Is Spiritual Care in the health care setting everyone's business?

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(Faith in Older People)

Introduction

In 2015 the then head of the spiritual care team in Lothian Health Board, Scotland, became concerned that the gradual reduction in hours allotted to the team was having an adverse effect on the spiritual care in the nine hospital based complex clinical care (HBCCC) units in the area. He brought together a working group to develop a rationale for increasing the team's resources, by studying the effects that the lack of spiritual care knowledge and education had on both staff and patients. He postulated that the staff on those units needed education to enable them to deliver elements of spiritual care confidently. The subsequent research can be found in Aird and O'Neill's paper (2017) which concluded that education of all staff was key to the delivery of spiritual care to patients on these units.

The outcome of the study is that:

- the educational resources should be identified and collated
- that education in spiritual care should be provided in undergraduate training of nurses and further embedded through continuing professional development. This should also apply to other health care professionals.

This paper acknowledges the sterling work of National Health Education for Scotland (NES); the Royal College of Nursing and the Lothian Health Board spiritual care team in providing education and awareness raising of the importance of spiritual care and we call on them to implement and reinforce this training.

Spiritual Care

Spiritual care can be defined in the words of the Purple Bicycle Project (Mowat and Swinton 2018):

'Spiritual care acknowledges the presence and importance of such things as joy, hope, meaning and purpose as well as the reality of disease, suffering, disappointment and death. This means that spiritual care is much broader than any one faith or religion and is of relevance to everyone. The Spiritual task is to offer friendship, comfort and hope to each other in ways that are meaningful to the individuals concerned.'

Mowat and Hunter (2014) cite the definition of chaplain from the dictionary of pastoral care and counselling which:

'… refers to a clergyperson who has been commissioned by a faith group or an organisation to provide a pastoral service in an institution, organisation, or governmental entity. Chaplaincy refers to the general activity performed by a chaplain, which may include crisis ministry, counselling, sacraments, worship, education, help in ethical decision-making, staff support, clergy contact and community or church coordination.'

While the title of chaplains for hospitals has changed to spiritual care teams and the qualification for being a member of this team is now embedded in accredited qualification, the philosophy remains the same.

Baldacchino (2015) describes a hospital chaplain as one who is an expert in clinical pastoral education giving help with theological beliefs and conflicts but may also go under the title of Pastor. Others (Barber and Parkes 2015) describe the spiritual care team or the chaplaincy team as a necessary member of the health service for the wellbeing of mental health. The spiritual care teams in health boards have immense specialist knowledge of counselling for various needs such as bereavement of a child, death and dying.

Spiritual care teams have been on the decrease in most health boards over the past ten years (Kelly 2012) although anecdotally the overall complement within teams has remained static (Aird, O'Neill 2017). However, this only accentuates the recognition that reducing spiritual care team hours will increase the work load and minimize the areas that are covered by members of the team. Distilling these teams requires managers to look elsewhere for the ability to fulfill the long-standing guidelines, although the Aird and O'Neill (2017) study discovered that most managers were not aware of either guidelines or resources available to them.

In the Scottish Government (SEHD HDL 2002) report it was recommended that the NHS provide healthcare chaplaincy services at the rate of one session for every 25-30 beds and spiritual care education for all NHS staff. However, by 2009, it had become clear that this had been an aspirational recommendation and so was removed from the subsequent report (SEHD HDL 2009).

Spiritual Care in the Health Setting

Since 2002 the Scottish Government (SEHD HDL 2002) has recognized the importance of spiritual care for the well being of all people but particularly those who receive health care within the NHS sector. Wallace (2011) maintains that 'spiritual wellbeing leads to a better quality of life' regardless of faith or no faith, because religion does not necessarily mean spirituality. The spiritual care teams seek to ensure the soul comfort of all patients and staff who require this specialised service, regardless of their culture, creed, faith or no faith.

