



ADDRESSING THE SPIRITUAL NEEDS OF OLDER PEOPLE IN CARE HOMES

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ABSTRACT

The research question prompting this study is, 'what do care home staff members understand by the concept of spiritual care?'

In each of 5 care homes, 3 staff were interviewed which included the manager, a senior carer, and an activities co-ordinator. Koenig's 14 aspects of the spiritual needs of older people (1994) were used and staff members were asked to identify the aspects that they personally and professionally found most relevant. They were asked to rank the cards in order of importance according to their own experience, and to give examples of the cards they chose. Their rankings have been tabulated and scored to give an indication of the most frequently understood meanings of 'spiritual care'. The answers vary to some extent in terms of role, although some of Koenig's 14 aspects have not been chosen at all, and others are popular in all three of the roles explored. An attempt has been made to interpret these findings. While the sample size and the scope of the research makes it impossible to draw firm conclusions, there are nevertheless some surprising findings which would benefit from further exploration.

INTRODUCTION AND BACKGROUND

This short study was funded by a small grant from the Scottish Government, and carried out in November 2014 to March 2015.

The National Care Standards (currently under revision) specify that spiritual needs are to be identified and met, along with physical, social, emotional and cognitive needs. The current version of the care standards combines the concepts of 'spiritual' with 'religious' and 'cultural'. Faith in Older People (www.faithinolderpeople.org.uk) defines 'spiritual need' as 'that which gives life meaning', and we feel this is an essential element of care that may not always be present in some homes. If every resident could continue enjoying 'that which gives life meaning' to them, one might consider that their closing years would be satisfying to them and a source of comfort to their families.

However, 'spiritual care' may be a nebulous concept, and care staff are much more familiar with the language of values – e.g. respect, dignity, choice – and of equality and anti-oppressive practice. In the dementia field, the concept of personhood (Kitwood) has also been important and since a high proportion of care home residents have dementia in some form and at varying stages, it is to be hoped that many staff are familiar with this concept.

I believe the concepts of dignity, rights, anti-oppression and especially personhood overlap with 'that which gives life meaning', and therefore it isn't surprising if care staff don't recognise the shades of meaning. Perhaps more significant is the extent to which the concept of spiritual need adds to these other concepts. This is a challenge for organisations like Faith in Older People – can we define the added extra we are offering by insisting on the value of spiritual care?

To address the research question, we decided to carry out a small study, interviewing staff in six care homes. We used Koenig's model of 14 types of spiritual need present in older people, since this is based on a systematic review of studies of older people's spiritual needs. It incorporates both religious and wider spiritual values.

1. Need for support in dealing with loss
2. Need to transcend circumstances
3. Need to be forgiven and to forgive
4. Need to find meaning, purpose, and hope
5. Need to love and serve others
6. Need for unconditional love
7. Need to feel that God is on their side
8. Need to be thankful
9. Need to prepare for death and dying
10. Need for continuity
11. Need for validation and support of religious behaviours
12. Need to engage in religious behaviours
13. Need for personal dignity and sense of worthiness
14. Need to express anger and doubt

The choice of homes was influenced by our networks, and those we thought might be willing to give us time for this. Since our networks feature several faith groups' own homes, we were probably skewed towards homes that were organised on a faith basis.

Unfortunately, one home had to drop out for practical reasons so the final sample included three homes which were founded by religious interests, and two which were independent and secular. Of these, one was part of a large care home group and one was a stand-alone, family-run business. Not represented in this study is the local authority perspective.

Accordingly, data from 15 interviews were available for analysis.

All the homes in this study were either already scoring 5s and 6s in their inspection reports, or were on a steadily improving curve having made significant management changes in recent years.

In each home in the study, I interviewed the manager, a senior carer who is involved in the assessment of need at the time of an older person's admission to a care home, and an Activities Co-ordinator.

