Merseyside and Cheshire Spiritual Care Audit

March 2011
Audit Group

- Dr Karen Groves
- Dr Andrea Whitfield
- Angelique Van der Woude
- Anne Black
- Cath Baldry
- Audrey Jones

- Graham Ellams
- Dr Carolyn Watt
- Dr Emma Taylor
- Dawn Valentine-Gray
- Dr Kathryn Gaunt
- Philip Saltmarsh
- Lucy Hughes
External Reviewer

- Professor Douglas Davies
  - Centre for Death and Life Studies
  - University of Durham

Dr Karen Groves
Guidelines

• Spiritual needs should be included as part of the initial holistic assessment and ongoing care for every patient who has contact with a palliative care professional.¹ [Level 4]

• Spiritual care should provide support to make sense of difficult life events. This may be achieved through exploration of spiritual and existential issues, fostering of realistic hope and the promotion of well being.¹ [Level 4]

• All palliative care professionals should be aware of spiritual issues for patients and families and be able and feel confident to respond in a flexible, non-imposing and non-judgmental manner. This will include support in living with unanswered questions without necessarily requiring an onward referral.¹ [Level 4]
• Palliative care professionals should be able to facilitate access to different forms of spiritual support, religious or otherwise, sought by patients and families and have a current awareness of local community resources in their area. \(^1\) [Level 4]

• Recognising the spiritual needs of staff, palliative care services should facilitate the support and education of their own staff members in the work they do in this area. Palliative care services should encourage the process of spiritual caring which requires constant reflection, assessment and review. \(^1\) [Level 4]
Standards

- Every patient record should demonstrate documentation of an initial spiritual care assessment. ¹ [Grade D]
- Every patient record should demonstrate a record of the patient’s faith tradition (religious affiliation or belief system) or its absence. There should also be a record of the significance for the patient. ¹ [Grade D]
- Every patient record should demonstrate evidence of ongoing spiritual assessment and care. ¹ [Grade D]
- All palliative care staff should be able to demonstrate attendance at training in spiritual awareness at least on induction and/or as part of their continuing professional development. ¹ [Grade D]
Standards

• All palliative care staff should be able to demonstrate that they undertake assessment of spiritual needs.¹ [Grade D]
• All palliative care staff should be able to demonstrate that they provide or arrange provision of ongoing spiritual care.¹ [Grade D]
• All palliative care staff should have access to a current directory of local community spiritual care resources (religious and other).¹ [Grade D]
• Each integrated clinical network should have a nominated person to be responsible for liaising with local faith leaders and other spiritual resources.¹ [Grade D]
Each integrated clinical network should have inpatient and day facilities with dedicated and accessible multifaith quiet space and equipment. ¹ [Grade D]
Each integrated clinical network should have palliative care services whose policies and procedures reflect recognition of the spiritual needs, support and education of their own staff members. ¹ [Grade D]
There should be an agreed network spiritual care policy. ² [Grade D]
References


Literature Review

Emma Taylor
Angelique Van der Woude
Philip Saltmarsh
‘Where the spirit does not work with the hand there is no art.’

Leonardo Da Vinci
‘One’s own self is well hidden from one’s own self: of all mines of treasure one’s own is the last to be dug up.’

Friedrich Nietzsche
‘One does not become enlightened by imagining figures of light, but by making the darkness conscious.’

Carl Jung
‘Even in the situation where you have no freedom at all, any human being, up to the last breath retains the freedom to choose the attitude towards this tragic situation’

Viktor Frankl
7.11 Patients and their carers should have access to different forms of spiritual support, appropriate to their needs
7.12 Patients and their carers should have opportunities for their spiritual needs to be assessed
7.13 Spiritual care should be an integral part of health and social care
7.14 Multidisciplinary teams should have access to suitably qualified authorised and appointed spiritual care givers
7.21 Spiritual care should be seen as the responsibility of the whole team
7.22 Providers within in-patient or day therapy should ensure the availability of a ‘quiet space’ equipped with religious equipment appropriate to the needs of the faith groups likely to use it
7.24 It is essential that health and social care staff have the necessary skills, knowledge and support to provide sensitive care.
Literature Review

