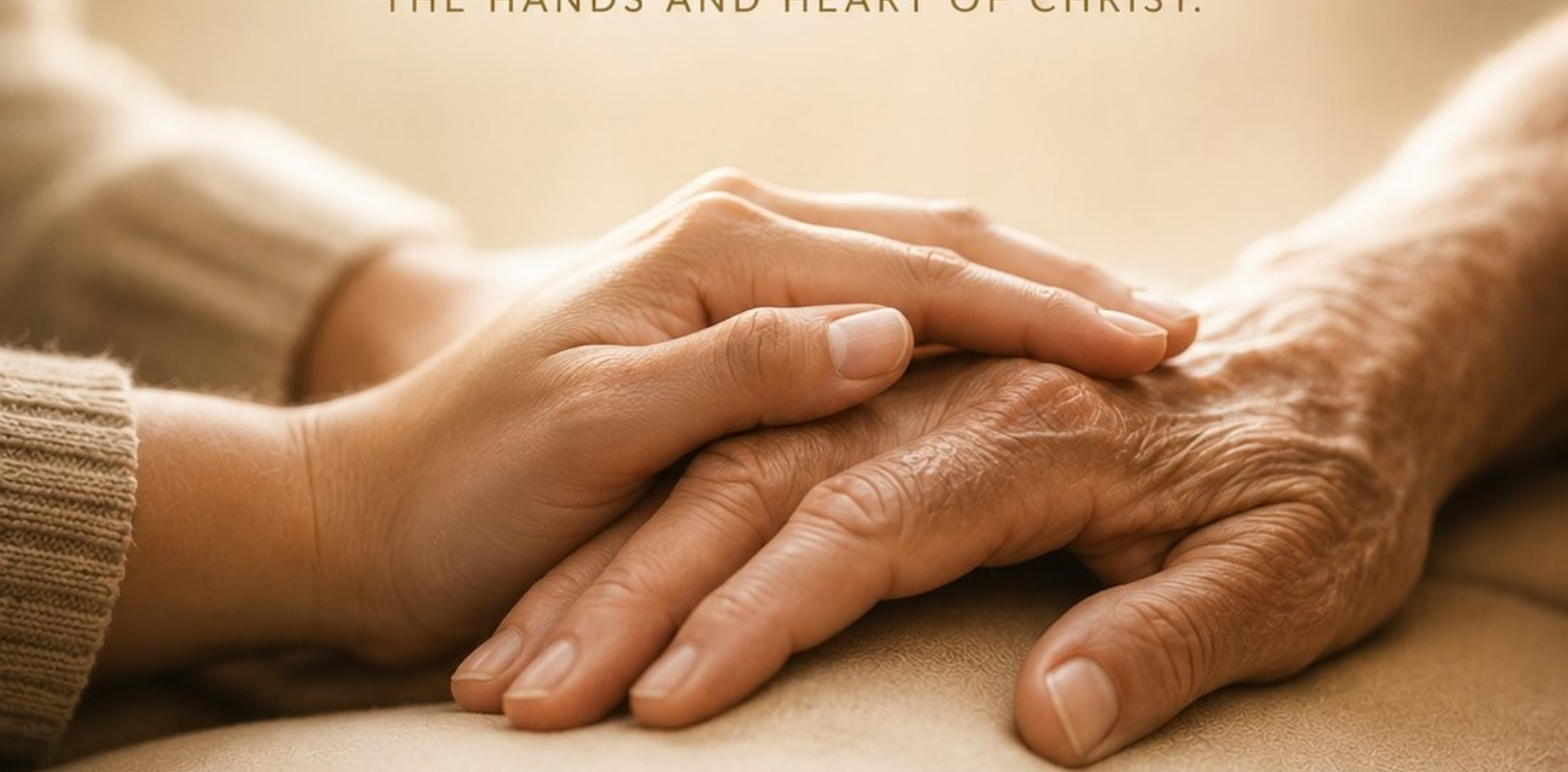


HOSPITAL & SHUT-IN VISITATION



COMPASSION. PRESENCE. HOPE.
THE HANDS AND HEART OF CHRIST.



By Pastor Vern Peltz

WORD OF LIFE MINISTRIES

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Foundational Principles

By Pastor Vern Peltz

This Manual is designed to help educate and unify this ministry at Word of Life. Our goal is to create a team that functions as a team. So whether one person, or various people visit and minister to an individual or family—there will be a consistency in how that ministry is carried out.

Our desire at Word of Life is to take care of the needs of people who may find themselves in the hospital or recovering at home or a facility. Too often when someone is out of sight, they become out of mind. We don't want that to happen here at Word of Life.

Thank-You for being a vital part of this ministry.

PLEASE NOTE: This Manual is designed to be used as an outline or notes. The full discussion of the materials is not included in this manual. Please listen to the teaching that applies to the manual.

There are five different sources of information that have been used in this manual to help bring some understanding to various aspects of this ministry. However before we look at each source, let's look at some foundational principles for this type of ministry.