After a couple of general introductory questions about the interviewee's role in spiritual care assessment, we explored the 14 aspects of spiritual need identified by Harold Koenig. I made cards up with a different need named on each one, and spread them out on a table between us for the participant to scan and select. They were invited to choose one card and discuss it; then a second, then a third. Then I offered them a blank card and asked what they would write on it in terms of their own experience of trying to meet the spiritual care needs of residents. Then I invited them to rank the cards in order, in terms of the most-to-least important or relevant, in terms of their own experience. And finally, I offered the chance of 'any further comments?' Each interview lasted about 45 minutes.

I have devised a quasi-quantitative method of identifying themes by counting the number of times each card was selected as one of the interviewees' 'top three for discussion'. Also, by looking at the ranking of all 14 cards and ascribing top points for a first choice, descending to lowest points for a last choice, I have derived scores against each of the 14 cards.

Our expectation/hope was that this small study may identify some possible patterns of response which would justify a more thorough exploration.

FINDINGS

These are explored in the same order as the questions in the interview schedule (see appendix).

Sec 1a - PRIORITIES AT TIME OF ADMISSION: All homes carry out a needs assessment when a new resident is admitted, and this assessment varies in shape and style from one home to the next. However, the aspects are derived from National Standards and all should cover spiritual need alongside other types of need.

For Managers, the emphasis was on pre-admission assessments and the gathering of information. Two mentioned finding out about religious practices. One had devised her own form which looked at 'maintaining personhood and relationships'.

Senior Carers were much more likely to mention religious preferences as significant at this stage. For two Senior Carers, religion was the only or main issue covered. Two out of five talked about the importance of getting a good life history. One talked about identity – 'keeping her who she is'. Two talked about finding out the resident's interests. Accordingly, at this early stage, it seems that Senior Carers are more likely to equate 'spiritual' needs with religious practices; but there is also evidence of a wider interpretation.

Activity Co-ordinators generally had less of a role at this stage – two out of five said they had no role at all, and one said 'sometimes'.

Sec 1b - PRACTICES AS TIME PASSES

Managers (M): Care plans and their upkeep are mentioned by only one manager. Enabling continuity of religious preferences is mentioned by three out of five – and these are the three homes which were founded by faith groups. All five managers made reference to enabling enjoyment, connections with past life, identifying activities that were meaningful to residents in their earlier years – this would accord with our understanding of spiritual need as 'that which gives life meaning'. The managers of the two secular homes mentioned the role of family in this respect.

Senior Carers (SN): Two of the five Senior Carers answered this question in specifically religious terms, and a third answered mainly in religious terms. The other two talked about getting to know the person and 'what made them tick'. One talked about activities rather than care roles. Indeed, none of them spoke about the intimate time spent with residents in

a care role and the opportunities that might afford to get to know them better. It seemed that for these five Senior Carers, spirituality meant either religious practice, or activities – as opposed to a more reflective approach, having conversations during the quiet one-to-one times like bath time or preparing for bed.

Activity Co-ordinators (AC): Everyone in this group talked about being very busy, under a lot of pressure, having to take on sole or main responsibility for many things because in three cases, they worked alone without a peer group (one home had two ACs, job-sharing one post and in the final home there was a team of four). There was notable increased confidence in role in the home that had a team of four – though all five came over as committed, proactive, creative and skilled in both teamwork, and in facilitating engagement with residents.

All the ACs talked about trying to find activities that were meaningful to individuals – proactively seeking information about the things that were important to each individual. A wide range of activities was provided, but there was no sense of ‘one size fits all’ – each AC knew her residents and tried to ensure the right kinds of activities were provided for their needs. One home specifically mentioned physical activities – exercise every morning, and music and movement – as being beneficial.

Staying connected with the outside world was a recurring theme, and one AC specifically mentioned ‘avoiding institutionalisation’. The value of festivals was important in orienting residents to time of year, and continuing traditions that would have been important to them throughout life. Reminiscence approaches were both formal and informal and in one of the faith-based homes reflected cultural issues – remembering earlier times in this country and surviving hard times. There was also 1:1 life story work. One AC mentioned keeping in touch with the events of the day, e.g. having discussions about the Scottish referendum. Most mentioned singing, and how the residents loved this. One AC talked about residents feeling uplifted – that for her was an indication of spiritual needs being met. She used a ball game to enable them to name emotions – and recognised that friendships were formed between residents, and that this was mood-enhancing.