Clear guidelines (SEHD 2002) were given for chaplaincy and spiritual care teams to contribute to the wider spiritual dimension and not solely the religious care of patients. This included definitions of the team as well as the difference between spiritual and religious care across the health boards. Person centeredness remains at the heart of the service as it still does today, but many subtle changes have been made to the guidelines which have been redrawn over subsequent years. Each change has commended and built on previous work, ensuring that current guidelines match the application required at the time of writing. The spiritual care teams now aim to meet all spiritual needs, contacting other agencies if necessary.

Scotland's House of Care model (2014), while it does not mention spiritual care per se, is implicit in its understanding of the need people may have for spiritual care. This is particularly evident in the HBCCC units where patients may be at the palliative stages of their lives, needing to have questions answered and a more acute understanding as to meaning in their lives. The Palliative Care Delivery Plan (Scottish Government, 2015) includes spiritual care in its final paragraph as a commitment from the Scottish government as needs that will be addressed for those in the last year of their life. The Spiritual Care (2009) guidelines from the Scottish Government stated that the development of spiritual care is both necessary and integral to whole person care. Points seven and eight from this document, deal with the concepts that embody care and compassion for fellow human beings and is the founding definition of the role of chaplains and spiritual care teams.

The new National Health and Social Care Standards (June 2017) were released for implementation in April of 2018. They embody the concepts of spiritual care in the five principles: dignity and respect; compassion; to be included; responsive care and support; well-being of persons. These new standards and guidelines underpin the rationale for delivering spiritual care within the philosophy of person centredness.

Whose Responsibility?

While nursing care staff have an excellent understanding of the delivery of person centred care, Aird and O'Neill (2017), found that an understanding of spiritual care was largely unknown to staff on the HBCCC units and, while often instinctively delivered, had no sense of cohesiveness and structure in its delivery. Education in spiritual care was found to be inconsistent and rarely accessible together with a lack of awareness of its the availability. Many of the staff seemed unware that a spiritual care team existed, neither did they know of resources to draw on if they required spiritual care intervention for their patients.

This study used the methodological approach of appreciative inquiry (Cooperider and Whitney 1998) which allowed the interviewees reflective space, not to change what was but to instead discover what could be. Although all members of the team were given the opportunity to be a part of the study, only 29 interviews were conducted partly due to time limits on the units and researcher's time. Given the 14 Health Boards across Scotland the researchers acknowledged that this was a very small sample and questioned the replicability of the study. It was noted that the study did not interview any chaplains or any of the spiritual care team, although they were consulted before, during and after the study. Some of the interviewees felt that responsibility for this specialised care lay with the spiritual care team, but on closer questioning it was not because they felt this was only that team's domain, but rather because they themselves did not have the ability or knowledge to deal with some of the challenges and questions they were being asked by patients.

It seems from the guidelines available from the last 15 years that although various stakeholders across the country have defined spiritual care; recognised the need for spiritual care as part of the person-centred wellness; provided centres of education through NES; spiritual care teams and the Scottish Government, no single agency has taken on the responsibility of standardised education for those who are the forefront of patient care delivery.

Just recently, an extensive study (Jaquet 2018) undertaken for FiOP and funded by the Life Changes Trust, examined the process by which spiritual care was delivered to people with dementia in care homes. This was a wide geographical project conducted over two years across Scotland revealing similar findings as the Aird, O 'Neill (2017) study. Its recommendations were unequivocal: that there should be a consistent implementation of education across all health and social care services given the evidence which shows that spiritual heath care when appropriately delivered improves patient wellbeing.

With the best will in the world there does not appear to be enough time for spiritual care teams to deal with the individual challenges presented to them across their enormous geographical location. To offer the kind of compassionate, listening care that takes time to enable critical questions to be answered in an unhurried way requires training and time away from an already squeezed nursing team. In theory the most obvious members of staff to offer spiritual care would be those that have the most to do with the patients, for their work has an immediacy of availability. It may be possible for the units to provide spiritual care with the specialist knowledge of the spiritual care teams in the background when required.

