and the family members know your role at the beginning and that you indicate how you can help fill any needs, given your own life pattern. Again, it is important that you take the initiative.

4. **DEPENDABILITY** – To people in crisis, whose lives are subject to so much unpredictability, it is essential to know that they can count on someone or something. Never offer more than you know you can deliver. The life of an injured or ill person has little variety and, therefore, each contact assumes larger-than-usual proportions and importance.
5. **LISTENING** – Always remember that your function as a Mission Ambassador volunteer is to first meet the needs of your patient and family, rather than your own. In most instances this means listening more than talking. It may mean listening to stories; stories that for whatever reason satisfy a need of the patient or the family in the telling. It may mean listening nonjudgmentally to outbursts of anger, frustration, and resentment which serve to release tension. You may even be the target for some of these negative feelings. Don't take it personally. People under severe stress often act inappropriately.
6. **CONFIDENTIALITY** – References to the patient/family should be confined to contacts with the care team, either individually or at meetings. Information of extreme confidentiality divulged by a patient or family member should not be shared in a group session unless it bears directly upon the designing of a care plan. Such information may be shared with the individual team members, however, if needed for peace of mind of the volunteer.

At no time should a volunteer promise 'not to tell anyone' any piece of information alluded to by a patient or family member. It is for the protection of both the patient/family and the volunteer that the volunteer be allowed to use his/her discretion as to whether information needs to be passed along to an appropriate team member, such as the consulting psychiatrist or the patient's physician. The names of patients should never be given to someone outside of the care team without the express permission of the patient or family member. You may not tell any clergy member, priesthood leader or neighbor even if you attend church with the patient.

7. **PHYSICAL CONTACT** – Some people like to touch and be touched. Others don't. It is helpful if you can be flexible with this issue yourself, so that you can cue in on the needs of those you are serving. In most instances, patients welcome hand-holding and other appropriate physical gestures as means of communicating, caring and 'connection' without necessity for tiring conversation. Family members, too, often respond to a hand on the arm or across the shoulders as a gesture of "I'm here. I care." Be open. Do what feels right.
8. **MEET THEM WHERE THEY ARE** – Over and over again in your training, the concept of tuning in to the family and meeting them in terms of their own values and life patterns is stressed. Regardless of how much you may disagree with a family's way of dealing with their situation, it is never appropriate to give unsolicited advice.

Patterns of interaction between family members, no matter how counterproductive they may seem to you, have been formed over years of association and are rooted in a history of which you are not a part. Your responsibility is to work as helpfully and harmoniously as possible within the given structure, not to try and change it.

9. **INITIATIVE** – At the outset of a relationship, the family will usually look to the volunteer to set that pattern of interaction. Don't assume that someone doesn't need to talk to you just because they haven't called you. On the other hand, be sensitive to the possibility in which you are doing most of the talking.

10. **"LITTLE THINGS MEAN A LOT"**

- Your personal grooming and manner of dress can affect a patient's mood. Color and attractiveness can help lift the spirit.
- Perfume or after-shave can be unpleasant to people on medication.
- A positive attitude and pleasant expression mean a lot. This does not mean phony cheerfulness or overly bright chattiness, but merely a clear message of caring and attention.
- Cards and flowers brighten a room and remind the patient that people care even when they cannot be present.
- Sometimes not talking, but sitting with a patient and letting him/her know you care by being there, is the greatest gift of all.

FRUSTRATIONS

Becoming involved as a volunteer may present unexpected frustration for some people. The team approach between team members and the volunteer is delicately balanced and depends more on the needs of the patient/family than it does on the relationship between team members and volunteers. In some cases, the social worker provides the primary support role for the team. This may be because the patient sees no need for a volunteer, or does not wish to share his/her personal life except in a professional way. In other cases, the patient might just need a friend. Bear in mind that the nurse's role is more defined, as well as other team members, and often more easily accepted, particularly in the beginning. As a volunteer, don't be frustrated by this. The advice is "tread lightly, but hang in there."

CONFLICTS

Another area that may cause frustration is personality conflict. There might be a conflict between the patient and the nurse, or between the volunteer and the patient or a member of the family, or even between the nurse and the volunteer. Remember, this is OK, because we are human. If the conflict is between the volunteer and the patient or family member, remember that it might be temporary, as the family or patient might resent needing anybody. In time, the initial rejection can turn into deep friendship. In truth, you will become very involved with some patients and remain relatively untouched by others.

PERSONAL REACTIONS

The relationship a volunteer has with a patient/family is sometimes a deeply personal one. The volunteer may also feel grief. Sometimes, these reactions are immediate and easily identified. Others may be delayed for some time, perhaps making it more difficult to identify the source.

The care team discusses each patient on a regular basis and the volunteer probably will not become a part of this conference. In the case of a hospital patient, the team approach offers several avenues for us to talk through our experiences. There may be a personal reaction. "How did this affect my life?" Time can be made to discuss personal reactions with fellow team members.

Some volunteers may pass through a preoccupation in their own lives with the fear of cancer or the fear of death for themselves or some close member of their family. This is not unusual, for most of us have not been this involved with death before. To some extent, this might have positive result; i.e., getting wills in order or funerals planned. We'd like to think we would be better equipped to handle our own close family member's death after this kind of hospital experience.

Visitation

Be Yourself

There are so many things you can do when visiting a patient. The most important rule is to be yourself. Someone once said, "... a patient's room is like his or her home." That is why some patients will act as a host and invite you in. Others will not. They have that prerogative. Be kind, thoughtful, and alert as you visit. **The plan to follow is to Stop, Look and Listen.**

Stop

Before you first go in to visit a patient, take a moment to clear your mind. Stop and relax. You should clear your mind before each patient visit. If you are visiting a lot of patients in a day, you might need to clear your thoughts and refocus before each visit.

Taking a few deep breaths, a couple of shoulder shrugs and head rolls, or a cool drink of water might just be the thing that gets your mind cleared and prepped to do your visiting better. Above all, go in a spirit of prayer. If appropriate, stop at the nurse's station to inform them of your presence on the floor before entering patient rooms.

Be sure to knock before you enter a room where the door is partially open or fully closed. Always introduce yourself. This is very important. Even if your ID is clearly visible, some patients may not see it or know who you are.

Look

You have been given five great senses with which you can get a good first impression of the patient. As you enter the room, be sure to look around the room for noticeable signs that supportive friends or relatives may have visited. Here are a few questions you might want to ask yourself as you look around the room:

- * Do you see flowers or cards?
- * Are there any books, newspapers or magazines?
- * Are there gifts that may have been brought in?
- * Are the curtains open or closed?
- * Does the patient have a neat appearance?
- * Do the men have a clean shave?
- * Are the women wearing make-up?
- * What do you perceive in the patient's eyes?
- * Do you get a blank stare or a happy smile?
- * Do you receive a cordial welcome?

This sensory inventory process should help you determine if the patient is in good spirits, sad, lonely, depressed, or just needing someone in the room for support.

CHARACTERISTICS OF A MISSION AMBASSADOR VOLUNTEER

1. Be natural, flexible, warm, understanding, supportive, open, sensitive, discreet and empathetic.
2. Recognize that disease and hospitalization is a part of life's experience and be willing to explore and study your own reactions to illness, death and dying, as well as approach problems, tasks, schedules and events in a manner reflecting this understanding.
3. Be a caring person who understands that the patient may need to give as well as receive, and to choose rather than to have choices made for him or her all the time.
4. Be a good listener—sometimes a sounding board, sometimes just being near. A good listener is an active listener who must have a skilled sense of timing and a willingness to share his or her own experiences and patience.
5. Realize that the patient may discuss information of a confidential nature. Such a trust, one of the highest compliments paid to a volunteer, must not be abused.
6. Do not replace a family member, but rather become a part of the patient-family experience as a concerned person, perhaps ultimately a friend.
7. Recognize that a volunteer does not receive any financial reimbursement for services. Although a close, friendly relationship can develop between the volunteer and patient, the volunteer must not become so consumed by the experience that the volunteer's own family suffers.
8. Be dependable and accountable. It helps to establish a rhythm to visits and services, so that the patient and family know the volunteer can be relied upon.
9. Recognize that a volunteer is a guest in the patient's room and is not there to take over.
10. Remember that the volunteer is a part of the hospital team of which the nurse, social worker and care manager are the case managers. The volunteer is not alone, but can consult the chaplain, nurse or social worker if feeling overwhelmed or uncomfortable about some aspect of the situation.

Adapted from an article by Edith Dorang in Nursing Outlook, March 1981

SUGGESTED WAYS TO SERVE PATIENTS AND FAMILY MEMBERS

What Are Some Specific Ways I Can Help?

- 1. Patient Support:** Praise patient for past life accomplishments, communicate with aphasic patients through print board, listen, sit quietly, hold hand, talk to patients about their trips, business and family, give reassurance, talk with patients about their fears. Give the patient the opportunity to review their life and share their memories with you.
- 2. Entertaining Patient:** Read books, play musical tapes, read newspapers, reminisce, take funny short stories to read, bring little gifts; i.e., homemade items. Share a jigsaw puzzle, crossword puzzle, photo album, magazine. Let the patient be in control as much as possible.
- 3. Spiritual Support:** Pray with patient, read scriptures/Bible, bring tapes of sermon/music from their church, read hymns, contact clergy/priesthood/Relief Society or other women's auxiliary, encourage them to talk about their faith, especially their fears or anger.
- 4. Family Support:** Respite time, give assurance to family, visit with family. If appropriate for your role, stay with the patient while the primary care person takes a nap, goes shopping or meets a friend.

A Few Tips to Remember

- Perfume and after-shave lotion can be unpleasant to some people taking medication.
- Cards and flowers last a while after your visit and remind the patient that you care.
- Baked food or fruit may be acceptable if appropriate.
- Often NOT talking, but sitting with a patient and letting him or her know you care by being there, is the greatest gift of all.
- When you visit, be sure to take your SIMLE with you.
- Be reliable and punctual.

Possible Problem Areas To Be Aware Of

1. Mustering up enough courage to start relationships when we first meet patients and family. Some times it is hard to enter into a room and not know exactly what role we will find to fill.
2. Some patients/families don't think they need the emotional and/or spiritual support you offer at first. Sometimes they have to see and sense your interest, concern and commitment.
3. Set time limits for visits. Sometimes people overstay reasonable time. It can be reemphasized what the volunteer has committed as far as time is concerned.
4. Small personal gestures and helps can go a long way to helping a patient feel more comfortable. However, a volunteer should never do anything that interferes with the goals of medical caregivers.
5. Know your patient and/or their family members and their needs before you introduce prayer or provide any religious service. These may be uncomfortable for the family if this is an area not wanted. Explore carefully with those present.

What I Need To Know and Some of My Responsibilities

A. ASSIGNMENT

The Mission Ambassador training is open to the entire workforce at Feather River Hospital, including physicians, staff and volunteers. Because of this diversity your assignment may be different than the rest of your class. However, your assignment as Mission Ambassadors is to listen to the patients, their families and friends, and your fellow hospital workforce and let them express their feelings to you while you offer emotional and spiritual support to them. Sometimes these encounters will take place in a formal manner and other times you will minister informally.

B. THE HOSPITAL TEAM

Your visit may be limited in scope. The nurse and social worker will continue to direct activities with the patient and family. Depending on your role, if you have any questions on a medical subject or any other problem, feel free to ask the social worker or nurse. Be sure to follow all signs on the door. The other team members will be glad to help you.

C. CONFIDENTIALITY

This is essential. References to the patient/family should be made only to one of the hospital or Pastoral Care team members. We realize that you may want to share your feelings, especially after a visit. This is the time to call a team member, not your neighbor. At no time should a volunteer promise not to tell anyone. If families ask you to keep a confidence, remind them that if the information is important to their care, you are obligated to share it with a team member. It is for the protection of both the patient/family and the volunteer that the volunteer be allowed to use his or her discretion as to whether the information needs to be passed along to an appropriate team member.

D. MEDICATIONS

Volunteers are not responsible for medications. Volunteers never take medication out of a bottle themselves. All medical care is immediately available. If a patient or family member asks you to help with medications, simply tell them you will get the nurse.

E. LISTENING

Always remember that your function as a volunteer is to first meet the patient needs rather than your own. It may mean that you will listen more than you will talk. It may mean listening, nonjudgmentally, to outbursts of anger, frustration or resentment that serve to release tension. You may be the target for some of the anger and frustration.

DON'T TAKE IT PERSONALLY. People under severe stress often act inappropriately, and the anger is really directed at life and circumstance, NOT AT YOU. The importance of being a good listener cannot be stressed too much. Try to make your visit quality time for the patient or the family.

F. MEET THEM WHERE THEY ARE

We keep stressing the idea of “tuning in” to the patient or family and meeting them in terms of their own values and life patterns. Never give unsolicited advice; refer to professional help as needed. Patterns of family relationships have been formed over years of association. Your responsibility is to work as helpfully as possible with the patient's needs, as they are, and not try to change things or be judgmental on any subject. Spiritual care is sensitive and must be respected. Never try to change a person. Listen to their religious or spiritual position without judging or giving advice. You may suggest that they follow up with any questions they have with their own clergy or priesthood leaders. It is OK to encourage patients to seek answers to any questions on their own.

G. REASSURANCE

The patient needs to be reassured that they are going to receive the best of care and that someone will be there to help with whatever problem he/she has. The family members or the primary care person needs encouragement and to be told that he or she is doing a good job. Show your concern by inquiring about the amount of sleep they are getting and about their meals and nutrition.

H. TOUCH

Some people like to touch and be touched. Others don't. For instance, in a new relationship, a touch on the arm or holding hands will tell them, “I'm here and I care.” We have found that a hug is sometimes welcomed and reassuring. Touch in a way that is comfortable for both you and the family.

I. RELIGION

Volunteers should never impose their religious beliefs on the patient or family. If the family does not have a church with a minister, priest or bishop visiting them, and they would like to have a visit, you can tell them about our Hospital Chaplain. He/She will visit the family if that is what they would like. The referral should be made to the Chaplain Services Department, which will notify the Chaplain and ask him or her to visit.

J. REPORTS

Please chart as appropriate for your role in the hospital.

K. MISSION AMBASSADOR VOLUNTEER SUPPORT GROUP MEETINGS

Regular monthly meetings may be held for the support, benefit and information of the volunteers and of the other members of the team so that the patient and family are better served. They give an opportunity for volunteers to talk about their visits, ask questions and receive guidance and advice from other team members and volunteers. Learning from other volunteers' experiences is an especially helpful aspect of these meetings.

L. ONGOING TRAINING

Training is continued in a one-hour, monthly meeting. In-service meetings may also be held to consider hospital-related subjects. Volunteers are asked to be there as often as possible.

M. ASSISTANCE

The Chaplain, a hospital nurse or a social worker is always available to assist with any concerns you have about your volunteer work. Be sure to contact them regarding any problems you are having with the patient or family.

Dress code and ID badges

Whether you are a Feather River Hospital volunteer or an employee, please dress according to the appropriate guidelines for your particular responsibility. T-shirts and jeans are not appropriate. For identification purposes, you must wear your FRH badge at all times while in the hospital and visiting patients or performing other volunteer duties.

Volunteers must be tested for TB annually and those working in the emergency centers should have a series of three hepatitis shots.

Documentation

Any patient information given is considered confidential. Provide appropriate staff with any information needed for appropriate follow-up.

Scriptures

Patients may request scriptures to read. Care should be given to provide the appropriate scriptures for each patient. Feel free to read the scriptures to patients who would benefit from it and desire that service. Below are a few scriptures you might choose from. Feel free to select any others, as requested by patients or based on your own experience in finding peace in difficult situations.

2 Corinthians 1:3-5

Psalm 23

Psalm 91

Psalm 100

Psalm 121 (At the time of, or shortly after death)

Luke 17:11-19
Hebrews 12:1-2

Add Other Specific Scriptures/Thoughts

DOs and DO NOTs

The following DOs and DO NOTs are listed as suggested guidelines. Some may seem trivial or silly, but while working in a hospital, certain rules are critical. They are to be followed for your protection as well as for the safety of the patients with whom you will be working.

1. **Do wear proper identification at all times.** It is important to knock before entering, introduce yourself, and explain the purpose of your visit to each patient.
2. **Do notify the nurse's station of your presence and purpose on the ward.**
3. **Do follow through on promises.** If you promise to visit a patient in a couple of days, do so. Nothing hurts worse than a broken promise.
4. **Do follow proper dress codes.** The Chaplains' office requests that you dress appropriately. This excludes blue jeans, shorts, and hats.
5. **Do wash your hands or use spray foam (as appropriate) before or after patient visitation.** Just like the medical staff, please wash your hands often so you do not pick up germs or diseases and pass them along to the next patient you visit or take them home to family and friends.
6. **Do be a good listener.** This is the most important part of your job. Patients often need someone to talk and share with. You will have many opportunities to be that person. You need to listen very attentively to the needs of the patient. And, as time goes by, you may begin to establish a relationship and be able to help meet the spiritual needs of the patient. It is important not to judge anything the patient may tell you. Just listen and be a friend. If Ecclesiastical authority, a pastor or priest is needed, **DO NOT** get into areas that are reserved for those who serve in that role. Encourage the patient to discuss private matters with the appropriate person.
7. **Do be trustworthy.** As a volunteer, you will be privy to a great deal of personal information, either through records, hospital staff, or the patient themselves. This information is only for you, and should be treated confidentially. If a patient shares something with you, they expect you to keep it to yourself. With the permission of the patient, information should be shared with the chaplain if doing so will benefit the patient.

8. **Do try to find ways to encourage and give hope.** A hospital can be a very gloomy place. You have an opportunity to give hope and encouragement to the patients and staff of this hospital.

9. **Do be committed and accountable.** When you volunteer, you are assigned specific tasks.

Therefore, when you are not here, those tasks do not get done. The Chaplain's office is counting on you, and is dependent upon you to carry out these responsibilities.

10. **Don't be a doctor (unless you are the doctor).** Ours is a distinctly religious/spiritual ministry--one of hope and hospitality. The medical staff alone will attend to medical needs. Avoid any "doctor talk"--specific illnesses, treatment plans, and diagnosis/prognoses. Focus on our unique message of faith and hope!

11. **Don't invade a patient's personal space.** Just being in a hospital takes away a patient's privacy. With nurses and doctors coming and going, the patient feels as if they are living on a freeway. This is where a patient's personal space becomes their only privacy. Unwelcome touching, even holding a person's hand or a touch on the shoulder, may be a violation of that space. Always be sensitive and discerning of the unique needs of individual patients.

12. **Don't sit on or touch a patient's bed.** A patient may offer you a chair if one is available. If there is no chair, the patient may be embarrassed and offer you a seat on the edge of the bed. (You may want to get a chair from some other area if you are invited to sit down.) When visiting, use common sense, etiquette, and hospitality.

13. **Don't preach.** Although it may be very tempting and you have a "captive" audience, **DON'T PREACH!** You may be able to share your own personal spiritual story. Your first purpose is to offer assistance by encouraging spiritual care, putting a patient in contact with clergy at their request, and giving information about sacraments and services offered. Secondly, you are to be a friend to the hurting and sick.

14. **Don't criticize the hospital staff or the hospital.** "Of course" you think this would never happen. Believe it or not, it does. Try to redirect any negative comments the patient may have to the proper staff member, or assist by being positive and helpful. The patient must have as much confidence as possible in the health care team. Healing will happen more quickly if positive support is given.

15. **Don't become an errand runner.** Unfortunately there are some patients who want you to work only with them. It is okay to help patients. However, you should not involve yourself in things that are not part of your function as a volunteer visitor. Your common sense and intuition are the best guide of what you should do.

16. **Don't ask what is wrong with a patient.** Unless it is necessary for your particular job, do not ask what is wrong with the patient unless a patient offers personal medical information. Some patients may not want anyone to know why they are in the hospital,

or they themselves may be unsure. As a rule of thumb, let the patient lead the conversation. Never pry or probe. Ask general questions to help learn from the patient. People will discuss what is first on their mind, usually according to their trust of the person with whom they are talking. Do not assume everyone wants to talk.

17. Do be kind and courteous to everyone. Remember that you represent the hospital and the Chaplain's office.

FRH Mission Ambassador

Volunteer Orientation

Module 2 – Spiritual Issues

Learning Objectives:

By the end of the session volunteers will:

1. Gain an understanding of “spiritual care”
2. Identify cultural differences in family practices and attitudes surrounding grieving, dying and death in society
3. Have an understanding of the importance of a life review
4. Gain an ability to assist patient/family through a life review

NOTES:

FRH POLICY

SPIRITUAL AND CULTURAL SUPPORT

Purpose

The purpose of Feather River Hospital's Chaplain Services Department is to provide a systematic process for the delivery of in-depth spiritual comfort, guidance, support, counseling and consultation for patients, their families, and the staff in times of physical, emotional and spiritual crisis. The Hospital and its Chaplain Services program recognize the varied cultural and spiritual backgrounds of the people we serve, so we strive to meet their needs through an interfaith, non-proselytizing approach to pastoral care. The Chaplain Services Department is organized for the specialty of the services it provides, reporting to the Chief Executive Officer of Feather River Hospital.

SCOPE OF CARE

The Chaplain Services Department performs a variety of duties to serve patients, families and staff. The Chaplain Services Department supports the hospital's philosophy of total care by meeting the spiritual and, at times, the emotional needs of patients and families as they relate to the patient's medical condition. Chaplains provide initial spiritual screening and assessment, education concerning religious/cultural beliefs and other services, some of which include:

- Religious rituals and services
- Crisis intervention and grief support
- Non-clinical aspects of end of life care and decision making
- Staff support
- Linkage with community religious groups
- Facilitation of issues involving meaning and purpose, faith, hope and relationship.
-

HOURS OF OPERATION/STAFFING

The Director of Chaplain Services provides in-house services from 8:00 a.m. to 4:30 p.m., Monday through Friday. Staff and on call chaplains are available at the request of patients, their family or staff, for emergencies or any special need. To request a Chaplain after hours, call the operator and ask for the on call chaplain to be paged.

SKILL LEVEL OF PERSONNEL

The Director of Pastoral Care is certified, or eligible and/or in process of certification by the Association of Professional Chaplains (APC) or the National Association of Catholic Chaplains (NACC). The staff chaplains have all received at least 1 unit of CPE and the

on call chaplains are trained local ministers or lay people. The chaplain volunteers all receive department specific training before providing chaplain care.

The Director is responsible to assure that the Chaplain Services Department staff and volunteers are in compliance with the Feather River Hospital Policies and Procedures relevant to State and Federal regulations and laws.

Spirituality and Illness

Assessing for Spiritual Needs (Two Models)

- Spirituality is the hope that there is something greater than ourselves. Religion is a community of shared spiritual values
- Humanity by its very nature is spiritual.

When we become ill, we tend to look outside of ourselves for help and hope that we can become well again. Our illnesses force us into the unknown and put us face to face with our mortality. By very nature we want to survive and we each make deals that help us continue our survival. These 'covenantal' agreements are usually brought into question when we are ill and facing death.

What is a Covenantal Agreement-

A Covenant is an if - then statement with our source of spiritual strength. This could be God, our community, or even ourselves. In a way, it is a way of tricking ourselves from seeing the realities of life. It is a natural response to a world we have no control over, but hope to overcome. Such covenants could include: "If I don't smoke, then I won't get cancer." "If I exercise, then I will not have a heart attack." "If I am a good person, God will leave me alone." "If I go to church every Sunday I will live a long and happy life."

Dennis Kenny, in his book **Promise of the Soul**, notes "sometimes these covenants are healthy and lead to good things. All too often, though, our covenants are not healthy and can lead to problems and crises in our adult lives." Inevitably life challenges our covenants and makes them useless and in need of revision. When this happens, according to Rev. Kenny, we lose faith in ourselves, our community or our purpose.

WAGS Assessment Tool

Using Howard Clinebell's four spiritual needs from his book, **Basic Types of Pastoral Counseling**, as a template, I have identified three core areas of spiritual need that need to be met. These are

- 1.) Self Worth**
- 2.) Community**
- 3.) Purpose**

Each of these needs should be balanced, when one dominates the other, we become spiritually ill. Many times this spiritual illness is made more manifest through our physical illness, other times our physical illness reveals our spiritual illness.

Self Worth - Illness or loss naturally brings into question our sense of self worth. Statements such as "I deserved this," "Don't bother wasting your time with me," "There's nothing anybody can do," "I should have known better," "I should have tried harder," show signs of a low sense of self worth. Sometimes merely a touch, holding a hand or telling somebody they are important can restore their sense of worth. Reminding them that they are not alone, but are loved by a community also helps.

Common Symptom - Depression, reticence, sadness

Community - When we become ill we lose our sense of community. Many times our own lack of self worth causes us to remove ourselves from our community. When that worth is regained, we enter our community again. Other times our over-inflated sense of worth cause us to leave our community. We often blame the community for our illness. Statements such as "Why me?" "I'm a good person, I don't deserve this," "Had they found this earlier I wouldn't be here" and "This is their fault" are common. The goal is to remind these patients that they are not alone, that others are just as sick and that they need to take their own personal responsibility.

Common Symptom – Anger, Blaming of others, Little outside support

Purpose- These patients are "lost." They do not feel a lack of self worth, nor do they feel left out of their community. They may have lost their hope. They are not questioning their illness, nor do they feel abandoned. Common statements are, "I don't know what I'll do," "I'm not sure why I'm still here," "I'm trying to figure out why I have this . . ." Or they may just say, "I'm fine." The hope is to work with the patient to find a new purpose or meaning in their life.

Common Symptom - Aloofness, despair, hopelessness, tired.

When these needs are balanced, we are then in a position to witness to others our experience and become teachers. The goal of a Spiritual Caregiver is to assist a patient change themselves. Our spiritual wellness can not be forced from outside.

Basic Spiritual Needs

A healthy spiritual life does not necessarily involve an organized religious practice, nor even a belief in God. Individuals that have a healthy spirituality are those that recognize their own worth and importance while contributing to their community and have a fulfilling sense of purpose.

Balanced Spirituality

The Giver

Song: "Alone Again, Naturally" by Gilbert O'Sullivan

Questions asked by Giver

- Am I really that important?
- Has my life had meaning?
- What did I do wrong to cause my illness?
- I deserved this, didn't I?

Signs of the Giver...

- Minimize their importance.
- "Don't worry about me, I'm sure there is somebody worse off that can use your help."
- "I have a little pain, but I can wait until you have time."
- Blame themselves for their illness
- "I must have done something to get Cancer. God must be punishing me."

Needs of the Giver

- To know they are loved.
- To know their life has had meaning.
- To know that they will not be forgotten.
- To share their love with others.
- Affirmation
- Empowerment
- Self Worth

How to approach the Giver

- Touch
- Saying thank you for their time shared
- Asking for advice or suggestions

- Sharing/hearing personal stories
- Simply reminding them that they are loved
- Validation

The Wanter

Song: “Take Away this Ball and Chain” by Social Distortion

Signs of a Wanter

- Does not feel heard.
- Blames others for illness (i.e. MD’s, HMO, family, companies, God, etc)
- Has few visitors, estranged family, damaged relationships.
- Failure to recognize others are also in need of care.
- Distrusts caregivers.

Questions asked by Wanters

- Why didn’t somebody catch this before?
- Why won’t anybody listen to my concerns?
- Don’t they know how sick I am?

Needs of a Wanter

- Need to recognize that they are not alone in their feelings.
- May need reconciliation with relationships that have been damaged.
- Need to recognize their own sense of responsibility and accountability.
- To be spoken to honestly by a trusted individual
- Community

How to approach the Wanter

- Listen and reiterate what has been said.
- Offer gentle reminders that there are others that also need support.
- Be direct and honest. That is what they are really wanting.
- Create firm, but fair boundaries
- Involve other professions such as Social Work and Chaplaincy to offer a realistic vision and help create a new community.

