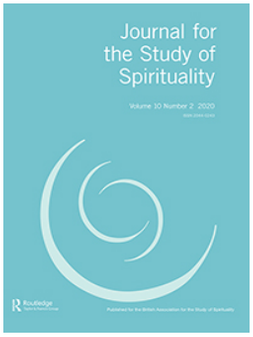

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How is spiritual care/pastoral care understood and provided in general hospitals in Victoria, Australia? – Staff perspectives

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ABSTRACT

There is strong movement worldwide towards the professionalisation of spiritual care in the healthcare system, accompanied by appropriate education pathways, defining of best-practice care models, and evidence-based practice. The aim of the study reported here was to explore the understanding and expectations of healthcare service staff, across the spectrum of staffing levels, in relation to the provision of spiritual care in their facility. It utilised semi-structured interviews with 32 staff members from three large metropolitan general hospitals in Victoria Australia. Interviews were audio-recorded, transcribed and thematically analysed. Overall, it was considered that spiritual care is an integral part of whole person care; more resources and in-house education of other staff are needed; and referral systems could be improved to better serve patient, family and staff spiritual care needs. Responses of clinical staff able to make referrals were compared with those of non-clinical staff who cannot make referrals. Spiritual care was regarded as important by all staff, but those who could make referrals were more likely to make specific improvement suggestions. Outcomes of this study are similar to others which have investigated these issues.

KEYWORDS

Spiritual care; pastoral care; staff perceptions; healthcare; whole person care; chaplaincy

Introduction

There is a strong movement in the healthcare sector worldwide towards the professionalisation of spiritual care provision (Fitchett et al. 2014; Flannelly and Jankowski 2014) as well as evidence of association between addressing patient spiritual needs and healthcare outcomes (Salsman et al. 2015). This has been emphasised locally with the recognition by the Victorian Department of Health and Human Services of 'Spiritual Care' as an Allied Health profession. This move has implications for both evidence-based practice (Fitchett 2012) and for the training of these professionals (Wintz and Hughes 2018) as equal partners in the interdisciplinary whole person care of patients and family members. Very important also in this context is how spirituality is defined and how this influences models of spiritual care provision. For the purposes of this study, it is

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acknowledged that spirituality may or may not include any association with a formal religion or religious practice; and the following definition is used:

> Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, community, society, nature and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices. (Puchalski et al. 2014, 644)

While, in some sectors of the healthcare system, such as palliative care, spiritual care is more broadly accepted as an essential element of whole person care, there are still discrepancies between patient and care provider perspectives on spirituality and spiritual care (Selby et al. 2017). In Australia, healthcare facilities generally claim to offer 'whole person care' or 'person-centred care'. This includes offering spiritual care (i.e. caring for the spiritual domain of each individual according their needs) as well as physical, emotional, social, psychological needs (Rumbold 2003; Butler et al. 2019). The participating facilities see spiritual care as a multi-disciplinary practice led by the spiritual care team. This broader understanding of spiritual care, and the fact that it may not for some people include specific religious care, has led to some confusion about the title of those who provide it. In some cases, in Australian hospitals, the terms 'spiritual care practitioner', 'pastoral care practitioner' and 'chaplain' are used interchangeably; in others, a chaplain may provide only specific religious practices to those who seek them. In this study, the term spiritual care is inclusive of all needs of the individuals in caring for their spiritual nature as they understand that. Others (e.g. Carey, Swinton, and Grossoehme 2018) use chaplaincy in a similar generic way, and also point out the diversity of language used.

Spiritual care as a profession faces the challenge of providing feedback to funding bodies concerning outcomes of interventions. This is linked with a need for more rigorous research practice (Handzo et al. 2015). As discussed by Liefbroer, Ganzevoort, and Olsman (2019), in an increasingly plural society it also involves identifying models for spiritual care provision. For example, is spiritual care only offered by professional spiritual care staff or is it provided through a multi-level competency model such as that reported by Gordon and Mitchel (2004)? It includes appropriate recording of spiritual care interventions in patient notes as per the World Health Organisation recommendations for spiritual care intervention codes (for the Australian context, see Australian Classification of Health Interventions ACHI 2017). This classification of spiritual care interventions includes the categories of spiritual assessment; spiritual counselling, guidance or education; spiritual support; and spiritual ritual. These intervention codes are inclusive of the general spiritual care interventions identified by members in the report published by Royal College of Nursing Spirituality Survey (2010).

