Student’s Final Evaluation Cover Sheet

NAME Wendy Perego\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERMANENT ADDRESS\_\_\_228 Riverside Lane\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY \_\_\_Natchez\_\_\_\_\_ STATE \_\_LA\_\_\_   ZIP \_71456\_\_\_\_\_\_

DENOMINATION \_\_Baptist\_\_\_\_\_\_\_ORDAINED/DATE\_\_\_\_\_\_\_\_\_\_\_\_\_

GRAD SCHOOL/SEMINARY \_\_\_Dallas Theological Seminary\_\_\_\_\_\_\_\_\_\_\_

DEGREES/DATES MACP (Master of Chaplaincy and Ministry Care)  December 20, 2024

ACPE EDUCATOR(S)\_Dr. Rev. Colette Gaffney\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEVEL OF TRAINING:  \_\_\*\_ CPE (Level I)              CPE (Level II)

DATES OF TRAINING\_\_May, 2024 -  Nov., 2024\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINICAL ASSIGNMENT AREA\_Ochsner-LSU Shreveport Health\_\_\_\_\_\_\_\_\_

PREVIOUS CPE UNITS \_\_Level 1A

I understand that my Student’s Final Evaluation will not be shared without my express written permission.  I understand that I am responsible to keep a permanent copy of it for my own use.

\_\_*Wendy Perego*       \_\_\_\_\_\_\_Nov. 6, 2024\_\_\_\_\_\_\_\_\_

Student’s Name Date

**Measuring Student Achievement (i.e., Scoring):**

**A student needs to receive an 80% achievement level to receive 1 credit and continue to the next level.**

**A student needs to receive a 70% achievement level and receive 1 credit but must remain at the same level.**

**A student needs to receive less than 50% achievement level does not receive credit.**

Level 1B Final Self-Evaluation Form

Ochsner Health System

CLINICAL PASTORAL EDUCATION

CONFIDENTIAL

Name: Wendy Perego

Unit Dates: May 2024- Nov. 2024

Educator. Dr. Rev. Colette Gaffney

Clinical Sites: Ochsner-LSU Shreveport Health

Date: Nov. 6, 2024

Instructions:

On a scale from 1 to 4 rank yourself on each indicator:

1 (Not Yet Engaging) 2 (Needs Improvement) 3 (Meets Expectations) 4 (Exceeds Expectations)

For each category write a narrative describing your learning related to that category and how you learning goals helped you meet that category of outcomes (a total of 5 narratives). Address your progress with your learning goals under the category they are connected to. The character limit for each indicator is 3200.

This evaluation is due to your mock committee one week before the mock interview (February 1).

Category A: Spiritual Formation and Integration

**Outcome 1: Narrative History**

• Indicator: Articulate how one's narrative history informs one's values and beliefs about spiritual care.

Rank: 4

Throughout my time in CPE, I have become more aware, and able to articulate how my narrative history informs my values and beliefs about spiritual care. My narrative history was grounded in a childhood in a strict evangelical Christian home. During life experiences such as traveling to other countries and cultures, and getting to know people from different areas of the united states, my values and beliefs about spiritual care have changed. I have had the honor or getting to know people from different backgrounds and facing unique challenges in my adulthood and also in clinical time at the hospital. It has narrowed the list of absolutes I hold in my spiritual beliefs and widened my compassion for other’s stories and how they have arrived at their own values and beliefs. My experience getting to know patients has given me appreciation for their value as humans and how their perspectives and experiences can expand my understanding and spirituality.

• Indicator: Demonstrate awareness in the moment of when a care encounter intersects with elements of one's narrative history.

Rank:4

I went to visit a 17 year old patient who shot themselves in the face and lay motionless in the hospital bed while his parents sat beside him feeling despondent, overwhelmed, and hopeless. One of my personal goals was to work through my counter transference in an encounter such as this as my own son attempted suicide twice when he was fifteen and I found myself at his bedside wondering if he would make it and what to do if he did. The day of the first encounter, I went home and sobbed. I decided this was too close to home and that I would not be effective as a chaplain for him. However, I reconsidered, and have been by his side for the past two months as he has had reconstructive surgery and has fought for his physical life as well as his spiritual and mental health. The most rewarding moment was when he was using a communication board and during a conversation, he lifted it up and it said, “I love talking to you.” He has continued to improve and is now able to speak and working with him has been a true pleasure.