- (1) This is a ministry. It needs to be viewed in that manner. The difference between ministry and simply hanging-out with someone becomes clear in the end result. Our goal is to minister to the entire person—spirit, soul, and body. Just spending time with someone can be good, but it will only meet the mental / emotional aspects of the person.
- (2) We need to determine what we are going to impart to the individual when we minister to them.
 - a. Comfort.
 - b. Encouragement.
 - c. Hope and Faith.
 - d. Healing.
 - e. Instruction and Education.
 - f. Freedom from Spiritual Attack.
 - g. Etc.

Some of this can be determined by their need. Most of it must be determined by what the Holy Spirit is saying they need.

(3) THIS IS NOT ABOUT US, IT'S ABOUT THEM.

Everyone likes to minister in the area of their strengths and gifting. As good as that may be, we can lose sight of the person as we try to do 'OUR THING'.

What is it that they are needing? What are they setting their faith toward? What is their physical condition, state of mind, emotional condition, and how are they doing spiritually?

We are there to meet their greatest needs by imparting something of substance that will help them step into a realm that will change their present situation.

- (4) **Guard against being so ‘super-spiritual’ that you can’t communicate or relate to the person.** (That will vary by individual)
- (5) **Guard against being so ‘non-spiritual’ that you are of no Godly use to the person.**
- (6) **Like in all other areas of ministry: LEARN TO READ THEIR BODY LANGUAGE.** Then read it and adjust what you are doing and how you are doing it accordingly.
- (7) And above all: endeavor to go to that person:
 - a. Full of the Spirit.
 - b. Full of Faith.
 - c. Full of Wisdom.(Acts 7)

“Freely you have received, freely give.” (Matt. 10:8)

Who we are, and what God has made us to be in Him—is what we’ll give.

- We can’t give what we don’t have.
- We can’t be who we’re not.
- However, we can be who he’s made **US** to be. (That’s what we have to work with)
 - Minister from that reservoir.
 - Minister from the fulness of the Spirit, Faith, and Wisdom that God has imparted into us.
- (8) We know that we are all growing spiritually, mentally, and emotionally. Like any area of ministry and servanthood, this type of ministry will challenge where we are at today in our growth. It will seem that more is required of us than we have to give, and in reality that’s true. That’s why we need to lean on the Spirit and keep him our source.

There have been many times I have sat in the parking lot or on the side of the road and cried after leaving individuals in the hospital or their home that I had visited. I have often felt frustrated and of no use to them.

 - They are believing for healing—and no matter how often I visit them and pray with them, when I prayed, nothing happened.
 - They have no hope—and I had nothing to say but the old christian-eze things that would impart the hope they so desperately needed.
 - They were needing answers to certain situations in life—and I had no answers.

- On and on the examples can go because virtually every visit you make will be a little different and need a different kind of solution or answer.

If You Love the Lord and the People—you will experience the same type of feelings. Guard against the failure feelings, and discouragement that may come against you and try to convince you that you are not good at this type of ministry. Because they will come, just like in any area of ministry.

(9) Remember: we are not their answer—Jesus is.

- Minister to the best of your ability, and point them to Jesus.
- He is their Savior and God—not us.

(10) If their hospital, facility or home stay goes for a prolonged period of time, we need to remain engaged.

Many times there is an almost ‘emergency’ type of mentality at the beginning of their situation, but once it’s gone on for a few weeks or months—the same people are often forgotten about. Let’s not do that.

**In some situations:
You will be the only representation of
Jesus and the Gospel
they will see.**

Let’s make it our goal to represent well.

The following information is by various sources. Even though there is some excellent information in each article, there may also be things we won’t implement at Word of Life.

Hospital Visitation 101

By Kathy McMillan

Hospital Etiquette

You can do several things to make hospital visitation more beneficial for all who are impacted by it, including yourself.

Identify yourself. Once you arrive at the nurses’ station, identify yourself as a pastor and ask the nurses on call if this is a good time to visit. For many reasons, clergy often arrive outside of visiting hours. Most hospitals will allow pastors to visit at any time—especially if the patient or their family has requested your presence. Pastors should always carry their ministerial license or credentials. This proof of

ministry is recognized by hospital staffs as a legitimate form of identification that allows pastoral access to patients who need to be visited—even outside of normal visiting hours.

Don't be intrusive. Do not ask the attending nurse for a report on the patient's condition. Due to privacy laws (often referred to as HIPAA by medical personnel), staff members cannot provide any information unless the patient has specifically given them permission to talk with you.

Be aware of sanitary rules. If the patient is in isolation, you may still visit, but make sure you understand what precautions need to be taken. Patients who are in respiratory isolation may need you to don only a mask, while other visits may require a gown, gloves, and a mask. These precautions are for your safety as well as that of the patient.

Before entering the room or touching the patient, wash your hands well. Germs are often passed by hand contact, and you can help prevent further infections. Wash again as you leave.