Another solution is to use other well-placed agencies to support the provision of spiritual care within the health care sector such as community groups; interfaith groups and other caring organisations. Those closest to the patients are doctors, nurses and health care assistants, who according to Aird and O'Neill (2017) recognise the need for spiritual care as part of person centred wellness, but due to time constraints and the challenge between choosing necessary clinical tasks and critical conversations veer on the side in which they have the greater knowledge and the immediacy of physical needs of the patient.

As one nurse put it:

N2 We give out tea, biscuits, meals but never spiritual care – it always has the last priority, the lowest priority.

However, time management is a learnt skill and as this piece of research pointed out, many critical conversations are carried out while the tasks are being undertaken – such as washing or bed changing. The research from this study identified issues of knowledge gaps such as the ability to answer critical questions – where am I going? am I going to die and what happens then? To the question 'I want to see a minister' there may not be an answer. If the unit is geographically distant then seeing a member of the spiritual care team may not be an option, and there may not be someone available at the time of need or request. The nursing care teams in this survey admitted that they did not have the knowledge and skills to confidently provide spiritual care and so the one who falls through the gap is the patient. This was substantiated by the RCN survey (McSherry 2010) to all 85,000 members of the RCN, of which just over 4,000 responded (1% of total members), showing that 79.3% of respondents agreed that spiritual care training was both insufficient and inadequate.

It seems then that if nurses were able to deliver some of the spiritual care to patients the spiritual care teams would not be so stretched in their resources and instead there could be a collaboration of skills.

Education

With the supposition that more responsibility for spiritual care was given to the nursing teams in the HBCCC units, it would mean that to facilitate learning within the context of a ward setting certain parameters need to be set in place. Those most likely to facilitate education would be those with the most appropriate knowledge and understanding, such as Higher Educational Institutions and the existing spiritual care teams, which although would place another burden on the spiritual care teams in the short term, the long term sustainable benefit would be for the patients and staff.

Chaplains are well-placed to provide education in spiritual care to ward-based teams. In 2009, the Scottish Government widened the scope of spiritual care to the promotion of research which broadened and enlightened the evidence base for the efficacy of spiritual and religious care in health. While this was a neccessary progression to enhance the service there was no direction as to how research recommendations would be implemented. Since August 2017 the UKBHC's (United Kingdom Board of Healthcare Chaplaincy) register of healthcare chaplains has been accredited by the Professional Standards Authority. The UK Board of Healthcare Chaplaincy (2015) defined the role of a band 5 training

chaplain (http://www.ksf.scot.nhs.uk/understanding-ksf-dimension) as someone who assesses the spiritual and religious needs of patients, visitors and staff, seeking to meet those needs or refer on. This gives a reasonable credibility to the spiritual care teams to enable them to deliver education across the health boards.

Resources are required to enable independent learning, and these already exist in many and varied forms, documented in the Aird and O'Neill study (2017). Because of the need to have current, available and standardised information across Scotland, there are various organisations which enable people to find the resources they need. One such organisation is Interfaith Scotland who maintain a website with information on spiritual care in the community and a Religion and Belief Training Programme which seeks to develop understanding of the diversity of faith. Faith in Older People (FIOP 2018) has an extensive online library available to all organisations including the health service. They have developed numerous training resources and are able to deliver these in person and on line. (https://www.faithinolderpeople.org.uk/project/spiritual-care-matters/)

Several useful documents have been produced by the NHS Education and can be downloaded:

- Religion and Belief Matter, An Introduction for Healthcare Staff
- Spiritual Care Matters
- A Multi-Faith Resource for Healthcare Staff
- Reflections of Life

The Royal College of Nursing has various resources that are available for nursing staff to use in their area of work.

Each health board has its own individual spiritual care team which can direct staff and patients appropriately as well as having their own educational resources.

