



Hospital and Shut-In Visitation
Pastoral Care Team Training
October 3, 2010, 6:30 – 8:30 pm

DO'S AND DON'TS OF A HELPING RELATIONSHIP

DO'S

1. Do touch, if this is comfortable to both of you. Try to avoid "condescending" touching, such as pats on the head.
2. Be ready to know your resident as he or she sees themselves. Take an interest in photographs and anecdotes from the past.
3. Make a regular commitment.
4. Share yourself. Allow yourself to be known to them.
5. Listen and take time to understand. Sometimes much more machinery is needed for disabled people to communicate:
6. Do respect the residents` dignity and rights to privacy.
 - be there
 - build trust
 - think along with the person
 - be aware of selective hearing process encourage independence
 - reach out
 - be respectful
 - be genuine, open, honest, cautious be dependable
 - be non-judgmental
 - focus on the person, not yourself
 - look for the positives
 - recognize where the person is move at the person's pace
 - let person initiate areas for discussion
 - use open-ended questions
 - err on side of caution and slow pace
 - maintain confidentiality
 - know your strengths and weaknesses
 - admit "I don't know" or feelings of insecurity

DON'T

1. "over compensate" :....make allowances for disabilities, deafness, blindness, etc., but recognize that the person is still the same inside, and treat them as such.
2. be "hurried" - allow yourself enough time to be fully available to the resident for the time you are there.
3. be too ready to do everything for the resident; - you will show more respect by giving them the time to do it for themselves.
4. get into telling role
5. use "you should"
6. give advice
7. focus on self-enhancement
8. do too much for person particularly if s/he is capable
9. interpret someone else's actions or make excuses
10. over praise
11. intrude
12. probe
13. hurry, appear busy or distracted
14. follow your own agenda
15. talk down to a person
16. assume a role
17. stay too long
18. do all the talking
19. gossip
20. get into premature discussion of action plans
21. patronize or placate - "that's all right now"
22. use clichés
23. change the subject
24. ignore the problem
26. use closed, irrelevant or inappropriate questions
27. use inappropriate warmth or sympathy
28. use inappropriate, irrelevant or premature self-disclosure

APPROACH TO THE PATIENT

1. Be aware that patients rarely ask for a visit. Normally referrals came from the staff, chaplain's aides etc. This means that we have to earn their trust and the right to extend the visit. Begin with the assumption that their bed area is their private space and we are uninvited guests.
2. Be aware that the patient does not want to be there. He/She often feels strange, threatened, dependant. Hence there may be spoken or unspoken resentment.
3. The patient's major objective is to be cared for and preferably cured.
4. We need awareness of our own religious stance as well as that of the patient. If there is either lack of clarity or major differences it is distressingly easy for judgment to creep in to the conversation.
5. Remember that patients have less energy and strength to defend themselves. We neither enlarge their theology nor add to their knowledge but rather help them to make use of their spiritual resources.
6. There will be some religious people who, because of their condition, are only thinking physically, their spiritual resources are there but cannot be applied. More likely the patient will have little or no religious background and little or no idea that they have spiritual resources.
7. The difference in approach between us and social workers lies in the motivation and also in what the patient perceives the helper has to offer. .
8. When asked about denomination, remember that we function ecumenically and try not to answer too readily. If the question really matters they will bring it up again.
9. Ask for permission to sit down or extend the visit as this is not a given, especially on a first visit.
10. If we are going to help we need to know what help the patient needs. Above all else listen!
11. We need to be aware that even without specific "God" language what happens can be real ministry.
12. If sent in to see one patient in a four bed ward try to spend some time with the other patients if possible to reduce the anxiety for the first patient.
13. "How are you ?" often evokes a double barreled answer, listen for both and try to deal with both,
14. If patients ask for the sacraments try to obtain the services of their own minister.
15. If patients contemplate major changes in their faith practice try to persuade them to wait until after they leave the hospital - this is an alien environment and can have strange effects.

PASTORAL CARE PROGRAM

Some Ethics for Pastoral Care Visitors

1. Definition

- What shall be the standards of conduct for the church visitor when visiting the Hospital?

2. Authorization to Visit

- from your Church
- from the Hospital through the Chaplain and/or the Volunteer Coordinator. The Hospital will provide identity tags.
- Advantages of Authorization to Visit - identity in the Hospital and in your church; recognition and accessibility in the Hospital; credibility and trust in the Hospital; self-confidence as a visitor because of these things.

3. Commitment and Training

- Commitment so that you can be depended upon. The Hospital builds its volunteer programming around commitment:
- Training prior to volunteering and during the course of your involvement as a volunteer as to assist the Hospital in its delivery of health care to the patient. Volunteers are a part of that delivery system. The patient has confidence in that system.

4. Knowledge of Hospital, Rules

- Visiting Hours: check with Information
- Length of visits: varies according to wards
- Who may Visit: check at Nursing Station, observe signs Dress: note "isolation unit" requirements
- Literature: religious literature to strangers not approved; only to 15e given to patients on request or with their permission
- Checking-In: Always check-in at the Nursing Station or with the appropriate Hospital authority
- Fire Alarms: do as instructed by staff; if no instructions given, stay with the patient until the alarm is over.

5. Patient Information

- Always check with the Nursing Station for information and authorization to visit.
- Do not snoop in patient files or push for information. Accept what information you are given.
- Never share information from the Nurse or Doctor directly with the patient unless requested to do so (rare!). (i.e. "The doctor/nurse told me ...") This is for your benefit as a visitor only.
- Never share patient information outside the Hospital.
- If a patient tells you something in confidence, then honour that confidence.
- If the patient tells you something you think the doctor or nurse should know, their permission is required before sharing that information.