**Outcome 2: Socio-cultural Identity**

• Indicator: Articulate how one's social identity informs one's approach to spiritual care.

Rank:4

My social identity informs my spiritual care on a daily basis as the majority of the demographic that I encounter is  African American, most often males, and come from a different spiritual upbringing. Much of the population there is from a low socioeconomical status. As a white woman, who is financially stable and comes from a Caucasian spiritual background, and older than the majority of patients I see, I have learned to be sensitive to the differences and work to make them know how valuable they are to me and to God and how much I respect their spiritual upbringing. I do this by giving them a generous amount of time and listen well to make sure we have a connection. I meet them where they are and offer any support helpful to them.

• Indicator: Demonstrate awareness in the moment when a care encounter intersects with elements of one’s social identity.

Rank: 4

I was called in for spiritual support of an African American male and his wife. The patient was dying of cancer. The wife was struggling with denial and he was asking her to “let him go.” It was such a poignant and sensitive moment. I listened to her and then spent time kneeling by his bedside listening to him. I did reflective listening and attempted to sooth his anxiousness. I felt like it wasn’t going anywhere. Then, a family member who is a pastor came in and “took over.” I stood back and watched. He did not spend time practicing curiosity about the details. He simply started praying and worshipping. It was powerful. The patient started speaking out in agreement with him and you could feel his spirits lifted. He thanked the pastor and said that was what he really needed. He and his wife were taken out of their despair for a long moment and able to gain perspective and strength. I learned that my approach is not always what people need. It’s important to bring other spiritual leaders in at times when I seem to be falling flat.

**Outcome 3: Spiritual/Values Based Orienting Systems**

• Indicator: Demonstrate how one’s orienting systems inform spiritual care encounters.

Rank: 4

My orienting system relies on honoring each person, including their spiritual beliefs and unique needs. I ask permission to interact with them, listen reflectively, and treat them as I would like to be treated. I recently had a former patient and his family come to the chaplains office to thank me for my support during his hospital stay. They are from different sociocultural experience than I am, and I always hope I am communicating genuine concern and support despite these differences. He (and his wife) told me that the spirit I brought into the room each visit lifted them up and gave them support and encouragement and how grateful they are. That meant the world to me because it showed me I was meeting my goals as a chaplain.

Spiritual Formation and Integration Narrative:

Category B: Awareness of Self and Others

**Outcome 1: Self-Care**

• Indicator: Articulate how one's self-care practices, including trauma informed approaches, support wellbeing in spiritual care.

Rank: 3

I made it a personal goal to develop a health care regimen including time-management, healthy meal prep, and regular exercise to de-stress in a healthy way. I am implementing these disciplines, but it has been challenging. In a didactic I recently presented on self-reflection, I became aware of stressors I have in my life that make this challenging including a challenging seminary course load. As I am graduating next month, I am taking time to prioritize self-care into daily time slots before they get taken up by new obligations as I move forward. My focus on this was stimulated when I felt a sting of rejection by a hospital staff member and I had to remove myself as I felt a lump in my throat and tears welling up in my eyes. After taking time to reflect, I became aware of how tired I was from lack of sleep and the root of the feeling of rejection for which I need to seek counseling. I realize that it’s imperative for me take care of my physical needs at age 54 to be healthy and effective chaplain. In addition, since this profession is especially heavy on trauma exposure, I must have someone to work through my own reactions and emotional load.

**Outcome 2: Justice-seeking awareness of biases**

• Indicator: Articulate an understanding of one’s implicit bias and systemic bias when providing spiritual care.

Rank: 4

An implicit bias I had to confront was that the Hispanic patients at the hospital are Catholic. This was introduced to me as the norm when I started my first CPE unit at the hospital. It is, in fact, common for Hispanic patients to be Catholic. However, there are certainly exceptions to this. I have also come to realize that they are generally warmly open to my spiritual care. I was tending to call in a priest when a Catholic was requesting prayer. While I still often reach out to a Catholic priest that considers the hospital a part of his parish for sacraments and things I am not ordained to offer, they are warmly welcoming to me to pray with them and support them during their stay. It has made me understand that our spirituality is not separated by theological boundaries, only some of our customs. The priest that I call upon does speak Spanish, so I do have him visit when I have difficulty verbally communicating with the patient and family.

