UK Board of
Healthcare Chaplaincy

Standards for Spiritual Care Services 2020

Overview of key principles

This document should be read in conjunction with the 2020 Competences and Capabilities (C&Cs). Whilst the C&Cs describe the knowledge, skills and behaviour of individual chaplains, these Standards focus on the actual service where chaplains work. The UK Board of Healthcare Chaplaincy (UKBHC) acknowledges the vision, experience and expertise of NHS Education for Scotland (NES) and the Scottish Chaplains Professional Leads Group, in co-ordinating this work, reflecting current Spiritual Care practice in Scotland.

The UKBHC acknowledges that differences persist in the ways in which Spiritual Care is structured, practiced and described in England, Northern Ireland, Scotland and Wales. It is the intention of UKBHC that all professionally accredited healthcare chaplains will work to an agreed set of standards, and that all healthcare chaplains will be professionally accredited by UKBHC by 2030.

The UKBHC also recognises that, for some time now, Spiritual Care in Scotland has been delivered in a generic way and that Scottish NHS Chaplains have not been employed by, or to represent, a specific faith or belief community in the work they do. In addition to this, Scotland has been at the forefront of developing a validated and internationally used tool for measuring the effectiveness of Spiritual Care (the Patient Reported Outcome Measure® or PROM®), an evidence-based and positively evaluated model for staff to reflect on their practice in a values-based way (Values-Based Reflective Practice® or VBRP®) and an evidence-based programme for deploying Spiritual Care support in the community (Community Chaplaincy Listening® or CCL®). All of this work, together with a generic mode of working, over the past decade has resulted in different emphasises in Scotland in the structuring and delivery of Spiritual Care and, therefore, in the articulation of Standards and C&Cs that these documents represent.

Recognising the many benefits that have come from Scotland to Chaplains throughout the rest of the UK, and indeed globally, the UKBHC wishes to endorse this set of Standards and the accompanying C&Cs only for use in Scotland over the next 18 months (from March 2020). This will allow necessary developments of post graduate education, training and formation for Chaplains in Scotland, to take place in line with the new C&Cs. It will also allow the UKBHC to monitor this trajectory and then to make any necessary adaptations to the national Standards and C&Cs.

Supported by:

Association of Hospice and Palliative Care chaplains, Northern Ireland Healthcare Chaplains Association, College of Healthcare Chaplains and NHS Education for Scotland

Introduction

The UK Board of Healthcare Chaplains protects the public by managing an agreed code of practice, standards and competencies for all NHS chaplains. The board's register of healthcare chaplains was accredited by the Professional Standards Authority (PSA) in 2017. This quality mark assures the public that any accredited practitioner is signed up to the UKBHC code of practice, demonstrates the competences articulated in UKBHC Competences 2020, and works within the standards articulated in this document.

These 2020 standards have been developed to align with the philosophy underpinning the National Delivery Plan for Spiritual Care. (Significant elements of the National Delivery Plan have been supported by the Scottish Government from 2014 to 2019, and the Scottish Professional Leads Group has held itself, and the delivery of Spiritual Care in Scotland, accountable to this plan. From June 2019, work has commenced on the development of a new Scottish Government strategy for Spiritual Care and Chaplains in Scotland). UK society is becoming increasingly secular[1], and healthcare is in the process of considerable change, as services move away from the 'fix me' culture, towards person centred, preventative care[2]. The standards have been updated to align with these developments. Their function is to facilitate the audit of spiritual care services, to ensure equality across services and to develop an integrated approach to the delivery of spiritual care while at the same time recognising the diversity of local services and needs. The standards apply to spiritual care services funded by NHS.

Scotland

Scotland has a rich and diverse heritage of culture, faiths and beliefs. While spiritual care is often referred to as a universal, the needs of faith or belief communities are specific and sit within the equality and diversity agenda. It is the task of spiritual care services and standards to meet the spiritual needs of all. The intention of these standards is to be open to and inclusive of all individuals, in order to '*respect the wide range of beliefs, lifestyles and cultural backgrounds found in the NHS and Scotland today*' (NHS HDL (2002) 76, No 8). To facilitate that openness, common terms have been developed and are described in the definition of terms, e.g. 'faith communities' is used to describe those who see themselves adhering to a particular faith, while 'belief communities' is used to describe those who would recognise themselves holding individual or group beliefs such as a humanist.

