Community Chaplaincy

So you don't go to church but…….

Often people in hospital who may have not declare a faith or belief affiliation find comfort and support from the pastoral and spiritual care given by the Chaplaincy team but what happens when they go home?

In Doncaster the role of Community Chaplaincy has been explored in relation to end of life care. For these patients, the support in terms of spiritual and pastoral care for them and their families is high on the agenda when in hospital or the hospice, but when they go home it can be a very different story.

A team of volunteers were trained in Community Chaplaincy support, and with support from GPs and palliative care staff were enabled to visit patients, in their own homes. Patients were advised that the service was available, community chaplaincy visitors were then given the referral from the GP practice and contacted the patient to arrange a visit.

Story One

Case 1: The female patient was referred to us as someone who was missing contact with her church. She was allocated to one of our volunteers who is active in her own church, of a different denomination from that of the patient. At the initial visit the volunteer was welcomed very positively, both by the patient and her husband. The patient was in the last months of life and appeared to have difficulty talking, or at least talking made things hard for her. The volunteer and the patient jointly decided that it was not necessary for there to be face to face visits. Instead contact was made for a while by telephone and then, when talking became even more difficult, contact was maintained by the volunteer sending the patient bible reading notes and prayers, which the patient very much appreciated. Towards the end of her life, the patient was admitted to the hospice and the volunteer visited her there. She reported that speech was even more difficult. [The nurses on the ward, and the specialist palliative care nurse all reported that the patient's speech was not causing her difficulty; indeed she used her voice to make her husband's life quite miserable, both at home and in the hospice, but the volunteer did not see this.] The patient returned home to die and her husband rang the volunteer to let her know and to tell her where and when the funeral was taking place. The volunteer said that they had quite a long conversation and she asked me if it would be all right to attend. I confirmed that it would and that, as the service is for patients and their families, if she felt the husband would welcome her continued support, it was all right to offer.

Visit were arranged depending on he needs of the patient and their family- usually once a week.
Most visits lasted no more that approximately 45 mins.

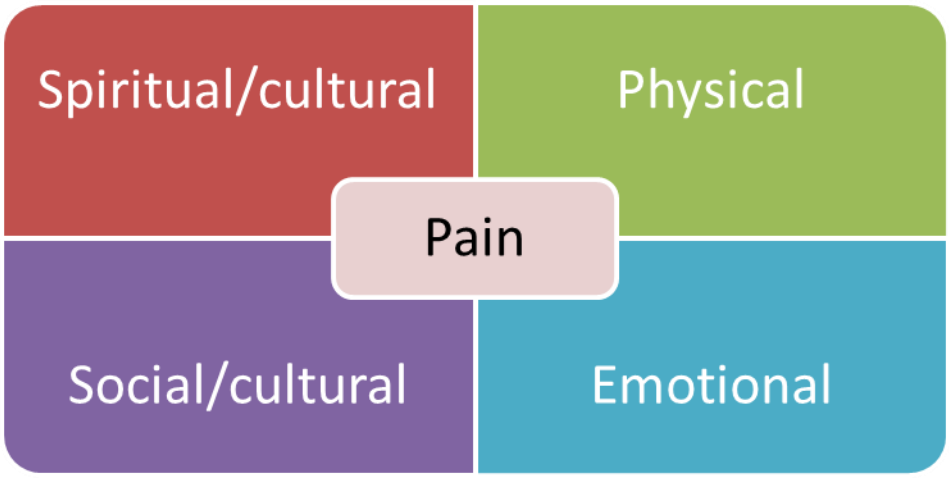
Story 2

The male patient was referred to us as someone who, as he was approaching the end of his life, was remembering a difficult beginning to his life and needed to talk about it. He was not religious but agreed to the referral. The volunteer, also active in her church, visited him at home. His wife was present and the volunteer said that he did not say very much. Our feeling was that he had opened up so much to the specialist palliative care nurse that he no longer needed our input in depth. He and his wife both said that they were pleased the volunteer had visited but that as he was able to get out quite a lot, they didn't feel the need for regular contact. However, the patient said that if the volunteer happened to be passing, it would be all right for her to call in. This she did on several occasions and mostly it was a chat on the doorstep, but sometimes she was invited in, especially when his wife was out. This was when the patient opened up more. The volunteer invited them to some non-church activities and they attended one. The patient is very gradually becoming worse and his ability to get out of the house is lessening. The volunteer continues to maintain contact.

The delivery of intentional spiritual care(Community Chaplaincy Support) is based on the model developed by Revd Debbie Hodge (2015). The four stages of the model are Encounter, Relationship, Transaction and Reflection as shown below. Under each stage is a description of the indicative content.

Encounter	Relationship	Transaction	Reflection
What will you encounter? Health, illness and suffering: the concept of total pain	Listening skills and attentive presence	Practical visits	Skills in reflection and evaluation
Meeting the patient and their family The place of spiritual care – Maslow et al	Loss, grief, bereavement – the process of dying	Spirituality and Health	

The aim of intentional spiritual care is to replace ‘Pain’ in the diagram below with ‘Peace’



This change is achieved when Spiritual care needs are met and the individual is at ‘ease’ with themselves and their situation, and may be related to faith or belief, understanding, resilience, relationships and self-awareness.

For more about this story contact debbie.hodge@freechurches.org.uk or meg.burton@freechurches.org.uk