Don't overstay your welcome. Even if you were invited to visit, remember that when someone is ill or in pain, their attention span is very short. If the patient wants you to stay longer, he or she will let you know. But even if the patient wants you to stay longer, it may not be best to do so. In such situations, you might wish to tactfully say, "I really do want to spend more time here with you; but I think it will be better if you focus your energies on getting healthy right now. I promise you that I will stay in touch with you."

Spiritual Care

Hospital ministry is a journey. Spiritual care does not come in a neatly wrapped package provided by a person who has "arrived" and given to a poor soul in distress. It may be more helpful to think in terms of a spiritual journey. You are on a journey, as is the person you are visiting. In the way that you listen—and through words you share—you will provide something that will help the patient on their spiritual journey. And they, in turn, will likely say something that will help you on yours. By viewing it as a mutual experience, it takes the pressure off trying to find the perfect thing to say.

Assess the situation. Try to determine how the patient feels, both physically and emotionally. One cannot assume that people waiting for biopsy results are frightened. They may be full of anger or guilt, or they may be very sad.

Listen. Western society tends to be uncomfortable with silence. Stop and absorb what the patient is saying without feeling the need to respond. In Chinese Mandarin language, the character for listen is a combination of the characters for eye, ear, and heart. What a powerful illustration of the multifaceted concept of listening! Anyone can hear words and repeat them. It takes discernment to read between the lines, to interpret the body language and discover the real message. Don't feel that you have to respond verbally to everything. Sometimes the most powerful response

is, “I’m really sad to hear your story. I don’t have any words that seem appropriate, but I want you to know that I care.”

Reassurance is usually not helpful. Can you recall school days when you took a very difficult exam? Was there a time when you wondered if you might have actually failed? Imagine coming home to your family and telling them the bad news. What would be the most likely response that you got from them? “Oh, don’t be silly. Of course you passed!” Did you feel any better? Probably not. In the same way, if a patient voices fear concerning the future, it won’t likely be helpful to say, “Everything will turn out for the best.”

Acknowledge the pain. Several years ago while I was preparing supper one evening, my children were in the backyard playing. My daughter fell and skinned her knee. She came crying to me, asking for a Band-Aid. Being rather task-oriented by nature, and not seeing any blood, I assured her that I thought she would be OK and sent her on her way. Several minutes later, my mother’s heart was pierced by a sobbing girl on the sofa. I dried my hands, got a Band-Aid, and went and sat beside her. “I’m so sorry!” I said. “I’ve had scrapes before and I know they can hurt really badly—even when they aren’t bleeding.” With that, I put the Band-Aid on, and she was immediately healed! That Band-Aid was a powerful symbol of the fact that I had acknowledged her pain. It’s no different with people’s hearts. They need someone to come beside them and say, “Wow! This must be so difficult.”

Don’t try to fix it. Let’s face it. Pastors like to fix things. It makes us feel good to know that we were able to help. We sometimes need to be needed. But too often we jump ahead of ourselves and get into trouble by not allowing others to find their own solutions.

I arrived home from work one evening about five-thirty and saw my neighbor’s son out by the mailbox. I greeted him and asked how he was doing. “We just got back from the emergency room,” he replied. His youngest sister had been jumping in the yard that morning and had fallen, breaking her arm. They spent nearly eight hours in the emergency room of a local hospital. Hearing about the situation, and knowing that my neighbor had five children and it was dinner time, I figured I could fix a problem. I told Donald to go tell his mom that I would make dinner. He said I didn’t need to do that, but I insisted. He again refused. Finally, realizing I was going to need to assert my adult power, I told him firmly, “Donald, your mom is always doing nice things for me and I want to do this. Please go tell her that I will make dinner.” His legs started to shake as he stammered, “Mrs. McMillan, my grandparents are coming and they are bringing dinner!” This was a powerful lesson in not getting ahead of the issue. When we allow patients to problem solve on their own, the solutions will be much more appropriate to the problem and will more likely be carried out.

Be aware of your nonverbal communication. Glancing at your watch while you stand next to the bed sends a powerful message. Even if your time is short, you can give the patient all of your attention while you are there. By sitting down, making eye contact, and speaking slowly, you can convey you care.

Use prayer carefully. Prayer should not be used to end an uncomfortable situation. Early in my nursing career while working on an oncology unit, there was a pastor who often came to visit his parishioners. It seemed that whenever a patient started to voice doubts or anger or fear, the pastor's response was "Let's pray." While his intent was good, he effectively cut off any further conversation. Because of his own discomfort with exploring negative feelings, he never allowed his ailing church members to voice them. Prayer became the end point that snuffed out further conversation.

Never assume that someone wants to pray. While most people expect a pastor to pray with them, sometimes they are not ready for it. A simple statement and question like the following can assess the situation. "When I'm feeling afraid, one of the things that really helps me is to pray. Would you like me to pray with you?" Also, ask the patient for what you should pray. It's easy to assume that someone who has just received a terminal diagnosis wants healing. But they may ask you to pray for acceptance, for peace, or for forgiveness.