These standards apply to all NHS services including acute, community, children and mental health as well as the staff working there. Where there is an issue of a person's ability to communicate then the normal protocols and legislation apply.

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

- National standards are under development and will set the criteria for what patients, carers, staff and volunteers can expect from Spiritual Care Services in NHSScotland (Under development as the draft *National Delivery Plan*);
- Service standards set the criteria for how spiritual care services will be put into practice by the service primarily responsible for delivering spiritual care: Spiritual care Services (These standards as prepared by NHS Education Scotland);
- *Competencies in Spiritual Care 2020*, which describe and assess the competence of individual health care professionals, including chaplains, to provide spiritual care (Developed by NHS Education Scotland).

The high level relationship between these three documents is illustrated in **appendix 1.**

Acknowledgements

These standards have been adapted from the 2017 UKBHC Standards, themselves adapted from 2nd edition of the Association of Hospice and Palliative Care Chaplains Standards for Hospice and Palliative Care Chaplaincy (AHPCC, 2006). NHS Education Scotland acknowledges with thanks the support and permission of the AHPCC to use and adapt these standards. NHS Education Scotland also acknowledge the insight and experience from the three chaplains' professional bodies: the Association of Hospice and Palliative Care Chaplains, the College of Health Care Chaplains and the Northern Ireland Association of Healthcare Chaplains.

[1] Alison, A., Siddiqui, M., Snowden, A., & Fleming, M. (2014). Faith and Belief Scotland. Edinburgh. Retrieved from http://faithandbelief.div.ed.ac.uk/wp-content/uploads/2014/07/Faith-and-Belief-Scotland-FINAL-VERSION-OF-REPORT.pdf

[2] Calderwood, C. (2017). Realising Realistic Medicine. Chief Medical Officer's Annual Report 2015-2016. Retrieved from http://www.gov.scot/Publications/2017/02/3336/downloads

Audit

An audit of spiritual care services using the UKBHC Standards for Spiritual Care Services should be carried out within 1 year of their introduction to provide a benchmark for spiritual care services.

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

Definition of terms

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

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

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

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

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

Spiritual Care
The National Delivery Plan states: '*it is widely recognised and accepted that questions of meaning, purpose, hope (or the lack of it), identity and relationship become acute when wellbeing and stability are threatened by illness, injury or loss in oneself or in a loved one. At such times people often need spiritual or religious care'*.

Spiritual care can be given in one to one or group relationships, is person-centred and makes no assumptions about personal conviction or life orientation. Spiritual care:

- offers a space in which individuals and their needs are regarded as central;
- offers person-centred rather than staff or system-centred care;
- elicits and honours an individual's story;
- journeys with an individual further into the pain, darkness, uncertainty or unknowing;
- holds out the possibility of other ways of seeing or understanding, without imposing personal views or frameworks;
- fosters autonomy and self-management rather than dependence and direction;
- is characterised by an equitable, respectful and non-judgemental relationship between two human beings.
- helps people connect or reconnect to their core values and beliefs

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

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

Standard 1 Spiritual Care

Standard Statement	Rationale	Criteria
Individuals/service users and their carers have their spiritual needs assessed and addressed.	The underpinning philosophy of spiritual care is person-centred care. Person-centred care has been defined as "*mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values, and which demonstrate compassion, continuity, clear communication and shared decision making*" (Scottish Government, 2010). Spiritual care has been shown to be important to individuals and service users and are acknowledged to have a significant and beneficial impact on their outcome (Healthcare Chaplaincy Network, 2016). Spiritual needs may be assessed and addressed by members of the healthcare team, which includes the health care chaplain, or with the service user's permission by contacting their faith representatives (Austin, Macleod, Siddall, McSherry, & Egan, 2016). Given that spiritual needs can change quickly, a process of continuous assessment enables healthcare professionals to be responsive to service users and their family/carer's needs. Hence the use of outcome measures to facilitate continuous assessment and to develop care plans for service users in need of such is encouraged (DAMEN, SCHUHMANN, LEGET, & FITCHETT, 2019). Grounded within the security of their belief systems, healthcare chaplains have an expertise in spiritual care. They are enabled to discern and assess the varied spiritual and religious needs of all patients, and where appropriate, their	(a) Spiritual 1.a.1 Spiritual needs are assessed and addressed and may include the following: • The use of evidence-based assessment tools; • Systematic approach to record keeping; • Exploring the service user's sense of meaning and purpose in life; exploring attitudes, beliefs, ideas, values and concerns around life and death; • Affirming life and worth by encouraging reminiscing of the past; exploring the service user's hopes and fears regarding the present and future; • exploring the individual/service user's concerns about how their illness will affect others; • Exploring the "Why?" question in relation to life, death, illness and suffering. 1.a.2 Liaise with local or national resources for spiritual support and with the patient's permission contact relevant communities/individuals. (b) Religious 1.b.1 Religious needs are assessed and addressed and may include ceremonies, meditation, prayer, rites, sacraments, and worship 1.b.2 With the service users' permission facilitate referrals to local faith communities and religious representatives. (c) Person-centred Spiritual Care