A systematic bias that I work to mend is with the patients with Sickle Cell Anemia. These patients are often seen as drug seeking and their pain and experience is  often minimized at the hospital. I have built a relationship with S.S. patients who come regularly and check in on them when I see them on the Spiritual Care Census. I give them time and listen well to the unique circumstances or pain that has brought them to the hospital each time. It seems to make the feel validated and heard. I also advocate for them when they seem to be in need of more than they are receiving during their care. This does not mean more pain medicine. This means time, attention, and care that they need or feel that is being disregarded.

**Outcome 3: Intercultural and Interreligious Humility**

* **Indicator:** Demonstrate respect for the orienting systems of others arising out of a sense of common humanity.

Rank: 4

As an interfaith chaplain, I encounter patients who reject my services as they have had religious trauma, or simply want privacy. When I visit patients in preop, there is a variety of acceptance of spiritual care. Some are eager for me to come in and pray with them and help them tolerate the anxiety that comes with having surgery. I never walk in and ask if they want prayer. I introduce myself as Wendy, a chaplain, and tell them I am checking to see how they are doing. I very rarely have someone not want to talk to me at all. Most invite me in and tell me about their circumstances and how they feel about them. I ask them if there is anything I can do to support them. Some ask for prayer, some want to talk more, and others just say, “No, I’m good.” I find that walking in with curiosity of what they may find supportive according to their orienting systems, cultures, and religions makes for a positive interaction with the majority of patients. Many are waiting in preop for lengthy amounts of time and they are happy to have someone come in and listen to  them.

Category C: Relational Dynamics

**Outcome 1: Empathy**

• Indicator: Articulate how one uses empathy when providing spiritual care.

Rank:4

One uses empathy by focusing completely on the patient’s care and concerns, listening well and validating their experience, and connecting with them on a human level what they are experiencing. One way that I frequently use empathy is relating as a mother to parents with their children in the NICU. No matter what background, religion, or culture they are coming from, a child is like a parent’s heart outside of their body. My children are grown, but I am able to connect with these parents effectively and regularly. Most of the nurses are young in this unit. They are among the best in the hospital, but many of them are quite a bit younger than me. I have the time and the empathy to go sit with the parents and listen to their story and their concerns. While  I rarely share an actual story from my parenting, I am able to relay that I empathize with the way our children pull on our heart strings. As an older parent, I am able to assure them that they will get through this and how children are able to overcome adversity and illness given proper treatment and support.

**Outcome 2: Relational Boundaries**

• Indicator: Articulate an understanding of healthy relational boundaries in spiritual care contexts.

Rank:3

 In spiritual care contexts, relational boundaries protect the patient, families, and me. I have found it to be important that I contextualize my spiritual care as being for a limited time and space. My heart goes out to patients and families when they are going through a trauma or a long term illness. I am tempted to tell each of them to stay in touch. However, I see as many as twenty-five patients a day, and staying in touch with them would be impossible. It would be a strain on my privacy, family, and self-care. I also believe it is healthier for them to learn of resources i.e. support groups, counseling, and religious organizations that can give them long term support after they leave the hospital. While I wish I could hear updates on how they are doing, I am convinced that my spiritual care is to be focused on the short term of patients and families while they are in the hospital setting.

**Outcome 3: Group Dynamics**

• Indicator: Identify group dynamics theories as they relate to providing spiritual care and one’s learning process.

Rank: 3

In the Lencioni model of group dynamics, the traits necessary for effective teams/groups include trust, conflict, commitment, accountability, and results. As a chaplain at a large hospital, I am a part of a group based on location of where my office is, and  a part of groups throughout the hospital, separated by floors and units. I am also a part of the patients’ individual care team and support, and a part of the spiritual care team at the hospital. For each one, I build trust with the other members, letting them know I choose to be a part of their group and desire to support them. In conflict, I am able to be a liaison and help members understand others’ points of view. I show them I am committed to them and they keep me accountable by noticing when I am present and asking about me if I have not been. The result is that we work together. They bring skills that I do not have, and I bring my own unique skill set. The patient is well taken care of and the individual members of the groups are supported. As this outcome states, groups are a part of one’s learning process. I have learned so much from other members such as spiritual care techniques from other chaplains and appropriate interaction with patients and staff from the other groups on campus.

Relational Dynamics Narrative:

Category D: Spiritual Care Interventions

**Outcome 1: Develop Spiritual Care Relationships**

• Indicator: Articulate an understanding of power dynamics and one's authority when providing spiritual care.

