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Stakeholder views on the role of spiritual care in Australian hospitals: An exploratory study

Cheryl Holmes^{1,2}

Spiritual Health Victoria, 3/25 Gipps St, Collingwood, 3067, Victoria, Australia

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ABSTRACT

Research increasingly demonstrates the contribution of spiritual care to patient experience, wellbeing and health outcomes. Responsiveness to spiritual needs is recognised as a legitimate component of quality health care. Yet there is no consistent approach to the models and governance of spiritual care across hospitals in Australia. This is consistent with the situation in other developed countries where there is increased attention to identifying best practice models for spiritual care in health. This study explores the views of stakeholders in Australian hospitals to the role of spiritual care in hospitals. A self-completion questionnaire comprising open and closed questions was distributed using a snowball sampling process. Analysis of 477 complete questionnaires indicated high levels of agreement with ten policy statements and six policy objectives. Perceived barriers to spiritual care related to: terminology and roles, education and training, resources, and models of care. Responses identified the issues to inform a national policy agenda including attention to governance and policy structures and clear delineation of roles and scope of practice with aligned education and training models. The inclusion of spiritual care as a significant pathway for the provision of patient-centred care is noted. Further exploration of the contribution of spiritual care to wellbeing, health outcomes and patient experience is invited.

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1. Background

The international research exploring the contribution of spiritual care to patient experience, wellbeing and health outcomes continues to grow [1–3]. Correspondingly there has been increased attention given to identifying best practice models for the provision and governance of spiritual care in health care [4–7]. While spiritual care is currently provided in many Australian hospitals, the models and governance guiding this care are varied, as are the capabilities and competencies of the providers. This is not a situation unique to Australia. In both the United Kingdom and the Republic of Ireland, Government funded health departments (NHS and Health Service Executive respectively) have supported and funded initiatives to identify best practice spiritual care models across the countries' health services [5,6]. These moves to identify best practice spiritual care are significant as they come at a time when the contribution of spiritual care to safety and quality has

been acknowledged in Australian reports. This creates an opportunity and context for the identification of best practice spiritual care in Australia, as undertaken in both the United Kingdom and Ireland. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has identified patient-centred care that incorporates concern for the patients' beliefs and values as a key component of safe and high quality care [8]. The focus on quality in health care has raised questions about how quality is defined and measured with a commensurate move away from assessing volume and quantity to measures of value and outcomes [9–11]. Internationally, proponents of spiritual care responded to this move with a call to action [12] and the development of international quality indicators to assess the quality of spiritual care [13]. While the provision of spiritual care has increasingly been recognised in Australian State and Federal Government reports [14–17], little attention has been given to how it is understood in the Australian context, the policy needed to guide its provision, and how the contribution of this essential element of care is measured. Many of the definitions for spiritual care have come from the nursing literature [18], however a more recent study across nine countries (excluding Australia) explored patients and carers perceptions of spiritual care as 'providing a safe space, listening and counselling' [19].

In 2015 Spiritual Care Australia (SCA) and Spiritual Health Victoria (SHV) established a working group to plan for a national

E-mail address: ceo@spiritualhealthvictoria.org.au

¹ The research for this publication was undertaken while completing a PhD at La Trobe University, 215 Franklin Street, Melbourne, 3000, Victoria, Australia.

² Chief Executive Officer at Spiritual Health Victoria, 3/25 Gipps St, Collingwood, 3067, Victoria, Australia.

consensus conference held in June 2017 to influence the Australian policy agenda for spiritual care. Earlier conferences held in the USA and then internationally established a precedent for this initiative [4].

In setting the priorities and agenda for the conference, the working group recognised that little is known about the attitudes and views of those involved in Australian hospitals towards spiritual care, or about their perceived barriers to the inclusion of spiritual care. Published research has tended to focus on the attitudes and views of doctors and nurses to spiritual care in health [20–22]. Accordingly SCA and SHV instigated an exploratory questionnaire based study to investigate the views of a broader range of stakeholders in Australia on the role of spiritual care in hospitals.