- General observations about your visit with the patient may be shared with the staff. This can be important in the total care of the patient (i.e. "the patient seemed tired/confused" or "the patient complained of stomach pains, etc.")

6. Relationships to Patient's Family and Friends

- To be limited to the Hospital and to the patient's hospitalization or illness.
- Confidences from family or friends about the patient are to be maintained at all times, (i.e. Don't tell a patient "your mother is worried about you"). Let them share that themselves. Your involvement with family members and friends is largely supportive, a ministry of presence.
- Stay out of family matters, discussions, or disagreements; you are not a referee.

7. Relationship to Staff

As a Hospital visitor, you are part of the Hospital's health care team; therefore; it is important that you work independently with the Hospital staff at all times:

- Show your credentials; make known your authorization to be a Hospital visitor (i.e. Name Tag, sign in and out).
- Know and obey all Hospital rules; this enables you to develop and maintain the good will of staff.
- Always announce yourself to the ward Nurses Station and enquire of the patients you plan to visit.
- If at a bedside, give way to the doctor or nurse (step aside and wait; or leave and announce that you will return later; or leave and say Good Bye; use your good judgment).
- Never comment on a Doctor's or Nurse's advice to a patient. Pass no judgment.
- Be constructive, seek not to become involved in a patient's negative comments about staff or the Hospital (i.e. "the food is terrible", or that nurse isn't very friendly").

PASTORAL CARE PROGRAM

GENERAL INFORMATION ON PASTORAL CARE VISITING

1. Kinds of Visitation in Which You May Be Involved (visitation themes)

- Problem Solving - "help me work it out" request
- Crisis Resolution - "do something now" request
- Ethical Decisions - "what to do, what is right and wrong" request
- Spiritual Direction - "what should I be doing", "how can I change", why is this happening".

2. Process of a Visit or Series of Visits

In order to have an effective visitation ministry, it is important to be aware of, and to seek to enable the following visitation process to happen (in a single visit or in a series of visits).

- Step 1 - ventilation - the patient unloads his/her feelings; you listen.
- Step 2 - differentiation - you assist the patient to -identify and sort out what his/her feelings. (i.e., to identify and-name the feelings if possible).
- Step 3 - integration - you assist the patient to deal with those feelings brought about by his/her illness or injury and hospitalization.

EVALUATING THE SICK CALL

It will be very helpful to both the visitor and the patient if the visitor will occasionally take the time to evaluate a call that was made. In grading there is a natural tendency to favor ourselves. If the evaluation is to serve its purpose, we must try to be as objective about it as we can. When making the evaluation the visitor will profit by it if he or she will assume the role of the patient who was visited. From the viewpoint of the patient, try to evaluate the call that was made as if you were calling upon yourself.

- 1) When I made the call, was the time of my call convenient for the patient"? _____ Did I think-about the patient's convenience? _____
- 2) Did I let the patient choose the-subject of the conversation? _____ or did I choose the topic of conversation? _____
- 3) How much of the time did I talk about myself? Half _____ A fourth _____ Practically none _____
- 4) How much of the talking did I do? Practically all _____ A half _____ A fourth _____
- 5) How long did I stay? Too long _____ Not long enough _____ About right _____
- 6) If I could not see the patient, did I leave a written message? _____
- 7) 7. Did I sit down before I was invited to? _____
- 8) Did I bore the patient with my problems? _____ The problems of others? _____
- 9) Did I criticize the patient's doctor? _____ nurse? _____ The hospital? _____ The clergyman? _____
- 10) Did the patient want me to read and / or offer a prayer? _____
- 11) Did I insist on offering a prayer when the patient really d i d n o t want me to? _____
- 12) When the conversation lagged did I know that I should leave? _____
- 13) When I said that I was going did I leave did I; Stand and talk a while longer? _____ Be seated again? _____
- 14) Did the patient thank me for calling? _____ Say that my call was helpful? _____ Ask me to come again? _____
- 15) Did I tell anyone anything the patient told me in confidence? _____ What? _____
- 16) How did I feel later about the visit? Good? _____ Bad? _____ Indifferent? _____
- 17) Re-reading this evaluation, answered as honestly as I could, how can I improve the next visits I make? _____

The foregoing is a 'soul-searching 'evaluation and I doubt that many will score perfectly on all questions. If you were critical of yourself and scored only one half of them as correct for your call, the chances are that you were helpful by showing your love and concern. However, if you scored low on 2,4,5,8,9, and 15, your call was harmful, and you should try desperately to improve in these areas.

If you scored yourself perfectly on all of them, you are either one of a few of the perfect callers, or you have over estimated yourself.

The purpose of this evaluation is to-assist and encourage the visitor so that in making visits to the sick, both the caller and the patient will have experienced a meaningful and helpful relationship.

QUESTIONS TO CONSIDER

1. You are planning to visit someone in a hospital. What does one need to look for or be aware of upon entering the hospital, while visiting the patient and upon leaving the hospital?
2. What do you do if the patient you are planning to visit does not want visitors?
3. Where should you sit when visiting the patient?
4. What would you do if you find that the patient's door is closed when you approach his or her room?
5. What do you do if the patient asks you to help him or her to the washroom?
6. What should you do if the nurse or doctor comes to visit the patient to hand out medicine, talk to the patient, etc.
7. How long should your visit be?
8. When you arrive on the ward, what is the first thing you should do?
9. Role Play:

John Brown has been in the hospital for several months being treated for cancer. His wife had passed away several months prior to John's hospital admittance. He is depressed over the loss of his wife, tired from the chemotherapy he has been receiving, and the length of his hospital stay. John and his wife had no children and we do not know his religious status.