None of the respondents, in any role, mentioned personal prayer life or devotions or meditation.

2: Cards chosen for discussion:

Interviewee/role	Choice 1	Choice 2	Choice 3
B1 AC	13	4	2
B2 manager	6	3/5	2
B3 sen nurse	9	1	4
E1 manager	8	13	6
E2 head of care	6	2	4
E3 AC	13	2	4
NB1 manager	13	9	10

NB2 sen supp worker	1	8	10
NB3 AC	10	9	12
BH1 manager	13	10	9
BH2 activities co-ord	5	13	2
BH3 sen carer	11	9	7
O1 manager	13	7	10
O2 sen carer	10	9	8
O3 activities co-ord	4	1	2

It is difficult to know whether the specific order in which these cards were chosen is significant – however given that interviewees were given 3 opportunities to choose cards which they felt were meaningful to them, in their role, it is likely that those cards selected for discussion were much more significant than those not chosen.

Across the whole group of interviewees there were some popular cards:

- 7/15 chose card 13 – personal dignity and a sense of worthiness
- 6/15 chose card 2 – rising above circumstances (and several them applied this to themselves rather than the residents – acknowledging the difficulties and challenges of the job)
- 5/15 chose card 10 – continuity (some discussed this in the context of the care home itself, ensuring predictable and reliable routines etc.; some discussed it in terms of the transition between their own home and the care home. This latter was less readily recognised than I expected however in discussion it became clear that in most cases, residents had spent time in hospital before coming into the home).
- 5/15 chose card 9 – preparing for death and dying (whereas in the later prioritising exercise, this card was chosen the least of all)
- 5/15 chose card 4 – to find meaning, purpose and hope

Grouping interviewees by role, different priorities emerge:

- Card 13 – personal dignity and a sense of worthiness – was chosen by 7/10 managers (M) and activity co-ordinators (AC), but not at all by senior carers (SC).
- Card 10 – continuity – was chosen by 5/10 M and SC, but by only 1 AC
- Card 4 - to find meaning, purpose and hope – was chosen by 5/10 AC and SC, but not at all by M
- Card 9 - preparing for death and dying – was chosen by 5/10 M and SC but only once by AC
- Only M were concerned about card 6 (2/5) – unconditional love
- The main interest in card 2 – rising above circumstances – was with AC (4/5) – and again, in some cases this was a reflection on their own need as ACs to rise above circumstances in order to do their job.

While remembering that this is a small sample, this would indicate the concerns of the different roles of care home staff as follows:

Managers	Senior Carers	Activity Co-ordinators
Personal dignity and a sense of worthiness Continuity Preparing for death and dying Unconditional love	Continuity To find meaning, purpose and hope Preparing for death and dying	Personal dignity and a sense of worthiness To find meaning, purpose and hope Rising above circumstances

Differentiating between 'religion' and 'spirituality':

- Only 3 of the 15 interviewees chose cards which are overtly religious (7, 11 and 12)
- 2/15 chose card 7 – feeling that God is on their side – and one (M) applied this to herself