- Medline/Cochrane/Cinahl databases
- 2006-2011
- Search terms: ‘spirituality’ (title), ‘palliative’, ‘end of life’ (keywords)
- 41 articles
- Key themes elucidated
  - Definitions/concepts
  - Assessment
  - Education
  - Provision
  - Barriers to provision
Recognition of Spirituality

- 87% of patients believe spirituality to be important in their lives\textsuperscript{6}
- 73% of patients with terminal disease report illness has strengthened their spiritual lives\textsuperscript{7}
- 47% of patients report unmet spiritual needs by religious community\textsuperscript{10}
- 72% by the medical system\textsuperscript{10}
**Improved quality of life and death**

- Spiritual support significantly associated with increased quality of life ($p = 0.0003$)\(^\text{10}\)
- Near-death quality of life increases by 28% for those receiving pastoral care or spiritual support\(^\text{10}\)
- Spirituality is a predictor of peacefulness at the end of life ($r^2 = 0.279$)\(^\text{7}\)
- Significant correlations between spirituality and serenity ($r = 0.573$), peacefulness ($r = 0.556$), comfort ($r = 0.399$) and cognitive coping ($r = 0.333$)\(^\text{7}\)
- Lower level of ‘hopelessness’\(^\text{5}\)
Definitions/concepts

• Latin: Spiritus=breath
• Chinese: Spirit equivalent to Chi
• Spirituality Vs Religions

• Vachon et al\textsuperscript{7} - 11 themes
  – Meaning and purpose
  – Self transcendence
  – Transcendence with higher being
  – Mutuality and feeling of communion
  – Faith and beliefs
  – Hope
  – Attitudes toward death
  – Appreciation of life
  – Reflection upon personal values
  – Developmental nature
  – Conscious nature
A singular definition?

‘a developmental and conscious process characterised by two movements of transcendence, either deep within the self or beyond the self’\textsuperscript{17}
Assessment tools

- SPIRITual history\textsuperscript{18}
- HOPE question\textsuperscript{19}
- Systems of Belief Inventory (SBI-15R)\textsuperscript{20}
- Functional assessment of chronic illness\textsuperscript{21}
- Brief measure of religious coping\textsuperscript{22}
- FICA\textsuperscript{23}

None validated or robustly evaluated
Predictors of spirituality

- Conflicting data
  - Female sex
  - Increasing age
  - Years of education

High spirituality associated with enrolment to hospice care\(^2\)
Education

7.24 It is essential that health and social care staff have the necessary skills, knowledge and support to provide sensitive care.

- No recommendations on the form training should take
- Medical school teaching variable
- Education has significant benefits in terms of confidence
- Exposure to spiritual situations leads to personal growth and enhances clinical practice
- Importance of practical experience
- Continuation of personal counselling after training
Education (2)

• Training should encompass emphasis on 3 main themes
  – Key skills
  – Key knowledge
  – Self and attitudes

• Reflective Practice\textsuperscript{30,31}

• More robust studies required
Provision and delivery of spiritual care

• Providers
  – Primarily the role of nurses
  – ‘Sensitive’ doctors
  – The entire MDT
  – Friends and family
  – Pastoral care

• Provision
  – Good communication
  – Non-imposition of own beliefs
  – Good understanding
  – Use of reflection
  – Environment- compassionate and loving
### Barriers to provision of spiritual care

- Discomfort
- Stress/guilt/inadequacy
- Institutional barriers
- Language/cultural/religious barriers
- Lack of education/training
- Time and timing
- Inaccurate documentation
‘What is required of spiritual care is a letting go of the need to control and an ability to be comfortable with mystery and the unknown. Caring for dying people forces one to face questions that have no answers, to help people make decisions for which there are no absolutes, and to open oneself up to sadness, grief, and loss when the patient, which one has been caring for and loving, dies. This is not an easy task and, in some ways, focusing on the physical is more comfortable and known territory.’ (Puchalski$^{38}$)
Facilitators

• Awareness/reflection of one’s own spirituality
• Vocation/calling
• Team support
• Satisfaction
• Buffer to emotional stress
• ‘Increased my enjoyment of dealing with people and dying because you don’t focus on the death so much as the meaning and purpose of life’

Conclusions

- Clear need for strengthening of evidence base with regard to spiritual care
- Lack of guidance on how to assess and deliver spiritual care
- No guidance on education and how it should be provided
- This must be addressed in order that the NICE guidance regarding spirituality may be met
Spiritual Care at the End of Life: a systematic review of the literature.
Margaret Holloway, Sue Adamson, Wilf McSherry, John Swinton.
(January 2011)