For the nursing staff there are several issues according to Aird and O'Neill (2017). Protected learning time should be available for all, but the staffing levels are such that there is no additional time to prioritise this learning. Neither is there available computer space as there is no dedicated learning computer on any of the units. Most eLearning is undertaken at home, which puts additional strain on family life. Rushton (2014) comments that two of the greatest barriers to the nursing teams offering spiritual care is time and the necessary learning.

However, the rationale for nurses to learn these additional skills are given through their code of practice. The NMC (2018) require nurses to possess the skills to meet patient's spiritual needs and to be able to:

'carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, **spiritual,** genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement.'

NICE (2004) guidelines for Palliative Care also give instructions for the delivery of spiritual care recommending appropriate training. Given that many patients in HBCCC units find themselves in just such a palliative place of care, these guidelines would seem very apposite.

In the NES 2016-17 local delivery plans there was a commitment to education for staff in spiritual care. Given that this team now forms a sustainable link with Scottish Government it is to be hoped that the training will filter down through all disciplines in the NHS. The random nature of training that is chosen as a part of CPD, however, still may not either address the barriers noted nor become a recognised part of the education required for healthcare staff. It is also possible that staff members will feel overwhelmed by yet another CPD requirement, but this should not be the case. In 2009 Levison (NES) noted that:

The provision of spiritual care by NHS staff is not yet another demand on their hard-pressed time. It is the very essence of their work and it enables and promotes healing in the fullest sense to all parties, both giver and receiver, of such care.'

Aird and O'Neill (2017) found that there was a deep insight into the need for spiritual care education by managers who recognised that it was not only the patients who benefitted but also the staff as noted by Levison's quote above. The staff needed spiritual support to carry out daily challenging duties, which could involve up to 10 patients requiring palliative care at any one time and possibly only two nurses on a twelve-hour shift. In all 29 interviews Aird and O'Neill found no one who had had training less than five years previously in any kind of spiritual care.

An important outcome of the Aird and O'Neill research (2017) was that most of the 29 interviewees did not know the definition of spiritual care, which they attributed to religion and faith, and neither were staff very aware of the spiritual care team and the role they could play in

support of both patients and staff. While this may be relatively simple to address in terms of learning and education it does bring financial implications. However, if this barrier is removed then the patient experience of whole person care could be significantly enhanced within the NHS.

To end this short article without giving appropriate recognition to the spiritual care teams would be missing the key ingredient. This nurse saw the burden of emotional care lifted for one patient and in doing so felt supported and ready to pass on that message:

N12 the chaplains were very proactive – I saw how much they did for a particular man who was preparing for dying, so the first thing I did when I came here was to think about how to prepare patients for end of life and departing in belief. So perhaps that is why I am quite proactive in asking for chaplaincy help in this unit particularly when there are end of life conversations and you want them not to be afraid of dying, this monster, but to be at peace' (Aird and O'Neill 2017).

Conclusions

This paper shows that spiritual care teams are valued and integral to spiritual care delivered in the NHS. It is recognised that nursing teams have little time or education in time management and spiritual care even although it is noted by NES (2009) that this should not be a barrier to the service. Managers are hard pressed to organise learning for their staff, particularly when they do not know where to access it or how to deliver it. Doctors are rarely in the ward at the critical moment of conversation and they too are time limited. Relatives often want someone else to answer the critical question and so turn to someone on the nursing team who are always there. Spiritual care teams have a geographical spread which is too wide to be in the right place at the right time. It appears that the key to the challenge of spiritual care delivery implementation would be education of nursing staff. Not as an additional task but integrated into the everyday continuum of person centered care. Every service provider should be able to offer spiritual care at the point of need and feel competent and confident in doing so with the support of both management and stakeholders across the board.

Education in spiritual care is available and guidelines are in place to support delivery. It is surely the role of researchers and educators to close the gap between recommendations and implementation.

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