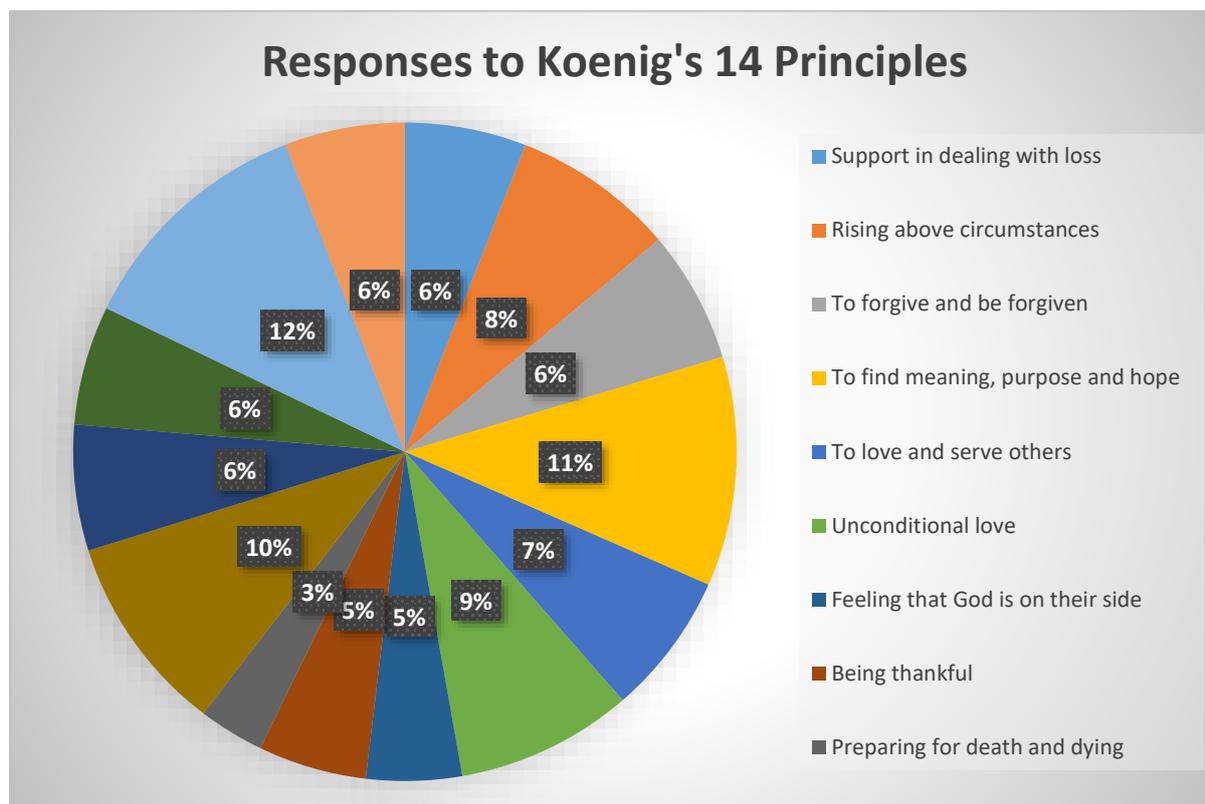
Cards not chosen at all for discussion:

- Card 3 – to forgive and be forgiven
- Card 14 – expression of anger and doubt

Sec 3 Order of priority of all cards, ascribing 14 points to first choice, 12 to 2nd etc all the way down to 1 point for 14th choice

	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	9 th	10 th	11 th	12 th	13 th	14 th
B1	13	4	2	6	5	8	14	1	10	11	12	7	3	9
B2	5	6	13	10	3	4	2	8	11	7	12	14	9	1
B3	10	4	2	12	13	8	6	7	14	3	1	5	11	9
E1	6	4	13	5	10	7	11	12	2	8	3	14	9	1
E2	4	6	8	3	13	1	2	10	11	12	9	7	5	14
E3	6	13	10	4	2	5	14	3	1	9	7	12	8	11
NB1	2	13	10	4	14	12	9	11	1	8	7	3	5	6
NB2	13	10	2	1	12	4	3	11	7	6	5	14	8	9
NB3	4	10	1	13	6	5	11	12	7	9	3	14	2	8
BH1	13	4	6	10	8	3	7	5	2	14	9	1	11	12
BH2	5	13	2	3	8	6	11	12	14	1	9	4	7	10
BH3	13	4	10	11	5	14	3	12	9	1	6	2	7	8
O1	10	13	14	1	6	11	4	12	2	7	9	3	8	5
O2	10	13	14	3	4	2	7	12	11	5	6	9	1	8
O3	13	4	11	1	5	6	8	3	2	10	14	12	7	9
Position points	14	13	12	11	10	9	8	7	6	5	4	3	2	1