Effective Hospital Visitation

By Emmanuel L. Williams

Hospital visitation is an important aspect of pastoral ministry. With approximately 38 million Americans being admitted to hospitals annually, pastors can anticipate that some of their members will be among them. With this in mind, a hospital visitation card has been designed to provide ministers with hints and reminders concerning hospital visitation.

Here are some ways pastors can increase the effectiveness of their hospital visits.

Biblical Basis

When we think of ministry, we often think of the words of Jesus in the Great Commission, "Go and make disciples" (Matt. 28:19). Jesus, however, also said something about caring for the sick. In relating the final judgment of the nations, Jesus said of the righteous, "I was sick and you looked after me" (Matt. 25:36). Furthermore, when He sent out His disciples for ministry, Jesus commissioned and empowered them to "heal every disease and sickness" (Matt. 10:1). In each of the Gospels the healing ministry of Jesus clearly illustrates His concern and compassion for the sick.

Jesus' example of caring for the sick was followed by the Early Church and has been practiced up to the present. Within the Pentecostal church the importance of meeting the physical needs of the sick is evident by the belief in and practice of divine healing. We earnestly believe that deliverance from sickness is provided for in the Atonement and is the privilege of all believers. Therefore, our understanding of the Christian responsibility for caring for the sick traces its origin not only to the

earthly ministry of the Good Shepherd and His apostles, but is found in the doctrine and practices of the Assemblies of God.

Compassion and Pastoral Care

The foundation of pastoral care is compassion. Historically, the Church has valued ministry to the sick as an important component of pastoral care. Our understanding of pastoral care is critical and directly related to the effectiveness of our ministry when visiting church members who are hospitalized.

In his book, *The Compassionate Visitor*, Arthur Becker states, “Pastoral care is providing compassion—being with people—just as God is ‘with us’ in Jesus Christ (Immanuel—Matt. 1:23).”¹

The pastor visits because of compassion for the one who is sick or suffering to alleviate the anxiety, fear, and despair that accompanies sickness and endeavors to replace those emotions with hope, courage, peace, and the ability to cope. The author of Hebrews provides insight into the importance of the Incarnation in pastoral care when he says, “For this reason he [Jesus] had to be made like his brothers in every way, in order that he might become a merciful and faithful high priest” (Heb. 2:17).

David Switzer believes there is a link between caring, agape love, and empathy. In the context of caring, agape love is defined as “action for the well-being of another, regardless of feeling or the nature of the relationship.” Switzer believes our love for God forms the basis for the ministry of taking care of those in need. With respect to empathy, unless the caregiver is able to view the other person’s situation as if he or she were that person, the caregiver would not be able to provide effective and meaningful pastoral care.²

The ministry of caring for the sick is a time-honored practice of the church and an act of agape love exemplified by Jesus’ compassion for those who were suffering. If we desire to increase the effectiveness of our hospital visits, we must seek to exemplify the same traits of compassion, agape love, and empathy that characterized the ministry of Jesus.

The Pastor and the Healthcare Team

Another factor that increases the effectiveness of hospital ministry is a collegial relationship with the hospital staff. A good place to start is the hospital chaplain who can arrange for introductions to key members of the hospital staff. If there is no staff chaplain, the director of the volunteer department or nursing service can usually assist. To become familiar with the layout of the hospital, the location of the waiting rooms, and nursing units, an orientation visit is recommended. During the visit, inquire concerning the policies for clergy visitation and access to critically ill patients.

Recent regulations require healthcare providers to enact policies regarding confidentiality and sharing patient information. There are provisions, however, for the disclosure of directory information: the patient’s name, location, and religious

affiliation to pastors visiting their members. Pastors are encouraged to determine the location of these directories and ensure their churches are included in the appropriate faith-group designations.

Emotional and Spiritual Preparation

A fourth area that is needed in making meaningful hospital visits is the minister's emotional and spiritual preparation. It is important that you know yourself to be an effective caregiver in the hospital setting. Included in knowing yourself is knowledge of your role as a minister, your emotions, mortality, and faith. For example, in respecting a patient's point of view, it is important that we avoid clinging to the status given to us by patients, but show our willingness to come alongside the patient and to have a relationship that is to and for the person.³

As pastoral caregivers we should anticipate that some of our visits with patients and relatives will be exhausting and draining. It is essential therefore, that we know our emotional limits and avoid allowing our irrational emotions to gain control. In situations involving death and dying, it is vital that we have resolved our own issues concerning death and grief and are able to cope with these issues in a manner that will help the bereaved.

It is critical that we are grounded in our faith so we can respond to questions about healing, suffering, and forgiveness that are raised by patients and relatives. Although the hospital room is not the place for theological arguments, there is a need for pastors to respond to these issues based on their knowledge of God, the Bible, and their church's doctrine.