	carers: e.g. the parents of patients who are children and young people and the carers of adults with incapacity. Reflecting the person-centred approach to the delivery of spiritual care, the perspectives of individuals/service users' should be respected at all times. This also relates to unsolicited visits from spiritual representatives or groups. Everyone whether spiritual or not needs support and when confronting serious or life-threatening illness or injury may have spiritual needs and welcome spiritual care as they seek to cope with suffering, loss, fear, loneliness, anxiety, uncertainty, impairment, despair, anger or guilt (Paterson, 2015). Those associated with a faith community may derive help and comfort from their beliefs, from the rituals and ceremonies of their faith, and the ministry of its leaders. The NHS must offer spiritual care with equal skill and enthusiasm (Austin et al., 2016). Spiritual Care is usually given in a one to one relationship and is completely person centred and makes no assumptions about personal conviction or life orientation. (Raffay, Wood, & Todd, 2016) Spiritual issues are important to people in primary care, and chaplains are highly valued by GPs (Macdonald, 2017) Spiritual care benefits from a process of continuous assessment. The key to such assessment is the knowledge skills and actions of the multidisciplinary team (Cunningham, Panda, Lambert, Daniel, & DeMars, 2017). The work of health care chaplains often has its roots in religion however, for the generic chaplain their personal faith provides a base from where they can journey with people of different religious traditions and those who hold another life stance. (Mowat, Bunniss, Snowden, & Wright, 2013)	1.c.1	The service will advocate for service users, in a person-centred way, while considering their diverse spiritual background and needs. Appropriate action will be taken, consistent with the service's visiting policy, when made aware of a service user's wish not to receive visits from faith or belief communities or their representatives.

Standard 2 Staff support and resilience

Standard Statement	Rationale	Criteria
As part of the hospital or unit's provision of support for staff and volunteers, the health care chaplain offers personal and professional support. This is expected to facilitate reflection on practice and concentration on the provision of holistic person-centred spiritual care, including but not limited to values based reflective practice (VBRP), pastoral care and supervision, and emotional resilience training. Essentially, staff support should be assets-based and person-centred.	Developing staff resilience is a proactive approach to providing staff support. It is recognised that working in a health care setting is stressful and may lead people to question their personal beliefs and philosophy including their understanding of life, death, illness, suffering and ethical issues. The complexity of issues can also cause professionals to question and reflect on their professional beliefs and to break new ground (Carey et al., 2016). Chaplains can offer an informed, confidential resource to enable individuals and groups to reflect on their beliefs, philosophy and practice. Health care chaplains are expected to be sources of ethical and moral support to staff which constitutes realistic medicine.(King, 2012) Spiritual caregivers will normally be responsible for supporting staff through pastoral care, the ministry of presence and, where appropriate, counselling; in consultation with local voluntary services, selecting, training, supporting and supervising volunteers to work with the chaplain and elsewhere. (NHS HDL (2002) 76) Chaplains need support and supervision to develop deep reflective skills (Paterson & Kelly, 2013).	2.1 The spiritual care service builds working relationships with members of staff and volunteers. 2.2 The spiritual care service responds to requests from members of staff and volunteers for personal and professional support. 2.3 The spiritual care service responds to requests from members of staff and volunteers for spiritual and religious support. 2.4 With the staff member's permission the spiritual care service facilitates referrals to other sources of support. 2.5 With the staff member's permission the spiritual care service facilitates referrals to other sources of support. 2.6 The use of one or more models of reflective practice is explicitly encouraged in policy documents associated with the spiritual care service. Examples include clinical pastoral education (CPE), pastoral reflective practice (PRP), value based reflective practice (VBRP), and/or clinical supervision.