This results in the following scores:



The bottom ranking of Card 9 'Preparing for death and dying' is one of the most surprising results here. At the early stage of the interviews, when interviewees were being asked to identify the first three cards which made immediate sense to them, Card 9 was chosen by a third interviewees and yet by the end of the interview, this aspect of spiritual care has dropped to bottom place. This requires further examination, given that all staff members in care homes live with the daily inevitability that the people they are working with/for will die in the relatively near future.

In one of the early interviews, a manager told me about a resident who was depressed about having come to the care home and had said, 'I'm just here to die'. The member of staff had said to them, 'Not at all! You have come here to *live*.' Maybe there is a parallel here with the medical profession, where doctors want to save lives and see death, or giving in to the inevitability of death, as a failure. There is no escaping it – but maybe staff members try to.

It must be challenging for care workers, especially those who are in their first year or two of care work, to have the people they care for die, on a regular basis and as a matter of course. Possibly more so for carers who are themselves quite young and may have little personal experience of loss and grief. How are they to cope with this? One possibility is that they adopt the defensive practices identified in 1975 by Isabel Menzies Lyth, withdrawing from emotional relationships with their residents so as not to be too hurt by the inevitability of death. In Menzies Lyth's original paper, this way of coping with anxiety was associated with

depersonalisation of patients. In the care home environment, with death around the corner for all the residents, it is surely essential that staff members are able/enabled to enter supportive relationships with them which do not balk at the coming separation through death. But it's a tall order.

Hockley (2014) points out that the care home sector is much bigger than the NHS, resulting in 20% of UK deaths now occurring in care homes, compared with 5% in hospices. In many cases, dying residents are transferred to hospital to die and palliative care practices vary considerably in care homes. This may mean that the actual death experience is not shared by other residents or staff. Improvement in palliative care practices is currently, and correctly, a focus of the Care Inspectorate and the needs of staff in dealing with this must be recognised.

Similarly, card no 1 (support in dealing with loss) is lower than I would have expected, given that many interviewees mentioned losses sustained in the homes by various residents.

Sometimes in the interviews, staff would veer away from the residents' spiritual needs, and identify the card they had chosen as relating to themselves. This supports conclusions made in a previous study (Welsh, Whittick and Mowat, 2006) that unless staff are aware of their own spiritual needs, they will be unable to identify and meet those of their residents.

The ranking of cards 12 and 14 (engagement in/validation and support of religious behaviours, both below the middle line) is surprising, given that in many of the interviews, a lot was said about making sure that those with religious affiliations were enabled to participate in worship.

The top ranking of card 13 – personal dignity and a sense of worthiness – supports my starting point, that care staff members equate spiritual need with the language of dignity, respect and choice.

The second ranking of card 4, finding meaning, purpose and hope, is reassuring in that my organisation's definition of spiritual need (that which gives life meaning) appears to be validated by this small sample of care home staff.

4 Nominations for 'wild card': Interviewees were invited, towards the end of the interview but before their final ranking of the 14 cards, to give a meaning for 'spiritual care'. These meanings are listed below:

- Being accepting of people as they are NOW – I haven't known them in the past and although that's interesting, we have to live with/honour the 'here and now'.
- Hope
- Acceptance – of being what they are now
- Tolerance – of people's behaviours and diverse views
- To find time getting to know the person, and what's important to them
- Maintaining links with the family (it's difficult for us to do this)
- Compassion

- Understanding and knowledge
- FAMILY
- ‘Grabbing every moment’
- [No specific title given but the interviewee goes on to ponder the meaning of spirituality]
- [Chooses another card instead]: Unconditional love (card 6)
- (For residents) to feel I’m still making my own decisions, and that these are respected.
- For the person to remain who they are for as long as possible
- Facilitating something they really loved doing in the past – even 1:1.