Responses to the questionnaire informed the Australian national consensus conference and identified the issues that need to be addressed through a national health policy agenda for the provision of spiritual care in Australian hospitals. This paper reports on the results from the questionnaire.

2. Method

The working group established for the Australian national consensus conference developed a self-completion questionnaire comprising both open and closed questions. There were five sections to the questionnaire with 41 questions as outlined below.

Section 1 comprised introductory statements consisting of three general statements reflecting the growing body of research on the contribution of spiritual care to patient wellbeing, health outcomes and patient experience. Section 2 included 10 policy issue statements based on the international quality indicators for spiritual care [13]. Section 3 described six policy objectives which respondents rated for both their desirability and feasibility. Following Sections 2 and 3 respondents were able to add additional policy issue statements or policy objectives through a free-text facility.

In Section 4, seven general questions were included, five of which were Likert scales directed specifically to those working in a hospital setting and two were open-ended providing opportunity for respondents to identify barriers to the inclusion of spiritual care and provide any final comments or questions about spiritual care in hospitals. Finally, seven demographic questions were included in Section 5.

The survey was reviewed by the working group to ensure content validity and was then piloted with experts in either health care and/or spiritual care and final adjustments were made based on feedback received.

2.1. Sample

The working group reached consensus on a distribution list to reach a broad range of stakeholders across the health sector. This included the CEOs of national health organisations and peak bodies, national and state health ministers and key government personnel and state and national spiritual care organisations. Working group members also provided names of individuals with key roles within the health sector or names of health academics/researchers to be added to the distribution list. The survey was distributed by email via the online tool Survey Monkey. The invitation email included information about the survey, the proposed use of survey data and invited participants to distribute the surveys to other stakeholders and/or colleagues thus creating a snowball sampling process. Participation was voluntary and completion of the questionnaire implied consent.

2.2. Data analysis

All data were held in a de-identified database. Analysis of the quantitative data was completed using the Survey Monkey platform that provided percentage responses and basic statistics (median, mean and standard deviation). This analysis enabled cross comparisons of data across response fields and demographic categories. The qualitative data from open-ended questions were exported and analysed thematically and coded using NVivo11 (QSR International) software. Thematic analysis enabled the identification of emergent themes and sub-themes that were then applied so that data could be organised into these broad themes and sub-themes [23]. Emerging themes and initial analyses were presented and discussed with the working group to establish trustworthiness [23].

2.3. Ethics

Ethics approval to analyse the survey data was obtained by the author through La Trobe University College Human Ethics Subcommittee, Melbourne Australia (Reference S17-019), and approval to access the database for research purposes obtained from Spiritual Health Victoria.

3. Results

Data from 477 complete questionnaires were analysed.

3.1. Demographic information

The majority of respondents were female (70.6%) with 71.3% of respondents indicating an active religious affiliation. Participants indicated current areas of work and were able to select as many areas as were applicable to them. The top four areas were spiritual care (53.6%), management (20.4%), allied health (18.6%) and nursing (14.6%). The predominant place of work was the hospital setting (67.6%) with 'other' including mental health, community, disability, not-for-profit, church, and aged care, nominated by 22.3% of respondents. Respondents came from public (58.6%), private (26.2%) and 'other', including not-for-profit, both private and public, NGO and retired (15.2%) sectors. There was a wide range of responses to the question identifying the first discipline respondents trained in. The top four responses were nursing (22.9%), 'other' (16.3%), theology (13.7%) and education (10.9%). There were respondents from all eight states and territories in Australia.

3.2. Quantitative results

The quantitative results from Sections 1–3 demonstrate that the majority of survey respondents have positive views of spiritual care.

3.3. Positive effects of spiritual care

There was a high level of agreement from the 477 respondents with the three statements about positive effects as seen in Table 1.