Standard 3 Partnership with faith and belief communities

Standard Statement	Rationale:	Criteria
Spiritual care services should work in partnership to ensure the appropriate provision of spiritual care for service users and their carers	Partnership working can occur in various forms including co-production which promotes engagement between citizens and the public sector for more efficient and effective use of assets and resources (Bovaird and Loeffler, 2013). It is recognised that service users and carers who are members of faith and belief communities may have specific requirements which can only be provided by representatives from their own communities, in particular rites and ceremonies (See Standard 1 Criteria 1.4). This is another form of partnership working in spiritual care services. Given that patient requests may come at short notice it is essential that there is a local referral protocol and that spiritual care services maintain and review a directory of local and national faith and belief community representatives with contact details. Chaplains have a role in facilitating contact, maintaining links, and advising local faith and belief communities on healthcare matters relating to spiritual care. Following discharge it is the leaders of faith and belief communities who are most likely to provide support for their own members in the community. They are also likely to build bridges with communities and the third sector. These can be facilitated via an integrated joint board (IJB) approach. Partnership working also involved engagement between health care chaplains and relevant third sector bodies, other health and social care services and ultimately service users.	3.1 Spiritual care services are an informed resource on spiritual and religious care for NHS staff and local faith and belief community representives. 3.2 Spiritual care services will maintain links between the NHS and local faith and belief community representatives e.g. through a spiritual care committee and training events. 3.3 A written protocol is in place for NHS staff to refer to local faith and belief community representatives. The protocol should include clear guidance stating that faith and belief community representatives can only be contacted with the permission of the patient or their family/carers. 3.4 A directory of contact numbers for representatives from local faith and belief communities is available in hospitals and units. The directory should include regional / national contact numbers for smaller faith and belief communities, or numbers that are likely to change e.g. the representative lives in their own home. 3.5 The local directory should be regularly updated and the faith and belief communities consulted on its content and updating.

Standard Statement	Rationale	Criteria
	NHS Spiritual Caregivers will normally be responsible for facilitating the support in hospital or other NHS facility of the representatives faith or belief communities who may seek assistance and advice. (NHS HDL (2002) 76). Providing spiritual care cannot be accomplished working in isolation and chaplains must be able to work effectively with other chaplains, health and social care professionals, and faith and belief community representatives. (Choi, Chow, Curlin, & Cox, 2018)	3.6 A manual outlining the principal beliefs and practices of the major faith and belief communities is available in all hospitals and units. It is recommended the NES manual *A Multifaith Guide for Healthcare Staff* is used. Where a local manual is also in use the relevant faith and belief communities should be consulted and this local manual should include: • Religious/belief issues that have an impact on healthcare practice with suggested alternatives e.g. blood transfusions; • Religious/belief needs that have implications for the patients stay and well-being e.g. diet, prayer, rites and ceremonies; • What to do in the event of an unexpected death e.g. a summary of common practices, dos and don'ts; • Information about actions or situations where it is important to be sensitive. 3.7 A written protocol for liaison and exchange of information with the identified representatives of faith and belief communities is in place. The protocol should respect patient confidentiality, adhere to the service's guidelines on the use of patient information, and clarify action to be taken when a service-user does not want to a visit from their faith or belief community. (See Standard 1 Criteria 1.c.1).

Standard 4 Access to spiritual care services

Standard Statement	Rationale	The admission procedure ensures a check that written information is given.
Health care chaplains have expertise and knowledge and act as resource to support others.	Effective healthcare requires a holistic approach to patient care including physical, psychological, social, and spiritual aspects of care (Calderwood, 2017). While all staff and volunteers have the potential to provide or facilitate spiritual care chaplains have a particular expertise in the spiritual, religious and cultural elements of patient care (Vandenhoeck, 2013). References The task of spiritual assessment is a skilled task best undertaken by those who directly care for patients and their families. Staff who are aware of spiritual need should be proactive in offering spiritual care and accessing spiritual care services. (Austin et al., 2016) Spiritual care should be a flexible service that should not be confined to crises and emergencies. Chaplains have wide ranging experience and specialist knowledge which enables them to work with staff, patients, and carers in exploring areas of need (Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014)	4.1 All patients receive written information on admission containing details of the spiritual care service available within the unit. 4.2 The written information contains an explanation of the spiritual care service, examples of situations in which the spiritual care service might be used and how contact with the spiritual care service may be obtained. 4.3 The written information is supported by verbal explanation of access to the spiritual care service during assessment. 4.4 The admission procedure ensures a check that written information is given. 4.5 There is a written protocol for referral to spiritual care services, including out of hours. (Note: The protocol may provide for the referrals themselves to be verbal) 4.6 There is a systematic approach to recording keeping, i.e. recording service user's visits (within the constraints of GDPR).