A capacity to measure patient-reported outcomes and experience – using measures such as the Scottish Patient Reported Outcome Measure (PROM) (Snowden and Telfer 2017; Snowden et al. 2018) – is clearly also vital, as well as more qualitative approaches to understanding patient needs (Egan et al. 2018). The way in which staff members across healthcare organisations perceive the provision of spiritual care in their facility, and its importance in patient care, is also vital to its integration into whole person care.

Our work to investigate how spiritual care is being offered and experienced in our health system, how it is viewed by staff across the providing facilities, the perspectives of patients about the outcomes of spiritual care and how it can be improved, are being

undertaken in three phases. This paper reports the outcomes of phase 1 (staff perspectives) of the overall study.

Aim, study design and methodology

The aim of this phase of the study was to explore the understanding and expectations of healthcare service staff, across the spectrum of staffing levels, in relation to the provision of spiritual care in their facility.

Human Research ethics approval for a multi-site project was given by the Human Research Ethics Committee (HREC) at one site and confirmed by the HREC at each of the other two participating sites.

This was a qualitative study utilising semi-structured interviews in which participants were asked about the value, if any, of spiritual care; how it was provided in their facility; its benefits, if any, for patients, family members and staff; and in what circumstances they would refer someone to spiritual care services. They were also invited to suggest ways in which spiritual care could be improved and the likely outcomes of these improvements (see questionnaire, Box 1)

Box 1: Staff semi-structured interview questions

- What do you see as the value, if any of providing spiritual care?
- What spiritual care is provided in your health agency?
  - What do you see as the roles of professional specialist spiritual care staff?
  - What do you see as the roles of other staff in relation to spiritual care?
- What do you see as the benefits, if any, of this spiritual care?
  - for patients?
  - for families?
  - for staff?
- What, if anything, would you like to be different about the provision of spiritual care in your facility?
- What benefits do you think these changes would bring?
  - for patients
  - for families
  - for staff
- What would encourage you to recommend spiritual care to patients and/or family members or staff?

Each of the participating sites in this study is a large metropolitan general hospital with bed capacities ranging between 600 and 900. Staff members at these participating facilities were informed about the study through internal staff newsletters and invited to express an interest to the site coordinator for the project, who was in each case the Manager of spiritual/pastoral care at the site. Facilitated by an experienced spiritual care practitioner, appointments were arranged with those who gave written consent for the interview and its audio recording. This study is based on the theoretical perspective of phenomenological interpretivism – seeking to interpret and understand the experience of participants in relation to spiritual care provision in their work site. The specific method was theme identification (Crotty 1998).

Transcripts were prepared of each interview by an external transcriber. These were checked for accuracy against the audio recordings, de-identified, apart from the site code, and independently analysed by two of the researchers, in relation to interviewees'

responses to the questions. Any differences were discussed and main themes in each area were formulated.

Results

A total of 32 interviews were conducted cross the three sites with staff in work roles, as shown in Table 1. They included both staff in clinical professional roles and other staff directly and indirectly involved in patient care.

The collated results from all interviews, as they relate to each question are summarised in Table 2.