Is there any hope for the Wanter?

- Wanters tend to open up to the care around them when they accept the reality of their illness. This is the opportunity for the patient to recognize that they are not alone and have a loving, caring health-care team to be with them.

The Seeker

Song: “All by Myself” by Eric Carmen

Who is the Seeker?

- The Seeker is somebody that views their life as meaningful, feels they have good connections with a community, but are feeling lost nonetheless.

Signs of a Seeker

- Pensive
- Shares advice freely but also shares that “something is missing.”

- Looks to caregivers for answers.
- Strong family connections, though patient may feel things are unresolved.
- May be questioning of God's will

Questions asked by the Seeker

- Why am I still here?
- Is there something I need to be doing?
- God must want me on earth for something, right?
- Is this normal?

Needs of a Seeker

- The Seeker needs somebody to journey with them. Though they ask questions, they don't want answers. They merely want to know that it is okay to ask.

How to approach Seeker...

- Ask reflective questions. "It sounds like you are feeling a lack of purpose. What do you feel you have left to do?"
- In end of life cases, reassure them that their life is complete and it is OK to die.
- Let them know that their questions are normal.
- Encourage them to share their stories and share their experiences.
- Explore how they managed during other times of "Seeking."
- Co-journey with them, help them discover the purpose they are seeking.

SPIRITUAL VIEWS

It is very important to understand the patient's beliefs about living, dying and what may follow death. While there are countless religious, philosophical and metaphysical beliefs about living, dying and what may follow death, it is fair to say there are three general approaches.

The first approach presumes that there is no afterlife, that what is here and now is all there is. In this approach there is no expectation of living again. The emphasis is on the importance and value of our experience at this moment.

The second approach presumes that there is an afterlife, that this afterlife is a reward—sometimes punishment—for events in this life. Usually there is absolution available for sins committed during this life, and there may be life everlasting for those who believe.

The third approach presumes that we live more than once, each life offering the opportunity to gain more love and spiritual knowledge. In this approach, life is generally viewed as one large soul organism, each one of us connected, yet on a different path toward spiritual awareness and freedom.

“When Someone is Dying” Edited by Martin Hall, Chapter 8

Religious Support

Sometimes a patient may ask you to pray with them. Some may want advice, prayer, or even counseling. How you deal with that depends on your faith and personality. You may routinely refer needs of this nature to the chaplain or suggest they consult their clergy or priesthood leaders. However, if you have established a relationship with a patient, they may feel comfortable to ask you for religious support, and will be open to your help.

Always be sensitive to the patient's spiritual needs. If you feel led to pray with a patient, there are a few guidelines you may want to follow for praying in a hospital room. Try to sit in a chair at their bedside or as near to the patient as possible. You may feel comfortable clasping the patient's hand. The hallmarks of prayer are brevity and sincerity. Prayer is most authentic when you and the patient are in a close personal relationship, something you may not be able to develop on your first visit.

When listening to a patient's spiritual needs, follow the rules listed above in listening and response.

SPIRITUAL Definitions

SPIRIT is the most general word in the sense of indicating any sort of nonmaterial existent being. This may include the souls of living things, the ghosts of dead things, or the essence of bodiless forms. It is also, in another sense, contrast to all nonmaterial or mental life with that of matter or body. It can also refer to the essence of anything. (Modern guide to Synonyms)

Our discussion will concentrate on the final sentence of the above definition referring to what various elements of our society consider to be the 'essence of death and dying.' What is the role of death in our value system? What is the meaning of death? Why do we die? Most of us seldom deal in depth with this question, we generally believe what we have been taught by our particular religion and other cultures having differing beliefs.

As volunteers in the hospital setting we have the opportunity to help people from a wide variety of belief systems, and it is beneficial to be able to accept them where they are, without judging their beliefs or trying to change them. Our mission as volunteers is to help ease their pain, not change nor challenge their beliefs. If we can expand our knowledge of the diversity of religious concepts about death and dying, we can enhance our understanding and tolerance.

Spiritual Publications

English & Spanish Bibles are available in the Chaplain's Office. These Bibles may be given to the patient or family and are provided by the Gideon's. Other religious literature is available as well in the chaplain's office or storage closet.

Recognizing Your Patients' Spiritual Needs

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When a person enters a hospital, he or she brings along their spiritual beliefs—possibly intensified by their illness. These beliefs can affect both their recovery rate and their attitude toward treatment. If you try to understand their beliefs—and respect them—you'll avoid embarrassment and problems.

A 45 year old woman was hospitalized for relative minor surgery, but she wasn't responding well to post-op therapy. Then the nurse overheard her explain her slow recovery to a visitor: "I'll get well if that's how it's meant to be. If not, there's nothing I can do about it." Later, the nurse learned that this patient believed disease to be a divine punishment or a test of faith. That's a belief held by many members of orthodox or fundamentalist groups. It could delay recovery, and that's something you should be aware of.

Religious beliefs may also affect illness in other ways. Some religious groups such as the Church of Christ Scientist (Christian Scientists) deny the reality of discomfort—both spiritual and physical. Strict followers avoid clinical consultation, deny needing treatment, and rarely enter hospitals. If they ever seek medical help, they may suffer from feelings of spiritual failure as well as physical affliction.

Some religious groups condemn modern science in general because of "false teachings" such as evolution. Some members of Jehovah's Witnesses or Fundamentalist Baptist groups may resist medical therapy.

Other religious groups support medicine in general, but object to certain practices. For example, the Seventh Day Adventist Church urges members to avoid drugs unless absolutely necessary. Also, some religious groups have dietary restrictions (particularly on ceremonial occasions), clothing restrictions, or restrictions about prolongation of life.

DISCOVERING YOUR PATIENT'S BELIEFS: Some patients or family members may hesitate to discuss religious restrictions because they don't want to seem "different" or be a nuisance. Others may want to discuss their beliefs, but feel uncomfortable about making overt statements. Instead, they may casually make a remark that touches on their

spiritual concerns. (“You know, a lot of churchgoers are hypocrites.”) Or they may describe troublesome dreams that express spiritual conflicts in symbolic forms. Or they may ask about your beliefs—searching for an understanding listener.

Such “feelers” almost always indicate the need for spiritual support and reinforcement. To provide this, avoid making statements that might increase feelings of conflict and distress. Instead, ask questions that will help the patient verbalize his beliefs (“I’ve wondered about that myself. What do you think?”) and show your interest by making supportive statements (“This seems to help you. Tell me more about it.”).

Ideally, you should be able to respond to each patient’s spiritual needs as naturally as you respond to his or her physical needs. However, you may feel uncomfortable if your beliefs differ from theirs. If so, suggest that they talk with appropriate clergy, or with other patients having similar beliefs. Or suggest that they try meditation or prayer, helping them to find a few quiet minutes in their hospital routine. This activity may strengthen their spiritual conviction and reduce stress.

Although you should usually wait for the patient to express spiritual concerns, you can help a reluctant patient by asking questions that will help them explore alternatives within their situation (“This isn’t an easy situation. Have you thought of some ways to handle it?”).

You may discover that your patient has temporarily lost their faith. He or she may ask you questions like, “Why has God done this to me?” In most cases, you can tell them what you believe and why. Most patients will respect your honesty, and if they disagree with your ideas, a short discussion can help them recognize and reinforce their own beliefs.

If your patient claims no spiritual beliefs, you may have difficulty comforting he or she. When they confronts conditions beyond their control, they’ll have difficulties admitting their helplessness, and may attempt to prove his strength with an outburst—blaming doctors or nurses for their shortcomings.

To deal with such a patient, you have to remember that their outbursts are attempts at concealing their feelings of helplessness and lack of power. Don’t try to convert them to your personal beliefs, but ask them questions that will help them recognize underlying concerns.

RELATING TO CLERGY: Many clergy have specific training that can help patients deal with spiritual crises. Often, they can be found as hospital chaplains or staff members of community pastoral counseling agencies.

Consult a member of the clergy if you need information about a patient’s beliefs. Request a clergyperson’s presence if your patient needs one, and assist the clergyperson if s/he asks. His/her specialized training will help your patient more if it’s supported by your daily involvement, so don’t compete with him/her.

If your patient needs counseling but you can't locate a clergy of his faith, consider asking the clergy or a member of another faith. For example, a catholic priest who visits a Jewish patient can ignite a spiritual spark. The patient may then ask to see a rabbi at a later time, or talk with you about some of the thoughts stimulated by the priest's visit. However, if you think the encounter would cause emotional upset rather than provide spiritual comfort, mention your doubts to the clergyman. Let him decide whether to visit the patient or to use you as an intermediary. If he decides to visit, try to locate or prepare a suitable environment in which counseling may occur in privacy and without interruption.

DEALING WITH SPIRITUAL CRISES: Four crises can cause spiritual stress for your patient: giving birth, needing certain medical procedures, being unable to participate in religious observances, and facing death. You can help relieve some of your patient's stress by asking him or her about their attitudes and discussing them with them.

GIVING BIRTH: If your patient is an expectant mother, try to learn her feelings about infant baptism and circumcision.

Infant baptism is a significant ceremony in such religious groups as Eastern Orthodox, Greek Orthodox, Roman Catholic, and some protestant groups, including Episcopalian, Lutheran, United Methodist, Moravian and Presbyterian. However, infant baptism is not appropriate for such religious groups as Pentecostal, Baha'i, Baptist, Church of Christ, Friends (Quakers), Islamic (Muslim), Jehovah's Witnesses, Mennonite, Adventist, and Mormon.

If the newborn child of a Roman Catholic family is in critical condition, call a priest immediately. In extreme cases, you can perform baptism by sprinkling water on the child's head and saying the following: "(Name of child), I baptize you in the name of the Father, Son, and Holy Spirit." However, if you perform this sacrament, inform a priest, because this sacrament can be performed only once.

For children in intensive care incubators, the Greek Orthodox Church permits the priest to perform baptism without water by saying the appropriate words while lifting the child and moving him or her in the sign of the cross.

The rite of circumcision (Briss) is a significant Jewish ceremony on the eighth day after a male's birth. This rite can only be performed by a Mohel, who may be a rabbi or a specially designated member of the congregation. The Mohel may ask you to sterilize the ceremonial instruments and ensure privacy for the ceremony, preferably in a room adjoining the mother's.

MEDICAL PROCEDURES: If your patient faces the possibility of abortion, amputation, or transfusion, try to learn about his or her spiritual attitudes toward such procedures.

The Greek Orthodox Church, Jehovah's Witnesses and the Roman Catholic Church oppose direct termination of life by abortion. Most other religious groups permit therapeutic abortions, especially if the mother's life is in danger. However, many religious groups place the responsibility for the final decision on the mother, a burden that can add stress to her during her hospitalization. Your attitude toward her can help relieve this stress. Even if you oppose her decision, do not judge her, but try to help her express her feelings, if she's willing to confide in you. Make sure you give her the same care and concern you give all of your patients.

Many Hindus consider the loss of a limb as a sign of wrongdoing in a previous life. Orthodox Jewish tradition and some Roman Catholic dioceses require burial of an amputated limb. Many Orthodox Jews include any surgically removed tissue in this restriction and oppose autopsy, except in extreme cases.

Jehovah's Witnesses oppose transfusions and transplants as well as medications that require blood for their manufacture. However, they have approved certain fluids for intravenous feeding: many members carry cards listing these fluids. If parents refuse transfusions for their child, the court may be petitioned to appoint a hospital official as temporary guardian. This guardian can then legally consent to the transfusion.

RELIGIOUS OBSERVANCES: Try to learn your patient's attitudes about the importance of anointing, laying on of hands, confession, communion, observance of holy days (including Sabbath), and restrictions in diet or physical appearance.

Many religions encourage either anointing of the sick or laying on of hands or both. Roman Catholics, for instance, consider the Rite of the Anointing of the Sick as a mandatory sacrament. Mennonites oppose laying on of hands and Jehovah's Witnesses oppose faith healing.

The Episcopalian, Greek Orthodox, and Roman Catholic churches encourage confession, often as a precursor to communion. In the Greek Orthodox Church, proper preparation for confession includes fasting, usually on Wednesday, Friday, and during Lent: however, fasting is not mandatory for patient.

Other religious groups that encourage fasting include Bah, Episcopalian, and Hindu. Others such as the Mormons simply discourage the excessive eating of meat throughout the year. The Russian Orthodox Church discourages eating meat or dairy products on Wednesdays, Fridays, and during Lent. Although the Roman Catholic Church no longer discourages eating meat on Fridays, many older Catholics still observe this restriction. Seventh-day Adventists recommend a vegetarian diet. Traditionally Jews require Kosher (ritually prepared) foods: meat and dairy products may not be eaten at the same meal or using the same plates and utensils.

Most religious groups observe the Sabbath on Sunday and make no restrictions about medical treatments on that day. However, some Orthodox Jews may resist surgery

on the Sabbath (between sundown Friday and sundown Saturday). A rabbi can suggest ways in which necessary procedures may be accomplished within Jewish tradition.

Some religious groups have restrictions about personal apparel and appearance. Russian Orthodox men, for instance, should not be shaved, except for surgery, and their cross necklace should be replaced immediately after surgery. Mormons receive a special undergarment in a religious ceremony and feel that it should be worn at all time, if possible.

DEATH: Try to learn if a terminally ill patient, or one in critical condition, requires any last rites or if their body will require any special treatment after death.

Call a priest to anoint a Roman Catholic patient, even if the patient is unresponsive or comatose. Call a rabbi to comfort a Jewish patient if the family cannot be reached.

Most religious groups either discourage prolongation of life in terminal cases or leave the decision to the individual and his family. However, the Greek Orthodox Church and Islamic (Muslim) Society encourage prolongation of life.

Most religious groups allow members to choose either burial or cremation. However, the Greek Orthodox Church and the Mormons discourage cremation. The Russian Orthodox Church discourages autopsy, embalming, and cremation. On the other hand, the Church of the Brethren and some Unitarian Universalist groups encourage their followers to donate their bodies to medical research facilities or schools.

Immediately after the death of a Hindu patient, the priest will pour water into the mouth of the corpse. The family will then wash the body, and the priest will tie a thread around the patient's neck or wrist to signify blessing. Do not remove the thread. Family members are particular about who touches the body.

Before an Islamic patient dies, they must confess his sins and beg forgiveness in the presence of their family, if possible. Only relatives or friends may touch the body—washing, preparing, and turning it toward Mecca. Unless required by law, no autopsy or removal of body parts is permitted.

After the death of a Jewish patient the Ritual Burial Society usually washes the body, and burial follows as soon as possible. Neither autopsy nor cremation is in keeping with traditional law.

Traditionally, after the death of a Russian Orthodox patient, the arms are crossed, the fingers set to symbolize the cross, and the unembalmed body clothed in natural fiber to facilitate the change to ashes.

Since your patient's beliefs can assist both his recovery rate and his attitude toward treatment, you should try to find out about his spiritual beliefs. You can do this

through discussions with the patient, their family and friends, or spiritual advisor. Try to reinforce beliefs that'll help them recover as quickly and as comfortably as possible.

Identifying Spiritual Distress

What is spiritual distress?

Spiritual Distress is a disruption in one's beliefs or value system. It affects a person's entire being. It shakes the basic beliefs of one's life.

Signs & Symptoms

- Anxiety, anger and/or depression
- Fear of falling asleep at night
- First time in a hospital
- Loss or grief—not always about dying
- Questioning the meaning of life
- Anger at God or a higher power
- Questioning own belief system
- Expression of regret
- Questioning the meaning of the illness
- Feeling a sense of emptiness and loss of direction
- Ethical end of life considerations
- End of life issues

Areas of Inquiry

1. Religious Practices
2. Issues of Meaning amid Change
3. Religiously Focused Expressions of Possible Distress
4. Permission for Referral to Chaplain

Possible Indicators of Spiritual Distress

1. Interruption of religious practices (especially prayer/meditation and social religious practices)
2. Possible Indicators of Issues of Meaning amid Change include:
 - a. Questions or expresses inner conflict about meaning or purpose of his/her pain or illness, life or life in general
 - b. Expresses a sense of injustice
 - c. Expresses hopelessness or despair
 - d. Withdrawal from, or loss of, relationships

- e. Evidences grief, including anticipatory grief
- f. Evidences a lack of acceptance of changes/losses
- 3. Religiously focused indicators may include:
 - a. Expresses feelings of abandonment by his/her own religious group or by God
 - b. Mentions God, especially in anger
 - c. Mentions “evil,” “the enemy,” “hell,” “purgatory,” or similar concepts
 - d. Interprets pain/illness as punishment, especially as “deserved” punishment
 - e. Expresses or evidences guilt
 - f. Refers to self as “bad,” “sinful,” or “unlovable”
 - g. Expresses or evidence anxiety or fear regarding an afterlife
 - h. Raises explicitly religious issues/themes
 - i. Avoids (defensively) the topic of spirituality or spiritual needs
 - j. Questions the moral or ethical implications of therapies, especially those involving the reproductive system, blood transfusion, amputation or removal of organs, dietary restrictions.
- 4. Referral may be made to the chaplain.

Possible Questions

1. Are there any religious activities or practices that have been interrupted because of your illness?
2. How do you feel about the changes in your life that have come because of your illness?
3. Illness is a hard thing physically. Has this been a hard thing spiritually for you? (Note that the phrasing here may help to normalize the response and may also invite the patient to draw connections between physical illness and spiritual distress)
4. Would you like to speak with someone about your spiritual concerns?

Religious Diversity-TRADITIONS ON LIFE AND HEALTH

ADVENTIST (Seventh-day Adventist, Church of God, Advent Christian Church)

BIRTH: Opposed to infant baptism.

Adults baptized by immersion.

DEATH: The dead are asleep until the return of Jesus Christ, at which time final rewards and punishments will be given.

HEALTH CRISIS: They believe in man's choice and God's sovereignty. Taking of communion or undergoing baptism may be desired. Some believe in divine healing and practice anointing with oil and the use of prayer.

DIET: Most do not drink alcohol, coffee or tea. Taking any narcotic or stimulant is prohibited because the body is the temple of the Holy Spirit and should be protected. A vegetarian diet is preferred.

BELIEFS: They regard Saturday as Sabbath. They accept the Bible as it reads and believe in the 10 commandments. They believe their duty is to warn mankind to prepare for the Second Coming of Christ. Most oppose the use of Hypnotism.

AMERICAN INDIAN

The approximately 3000 different Indian tribal groups and geographically classified bands of Indians, each with their own culture, make it impossible to generalize about specific responses to specific situations. All have religion, magic, folklore, disease treatment, and herbal medicine, these differing from tribe to tribe. Medicine men, shamans, and conjurers in various tribes perform by use of many different symbolic

actions, against illnesses, social taboos, powers of nature, and "enemy-oriented" diseases. Protection against disease is sought by the help of superhuman powers. These practices have two distinct forms, according to the fundamental concept of the disease. Disease is conceived as taking two principal forms; one is the presence of material object in the patient's body and the other is an effect of the absence of the soul from the body. Today many Indians follow modern Christian religions, while some continue with their Indian beliefs.

ARMENIAN

BIRTH: Traditionally, baptism involves immersion 8 days after birth with confirmation immediately after baptism. On the fortieth day after birth, the parents bring the child to church.

DEATH: Last rites are practiced by the administration of Holy Communion

HEALTH CRISIS: They advocate taking communion and the laying on of hands.

DIET: Fasting during Lent for 6 hours before Communion.

BELIEFS: No conflict between modern medicine and religion.

BAHA'I

BIRTH: No baptism.

DEATH: No last rites.

HEALTH CRISIS: They advise prayer and if medically permissible, fasting.

DIET: Alcohol and drugs permitted only on doctor's prescription.

BELIEFS: No conflict between modern medicine and religion. The sick are specifically instructed in Baha'i

scriptures to seek the advice of competent doctors. Spiritual health is felt to be conducive to physical health. Prayer adjunctive to healing by physical and chemical means is considered legitimate or even indispensable.

BAPTIST (27 groups)

BIRTH: Opposed to infant baptism. Only believers should be baptized and it must be done by immersion.

DEATH: Clergy seeks to minister by counsel and prayer with patient and family.

HEALTH CRISIS: Some Baptists believe and practice healing by the laying on of hands.

DIET: Some groups condemn coffee and tea. Most condemn alcohol.

BELIEFS: Supreme authority of the Bible in all matters of faith and practice. Many Baptists condemn what the American Baptist Association terms "so-called modern science." Although the practical expression of this view is largely confined to opposition to Darwinism, resistance to medical therapy may be encountered. Most, however, believe that God works through the doctor. Some who believe in predestination respond passively to care.

BUDDHIST CHURCHES of America

BIRTH: Rites such as infant presentation, affirmation, confirmation, or ordination are performed after the child has become mature enough.

DEATH: Last rite chanting is often practiced at bedside soon after death. Contact the deceased's Buddhist priest or have the family make the contact.

HEALTH CRISIS: A Buddhist priest should be notified for counseling. However, it should be at the patient's or their family's request.

DIET: No restrictions on diet for most members although some sects are strictly vegetarian. Most members practice moderation and discourage the use of alcohol, tobacco, and drugs.

BELIEFS: They are in harmony with modern science. There is no divine punishment; every occurrence depends on the law of causality, so illness is a trial to aid the development of the soul. This is a religion of supreme optimism as it teaches a way to overcome fears, anxieties, and apprehension. Special holy days are: January 1 and 16, February 15, March 21, April 8, May 21, July 15, September 1 and 23, December 8 and 31. Patients should be questioned how they feel about medical or surgical treatment on these days.

BLACK MUSLIM

BIRTH: No baptism.

DEATH: Carefully prescribed procedure for washing and shrouding the dead, and performing funeral rites.

HEALTH CRISIS: Faith healing is not acceptable except to lift the patient's morale.

DIET: Prohibit alcoholic beverages, pork and foods traditional among American blacks including corn bread and collard greens.

BELIEFS: General adherence to Moslem tenets is overlaid in many instances by antagonism to Caucasians, especially Christians and Jews. They do not indulge in activities (such as sleeping) more than is necessary to

health and always maintain personal habits of cleanliness.

CHURCH OF CHRIST SCIENTIST (Christian Scientist)

BIRTH: No baptism.

DEATH: No last rites; no autopsy, except in cases of sudden death. Individual decision regarding burial or cremation.

HEALTH CRISIS: They deny the existence of health crises; sickness and sin are errors of the human mind and can be eliminated by altering thoughts, not by drugs or medicines. They do not allow hypnotism or any form of psychotherapy that alters the "Divine Mind." A Christian Science practitioner can be called to administer spiritual support; the "Christian Science Journal" contains a directory of Christian Science nurses available to help bandage wounds, set bones, etc.

DIET: Alcohol, coffee, and tobacco are seen as drugs, and are not used.

BELIEFS: Disease is a human mental concept that can be dispelled by "spiritual truth." Many Christian Scientists adhere to this belief to the extent that they refuse all medical treatment, but each individual may decide whether he wishes to rely completely on Christian Science. Many adherents desire the services of a practitioner or reader. The church operates several nursing homes that rely solely on such "spiritual" means of health maintenance. They do not use drugs or blood transfusions, accept vaccines only when required by law and do not seek biopsies or physical examinations.

CHURCH OF CHRIST

BIRTH: No baptism until a minimum of 8 years, then baptism by immersion.

DEATH: No last rites.

HEALTH CRISIS: Communion offered only to members of this church. Belief in the anointing with oil and the laying on of hands by the ministry for healing sick. Ministers (elders) will visit any who desire.

DIET: No requirements or restrictions; most members refrain from using alcoholic beverages.

BELIEFS: Members believe that the church is the body of Christ with Jesus as the head. No objection of "modern science" or therapy per se, but a simple recognition of human limitations to wisdom and understanding. Sunday is observed as the Sabbath, but no objections to medical care on Sunday.

CHURCH OF GOD

BIRTH: No baptism at birth but babies may be dedicated to the Lord upon request of the parents.

DEATH: No last rites. There is a home-going service for the deceased. Do not believe in cremation.

HEALTH CRISIS: Adherents believe in divine healing through prayer, though more liberal members do not prohibit medical therapy at the same time.

DIET: No requirements or restrictions, individual fasting may be practiced. Members refrain from all alcoholic beverages and tobacco.

BELIEFS: "Speaking in tongues" is a mystical experience.

CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS (Mormons)

BIRTH: Baptism by immersion at 8 years or older.

DEATH: they believe it proper to bury in the ground; cremation is discouraged. Baptism for the dead is held essential, though a living person may serve as proxy. Preaching the Gospel to the dead is believed to be going on for those who never received the opportunity in mortal (earthly) life.

HEALTH CRISIS: Devout adherents believe in divine healing through the laying on of hands, though many do not prohibit medical therapy. The Church maintains an extensive and well-funded welfare system, including financial support for the sick.

DIET: They prohibit alcoholic beverages, tobacco, hot drinks (tea and coffee) or any other substance that may be injurious to the body. Sparing use of meats but no outright prohibition.

BELIEFS: There's a strong tradition of revelation through visions. Many members wear a special undergarment. Patients may desire to have a Church Priesthood holder administer the Sacrament of the Lord's Supper while in the hospital, usually on Sunday.

EPISCOPALIAN

BIRTH: Infant baptism is mandatory and especially urgent if prognosis is poor, although aborted fetuses and still-borns are not baptized.

DEATH: Last rites ("Rite for the Anointing of the Sick") is not mandatory for all members.

HEALTH CRISIS: Some believe in spiritual healing.

DIET: Some abstain from meat on Fridays and some fast before receiving Holy Communion, which may be daily.

BELIEFS: Many practice a confession of sins and absolution.

FRIENDS (Quakers)

BIRTH: Do not baptize at birth, and infant's name is recorded in official books.

DEATH: They do not believe in life after this life.

HEALTH CRISIS: They have no restrictions and allow individual members to make decisions.

DIET: Up to the individual, but most practice moderation, avoiding alcohol and drugs.

BELIEFS: They are pacifists and conscientious objectors in wartime. Believe in plain speech and dress and refusal of tithes, or oaths. God is in every man and can be approached directly.

GRACE BRETHREN

BIRTH: Do not practice infant baptism. Baptism by immersion is practiced by those old enough to profess their faith.

DEATH: No last rites and it is an individual decision regarding burial or cremation.

HEALTH CRISIS: Anointing with oil is practiced for physical healing and spiritual uplift.

DIET: No dietary restrictions, but most abstain from alcohol, tobacco, and illicit drugs.

BELIEFS: No conflict with modern science. Generally request non-combatant military service.

GREEK ORTHODOX

BIRTH: Baptism is significant. Prefer to baptize the child at least 40 days after birth. If it is not possible to baptize by sprinkling or immersion, the church allows the child to be baptized “in the air” by moving the child in the sign of the cross as appropriate words are said.

DEATH: Last rites are the administration of the Sacrament of Holy Communion.

HEALTH CRISIS: In most cases each health crisis must be handled by an ordained priest though a deacon of the church may also serve in some cases. Usually a priest administers Holy Communion in the hospital room in a procedure that takes only a few minutes. Some patients may also want the Sacrament of Holy Unction that the priest can conduct in the hospital room in a brief time in an abbreviated service.

DIET: The church usually prescribes a fast period, which means avoidance of meat and in many cases, dairy products. However, if these rules conflict with medical treatments, they need not be enforced. Some Orthodox patients will insist upon fasting even when in the hospital. If decision and desire to fast in the hospital do not interfere with medical procedures, there would be no reason for this to be refused. However, if this would adversely influence the medical condition of the patient, a priest should be called to convince the patient to forego fasting until his health is restored. The usual fasting days are Wednesday, Friday, and during Lent.

BELIEFS: They oppose euthanasia and feel that every reasonable effort should be made to preserve life until terminated by God. They discourage autopsies that

may cause dismemberment and prefer burial to cremation.