• 248 sources
• 5 themes
  – 1. Disciplinary and professional contexts
  – 2. Concepts and definitions
  – 3. Spiritual assessment
  – 4. Spiritual interventions
  – 5. Education and training
Recommendations

- Continuing work on conceptual work and conceptual clarity.
- Further work should be undertaken to translate and communicate the concepts underpinning contemporary understandings of spirituality into the practice of palliative care. To achieve greater conceptual clarity, they do not advocate a continuing search for a single definition,
- Further work to produce a simplified range of tools which practitioners might draw upon
- Strengthening of the evidence base for spiritual care.
- Evaluation of the use of models in practice
**Recommendations (2)**

- Use of competencies and standards
  - To identify gaps and complementary roles
  - To consider implications for delivery of religious and spiritual care
  - As tools to reflect on and improve current practice
  - To identify training needs
- Need for training and education in spiritual care to be incorporated into the teaching curricula for health care professionals.
- Further research to explore the role of spiritual support in end of life care with diverse ethnic and religious groups.
- make links across other DH programmes such as Dignity in care agenda
- To develop policy and practice in community settings to support people dying at home.
Spiritual Care Audit Results

Dr Kathryn Gaunt
Methods

- **Supra-regional Audit**
  - Results include Blackpool and Lancaster

- **Aim was to establish which of the current standards were being met.**
  - Telephone survey to determine spiritual care resources within each ICN
  - Web-based survey of HCPs to determine perceptions of practice
  - Case note audit to determine actual practice.

- **Some comparison will be made with the results of the 2006 audit**
Survey of Spiritual Care Resources

- Telephone Survey carried out in July 2010
- Spoke to SPC inpatient, hospital and community services within each ICN (included Blackpool and Lancaster)
- Spoke to Spiritual Care Co-ordinator or Director of Nursing/Matron for the service
Do You Have a Spiritual Care Policy?

- **Community**: 1 Yes, 8 No
- **Hospital**: 1 Yes, 8 No
- **SPC inpatient**: 4 Yes, 5 No
Does your Service Provide Access to Multifaith Quiet Space?

- Hospital: Yes, score 9
- SPC inpatient: Yes, score 9
Do You Have Access to a Current Directory of Local Community Spiritual Care Resources (Religious and Other)?

- Community: No - 1, Yes - 4
- Hospital: No - 1, Yes - 8
- SPC Inpatient: No - 9, Yes - 5
Do Your Staff Members Have Access to Training in Spiritual Care?

- Community: 3 No, 6 Yes
- Hospital: 2 No, 7 Yes
- SPC inpatient: 3 No, 6 Yes
Do you have Access to Suitably Qualified, Authorised and Appointed Spiritual Care Givers?

- Community: 5 (4 in brackets)
- Hospital: 9 (8)
- SPC inpatient: 9 (8)

Number in brackets is the number of care-givers employed rather than voluntary.
2006 Audit

Do you have Access to Suitably Qualified, Authorised and Appointed Spiritual Care Givers?

Number in brackets is the number of care-givers employed rather than voluntary.
Do your Staff have Access to Services to Support their own Spiritual Needs?

- Community: 2 Yes, 7 No
- Hospital: 9 Yes
- SPC inpatient: 9 Yes
Who is your nominated person to be responsible for liaising with local faith leaders/other spiritual resources?

- Email to ICN leads
- 5/9 responses
- 4/5 had a nominated person and knew who they were.
Survey of Health Care Professionals

- Web-based survey – ‘Surveymonkey’
- 192 Responses
  - Attrition throughout the survey
  - 138 completed
In which palliative care setting do you work?

- Hospital specialist palliative care: 18.8% (36)
- Community specialist palliative care: 10.4% (20)
- Hospice/specialist palliative care unit: 62.0% (119)
- Integrated service: 4.7% (9)
- Other (please specify): 4.2% (8)
# What is your understanding of spiritual support/care?