Standard 5 Education, training and research

Standard Statement	Rationale	Criteria
The spiritual care service is committed to supporting the continuing professional development of health care chaplains and the continuing development of volunteers. To improve service standard, the service also contributes to the healthcare team's professional education, training and research programmes.	Continuing Professional Development (CPD) within the Knowledge and Skills Framework enables chaplains to develop their capabilities and potential to fulfil their role within the healthcare team. Through CPD the chaplain will know what is expected of them, get feedback on their performance and will be able to identify and satisfy their development needs. Accessing individual or group clinical supervision which is focused on reflective practice is an integral part of CPD (Ragsdale, 2018). Education and training of healthcare staff, social care staff and medical students on the issues involved in the provision of spiritual care, including the role of health care chaplains, enhances the confidence and knowledge of care and can improve care for individuals, service users and their carers. However, the education standards provided for these groups differ from those provided for new health care chaplains and volunteers (UKBHC, 2020 Competences). Increasing expectations and new technologies, drugs and treatments can raise ethical questions for all healthcare professionals. Experienced chaplains can be an informed resource to support healthcare professionals, patients and carers in the discussion of ethical issues (Swinton, 2013). The promotion of evidence-based practice is enabled and supported by active participation in research (Snowden et al., 2017).	5.1 Spiritual care services are committed to continuing professional development (CPD) within the Knowledge and Skills Framework to promote its integration and development. To this end, all chaplains are expected to keep an annual record / portfolio that evidence CPD and engage in at least 15 hours of CPD per year pro rata. This can include developmental activities such as: • Attendance or presentation at conferences; • Formal education (courses attended or taught); Teaching delivered; • Training on the use of relevant resources and tools such as the Scottish PROM; • Articles and books written or reviewed; • Journal club membership; • Reflective practice, e.g. VBRP Clinical Supervision or Clinical Pastoral Education. 5.2 Spiritual care services and contribute to staff induction for new members of the healthcare team. 5.3 Spiritual care services contribute to the healthcare team's education and training programme. Topics may include: • Spiritual and Religious Care; • The Role of the Spiritual care Service and Chaplains; • Loss, Grief, and Bereavement; • Making a spiritual assessment; • Diversity issues relating to religion and belief. 5.4 Complex ethical issues. Spiritual care services make recommendations for educational and training resources. e.g. recommendations for the unit's library, an appropriate course or attendance at a conference.

		5.5	Spiritual care services are available to the healthcare team as an informed resource for ethical issues and discussion. E.g. serving on a local ethics committee, for consultation on individual cases, contributing to ethical debate and discussion (See also criteria 7.4).
		5.6	Spiritual care services initiate, support, and contribute to research within the healthcare setting, , e.g. local research projects, multi-site research projects and national research projects.
		5.7	Spiritual care services are aware of current research and best practice and consider and implement its findings.
		5.8	Each organisation should have a standard for an induction programme for new staff.