Acceptance and tolerance come over as strong themes here, with compassionate responses very explicit. These definitions speak very clearly of vocation and the staff’s personal and professional identification with the cause of good care. Some people also recognise the importance of working well with family members.

EXAMPLES GIVEN OF NON-RELIGIOUS SPIRITUALITY:

- One lady, R, loves the trees and loves to see and hear the rain. We make sure she gets to sit by the window when the rain is battering down as she loves it so much. (B2)
- On a Friday, there’s a group of men who always go to the pub – they call it their ‘payday pint’ – it harks back to when they were working and always on a Friday went to the pub on their way home from work. They love it. Last week it was too windy to go out, so the Activities staff went out and bought some beers in, and they sat in the corner of the sitting room playing cards. It was better than missing the routine altogether
- And we’ve got a gardening club, and we celebrate things – one of the Activities staff took photos of the men with the giant carrots they’d grown! It’s a bit of a laugh.
- We had an old man who’d been a keen bowler, so we arranged for him to go and watch the bowling at the bowling club up the road, have a pint of lager – he loved it. And we had a lady who had loved ice-skating – we took her to see the ‘show on ice’ when it came to the Alhambra. And another lady who loved hockey – we took her to see the Fife Flyers in Kirkcaldy – maybe a bit rough compared to what she was used to! But she still loved it.

EXAMPLES GIVEN OF RELIGIOUS SUPPORT:

The role of the local church in supporting residents who used to be members of their congregation is of interest to FiOP and we often have requests from pastoral visitors for support in visiting care homes. The staff I spoke to seemed to see this as a matter of course but there may be scope for looking at this as a good practice matter.

Two of the homes had their own chaplain and this role seemed to be valuable to both the residents and the staff. One manager told me about a new 'workplace chaplaincy' system that is developing, and felt this would be valuable for staff. I wonder whether this might be worth a closer look, in the light of the possible anxieties and avoidance of issues of death and dying.

QUOTES RE MANAGER ROLE:

- Prior to admission – it's usually me that does it (I'm like Jesus! Nobody gets in here except past me!) – I need to get plenty info so as not to 'set the placement up to fail'.

QUOTES RE ACTIVITY CO-ORDINATOR ROLE:

- 20 hours a week are not enough. I feel I should be full-time, and also have an assistant! It's a very lonely role – a lot of responsibility for what you get paid. I rely heavily on volunteers. There's no cover when I go on holiday – I end up feeling guilty to be going away. I'm an artist in the rest of my time – this job keeps me afloat. A lot of skills are required. There should be higher qualifications required for this job, and it should be better paid.
- I work 3 days a week – 27 hours plus I prepare a lot at home. There are 3 volunteers who come in and help – they do Jewish reminiscence, plus some 1:1 work. I've done training in various courses, plus 'Namaste'.
- (Comment by a manager) we have a great team of activity co-ordinators, four of them with a blend of different skills and aptitudes – they're brilliant – they just got us a 6 for our inspection report! They each do 30 hours a week. We're looking at doing some in-house training for (or with?) them.
- We deal with people on a daily basis – there are four of us so we can cover 7 days.
- There's a six-month 'official' review but on a daily basis we use a Comms book – that's within the Activities team – we leave notes so that people can keep an eye on things.
- I'm part-time but I used to be full-time – I needed to go part-time for personal reasons, and now I have a job share partner. We have 34 residents.

COMMENTS RE SENIOR CARER/CARER ROLE:

A few staff, alongside their professional comments, acknowledged that sometimes its difficult being on the receiving end of aggression, and that you don't always like the people you work with (i.e. some of the residents). I think this is quite a difficult thing for a member of staff to say, and it must certainly be a real dilemma in practice. None of them are well paid and it's easy to see how some homes find it difficult to retain staff. Some of the comments in my interviews praised managers and some, their teams for support. Bearing in mind that I was interviewing staff in homes I perceived to be very good, there might be scope here for 'sharing good practice' – helping managers and other staff to address the difficult, almost unmentionable aspects of their working lives.