HINDU

DEATH: Certain prescribed rites are followed after death. The priest may tie a thread around the neck or wrist to signify blessing and the thread is not to be removed. Immediately after death, the priest will pour water into the mouth of the corpse and the family will wash the body. They are particular about who touches their dead and the bodies cremated.

HEALTH CRISIS: Some conditions, such as loss of limb, represent “sins” committed in a previous life.

DIET: There are many dietary restrictions that conform to individual sect doctrine. The patient should be questioned when admitted.

BELIEFS: Accept most modern medical practices. Do not believe in artificial insemination because sterility reflects divine will.

ISLAMIC

BIRTH: If abortion occurs before 130 days, the fetus is treated as any other discarded tissue. After 130 days, an aborted fetus must be treated as a fully developed human being.

DEATH: The patient must confess sins and beg forgiveness before death, and the family should be present. The family washes and prepares the body, then turns it to face Mecca. Only relatives or friends may touch the body and unless required by law, there should be no postmortem and no body part should be removed.

HEALTH CRISIS: In pathologic conditions, faith healing is not acceptable unless the psychological

condition of the patient is deteriorating. Only then is it done for the patient's morale.

DIET: All pork products are proscribed. On the ninth month of the Mohammedan year (Ramadan), daylight fasting is practiced.

BELIEFS: Older or more conservative Muslims often have a fatalistic view that can militate against ready compliance with therapy.

JEHOVAH'S WITNESSES

BIRTH: No infant baptism.

DEATH: No last rites.

HEALTH CRISIS: Adherents are generally absolutely opposed to blood transfusion, though individuals can sometimes be persuaded in emergencies. When parents refuse consent for a child's transfusion, a court order may be sought to appoint a key hospital official temporary guardian of the child. The official may then legally consent to the transfusion.

DIET: They do not eat anything to which blood has been added and can only eat animal flesh that's been drained.

BELIEFS: They oppose "false teachings" of other religions and opposition often extends to modern science, including medicine. They try to convert others. They don't participate in nationalistic ceremonies or celebrate holidays by gift-giving. Some are pacifists and conscientious objectors in wartime.

JUDAISM

BIRTH: Ritual circumcision is mandatory among Orthodox and Conservative adherents on the eighth day after birth. Reformed Jews favor ritual circumcision, but not as a religious

imperative. A fetus is to be buried rather than discarded.

DEATH: Members of the Ritual Burial Society ritually wash Human remains following death and the burial should take place as soon as possible.

Cremation is not in keeping with Jewish law. All Orthodox Jews and some Conservatives are opposed to autopsy.

HEALTH CRISIS: They demand that an ill person seek medical care.

Donation or transplantation of organs requires rabbinical consultation.

DIET: Orthodox and Conservative Jews observe strict kosher dietary laws, which mainly prohibit pork, shellfish and the eating of meat and milk products at the same meal. There are complex proscriptions and preparations.

Reformed Jews do not usually observe kosher dietary laws.

BELIEFS: Orthodox and conservative adherents observe the Sabbath from sundown Friday to sundown Saturday. They may resist surgical procedures during this period, unless a rabbi counsels that such procedures are medically necessary and are therefore permitted by Talmudic law. Organs or other body tissues should be available to the family for burial. Parts of the body are not to be donated to medical science or removed, even during autopsy.

LUTHERAN

BIRTH: Baptize only living babies at 6 to 8 weeks after birth by pouring or sprinkling water or by immersion.

DEATH: Last rites are optional.

HEALTH CRISIS: If the prognosis is poor, the patient may request anointing and blessing.

DIET: No requirements or restrictions.

BELIEFS: They accept developments of science and technology, but would raise objections if such techniques were administered unjustly, or were clearly contrary to Christian theology.

MENNONITE

BIRTH: Baptism during early and middle teens.

DEATH: No formal prescribed action. Personal assistance and prayer as appropriate while the patient is still conscious.

HEALTH CRISIS: No taking of communion or laying on of hands.

DIET: No official restrictions. Many congregations require abstention from alcohol.

BELIEFS: Not a sacramental church. There is a deep concern for the individual's dignity and self-determination, which would conflict with shock therapy, medicine, or treatment affecting the individuals personality and will.

MORAVIAN

BIRTH: Infant baptism is usual, though they do not deny choice of adult baptism.

DEATH: No last rites—when illness is diagnosed as terminal, they do not believe that life should be extended at all costs. Patient should be kept comfortable.

HEALTH CRISIS: Communion is received in two forms, both public and private, by the laying on of hands for consecration of ordained persons, both male and female. No problem with blood transfusions or organ transplants.

DIET: No requirements or restrictions.

BELIEFS: Disease is not a form of divine punishment, although they feel that breaking God's laws of "good stewardship" can often lead to physical problems.

NAZARENE

BIRTH: Baptism is parent's option, not considered a saving sacrament. No need to baptize a baby or an adult who is dying.

DEATH: No last rites. Cremation is permitted and still-borns are buried.

HEALTH CRISIS: Local pastor will administer communion and the laying on of hands, which are means of grace.

Adherents believe in divine healing, but not exclusive of medical treatment.

DIET: Use of alcohol and tobacco prohibited.

BELIEFS: No conflicts with modern science.

PENTECOSTAL (Assembly of God, Foursquare Church)

BIRTH: Water baptism by immersion after age of accountability.

DEATH: No last rites.

HEALTH CRISIS: No inhibitions against blood transfusions or medical care. Believe in possibility of divine healing through prayer. Anointing with oil may be practiced with laying on of hands.

DIET: Abstain from alcohol, tobacco, and eating strangled animals or anything to which blood has been added.

Individuals may refuse pork products.

BELIEFS: Some insist illness is divine punishment, but most consider illness an intrusion of Satan. Deliverance from sin and sickness are provided for in atonement. Pray for divine intervention

in health matters and seek to reach God in prayer for themselves and others when ill.

ORTHODOX PRESBYTERIAN

BIRTH: Sprinkling is the most common in infant baptism.

DEATH: Last rites are not a sacrament procedure. They read scriptures and have prayer.

HEALTH CRISIS: Communion administered when appropriate, and convenient and local pastor or elder should be called. There is no formal laying-on-of-hands ceremony but prayer is appropriate. Blood transfusion acceptable when advisable

DIET: No requirements or restrictions.

BELIEFS: True science to be utilized for relief of suffering and recognized as a gift of the Creator. Full forgiveness through genuine repentance for any illness connected with a sin. Heaven and hell are thought of in material terms.

ROMAN CATHOLIC

BIRTH: Infant baptism is mandatory, especially urgent if prognosis is poor. Baptism is demanded if an aborted fetus may not be clinically dead. For baptismal purposes, “death” is a certainty only if there is obvious evidence of tissue necrosis.

DEATH: The Rite for the Anointing of the Sick is mandatory. If the prognosis is poor, the patient or his family may request it.

HEALTH CRISIS: The patient or their family may desire that a major amputated limb be buried in consecrated ground. There is no blanket mandate for this, but it may be required within a given diocese.

DIET: Most hospital patients are exempt from fasting or abstaining from meat on Ash Wednesday and Good Friday. Some older Catholics may still adhere to the former rule of abstaining from meat on Fridays.

BELIEFS: They permit donation or transplantation of organs, providing the recipient’s potential benefit is proportionate to the donor’s potential harm.

RUSSIAN ORTHODOX

BIRTH: Baptism by priest, by immersion, three times as John the Baptist did, and only on certain days.

DEATH: They do not believe in autopsies, embalming or cremation. Traditionally, after death, arms are crossed and fingers set in a cross. Clothing at death must be of natural fiber so that the body will change to ashes sooner.

HEALTH CRISIS: Cross necklaces are important and should be replaced immediately when a patient returns from surgery.

DIET: On Wednesdays, Fridays and during Lent, they don’t eat meat or dairy products.

BELIEFS: Important not to shave male patients except in preparation for surgery.

UNITARIAN/UNIVERSALIST

BIRTH: Some practice infant baptism but most consider it unnecessary.

DEATH: Attitudes toward immortality vary widely and cremation is preferred to burial.

HEALTH CRISIS: No official sacraments. Reason and practicality are most important.

DIET: No requirements or restrictions.

BELIEFS: They emphasize use of reason and knowledge and believe each

**RELIGIOUS PRACTICES
AND
THE DYING PERSON**
(Palliative Care Patient
and Family Counseling Manual)

The following is a summary of the religious practices important to the dying person belonging to one of these five groups: Christianity, Judaism, Hinduism, Islam, and Buddhism. These subgroups have beliefs and practices that may differ considerably from those of the main group, necessitating individual assessment of the interventions that will provide spiritual comfort for a particular individual. This summary is intended to provide only an overview of some of the dominant practices of each group.

CHRISTIANITY

Although a discussion of Christianity may seem unnecessary to many, it needs to be included for the same reasons that each of these major world religions are being presented: an increasing number of professional persons functioning in Western society come from parts of the world where a religion other than Christianity is the dominant belief. These persons may be as unfamiliar with the basic tenets of Christianity as the average North American or European is with the Eastern religions.

Christians believe that the love of God is manifested through the life, death, and resurrection of Jesus Christ. Through Jesus, sin and evil have been overcome, and the gifts of salvation and eternal life are offered to all who believe in Him. Many branches of the Christian church exist with tremendous variation in practices, and it is important to determine what rituals the dying person desires to follow. Common practices are for the person to request a visit from a minister or priest during which prayer will be offered, sometimes accompanied by an anointing with oil, communion, or confession. Other practices may include prayer and

meditation, reading selected portions of the Bible such as Psalm 23, dietary restrictions, and special articles of clothing. While death is understood to result from failure of body organs, in a larger sense, it may be thought to be due to sin against God. Death is often approached calmly by those who believe that eternal life is given to those who believe in Jesus as Lord and Savior, such as fundamentalists, or those who believe absolution from sin ensures eternal life, such as Catholics. Other persons, without these beliefs, may conduct an extensive life review to assure themselves that the good they have done is greater than their sins and may need the reassurance of a pastor or another Christian that they are loved and accepted by God. Following death, the body is typically straightened and the hands folded across the chest. The request for an autopsy generally is not resisted, and the body may be buried or cremated, depending on the beliefs and preferences of the person.

JUDAISM

The Jews consider Abraham to be the father of their culture and religion. According to the Torah, Abraham was called by God to leave his

home in Ur of the Chaldees, modern Iraq, and migrate to the land of Canaan, modern Israel, leaving behind the worship of his fathers and dedicating himself and his family to the worship of Yahweh, God. His descendants, called the children of Israel after Abraham's grandson, migrated to Egypt due to famine, where they became enslaved and escaped by the miraculous intervention of God working through Moses. During the return of the Israelites to Canaan, God met with them and gave them the Ten Commandments and other specific codes of behavior for religious and civil life. These codes structure the behaviors of the Jew and include rituals such as observance of Sabbath from sundown Friday night to sundown Saturday night, a cycle of yearly festivals, such as Passover and the High Holy days of Rosh Hashanah and Yom Kippur, and kosher dietary restrictions. The extent to which a Jew desires to follow these practices will depend on whether the practitioner follows Orthodox, Liberal, or Reformed Judaism. Although the prayers of the Orthodox believer include reference to an afterlife, the primary focus of concern for the Jew is on the importance of the current life, not the possibility of future life. Although the sick are well cared for, the dying may be neglected, possibly because of the strong emphasis on life. However, the Jewish community is very supportive of the bereaved. The dying Jew may request a visit from a rabbi during which the person is encouraged to say a portion of the Shema ("Hear O Israel, the Lord is our God, the Lord is one.") and may also be comforted to know that the kaddish, the mourner's prayer, will be said on his behalf. When death is believed to have occurred, a feather may be placed over the mouth and nose to assess any signs

of breathing. If none are present, the eyes and mouth are closed and the jaw tied up, preferably by the deceased's son or nearest relative, although anyone may perform this duty. The limbs are straightened, the arms placed at the sides, and the body is wrapped in a plain sheet. For the Orthodox Jew, someone will remain with the body until burial, reciting passages from the Psalms. For the Liberal, Reform, or nonobservant Jew, this practice may not be followed, and the body may be either buried or cremated. An autopsy or request for organ donation will likely be refused by the Orthodox Jew but may not be resisted by less strict groups.

HINDUISM

Hinduism is an ancient religion from the Indian subcontinent based on the worship of thousands of gods. The three major gods are Brahma (the creator), Vishnu (the preserver), and Shiva (the destroyer and regenerator of life). There are many variations of Hindu beliefs and practices, depending on which god is worshiped. Common Hindu practices include meditation, prayer, exercise such as yoga, purification through bathing in running water, dietary restrictions such as vegetarianism, abstinence from beef, fasting on holidays, strict guidelines of food preparation, and extreme modesty to the extent of not being examined or cared for by a person of the opposite sex. It is necessary for care providers to ask the person what arrangements or supplies will be needed for the rituals to be followed. Respecting these practices and providing for their continuation will provide spiritual comfort for the dying person. A Hindu priest may be called to facilitate the person's acceptance of

death as a part of the continual cycle of life. Because of this philosophical view of death, the event of dying is generally faced calmly. Following death, the body should be wrapped in a plain sheet. Cremation, rather than burial, is practiced, often accompanied by water from the river Ganges. Autopsies are usually rejected as an indication of disrespect for the dead. Because of the variability of Hindu beliefs, the dying person or a family member should be asked if there are any additional religious practices desired. Such individualization of care demonstrates respect for the person and promotes spiritual comfort.

ISLAM

The religion of Islam is based on the belief that there is only one God, Allah, as revealed by the prophet Muhammad, and that one's personal will is to be submitted to the will of God. The practicing Moslem follows a precise code of behavior, derived from the Koran and the life of Muhammad. These practices include praying five times a day facing Mecca, ritual washing in running water before prayer, observing Friday as the day of worship, fasting during the month of Ramadan (food and fluid may be taken before sunrise and after sunset), following dietary restrictions such as no pork products, exclusion of any fish not having fins and scales, and abstinence from all alcohol including alcohol-based oral medications, and exhibiting modesty through dress and contact with health care professionals only of the same sex. Although the terminally ill person may be exempt from these practices, many will want to continue the rituals as long as possible, possibly

resulting in difficulty providing physical comfort for the person. For example, any intake, including pain medication administered intravenously, may be rejected during a period of fasting. The decision of the person to give precedence to spiritual comfort rather than physical comfort should be respected. Death is considered to be Allah's will and is to be accepted without resistance. The last words the dying Moslem should speak or hear are the Islamic declaration of faith: "There is no god but God (Allah), and Muhammad is his prophet." After death, the body should be touched only by a Moslem, or, if contacted by a non-Moslem is unavoidable, gloves should be worn. The body should be straightened, eyes closed, head turned to the right in order to face toward Mecca after burial, and wrapped in a plain, white cloth. Burial usually takes place within 24 hours and the body is never cremated.

BUDDHISM

Buddhism was begun by Siddhartha Gautama, an Indian prince living about 2,500 years ago. Concerned with the distress he observed among his people, he sought a method of promoting their happiness and contentment through truth. During this process, he became aware of the four noble truths, and thereafter was known as Buddha, the enlightened one. The philosophy he developed in his search for truth emphasizes brotherhood, non-violence, and spiritual growth. Through multiple rebirths and the accumulation of knowledge enabling the person to follow Buddha's teachings more fully, the Buddhist gradually moves toward a state of perfection or *nirvana*. Many different forms of Buddhism exist, with variations

in the rituals followed. It is important to ask what practices the dying person wishes to follow. Some of the more common practices are meditation preceded by washing, and dietary restrictions such as vegetarianism. Although the relief of pain is important, a higher need is to maintain a clear awareness. For those deeply involved in meditation practices, pain medications may be refused unless the dying person can be assured that the dosage will lessen pain but not affect the senses. When nearing death, the patient may desire a visit from a Buddhist monk or sister. Contacting a local Buddhist center usually results in a rapid response to this request. Following death, the body should be wrapped in a plain sheet, due to the belief that any pattern or emblems may disrupt the consciousness as it departs the body. Cremation services are usually conducted by the monk or sister.

CARING FOR OTHER RELIGIOUS FAITHS AND DYING PERSONS WITH NO RELIGIOUS COMMITMENT

When interacting with dying persons, it is likely that the professional

at some time will have contact with persons of religious beliefs other than these five groups (such as Taoism, Sikhism, and Animism). It is difficult to have a working knowledge of the practices of every religion, but effort should be made to become familiar with the beliefs and rituals of the groups most likely to be encountered within the locality served by the professional. Provision of spiritual care measures, individualized to meet the needs of the dying person, will provide comfort to that person and family during a time of change and loss.

For the dying person who has no religious commitment and who declines offers of spiritual comfort or a final opportunity to talk to a spiritual counselor, providing spiritual comfort may be interpreted as providing comfort for the psychological needs of the person. The person will need reassurance of love from significant others and confirmation that his or her life has been meaningful. Efforts to compel the person to experience a “death-bed conversion” are likely to result in psychosocial discomfort for the person, rather than comfort.

Source: Ida M. Martinson and Elizabeth Bossert, “Comfort Measures for the Dying Person,” University of California, San Francisco, California.

The Value of Reminiscence in Hospice Care

Dorothy Wholihan, RN,
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Any professional or volunteer who has worked with dying patients can attest to the multitude of emotional problems these patients can face. The healthcare literature describes the devastating effects of such emotional difficulties as fear, loneliness, depression, and anxiety.¹⁻⁴ In terminally ill patients, factors such as pain, increasing dependency, social isolation, loss of role function, and altered appearance can all interact to cause emotional distress. Patients with advanced disease appear to experience these problems to a greater degree, as they face their deteriorating physical condition, increasing losses, and impending death.

However, many of these devastating emotional problems might be mitigated by the use of a simple tool: Reminiscence.

Webster defines reminiscence as “the act or process of recalling past events or experiences.” No longer considered the wandering musings of the senile elderly, reminiscence has drawn steadily increasing interest within the mental health field over the past years. Erikson’s developmental theory stresses the importance of reminiscing to the psychological health

of the individual.⁶ He describes a person’s last developmental task as the reworking of one’s past, resulting in either ego integrity or despair. According to Erikson, the successful resolution of this last crisis is the maintenance of ego integrity—the acceptance of one’s life as it had to be, and the maintaining of respect for oneself, for what one has been.

Erikson’s apt phrase is: “**to be—
through having been.**”²

Robert Butler’s work on the life review process has been the main force responsible for popularizing the concept of reminiscence within the field of geriatrics.⁷ He describes life review as the universal, spontaneous process of recalling and judging past experiences, in particular unresolved conflicts which are surveyed and then re-integrated. He postulated that this review occurs most frequently in early old age and in anyone facing death.

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Butler’s view on the judgmental evaluation of one’s life is only one of many theories about reminiscing. Gerontologist Peter Coleman believes that in addition to the analytical role of life review, reminiscence can also lead to the passing on of knowledge or attitudes. This phenomenon he calls “informative reminiscence.”⁸ Psychiatrists McMahon and Rhudick⁹ add yet another category: reminiscence which glorifies the past and depreciates the present.

It has been speculated that each type of reminiscence can benefit different groups of people. Butler’s life review has been used most as a form of psychotherapy with clinically depressed geriatric clients. He cites some of the positive results as including: a righting of old wrongs, coming to acceptance of mortal life, pride in accomplishment, and a feeling of having done one’s best.⁷

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Coleman hypothesizes that the teaching function of informative reminiscence benefits those facing severe role loss in old age.⁸ McMahon and Rhudick support this theory by comparing the instructive reminiscer to the aged of primitive societies who passed on knowledge in pre-literature times.⁹

“Simple”⁸ or “positive”¹⁰ reminiscing is simply the recalling of past accomplishments and good feelings. It is for and of remembering, performed either through direct questioning or in free-flowing conversation that is frequently seen in social interactions among hospice patients, staff, and caregivers.

This positive reminiscence assists in the adaptation to multiple losses and the maintenance of self-esteem, according to Coleman.⁸ He describes this kind of reminiscence as providing comfort and consolation for people facing severe loss. In a 1974 study, he measured and classified reminiscence characteristics as elicited from spontaneous conversations with elderly residents of London housing complex. He reported that “the consoling use of the past would occur more often in the presence of considerably changed circumstances threatening sense of self-continuity. (p. 283)

The benefits of reminiscing have been supported by a substantial number of research studies.^{12,13} empirical studies include McMahon and Rhudick’s study of 25 elderly men.⁹ Based on content analysis of interviews, subjects were rated on frequency of reminiscence and a depression score. This score was tabulated based on affect, expressed feelings of hopelessness, and evidence of self-esteem loss. The researchers found a negative correlation between frequency of reminiscence and depression.

Gerontological nurse Lappe compared the self-esteem scores of two groups of institutionalized elderly

in an experimental study.¹⁴ She hypothesized that reminiscence would allow the elderly “a sense of security through recall of comforting memories ... and an increased self-esteem through confirmation of uniqueness” (p. 13). The researcher compared two randomly assigned groups of nursing home residents. One group discussed current events, while the other focused on reminiscing. Her results showed that the reminiscing group scored significantly higher on the Rosenberg Self-Esteem Scale ($f=10.30$, $p<.05$).

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Although reminiscence therapy has become popular in many different health professions, the focus has remained mostly within geriatrics. In examining its role in hospice care specifically, theoretical references to the possible benefits of reminiscence for the dying are found in the literature.¹⁸ Butler writes, “the relation of the life review process to thoughts of death is reflected in the fact that it occurs not only in the elderly, but also in younger persons who expect death—for example, the fatally ill or condemned.”⁷

In one exploratory study, nurses Simmons and Given attempted to determine what content terminal patients would most likely discuss in a free flowing interview.¹⁶ Among their results, they found that over one-third of the 51 patients interviewed used the time to reminisce and review their lives, specifically “to point out their contributions and accomplishments.”

An experimental study conducted by this author explored the extent of self-esteem disturbance in terminally ill cancer patients and assessed the efficacy of a guided reminiscence intervention in mitigating the problem.¹⁷ Fifty-five percent of hospice patients tested were found to suffer from self-esteem disturbance. Patients who engaged in guided reminiscence showed 16 times more improvement in self-esteem scores as compared to patients engaged in social conversation.

Reminiscence is not a new concept to hospice care. However, reminiscence therapy is often practiced on an informal basis. Healthcare personnel, volunteers, and caregivers frequently engage patients in reminiscence without conscious thought to the therapeutic value of such interventions..

Reminiscence might be more fully utilized if one develops an appreciation of its potential benefits. Although intensive life review therapy may need the expertise of a trained therapist, positive reminiscence—the

simple recalling of past accomplishments and good feelings—can be encouraged by all with few negative responses.

And so, one sees a wide range of theoretical and research-based work which provides support for the use of reminiscence as a clinical tool in hospice care. The following guidelines, formulated from several sources,^{16,18-20} can serve to facilitate the process of reminiscence:

1. Childhood events and celebrations are among the most recalled memories.
2. These topics may provide a useful starting point for those wishing to initiate reminiscence. In their study of centenarians, psychiatrists Costa and Kastenbaum found that subjects most frequently reminisced about their childhood years.²² Furthermore, Wholihan found that the memories discussed by hospice patients in most detail and with the most apparent enjoyment revolved around holidays and celebrations.¹⁷
3. Use of photographs, memorabilia,
4. and music may enhance reminiscence.
5. Lewis and Butler²³ recommended the use of scrapbooks, photo albums, old letters, and other memorabilia to assist in interviewing and establishing positive rapport. Moreover, they suggest, “even persons with moderate brain damage can remember many details through pictures and keepsakes.”(p.168)
6. Confidentiality must be respected.
7. The client must be reassured about this guarantee.
8. In-service classes should be used to reach reminiscence therapy.
9. All healthcare personnel, as well as volunteers and family are potential guides for reminiscence. Formal educational programs can serve to reinforce the therapeutic benefits of such interventions as well as refine facilitative skills.
10. Supportive listening and promotion of self-expression are the goal, not in depth psychotherapy.
11. When non-professionals such as family, auxiliary staff, and volunteers are involved, resources for referral must be identified. In-house resources can then be consulted if emotional distress should develop, and further counseling is needed.
12. reminiscing that restores a sense of identity and role should be encouraged.
13. Past jobs, accomplishments, and “instructive” reminiscence are topics which can assist in this process. Table 1 provides a list of questions which might assist in a structured

session or provide questions for catalysts to reminiscence.

14. Interventions should be timed according to the patient’s cues.

15. It is essential to remain aware of fatigue, pain, and emotional status—all of which may influence the timing and extent of your interactions.

16. Reminiscence sessions should be documented.

17. Patient response should also be noted. Successful reminiscence therapy can then become an on-going intervention used by an interdisciplinary team.

18. Consider a research project involving reminiscence therapy.

19. This therapy exemplifies the many interventions which hospice providers perform, but have not systematically documented or evaluated. Such research may help to further define the contributions of hospice care professionals.

20. This article has examined the past work defining the therapeutic benefit of reminiscence and provided basic guidelines for its incorporation into practice. Reminiscence therapy is a simple but apparently effective tool in alleviating some of the emotional problems hospice patients face. By reaffirming a sense of identity, uniqueness, self-worth, and accomplishments, reminiscence can help patients face death more peacefully.

Table 1. Suggested questions for guided reminiscence.

1. Tell me about what you did for work when you were well and what you liked most about your work.
2. When you were not working, what did you enjoy doing?
3. Tell me about a past accomplishment of which you are particularly proud. (Could be related to family, work, sports, recognition by friends or work colleagues.)
4. What would you describe as “the happiest day of your life” and why?
5. Tell me about a happy memory of your childhood.
6. Tell me about a particular holiday which holds special meaning for you. How did you celebrate it?
7. Can you tell me about a “first?” (First TV, first date, first plane ride, first birth.)
8. Tell me about a time when you helped someone out in a time of need. How were you useful to them?
9. Tell me about a home or place you once lived—the place liked best and why.
10. Please tell me about someone who you once thought of as “best friend” and some of the good times you shared.

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Feather River Hospital Mission Ambassador
Volunteer Orientation

Module 3 - Communication Skills

Learning objectives:

By the end of the session volunteers will:

1. gain a better understand the communication process.
2. discuss verbal and nonverbal communication.
3. apply active listening skills in responding to typical patient and family comments and questions.
4. respond appropriately through listening and verbal interaction to patient's expression of feeling.

Notes:

Important Aspects of Communication

How we communicate:

Communications experts

Estimate that only 7 percent of

communication is represented by the

words we say, another 38

percent by our sounds, and 55

Body

List of Tools

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FOR SERVICE QUALITY:

"The Client must be the central focus of the relationship."

Communication Skills

Ideas for Improving Your Communication Skills

1. If you are really serious about improving your interactions skills, write down what you do and examine it yourself, then check it out with colleagues.
2. Pay close attention to what the patient/family is saying.
3. Don't push! Families are afraid not to comply. When offering a choice, give the alternatives "equal billing" so as not to influence their decision.
4. Get sensitive to what people may be going through.
5. The goal is to be with them moment to moment on a "gut level".
6. Realize your limitations and don't offer more than you can provide.
7. Listen and allow the patient/family to go as they can. Don't try to cheer them up or talk them out of feeling low. Permitting them to "touch bottom" will free up their energy and hope.
8. You don't have to solve all your own problems about issues such as death before being helpful to others. It is important, however, to be keenly aware of which problems/concerns are theirs and which are yours.
9. Be direct and use words directly. If you do not use words such as cancer, blind, etc. patient/families will get the impression YOU don't feel comfortable talking about their condition. As a result, when they really need someone to *talk* to, they won't see you as a resource.
10. Show your feelings. (If you feel sad, show it.) Role model that nothing terrible happens when you allow emotions to show.
11. You are not there to SOLVE problems. This ties you up in outcomes and only serves to create frustration for you and the family.
12. Trust your gut reactions. If you are worrying about the right thing to say, you're not WITH them. Afterwards is the time to evaluate what was said or what might have been more helpful.
13. Don't be judgmental - whether their behavior is too much too little, etc. isn't that important. Don't generalize from small bits of behavior.
14. Follow-up is crucial if the patient dies. The family must not be abandoned then.