3.4. Policy issue statements

There was a high level of agreement from the 477 respondents with eight of the ten Policy Issue Statements as shown in Table 2. With regard to the two statements with more variable response, the statement about 'faith representatives' was the only statement framed as a negative statement (to test for response bias) and elicited a range of responses. While there was support for the statement about patient assessments, this statement had a greater

Table 1

Responses showing levels of agreement/disagreement to the three statements about positive affects of spiritual care.

Introductory Statements	Strongly Agree (1) % n	Agree (2) % n	Unsure (3) % n	Disagree (4) % n	Strongly disagree (5) % n	Mean	Standard Deviation
1. Spiritual care positively affects wellbeing	72.1 344	24.7 118	1.4 7	0.6 3	1.0 5	1.34	0.65
2. Spiritual care positively affects health outcomes	57.4 274	35.8 171	5.4 26	0.6 3	0.6 3	1.51	0.69
3. Spiritual care positively affects patient experience	62.0 296	33.7 161	3.3 16	0.4 2	0.4 2	1.43	0.62

Table 2

Responses showing levels of agreement/disagreement with the ten Policy Issue Statements.

Policy Issue Statement	Strongly Agree (1) % n	Agree (2) % n	Unsure (3) % n	Disagree (4) % n	Strongly disagree (5) % n	Mean	Standard Deviation
1. All patients should be offered the opportunity to have a discussion of their religious/spiritual concerns	61.4 293	34.3 164	2.9 14	0.8 4	0.4 2	1.44	0.64
2. Patient's values and beliefs should be integrated into care plans.	63.5 303	29.7 142	5.0 24	0.8 4	0.6 4	1.46	0.71
3. Spiritual care quality measures should be included as part of the hospital's quality of care reporting.	50.3 240	35.0 167	11.3 54	2.3 11	1.0 5	1.69	0.84
4. All health professionals should receive training about spiritual care.	45.7 218	41.3 197	8.1 39	4.4 21	0.4 2	1.73	0.82
5. Representatives of local faith communities should not be recognised as part of the hospitals' spiritual care team.	8.3 40	17.1 82	22.0 105	32.7 156	19.7 94	3.38	1.22
6. All patients should have an assessment of their spiritual needs.	29.3 140	45.7 218	16.5 79	6.9 33	1.4 7	2.05	0.93
7. Information gathered from assessments of spiritual needs should be included in the patient's overall care plan.	37.3 178	50.3 240	8.1 39	3.1 15	1.0 5	1.8	0.80
8. Families should be given the opportunity to discuss spiritual issues with health professionals.	41.0 196	50.9 243	4.8 23	2.7 13	0.4 2	1.7	0.72
9. Hospitals should provide a dedicated space for meditation, prayer, ritual or reflection.	69.6 332	24.7 118	3.1 15	1.8 9	0.6 3	1.39	0.70
10. There should be a paid professional spiritual/pastoral care workforce in hospitals.	66.6 318	22.0 105	8.3 40	1.6 8	1.2 6	1.49	0.82

spread of responses with a standard deviation of 0.98 and the highest level of 'unsure' responses [$n = 79$].

3.5. Policy objectives

A total of 460 respondents completed this section. Policy objectives were found to be both desirable and feasible as shown in [Tables 3 and 4](#) below. There was greatest difference in response to the Policy Objective 'Spiritual care workers are recognised as health professionals' with this objective recording the highest number of 'unsure' responses for both desirability and feasibility and standard deviations of 1.10 and 1.14 respectively.

3.6. Experience of spiritual care in the respondents' hospital

The majority of respondents indicated that spiritual care is provided in the hospitals in which they work (79.6%, $n = 452$) and the hospitals directly employed spiritual care workers (60.3%, $n = 451$). A small number of hospitals had spiritual care workers paid by other agencies (31.0%, $n = 451$). Almost half of respondents indicated that there was a spiritual care policy in their hospital (47.8%, $n = 445$). The positions most likely to have oversight of spiritual care in these hospitals were the Director of Mission, Director of Allied Health or the Director of Nursing.

