Chaplains' Roles Expand In Redesign

Multidisciplinary Care Teams Increase Chaplains' Visibility and Influence

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Patient-focused care is significantly changing the roles of chaplains who work in healthcare settings, improving their communication with other care givers, increasing their visibility and influence in the hospital and the community, and enhancing other care givers' understanding of the importance of spiritual care. CARE 2000, the redesign project at Mercy Hospital Scripps Health San Diego, demonstrates one way these changes are brought about.

Mercy's new model means that its care givers must be politically aware and vocal concerning healthcare issues in our country; it means that Mercy's leaders must apply the principles of continuous quality improvement (CQI) to enhance the effectiveness of chaplaincy services; it means collaboration rather than competition among Mercy's departments; and it means that chaplains must get involved, through shared governance, in the day-to-day decisions that improve patient care on our nursing units.

Under this redesign, chaplains' skills as consultants and resource persons have been more actively used. For example, as chaplain for Mercy's Maternal Child Health unit, I have been consulted by persons in the community about infertility and adoption. My counseling of couples in this sensitive area has occurred because Mercy's redesign made its chaplaincy services more visible.

Chaplains Learn New Roles

Planning for CARE (Creative Actions Reflect Excellence) 2000 began in June 1990. Focus groups had shown that what patients wanted most in the hospital experience was a caring, concerned, and competent staff who communicated well. They did not want to be shuttled from floor to floor for diagnostic tests; nor did they like the long wait for services to be completed. A multidisciplinary Care 2000 team, including our active chaplaincy staff, was involved in the gathering of data and planning for the redesign.

Increasing patient acuity, healthcare labor shortages, changing reimbursement, and increasing hospital costs made this restructuring effort necessary. As all units embraced the redesign, they implemented the principles of simplifying documentation, placing services closer to the patient, broadening care-giver qualifications, and simplifying processes.

CARE 2000 Goals

All of Mercy's units have completed the restructuring to fit the CARE 2000 goals:

- Continually improving the quality of care delivered

Summary CARE 2000, the patient-focused redesign at Mercy Hospital Scripps Health San Diego, is significantly changing the roles of the facility's chaplains.

On one hand, Mercy's chaplains have received training in the roles of other care givers, learning, for example, how to give bed baths, take vital signs, and apply CPR. On the other hand, the chaplains have taught courses in which other care givers learned, for example, about the differences between spirituality and religion, the grieving process, and spiritual growth.

Through such cross training, Mercy's chaplains have increased their visibility in the hospital and the community, improved their communication with other care givers, and enhanced other care givers' understanding of the importance of spiritual care.

- Creating an empowered work force
- Creating an environment that supports and values teamwork and collaboration
- Increasing resource and operation effectiveness
- Enhancing physician efficiency

All chaplains received two to three weeks of intensive training, taught by staff nurses and management teams. We learned the various roles of other care givers. We also learned how to give bed baths, take vital signs, document intake and output, apply CPR, and interview and discharge patients. We assisted staff members in giving patients physical therapy. We learned to be comfortable with the roles of other care givers, helping out when we see there is a need. For example, once in the nursery I saw that a nurse, needing to take blood from a crying newborn, was having a difficult time. I put on protective gloves and helped her position the baby so that she could complete the procedure and comfort the baby. This situation was not unusual because we were learning to be members of multidisciplinary teams, where the roles are less defined than in the past.

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Not only were we learning "to walk in another's shoes," but other care givers were learning the chaplain's role and the importance of spiritual care for patients, families, and staff. Our chaplaincy team emphasized from the beginning that it was just as important to learn to recognize spiritual distress as it was to learn the language of nursing.

Chaplains and Cross Training

As more and more units became part of CARE 2000, chaplains provided courses in spirituality and advance directives for healthcare. The session "Illness and Healing: A Journey Toward Wholeness," which was written and developed by chaplaincy staff, provided opportunities for participants to differentiate between religion and spirituality, explore the process of spiritual growth and the grieving process, and develop skills they could use to empower their patients to become spiritually whole. According to the CARE 2000 leadership, this class was one of the most popular in the training programs. Nursing staff recognized their own need for spiritual care and became more aware of how much spiritual care they do give their patients.