THE NATURE OF LISTENING

Listening is an art, a skill and a discipline. As in the case of other skills, it requires control both intellectual, emotional and behavioral. The individual must understand what is involved in listening and in developing the necessary self-mastery to be silent and listen, by subordinating his own ego and substituting a sense of humility.

Listening obviously is based on hearing and understanding what others say to us. Hearing becomes listening only when we pay attention to what is said and follow it very closely.

Listening is a personal, private, and intimate relationship, particularly if people are talking about personal, private, and intimate problems. Consequently, listening is different with each individual.

Whenever we are dealing with people face-to-face, day-to-day, on a wide range of problems, we must listen to them in order to understand them, their problems, and their needs. The better we understand them, the more willing and able they are to understand us.

Listen

When talking with patients, you will not only want to offer chaplain assistance, such as offering to contact clergy, encouraging spiritual care, offering blessings or sacraments, etc., but you will also want to be a friend to the patients. This involves good listening skills. Yours is a ministry of presence and friendship. The Listening Flower that follows gives some practical listening skills.

Face the patient squarely, on his or her level. Facing the patient can show that you are giving that person your full attention. With your body, you're saying "Right now, this conversation is what I'm most interested in."

Lean forward slightly toward the patient. This is especially important when you are sitting. It helps keep you alert, and it shows you are interested. If you lean back too much, you may end up slipping down in your chair. This can make you appear to be disinterested.

Open posture is important. Your body and your face--your smile, your eyebrows, your eyes--all can show your emotions, whether positive or negative. Angry? Bored? Worried? Pleased? Tired? Eager? Think about what your face and your body is silently saying about your state of mind. This point includes two "don'ts" of good listening.

* Don't fold your arms in front of you or make fists as if you were closing the other person out.

* Don't make annoying motions: Drumming your fingers on a table, looking at your watch repeatedly, or playing with a pen or other object you are holding.

Watch your distance. Set yourself at an appropriate distance - not too close and not too far away. Every culture has a different idea of how much space a person needs before feeling "crowded."

Maintain eye contact. If you're staring out the window, at your shoes, or at other people, you send a signal that says, "You're not important." Maintain eye contact with the patient, but don't stare that person down.

Occasionally glance away, but center your focus and attention on the patient. This is a general rule, but try to be sensitive to the patient, especially if he or she is foreign. In some cultures direct eye contact is in bad taste.

Relax and be sincere. It's important to feel comfortable even while being aware of your body language. Don't overreact. Do you know people who always wear fake smiles? People whose body language doesn't match the situation? Adapt these points to your own style and to the situation you're in.

Always use good common sense. These flower points are general guidelines and not absolute commands. Don't be phony or mechanical.

Your Response

After you have listened to a patient, you'll have a much clearer knowledge how to respond. Listed below are some special characters who can teach you through their mistakes how not to respond.

Pollyanna Perfect. This person denies that you have any problem, despite anything you say. Pollyanna perfect often says, "Hey, everything is really fine. You just need a more positive outlook."

Denny Detective. He keeps interrupting with questions, trying to get information he wants. There's nothing wrong with asking questions. It's the endless number of questions and the interrupting that makes Denny a villain. Denny Detective often cuts into the middle of a sentence.

Darlene Drill Sergeant. She likes to tell you what to do. Darlene's favorite lines are "You should.." "You must..." "You have to stop.."

Susie Soothsayer. She's always telling you what's going to happen in the future. Susie's like a broken record, "If you don't, then..." or "If you do this, then that will happen."

Norman Negotiator. No matter what you say, Norman says it's wrong. He's often overheard saying, "You shouldn't feel that way," or "That will never work."

Rosita Rescuer. Rosita always knows what's best for you. She frequently says, "I suggest," "Let me help you," or "What you need is..."

Mona Monopolizer. She always has a story better than yours; "Let me tell you my problem," "That reminds me of," or "That's nothing, I once..."

Sammy Space Cadet. You know his mind is far away, maybe in outer space. He doesn't pay attention to what you're saying. Occasionally, Sammy comes back to earth and responds, "What did you say?"

Henrietta Holy. She frequently interrupts you with an easy-answer Bible verse or a pet religious phrase. Henrietta has been known to say, "It's God's will," "The Lord will work it out," or "The Bible says." All of that is usually repeated in five minutes.

Felix Filler. Felix can't stand silence in a conversation. If there's a pause, he jumps in and starts talking about most anything, just to fill the silence.

Response Skills

Now that you see these don'ts of responding to someone, you may not want to say anything at all! But don't give up. As mentioned throughout this handbook, the first and best thing you can do is to be present. Many times a patient may just want to talk or get something off his or her chest. The best response skill you can have is knowing when to respond and when not to respond. This comes from developing good listening skills.

Be honest and sincere. Address your response in a manner that is not judgmental, condemning, threatening or vague, such as "I believe that," or "I often think." This lets the speaker know that you are only suggesting something that you would do, not what they must do.

If you feel that you have gotten way over your head in a conversation, say so. You may want to think about your response or get an opinion (If permissible with the patient, but just be honest). This will show that you are being up front and sincere, and possibly that you do not know everything. Feel free to ask if you could consult with the chaplain. You may want to suggest a visit from the chaplain or a member of his/her clergy or priesthood. Because patients are in the hospital for such a short time, our/your purpose is to help them through the crisis of hospitalization. Those who will provide the long-term support should attend to long-term needs.

When responding, do not hesitate to ask a patient to repeat something. This will show that you are interested. You can also ask, “Did you say?” or “I’m not quite sure I understand.” This will help you to get a better understanding for your response.

Non-Verbal Communication

Non-verbal communication includes every action except speech. As part of the entire message, non-verbal communication is more powerful than words, and can convey up to 93 percent of the message. Even before you speak, you convey information about yourself. First impressions do count and those impressions are based on dress, body position, eye contact, and grooming. Changing non-verbal communication is relatively easy if you concentrate on small changes.

Assertive Non-Verbal Behavior:

1. Eye Contact	Look into the other person's eyes directly but do not stare. Avoid looking down or sideways when making an important statement.
2. Facial Expression	Smiling is appropriate when feeling happy, not when feeling angry. Forget worrying about wrinkles. Let your face do some of the talking, as your expression should convey inner feelings.
3. Voice	Tone should reflect feeling. Be firm, but not harsh. Watch volume control and enunciation to be sure you are heard. Pacing of words conveys conviction. Speak deliberately and avoid rambling.
4. Body Position	Stand erect and sit either erect or slightly forward. Avoid slumping.
5. Non-Words	Avoid non-words such as ah, um, gee, well, you know.
6. Dress	Dress as an adult businessperson. Pay attention to the response you get from other people. Dress invites behavior from others.
7. Hand Gestures	Do not fiddle, poke, prod, and primp. Shake hands firmly or hug, if appropriate.

OBJECTIVES IN LISTENING

The objectives when we listen to people are both basic and simple.

- We want people to talk freely and frankly.
- We want them to cover matters and problems that are important to them.
- We want them to furnish as much information as they can.

- We want them to gain greater insight and understanding of their problem as they talk it out.
- We want them to try to see the causes and reasons for their problems and to figure out what can be done about them.

SOME DO'S AND DON'TS OF LISTENING

IN LISTENING WE SHOULD TRY TO **DO** THE FOLLOWING:

- Show interest.
- Be understanding of the other person.
- Express empathy.
- Single out the problem if there is one.
- Listen for causes to the problem.
- Help the speaker associate the problem with the cause.
- Encourage the speaker to develop competence and motivation to solve his or her own problems.
- Cultivate the ability to be silent when silence is needed. Successful people usually know how to remain silent and keep their counsel.

IN LISTENING, **DON'T DO** THE FOLLOWING:

- Argue.
- Interrupt.
- Pass judgment too quickly or in advance.
- Give advice unless it's requested.
- Jump to conclusions.
- Let the speaker's sentiments react too directly on your own.

**THE URGENT NEED FOR LISTENING ALLOWS US THE
OPPORTUNITY TO UNDERSTAND THE COMPLEXITY OF
PROBLEMS.**

- We think we understand people and all the difficulties involved when frequently we don't listen intently to them.
- We think we understand a situation when we see only part of the situation and experience even less of it.
- We think we understand the problems people face when we may have only a surface acquaintance with their elements and relevance, and in actuality we may be dealing merely with symptoms and not causes.
- We should realize that listening is a key to knowing and understanding.

**ONE WAY TO KNOW MORE IS TO LISTEN MORE
AND TO GET MORE INFORMATION UPON WHICH
JUDGMENTS AND DECISIONS ARE BASED.**

- A man's judgments and decisions are only as good as the information upon which they are based.
- We need to approach people and their problems with greater humility and recognition of the complexities involved.
- We can never know all about anything.
- We need to listen with greater intensity. We need to observe with greater acuity.
- We need to react to other people with greater empathy.
- We need to synthesize what they say, think, and feel, with greater understanding.
- We can be aware of overtones, what they mean and convey, as well as undertones.
- Does the speaker have a positive or negative approach in terms of what he proposes to do?
- We can be aware of the signal reaction, responding automatically in terms of

previous thought and habit patterns

- We can remember, in understanding people and their problems, that words are only symbols for things but they are not the things themselves. Words do not always mean what people mean.

RECOGNIZING THE DIFFICULTY AND COMPLEXITY OF PEOPLE, SITUATIONS AND PROBLEMS ENABLES US TO BECOME BETTER LISTENERS.

- We can listen not just for words and sounds but for what lies behind them. We can listen for facts, meanings, and reactions.
- We can listen for feelings, sentiments, and emotions.
- We can seek to distinguish between an actual event and people's interpretations of that event.

SPECIFIC LISTENING TECHNIQUES

- Clarify to get at additional facts and to explore all sides of the problem.
- Restate to show you are interested, and that you are listening and understand.
- Reflect to help evaluate the feelings expressed.
- Summarize to bring discussion in-focus and keep open for any additional aspects of the problem.

Here are five things you can do to improve your listening skills:

1. Learn to concentrate. Play the games used in listening/training courses. For example: 2 plus 3, minus 5, plus 4, times 2, minus 6. What is the answer?
2. Run a television test with a friend. Watch a program, then see how many of the ideas presented you can recall. With the other viewer, try to agree on a specific statement of the main idea.
3. Cut out distractions. If someone wants to talk to you, put aside the paper or turn off the radio.
4. Accept controversy. When someone brings up a controversial subject, listen. Don't go deaf.
5. Repeat instructions until you get them correct.

Good listening isn't easy. Hearing, understanding, and remembering take time and energy. But good listening pays off. It brings knowledge, creates better communication, and generally makes you a better conversationalist.

How Well Do You Listen?

Though a good portion of every day is spent listening to others, most people are poor listeners. The average person spends 9% of his/her day writing, 16% reading, 30% speaking and 5% listening.

Experts claim that while listening we have only a two-or-three-second attention span.

The speaking rate, they found, is much lower than the thinking rate. Thus the listener has plenty of time to think and is therefore susceptible to distraction.

Here are some of the more common bad listening habits:

1. Your thoughts race ahead of the speaker, so you "tune out" what is being said.
2. You think you know what will be said so you listen with only one ear.
3. You look instead of listen, especially when being introduced to someone.
4. Your mind wanders because you are doing something else such as reading a newspaper while trying to listen to the radio, trying to overhear another conversation, etc.
5. You miss the big idea. A poor listener just hears the words but not the main idea.
6. Your emotions make you deaf. This is the case when someone presents opposing ideas about such subjects as politics and religion. We mentally stop receiving them while we plan our own verbal counterattack.

Our egos sometimes keep us from being good listeners. Instead of concentrating on a conversation, we mentally consider what we're going to say or how we can impress the speaker with our next statement.

Check It Out: Make sure you are hearing accurately by checking back periodically with the person. One of the best ways to validate your understanding of what they are saying is by paraphrasing, or repeating what has been said, in your own words. You can lead into the paraphrase by saying: "If I understand you right, what you are saying is..."

The first step then in helping another is to hear where they are. Hear their problem and their feelings.

Listen to all cues for their feelings. Clarify anything you don't understand. Acknowledge what you hear. Check out what you think you understand.

Clarifying, acknowledging, and checking out the feelings you hear, are the basic actions and skills that need to be developed if you are going to become an effective helping agent.

Active Listening Skills

Active listening is a means of communication that involves interaction with family members and provides them with proof of the volunteer's understanding and acceptance. In active listening, volunteers feed back only what they feel the family members want reflected back to them.

Here is an example of the active listening process:

PCP says:

"My daughter is having a baby in July; it would have been Jack's third grandchild."

Volunteer reflects back:

"You seem sad that Jack won't be there to see his third grand baby."

The Following are Guidelines for Active Listening:

1. Know when to use active listening. Remember that active listening is only a technique so you can better communicate your acceptance and empathy. Use this when you're free enough of your problems to feel accepting and want to help families with their problems.
2. Competence comes only with practice. You won't become proficient at active listening without lots of practice. Practice with your family and friends.
3. Don't give up too quickly. It takes time for families to realize you really do want to understand and you are accepting of their problems and feelings. Remember, they might be accustomed to hearing family and friends warn, preach, teach, advise and interrogate.
4. Accept that active listening at first will feel artificial. It undoubtedly feels more gimmicky to you than to the families. With practice you'll feel more natural and less clumsy.
5. Try using more of the other listening skills, such as passive listening, acknowledgment responses, and door openers. Every response of a family member does not need feedback. Use active listening primarily when feelings are strong and the family members need for talking or sorting out feelings is apparent.
6. Avoid pushing or imposing your active listening on family members. Listen for clues that tell you they don't want to talk or are through talking. Respect their need for privacy.

7. Don't expect families to arrive at your preferred solution. Remember, active listening is a tool for helping family members with their problems and finding their own solution prepared for times when no solution surfaces. They might not even tell you how they later solved the problem. They will know, but you won't.

ACTIVE LISTENING TIPS

- Stop talking. Give the other person time and attention.
- Clarify what's being said. Ask questions and paraphrase.
- Pay attention to body language.
- Provide affirmative listening responses. Nod and use eye contact to reassure interest.
- Search for cause, not blame.
- Don't interrupt.
- State your own concerns only after you feel you have heard the other person's needs and concerns.
- Restate what is important to you and what is important to the other person.

At end of discussion, summarize points made and points agreed to.

What to listen for

1. Words used to express feelings:

"Everyone has gone home." I feel alone.

"We used to go out all the time." I don't go anywhere now. It isn't the same without her.

"We used to play cards with our friends." They don't come over now.

2. Voice inflexion:

Monotone

Tearful

Angry Matter-of-fact

Judgmental

Hyper

(1) Agitated

(2) High-pitched voice

3. Willingness to participate in conversation. Responses beyond "yes", "no", "OK".

4. Expressions of need:

"I don't drive."

"I can't understand the taxes."

"The roof is leaking and I don't know who to call."

Active listening won't work if:

1. The behavior of the family member is causing you a problem in any way.
2. You fail to understand the tone or intensity of the feeling of the sender. If this happens, simply relay back, "Do I hear you saying that..."
3. You are more concerned with solving the problems of the family rather than reflecting their thoughts back to them so that they can solve their own problems.
4. You are in a hurry.
5. You are focusing on the subject of concern rather than the person. Example: The family in a local town is not visiting the patient. If you focus on the subject you might say, "They are really being selfish, aren't they?" To focus on the person say, "You must really be hurt that they are not visiting John during these last weeks."
6. You are distracted by personal problems.

Elements of Active Listening

- Want to listen.
- Place the patient and family's needs ahead of one's own needs.
- Be aware of what is said and what is not said.
- Use nonverbal and verbal behavior with which the patient and family are comfortable in order to encourage them to share thoughts and identify needs. Use good eye contact and appear relaxed, open, ready to listen, and accepting of what is said.
- Be aware of congruence between verbal and nonverbal communication on the part of the patient and family.
- Use a variety of interviewing techniques, such as closed-ended questions, open-ended questions, leading phrases, clarification questions or statements, summarizing statements, and reflecting or paraphrasing the patient's and family's words, to elicit more information and to provide support and reassurance.
- Speak judiciously, with a warm yet clearly audible tone of voice, refrain from giving advice, and avoid interrupting the patient and family.
- Let silence speak for itself.

Source: Charlette R. Gallagher-Allred, *Nutritional Care of the Terminally Ill*. Aspen Publishers, Inc., © 1989.

HOW TO BUILD RAPPORT

- Place yourself at the same level as the person with whom you are visiting. Sit down, if only for a few minutes.
- Say the person's name. Establish with the person how they wish to be addressed. A first name may be preferred, or it may be experienced as patronizing to use the first name. A "pet" name, for instance, is usually the prerogative of a special relationship. Hearing your own name spoken is very grounding, especially when spoken by one who cares for you. It feels particularly good to be known and called by name when you find yourself dependent and in a depersonalizing environment.
- Offer the opportunity for privacy and uninterrupted time for unhurried discussion. Several brief discussions may be better than a single, lengthy one.
- Be yourself. Be ordinary. Take time to settle in. Let the person take your measure. This is a relationship and cannot be one-sided.
- Observe and match mood and behavior. Do not pit your peace against anger, your exuberance against depression, or your openness against protectiveness.
- Be guided by the patient about how much contact is comfortable. Some people want eye contact or physical contact. Others feel that it is an intrusion.
- Match behaviors by breathing or talking at the same pace, or by sitting in the same position as the person with whom you are building rapport. It creates the feeling that you are the 'right kind' of person.
- Find common ground (e.g., explore interests, patient's preferences in music, patient's background).
- Always acknowledge heaviness, sadness, anger, or frustration before any further issues are raised.
- Be specific about how you can help and what is going to happen.
- Set boundaries. Boundaries help people to feel safe; the patient needs to know what he or she can and cannot expect from you. For example, if a procedure is necessary, you might help the patient by saying, "I am going to turn you on your right side" or "You may feel a prick now."
- Establish a time frame and follow through. "We'll try this for three days," "I'll see you again in a week," etc.
- Look for opportunities to discuss death and funeral arrangements. Not speaking of death suggests that it is too terrible to be spoken of.
- Be respectful. Helpers are ideally consultants who enter the lives of others with great respect.
- Recognize signs that the person is at ease. For example, he or she may match some expression, word, laughter, movement, or posture of yours. They may also express agreement verbally. You may then "lead": make suggestions, guide, or ask a question.

Source: "Medical Care of The Dying." 2nd Edition, Victoria Hospice Society. Victoria, British Columbia, Canada. 1993.

Ways To Connect

- **Ask, don't tell.** Monitor your airtime.
- **Ask to look at photos.** If asking to see photos of people seems forward, ask for photos of things the family has mentioned ("Do you have any pictures of your garden/cabin/old boat?"). These photos will likely lead to others.
- **Ask for their histories.** "Tell me about when you and your husband met" or "What was your very first job?"
- **Ask about prized possessions.** For example, ask about evidence of hobbies, collections, or books on the family's shelves.
- **Ask about the people in their lives.** "Who are your favorite relatives?"
- **Ask about their traditions.** "How does your family celebrate birthdays? Halloween? Thanksgiving?"
- **Ask about their experiences.** "Did you like school?" or "Did you always have pets?" or "What were your happiest times as a parent?"
- **Remember these two rules for initiating especially difficult topics:**
 1. Ask permission.
 2. Give other persons an out at *your* expense, not theirs.

NOTES:

Avoid “Evaluating” When You Give Feedback

- Use minimal encouragers ("Um hmm").
- Remember that even 'um hmm' can carry judgment.
- Ask for more information instead of commenting on what you just heard ("And what happened then?" rather than "He sounds like a difficult person to be around!")
- When someone asks you for advice, they don't really want it. They want to talk about it! So, respond like this: "I'm not sure what I'd do. Tell me more about it."
- Paraphrase to play back what the person said, instead of providing your opinion. Use different words than the ones the speaker chose to clarify underlying or hidden feelings. "So, you were feeling angry, or maybe hurt, because he didn't seem concerned?" rather than "Doctors can be insensitive sometimes."
- Acknowledge/affirm what the person has said, without judging ("I can see that was frustrating" instead of "Why sweat the small stuff?")
- Avoid "naughty" words (for example, *should*, *never*, *always*, *why* or "loaded" words). They create extra defensiveness.
- The quickest way to end a conversation is to provide your opinion.
- Expect to see these defense mechanisms:
 - denial
 - projection
 - rationalization
 - repression
 - compensation
 - reaction formation
 - passive aggression

Courtesy of McRay Company, 780 North Arm Drive, Mound Minnesota 55364.

Don't Be Too Shy To Ask

- What is this experience like for you?
- How is your mother/spouse/child/friend reacting to all this?
- Do you think about what happens 'after'?
- Do the people you love know what they mean to you, and why?
- Are you ever afraid?
- Are you having any interesting dreams/ideas/revelations?
- How do you prefer to spend this time?
- Does this experience have any special meaning for you, in a spiritual sense?
- What do *others* consider to be your major accomplishments? How about *you*?
- Are there any regrets? Any unfinished business? Any wishes?
- How might a person in your situation wish to be spoken of and remembered?
- What people do you most prefer to see?
- Is there anyone you haven't seen that you'd *like* to see?
- What have been the hardest/easiest/most surprising parts of all this?

NOTES:

How Do You Know You Are on the Right Track?

There may be:

- A smile---sometimes a secret smile
- A startled reaction
- Welling up of tears
- Slowing of breath
- Color returns

How Do You Know If You Are Off Track?

There may be:

- An expression of tiredness
- Negative response
- A tensing up
- A quickening of breath
- A holding of breath
- No response

How Do You Get Back On Track?

- Ask the person what is happening now.
- Ask the person if there is something that the person needs to do.
- Invite the person to do what they need to do now.

NOTES:

Source: "Medical Care of the Dying," 2nd Edition, Victoria Hospice Society, Victoria, British Columbia, Canada © 1993.

Listening and Communication Skills

DOs

- Listen:
 - Hear the words.
 - Hear the feelings behind the words.
- Sit with the silence:
 - Appreciate the communication without the words.
 - Recognize that you do not need to fill in what may seem like empty space.
- Empathize:
 - Try to feel what they feel about the experience.
 - CAUTION: Avoid saying “I know how you feel.”
- Support:
 - Let them know you believe in their strength and ability to carry on, to manage, to make decisions, etc.
- Validate:
 - Let them know you believe they have a right to feel what they feel (for example: anger, grief).
- Clarify:
 - Repeat back their comments to make sure you understand.
 - Repeat back their comments to help them hear what they have said.
 - Restate their comments to help them understand what they may have been trying to say.
- Read body language:
 - Recognize what the body/facial expressions are silently saying.

DON'Ts

- Don't initiate a new topic. Remember, that unless they mention a topic directly, do not bring it up.
- Don't personalize their anger. Recognize the anger they are feeling is probably toward the illness, doctors, etc., even though it may come out as if toward you.
- Don't feel that you have to have the answers. Remember that your best expertise is in just being there, listening, and empathizing.
- NEVER say “I know how you feel.”
Courtesy of Dr. Karen Gail Lewis, Gaithersburg, Maryland.

Barriers to Active Listening

- Letting others talk, but not focusing on what they say, rather waiting for your turn to talk
- Hearing what others say, but not hearing what they mean
- Talking about what you want, rather than patient/family concerns
- Talking about what you think they ought to discuss
- Steering them away from their areas of concern and toward an area that you feel comfortable with
- Cutting off communication by a gesture or expression
- Appearing to be impatient or disapproving
- Responding to a patient/family's views or words by brushing aside their fears or anxieties with a trite phrase or a dismissing gesture
- Not "reading" constantly their shifts in mood, changes in their needs, many foci, or their concerns

NOTES:

Courtesy of Dr. Karen Gail Lewis, Gaithersburg, Maryland.

EXAMPLES OF PLATITUDES TO AVOID

- Everything will be all right.
- You will find the strength.
- It is all part of a grand plan.
- Things will work out for the best.
- Keep your chin up—you'll feel better.
- Every cloud has a silver lining.
- I'm sure you'll feel better tomorrow.
- I know just how you feel.
- God won't give you more than you can handle.
- You'll be a stronger person because of it.
- Only the good die young.

Courtesy of Dr. Karen Gail Lewis, Gaithersburg, Maryland.

Helpful Phrases

1. Establishing your willingness to listen.
 - “I’m listening.”
 - “I’m here.”
 - “Would you like to talk about that?”
 - “Do you feel like talking about that?”
 - “Yes?”
 - “Could you say more about that?”
 - “That (listening) is what I’m here for.”
 - “Sounds like talking about that will be hard for you.”
 - “It’s going to be hard to get started (talking).”
2. Recognizing the person behind the words, hearing, and acknowledging feelings.
 - “It sounds like you are angry about that.”
 - “How did it feel when that happened?”
 - “What kind of feelings are you having right now?”
 - “You must have felt very hurt.”
 - “I can’t tell how you feel about that.”
 - “Are you still upset when you think about that?”
 - “Have you had those feelings at other times?”
 - “You sound very lonely.”
 - “You wish things could be different?”
 - “You feel things are pretty hopeless right now?”
 - “Do you have a trapped feeling?”
3. Helping the person think and discover what he or she already knows and feels.
 - “What ideas have you already considered?”
 - “You seem to have several ideas about what would help.”
 - “You’ve tried ideas that didn’t work?”
 - “Can you tell me what you have already done about that situation?”
 - “Has this type of thing happened to you before? What did you do then?”
 - “Have you talked to anyone else about this? What did they think?”
 - “How long has this been happening to you?”
 - “Have you thought about why this happened to you? What thoughts did you have?”
 - “Sometimes it’s hard to decide on these things.”
 - “Do I hear you saying that...” (Summarize)
 - “A minute ago you said (repeat). Would you explain more about that?”
 - “Can you tell when all this began?”

- “How do you act when that happens?”
 - “Where do all those feelings go? What do you do with them?”
 - “What part of that problem is really yours, or something you can control?”
4. Helping the person begin the decision-making process.
- “How would you like to feel?”
 - “What do you want to do?”
 - “What do you feel you should do?”
 - “How would you like for things to be?”
 - “What are you going to base your decision on?”
 - “What choices do you have (or do you see)?”
 - “Will what you do affect anyone else?”
 - “What do you see as the next step?”
 - “Are you worried about what is right or wrong?”
 - “Something seems to be holding you back.”
 - “Has anyone told you what you should do?”
 - “What are your plans right now?”
 - “Do you think you need to do something about that?”
 - “Is there really anything you can do, except maybe accept that that’s the way it is?”
5. Offering information, ideas, or insights of your own, or making people aware of referral agencies.
- “Does it seem to you that _____?”
 - “I wonder if _____?”
 - “How do you feel about my saying that?”
6. Helping the person put together what happened during your conversation.
- “How do you feel about that now?”
 - “Do you know now what you want to work on?”
 - “How do you feel now about your control over that situation?”
 - “Are you feeling differently now?”
 - “You sound a little stronger now.”
 - “What we have talked about seems clearer now.”
 - “Do you understand more about what has happened?”
 - “You seem to have a different feeling about that now.”
 - “You see the situation differently now.”
 - “What are you going to do next?”

7. Helping the person close the conversation.

- "Maybe you could talk about this again after you think about it some more."
- "I hope things will be better for you soon."
- "Well, I wish you luck with your plans."
- "I'm glad you decided to talk about this."