Rank: 3

In a hospital, there are built in power dynamics. I have a supervisor who checks in on how I am doing and confronts me if there is a concern. He also has the power to advocate for services or resources for providing for spiritual care. Another power dynamic is the ranking of the health care providers. The doctors are seen as the top of the totem pole and the janitorial service is seen as the bottom. I show respect for the doctors when I am in the trauma unit, staying out of their way as their care for the patient is the most critical at the moment. I support them and my presence lets them know I am available if any support is needed such as talking to a family or giving spiritual care to a patient in some circumstances. I also respect the nurses and other health care personnel, always waiting outside of a room if they are tending to a patient. Lastly, I leave the power of the choice of care to the patient, always asking permission to enter a room, and respectfully provide the care that they indicate would be beneficial. I never use a sense of spiritual authority when addressing patients. (as though I know what they need.)

• Indicator: Articulate how one's communication styles and skills, including trauma informed approaches, develop spiritual care relationships.

Rank: 4

My communication styles and skills include good reflective listening, awareness of non-verbal cues of my own and of the patient/family/staff, practicing empathy, and clarifying needs. With these skills, I am able to hear what the patient is going through and what kind of support I can provide for them. Listening and providing empathy is something that is needed in the hospital setting, as many staff come in and out of the room, but not many see them as a whole person who may need to process what they are experiencing. When I am listening , I am also looking for the non-verbal such as tone of voice and facial expressions. I can communicate empathy with my own facial expressions and gestures while listening well and letting them know I am  “tracking.”

A chaplain/patient spiritual care relationship is not a friendship or an authority figure interacting with the vulnerable. It is a supportive connection with a valued human being that is focused not on the care-giver, but the care receiver. In the case of trauma, it is providing a safe, trustworthy support, listening to and working with the patient to help them to process, cope, and plan during their hospitalization.

**Outcome 2: Use of Cultural, Religious and Spiritual Resources**

• Indicator: Articulate how one uses spiritual resources when providing spiritual care.

Rank: 4

One uses a variety of spiritual resources when providing Spiritual care. Sometimes the patient is wanting someone to pray with them and their family. Sometimes providing a quiet ethos where they can meditate, breathe, reflect is most beneficial. There are times to call in resources such as minister from their religion or faith, and times to arrive and stay amongst the grieving with a compassionate presence. Some patients request Bibles, and some would like for you to read to them. There is an interfaith chapel that is maintained in the hospital providing prayer rugs, rosary beads, Bibles, and a quiet, low lit, private space for them to use in whatever way is beneficial. Resources can be provided for extended spiritual care beyond the hospital stay. I have found that time and a listening ear is the most useful resource I have used.

**Outcome 3: Use of Spiritual Assessments and Care Plans**

• Indicator: Articulate how one uses spiritual assessments when one provides spiritual care.

Rank: 4

One of my competence goals for this unit was to become more proficient at spiritual assessments. I learned that a spiritual assessment is not asking about someone’s religious background or tradition. Studying the Spiritual Aim Model, an assessment involves listening for the primary unmet spiritual need including (1) Meaning and Direction (2) Self-Worth and belonging to community, or (3) Reconciliation/ to love and be loved. This is done using indicators such as where one places blame and how they express their concerns and situation. When this primary need is assessed, the spiritual care provider can guidance, value, or be a truth-teller. It is important to point them resources upon hospital release such as a support group or therapy for long term support. The Spiritual Aim Model is only one Spiritual Assessment Tool, and I plan to expand into others as a future goal.

**Outcome 4: Documentation**

• Indicator: Articulate how one uses documentation when providing spiritual care, as appropriate to one's context.

Rank: 3

One can use various tools for documentation when providing spiritual care. While at Ochsner, I document patient encounters using the Spiritual Care Flow Sheet in Epic which records the context, who was visited and for how long, what spiritual needs were addressed and how they were provided for, whether or not to visit them again, etc. If one would want to do a more individualized narrative of the encounter, the SOAP method is one that I would use. It includes the **s**ubjective matter (the patient’s self-report), the **o**bjective (the observations and results from test results), the **a**ssessment (opinion/summary) and the **p**lan moving forward.