3.7. Qualitative results

Six main themes emerged from the qualitative data obtained from the open-ended comment sections in the questionnaire: [1] Models for spiritual care provision, [2] Education and training, [3] Resources, [4] Understanding of terminology and roles, [5] Research and [6] Diversity. [Table 5](#) details the number of respondents who

answered the free-text option and the number of references in the data coded for each of the themes.

3.7.1. Models for spiritual care provision

Many respondents provided comments in all free-text sections that related to models of spiritual care provision. The need for a professional spiritual care model, as opposed to a purely faith based model, often reliant on volunteers, was a predominant message coded under the sub-theme of 'Practice':

A new model needs to be developed as many people are not religious but are looking to still make meaning, find hope and make sense of what is going on. [Respondent 268].

Over reliance of volunteers; linking of spiritual care to funding by churches rather than direct employment by institutions (this perpetuates the link that spiritual care is ONLY religious care). [Respondent 358].

It was also apparent that respondents' experiences covered a variety of models of spiritual care provision and a number were satisfied with the status quo:

Spiritual health is extremely important and is currently well provided through the local churches. [Respondent 78].

A second sub-theme to emerge from the data related to 'Governance' covering areas such as the need for national standards for practice, remuneration, and accreditation. Comments ranged from simply stating:

Poor governance. [Respondent 235].

To identifying more complex measures needed:

Table 3

Responses showing the desirability of six Policy Objectives.

Policy Objective	Highly Desirable (1) % n	Desirable (2) % n	Unsure (3) % n	Undesirable (4) % n	Highly Undesirable (5) % n	Mean	Standard Deviation
1. Spiritual care is incorporated at all levels of the health system in Australia	54.5 251	36.0 166	7.1 33	1.9 9	0.2 1	1.57	0.73
2. Spiritual care is included in the education and training of all health professionals	50.6 233	38.7 178	6.3 29	3.4 16	0.8 4	1.65	0.82
3. Spiritual care workers are recognised as health professionals	52.3 241	24.5 113	11.3 52	9.3 43	2.3 11	1.85	1.10
4. Professional spiritual care workers are included as members of multidisciplinary teams	63.9 294	25.2 116	6.3 29	3.4 16	1.0 5	1.53	0.85
5. Research is conducted on the contribution of spiritual care to quality of care.	62.1 286	29.5 136	6.7 31	0.8 4	0.6 3	1.48	0.72
6. Research is conducted on the effectiveness of spiritual care.	61.3 282	30.6 141	6.5 30	0.8 4	0.6 3	1.49	0.71

Table 4

Responses showing the feasibility of six Policy Objectives.

Policy Objective	Highly Feasible (1) % n	Feasible (2) % n	Unsure (3) % n	Probably infeasible (4) % n	Highly infeasible (5) % n	Mean	Standard Deviation
1. Spiritual care is incorporated at all levels of the health system in Australia	30.6 141	44.3 204	12.3 57	11.9 55	0.6 3	2.08	0.98
2. Spiritual care is included in the education and training of all health professionals	40.6 187	41.3 190	7.8 36	8.2 38	1.9 9	1.90	0.99
3. Spiritual care workers are recognised as health professionals	41.3 190	30.4 140	13.9 64	10.6 49	3.7 17	2.05	1.14
4. Professional spiritual care workers are included as members of multidisciplinary teams	53.4 246	30.6 141	7.6 35	6.9 32	1.3 6	1.72	0.96
5. Research is conducted on the contribution of spiritual care to quality of care.	51.3 236	35.8 165	8.7 40	3.0 14	1.0 5	1.67	0.84
6. Research is conducted on the effectiveness of spiritual care.	48.0 221	36.3 167	11.3 52	3.4 16	0.8 4	1.73	0.86

Table 5

Number of references coded for each theme identified in all free-text sections of the survey.