LISTENING SKILLS

This is a self-inventory to help you determine whether or not you are listening, and how well you listen

1.	Do you tend to give advice and tell others how to solve their problems?	Yes	No
2.	Can you listen for five minutes or more without interrupting when you are talking alone with another person.	Yes	No
3.	Are you skilled at reflecting what someone is saying so you encourage him to clarify his point and draw out his feelings?	Yes	No
4.	Do you make time on a regular basis for others to talk with you about their plans?	Yes	No
5.	Do you make it a point to give others credit for helping you think through a plan or decision?	Yes	No
6.	Would most people you know describe you as a good listener?	Yes	No
7.	Do you prefer to listen to a logical, reasonable discussion of facts rather than someone's opinions, attitudes, or feelings?	Yes	No
8.	Do you lead or direct most conversations along lines important to you?	Yes	No
9.	When you feel strongly about what you are hearing, do you usually interrupt to make your point?	Yes	No

From 'Outline of Staff Development Program' for Field Counselors and Senior Specialists, Home Aid Service, Cincinnati, Ohio

Feather River Hospital Mission Ambassador

Volunteer Orientation

Module 4 – Understanding the Bereavement Process

Learning Objectives:

By the end of the session volunteers will:

1. define key bereavement concepts
2. identify different dimensions of the grief experience
3. describe 2 main theoretical models of grief work
4. articulate the difference between “reconciliation or accommodation” and “recovery
5. Define and describe “complicated grieving”
6. Name a variety of support services for the bereaved in their community

NOTES:

QUOTES

“Not everything that is faced can be changed, but nothing can be changed until it is faced.”

James Baldwin

“I do not believe that sheer suffering teaches. If suffering alone taught, all the world would be wise since everyone suffers. To suffering must be added mourning, understanding, patience, love, openness and the willingness to remain vulnerable.”

Morrow Lindbergh

*“Should you shield the canyons from the windstorms,
you would never see the beauty of their carvings.”*

Elisabeth Kübler-Ross

“If you don’t finish your unfinished childhood business, your future becomes your past.”

Paul Brenner

*Grief is like all the four seasons bunched together.
She is going through winter time right now.”*

Grandpa Walton

*“To resolve your grief, you must accept the fact: What was will never be again.
You will have to give yourself permission to grieve for it; If you do not, you will
never
appreciate the future which may be even better and more meaningful than the
past.”*

Elisabeth Kübler-Ross

*“What we have once enjoyed, we can never lose.
All that we love deeply becomes a part of us.”*

Helen Keller

*“After all, what’s a life anyway? We’re born, we live a little while, we die. By
helping you, perhaps I was trying to lift up my life a trifle. Heaven knows anyone’s life
can stand a little of that.”*

“Charlotte’s Web”

*After the Mastectomy:
They were afraid it would be different
To make love without
Her breast on
And it was.
Right from the start*

*It brought him closer
To her heart.*
Carol Lynn Pearson

Hospice of Schenectady

Excerpt from

A GRIEF OBSERVED

BY C. S. Lewis

No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing.

At other times it feels like being mildly drunk, or concussed. There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps, hard to want to take it in. It is so uninteresting. Yet I want the others to be about me. I dread the moments when the house is empty. If only they would talk to one another and not to me.

There are moments, most unexpectedly, when something inside me tries to assure me that I don't really mind so much, not so very much, after all. Love is not the whole of a man's life. I was happy before I met H. I've plenty of what are called "resources." People get over these things. Come, I shan't do so badly. One is ashamed to listen to this voice but it seems for a little to be making out a good case. Then comes a sudden jab of red-hot memory and all this "commonsense" vanishes like an ant in the mouth of a furnace.

On the rebound one passes into tears and pathos. Maudlin tears. I almost prefer the moment of agony. These are at least clean and honest. But the bath of self-pity, the wallow, the loathsome sticky-sweet pleasure of indulging it—that disgusts me. And even while I'm doing it I know it leads me to misrepresent H. herself. Give that mood its head and in a few minutes I shall have substituted for the real woman a mere doll to be blubbered over. Thank God the memory of her is still too strong (will it always be too strong?) to let me get away with it?

And no one ever told me about the laziness of grief. Except at my job—where the machine seems to run on writing but even reading a letter is too much. Even shaving. What does it matter now whether my cheek is rough or smooth? Only a dog-tired man wants an extra blanket on a cold night; he'd rather lie there shivering than get up and find one. It's easy to see why the lonely become untidy; finally, dirty and disgusting.

An odd by-product of my loss is that I'm aware of being an embarrassment to everyone I meet. At work, at the club, in the street, I see people, as they approach me, trying to make up their minds whether they'll "say something about it" or not. I hate it if they do, and if they don't. Some flunk it altogether.

R has been avoiding me for a week. I like best the well-brought up young

men, almost boys, who walk up to me as if I were a dentist, turn bright red, get it over, and then edge away to the bar as quickly as they decently can. Perhaps the bereaved ought to be isolated in special settlements like lepers.

Hospice Development, Inc.

EMPATHY

By

Donald A. and Nancy L. Tubesing

Empathy literally means "to feel in"- to stand in another's shoes for a moment, to get inside his feelings. It's a temporary, partial identification with at least one segment of another person's experience.

This essay describes empathy in three ways:

- 1) Empathy is an acquired skill that persons can use to tune in to and understand each other's feelings.
- 2) Empathy involves a four-part process of activities: Tune in to yourself, express yourself, tune in to others and respond with understanding.
- 3) Empathy is a powerful resource for building relationships, and is the foundation for the ability to really help another.

1. Empathy is an Acquired Skill

Empathy involves overcoming some interpersonal pitfalls and accurately tuning in to and responding to the feelings of another person. It is facilitated by various skills and personal characteristics that can be increased through practice.

Empathy is the process by which two persons begin to show understanding and acceptance for each other's feelings. It involves both tuning in to the feelings of another and responding to the feelings in a way that allows the other to know he has been heard. The listener loses his distance and really feels the feeling of the other person. Empathy involves "hearing the PERSON" (who is he, how he feels about himself and his world), not merely his words.

The sharing, understanding and accepting of feelings are the heart of human relationships. Empathy is the skill that activates these processes between people, and allows people to "tune in to" and respond to the feelings of others.

It is a finely honed interpersonal skill that can be improved by specific practice. Identification of feelings, accurate interpretation of facial and vocal cues, and responding to others with understanding, are all skills that improve with specific training and experience.

A long process of interpersonal learning must occur before full empathy can take place. Empathy is not something "you are born with."

An infant has no way of perceiving the difference between himself and his environment. He interprets all sensations that come to him as belonging to him. If mother is anxious, he senses this and fusses. The infant is anxious and unhappy. He has no way of knowing that his feelings can be separated from mother's feelings. In fact, at first he has no way of separately identifying himself from mother. Slowly the infant **LEARNS** to distinguish between himself and other things, himself and other people. This learning is unrefined, but it is the foundation of mature empathy, the "feeling with" another while maintaining your own identity.

Most people do not go on to develop their interpersonal skill to the extent they could. Human beings tend to repeat activities that work, so they develop relationship habits that are based on childlike ways of responding. As we grow and our relationships change, we still interact using these learned response patterns. Many interpersonal communication habits, which we have learned and repeated from infancy, militate against the development and full utilization of empathy. The art of empathy is not fully developed because our bad habits govern our interaction. Three common bad habits are: not attending to feelings, speaking before listening, and giving advice rather than understanding.

People need to practice **EMPATHY** in order to become skillful and to avoid habitual roles. Five habitual roles we all play at times are: Fact-finder (seeking information, ignoring feelings); Fix-It Specialist (solving the problem for another); Advisor (telling another what to do); Judge (evaluating others' feelings), and Questioner (always seeking more information). If we can develop our empathy skills, we can avoid these unfulfilling personal response habits and move on toward more satisfying interpersonal relationships.

Sympathy and projection are two pitfalls which detract from the process of empathy. Both are activities which focus upon the listener's, rather than the sharer's feelings. Both "steal" the focus from the sharer's feelings and make it owned by the listener.

Sympathy is a process of feelings for another, in contrast to empathy, which is feeling with another. Empathy focuses upon the feeling of the other. Sympathy hears the feeling of the other, but focuses upon the feeling produced in the listener by that feeling.

Projection is the subjective, egocentric activity of attributing one's own feelings to another. It is a tendency to "hear" another's feeling in relationship to one's own self-concept and experiences. Projection, like sympathy, "steals" the focus from the other's feelings and places the focus on one's own feelings. A person using projection will make many errors in listening to others, since projection distorts the accuracy and depth of understanding another.

2. Empathy is a Four-Part Process

Empathy really involves the simultaneous blending of at least four processes: (1) tuning in to your feelings, (2) expressing your feelings, (3) tuning into another's feelings, and (4) responding to those feelings with understanding.

Step 1: Tuning Into Your Own Feelings

Every person experiences a continuous flow of feelings; about himself, about how the conversation is going, about personal comfort or discomfort, and about the other person. At times the various feelings are in conflict with each other. At times they affect the physical state of the individual. These feelings can act as a "screen," making it most difficult for him to tune into other feelings being expressed.

Step 2: Expressing Your Feelings

People are continuously sending out signals that are indications of the feeling occurring within them. At times we may attempt to express them directly. At other times we may attempt to "hold them in". The expressions can be verbal, or are through gesture, posture, or facial movements. Sometimes we express feelings clearly using understandable signs, at other times the expression may lead to misinterpretation and confusion. Congruence (consistency of expression) is essential for accurate communication of feelings.

Step 3: Tuning Into Another's Feelings

Conversely, in a conversation with another, every person constantly receives signals indicating the feeling state of the other person. Even when the signals of the communication are consistent with each other and are accurate reflections of the other's feeling state, the "listener" may not pay attention to the other's feeling state. The "listener" may not pay attention to the signals, or may pay selective attention (selective inattention) to only some of the signals. He may interpret the signals correctly or incorrectly.

Step 4: Responding to the Feelings With Understanding

When we hear the indication of feelings from another, we have a variety of response choices. We can choose to ignore the feelings, responding instead to something within ourselves, or something external to both persons. We can attempt to minimize, change, or "solve" the feelings, or we can indicate that we understand and accept the feelings.

Communication is most helpful (therapeutic, relationship building) when the feelings within both individuals are recognized, expressed, accurately "heard," and responded to with understanding and acceptance.

3. Empathy is a Powerful Resource for Building Relationships and Helping Others

The need for empathy is fairly easy to establish. Merely look around you at the signs others are sending. People are lonely, at times unsure of themselves. Can you hear and see the cry, "No one knows how I feel. No one cares?" Signs are found in successful people, in achievers, in quiet persons, in those happy and those depressed, and in friends and strangers. Small glances and mighty speeches seem to say, "LISTEN TO ME!" "PLEASE, SOMEONE JUST UNDERSTAND ME!"

Why aren't these needs met? For one reason, at times everyone is so caught up in his own cry for attention that no one can get free time to listen. A second contributing factor is that in our culture feelings take a back seat to ideas and reason. We say, "Don't be so emotional," "Calm down," or "You shouldn't feel that way," when feelings crop up. We pride ourselves in being practical in getting the facts, in being efficient and producing something. If we pay attention to problem feelings, we most often fall prey to the temptation to fix, to change, or to solve the problem feelings, rather than to understand, accept and support the other person with his feelings. Our cultural atmosphere engrains in us that "merely" understanding and accepting feelings is not enough. Most wish to "fix the problem." For whatever reason, most people find it very difficult to only understand and acknowledge another's feelings.

Perhaps you have had the experience of someone understanding and acknowledging your feelings. If so, you probably treasure the experience warmly. Empathy helps people feel in touch with each other. It creates hope, confidence and trust. It frees a person of hostility and allows them to be who they are, rather than to be measured against a standard judgment. It frees them from the necessity of defending themselves. It allows him to use energy in creative ways, to find answers or themselves, and to assume responsibility for themselves.

IT FREES THEM

How do you go about helping people? Who are the most helpful people? It's been said that the "greatest counselors" are mothers and bartenders, (not necessarily in that order). Why? The great bulk of current research in the area of helping others indicates that a helping relationship is characteristic by a number of facilitative (health promoting) conditions. Most prominent of these is empathy. There is little doubt that empathy is a necessary component of a helping relationship. A number of prominent researchers have pointed out that advice doesn't really help another. First, a person has already thought of "what he could do about" problem feelings. And second, he usually wants to be understood and accepted rather than advised. Often persons resent and resist advice. Empathy frees a person to be themselves and feel the way they feels, while supporting them, but letting them know that someone understands, and is standing with them.

Helping does not consist of solving problems for others. It may, however, mean, assisting another in understanding their problems and their feelings about them. Helping may be just standing by (with) them in their problem. This may sound obvious, but remember that you must stand by them. You must be sure you have heard the real feelings before moving on. How can you do this? There are four essential steps to helping another person in problem solving.

Listen for Their Feelings: As you listen to the person, watch for all the cues that indicate what he or she is feeling; the non-verbal and the verbal both. It gives in to the fact-finding urge. Tune into the feelings.

Acknowledge Their Feelings: Respond to feeling expressions by identifying what you see and hear. If the other person sounds annoyed, you acknowledge their feelings by saying, "You sound irritated, angry, furious, impatient, etc." Acknowledge what the feelings sound like to you, even if you disagree with it or don't like it. At this stage you have a chance to demonstrate you are listening with concern, and really are "hearing" their feelings.

Clarify the Feelings: If you are confused or unsure about what the person is trying to express, ask for clarification. Take nothing for granted. Phrases like these are helpful when seeking clarification

"Is your feeling something like...?"

"Could you tell me more about this?"

"I'm not sure I understand what you meant by..."

"Are you saying..."

TYPICAL PHYSICAL, BEHAVIORAL, COGNITIVE, AND EMOTIONAL RESPONSES DURING GRIEF

PHYSICAL SENSATIONS

Tightening in the chest
Over-sensitivity to noise
Dryness of mouth
Breathlessness
Weakness of muscles
Lack of energy

reminders

BEHAVIORS

Absent-mindedness
Social withdrawal
Sleep disturbances
Restlessness/over-activity
Appetite disturbances
Crying, sighing
Visiting places that are

Calling out for the deceased

COGNITIONS (Thoughts)

Disbelief
Confusion
Preoccupation with thoughts or memories
Sense of his/her presence

FEELINGS

Sadness	Shock
Anger	Yearning
Guilt or self-reproach	Relief
Anxiety	
Loneliness	
Numbness	
Fatigue	
Helplessness	

SYMPTOMS OF GRIEF

- Sense of disbelief, shock, numbness
- Change in appetite and/or weight
- Gastrointestinal distress
- Change in spiritual values
- Difficulties with sleep; fatigue
- Dreams of the deceased
- Restlessness
- Poor concentration; forgetfulness
- Wide ranging mood swings
- Irritability
- Anger and/or guilty feelings
- Emotional outbursts; crying unexpectedly
- Sensing the deceased's presence
- Change in sex drive

Courtesy of Rev. Richard B. Gilbert, *Connections-Spiritual links*, 1504 North Campbell, Valparaiso, Indiana 46383. 219-464-8183.

COMMON "GRIEF EXPRESSIONS"

- "Why is this happening to me?"
- "Why is God punishing me?"
- "There is no God."
- "Am I going to die?"
- "I am going 'home.'"
- "What did I do to deserve this?"
- "I feel so alone."
- "I hate you. Get out of here. Leave me alone!"
- "What's happening?"
- "Is there any hope?"

Courtesy of Rev. Richard B. Gilbert, *Connections-Spiritual links*, 1504 North Campbell, Valparaiso, Indiana 46383. 219-464-8183.

Grief and Mourning

- Grief is not understood in our society, and mourners are expected to recover quickly. Be gentle with yourself during the many ups and downs.
- The experience is unique to each person, yet there is much you will have in common with others. Guard against putting expectations on your partner and others.
- Tears are healthy and acceptable as you process the pain following the death of your loved one. Cry freely and do not apologize for tears.
- Grief affects your eating and sleeping habits, your energy level, and your ability to concentrate. A balanced diet, adequate fluids, moderate physical exercise, and rest are especially important during the mourning period. Have a checkup if you have physical symptoms.
- Alcohol and sedatives can cloud thinking and slow down the bereavement process. Use prescribed medications sparingly and only under supervision.
- Friends and relatives may avoid you and talking of the death of your loved one. Let them know you need to talk about your loved one and that it helps to talk. Share with them as you can.
- Search for listening friends and/or others with a similar experience to help you through this time.
- Delay major decisions at least a year (changing jobs or home, another pregnancy, etc.).
- Keep your loved one's clothes and other preparations until you are ready to decide what you want to do. Time is needed in making a good decision about these things.
- Suicidal thoughts may occur and are normal. The meaning of life will return in time. The pain does lessen. Talk over feelings with a trusted friend as they surface.
- Express your guilt feelings and thoughts. They may be illogical to some, so share them with a listening person who will help you explore and forgive yourself in time.
- Anger is a common and a normal response, although it may be unacceptable to you and difficult for others to witness. Find healthy and safe ways to express anger (e.g., beat a pillow).
- Your anger may be directed toward God. You may feel that your faith has weakened as you question past strong beliefs. Tell God how you feel and talk to those who can help you explore. Your faith can help you through this time, yet expressing doubts and feelings aids in processing what you are experiencing.
- Include your children in your grief. Do not hide your tears from them, but be open and honest about your feelings. They, too, are grieving and need an avenue to express their feelings. They need to be included and to feel your love. You may

find it helpful to find a close family member who can supply what you are not able to give at this time.

- Holiday and anniversary times are reminders of your empty arms. Plan ahead to avoid some of the added stress. Do not expect others to remember or be sensitive to how you might feel. Lower expectations on yourself. Take time for your needs.
- Mutual help groups put you in touch with others having a similar experience. By sharing, deeper feelings will surface and can then be processed in an atmosphere of understanding and acceptance. Know that you are not alone. There are others who understand and who care.

Courtesy of the National SHARE Office. St. Joseph Health Center, 300 First Capitol Drive, St. Charles, Missouri 63301-2893

Twelve Steps in the Grief Process

STEP 1—RECOVERY FROM A LOVED ONE’S DEATH REQUIRES MORE THAN TIME

Yet, if we allow ourselves the time to mourn, we can gradually break grief’s grip on us. Recognizing the role and value of the grieving process orients us to accept the fact of the death. Acceptance marks a major step toward recovery.

STEP 2—GRIEF IS UNIVERSAL BUT GRIEVERS ARE DISTINCTIVE

Grieving follows a pattern, but each person grieving experiences it differently. Awareness of the basic pattern reveals common ground for mutual help and support. Recognition of uniqueness enables grievers to help themselves and guides sympathizers in what to say and do.

STEP 3—SHOCK INITIATES US INTO MOURNING

We go numb when someone we love dies. We feel stunned, in a trance. This is nature’s way of cushioning us against tragedy. The length and depth of this state varies according to our relationship, the cause of death, whether it was sudden or expected, etc. Shock allows us time to absorb what has happened and to begin to adjust. The guidance of caring people can sustain new grievers. As numbness wears off and acceptance grows, we regain control of the direction of our lives.

STEP 4—GRIEF CAUSES DEPRESSION

Grievers typically, but in varying degrees, experience loneliness and depression. This pain, too, will pass. Being alone need not result in loneliness. Reaching out to others is a key way to lessen loneliness and to overcome depression.

STEP 5—GRIEF IS HAZARDOUS TO OUR HEALTH

The mental and emotional upset of a loss by death causes physical distress and vulnerability to illness. Grievers sometimes neglect healthy nourishment and exercise, or overindulge in drinking, smoking, or medication. We might need a doctor’s advice in regard to our symptoms, their causes, and their treatment.

STEP 6—GRIEVERS NEED TO KNOW THEY’RE NORMAL

The death of a loved one makes the future very uncertain. We might panic in the face of the unknown and fear life without the one who died. Panic prevents concentration and defers acceptance of the finality of death. It tempts us to run from life, to avoid people, and to refuse to try new things. We might even think we’re going crazy.

Patience with ourselves and a willingness to accept help enable us to subdue panic and outgrow its confusion.

STEP 7—GRIEVERS SUFFER GUILT FEELINGS

Many blame themselves after a loved one's death, for the death itself or for faults in the relationship. We have all made mistakes, and sincere regret is the best response to them. However, self-reproach out of proportion to our behavior affects our mental health and impedes our recovery. Close friends or a trusted counselor can aid us in confronting and dealing with guilt feelings, whether justified or exaggerated.

STEP 8—GRIEF MAKES PEOPLE ANGRY

People in grief naturally ask "Why?" "Why him?" "Why me?" "Why now?" "Why like this?" Most of these questions have no answers. Frustration then causes us to feel the resentment and anger. We want someone to blame: God, doctors, clergy, ourselves, even the one who died. If we can accept the lack of answers to "Why?" we might begin to ask, instead, what we can do now to grow through what has happened. Then we have started to move beyond anger and toward hope.

STEP 9—EMOTIONAL UPHEAVAL CHARACTERIZES GRIEVERS

A loved one's death disrupts emotional balance. The variety and intensity of feelings seems overwhelming. Other grievers and counselors can help us interpret and deal with these feelings. As we come to understand what we experience, we can find appropriate ways to ventilate our emotions and to channel them constructively.

STEP 10—GRIEVERS OFTEN LACK DIRECTION AND PURPOSE

At times in the grieving process, a kind of drifting occurs. Mourners find familiar and necessary activities difficult. We prefer to daydream about what was or fantasize about what might have been. If we can foster gratitude for the past and begin to assess our potential for the future, this will prove a passing phase, not a permanent state.

STEP 11—HEALING BRINGS HOPE TO GRIEVERS

It takes time and effort, but gradually hope dawns for bereaved people. We learn to express emotions without embarrassment or apology. We cherish memories, bittersweet though they are. We begin to feel concern for and show interest in others. We make decisions and assume responsibility for ourselves. The example of other recovered grievers helps us discover and develop our own potential.

STEPS 12—SURVIVORS REAFFIRM THEMSELVES AND SHOOSSE LIFE

Eventually, grievors recognize and embrace a healing truth: *Grief has changed me, but has not destroyed me.* I've discovered new things about myself. I can build on strengths developed through

adversity. I'm no longer my "old self," but I'm still me, and I face the future with confidence. Life is worth living because I can love and be loved.

Source: "Grief Is Not a Sign of Weakness." THEOS Foundation, International Headquarters. 1301 Clark Building, 717 Liberty Avenue, Pittsburgh, Pennsylvania 15222

Grief—Expectations You Can Have for Yourself

You can expect that:

- Your grief will take longer than most people think it should.
- Your grief will take more energy than you can imagine.
- Your grief will involve continual changes.
- Your grief will show itself in all spheres of your life and who you are. It will affect your social relationships, your health, thoughts, feelings, and spiritual beliefs.
- Your grief will depend upon how you perceive the loss.
- You will grieve for many things (both symbolic and tangible), not just the death itself.
- You will grieve for what you have lost already as well as for the future—for the hopes, dreams and unfulfilled expectations you held for and with that person.
- Your grief will involve a wide variety of feelings and reactions: some expected, some not.
- This loss will resurrect old losses, feelings and unfinished business from the past.
- You may have some confusion about who you are. This is due to the intensity and unfamiliarity of the grieving experience and uncertainty about your new role in the world.
- You may have a combination of anger and depression, irritability, frustration, and intolerance.
- You may feel guilt in some form.
- You may have a poor sense of self-worth.
- You may experience spasms, waves, or acute upsurges of grief that occur without warning.
- You will have trouble thinking and making decisions, poor memory, and poor organization.
- You may feel like you are going crazy.
- You may be obsessed with the death or preoccupied with thoughts of the dead person.
- You will search for meaning in your life and question your beliefs.
- You may find yourself acting differently.
- Society has unrealistic expectations about your mourning and may respond inappropriately.
- You will have a number of physical reactions.
- Certain dates, events, seasons, and reminders will bring upsurges in your grief.
- Certain experiences later in life may resurrect intense grief feelings for you.

Source: "Medical Care of the Dying," 2nd Edition. Victoria Hospice Society, Victoria, British Columbia, Canada, © 1993.

Grief Recovery—Moving in the Right Direction

Here are some suggestions to keep you moving in the right direction:

- **Accept the grief.** Roll with the tides of it. Do not try to be brave. Take time to cry.
- **Talk about your loss.** Share your grief within the family. Do not try to protect them by silence. Also, find a friend to talk to. Talk often. If the friend tells you to “snap out of it,” find another friend.
- **Deal with guilt, real or imagined.** You did the best you could at the time. If you made mistakes, accept the fact that you, like everyone else, are not perfect. Only hindsight is 20-20. If you continue to blame yourself, consider professional or religious counseling. If you believe in God, a pastor can help you believe also in God’s forgiveness.
- **Keep busy.** Do work that has a purpose. Use your mind.
- **Eat well.** Grief stresses the body. You need good nourishment now more than ever, so get back to a good diet soon. Vitamin and mineral supplements may help.
- **Exercise regularly.** Exercise lightens the load through biochemical changes. It also helps you to sleep better. Return to an old program or start a new one. An hour-long walk every day is ideal for many people.
- **Nurture yourself.** Each day try to do something good for yourself. Think of what you might do for someone else if they were in your shoes, and then do that favor for yourself.
- **Join a group of others who are sorrowing.** Your old circle of friends may change. Even if it does not, you will need new friends who have been through your experience.
- **Associate with old friends also.** Some will be uneasy, but they will get over it. If and when you can, talk and act naturally, without avoiding the subject of your loss.
- **Postpone major decisions.** Wait before deciding whether to sell your house or to change jobs.
- **Record your thoughts in a journal.** Writing helps you get your feelings out. It also shows your progress.
- **Turn grief into creative energy.** Find a way to help other. Sharing someone else’s load will lighten your own. Write something as a tribute to your loved one.
- **Take advantage of a religious affiliation.** If you have been inactive, this might be the time to become involved again. For some people, grief opens the door to faith. After a time, you might not be as mad at God as you once were.

- **Get professional help.** Do not allow crippling grief to continue. There comes a time to stop crying and to live again. Sometimes just a few sessions with a trained counselor will help a lot.

No matter how deep your sorrow, you are not alone.

Others have been there and will help share your load if you will let them.

Source: Amy H. Jensen, "Healing Grief," a 24-page booklet by Media Publishing, PO Box 89, Redmond, Washington 98073-0089, © 1995.

Grief Rituals

The value of creating “GRIEF RITUALS” is to help us remember our loved ones in loving, healing ways and with a sense of peace. Too often, bereaved individuals feel they must “hold on” to pain, seemingly forever, in order to remember those they love. Some examples of rituals are listed below. **REMEMBER: IT IS IMPORTANT FOR YOU TO CREATE A RITUAL YOURSELF OR TOGETHER WITH YOUR FAMILY THAT WILL HAVE THE MOST MEANING AND HEALING SIGNIFICANCE TO YOU AND THOSE YOU LOVE.**

- ◆ Buy a very special candle and light it at times that are special to your loved one’s memory, i.e. birthday, father’s day, anniversaries, etc.
- ◆ Write special notes in balloons and let them go
- ◆ Help feed the hungry/homeless at Thanksgiving, holidays, etc.
- ◆ Create a scrapbook of memories/photos...a memory book
- ◆ Donate gifts, quilts, etc. in loved one’s name
- ◆ Plant a strong, healthy tree or rosebush in loved one’s name
- ◆ Find a tree in the canyons or woods, tie a yellow ribbon around, go frequently to remember (this is especially helpful when ashes have been scattered and there is no gravesite)
- ◆ Let balloons go along with a prayer or special wish to loved one
- ◆ Offer a scholarship in loved one’s name
- ◆ On birthdays, holidays, anniversaries, etc., buy your loved one a gift and donate it to a hospital, nursing home, etc.
- ◆ Christmas stockings – hang one for a loved one and have everyone write a special note to put inside
- ◆ Buy a Christmas ornament each year to remember your loved one

- ◆ If you go on a trip at a special anniversary time, do something special to remember your loved one on the trip (i.e. toss a rose in the ocean, light a candle)
- ◆ Have wedding ring made into a new setting for a necklace, etc.
- ◆ Have a birthday party for your loved one on his or her birthday
- ◆ Have a family “memory” evening where you share pictures, reminisce about special times, create a scrapbook of memories, etc.