There were a number of areas on which there was general agreement, as follows:

Spiritual care is a valuable part of whole person care

It was generally considered that spiritual care was of considerable value when provided by professional practitioners and that it is an essential element of whole person care for patients, family members and staff:

> A hundred percent. I think it's very important. With technology, and everything else that's happening now, we don't have the time that we did have. (Participant 19)

> Spiritual Care is very important for my patients and part of the whole care which needs to be brought by professionals. It gives people a sense of meaning and of their inner framework. (Participant 2)

> Huge value especially in life events which raise existential questions. (Participant 28)

It was also commonly thought that spiritual care provided opportunity for a patient to talk about things that they did not tell clinical staff or their families and that this provided important care:

> Give them time and opportunity to speak honestly about issues which they may not want to burden their family or friends with. Other staff lack time. (Participant 27)

It was apparent that not only did models of care vary between facilities but that there was evidence of variation within the same facility. Contributing factors to this variation within facilities were possibly a reflection of the views of some staff that spiritual care was more important in settings such as palliative care, extreme distress or death; and a shortage of staff which lead to prioritising referrals according to perceived need:

> (Spiritual care) could be everywhere but particularly in palliative care when people are facing their mortality, the end of life, they're looking at their values and things. (Participant 4)

Table 1. Work role of staff interviewed.

Staff work role	Number interviewed	Number of sites of these interviews
Allied health staff	2	1
Executive	2	1
Data management and administration	4	2
Environmental staff and volunteers	3	2
Medical	5	3
Nursing	10	3
Quality control and liaison	6	2

Table 2. Collated data from all interviews.

Question	Main ideas
1. Perceived 'Value of Spiritual Care' (SC)	• Great value/essential/integral/essential to whole person care • Opportunity to explore existential issues, fears, meaning, loss and meeting people's values. • It is related to religion but not necessarily confined to it (differing views on the latter) • Particularly important in times of stress, bereavement, death, trauma and bad news • Provides support and nurturing to staff, patients and their families • Very good, adds to healing when offered by skilled specialists • A nice added extra for people who want to talk (1)
2. What SC is provided at your facility	• Specialist with a good knowledge of spirit and how it works • Provides help and support as in 1 above • Attends to person-centred specific religious, cultural, ritual and worship needs and to freedom to speak confidentially. • Should be a priority but variable on the ground. Particularly hard in acute settings. • Provides resources, network connections. Palliative Care could not do without them.
2a. Role of professional SC staff?	• Assist in times of death and crisis – can impact healing. • Meeting specific religious and other spiritual needs with expert knowledge and skills including multi-faith • Listening empathetically, counselling, guiding, giving solace, identifying specific cultural needs. • Don't come much – must be understaffed • Must only be offered to those who want it.
2b. Role of other staff in SC provision?	• Be educated about SC – and include SC as part of care • Able to identify spiritual needs and make appropriate referrals to other professional help available e.g. social work. • All staff need to be person centred with patients they are real people – everyone is part of whole person care • Culture awareness is important especially for nurses
3a. Benefits SC for patients	• Brings hope, comfort, peace, acceptance a sense of being valued, reassurance, needs assessed and flexibly provided. • Receive specific religious or spiritual care according to need • Can impact physical healing very positively while a lack of consciousness in this area can hinder healing • Opportunity to talk about feelings, concerns, fears they may not want to talk to anyone else about
3b. Benefits SC for families	• Similar benefits to patients • Can bring strength, courage, resolution and understanding as well as specific religious care as needed. • Peaceful patient benefits the family too • Particularly important in times of bad diagnosis, death, loss and other crisis • Provides safety, support, understanding and the sense of being treated like a whole person • Provides mediation and de-escalation opportunities that other staff may not have time for
3c. Benefits SC for staff	• Very important opportunity to address the hard stuff • Good job satisfaction when patients are being cared for more fully • Good for team unity and connection • General staff well-being: addressing slow stress build-up, personal issues triggered, breathing space, religious practice
4. What could be different	• More SC staff, more hours and more resources badly needed i.e. more money 24/7 care. Offering of this service should be standard • More staff training and education regarding what it is, assessment, referral, starting conversations

(*Continued*)

Table 2. Continued.