Standard Statement	Rationale	Criteria
The unit ensures that spiritual care services are provided with the resources to fulfil service standards, job description, supervision and training needs, within the constraints of GDPR. The use of resources such as the Patient Reported Outcome measure of Spiritual Care (PROM) to measure the impact of services provided by health care chaplains is encouraged.	To enable health care chaplains to fulfil their remit as health care professionals, the resources required to meet the service standards for spiritual care services should be made available. All employed members of the spiritual care department should receive standardised job descriptions (Cramer & Tenzek, 2012), an induction to the post and undertake introductory training as offered through NHS Education for Scotland (NES) or professional organisations. Members of the spiritual care services require development, education and training to enable, maintain and enhance their skills . Professional organisations and specialist interest groups can provide advice a source of experience and professional/ personal development opportunities for individuals and units. References All NHS Organisations, wherever feasible, should have Quiet Room, Multi faith Sanctuary or Worship Space, a room for meeting and teaching. Information and Signage (NHSHDL (2002) 76) There should be a system for accurate documentation and referral for those who wish to request a visit from a chaplain or chosen faith representative (Timmins et al., 2016)	(a) Spiritual care services should have: 6.a.1 Access to quiet and private areas for confidential support of patients, carers, staff and volunteers. 6.a.2 Access to a language acceptable for the religious observance of all faiths. 6.a.3 Access to patient information systems for providing and facilitating appropriate spiritual or religious care and recording information and interventions. 6.a.4 Access to office accommodation and administrative support. 6.a.5 Access to communication systems to facilitate internal communication and on-call cover. For example: Pager, mobile phone Intranet e-mail 6.a.6 Appropriate level of staffing to meet the spiritual and religious needs of patients, carers, staff and volunteers, including out of hours cover. All chaplains have: 6.a.7 Regular appraisal (at least annually) to review professional development and training needs. Identified needs to be resourced. (b) Chaplains should 6.b.1 Be a member of a professional associations for chaplains, "specialist interest group" if there is one.e.g. Association of Hospice and Palliative Care Chaplains (AHPCC) College of Health Care Chaplains (CHCC) Northern Ireland Healthcare Chaplains" Association (NIHCA) Maintain professional registration for the protection of the public and to ensure safe and effective practice. 6.b.2 Have a mature and reflexive world stance that evidences their 'intentional use of self'. To achieve this, health care chaplains should belong to a faith or belief community that provides a formational foundation for their values and behaviour out of which they can deliver their work

Standard 7 Spiritual Care Services to the organisation

Standard Statement	Rationale	Criteria
Spiritual care services provided by health care chaplains are resources for the hospital or unit's major incident plan and other events that need a communal recognition and action. Spiritual care services can assume symbolic and representative roles. They can: • enhance high level board decisions; • promote value-based leadership; and influence Scottish Government decisions and/or public policy and procedures.	Spiritual care services have a significant contribution to make when a major incident has been declared for example providing support to relatives and staff and offering spiritual and religious support to the injured or dying. Policies and procedures relating to major incidents should include the Spiritual care service (Morgan & Tan, 2015). Events in the hospital or unit, external events such as natural disasters, world events, or personal events such as the death of a member of staff can create individual or collective needs that the Chaplain is best placed to address, either through spiritual care or by holding a suitable communal ceremony. Where appropriate, consideration should be given to involving representatives of other faith and belief communities. Through regular staff contact the chaplain may have insight into significant factors affecting the morale of the unit. The morale of the unit can be enhanced by raising issues and concerns with managers without breaking individual confidences. Through links with local communities, patients, carers and staff, chaplains can have insight and experience that can be used as an experienced ethical resource to inform changes in healthcare services and provision (Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014). Chaplains have a duty to care for the colleagues they work with. Those who are frequently exposed to high stress situations require support, comfort and counsel. If this is	7.1 The spiritual care service has its policies and procedures clearly articulated. This is included in the hospital or unit's policies and procedures for responding to major incidents. For example: • The spiritual care service is included in the call out list; • Members of the spiritual care service are involved in emergency exercises; • Use of the spiritual care centre; • Liaison with local faith and belief communities. The spiritual care service responds to: 7.2 Events in the unit which are having an impact on staff and require a communal response or event. For example: • Death or illness in a member of staff; • Unusual patient or family events. 7.3 Events external to the unit which are having an impact on staff and require a communal response or event. For example: • National disasters; • World events; • Remembrance/anniversaries. 7.4 An awareness of issues or events affecting the morale or functioning of the unit which require management awareness to resolve. For example: • Managing change; • Communication

	provided in a sensitive and timely manner, it can reduce the incidence of breakdown, absenteeism and low morale (Snowden, Gibbon, & Grant, 2019). In understanding the relationship of spirituality to healthcare, chaplains recognise that values, meaning and beliefs play an important role in the life and work of the healthcare organisation. This distinctive approach enables the chaplain to be a resource to the institution and provide insight into a wide range of issues (Cunningham et al., 2017).	7.5	Requests for consultation on ethical issues relating to restructuring, changes in buildings, local priorities and working practices. For example: • Restructuring of services; • Impact on patients, carers and staff; • Equality and diversity. (Also see criteria 5.5)

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The National Delivery Plan, UKBHC Standards and Competencies

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Philosophy

National Delivery Plan

Objective 1:To promote assets based approaches to resilience and wellbeing in all areas of practice

The aim of this outcome is to develop further spiritual care services in which all work with service users and staff is person-centred and assets-based and to ensure that services in all Health Board areas expand their remit to engage fully with primary care and community settings as well as with the acute sector as they move towards increased integration.