Bereavement—Guidelines for Growth

With the death of your loved one, your life has been irrevocably changed. A death experience can have strong and lasting effects, but it can also open the way to new growth.

Because you have loved the person who died, you will, step by step, want to reinvest in life again. There are many ways to accomplish this. Perhaps these ideas will inspire you:

- *Write.* You may find keeping a journal will help to externalize your feelings. Or, you may want to write something influenced by or dedicated to the memory of the one you loved.
- *Educate* yourself about the grief process. The more you know, the more you will be able to help yourself. Funeral homes, hospices and public libraries should be able to help you find reading material and help you connect to groups with other resources.
- *Assist* other bereaved people. Find an organization through which you can be a friend to the griever.
- *Set a goal* that is new and interests you.
- *Take advantage of your religious affiliation*, if you have one. If you have been inactive in matters of faith, this might be the time to become involved again. The Bible has much to say about sorrow. Old hymns are relevant.
- *Exercise regularly.* Return to your old program or start one as soon as possible. Depression can be lightened a little by the biochemical changes brought by exercise, and you will sleep better. An hour-long walk every day is ideal for many people.
- *Recall the humorous times* and laugh about them. Some will disapprove if you laugh “too soon,” but it’s not disrespectful. Remembering with laughter is helpful.
- *Check on adult education* and college programs available in your area. Choose a subject or skill you’ve always wanted to explore.
- *Write down any goals* that you may have for the future. For example, getting a new job, taking a long-wished-for trip, continuing your education, or trying a new hobby.

You will reach a stage where you can accept your loss. You will be able to remember with less pain and focus on a future filled with hope. Whatever you do, do not waste your life in unproductive sorrow. The best memorial to a loved one is a full, growing life.

Courtesy of Providence Hospice of Yakima, Yakima, Washington.

Beyond Surviving: Suggestions for Survivors

By Iris M. Bolton

Hundreds of books have been written about loss and grief. Few have addressed the aftermath of suicide for survivors. Here again, there are no answers; only suggestions from those who have lived through and beyond the event. I've compiled their thoughts.

1. Know you can survive. You may not think so, but you can.
2. Struggle with “why” it happened until you no longer need to know “why,” or until you are satisfied with partial answers.
3. Know you may feel overwhelmed by the intensity of your feelings but all your feelings are normal.
4. Anger, guilt, confusion, and forgetfulness are common responses. You are not crazy; you are in mourning.
5. Be aware you may feel appropriate anger at the person, at the world, at God, or at yourself. It's okay to express it.
6. You may feel guilty for what you think you did or did not do. Guilt can turn into regret, through forgiveness.
7. Having suicidal thoughts is common. It does not mean that you will act on those thoughts.
8. Remember to take one moment or one day at a time.
9. Find a good listener with whom to share. Call someone if you need to talk.
10. Don't be afraid to cry. Tears are healing.
11. Give yourself time to heal.
12. Remember, the choice was not yours. No one is the sole influence in another's life.
13. Expect setbacks. If emotions return like a tidal wave, you may only be experiencing a remnant of grief, an unfinished piece.
14. Try to put off major decisions.

15. Give yourself permission to get professional help.
16. Be aware of the pain of your family and friends.
17. Be patient with yourself and with others who may not understand.
18. Set your own limits and learn to say no.
19. Steer clear of people who want to tell you what or how to feel.
20. Know that there are support groups that can be helpful, such as Compassionate Friends or Survivors of Suicide groups. If not, ask a professional to help start one.
21. Call on your personal faith to help you through.
22. It is common to experience physical reactions to your grief, ie. headaches, loss of appetite, and inability to sleep.
23. The willingness to laugh with others, and at yourself, is healing.
24. Wear out your questions, anger, guilt or other feelings until you can let them go. Letting go doesn't mean forgetting.
25. Know that you will never be the same again, but you can survive and even go beyond just surviving.

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SUGGESTIONS FOR HELPING YOUR SELF THROUGH GRIEF

1. Go gently. Don't rush too much. Your body needs energy for repair.
2. Don't take on new responsibilities right away. Don't over-extend yourself. Keep decision-making to a minimum.
3. Accept help and support when offered.
4. Ask for help. No one can read our minds. It is very important to find someone who cares, understands, and with whom you may talk freely. It's okay to need comforting.
5. Seek the support of others. Invite a relative/friend for dinner or overnight. Also, consider meeting new people.
6. Be patient with yourself. Healing takes time.
7. Lean into the pain. It cannot be outrun. Let the grief/healing process run its full course.
8. Through this emotional period, it is okay to feel depressed. Crying does make you feel better.
9. If Sundays, holidays, etc. are especially difficult times, schedule activities that you find particularly comforting for these times.
10. Seek the help of a Counselor or Clergy if grief is unresolved.
11. Try to get adequate Rest. Go to bed earlier. Avoid caffeine.
12. Good nutrition is important. Decrease junk food. Eat a balanced diet.
13. Keep a journal. It is a good way to understand what you are feeling/thinking and, when re-read later, you will see you are getting better.
14. Read. There are many helpful books on grief. If grief is understood, it is a little easier to handle.
15. Exercise. It offers an opportunity to work off frustration and aids sleep.
16. Try to socialize with family and friends. Don't feel guilty if you have a good time. Your spouse would want you to be happy.
17. It's okay to be angry. You may be angry at yourself, God, your spouse, others, or just angry in general. Don't push it down. Let it out. (Hit a pillow, scream, exercise, hit a punching bag, etc.)
18. Do not have unrealistic expectations of yourself. Grief takes TIME. It comes and goes.
19. Do things a little differently, yet try not to make a lot of changes. This sounds like a contradiction, but it is not.
20. Plan new interests. Join a class (exercise, tennis, self-awareness, craft, or adult education), read, or learn something new. Rediscover old interests, activities, and friends.
21. Plan things to which you can look forward—a trip, visit, lunch with a friend.
22. Find quotes/posters/poems that are helpful to you and post them where you can see them.
23. Pray, talk to your spouse.
24. Other ideas: take a hot relaxing bath, bask in the sun, take time for yourself (movie, theatre, dinner). Be good to yourself.
25. Do something for someone else. Join a volunteer or support group. Helping others does much to ease the pain. Reach out and touch someone.
26. Be determined to work through your grief.
27. Remember - you will be better. Hold on to HOPE. Some days you just seem to exist, but better days will be back.

28. Simply stated, put balance in your life: PRAY, REST, WORK AND PLAY.

God grant me the serenity to accept
The things I cannot change,
The courage to change the things I can,
And the Wisdom to know the difference.

What Are Patients and Families Experiencing?

Each Hospital patient and family is unique. The reactions to a prognosis of a terminal illness are as varied as the number of patients we have. Culture, religion, past experience, age and personality are but a few of the factors that influence people's attitude toward death and dying. Elizabeth Kubler-Ross, a well-known psychiatrist, describes the ways people cope with death and dying in her book, On Death and Dying.

Please remember that not all people experience all of the reactions described by Kubler-Ross. People sometimes move from one stage to the next and back again. Dying persons may differ from their families in their degree of acceptance. The emotions, behaviors and responses described here will help you understand some of the emotions patients and their families may experience.

	PATIENT BEHAVIOR	HELPFUL RESPONSE
DENIAL	In effect, the patient says, it cannot be true. Patients often search frantically for a favorable diagnosis.	Understand why the patient is "grasping at straws." Patience and willingness to talk are important.
ANGER	The patient says, "Yes, but why me?" Deep anger follows and the patient may bitterly envy those who are well and complain incessantly about almost everything.	Consider that the patient is angry over the coming loss of everything; family, friends, home work, and play. Treat the patient with understanding and respect, not by returning the anger.
BARGAINING	The patient says, "Maybe I can bargain with God and get a time extension." Promises of good behavior are made in return for time and some freedom from physical pain.	If the patient's "bargain is revealed, it should be listened to, not brushed off. This stage passes in a short time.
DEPRESSION	The patient grieves and mourns approaching death.	Attempts to cheer up or reassure the patient mean very little. the patient needs to express sorrow fully and without hindrance.
ACCEPTANCE	The patient is neither angry nor depressed, only quietly expectant.	News of the outside world means little and few visitors are required. There will be little talk, and it is time merely for the presence of close family.

Anticipatory Grief—A Patient’s Perspective

When anyone is put in a position of having to face the possibility of their own death, they go through a process called grief. This material will help you understand what grief may mean for you. You will likely experience a wide range of thoughts, feelings, and responses over the course of your illness. Due to the intensity of your reactions, you may find yourself feeling frightened and overwhelmed; this is quite normal. It helps to know what to expect and that these reactions are a necessary part of grief.

SOCIAL ISSUES

As you face changes in the roles and responsibilities you fulfill, you may experience self-consciousness and low self-esteem. Your former activities and interests may no longer be available to you. Some people feel indifferent to social contact and withdraw from friends. Others need company, but find it difficult to ask. You may find that those around you have unrealistic expectations about your grief.

YOUR BODY

Trying to adjust to the continual changes in daily activities and the losses of your former lifestyle will increase your fatigue and sap already low levels of energy. Pace yourself and plan to spend your energy on what counts most to you. The loss of independence, both physical and personal, is difficult.

YOUR FEELINGS

You will experience a wide variety of feelings, which may occur as sudden upswings of emotion. Anger, sadness, depression, and guilt are common and natural feelings. You may find yourself irritable and frustrated, with little tolerance for many things. Your grief may suddenly raise old feelings, issues, or unresolved conflicts from the past. You may experience anxiety, or even fear, about yourself and others. Concern for the future well-being of your family may be very heavy for you.

YOUR THOUGHTS

The stress that you are experiencing may interfere with how well your mind works. You will find that your ability to concentrate is less than it used to be. Your memory may slip, making it hard for you and your family to rely on you for decisions. At times, you might even have an odd sense of unreality or of “going crazy.”

It is natural and understandable to swing back and forth between acceptance and denial of your situation. These ambivalent thoughts and feelings are helpful in trying to work through what this illness is doing to you. At times, you will feel OK, but at other times you will think, “This just can’t be happening.”

CHILDREN AND DEATH—AGES TWO THROUGH ADOLESCENCE**CHILDREN AND GRIEF—AGES 2-5****Understanding of Death**

- Extremely egocentric and concrete; see death as a loss of love and protection, as abandonment.
- See death as a temporary departure or a separation; find it difficult to understand the concept of finality.
- May forget the person has died.
- Connect death with the event(s) that precede it, in a cause-and-effect way.
- See some distinction between life and death; associate life with movement and death with lack of movement; may confuse death with sleep.
- May attribute life to inanimate, moving objects.

Common Reactions

- Feeling abandoned, overwhelmed, and lonely
- Denial, repression of facts
- Regression in behaviors
- Confusion about the circumstances of the death and a need to review it frequently.

What Helps

- Consistent repetition of the facts
- Simple explanations about whatever happens (e.g., funerals, rituals, burial, the death)
- Someone to support them and answer questions at high-stress times (e.g., following the death, funerals, visits to cemetery)
- Accurate, honest information at their level of understanding
- Discussing what the person who died can no longer do (e.g., move, breathe, eat)
- Physical contact, calm/soothing tones, quiet times

- Both concrete and magical thinking:
 - Language is used and understood literally
 - Engage in wishful thinking (“if only”)
 - Think of life as being linear, with a beginning and an end.
 - See death as external and therefore avoidable (won’t happen to them or their loved ones).
 - May see death as a punishment (for the dead person or themselves).
 - May see death as a result of old age.
 - Personify death as monsters or the boogey man.
 - The concept of “life after death” is a contradiction of terms because death is seen as the end of life functions.

Common Reactions

- Ask a lot of questions, do research into the disease and death, focus on gory details.
- Have fears of being abandoned, of changes in their world, of more family deaths.
- Feel responsible for the death, for the family’s future, for making family members happy.
- Experience nightmares, restlessness, diarrhea.
- Show regression in behaviors and emotions (e.g., bedwetting, thumb sucking, fears).

What Helps

- Information and explanations should be accurate and literal.
- Explain death in term of body functions (e.g., breathing, heart, brain).
- Grant permission to decide their own level of involvement in rituals, funerals and gatherings.
- Provide a support person and models for appropriate grieving.
- Provide information and reassurances about their grief reactions and feelings,

- Continued reassurances (e.g., about their future, about events prior to the death)
- Consistent maintenance of usual routines and discipline

their responsibility for the death, and their future.

- Encourage child to engage in concrete survival activities (e.g., chores, play and exercise).

Provide opportunities to share their

experiences with other grieving children.

CHILDREN AND GRIEF—AGES

6-8

Understanding of Death

- Conflicting beliefs about death
- Confusion and misunderstanding

Continues

MANUAL

Children and Death continued

CHILDREN AND GRIEF—AGES	CHILDREN AND GRIEF—AGES
9-12	13-17
<p data-bbox="391 646 678 678">Understanding of Death</p> <ul data-bbox="315 709 824 1297" style="list-style-type: none"> • Become less egocentric and develop social concerns. • Make transition from concrete to more abstract thinking: <ul data-bbox="363 842 824 1066" style="list-style-type: none"> – Understand the universality of death; See death as removed in time from themselves. – Can generalize about death and understand its magnitude. – Begin to believe that it can happen to anyone and struggle with this. • See death clinically; fear it may be painful and scary. • See death as part of life—natural, universal and permanent. • Express interest in what happens to person’s body and spirit after death; fear nonexistence and separation. <p data-bbox="391 1304 623 1335">Common Reactions</p> <ul data-bbox="315 1367 797 1696" style="list-style-type: none"> • Anxiety and general fearfulness • Covering up emotions and trying to appear normal • Concern about other survivors • Concern about personal future and security • Regressive behaviors (bedwetting, nightmares, acting out) • Withdrawal or endless questions about the death <p data-bbox="391 1703 532 1734">What Helps</p> <ul data-bbox="315 1829 797 1852" style="list-style-type: none"> • Honest and accurate information about 	<p data-bbox="963 646 1250 678">Understanding of Death</p> <ul data-bbox="886 709 1399 1066" style="list-style-type: none"> • Intellectually able to understand implications of death as an adult would. • Feel shocked that it could happen to their family and confused about how to react. • Feel overwhelmed by intensity of the emotions. • Feel a sense of isolation and loneliness even among friends and family; feel different. • Vacillate between acting like an adult and a child. <p data-bbox="963 1073 1195 1104">Common Reactions</p> <ul data-bbox="886 1136 1385 1535" style="list-style-type: none"> • Withdrawal; difficulty in finding a balance. • Guilt about things said or not said, done or not done • Fear or disgust of the body. • Tendency to remember only good things about the person • Tendency to blame others for the death and how it affects their life. • Totally empty feeling and exhaustion; may not cry • Difficulty with eating or sleeping <p data-bbox="963 1598 1104 1629">What Helps</p> <ul data-bbox="886 1661 1369 1852" style="list-style-type: none"> • Honest and accurate information about the death and its circumstances. • Support from friends and teachers, as well as family. • Inclusion in discussions and decision-making, as wished.

the death

- Opportunities to ask their own questions
- Reassurance about their future (e.g., if the other parent died, who would care for them and how)
- Adults to model appropriate grieving
- Respect for the privacy of their thoughts, feelings and writings
- Inclusion, as wished, in adult activities associated with the death (rituals, funeral, discussions, plans)
- Opportunities to spend more time alone.
- Balance between having time to be a child and time to take on some adult responsibilities.
- Keeping a journal or diary

Source: "Medical Care of the Dying, "2nd Edition, Victoria Hospice Society, Victoria, British Columbia, Canada, © 1993.

CLICHES TO BE AVOIDED

The following clichés are inappropriate to use with grieving children. It is important to remember that a child thinks in literal terms, and therefore, what we say is what the child will believe. Always tell the child the truth about the death. To lie about it, especially if the death is multiple and/or traumatic, as in a murder or suicide, is to plant the seeds of confusion and distrust. The truth will always present itself eventually. Answer all questions simply and honestly, without elaboration.

INAPPROPRIATE: *“Grandpa went to sleep last night and is now in heaven.”*

CHILD’S RESPONSE: Fear of sleep. Fear of the dark. Nightmares.

APPROPRIATE: *Grandpa died last night. This will be a sad time for all of us, but we will get through it together*

INAPPROPRIATE: *God loved Daddy so much that He took him to Heaven to live with the angels.*

CHILD’S RESPONSE: Fear of God. Fear Mother will also die. Fear of Love.

Rejection of spiritual values.

APPROPRIATE: *“We believe that Daddy is in Heaven with God and that God knows how very much we miss Daddy.”*

INAPPROPRIATE: *“Grandma went on a long trip and won’t be coming back.”*

CHILD’S RESPONSE: “Why didn’t Grandma say goodbye before she left? Doesn’t Grandma love me? Is that why she left without saying goodbye? Where did she go?” Fear

of loss as Mommy and Daddy leave for a while (i.e., to work or for shopping). This is abandonment.

APPROPRIATE:

“Grandma was very sick and the sickness made her die. We believe that because she was such a good Grandma, God said she could come and be with Him in Heaven.”

INAPPROPRIATE:

(Overheard after the death of a child) “Well, you know what they say, how the good die young.”

CHILD’S RESPONSE:

“If the good die young, I don’t want to die so I won’t be good.” Or “Does that mean that I am bad?”

- APPROPRIATE: *How sad that such a young child died. I wonder if there is anything I can do to help the family?"*
- INAPPROPRIATE: *"You must always be a good little boy/girl, because Daddy is watching from Heaven."*
- CHILD'S RESPONSE: Paranoia. Fear of making mistakes. Extreme guilt feelings when they are naughty coupled with an inability to "make it up" to the deceased parent. Feelings of loss of privacy (i.e., everything is open to scrutiny.)
- APPROPRIATE: *"Daddy's love for you can never die. He is not with us like he used to be, but we will always remember and love him very much."*

Sister Teresa McIntier, RN, ML

Bereavement and the Couple's Relationship—Tips on Coping

- Your marital relationship is the most important relationship. Let it take precedence over all others.
- When a baby dies, the grief affects both parents at the same time. Other stresses in marriage usually don't affect both partners simultaneously. Therefore, your closest support is not always able to respond to you, because he/she is trying to deal with his or her own grief.
- Each person in the relationship will grieve in his or her own individual way. Learning to accept your spouse's way can be difficult.
- Difficulties can arise in the best of marriages. Keep working at communicating your emotional needs.
- Your spouse doesn't have to be your sole supporter.
- There could be stresses on your sexual relationship. Communicate openly your feelings.
Remember human touch and hugs can be healing.
- Each person in a relationship may need some privacy with his or her feelings. Respect each other and give the space needed. This could be a time for you to share later.
- Each person who has experienced a loss is not the same person they were before the baby died. It may take time to accept and understand these changes.
- Each of you will search for a meaning of your loss; one may turn to faith, one may not.
- It is okay to enjoy life. Your baby doesn't expect you to be sad all the time. Sharing laughter and tears together helps you to heal. Search for some relaxing things to do. It helps give you a new perspective.
- This is a difficult time for both. Remember—if your relationship was secure prior to your loss, it can become a deeper relationship during your healing.
- Each partner may feel different regarding the choices of your child's memorabilia. Talk about your differences and compromise if possible.
- Your losses are from broken hopes and dreams. Each person may have different dreams for this special baby.

Ways to Survive As A Couple

- Seek outside support from a support group, clergy or professional counselor.
- Take time for each other, alone.
- Set a time to talk each day.
- Work on your communication skills.
- Pray together.
- Give yourselves the time to adjust to your loss.

Courtesy of the National SHARE Office, St. Joseph Health Center, 300 First
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The Final Stage of Life

Volunteers are sometimes apprehensive about their reaction to the dying patient and family. Volunteer training will help you come to terms with your own feelings toward death and dying. Working through these feelings and facing death, as an inevitable event, will help you deal with patients and families.

As the time of death nears, the hospital team remains in close contact with our patients and families. This is a very private and intimate time for the families. It is also a time when hospital staff and volunteers need to be particularly sensitive to their needs. Listening and encouraging families to share their feelings is important. Your willingness to be there and listen is a priceless gift you can give to a dying patient.

The following is information about physical changes that the patient may experience as the body prepares itself for the final stage of life. This information is for the families of dying patients and is included in their admission packet. You, as a volunteer, may also wish to familiarize yourself with the information in order to support and encourage the families to refer to it.

- The need for food and water gradually decreases. Allowing them to decide how much they want is best.
- Spending more and more time sleeping, and at times being difficult to arouse is natural. Plan your times with them for those occasions when they seem most alert.
- As the amount of liquid intake decreases, the urine may become dark and more concentrated. If the loss of bodily functions occurs, they may need protective pads or a catheter to keep them clean and dry.
- There may be a decrease in the ability to hear and see. Reassure them that they are not alone by leaving the light on, holding their hand and speaking softly. Always remember that hearing is the last of the senses to be lost.
- Restlessness, pulling at the bed linen and having visions of people or things that do not (or they are real) exist may occur. Also, they may be confused about time, place and familiar faces. Remind them frequently what day it is, what time it is, and who is in the room talking to them.

PATIENT QUESTIONS	
ABOUT PATIENT	ABOUT FAMILY/FRIENDS
<ul style="list-style-type: none"> • Am I a valuable person? • Am I still attractive? • Can I enjoy life? • Would it be better if I had died? • Will I be able to accept these physical changes? • Can I be sexually active? • Why did this happen? • How much pain will I go through? 	<ul style="list-style-type: none"> • Am I a burden to my family? • Will I be a good parent (spouse, child, etc.)? • Will I be able to support myself and/or my family? • Will I be able to physically protect myself and/or my family? • Will my friends stand by me? • Will I be able to keep friendships? • What will happen to my family when I die?

FAMILY QUESTIONS	
ABOUT PATIENT	ABOUT FAMILY/FRIENDS
<ul style="list-style-type: none"> • Will he/she live for long? • Is he/she going to be dependent on me? • Will he/she always be depressed? • Will he/she be able to return to work? • Will he/she stay this way? • How much pain will he/she go through? 	<ul style="list-style-type: none"> • Why did this happen to us? • What can we do to help? • How can we protect him/her? • Can we manage care at home? • Will there be enough money? • How will we cope? • How will our friends react?

Talk with any team member about any concerns.

For Adults: Responding to a Child's Grief

The way you respond when talking to young children about death is determined by your own personal and spiritual views on the topic. The following suggestions will help you explain some of the practical aspects of what happens when death occurs.

When talking to young children about death, it is a good idea to start by finding out what they already believe. It is quite surprising what misconceptions they may have already developed. During a talk like this, it is good to have as much touching and holding as possible to make them feel secure and less afraid. The conversation may be difficult and you may not have all the answers, but do not be afraid to say you do not know. This is usually better than making up some fantasy that may later confuse and upset them.

It is all right to let children know that you feel sad and even to see you cry. Explain why you are sad, and reassure them that it is okay for them to feel sad and cry if they want to. Tell the truth. Children are more resilient than adults think. Do not create lies to protect them or they may resent you later for not being truthful. Keep your answers simple and at a level they can understand.

Although it is difficult for young children to understand the finality of death, it is best to confront the issue honestly. Never tell them the person went away on a trip and will return later. Also, never equate death to sleeping. Stories like these confuse and upset children more than the truth. Even though you tell children the person will not return, they may frequently ask you when the person will be back. This question is natural and should be answered truthfully each time.

Children may think something they said or did made the person die. Reassure them this is not true. Explain that they may even feel angry at the deceased because they died. Let them know that this is normal and that even adults feel this way sometimes. They may be afraid that you will die or that anyone who gets sick or goes into the hospital will die. Reassure them that illness and death do not go hand in hand, and that you plan to stay alive for a long time.

Encourage children to attend funeral or memorial services and make visits to the cemetery, but never force them. They are members of the family and have a right to take part in such events. Attending will often clear up the fantasies and fears they have. If possible, let them take some active part in the service. This makes them feel important and closer to the person who died. Visiting the grave periodically may initiate a discussion of how and what they are feeling.

Source: Ralph L. Klicker, "Kolie and the Funeral." Thanos Institute, PO Box 1928, Buffalo, New York 14231-1928 © Ralph L Klicker, Ph.D.

MANUAL

HOW CHILDREN EXPERIENCE GRIEF

How a child experiences and expresses grief will depend on a number of factors:

- Developmental level, age, gender
- General life experiences, specific loss experiences
- Individual personality, coping style, adjustment
- Family myths and attitudes about loss or death
- Family cultural background and current environment
- Family communication, dynamics
- Grieving styles of significant adults
- Availability of support
- Length of time since the death
- Relationship with the deceased, implications of the loss, secondary losses already experienced or anticipated
- The nature of the loss or death (sudden, expected, lengthy)
- Preparation for the loss of death (information, time for anticipatory grief, etc.)

Source: "Medical Care of the Dying, "2nd Edition, Victoria Hospice Society, Victoria, British Columbia, Canada, © 1993.

Facts and Misconceptions about Children and Grief

<i>Misconceptions</i>	<i>Facts</i>
They don't understand what has happened; they're too young.	Even the very young know when those around them are upset. Most understand more than adults realize.
Going to the funeral would just upset them.	Not being included in family rituals could be more upsetting.
I must protect them from loss and pain.	It helps to see how adults grieve. All children do experience losses and need help in learning ways to deal with them.
Children don't feel grief the same as adults.	Everyone grieves in their own way, depending on circumstances, developmental level, and life experience.
When they have grieved once, it should be over.	This is usual and healthy. As they develop, children must re-grieve losses in light of new understanding and abilities.
I won't say or do the right thing; I must be in control to talk to them.	There are no right answers, only honest ones.
	Saying something acknowledges their grief, dispels fears and misunderstandings.
They won't want to talk about it.	Let that be their choice, not yours.
I might upset them.	That's often all they want to talk about. They're already upset; that is a natural part of grieving.
They need to keep busy.	Routine activities are important, but new activities may be confusing.
	Not thinking about it delays grief.
Getting rid of reminders helps; encourage only good memories.	This suggests it's wrong to think of the person who died or to have bad memories.
I won't mention it unless they do.	This suggests it is not right to mention the person; that there is something bad about them or their death; that you don't care.
Once they've been angry or guilty that will should be the end of it.	Grief is a process, not steps. Feelings surface repeatedly, as each aspect of the loss is realized

<i>Misconceptions</i>	<i>Facts</i>
It is morbid to want to touch or talk about the body.	This is normal for children. It is a good way to say good-bye and make the death seem real.
Use terms like “passed away” or gone to heaven.”	These are misleading and will confuse and frighten children. “Dead” is better.
If they are not expressing grief, children Aren’t grieving.	They may not know how to express feelings or know they have permission to grieve. They may delay grief to avoid upsetting others.
I should tell them all the facts immediately.	They may not be able to understand all aspects of the death or handle the intensity of the situation right away.

Source: “Medical Care of the Dying, “2nd Edition, Victoria Hospice Society, Victoria, British Columbia, Canada, © 1993.

QUESTIONS: GETTING IN TOUCH WITH ONE'S OWN DEATH

1. Is there someone I now need to forgive?
2. Where in my life do I need forgiveness?
3. What in my life is my special gift to give?
4. To whom will I give my gifts?
5. What gifts have I received from those who have died?
6. Who feels close to me?
7. To whom do I feel close?
8. What do I hold back to say?
9. What do I wish others would say to me?
10. What kind of death do I fear the most?
11. When in my life have I been most afraid?
12. Where do I find peace when I feel this way?
13. Whom do I wish were still alive?
14. What do I miss most about this person?
15. What do I wish I had done before that person died?
16. What gifts have been given to me from that loss?
17. If I were to live my life over again, what would I do once more? What would I change?
18. What do I still want to accomplish before I die?
19. What do I want others to remember about me?
20. Who do I want to be there when I die?