	Issues n = 102	Objectives n = 51	Barriers n = 330	Final Comments n = 137	Total
Models for spiritual care provision	82	25	85	113	305
Education & Training	20	10	106	13	149
Resources	8	9	112	9	138
Understanding of terminology & roles	2	5	109	0	116
Research	3	11	36	13	63
Diversity	13	4	24	9	50
Total	128	64	472	157	885

Having policies, structures and resources are crucial. They all stem from the will of the Trustees to keep it central to the dignity of the whole person. [Respondent 340].

The final sub-theme was identified as the dominance of the 'Medical Model' that was often seen to exclude holistic care. In identifying barriers to spiritual care respondents stated:

Hospital needs to move from the medical model to a holistic model of care. [Respondent 412].

3.7.2. Education and training

Respondents identified the need for education and training models to support different levels of spiritual care provision and to address the lack of understanding that was identified as such a significant barrier to the inclusion of spiritual care.

There needs to be a growing recognition that spiritual care training and expertise is needed in acute hospital settings. [Respondent 268].

The three sub-themes identified the groups of people respondents recognised as needing education and training in order to: understand spiritual care; incorporate spiritual care into their own health care provision as appropriate; and support the provision of

spiritual care by spiritual care practitioners integrated as members of the multi-disciplinary team. Responses were directed to the education and training needs of 'Health Professionals', 'Management' and 'Spiritual Care Practitioners'

I do feel spiritual care assessment for patients and education for staff and paid spiritual care workforce would be beneficial. [Respondent 492].

Lack of education/importance of the role at senior management level for additional funding. [Respondent 396].

3.7.3. Resources

Respondents identified a lack of resources as a significant issue for the provision of spiritual care. This was seen to impact the capacity for implementation of policy issue statements, the feasibility of policy objectives and was identified as a significant barrier to the inclusion of spiritual care in hospitals. Four sub-themes emerged from the responses. These focused on the 'Funding' required, the 'Priorities' of decision makers, the numbers of 'Staff' required, and the lack of 'Time' for attending to these aspects of care. Examples of these sub-themes can be seen in the following:

There needs to be dedicated funding to facilitate all of the above. (Referring to the Policy Objectives) [Respondent 169].

Held by many to be low priority. [Respondent 322].

Availability of appropriately qualified staff. [Respondent 152].

Lack of time for health professionals to ask anything about wellbeing. [Respondent 31].

3.7.4. Understanding of terminology and roles

This theme most clearly emerged in the responses identifying barriers to the inclusion of spiritual care. Many of the comments related to the confusion between spirituality and religion and the conflation of the two by some people. The use of different terminology in the responses (chaplaincy, pastoral care, spiritual care) demonstrates the inconsistency in language used in the field. These issues were identified as a sub-theme related to 'Definitions and terminology':

I think people confuse spiritual with religion. [Respondent 34].

Spiritual/pastoral needs an agreed definition that includes all beliefs (including Humanist beliefs). [Respondent 156].

'Attitudes of staff' was the second sub-theme to emerge from the data with respondents recognising the impact that staff have on the provision of spiritual care through the positive or negative attitudes they carry:

Negative attitudes towards spiritual care. [Respondent 240].

Respondents identified some confusion about roles. This included questions related to whose role it is to provide spiritual care and the lack of understanding surrounding the spiritual care role itself. This was identified as the final sub-theme 'Roles':

Health workers don't see it as their role. Patients don't see it as the health workers role. [Respondent 39].

3.7.5. Research

A number of respondents pointed to the need for further research to build on the evidence base for spiritual care. Others pointed to the evidence that already exists in the literature.

Not enough high quality literature and evidence base to prove just how well it works. Another reason why no one is paying attention. [Respondent 233].

There was concern expressed by a small number of respondents on this theme:

Spiritual carers are NOT health professionals but DO have a role in wellbeing of patients. It is not a science and it cannot be measured but it is important to many patients (and their carers). [Respondent 132].