Spiritual Care Interventions Narrative:

Category E: Professional Development

**Outcome 1: Clinical Method of Learning**

• Indicator: Articulate how the clinical method of learning shapes one’s provision of spiritual care.

Rank: 4

The clinical method of learning is indispensable in spiritual care. The provider learns from the patient while in the environment where the patient is experiencing spiritual care need. Every patient is different, so learning how different people react and manage pain or stress is invaluable. Spending time with them on site allows the caregiver to understand what goes well and what does not go well. They learn from the patient what the individual need is. The caregiver also becomes aware of their own triggers and counter transference and learns to manage them. This cannot be taught by a text book. In addition, the relationship built with the patient is what helps the caregiver learn to connect and grow. They become a part of the patient’s experience at the hospital. There are also different populations and environments of hospitals, and a spiritual care giver must learn to assess the needs and unique approaches that work best for the population they are serving. This provides education through trial and error, making mistakes, and being humble enough to ask what the patient needs from them.

The clinical method has helped me to learn skills not taught in the classroom. For instance, I have learned to use an electronic medical record, have learned the flow of the ER, the pre-op area, and visitation hours for families. While some CPE students may be planning to work in environments outside of the hospital, this setting allows you to work with an endless line of clients that are ever changing, and how to navigate caring for patients while being aware of your environment.

**Outcome 2: Ethical Practice and Professionalism**

• Indicator: Demonstrate ability to recognize ethical issues in one's context and seek consultation.

Rank: 4

Some ethical issues that I may encounter at the hospital include a patient being neglected, a family in conflict over end of life decisions, a patient with a medical request because of religious convictions, privacy issues, avoiding proselytization, claims of malpractice, child neglect/abuse, sexual harassment, and inappropriate relationships with the patient. and  I would seek consultation for these issues with other chaplains, the hospital ethics manual and ethics board, floor nurses, physicians, the hospital human resources department,  a hospital social worker, child protection services, and if necessary, a lawyer.

• Indicator: Demonstrate knowledge of and adherence to attributes of personal and organizational responsibility and professional boundaries in the practice of spiritual care and the learning process.

Rank: 4

I have personal and organizational responsibility and professional boundaries in the practice of Spiritual care and the CPE learning process. As a volunteer, I have a time sheet, and an ID that allows me into most areas of the hospital. I carry a pager and notify the switch board when I am on campus. I received training from Ochsner on ethical behavior and guidance on interacting professionally with staff and patients. I receive the mandated vaccines to comply hospital standards. I do not enter a room marked with contamination precautions without a mask, gloves, and gown. In particularly as a chaplain, I adhere to the no proselytization policy. I protect patient’s privacy and personal information. I am careful to have appropriate boundaries in relationships with patients.

**Outcome 3: Consultation and Feedback**

• Indicator: Initiate consultation when faced with challenges in the spiritual care context.

Rank: 3

I ranked myself a three on this because I do consult others when challenges arise, but I am also generally a person that likes to work independently and not burden others, so I could probably practice this more. I have reached out to my CPE Supervisors on campus and by phone/text/email/zoom with Colette Gaffney. For instance, I will schedule a call with Colette when I need advice on my education process, or if I am struggling with a difficult situation personally. I will reach out to my supervisor on campus if there is an issue that needs to be addressed such as a minister from a certain denomination that was overstepping his bounds by evangelizing. I also initiate consultation regularly during our CPE hybrid class using verbatims or bringing up a situation and getting feedback from my peers.

• Indicator: Engage and integrate feedback in one's learning process and when providing spiritual care.

Rank: 4

I have worked on engaging feedback more with my peer chaplains this unit. For the first unit, I listened a lot and just wanted to learn from others. In this unit, I have tried to put myself out there more and share insights that I have when they are sharing. Sometimes it is uncomfortable, and I find myself scaling back when I think I am overstepping my bounds. I do think it’s important to develop skills as a chaplain and then learn to help new chaplains along the way.

As far as integrating feedback, I take the feedback I learn in class seriously. I process it over a few days and most always, realize that implementing the ideas would grow me and help me be a better chaplain. I also learn from feedback from staff and patients at the hospital. I have been admonished a couple of times by staff who were rather critical or generally unfriendly. Those are painful, but it helps me to take that in, process it, improve in that area, and learn to move on. Other feedback from staff is most often positive and encouraging and that is always uplifting. The feedback from patients such as, “I’m really glad you came by” make my heart swell.