Hospice of Schenectady

PLEASE, SEE THROUGH MY TEARS

You asked, “How are you doing?”

As I told you, tears came to my eyes, you immediately began to talk again. Your eyes looked away from me, your speech picked up, and all the attention you had given me went away.

How am I doing? I do better when people will listen to my response, even though I may shed a tear or two, for I so want their attention; but to be ignored because I have in me pain which is indescribable to anyone who has not been there, I hurt and feel angry. So when you look away, I am again alone with it.

Really, tears are not a bad sign, you know! They’re nature’s way of helping me to heal. They relieve some of the stress of sadness. I know you fear that asking how I’m doing brought this sadness to me. No, you’re wrong, the memory of my son’s death will always be with me, only a thought away. It’s just that my tears make my pain more visible to you, but you did not give me the pain, it’s just there.

When I cry, could it be that you feel helpless? You’re not, you know. When I feel your permission to allow my tears to flow, you’ve helped me more than you can know. You need not verbalize your support of my tears, your silence as I cry is my key, do not fear.

Your listening with your heart to “How are you doing?” helps relieve the pain, because once I allow the tears to come and go, I feel lighter. Talking to you releases things I’ve been wanting to say aloud, and then there’s space for a touch of joy in my life.

Honest, when I tear up and cry, that doesn’t mean I’ll cry forever—maybe just a minute or two—then I’ll wipe the tears away, and sometimes you’ll even find I’m laughing at something funny ten minutes later.

When I hold back my tears, my throat grows tight, my chest aches and my stomach begins to knot up, because I’m trying to protect you from my tears. Then we both hurt; me, because I’ve kept the pain inside and it’s a shield against our closeness, and then you hurt because suddenly, we’re distant.

Please, take my hand, and I promise not to cry forever. It’s physically impossible, you know.

When you see me through my tears, then we can be close again.

From “Safe Place” – Anita Savage, Stanford, CT Hospice of Kona, Inc., P. O. Box 1657

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APPENDIX F

NATIONAL RESEARCH CORPORATION SURVEY

Adventist
Health

Feather River Hospital

OMB# 0938-0981

SURVEY INSTRUCTIONS

You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient. Answer all the questions by checking the box to the left of your answer.

Questions 1-22 and the "About You" section in the enclosed survey are part of a national initiative sponsored by the United States Department of Health and Human Services to measure the quality of care in hospitals. Your participation is voluntary and will not affect your health benefits. **You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.**

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

- ☐ Yes
☐ No → If No, Go to Question 1

Please answer the questions in this survey about your stay at the hospital named on the cover. Do not include any other hospital stay in your answers.

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?¹⁸⁸⁷⁶

- ☐ 1 Never
☐ 2 Sometimes
☐ 3 Usually
☐ 4 Always

2. During this hospital stay, how often did nurses listen carefully to you?¹⁸⁸⁷⁸

- ☐ 1 Never
☐ 2 Sometimes
☐ 3 Usually
☐ 4 Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?¹⁸⁸⁷⁹

- ☐ 1 Never
☐ 2 Sometimes
☐ 3 Usually
☐ 4 Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?¹⁸⁸⁸²

- ☐ 1 Never
☐ 2 Sometimes
☐ 3 Usually
☐ 4 Always
☐ 5 I never pressed the call button

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?¹⁸⁸⁷⁵

- ☐ 1 Never
☐ 2 Sometimes
☐ 3 Usually
☐ 4 Always

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6. During this hospital stay, how often did doctors listen carefully to you?¹⁸⁸⁷⁷

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?¹⁸⁸⁸⁴

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?¹⁸⁸⁸⁸

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

9. During this hospital stay, how often was the area around your room quiet at night?¹⁸⁸⁸⁹

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?¹⁸⁸⁹⁴

- ① Yes
- ② No → Go to Question 12

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?¹⁸⁸⁹⁶

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

12. During this hospital stay, did you need medicine for pain?¹⁸⁹⁰⁷

- ① Yes
- ② No → Go to Question 15

13. During this hospital stay, how often was your pain well controlled?¹⁸⁹¹⁰

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?¹⁸⁹¹¹

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

15. During this hospital stay, were you given any medicine that you had not taken before?¹⁸⁹¹⁶

- ① Yes
- ② No → Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?²²⁵⁶⁰

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

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17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?²²⁵⁴⁷

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?¹⁸⁹²⁹

- ① Own home
- ② Someone else's home
- ③ Another health facility
- Go to Question 21

19. During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?¹⁸⁹³⁵

- ① Yes
- ② No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?¹⁸⁹³⁷

- ① Yes
- ② No

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover. Do not include any other hospital stays in your answer.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?¹⁸⁹⁴¹

- ① 0 Worst hospital possible
- ② 1
- ③ 2
- ④ 3
- ⑤ 4
- ⑥ 5
- ⑦ 6
- ⑧ 7
- ⑨ 8
- ⑩ 9
- ⑪ 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?¹⁸⁹⁴³

- ① Definitely no
- ② Probably no
- ③ Probably yes
- ④ Definitely yes

ADDITIONAL QUESTIONS ABOUT YOUR EXPERIENCES IN THIS HOSPITAL

23. How organized was the admission process?²¹⁸⁰³

- ① Not at all organized
- ② Somewhat organized
- ③ Very organized
- ④ Completely organized

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24. If you had to wait to go to your room, did someone from the hospital explain the reason for the delay?²²⁵⁷⁷

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely
- ⑤ Did not have to wait

25. Were your scheduled tests and procedures performed on time?²¹⁸²⁹

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always
- ⑤ Did not have tests or procedures

26. Did nurses ask your name, check your ID band, or otherwise confirm who you were before giving you any medications, treatments, or tests?²²⁵⁷⁶

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

27. Sometimes in the hospital, one doctor or nurse will say one thing and another will say something quite different. Did this happen to you?²¹⁸²²

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

28. Did someone on the hospital staff explain the purpose of the medicines you were to take at home in a way you could understand?²¹⁸⁴¹

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely
- ⑤ Did not need explanation
- ⑥ No medicines at home

29. Did they tell you what danger signals about your illness or operation to watch for after you went home?²¹⁸⁴³

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely

SPEAKING WITH YOUR CARE PROVIDERS

30. An interpreter is someone who repeats or signs what one person says in a language used by another person. Did you need an interpreter to help you speak with doctors or other health providers?¹²⁰⁶⁴

- ① Yes
- ② No

31. When you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?¹²⁰⁶⁵

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always
- 89 I did not need an interpreter

MORE QUESTIONS ABOUT YOUR STAY AT THE HOSPITAL

The next set of questions will give us more detailed information about how we can improve the care and treatment we provide.

32. Was your hospital stay an emergency or planned in advance?⁸⁰⁸⁶

- ① Emergency
 - ② Planned in advance
- Go to Question 35

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33. How organized was the care you received in the emergency room?²¹⁸⁰¹

- ① Not at all organized
- ② Somewhat organized
- ③ Very organized
- ④ Completely organized

34. While you were in the emergency room, did you get enough information about your medical condition and treatment?²¹⁸⁰²

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely

HOSPITAL STAFF

35. Was there one particular doctor in charge of your care in the hospital?²¹⁸⁰⁶

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

36. If you had any anxieties or fears about your condition or treatment, did a doctor discuss them with you?²¹⁸⁰⁸

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always
- ⑤ Did not have anxieties or fears

37. Did you have confidence and trust in the doctors treating you?²¹⁸⁰⁹

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

38. Did doctors talk in front of you as if you weren't there?²¹⁸¹⁰

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

39. If you had any anxieties or fears about your condition or treatment, did a nurse discuss them with you?²¹⁸¹⁴

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always
- ⑤ Did not have anxieties or fears

40. Did you have confidence and trust in the nurses treating you?²¹⁸¹⁵

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

41. Did you have enough say about your treatment?²¹⁸²³

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

42. Did your family or someone else close to you have enough opportunity to talk to your doctor?²¹⁸²⁴

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always
- ⑤ No family or friends involved
- ⑥ Family did not want or need information

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43. Was the right amount of information about your condition or treatment given to your family or someone close to you?²¹⁸²⁵

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always
- ⑤ No family or friends involved
- ⑥ Family did not want or need information

44. Was it easy for you to find someone on the hospital staff to talk to about your concerns?²¹⁸²⁶

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always
- ⑤ Did not want or need to talk

45. Did family members or someone close to you ever have to do something or say something to staff to be sure that your medical needs were met?²¹⁸³³

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always
- ⑤ Do not know
- ⑥ Did not have family members or others close to me present

SURGERY

46. Did you have surgery in the hospital?⁸²⁰¹

- ① Yes
- ② No → Go to Question 51
- ③ Not sure → Go to Question 51

47. Did the surgeon explain the risks and benefits of the surgery in a way you could understand?²¹⁸³⁷

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely
- ⑤ Explained to spouse or someone else
- ⑥ I did not want anything explained

48. Did the surgeon or any of your other doctors answer your questions about the surgery in a way you could understand?²¹⁸³⁸

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely
- ⑤ Did not have questions

49. Did doctors or nurses tell you accurately how you would feel after surgery?²¹⁸³⁹

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely

50. Were the results of the surgery explained in a way you could understand?²¹⁸⁴⁰

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely
- ⑤ Explained to spouse or someone else

GOING HOME

51. Did they tell you when you could resume your usual activities, such as when to go back to work or drive a car?²¹⁸⁴⁴

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely

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52. Did the doctors and nurses give your family or someone close to you all the information they needed to help you recover?²¹⁸⁴⁵

- ① Not at all
- ② Somewhat
- ③ For the most part
- ④ Definitely
- ⑤ No family or friends involved
- ⑥ Family did not want or need information

53. Did a member of the hospital team ask about your spiritual or religious needs? ³⁰²⁹²

- ① Yes
- ② No

54. If you expressed a spiritual or religious need, did someone meet that need?³⁰²⁹³

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

55. During your experience at our hospital, did the care team show a spirit of compassion and caring?³⁰²⁹⁴

- ① Never
- ② Sometimes
- ③ Usually
- ④ Always

ABOUT YOU

There are only a few remaining items left.

56. In general, how would you rate your overall health?¹⁸⁹⁴⁵

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

57. What is the highest grade or level of school that you have completed?¹⁸⁹⁴⁹

- ① 8th grade or less
- ② Some high school, but did not graduate
- ③ High school graduate or GED
- ④ Some college or 2-year degree
- ⑤ 4-year college graduate
- ⑥ More than 4-year college degree

58. Are you of Spanish, Hispanic or Latino origin or descent? ²⁵⁵⁴¹

- ① No, not Spanish/Hispanic/Latino
- ② Yes, Puerto Rican
- ③ Yes, Mexican, Mexican-American, Chicano
- ④ Yes, Cuban
- ⑤ Yes, other Spanish/Hispanic/Latino

59. What is your race? Please choose one or more.²³²⁹⁶

- ① White
- ② Black or African American
- ③ Asian
- ④ Native Hawaiian or other Pacific Islander
- ⑤ American Indian or Alaska Native

60. What language do you mainly speak at home?¹⁸⁹⁵²

- ① English
- ② Spanish
- ③ Some other language (please print):

61. If you could change one thing about the hospital, what would it be? (Please print your answer on the lines provided below.)

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Items 1-22 and the first five items in the About You section are HCAHPS®.

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Please use the enclosed envelope and mail the completed survey to: NRC Picker Survey Processing Center, PO Box 82660, Lincoln, NE 68501-2660. To contact us call 1-800-733-6714.

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APPENDIX G

NATIONAL RESEARCH CORPORATION SURVEY RESULTS

CAHPS-IP-A: Would Recommend Hospital

Catalyst Trend by Dimensions - FRH - HCAHPS

Feb 17, 2016

	NRC 75th Percentile	Qtr 1 2015		Qtr 2 2015		Qtr 3 2015		Qtr 4 2015		Qtr 1 2014		Qtr 2 2014	
	Positive	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size
CAHPS Dimensions													
Adult Inpatient Hospital CAHPS													
Care Transitions	56.0	47.8	97	45.2	104	54.2	71	52.2	83	47.4	135	52.9	115
Cleanliness / Quietness	73.3	54.3	105	57.5	106	59.5	74	57.2	83	52.5	138	62.2	119
Communication About Meds	69.7	55.9	59	60.7	61	66.3	46	67.7	48	61.0	77	71.3	68
Communication with Doctors	85.2	72.1	104	77.0	105	78.7	72	78.1	83	74.0	138	77.8	118
Communication with Nurses	83.2	73.2	105	80.5	105	81.5	74	80.7	83	72.5	138	75.6	119
Discharge Information	90.4	84.8	89	86.5	100	89.1	69	92.3	78	86.1	119	92.9	105
Overall Rating of Hospital	77.6	68.6	105	78.3	106	83.1	71	76.8	82	67.4	138	76.3	118
Pain Management	75.2	64.5	69	68.4	76	67.9	53	67.0	56	65.8	95	76.8	82
Responsiveness of Hospital Staff	73.7	63.4	97	59.7	93	68.9	66	62.8	78	56.1	131	63.0	104
Would Recommend Hospital	79.9	71.8	103	83.2	107	87.5	74	80.2	81	70.3	138	83.2	119
Picker Dimensions													
Adult Inpatient Hospital CAHPS													
Continuity and Transition	87.6												
Information and Education	74.0	58.9	56	61.1	60	69.8	43	65.9	44	57.7	74	70.1	67
Overall Rating of Hospital	77.6	68.6	105	78.3	106	83.1	71	76.8	82	67.4	138	76.3	118
Patient Safety	79.4	63.6	55	65.4	52	75.6	39	69.1	47	65.0	70	75.0	58
Physical Comfort	73.7	62.0	84	64.1	85	64.9	62	64.7	65	57.5	118	68.8	99
Respect for Patient Preferences	84.8	75.0	104	81.4	104	83.4	73	82.2	83	76.1	137	79.5	118
Would Recommend Hospital	79.9	71.8	103	83.2	107	87.5	74	80.2	81	70.3	138	83.2	119

Qtr 3 2014		Qtr 4 2014		Qtr 1 2015		Qtr 2 2015		Qtr 3 2015		Qtr 4 2015		Total	
Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size	Positive	n Size
51.1	103	62.5	109	49.4	103	50.6	106	43.8	131	45.0	107	49.9	1,263
55.5	110	64.5	114	57.0	107	52.8	107	54.5	134	60.3	112	57.2	1,309
55.6	63	72.1	61	57.5	60	56.6	53	51.3	77	57.4	61	60.8	734
72.5	109	81.6	113	74.8	107	74.6	105	69.8	133	78.6	112	75.6	1,299
79.1	110	79.9	113	73.8	107	75.4	107	70.9	134	79.6	111	76.5	1,306
84.5	103	87.9	107	86.9	88	87.0	96	89.0	118	87.6	101	87.8	1,173
68.2	107	79.6	113	71.4	106	65.4	107	75.4	130	77.7	112	73.6	1,294
67.6	74	74.7	73	69.6	69	55.7	70	64.7	95	70.9	79	67.8	891
60.0	100	69.8	101	65.4	104	58.9	95	58.9	123	64.4	101	62.2	1,193
75.2	109	80.5	113	72.6	106	72.9	107	78.8	132	79.1	110	77.6	1,299
		90.9	82	86.9	88	87.0	96	89.0	118	87.6	101	88.2	485
63.9	60	71.3	98	66.0	106	65.0	98	59.6	128	69.5	110	64.9	944
68.2	107	79.6	113	71.4	106	65.4	107	75.4	130	77.7	112	73.6	1,294
61.8	55	73.1	93	62.5	100	59.4	96	61.0	127	66.5	103	65.6	895
60.6	84	69.6	85	66.0	85	54.4	84	58.1	114	66.0	91	62.8	1,056
77.3	109	83.3	113	76.0	107	77.1	107	73.9	134	80.8	112	78.5	1,301
75.2	109	80.5	113	72.6	106	72.9	107	78.8	132	79.1	110	77.6	1,299

APPENDIX H

ADVENTIST HEALTH SPIRITUAL CLIMATE SURVEY

Adventist Health Spiritual Climate Survey, 2015

Hospital: _____

Unit: _____

Today's Date: _____

Thank you for taking the time to share your thoughts about spirituality on your unit! This is an important aspect of our Adventist Health mission and what you share will help us make our spiritual climate even better!

All answers are kept confidential and information will only be shared aggregately at the unit level. Only unit data with over 5 respondents and at least a 40% response rate will be reported.

Directions: Please rate your level of agreement with each question by placing a check mark in the appropriate box below.

	DISAGREE STRONGLY	DISAGREE SLIGHTLY	NEUTRAL	AGREE SLIGHTLY	AGREE STRONGLY	N/A
1. I am encouraged to express spirituality in this work setting.	☐	☐	☐	☐	☐	☐
2. My spiritual views are respected in this work setting.	☐	☐	☐	☐	☐	☐
3. My spirituality has a comfortable home in this work setting.	☐	☐	☐	☐	☐	☐
4. A diverse set of spiritual views are accepted in this work setting.	☐	☐	☐	☐	☐	☐
5. People in this work setting feel comfortable talking about God.	☐	☐	☐	☐	☐	☐

6. If there is ONE recommendation that you can do to improve spirituality on your unit or department, what would it be? (Please describe below)

Thank you!

For questions about this survey, contact Bonnie Casebolt at
Bonnie.Casebolt@ah.org or -916-781-4760

APPENDIX I

ADVENTIST HEALTH SPIRITUAL CLIMATE

SURVEY RESULTS

Score Calculation Methodology

- The scores represent the % of positive respondents in the unit

Individual Item Score: percentage of respondents who score this question $\geq 75\%$.

- For example, there are 7 out of 10 respondents who agree (75) or strongly agree (100), so the score of this item 1 is 70%.

	Item 1	Item 2 (neg)	Item 3	Item 4	Item 5	Scale Score
Tom	75	50	75	75	50	65
Jim	50	25	100	100	75	70
Mary	75	75	75	100	75	80
Bill	75	75	50	50	75	65
Jen	50	100	100	100	50	80
Cliff	100	100	100	100	100	100
Ryan	100	50	50	75	75	70
Will	75	75	75	75	50	70
Gina	75	75	75	75	75	75
Julia	50	100	75	50	75	70
Count	7	7	8	8	7	4
%	70%	70%	80%	80%	70%	40%

Domain Score: % of respondents who have average score $\geq 75\%$ for all items that made up that domain.

- For example, only 4 out of 10 respondents have average of item scores ≥ 75 , so the Domain score is 40%.

APPENDIX J

2014 AND 2015 GALLUP SURVEY RESULTS

Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup

Unit B: SR: Entity: Feather River Hospital

Unit C: Adventist Health West Overall

Summary

	Respondents	Grand Mean		Mean Percentile Rank		Current Mean
		Current Mean	Last Mean			
Unit A	885	3.93	3.84	40	Strengths	
					Q01: Know What's Expected	4.49
Unit B	885	3.93	3.84	40	Opportunities	
					Q11: Progress	3.68
Unit C	19373	4.08	3.89	51	Q07: Opinions Count	3.53

Engagement Index

Past Engagement Index

* Not shown if n < 5 for Mean and Top Box, n < 10 for Frequency, or data is unavailable.

** Last Date for the current unit.

*** Mean Percentile Rank and Strengths and Opportunities are being calculated against the Gallup Overall database.

**** A change in score is meaningful if the score changes by 0.2 or more between survey periods.

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Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup
Unit B: SR: Entity: Feather River Hospital
Unit C: Adventist Health West Overall

Survey questions > Gallup Q¹² Items

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Q05. My manager, or someone at work, seems to care about me as a person.	A	887	4.16	4.11	0.05	53	51	4	6	12	25	53
	B	867	4.16	4.11	0.05	53	51	4	6	12	25	53
	C	19030	4.22	4.07	0.15	56	49	4	5	12	24	56
Q06. There is someone at work who encourages my development.	A	870	3.87	3.77	0.10	41	38	6	9	17	26	41
	B	870	3.87	3.77	0.10	41	38	6	9	17	26	41
	C	19058	4.01	3.83	0.18	45	39	5	7	15	27	45
Q07. At work, my opinions seem to count.	A	871	3.53	3.46	0.07	31	26	11	11	21	25	31
	B	871	3.53	3.46	0.07	31	26	11	11	21	25	31
	C	18998	3.74	3.57	0.17	35	29	8	9	20	29	35
Q08. The mission or purpose of my organization makes me feel my job is important.	A	869	4.09	3.96	0.13	48	43	3	7	15	26	48
	B	869	4.09	3.96	0.13	48	43	3	7	15	26	48
	C	19039	4.23	4.05	0.18	52	45	2	4	13	28	52
Q09. My fellow employees are committed to doing quality work.	A	872	4.11	4.12	-0.01	44	42	2	4	18	31	44
	B	872	4.11	4.12	-0.01	44	42	2	4	18	31	44
	C	19099	4.10	4.05	0.11	46	40	2	4	15	33	46

Percentile Range in Gallup Overall Database ■ < 25th Percentile ■ 25-49th Percentile ■ 50-74th Percentile ■ ≥ 75th Percentile

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** Last Data for the current unit.

*** Mean Percentile Rank and Strengths and Opportunities are being calculated against the Gallup Overall database.

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Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup
Unit B: SR: Entity: Feather River Hospital
Unit C: Adventist Health West Overall

Survey questions > Custom Questions

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
A01. I received feedback on the previous Gallup Employee Engagement Survey conducted at my organization.	A	720	4.06	NA	NA	53	NA	8	5	13	22	53
	B	720	4.06	NA	NA	53	NA	8	5	13	22	53
	C	14844	4.09	NA	NA	52	NA	7	5	13	23	52
A02. My team participated in an effective action planning session following last year's Gallup Employee Engagement Survey.	A	664	3.46	NA	NA	33	NA	15	12	19	21	33
	B	664	3.46	NA	NA	33	NA	15	12	19	21	33
	C	14250	3.83	NA	NA	42	NA	9	8	17	25	42
A03. My team has made progress on the goals set during our action planning sessions after the last Gallup Employee Engagement Survey.	A	625	3.33	NA	NA	28	NA	16	13	22	21	28
	B	625	3.33	NA	NA	28	NA	16	13	22	21	28
	C	14085	3.74	NA	NA	37	NA	9	8	19	27	37
C01. I would recommend my organization to my friends and family for care.	A	867	4.18	4.17	0.01	49	48	2	5	14	30	49
	B	867	4.18	4.17	0.01	49	48	2	5	14	30	49
	C	19026	4.21	4.07	0.14	50	44	2	4	14	30	50

Percentile Range in Gallup Overall Database ■ < 25th Percentile ■ 25-49th Percentile ■ 50-74th Percentile ■ ≥ 75th Percentile

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Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup
Unit B: SR: Entity: Feather River Hospital
Unit C: Adventist Health West Overall

Survey questions > Custom Questions

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
S01. Patient safety is never sacrificed to get more work done.	A	659	4.15	3.67	▲ 0.48	54	35	4	8	11	23	54
	B	659	4.15	3.67	▲ 0.48	54	35	4	8	11	23	54
	C	13445	4.13	3.73	▲ 0.40	52	37	5	6	13	24	52
S02. Our procedures and systems are good at preventing errors from happening.	A	660	3.88	3.69	0.19	35	26	4	8	20	33	35
	B	660	3.88	3.69	0.19	35	26	4	8	20	33	35
	C	13504	3.89	3.75	▲ 0.24	36	27	3	6	17	38	38
S03. It is just by chance that more serious mistakes don't happen around here.	A	639	3.78	3.58	▲ 0.20	42	32	9	11	17	21	42
	B	639	3.78	3.58	▲ 0.20	42	32	9	11	17	21	42
	C	13035	3.54	3.36	0.18	35	27	11	15	18	20	35
S04. We have patient safety problems in this unit.	A	631	4.04	3.68	▲ 0.36	51	37	5	9	13	21	51
	B	631	4.04	3.68	▲ 0.36	51	37	5	9	13	21	51
	C	13082	3.85	3.57	▲ 0.28	46	33	8	11	15	20	46
S05. Staff will freely speak up if they see something that may negatively affect patient care.	A	654	4.13	3.99	0.14	40	33	0	4	17	38	40
	B	654	4.13	3.99	0.14	40	33	0	4	17	38	40
	C	13416	4.12	3.94	0.18	41	31	1	4	17	37	41
S06. Staff feels free to question the decisions or actions of those with more authority.	A	644	3.32	3.25	0.07	17	12	8	16	29	31	17
	B	644	3.32	3.25	0.07	17	12	8	16	29	31	17
	C	13320	3.51	3.39	0.12	22	16	5	14	28	32	22

Percentile Range in Gallup Overall Database ■ < 25th Percentile ■ 25-49th Percentile ■ 50-74th Percentile ■ ≥ 75th Percentile

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11/20/2015

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Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup
Unit B: SR: Entity: Feather River Hospital
Unit C: Adventist Health West Overall

Engagement Hierarchy

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Q00 How satisfied are you with your organization as a place to work?	A	882	3.78	3.76	NA	26	25	3	7	24	40	26
	B	882	3.78	3.76	NA	26	25	3	7	24	40	26
	C	19216	4.00	3.82	NA	33	27	2	5	18	42	33

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
What do I get?	A	NA	4.25	4.30	-0.05	52	54	NA				
	B	NA	4.25	4.30	-0.05	52	54	NA				
	C	NA	4.39	4.28	0.11	58	52	NA				

Q01. I know what is expected of me at work.	A	881	4.45	4.48	0.01	65	64	1	2	8	24	65
	B	881	4.45	4.48	0.01	65	64	1	2	8	24	65
	C	19272	4.59	4.49	0.10	69	62	0	1	5	24	69

Q02. I have the materials and equipment I need to do my work right.	A	880	4.01	4.13	-0.12	39	44	3	7	16	35	39
	B	880	4.01	4.13	-0.12	39	44	3	7	16	35	39
	C	19235	4.18	4.05	0.12	47	41	2	5	14	33	47

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Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup
Unit B: SR: Entity: Feather River Hospital
Unit C: Adventist Health West Overall

Engagement Hierarchy

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Do I belong?	A	NA	3.87	3.73	0.14	41	35	NA				
	B	NA	3.87	3.73	0.14	41	35	NA				
	C	NA	3.88	3.78	0.20	43	36	NA				
Q07. At work, my opinions seem to count.	A	871	3.53	3.46	0.07	31	26	11	11	21	25	31
	B	871	3.53	3.46	0.07	31	26	11	11	21	25	31
	C	18998	3.74	3.57	0.17	35	29	8	9	20	29	35
Q08. The mission or purpose of my organization makes me feel my job is important.	A	869	4.08	3.96	0.13	48	43	3	7	15	26	48
	B	869	4.09	3.96	0.13	48	43	3	7	15	26	48
	C	19039	4.23	4.05	0.18	52	45	2	4	13	28	52
Q09. My fellow employees are committed to doing quality work.	A	872	4.11	4.12	-0.01	44	42	2	4	18	31	44
	B	872	4.11	4.12	-0.01	44	42	2	4	18	31	44
	C	19099	4.16	4.05	0.11	46	40	2	4	15	33	46
Q10. I have a best friend at work.	A	846	3.74	3.37	0.37	41	29	9	11	17	21	41
	B	846	3.74	3.37	0.37	41	29	9	11	17	21	41
	C	18223	3.89	3.44	0.36	41	30	9	9	17	24	41

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Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup
Unit B: SR: Entity: Feather River Hospital
Unit C: Adventist Health West Overall

Indices

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Teamwork Index	A	NA	4.21	4.19	0.02	52	49	NA				
	B	NA	4.21	4.19	0.02	52	49	NA				
	C	NA	4.19	4.10	0.09	50	44	NA				
S09. People support one another in this unit.	A	664	4.20	4.19	0.01	51	48	3	5	14	28	51
	B	664	4.20	4.19	0.01	51	48	3	5	14	28	51
	C	13575	4.16	4.08	0.08	49	43	3	5	15	29	49
S09. When a lot of work needs to be done quickly, we work together as a team to get the work done.	A	662	4.25	4.30	-0.05	55	55	3	4	12	25	55
	B	662	4.25	4.30	-0.05	55	55	3	4	12	25	55
	C	13580	4.26	4.18	0.08	54	49	3	4	12	28	54
S10. In this unit, people treat each other with respect.	A	666	4.18	4.09	0.09	49	43	3	4	14	30	49
	B	666	4.18	4.09	0.09	49	43	3	4	14	30	49
	C	13665	4.15	4.05	0.10	47	41	3	5	14	31	47
		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Openness Index	A	NA	3.64	3.53	0.11	25	20	NA				
	B	NA	3.64	3.53	0.11	25	20	NA				
	C	NA	3.71	3.57	0.14	28	21	NA				

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Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup
Unit B: SR: Entity: Feather River Hospital
Unit C: Adventist Health West Overall

Indices

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
S02. Our procedures and systems are good at preventing errors from happening.	A	660	3.88	3.89	0.19	35	26	4	8	20	33	35
	B	660	3.88	3.89	0.19	35	26	4	8	20	33	35
	C	13504	3.99	3.75	▲ 0.24	36	27	3	6	17	38	36
S03. It is just by chance that more serious mistakes don't happen around here.	A	639	3.78	3.58	▲ 0.20	42	32	9	11	17	21	42
	B	639	3.78	3.58	▲ 0.20	42	32	9	11	17	21	42
	C	13035	3.54	3.36	0.18	35	27	11	15	18	20	35
S04. We have patient safety problems in this unit.	A	631	4.04	3.68	▲ 0.36	51	37	5	9	13	21	51
	B	631	4.04	3.68	▲ 0.36	51	37	5	9	13	21	51
	C	13082	3.85	3.57	▲ 0.28	46	33	8	11	15	20	46
		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Communication Index	A	NA	3.34	3.26	0.08	25	22	NA				
	B	NA	3.34	3.26	0.08	25	22	NA				
	C	NA	3.68	3.44	▲ 0.24	33	28	NA				
C04. My immediate supervisor keeps me informed about what is going on at this organization.	A	858	3.70	3.69	0.01	36	35	9	11	18	26	36
	B	858	3.70	3.69	0.01	36	35	9	11	18	26	36
	C	19037	3.97	3.78	0.19	45	37	6	7	15	28	45

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Adventist Health

Report Period: 2015

Unit A: Erich, Kevin R - FRH Rollup
Unit B: SR: Entity: Feather River Hospital
Unit C: Adventist Health West Overall

Indices

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
A02. My team participated in an effective action planning session following last year's Gallup Employee Engagement Survey.	A	664	3.46	NA	NA	33	NA	15	12	19	21	33
	B	664	3.46	NA	NA	33	NA	15	12	19	21	33
	C	14250	3.83	NA	NA	42	NA	9	8	17	25	42
A03. My team has made progress on the goals set during our action planning sessions after the last Gallup Employee Engagement Survey.	A	625	3.33	NA	NA	28	NA	16	13	22	21	28
	B	625	3.33	NA	NA	28	NA	16	13	22	21	28
	C	14085	3.74	NA	NA	37	NA	9	8	19	27	37

Percentile Range in Gallup Overall Database ■ < 25th Percentile ■ 25-49th Percentile ■ 50-74th Percentile ■ ≥ 75th Percentile

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** Last Date for the current unit.