DISCUSSION

This study has many limitations. Firstly, it would be more robust if based on a more thorough literature review; and if another method were used to seek another angle – for example a document analysis of care plans. However, the funding and time available did not enable this.

Secondly of course, the sample is very small. This is not necessarily a problem in terms of validity in qualitative research methods. However, the shortage of time to more fully analyse the results is regrettable.

The interviews were not taped, partly because of resource constraints but also because, given the focus on cards, the words spoken might not clarify which issues were being discussed and this would potentially render transcripts somewhat obscure. Notes were taken throughout the interviews. It is acknowledged that these will be unavoidably incomplete and no doubt reflect the bias of the researcher's preoccupations and interests.

On the positive side, there was no difficulty at all in facilitating reflective discussion and the participants were able to be quite personal and reflective in their responses.

The findings appear to support a closer look at several issues:

1. How can care home staff be supported in dealing sensitively with residents in the last years of their lives? In particular, how can the reality of death and dying be accepted in an environment which also strives to make meaningful the life experiences of those within its care?
2. The role of Activities Co-ordinator is not a requirement in care homes and many homes do not in fact have such a role. In those that do, there is often only one part-time member of staff trying to do the work alone. There is no professional association for such workers and the professional networks are fragmented and opportunistic. Terms and conditions are no doubt very varied and there is no clear route for ongoing learning and development. And yet this study suggests that Activity Co-ordinators are centrally involved in the spiritual care of older people –

enabling meaningful activities to be undertaken. It would be helpful to conduct a broader enquiry, exploring the extent to which care homes in Scotland are employing Activity Co-ordinators, how they are using them, and how to share good practice.

3. This should not ascribe the full responsibility for spiritual care to Activity Co-ordinator as clearly there is a role for all staff.
 - a. Managers need to provide excellent leadership to keep these values at the forefront of good care, and help staff explore and understand their own spiritual needs
 - b. Care staff need to be supported in forming meaningful relationships with their residents, especially given the intimate nature of the work they undertake.
4. The role of care home chaplains ought to be further explored. In two of the homes represented in this sample, there was an organisational chaplaincy role. This is perhaps unusual. More often, care homes are served by local faith groups who may involve themselves to a greater or lesser extent. However, this latter approach is less systematic, and much less likely to offer support to staff struggling with the emotional anxieties of the job. There is also a Workplace Chaplaincy initiative which one of the homes in the sample mentioned – they were thinking of buying in that service. Chaplaincy is now well established within the NHS and the lessons learned in that field would be a valuable resource for care homes in establishing their own support systems.

It is the author's sincere hope that these interviews and their analysis provide a useful snapshot of the meanings ascribed to spiritual care of older people, and give support to further research initiatives.

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Faith in Older People

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APPENDIX: INTERVIEW SCHEDULE
Care homes spirituality research study

Name of home

Role of interviewee

Date

1. What do you do regarding an assessment of residents' spiritual care needs?(Prompt if necessary)
 - a. At time of admission?

 - b. Ongoing?

2. Based on previous research, Koenig (further info?) came up with a model of older people's care needs – show cards – here they are (lay out on table):
 - a. Is there any one of these which immediately seems to you to be relevant?
 - i. Can you give an example from your recent experience please of this aspect of need being very apparent?

 - ii. Any other examples?

- b. Look at the cards again – any other which catches your eye?
 - i. Examples?

 - c. Any other cards?
 - i. Examples?

 - d. There's a blank card which I'm calling a 'wild card' – is there any spiritual need of older people which you feel Koenig has missed, or which you would name differently? If so, please fill it in.
 - i. Can you give an example of this?

 - ii. Any other examples?

 - e. Would you like to put the cards in order of importance, in terms of your own experience of residents' spiritual needs?
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3. Is there anything else you would like to say, from your own experience, about meeting the spiritual care needs of residents in an older people's care home?

Thank you very much.