Objective 2: To enable and support Health and Social Care staff to foster and sustain their spiritual wellbeing

The aim of this outcome is twofold. First, to provide spiritual support to staff members in order to help them to better manage their own wellbeing and resilience. Second, to provide training opportunities for staff to develop increased reflexivity in their practice and to better understand how to address the spiritual needs of those for whom they care.

Objective 3:To further develop evidence-based practice

The aim of this outcome is fourfold. First, to strengthen and deepen evidence about the impact of spiritual care interventions across in-patient and primary care settings. Second, to ensure that robust mechanisms of data capture are in place in all Health and Integrated Joint Board areas. Third, to further develop the theory that undergirds the practice of spiritual care. Fourth, to continue and expand Scotland's contribution to the international field of evidence-based practice in spiritual care.

Objective 4:To build and sustain a flexible workforce whose primary resource is the individual grounded in a mature and reflexive spiritual world view.

The aim of this outcome is threefold. First, to ensure that provision is made for chaplains to maintain their fitness to practice through regular supervision, reflection and CPD. Second, to ensure that the standards, which govern spiritual care staff and services are consonant with person-centred, assets-based practice in in-patient and primary care settings. Third, to establish a recognised career/training pathway for entry into the spiritual care profession.

Objective 5:To develop service-wide consistency of practice and accountability

The aim of this outcome is threefold. First, to address these inconsistencies. Second, to put in place a mechanism for leadership training, and mentoring for all chaplains at Health Board and national level. Third, to continue to seek registration as a healthcare profession.

Organisation

Standards

Standard 1: Spiritual Care

Spiritual care: Patients and their carers have their spiritual needs assessed and addressed.

Standard 2: Access to chaplaincy services

Access to spiritual care services: Health care chaplains have expertise and knowledge and act as resource to support others.

Standard 3: Partnership with faith communities and belief groups

Partnership with faith and belief communities: Spiritual care services should work in partnership to ensure the appropriate provision of spiritual care for patients and their carers.

Standard 4: Staff Support and resilience

Staff support and resilience: As part of the hospital or unit's provision of support for staff and volunteers the chaplain offers personal and professional support.

Standard 5: Education, training and research

The chaplaincy service is committed to supporting the continuing professional development of chaplains and contributes to the healthcare team's professional education, training and research programmes.

Standard 6: Resources

The unit ensures that spiritual care services are provided with the resources to fulfil service standards, job description, supervision and training needs.

Standard 7: Chaplaincy to the organisation

Spiritual care services provided by health care chaplains are resources for the hospital or unit's major incident plan and other events that need a communal recognition and action.

Chaplain

Competencies

Domain 1 Knowledge and skills for professional practice

1.1 Chaplains continually develop and update their knowledge of spiritual care, current policy, and research evidence relevant to spiritual care services, and uses this to promote and develop safe, effective, evidence-based practice

1.2 Practising ethically: The chaplain maintains and develops their knowledge of culture, diversity, ethical, professional and legal theory and frameworks. This knowledge is used to support everyone accessing spiritual care services.

1.3 Communication skills: Chaplains maintain and develop the communication skills necessary for the spiritual and religious care of service users and in promotion of the service

1.4 Education and training: The chaplain contributes to and delivers education consistent with the needs of the service.

1.5 Leadership, Organisation and Service Development: Chaplains are all expected to demonstrate leadership consistent with their role and responsibility and the needs of the service.

Domain 2: Spiritual assessment and intervention

Spiritual assessment: The chaplain assesses the core values and beliefs that resource the service users and responds in ways which can include referral and signposting to other care providers.

Domain 3 Team working

3.1 Team working: The chaplain works in an integrated way with other health and social care teams.

3.2 Staff support: The chaplain intentionally supports members of staff through therapeutic pastoral support, pastoral supervision and group reflective practice e.g. VBRP.

3.3 Chaplain to the Organisation: The chaplain is aware of their role in the organisation's major incident plan and responds to staff issues and events that need a communal recognition and action.*

Domain 4 Refelctive Practice

Reflective Practice: As part of the process of continuing professional development the chaplain demonstrates the ability to reflect upon practice in order to develop and inform their professional practice.