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Action Plan Worksheet

Item we will focus on when we action plan:		Mean Score of this item:	%5 of this item:
Title of this Plan:	Is this item a strength or an area of opportunity?	Who will be involved?	
This is what we'll do:		This is what success will look like:	
When will we start?	When is our plan due?	How often will we focus on this plan?	

Adventist Health

Report Period: 2014

Unit A: Erich, Kevin Rollup

Unit B: SR: Entity: Corporate Office (Roseville)

Unit C: Adventist Health West Overall

Summary

	Respondents	Grand Mean		Mean Percentile Rank	Strengths	Current Mean
		Current Mean	Last Mean			
Unit A	839	3.85	NA	34	Q03: Opportunity to Do Best	4.14
Unit B	1138	3.99	NA	43	Opportunities	
Unit C	15996	3.89	NA	37	Q11: Progress	3.39
					Q10: Best Friend	3.38

Engagement Index

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Adventist Health

Report Period: 2014

Unit A: Erich, Kevin Rollup
Unit B: SR: Entity: Corporate Office (Roseville)
Unit C: Adventist Health West Overall

Survey questions > Gallup Q¹² Items

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Q05. My supervisor, or someone at work, seems to care about me as a person.	A	830	4.12	NA	NA	51	NA	5	5	15	24	51
	B	1124	4.29	NA	NA	57	NA	3	5	9	26	57
	C	15744	4.07	NA	NA	49	NA	5	7	13	25	49
Q06. There is someone at work who encourages my development.	A	823	3.77	NA	NA	38	NA	8	10	17	27	38
	B	1125	3.92	NA	NA	41	NA	5	9	18	28	41
	C	15702	3.83	NA	NA	39	NA	7	9	18	28	39
Q07. At work, my opinions seem to count.	A	824	3.47	NA	NA	26	NA	11	14	18	30	26
	B	1119	3.83	NA	NA	36	NA	5	11	17	31	36
	C	15670	3.57	NA	NA	29	NA	9	11	21	29	29
Q08. The mission or purpose of my organization makes me feel my job is important.	A	826	3.96	NA	NA	43	NA	5	7	17	28	43
	B	1123	4.24	NA	NA	52	NA	2	5	14	28	52
	C	15691	4.05	NA	NA	45	NA	4	6	16	29	45
Q09. My fellow employees are committed to doing quality work.	A	821	4.13	NA	NA	43	NA	2	5	16	35	43
	B	1129	4.17	NA	NA	45	NA	1	5	14	34	45
	C	15744	4.05	NA	NA	40	NA	2	5	17	35	40

Percentile Range in Gallup Overall Database ■ < 25th Percentile ■ 25-49th Percentile ■ 50-74th Percentile ■ ≥ 75th Percentile

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Adventist Health

Report Period: 2014

Unit A: Erich, Kevin Rollup
Unit B: SR: Entity: Corporate Office (Roseville)
Unit C: Adventist Health West Overall

Survey questions > Custom Questions

Other Questions

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
C01. I would recommend my organization to my friends and family for care.	A	826	4.17	NA	NA	48	NA	3	4	15	31	48
	B	1091	4.25	NA	NA	51	NA	2	4	12	32	51
	C	15652	4.07	NA	NA	44	NA	4	5	16	32	44
C02. Leaders in my organization help me see how changes made today will affect my organization's future.	A	815	3.40	NA	NA	23	NA	11	13	23	29	23
	B	1113	3.74	NA	NA	31	NA	5	10	21	34	31
	C	15579	3.59	NA	NA	28	NA	8	11	23	31	28
C03. The organization cares about my spiritual well-being.	A	808	3.73	NA	NA	36	NA	7	11	20	27	36
	B	1103	4.12	NA	NA	47	NA	3	5	16	28	47
	C	15377	3.78	NA	NA	36	NA	7	9	20	28	36
C04. My immediate supervisor keeps me informed about what is going on at this organization.	A	824	3.70	NA	NA	35	NA	9	9	21	26	35
	B	1126	3.95	NA	NA	40	NA	5	8	16	31	40
	C	15726	3.78	NA	NA	37	NA	8	9	17	29	37
C05. At work, the communication I receive is perfect for me.	A	822	3.20	NA	NA	17	NA	13	16	26	28	17
	B	1121	3.42	NA	NA	19	NA	8	14	25	33	19
	C	15745	3.38	NA	NA	22	NA	10	14	25	29	22

Percentile Range in Gallup Overall Database ■ < 25th Percentile ■ 25-49th Percentile ■ 50-74th Percentile ■ ≥ 75th Percentile

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** Last Data for the current unit.

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Adventist Health

Report Period: 2014

Unit A: Erich, Kevin Rollup
Unit B: SR: Entity: Corporate Office (Roseville)
Unit C: Adventist Health West Overall

Survey questions > Custom Questions

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
S04. We have patient safety problems in this unit.	A	250	3.68	NA	NA	37	NA	8	14	19	22	37
	B	26	3.96	NA	NA	54	NA	8	4	27	8	54
	C	6328	3.57	NA	NA	33	NA	10	14	19	24	33
S05. Staff will freely speak up if they see something that may negatively affect patient care.	A	255	4.00	NA	NA	33	NA	1	5	21	40	33
	B	28	4.04	NA	NA	29	NA	4	0	14	54	29
	C	6382	3.94	NA	NA	31	NA	1	6	21	41	31
S06. Staff feels free to question the decisions or actions of those with more authority.	A	254	3.26	NA	NA	12	NA	6	20	30	33	12
	B	27	3.56	NA	NA	15	NA	4	11	26	44	15
	C	6335	3.39	NA	NA	16	NA	5	16	31	32	16
S07. Staff are afraid to ask questions when something does not seem right.	A	253	3.35	NA	NA	14	NA	5	13	37	30	14
	B	29	3.34	NA	NA	7	NA	7	10	31	45	7
	C	6359	3.37	NA	NA	15	NA	5	14	35	32	15
S08. People support one another in this unit.	A	259	4.20	NA	NA	49	NA	2	4	16	29	49
	B	31	4.29	NA	NA	52	NA	0	3	16	29	52
	C	6388	4.08	NA	NA	43	NA	3	5	17	33	43
S09. When a lot of work needs to be done quickly, we work together as a team to get the work done.	A	259	4.31	NA	NA	56	NA	2	3	13	27	56
	B	32	4.25	NA	NA	50	NA	0	3	19	28	50
	C	6398	4.18	NA	NA	49	NA	3	5	14	30	49

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Unit B: SR: Entity: Corporate Office (Roseville)
Unit C: Adventist Health West Overall

Engagement Hierarchy

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Q00 How satisfied are you with your organization as a place to work?	A	832	3.76	NA	NA	25	NA	2	9	24	39	25
	B	1135	4.01	NA	NA	32	NA	1	5	18	44	32
	C	15832	3.82	NA	NA	27	NA	3	7	23	41	27

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
What do I get?	A	NA	4.30	NA	NA	54	NA				NA	
	B	NA	4.17	NA	NA	44	NA				NA	
	C	NA	4.28	NA	NA	52	NA				NA	

Q01. I know what is expected of me at work.	A	831	4.48	NA	NA	64	NA	1	3	7	25	64
	B	1132	4.25	NA	NA	49	NA	1	4	13	33	49
	C	15910	4.49	NA	NA	62	NA	1	2	7	28	62

Q02. I have the materials and equipment I need to do my work right.	A	832	4.13	NA	NA	44	NA	2	6	13	35	44
	B	1132	4.08	NA	NA	40	NA	1	7	15	38	40
	C	15863	4.06	NA	NA	41	NA	3	6	15	36	41

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** Last Date for the current unit.

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Engagement Hierarchy

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Do I belong?	A	NA	3.74	NA	NA	35	NA	NA				
	B	NA	3.92	NA	NA	40	NA	NA				
	C	NA	3.78	NA	NA	36	NA	NA				
Q07. At work, my opinions seem to count.	A	824	3.47	NA	NA	26	NA	11	14	18	30	26
	B	1119	3.83	NA	NA	36	NA	5	11	17	31	36
	C	15670	3.57	NA	NA	29	NA	9	11	21	29	29
Q08. The mission or purpose of my organization makes me feel my job is important.	A	826	3.98	NA	NA	43	NA	5	7	17	28	43
	B	1123	4.24	NA	NA	52	NA	2	5	14	28	52
	C	15691	4.05	NA	NA	45	NA	4	6	16	29	45
Q09. My fellow employees are committed to doing quality work.	A	821	4.13	NA	NA	43	NA	2	5	16	35	43
	B	1129	4.17	NA	NA	45	NA	1	5	14	34	45
	C	15744	4.05	NA	NA	40	NA	2	5	17	35	40
Q10. I have a best friend at work.	A	757	3.38	NA	NA	29	NA	14	13	23	20	29
	B	1065	3.44	NA	NA	28	NA	12	13	21	25	28
	C	14745	3.44	NA	NA	30	NA	14	12	22	22	30

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Indices

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Teamwork Index	A	NA	4.20	NA	NA	49	NA	NA				
	B	NA	4.27	NA	NA	51	NA	NA				
	C	NA	4.10	NA	NA	44	NA	NA				
S08. People support one another in this unit.	A	259	4.20	NA	NA	49	NA	2	4	16	29	49
	B	31	4.29	NA	NA	52	NA	0	3	16	29	52
	C	6398	4.08	NA	NA	43	NA	3	5	17	33	43
S09. When a lot of work needs to be done quickly, we work together as a team to get the work done.	A	259	4.31	NA	NA	56	NA	2	3	13	27	56
	B	32	4.25	NA	NA	50	NA	0	3	19	28	50
	C	6398	4.18	NA	NA	49	NA	3	5	14	30	49
S10. In this unit, people treat each other with respect.	A	259	4.10	NA	NA	44	NA	3	5	16	33	44
	B	32	4.28	NA	NA	50	NA	0	6	9	34	50
	C	6428	4.05	NA	NA	41	NA	3	6	16	34	41
		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Openness Index	A	NA	3.54	NA	NA	20	NA	NA				
	B	NA	3.65	NA	NA	17	NA	NA				
	C	NA	3.57	NA	NA	21	NA	NA				

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Indices

		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
S02. Our procedures and systems are good at preventing errors from happening.	A	257	3.70	NA	NA	26	NA	4	11	21	37	26
	B	28	3.93	NA	NA	32	NA	4	7	14	43	32
	C	6393	3.75	NA	NA	27	NA	5	8	22	39	27
S03. It is just by chance that more serious mistakes don't happen around here.	A	253	3.58	NA	NA	32	NA	10	10	23	24	32
	B	29	3.59	NA	NA	34	NA	14	7	21	24	34
	C	6238	3.36	NA	NA	27	NA	12	16	21	23	27
S04. We have patient safety problems in this unit.	A	250	3.68	NA	NA	37	NA	8	14	19	22	37
	B	26	3.96	NA	NA	54	NA	8	4	27	8	54
	C	6328	3.57	NA	NA	33	NA	10	14	19	24	33
		Total N	Current Mean	Last Mean	Change	Current Top Box	Last Top Box	Frequency Distribution				
								%1	%2	%3	%4	%5
Communication Index	A	NA	3.26	NA	NA	22	NA	NA				
	B	NA	3.49	NA	NA	25	NA	NA				
	C	NA	3.44	NA	NA	26	NA	NA				
C04. My immediate supervisor keeps me informed about what is going on at this organization.	A	824	3.70	NA	NA	35	NA	9	9	21	26	35
	B	1126	3.95	NA	NA	40	NA	5	8	16	31	40
	C	15726	3.78	NA	NA	37	NA	8	9	17	29	37

Percentile Range in Gallup Overall Database ■ < 25th Percentile ■ 25-49th Percentile ■ 50-74th Percentile ■ ≥ 75th Percentile

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Q¹² Suggested Action Items

The circles with numbers indicate the quartile in which the item was scored when compared against Gallup Overall Database.

1 < 25th Percentile 2 25-49th Percentile 3 50-74th Percentile 4 ≥ 75th Percentile

2 Mean Score 3.84	Q12	This last year, I have had opportunities at work to learn and grow. <ul style="list-style-type: none"> Ask your department to define what the terms "opportunity" and "grow" mean specifically in relation to learning. Recognize that learning comes in many forms and the opportunity to learn is individualized per employee. Talk with team members individually about their career goals. Encourage team members to participate in training programs offered by your company.
1 Mean Score 3.39	Q11	In the last six months, someone at work has talked to me about my progress. <ul style="list-style-type: none"> Communicate with team members about their individual performance expectations. Utilize your company's established performance review process. Talk with underperforming team members to understand the current situation.
2 Mean Score 3.38	Q10	I have a best friend at work. <ul style="list-style-type: none"> Facilitate an in-depth discussion about the definition of "best friend at work" during the engagement impact planning meeting. Hold team building sessions with your team. Create opportunities for team members to work on projects with other team members. Consider community service projects that help fulfill our Adventist Health mission.
2 Mean Score 4.13	Q09	My fellow employees are committed to doing quality work. <ul style="list-style-type: none"> Ensure new team members are trained appropriately about quality. Set quality standards for the workgroup so that every team member has a common reference point. Specify gradations in quality standards, from barely acceptable quality to superlative quality.
2 Mean Score 3.96	Q08	The mission or purpose of my organization makes me feel my job is important. <ul style="list-style-type: none"> Host a meeting to review the mission or vision of the company or department. Schedule a one-to-one meeting with each team member to talk about the importance of his or her role to the department and company. Recognize team members' talents and indicate how they contribute to the department and company mission.
2 Mean Score 3.47	Q07	At work, my opinions seem to count. <ul style="list-style-type: none"> Host a team meeting to ask for suggestions and listen to concerns. Host a "Question and Answer" forum every month for team members to raise concerns, and invite key leaders to the forum. Follow up on commitments from meetings.
2 Mean Score 3.77	Q06	There is someone at work who encourages my development. <ul style="list-style-type: none"> Meet regularly with team members to talk about their development. Establish development goals for team members in current roles. Give team members stretch assignments to encourage their development.
2 Mean Score 4.12	Q05	My supervisor, or someone at work, seems to care about me as a person. <ul style="list-style-type: none"> Greet team members at the start of each work day. Actively address the concerns of team members during times of change. Recognize the need for balance between work and personal time.
2 Mean Score 3.39	Q04	In the last seven days, I have received recognition or praise for doing good work. <ul style="list-style-type: none"> Encourage team members to acknowledge the good work of others. Learn how each of your team members likes to be recognized, and tailor your approach to meet their individual needs. Thank team members for their contributions.
3 Mean Score 4.14	Q03	At work, I have the opportunity to do what I do best every day. <ul style="list-style-type: none"> Ask your team members what they consider as their strengths. Talk to team members monthly or quarterly about using their strengths in their roles. Match individual team members' talents with role requirements.
2 Mean Score 4.13	Q02	I have the materials and equipment I need to do my work right. <ul style="list-style-type: none"> Promptly follow up with team members about their requests for resources (tools, equipment, access to information or management, materials, etc.) they need to do their job right. Take actions to provide the resources that team members need to do their jobs efficiently and effectively. Explain the processes for requesting resources or accessing information at Adventist Health.
2 Mean Score 4.48	Q01	I know what is expected of me at work. <ul style="list-style-type: none"> Clearly communicate each team member's roles and responsibilities. Set aside time to explain to each team member how his or her role contributes to workgroup success. Provide informal feedback to clarify expectations.

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Adventist Health

Report Period: 2014

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Unit C: Adventist Health West Overall

Strengths and Opportunities Worksheet

Please refer to the suggested questions below to prompt meaningful dialogue with your workgroup about your team's strengths and biggest areas of opportunity.

- Do our results on any of these items surprise you?

- What were you thinking about when you answered this particular item?

- Do the results reflect how you feel now?

- What would a "5" look like on this particular item?

- What are we doing that makes this a strong or a weak result?

- What does our work unit need to do to improve on this item?

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UNDERSTANDING THE SCORES

THE SURVEY SCALE: The engagement survey utilizes a 5-point scale with 1=Strongly Disagree and 5=Strongly Agree. For each question, employees have the option to also select "Don't know" or "Does not apply."

TOTAL N: The total number of employees who responded to the survey.

MEAN SCORES: The average score using the 5-point survey scale, with 5.00 being the highest score and 1.00 being the lowest.

TOP BOX%5: The percentage of employees who responded "5 – Strongly Agree" to the survey item.

DISTRIBUTION OF RESPONSES: The percentage of employees who responded "1", "2", "3", "4," or "5" to an item. If 10 or more employees respond to the survey, the report could display a full distribution of responses. Otherwise, only the percentage of employees who responded with a "5" (TopBox) and item means will display.

SUPPRESSED DATA: Confidentiality of responses is extremely important to Gallup. If too few employees respond to a survey item, the data will be suppressed (not published) and an asterisk ("*") will appear in its place. Data will also be suppressed if they risk the confidentiality of an individual's responses, referred to as "suppression due to a difference of 1."

COMPARISONS

STRENGTHS & OPPORTUNITIES: The Q1st items with the highest and lowest percentile ranks, compared to the selected Gallup Database.

EXTERNAL BENCHMARKING: (GALLUP DATABASE COMPARISON): Used as a benchmark to determine how your team's results compare to other workgroups within the Gallup Database of clients.

INTERNAL BENCHMARKING: (YOUR COMPANY COMPARISON): Used as a benchmark to determine how your team's results compare to other workgroups within your company.

PERCENTILE RANKING: The 25th percentile indicates 75% of workgroups fell above this score; the 50th percentile indicates 50% of workgroups fell above and below this score; the 75th percentile indicates only 25% of workgroups fell above this score. The higher your percentile, the stronger the item is in relation to the database. Used as a benchmark to determine how your team's results compare to internal and external workgroups.

APPENDIX K

MAT FLYER AND FEATHER RIVER
RAPIDS ADVERTISEMENT

The flyer is titled "Mission Ambassador Training" in a large, bold, white font on a dark blue background. Above the title is a decorative border with colorful, overlapping semi-circles in shades of green, blue, brown, red, orange, green, purple, and yellow. The text is arranged in a clear, organized manner with bullet points and bold headings. The overall design is professional and inviting.

Adventist Health
Feather River Hospital

Mission Ambassador Training

The Mission Ambassador Training will help you:

1. Learn to apply our mission to your work setting.
2. Learn to provide spiritual support to peers.
3. Learn to pray with patients appropriately.
4. Learn about different cultures and beliefs.

*The Mission Ambassador Training is open to the entire FRH workforce and persons of all faiths. This class is offered as an inservice and there will be CE units available for the classes in 2015.

Class Size: 10 **Class Length:** One 4 hour block
Sign up: HealthStream or contact Brad Brown in
Chaplain Services at 876-7102 or ext. 7102.

Upcoming Dates/
1/12/2015: 8:00 am to 12:00 pm at FSL
(CE available)
2/12/2015: 12:30 pm to 4:30 pm at FSL
(CE available)

Provider approved by the California Board of Registered Nursing,
Provider Number CEP 425 for 4 contact hours.

APPENDIX L

TIMECLOCK AND COMPUTER SCREEN MAT MESSAGE

“Become a Mission Ambassador

Chaplain Services is providing a 4 hour training on “how to” of spiritual care. Everyone is invited to attend. CEU credits are available.”

APPENDIX M

MISSION AMBASSADOR BROCHURE

"We are therefore Christ's ambassadors, as though God were making his appeal through us. We implore you on Christ's behalf: Be reconciled to God."

"Lord Jesus, you know the things that are trembling upon our lips, stirring in our hearts, and along the corridors of our souls, walking on tiptoe across the cloistered spaces of our consciousness, looking expectantly upward, making prayers without words, breathing aspirations that have only wings."

Hear us as we pray, as we call upon you for help, for strength, for peace; for grace, for reassurance, for companionship; for love, for pardon, for health, for salvation, for joy. Amen."

- Prayer of Peter Marshall, US Senate Chaplain

**Adventist
Health**

Feather River Hospital

MISSION AMBASSADOR TRAINING

DATES/TIMES:

12/15/2014 FROM 8AM—NOON

1/12/2015 FROM 8AM—NOON

2/12/2015 FROM 12:30—4:30PM

PLACE: FIRESIDE LOUNGE

REGISTER: CALL CHAPLAIN
OFFICE @ EXT. 7102

What is the Mission Ambassador Program

A Mission Ambassador is an official diplomatic agent of the highest rank accredited as the resident representative in your department of the mission of Feather River Hospital "to share God's love through physical, mental and spiritual healing."

Chaplain Services Department believes our entire workforce is privileged to share in the mission, vision and values of FRH. Everyone can participate in the spiritual healing through sharing God's love through "the compassionate healing ministry of Jesus."

However, even though many of our workforce have a desire, some are uncertain as to how and when to appropriately provide spiritual care. The Mission Ambassador training provides tools, knowledge, role playing and support to increase your comfort in providing spiritual care. By the end of the training our goal is send you out as ambassador of our mission to share God's love.

How to Become a Mission Ambassador

The most important thing is to have a heart of love for people. We encourage you to pray about this decision. A mission ambassador is about representing God's love at the deepest level, the spiritual and emotional. It is a journey of the heart—theirs and yours.

To register, contact Chaplain Services Department and ask for a registration form. Complete the registration form and return it to Chaplain Services. The Mission Ambassador Program will be offered quarterly and is a one day event. The class time is a 4 hour block which includes both lectures and an interactive session for self analysis and honing your new tools.

Lecture Topics and Activities

- Learning to Apply AH Mission to your Work Setting.
- Exploration of Spiritual/Religious Beliefs and Values
- Better Define Cross-discipline Spiritual Care.
- Learn to Provide Appropriate Spiritual and Emotional Care.
- Learn to Recognize Spiritual and Emotional Distress.
- Communication and Listening Skills.
- Learn to Pray with Patients Appropriately.
- Explore Death and Grief.
- Participate in Role Playing Activities.
- When to Make Referrals.

Contact Us

Outside the Hospital
(530) 878-9361 ext. 7102
Email: brad.brown@ah.org

APPENDIX N

FICA ASSESSMENT

F – Faith and Belief

“Do you consider yourself spiritual or religious?”

“Do you have spiritual beliefs that help you cope with stress?”

“What gives your life meaning?”

I – Importance

“What importance does your faith or belief have in your life?”

“Have your beliefs influenced how you take care of yourself in this illness?”

“What role do your beliefs play in regaining your health?”

C – Community

“Are you part of a spiritual or religious community?

Is this of support to you and how? Is there a group of people you really love or who are important to you?”

A – Assist

“How would you like me, your healthcare provider to address these issues in your healthcare?”

-George Washington Institute of Spirituality and Health

FICA Spiritual
Assessment

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VITA

NAME	Brad B. Brown
BACKGROUND	I was born September 20, 1975, in Portland, OR, but raised in Eagle Point, OR. I have one older brother and was raised in the Seventh-day Adventist Church by loving parents who are still married. I was baptized into the body of Christ and became a Seventh-day Adventist in 1986. I am a product of Adventist Christian education and have attended Seventh-day Adventist schools from 2 nd grade through university.
FAMILY	I was married December 15, 1996, to Melea A. Spencer, from Manzanita, OR. We have two children, Jaron Spencer (born in 2002) and Alina Ann (born in 2005).
EDUCATION	
2016	DMin, Andrews University, Berrien Springs, MI
2000-2002	MDiv from Andrews Theological Seminary
1994-1998	BA, Theology, with minors in Speech Communication and Biblical Languages, Walla Walla University
ORDINATION	
2007-present	Ordained by Washington Conference of Seventh-day Adventist and currently hold ministerial credentials through Northern California Conference of Seventh-day Adventist
EXPERIENCE	
2012-present	Director of Chaplain Services, Feather River Hospital, Paradise, CA
2008-2012	Senior Pastor, Billings and Bridger Seventh-day Adventist Churches, Billings and Bridger, MT
2004-2008	Senior Pastor, Graham and Yelm Seventh-day Adventist Churches, Graham and Yelm, WA
2003-2005	Senior Pastor, Graham Church Associate Pastor, Windworks Seventh-day Adventist Fellowship, Graham and Lacey, WA
2002-2003	Associate Pastor, Forest Park and LifeHouse Seventh-day Adventist Churches, Everett and Lake Stevens, WA
1998-2000	Associate Pastor, Tacoma Central Seventh-day Adventist Church, Tacoma, WA