The Visit

Having examined some ways to increase effectiveness in hospital visitation, here are some helpful hints for pastoral visits to hospital patients.

Do's

Call the hospital prior to your visit to determine if the patient is well enough for a visit and what would be a good time.

Stop at the nursing station and introduce yourself. Knock on the patient's door and wait to be invited in. Observe any signs that may be posted on the door regarding infection control procedures. If you are uncertain about the procedures to be followed, ask the nurse for clarification. Monitor the length of time of your visit. Watch for cues from the patient that might indicate you need to leave.⁴

Introduce yourself to the patient, especially if you do not personally know him or her. Sit, if possible, where you can maintain comfortable eye contact with the patient. Be cheerful and make pleasant conversation that focuses on the patient. Ask open-ended questions, "Tell me what brought you here, and how long do you expect to be here?" Display concern for the patient's illness and respect for his or

her feelings. Watch for doors that lead to the feeling level of communication and be alert for negative feelings.⁵

Shape the tone and substance of your conversation from cues, verbal and nonverbal, offered by the patient. Listen attentively and be empathetic. Take notice of what is not said as much as what is said. Let the patient know he or she can talk about sensitive subjects. Offer to leave the room if medical personnel enter to perform a procedure unless requested to stay. Share Scripture and ask patients if they have special needs as you prepare to pray. A gentle touch on the hand or cheek lets a patient know you care. If you have not previously met the patient, ask permission.⁶

Don'ts

- Don't be insulted by a patient's words and attitudes or register shock at a patient's appearance.
- Don't offer false optimism about a patient's recovery or participate in criticism about the doctor, hospital, or treatment.
- Don't touch equipment even if requested by the patient, or sit on the patient's bed.
- Don't tell the patient unpleasant news including your troubles.
- Don't whisper when talking to relatives or medical staff in the patient's room.
- Don't break hospital rules or violate confidentiality issues.
- Don't awaken a sleeping patient unless the nurse approves.
- Don't help patients get out of bed or give food or drink without the nurse's approval.
- Don't assume a comatose patient cannot hear.

While the above lists of dos and don'ts are not inclusive, they contain the primary hints that will enhance the quality of our hospital visitation. For more helpful hints, consult the resources mentioned in the endnotes. Through the application of the above ideas and the empowerment of the Holy Spirit, our ministry to the sick can become more effective.

Do	Don't
(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.	(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.

Do	Don't
(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.	(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.

Endnotes

1. Arthur Becker, *The Compassionate Visitor: Resources for Ministering to People Who Are Ill* (Minneapolis: Fortress Press, 1985), 27.
2. David Switzer, *Pastoral Care Emergencies* (Creative Pastoral Care and Counseling Series) (Minneapolis: Fortress Press, 1999), 14.
3. Neville Kirkwood, *Pastoral Care in Hospitals* (Harrisburg, Pa.: Morehouse Publishing, 1999), 153-170.
4. Katie Maxwell, *Bedside Manners: A Practical Guide to Visiting the Ill* (Grand Rapids: Baker Book House, 1990), 30.
5. Lawrence Reimer and James Wagner, *The Hospital Handbook: A Practical Guide to Hospital Visitation*, revised ed. (Harrisburg, Pa.: Morehouse Publishing, 1988), 13.

6. Perry Biddle Jr., *A Hospital Visitation Manual* (Grand Rapids: Wm. B. Eerdmans Publishing Co., 1994), 29.

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Hospital Visitation Guidelines for Pastors and Leaders

October 4, 2011

When we think of ministry, we often think of the words of Jesus in the Great Commission, “Go and make disciples” (Matt. 28:19). Jesus, however, also said something about caring for the sick. In relating the final judgment of the nations, Jesus said of the righteous, “I was sick and you looked after me” (Matt. 25:36).

People will forget whether or not a pastor came to their birthday party or wedding. But they’ll remember if he comes to visit them in the hospital, or to a loved one’s funeral.

Suggestions

- (1)** Pray before you arrive.
- (2)** Have a plan (but don’t expect to use it). Don’t just assume you’ll think of a story from the Bible, or will come up with a scripture.
- (3)** Understand HIPAA: The Health Insurance Portability and Accountability Act (HIPAA Privacy Rule) places severe restrictions on information that can be disclosed about a patient’s medical record. A patient will have a list of people who can know about his condition. There might be a benefit of getting on that list, if the patient doesn’t have close family members.
- (4)** Don’t obstruct the flow. Doctors will be coming in and out—get out of their way. Medical people enter to do a procedure from time to time; it is best to exit. If a therapist is coming for therapy, etc., they will often give you 3 minutes to pray if you ask.
- (5)** Keep it short! Visit for ten minutes or so, less if the person is in discomfort. People don’t realize how exhausting it is to be a patient. Between medicines, therapies, and other visitors, many patients are too tired to talk.
- (6)** Be sensitive, but not timid. Don’t avoid the pressing conversations about surgery or a serious diagnosis. Also, assess the depth of conversation. Ask yourself, Is this a time to address fears? Is this a good time to be silent? Look into their eyes to see their heart, to see if they’re tired or scared.