- 142 responses
- Individual to the patient
- About addressing patients’ feelings, concerns, fears, beliefs
- Understanding patients’ perceptions about the meaning of life
- Not just about religion
- Non-judgemental
- Spirituality is what gives life meaning
“Everybody has a soul with a varying degree of ability to ‘be in contact’ with it. The contact is likely to be stronger at times of crisis or when end of life looms. Spiritual care is the support of this process in whatever way is directed by the individual patient”
How often do you assess spiritual/religious needs?

- **Spiritual**
  - Always: 54.9% (78)
  - Sometimes: 31.0% (44)
  - Occasionally: 1.4% (2)
  - Only if led by patient: 9.2% (13)
  - Never: 3.5% (5)

- **Religious**
  - Always: 43.0% (61)
  - Sometimes: 37.3% (53)
  - Occasionally: 6.3% (9)
  - Only if led by patient: 11.3% (16)
  - Never: 2.1% (3)
Do you Assess Spiritual/Religious needs? (2006 audit)

**Spiritual**
- Yes: 85%
- No: 12%
- Sometimes: 1%
- Not known: 2%

**Religious**
- Yes: 75%
- Not known: 9%
- Sometimes: 3%
- No: 13%
When in the assessment process do you usually discuss spiritual/religious needs?

- **Spiritual needs**
  - Initial assessment: 54.2% (77)
  - Subsequent assessment: 16.9% (24)
  - Ongoing assessment: 41.5% (59)
  - As led by patient: 34.5% (49)
  - Never: 2.8% (4)

- **Religious needs**
  - Initial assessment: 62.0% (88)
  - Subsequent assessment: 12.7% (18)
  - Ongoing assessment: 29.6% (42)
  - As led by patient: 33.8% (48)
  - Never: 2.8% (4)
How often do you record the patient’s religion?

- Always: 53.5% (76)
- Sometimes: 26.1% (37)
- Occasionally: 7.0% (10)
- Never: 3.5% (5)
- Other (please specify): 9.9% (14)

2006 Audit
- Yes: 72%
- No: 23%
- Sometimes: 3%
- Not known: 2%
Where do you record the following?  
(Choose as many as apply)

<table>
<thead>
<tr>
<th>Category</th>
<th>Orange</th>
<th>Blue</th>
<th>Purple</th>
<th>Green</th>
<th>Brown</th>
<th>Blue</th>
</tr>
</thead>
<tbody>
<tr>
<td>spiritual needs</td>
<td>7.0%</td>
<td>31.7%</td>
<td>45.1%</td>
<td>19.7%</td>
<td>38.7%</td>
<td>5.6%</td>
</tr>
<tr>
<td></td>
<td>(10)</td>
<td>(45)</td>
<td>(64)</td>
<td>(28)</td>
<td>(55)</td>
<td>(8)</td>
</tr>
</tbody>
</table>

- assessment proforma
- medical notes
- nursing notes
- specific tool
- advance care plan
- liverpool care pathway
- nowhere
Do you use a specific spiritual/religious assessment tool?

- **No**: 92% (128 respondents)
- **Yes**: 9.9% (14 respondents)
- **Response 4%**: 4%
If spiritual or religious needs are identified, how often do you arrange or provide ongoing spiritual / religious support?

- **Spiritual care**
  - Always: 53.9% (76)
  - Sometimes: 16.3% (23)
  - Occasionally: 1.4% (2)
  - At patient request: 25.5% (36)
  - Never: 2.8% (4)

- **Religious care**
  - Always: 49.6% (70)
  - Sometimes: 14.2% (20)
  - Occasionally: 2.1% (3)
  - At patient request: 28.4% (40)
  - Never: 5.7% (8)
Have you participated in any training specific to spiritual assessment and/or support? (choose all that apply)

- None: 47.8% (66)
- E-ELCA (national e-learning for end of life care): 3.6% (5)
- 'Opening the Spiritual Gate': 23.2% (32)
- Theology course or similar: 5.1% (7)
- Other (please specify): 29.7% (41)
Confidence Scales

- Assessment of spiritual needs (0-10)

Mean = 6.4
(2006 Mean = 4.7)
Confidence Scales

• Assessment of religious needs (0-10)

0
Least Confident

Mean = 6.7
(2006 Mean = 5.3)

10
Most Confident
Confidence Scales

• Referring on for spiritual support (0-10)

Mean = 7.3
Confidence Scales

- Referring on for religious support (0-10)

Mean = 7.8
Confidence Scales

- Providing spiritual support ourselves (0-10)