Question	Main ideas
	• More research to assess outcomes and benefits • SC more involved in patient management, multi-disciplinary teams, hospital committees etc. • More spiritual care knowledge and visibility: staff education on multiple levels e.g. communications skills, sacred space awareness, multi-faith knowledge, regular slot hospital news • Data collection and patient feedback: needs to be much better including admission data • No changed needed or don't know (3)
5a. Change benefits patients	• Benefits as already described • Immediate access anytime for all patients • These wider services SC would have ripple impact on other staff and services • Include discharge planning and assess the long-term benefits
5b. Change benefits families	• Increased support for families resulting their having a better experience at hospital • Benefits as per patients – more people can get it • Broad ripple effects when family are also included more often
5c. Change benefits staff	• Better teams who have their own issues addressed before burnout – greater awareness of service availability • Increased skills and opportunity in whole person care and referral • Greater awareness of the benefits of SC • More data on impact of this care for staff – sick leave, satisfaction • Potential issues with relationship with other staff care services. • More awareness of SC staff of other staff needs in the ICU
6. What would encourage recommendation of SC	• More staff awareness of the benefits and availability of SC • Broader acceptance of SC as a regular part of care • We already do enough – don't want to probe • Improved pastoral care team and availability • Improved assessment skills of staff and education about SC.

> They used to come to the emergency department on a regular kind of basis, but lately … . I don't know whether it's a funding issue or whatever they don't seem to come that often, or they find the department is too challenging, because this happens all the time here. (Participant 11)

More resources and education needed

Most participants considered that there were insufficient resources for spiritual care to fully meet the needs of patients, family members and staff. Generally, it was acknowledged that spiritual care is the concern of all staff involved in whole person care:

> They (non-spiritual care staff) have a role to identify when a referral is needed to spiritual care specialists. (Participant 22)

> I think we all have a role because patients want to talk at random times. We can offer what we can and make a referral to spiritual care when that is needed. (Participant 23)

A common view was that, for the benefit of staff, patients and family members, an increased number of professionally accredited staff were needed, and that they should be available for both patients and staff 24/7:

> It should be a seven days a week service. I know that is a difficult thing, but the service is a 24 h, seven days a week service and we get big cases coming in on Fridays. (Participant 14).

It was also seen as particularly important that there was a great deal more education of non-spiritual care staff about the nature of spiritual care across all levels of staff within the facility:

> Absolutely staff education about spiritual care and what is available is a very big part. (Participant 13)

> De-mystifying spiritual care for staff. (Participant 28)

> Resource folder and give that to families as well … . Looking at rebranding, educating, promoting then you'd have to back up by additional resources to ensure that that increased demand would still be able to be met. (Participant 12)

Improved referral system

It was felt that a clearer referral system would bring significant improvement in the level and quality of spiritual care provided. This was considered in the context that spiritual care is a multi-disciplinary responsibility and that, as a minimum, all staff treating patients need to have the capacity to identify spiritual needs and to refer as appropriate.

> Better and clearer referral systems are needed. (Participant 31)

> I think all staff have a role to play in helping people find meaning in what they're experiencing. (Participant 5)

> That's teamwork. If we work as a team then other members can pick up on that (their specialty). (Participant 20)

Some participants indicated that better screening tools, or at least applying the existing screening tools for spiritual needs would be useful in avoiding inappropriate or unwanted referrals:

> At the moment we triage based on our perception of people's needs but if we are not perceiving that correctly … then we are under referring or under identifying … that might go back to understanding what the role [of spiritual care] is and what questions the clinicians can be asking to help identify those referrals. (Participant 3)

A few staff expressed a concern about referring people, reluctant to be seen as imposing or interfering in what they regard as personal matters:

> Unless they tell us their faith it is very hard. We don't want to probe into their private things. (Participant 11)

Relationship of capacity to refer patients to views on spiritual care provision

A comparison of key responses to question 1 (perceived value of spiritual care), question 4 (how do they think it could be improved at their site) and question 6 (what would encourage them to make more referrals to spiritual care staff), are summarised in Table 3 (staff who are able to make referrals) and Table 4 (staff who are not in a position to make direct referrals).