- (7)** Lend a healing touch. A pastor's touch can represent some of the only non-clinical contact a patient receives. Jesus touched the sick and dying. Take a hand while praying or reading Scripture. Before you initiate any kind of touch, however, ask permission. You do not want to interfere with IV's, etc. and you don't want to spread germs to a person whose immune system might be compromised (don't touch nor visit the patient if you are sick).
- (8)** Don't rush out the door. Be sensitive to certain situations when it is best to stay longer—when the patient has few visitors, needs practical help, or clearly desires the counsel of a pastor. Feel free to sit in silence, too. What you say isn't really important. Your presence matters more than anything. Don't give them false hope, but do express that they are needed and that you are praying for them.
- (9)** Remember the family. Don't overlook the family that is waiting around. They often require similar pastoral care. Visit at least once while the family is there and share your desire to serve them, too.
- (10)** Do not sit on the bed.
- (11)** Mealtimes happen. Cut your visit short (less than 5 minutes) if the person is eating (unless they are nearly done); you might offer to come back in 15 minutes.
- (12)** Bedpan issues can be embarrassing; if someone says they need to go, get out of there; do not make them cringe. If the curtains are drawn as you enter the room, ask a nurse if it is okay to go on that side of the room.
- (13)** Do not visit if you have a cold or contagious condition. A phone call is better in such cases. A patient's health is more important.
- (14)** Avoid being a medical know-it-all and do not put down a patient's doctors.
- (15)** If the door is closed, check at the nurse's station before entering: someone may be on the bedpan or receiving a bath or change of dressing.
- (16)** Watch for cues from the patient that might indicate you need to leave.
- (17)** Call the hospital prior to your visit to determine if the patient is well enough for a visit and what would be a good time. Stop at the nursing station and introduce yourself. Knock on the patient's door and wait to be invited in.
- (18)** Be wise about what you take into the room. Candy (which the patient cannot eat) and big fruit baskets (that are off-limits) may do more harm than good to the patient. What is appropriate to bring?

Don'ts

- (1)** Don't be insulted by a patient's words and attitudes or register shock at a patient's appearance.
- (2)** Don't offer false optimism about a patient's recovery or participate in criticism about the doctor, hospital, or treatment.

- (3) Don't touch equipment even if requested by the patient, or sit on the patient's bed.
- (4) Don't tell the patient unpleasant news including your troubles.
- (5) Don't whisper when talking to relatives or medical staff in the patient's room.
- (6) Don't break hospital rules or violate confidentiality issues.
- (7) Don't awaken a sleeping patient unless the nurse approves.
- (8) Don't help patients get out of bed or give food or drink without the nurse's approval.
- (9) Don't assume a comatose patient cannot hear.

Good Scriptures to Read

Ps. 86; Ps. 27; Isa. 40:28-31; Phil. 4:4-9; others?

If the Patient Is Near Death

- (1) Ask if they have a will.
- (2) Ask if there is anything they want you to mention to family during memorial service.
- (3) Ask if there is anything special that they want for her/his memorial service.
- (4) Ask if there is anything on their heart, that they need to release/share/confess.

Anointing with Oil

James 5:13-16 Is any one of you in trouble? He should pray. Is anyone happy? Let him sing songs of praise. Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven. Therefore confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous man is powerful and effective.

The Lord's Supper for Sick / Elderly

I Cor. 11:23-26

Hospital Visitation Guidelines — A Practical List

From Slide Share / LinkedIn Learning · Published Feb 7, 2013

When You Visit Someone in a Hospital

- Call the hospital before you visit to ensure they are still admitted and have not been discharged.
- Choose a time during the day to visit, unless you have been called by a family in crisis.
- It is acceptable for one to visit a patient of opposite gender.
- Pray before leaving the car or entering the room that the Lord will give you the right words of encouragement to minister to the patient.
- Use the Purell, or other hand sanitizer outside the door, before and after.
- If visiting a patient of the opposite sex, ask a nurse to enter the room prior to you to ensure that the patient is appropriate to receive your visit.
- Knock before entering the room; do not interrupt doctors or staff who are treating the patient; simply leave and return at another time or wait outside the door until the staff have left.
- Never wake up a patient; if a relative is there, you can address them or offer to talk with them outside the door.
- Introduce yourself and provide a hospital visitation card.
- If the patient is alone and asleep, simply leave the hospital visitation card on their bedside table with a note that you are praying for them—be sure you do pray for them afterward in your quiet time.
- If the patient is awake and alert, speak clearly and positively, and do not ask probing questions; just listen; if they offer information about their condition, hold this information as confidential, only providing necessary information to Church Pastor (never say, “I know what you are going through,” because you really don’t know).
- Talk in a volume that is respectful of them and their semi-private neighbor on the other side of the curtain. There should be no loud talking or heavy laughter. However, since laughter is good medicine, it would be appropriate to keep your conversation light and positive.
- Watch your time and do not outstay your welcome (usually 15 minutes or less), unless you are sitting to give a family member a break away; give the patient the opportunity to fall asleep as you sit quietly; do not ever turn their television on; if it is on, that is their choice but keep your focus on them.
- Pray with the patient before you leave the room. When family is present, remember them in your prayer as well. Oftentimes, it is a sweet thing to all hold hands around the patient, depending on how many are there and if the opportunity is there. It is okay to hold their hand or touch their arm as you pray. Make sure you cleaned your hands before you entered the room. If not, excuse yourself to wash your hands in the room before you hold their hand in prayer.