Within the CARE 2000 model, all care givers remain experts in and continue to perform their usual jobs—as, for example, a registered nurse, chaplain, physical therapist, case manager, or social worker. But they are also cross trained so that they can appreciate the jobs other care givers do. The goal of the cross training is to change attitudes, so that employees who might once have thought, "That's not my job" or "I'll get your nurse" will now say, "I can do that for you!"

It is true, however, that our responsibility as chaplains is, first and foremost, to meet the spiritual and emotional needs of all patients and families as soon as possible. Therefore it is not always practical for us to get involved in helping to bathe a patient, for example, because we could be called away for an emergency at any time. For this reason, it has been necessary to educate other care givers constantly on what we do as chaplains. Flexibility has been the operative word in making this new paradigm work.

A Multidisciplinary Team

The model that emerged was built around four kinds of multiskilled healthcare workers:

- *Clinical partners.* These are licensed professionals with expertise in a specific area of healthcare; they include chaplains, registered nurses, or social workers.
- *Technical partners.* These are paraprofessionals trained in a wide variety of supportive roles, such as patient care assistants or pharmacy technicians.
- *Service partners.* These are support staff responsible for distribution of supplies, custodial services, management of inventory, and minor unit maintenance.
- *Administrative partners.* These are responsible for admission and discharge, financial coun-

seling, patient record maintenance, and insurance information.

All administrative needs are taken care of on the unit to which the patient is admitted. In addition, a satellite pharmacy is located on the floor so that medication can be distributed in a timely way. CARE 2000 places a pharmacist on each unit. This practice tends to involve chaplains in pain management. Because chaplains have an ongoing relationship with patients, the latter often feel free to discuss their physical pain with the chaplain. The chaplain can immediately contact the pharmacist, who will assess the patient and pass the result on to the treating physician. The physician will then quickly adjust the patient's medication and relieve his or her pain.

CARE 2000 has stretched the chaplain's role without changing its mission.

Laboratory tests, some x-rays, EKGs, and other diagnostic tests are also done on the nursing unit. Patients are prepped on the same nursing unit where they are to be admitted for surgery. It is at this point that chaplains address the question of advance directives and durable power of attorney. Chaplains have found it helpful to speak with patients and their families about this important document several days before the scheduled surgery. Patients seem to be more receptive and less anxious when a relationship with the chaplain has been established before they even come to the hospital for surgery.

We chaplains fit well into patient-focused redesign because our services have always taken us to the patient's bedside for pastoral counseling and sacramental ministry. Now we occasionally help pass meal trays, transport patients, and discharge them also. The role of the chaplain has been expanded, not limited.

The New Chaplaincy Team

Our staff of 11 part-time chaplains is now a self-managed team rather than a department. Duties that were formerly the responsibility of the manager—scheduling, tracking productivity, ordering office supplies, planning conferences and staff meetings, and helping eucharistic volunteers from the community become familiar with the hospital—are now shared by team members, who also continue to carry out their usual responsibilities with patients, families, and staff.

We chaplains have also changed the way we carry out our annual merit evaluations. We now base these evaluations on the certification process established by the National Association of Catholic Chaplains. In that process, three team members meet with the chaplain being evaluated, and together they reach a consensus on how to rate the chaplain's performance.

"Shared governance," a decision-making model that allows employees to have input into decisions in their practice areas, has been a driving force at Mercy for the past eight years. In this model, members of healthcare teams share responsibility and accountability. Our chaplaincy team is represented on four of the five housewide shared governance councils: Leadership, Practice, Education, and CQI. One of our chaplains recently completed a CQI survey concerning chaplaincy services at our hospital, collecting data and providing many valuable statistics for our team.

During the implementation of CARE 2000, we saw an increase in our leadership roles as chaplains, bringing us more opportunities to act as teachers, mentors, and resources in the hospital and the community. We developed a *Spirituality Inventory* of attitudes and beliefs about spirituality in our hospital; it is used in training and in in-services for student nurses. Some of our staff, who had never published before, wrote articles and gave presentations, both locally and nationally.

Patient-focused redesign at Mercy has stretched the chaplain's role without changing its mission. As before, our focus is on the spiritual and emotional care of patients, families, and staff. But CARE 2000 helps us do this in ways enriching to our hospital and the wider community. □

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