Spiritual care was widely seen as an important part of whole person care although there was a broader spectrum of views among the non-referring staff members interviewed. The need for more spiritual care resources (staff, time, availability) was broadly accepted regardless of staff role:

> More resources so that 24/7 service can be available … . This would be of benefit to both patients and staff some of whom only work on weekend for instance. (Participant 19)

> Spiritual care should also be represented on multi-disciplinary committees and ward meetings. (Participant 14)

Most staff also considered that referral was more likely if there was better knowledge and understanding of what spiritual care offered and clearer referral processes. In addition, referring staff considered it important that spiritual care staff more consistently recorded interventions and outcomes in patient notes as is expected of other professional staff:

> I'd like to see a better understanding of the importance of the role by other members of the multi-disciplinary team in terms of sharing information. This may well be improved with better recording of interventions and outcomes in patient notes by the spiritual care team. (Participant 7)

Value of spiritual care

Overall, spiritual care was considered important and integral to whole person care across the staff spectrum, although the views of referring staff were more consistent in this case than those of the non-referring group, the two outlier opinions being presented by non-referring staff:

> A nice added extra for people to talk about what they want to talk about. (Participant 22)

What could be different?

There was a generally consistent view that spiritual care should be integrated in the system and provided with more staff who are professional spiritual care practitioners, with more resources; and that other staff should be more informed about the role of spiritual care.

Table 3. Key outcomes for referring staff to questions relating to perceived value, changes needed and referring.

Staff role	No. respondents/ sites	Value of spiritual care – Q.1	What could be different – Q.4	What would encourage referral – Q.6
Medical	5 from 3 sites	Very important/ integral, religious or spiritual, must be professional	Better and 24/7, advertised/education with clear language, better whole team involvement and data referral systems	Better noting of before/after of SC, observing times of distress, regular assessment of patient spiritual needs
Nursing	10 from 3 sites	Integral to whole patient care regardless of faith or religion	More staff 24/7, more resources, more staff training about it, data systems that talk to each other.	Clear guidelines – intuition not enough, more availability, normalisation of service
Allied health	2 from 1 site	Very important – especially in stress	More hours/more staff/more money, become standard practice	More services available, when I sense need for in-depth conversation
Summary: Referring staff	Total 17	Very important – integral	Bigger/better staff, hour, resources, other staff education	Better noting in records, clear referral guide – lines, more availability

Table 4. Key outcomes for non-referring staff to questions relating to perceived value, changes needed and referring.

Executive	2 from 1 site	We are whole beings – must care for spiritual too	Embedded 24/7 care and staff education re SC	Well-structured pastoral care team – regular PD
Quality care and liaison	6 from 2 sites	Ranged from essential – much support provided to 'nice added extra'	More resources: brochures, education for staff, obvious sacred space	More widely known about – especially stressed people
Environmental and volunteer	3 from 2 sites	Fundamental – especially in bereavement, etc.	More experienced staff with strong leadership	More staff awareness and understanding of what it is
Data management and admin.	4 from 2 sites	General view (1 exception) of very important	Overall more info, more staff.	Better known service and clearer referral criteria
Summary: non-referring staff	Total 15	Overall seen as important but wider range of views than referring staff	More time, more staff, more resources	More staff awareness and clearer referral process

What would encourage more referrals to spiritual care?

The main issues were that there needs to be better recording in the notes of spiritual care interventions, clearer referral guidelines (a stronger recommendation among the referrers) and that there needs to be more education of non-spiritual care staff about spiritual care.

Discussion

This study investigated the views of a wide spectrum of staff, both clinical and non-clinical, in three large metropolitan general hospitals, regarding their understanding of spiritual care, of how it was offered at their site, and how it might be improved.