Intensive Care Visits

- Be aware of the hours of visitation before you go.

- Be aware of the signage at the doors—regarding gowns, masks, and gloves—and follow the hospital instructions; dispose of these items in the appropriately designated places.
- Keep visits very brief, acknowledge family who are present, leave a business card if you have one in case the patient is asleep.
- Do not take flowers or gifts while the patient is in ICU—flowers eat up oxygen, and gifts often get lost (especially when the patient is moved to another room) or stolen.

No Gifts — Other Ways to Help

- Offer to sit with the patient while family goes to the hospital café for a meal.
- Offer to assist with needs before leaving the hospital room (if you can follow through).
- Offer to sit with a patient who is bed-bound; read book or scripture.
- Offer to run an errand to the grocery store or pharmacy for the family.

Remember that you are representing God when you visit and it is a called honor to make this visit.

Shut-In Visitation

The Ministry of Pastoral Care to the Sick and Homebound · Saint Patrick Parish, Stoneham, MA

Prepare to visit the sick and homebound by praying, planning and trying to place distractions aside. Remember, God is an active presence and participant in any interaction that occurs between you and the person(s) you visit.

A day or two before your plan to visit, call and make arrangements for the visit and be faithful to the day and time you set.

Try to neither overstay your visit nor end it prematurely. If uncertain, you can ask: “Are you tired?” Sometimes it is helpful to state at the beginning of the visit: “I can spend ___ minutes with you today.”

Work on building a relationship; invite sharing of personal history and inquire as to the person’s well-being.

Some Suggestions to Keep in Mind

- (1) Use the person’s name.
- (2) Listen more than you talk.
- (3) Be comfortable with silence.
- (4) Remain focused on the person.

- (5)** Use gentle touch, when appropriate.
- (6)** Use good eye contact. Place yourself in direct line of vision, sitting if possible.
- (7)** Practice active listening; acknowledge feelings and information that are shared with you.
- (8)** Be comfortable with accepting negative feelings or strong emotions.
- (9)** Avoid arguing, showing shock, or aggressively probing or ignoring another's boundaries.
- (10)** Provide reassurance but do not make unrealistic promises and do not become overly focused on medical conditions.
- (11)** Do not exchange any medical information or offer examples from your own experience.
- (12)** Avoid giving advice, promising to fill special requests, and offering to solve problems.
- (13)** If a person is in a hospital or nursing center and is requesting food or water or some type of physical assistance, ALWAYS check with a staff person before assisting.
- (14)** The question of accepting money from the person you visit may arise. When you are visiting a homebound person for the purposes of pastoral visiting or to bring Eucharist, you are doing so as a VOLUNTEER, and therefore, you should never accept money for yourself.
If the person is insistent, tell them you are going to give the money to the Church, and after the visit, put the donation in the offering.
- (15)** Believe in the value of what you are doing. It does make a difference!

The following article has been included for the purpose of emphasizing the importance of a team approach to this ministry. Our goal at Word of Life is to take care of the needs of all the people while we grow numerically so others can experience and become a part of what is happening here. To do both, we need people to join in the ministry that God has for each of us (Eph. 4:11-16).

How Pastoral Care Stunts the Growth of Most Churches

By Carey Nieuwhof

Of all the mysteries that shouldn't be mysteries, why most churches remain small is perhaps the greatest.

I'm sure there are a few leaders who want to keep their churches small, or who don't care about growth.

But most small church leaders and pastors I meet actually want to reach more people. They want to see their mission fully realized. They hope and pray for the day when they can reach as many people as possible in their community.

But that's simply not reality.

The Barna group reports the average Protestant church size in America as 89 adults. 60% of Protestant churches have less than 100 adults in attendance. Only 2% have over 1,000 adults attending.

As a result, the dreams of pastors of most small and even mid-sized churches go unrealized. Why?

There are eight reasons most churches never break the 200 attendance mark, but today I want to drill down deeper on one that kills almost every church and pastor: pastoral care.

If pastors could figure out how to better tackle the issue of pastoral care, I'm convinced many more churches would grow.

Here's why. And here's how.