Mean = 6.4
(2006 Mean = 4.5)
**Confidence Scales**

- Providing religious support ourselves (0-10)

\[ \text{Mean} = 5.3 \]  
\[ (2006 \text{ Mean} = 4.8) \]

0  
Least Confident  

10  
Most Confident
Confidence Scales

- Perceived need for education in this area (0-10)

Mean = 4.4
(2006 Mean = 3.4)
Assessment of Spiritual Needs

Training

Mean = 8.6

No Training

Mean = 5.6
Providing Spiritual Support Ourselves

Training

No Training

Mean = 8.6

Mean = 5.7
Case Note Audit

- 120 sets of specialist palliative patient records
  - 40 SPC Inpatient records
  - 40 Hospital SPC records
  - 30 Community SPC records
  - 10 SPC Day Therapy records
Religious Affiliation Recorded?

2006

No 9% 

Yes 91%

2010

No 22% (26) 

Yes 78% (94)
Spiritual Needs Recorded?

- **2010**
  - Yes 72% (87)
  - No 28% (33)

- **2006**
  - Yes 60%
  - No 40%
Spiritual Care Recorded

- No 43% (56)
- Yes 57% (68)
Religious Need Recorded

No 53% (64)  Yes 47% (56)
Religious Care Recorded

- Yes 27% (32)
- No 73% (88)
Results Summary

- Community Services under-resourced in provision compared to other settings.
- Confidence in assessment and provision has improved since 2006.
- Confidence appears to be greater in those that have undergone training.
- The poorest area of documentation is of religious need and ongoing religious care.
Proposed New Standards and Guidelines

Dr Andrea Whitfield
Guidelines

• Specialist palliative care services should encourage the process of spiritual caring, which requires constant reflection, assessment and review.¹ [Level 4]

• All specialist palliative care professionals should be aware of spiritual issues for patients and families and be able and feel confident to respond in a flexible, non-imposing and non-judgmental manner. This will include support in living with unanswered questions without necessarily requiring onward referral.¹ [Level 4]

• Accurate and timely evaluation of spiritual issues should be facilitated through a form of individual assessment, based on recognition that spiritual needs are likely to change with time and circumstances.¹ [Level 4]
Guidelines

• Assessment of spiritual needs does not have to be structured, nor require the use of an assessment tool, but would need to include care elements such as
  – Exploring how people make sense of what happens to them
  – Identifying sources of strength they can draw on
  – Exploring whether these are felt to be helpful to them at this point in their life.¹ [Level 4]

• Spiritual care should provide support to make sense of difficult life events. This may be achieved through exploration of spiritual and existential issues, fostering of realistic hope and promotion of wellbeing.¹ [Level 4]
Standards

• Every patient record should demonstrate documentation of an initial spiritual needs assessment.$^{1}$ [Grade D]

• Every patient record should demonstrate a record of the patient’s faith tradition (religious affiliation or belief system) or its absence.$^{1}$ [Grade D]

• Where there is a faith tradition, the significance to the patient should be recorded.$^{1}$ [Grade D]

• Every patient record should demonstrate evidence of ongoing spiritual assessment and support where indicated.$^{1}$ [Grade D]

• Where the patient has a documented faith tradition, the patient record should demonstrate evidence of ongoing religious assessment and support where indicated.$^{1}$ [Grade D]
Standards

• All specialist palliative care staff should be able to demonstrate evidence of training in spiritual awareness as part of their continued professional development.¹ [Grade D]

• All specialist palliative care services should have access to suitably qualified, authorised and appointed spiritual care givers.¹ [Grade D]

• All specialist palliative care services should have access to a current directory of local spiritual care resources (religious and other).¹ [Grade D]

• Each Integrated Clinical Network should have a nominated person to be responsible for liaising with local faith leaders and other spiritual resources.¹ [Grade D]
• Each Integrated Clinical Network should have specialist palliative care inpatient and day facilities with dedicated and accessible multifaith quiet space and equipment.¹ [Grade D]

• Each Integrated Clinical Network should have specialist palliative care services whose policies and procedures reflect recognition of the spiritual needs, support, and education of their own staff members.¹ [Grade D]

• There should be an agreed Network Spiritual Care Policy.² [Grade D]
References


Thank you for listening
We welcome your comments