There was a general view that spiritual care is very important and, in many cases, it was seen as an essential element of whole person care, which is the published aim of each of the participating sites. This is consistent with other published material such as Salsman et al. (2015) and Cunningham et al. (2017). There was some variation in opinions about who is responsible for providing this care. For example, a number of participants indicated that some level of spiritual care can and should be given by staff across the spectrum of care, with referrals being made to the professionals as needed; this is consistent with Selby et al. (2017) and the model promoted by Gordon and Mitchel (2004). On this basis, a Public Health England report (2016, 25) recommends that services 'ensure all staff involved in care and bereavement support are trained in faith sensitivity and effective communication'. Our related research (Gardner, Tan, and Rumbold 2018, 7) from the perspective of patients and families supports the view that 'all staff and volunteers should be seen as contributing to spiritual care in healthcare from those trained specifically in spiritual care to those providing treatment and support services.'

There was, however, the view, regardless of what the participant understood to be the model of spiritual care, that well-trained professional spiritual carers were vital to effective spiritual care and should be integrated into interdisciplinary teams. This view has also been mooted by other authors (e.g. Flannelly and Jankowski 2014; Fitchett et al. 2014). These views are not necessarily incompatible. If we are aiming to create a culture in an organisation of spiritual acceptance and awareness, it makes sense that all staff should be aware of this and that they should have at least a basic capacity to recognise and engage in such conversations, and an awareness of when to refer patients to those with

more specialised knowledge. Given the limited staffing for spiritual care, this is also a realistic use of resources.

Another very strong theme in the results of this study was the view that, if spiritual care is to be more widely and more effectively offered in large hospital systems, then there must be an increase in resources, including more professional staff who are available 24/7, and more education of other staff about what spiritual care is and how it is best offered. These matters have also been reported before. There has been much discussion about what constitutes spiritual care (e.g. Puchalski et al. 2014); and the need for professional practitioners who are reliably qualified both in spiritual care and in the environment of major healthcare providers (Flannelly and Jankowski 2014; Fitchett et al. 2014; Handzo et al. 2015; Wintz and Hughes 2018). This professionalisation process also, of course, includes training in evidence-based practice, another topic which is being currently well explored (Egan et al. 2018; Fitchett 2012; Snowden and Telfer 2017).

A number of factors arose in relation to the education of other staff in the facility about spiritual care. This included many suggestions about more visible and better signposted sacred spaces, but particularly about the provision of information flyers and packages for staff and patients, as well as the inclusion of a spiritual care segment in in-house staff orientation programmes. A recent publication reported a successful outcome of such a programme for hospital staff (Van de Geer et al. 2017). More broadly, the literature also addresses the matter of spiritual care training being part of undergraduate training programmes for both doctors and nurses (Paal, Helo, and Frick 2015; Puchalski 2006).

Two other areas, more easily improved internally within sites than integration into undergraduate programmes, were the provision of clearer referral pathways, which would also include better spiritual care assessment skills among non-spiritual care staff; and better recording by spiritual care staff in patient notes about key spiritual issues and their interventions. There is a lot of work being done about spiritual assessment, for example Fitchett and Balboni et al. (2017). Likewise, work is being carried out worldwide to improve the documentation of spiritual care in healthcare facilities (e.g. Peery 2012; Tartaglia et al. 2018; Spiritual Health Association 2019). It is easy to speculate that these matters will become more natural parts of practice in healthcare facilities as spiritual care is increasingly integrated in interdisciplinary teams. On-going research and education in this area is still needed.

Limitations

This study was limited to only three sites all of which are large general hospitals in metropolitan Melbourne. A larger range of hospital type, size and setting may have produced different outcomes.

Conclusion

While this study has its limitations in relation to sample size and type of healthcare facility, it has confirmed issues such as the importance of spiritual care from the perspective of a broad range of health facility staff, and the need for professional spiritual care staff who utilise evidence-based practice and are appropriately resourced. The importance of

integrating this part of whole person care into the interdisciplinary care team, along with appropriate education for non-spiritual care staff about spiritual care, is something that would be assisted by better referral systems and improved data recording of spiritual assessment and interventions.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

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Heather Tan is Manager of Education and Research, Spiritual Health Association, Australia. She was chief investigator, data analyst and manager of the research project.

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