If pastors could better handle the issue of pastoral care, many more churches would grow.

How Pastors Die Trying

When the pastor has to visit every sick person, do every wedding and funeral and make regular house calls, attend every meeting, and lead every Bible study or group, he or she becomes incapable of doing almost anything else.

Message preparation falls to the side, and providing organizational leadership for the future is almost out of the question.

The pastoral care model of church leadership simply doesn't scale.

It's somewhat ironic, actually.

If you're a good pastoral care person (and many pastors are), people will often love you so much that the church will grow to two hundred people, at which point the pastoral care expectations become crushing.

Inevitably, pastoral leaders with larger churches can't keep up and end up disappointing people when they can't get to every event anymore.

*Caring for 30 people personally is possible. Caring for 230 is not.
Many pastors burn out trying.*

The pastoral care model most seminaries teach and most congregations embrace creates false and unsustainable expectations.

Consequently, almost everyone gets hurt in the process.

The pastor is frustrated that he or she can't keep up. And the congregation is frustrated over the same thing.

Eventually, the pastor burns out or leaves and the church shrinks back to a smaller number. If a new pastor arrives who also happens to be good at pastoral care, the pattern simply repeats itself: growth, frustration, burnout, exit.

It's ironic. The very thing you're great at (pastoral care) eventually causes your exit when you can no longer keep up.

Or, if you stay for a long time, your church settles down to around 100 people and you simply can't grow it beyond that.

You need to structure bigger to grow bigger.

Complication 1: Pastors Who Won't Let Go

Several other factors make pastoral care complicated.

Many pastors I know are people-pleasers by nature. Wanting to not disappoint people fuels conflict within leaders: people want you to care for them, and you hate to disappoint them.

In some respect, pastoral care establishes classic co-dependency. The congregation relies on the pastor for all of its care needs, and the pastor relies on the congregation to provide their sense of worth and fulfillment: the pastor needs to be needed.

Traditional pastoral care establishes a real co-dependency; the pastor needs to be needed.

Complication 2: Congregations That Won't Let Go

Many congregations define the success of their leader according to how available, likable and friendly their pastor is.

It's as though churches want a puppy, not a pastor.

Since when did that become the criteria for effective Christian leadership?

By that standard, Moses, Jeremiah, Ezekiel, Hosea, the Apostle Paul and perhaps even Jesus failed the test.

That's no excuse for being a jerk or insensitive, but leadership requires that at times, you need to do what's best, not what people want.

The goal of Christian leadership is to lead, not to be liked.

If a church is going to grow, congregations have to let go of the expectation that their pastor will be available for every medical emergency, every twist and turn in their lives, every family celebration and every crisis.

That's a tough sell for many congregations, but if a church is going to grow, it has to happen.

How to Break Through

So how do you deal with this? Have the courage to shift care to the congregation.

The best answer I know of for pastoral care in a larger church is to teach people to care for each other in groups.

Groups-based care is thoroughly biblical: going back to Exodus 18, when Jethro confronted Moses about doing everything himself.

Even Jesus adopted the model of group care, moving his large group of hundreds of disciples into groups of seventy, twelve, three, and then one.

Groups-based care isn't just practical. It's biblical.

I have been the pastoral care giver in a small church. Some of those original people are now part of our much larger church where care happens in groups. In the process, both they and I have made the transition.

As a result, here's what I've come to believe about pastoral care: 98% of pastoral care is having someone who cares. It doesn't have to be the pastor.

2% of the time you'll have situations where the need of a member exceeds the ability of the group to help. That's what trained Christian counselors are for. The tool kit of a trained Christian counselor is deeper and better than the counseling ability of the vast majority of pastors.

I rarely if ever counsel people. Why? Because I care about people too much. Instead, I send them to people who can actually help them.

If you're wondering how to start the discussion, I started it with my elders and leaders when we were about 100 in attendance and told them my role would be changing.

The journey was tough, but we made it. We now have a church of 3,000 people with 1,500 in attendance on weekends.

It's tempting to say I'd be dead if I was still trying to do pastoral care personally, but that's simply not true. I'd be alive, very tired (it's not my key gifting) and our church would be under 200 people. I also likely would have quit. We would never have grown. That's the reality.

It's simply impossible for a church to grow beyond 200 under one person's direct care and leadership.

98% of pastoral care is having someone who cares. It doesn't have to be the pastor.

Too Scared?

Too scared to have the conversation?

If you're a people-pleaser, do what you need to do to get over it. Go see a counselor. Get on your knees. Do whatever you need to do to get over the fear of disappointing people.

If you're afraid to have the conversation, have it anyway.

Courageous leadership is like courageous parenting. Don't do what your kids want you to do; do what you believe is best for them in the end.

Eventually, many of them will thank you.

And the rest? Honestly, they'll probably go to another church that isn't reaching a lot of people either.

I'm convinced that if we changed how we do pastoral care, we'd reach more people. And in the process, we'd care for people much better than we do now.