3.7.6. Diversity

Many respondents identified the need for spiritual care to be understood as more than just religious care, that there needs to be a model of care that is responsive to the spiritual diversity of the whole population.

Spiritual care must be provided in the faith or belief of the patient not just as one religion to cover all as we see currently. [Respondent 13].

While this theme of 'Diversity' had the smallest number of references, the responses drew attention to the recognition of the diverse cultural, religious and spiritual views that need to be taken into account in any spiritual care provision.

4. Discussion

Wellbeing, health outcomes and patient experience are increasingly framing the discussions on quality of care in health [16,24,25]. Spiritual care is an essential aspect of these components clearly expressed through the paradigm of patient-centred care [8,26], and this connection should be of interest to policy and decision-makers as they seek to improve the quality of patient care. Just how spiritual care positively affects these components is yet to be fully explored although some research has been undertaken in these areas [1,3,27]. This developing evidence makes it clear that patients want their spiritual needs addressed as part of quality health care [28,29]. Our findings lend further support for a policy approach that places spiritual care within the requirements for high quality health care delivery. Specifically the high-level agreement we found with the policy issue statements suggests that further work with these as quality indicators to benchmark against best practice spiritual care and influence policy development within Australian hospitals is warranted. These statements point towards a professional and integrated model of spiritual care with clear policy parameters and given these were derived from International Quality Indicators [13], proponents for spiritual care in other countries might consider exploring the potential of these as policy levers in their own contexts. While taking into account the limitations of the questionnaire as described below, responses may still provide some guidance for understanding why there are multiple models and governance approaches to the provision of spiritual care in Australia.

The four major themes identified as barriers to the inclusion of spiritual care [Resources; Understanding of terminology and roles; Education and Training; and Models for spiritual care provision] are consistent with other research reporting on barriers [30–33]. It is not surprising that there are a wide variety of approaches to spiritual care when 'understanding' was identified as a major barrier. The language itself has shifted over the last two decades with the addition of 'pastoral care' and 'spiritual care' to the chaplaincy language that had previously dominated. Today there are pastoral or spiritual care services provided by a range of providers who may be employed directly by health services, or appointed by other agencies, and these providers may or may not have a formal faith affiliation. There is also an increasing expectation that all staff have a responsibility for spiritual care [34]. In this context language and definitions become increasingly important as does defining the role and scope of practice of providers, whether they are spiritual care practitioners, other health care professionals, faith representatives or volunteers. The publication of the revised ICD-10AM ACHI/ACS Spiritual Care Intervention Codes in 2017 began to address the need for consistent language and clear definitions, but the use of these by spiritual care providers to report in patient medical records is currently not mandated [35]. In addition, the development of a Capability Framework for Spiritual Care Practitioners in Health Services to define the role and scope of practice of spiritual care practitioners was completed in 2016 and distributed to health services in Victoria [36]. There are increasing resources available to address the identified issues but implementation needs integration into national spiritual care standards.

Identifying the clear pathways required for initial and ongoing education and training of spiritual care providers emerges as a significant issue to be addressed. Interdisciplinary models for spiritual care education and training are developing and the potential for integration of such programs into medical and health care professional education warrants further exploration [37]. For spiritual care practitioners an emphasis on theological education can leave them with inadequate knowledge and understanding of health care and hospital systems. The spiritual care quality indicators and required capabilities provide important resources to identify the core curriculum for spiritual care practitioners. Collaboration

between education providers, professional associations and policy makers is needed to fully scope this issue.

The 'Models for spiritual care provision' theme begins to identify the systemic nature of resistance towards anything that sits outside of the predominant medical model in which health care is immersed. In this context, where there is limited understanding and acknowledgment of the contribution of spiritual care to health outcomes, it is not surprising that the issue of resource availability is also identified as a significant barrier [18,31,38].

Implementing a nationally consistent approach to the provision and governance of spiritual care may be a significant step towards addressing these barriers and would require the support and development of policy at national and state levels.

The data has begun to identify a number of possible components to inform a national policy agenda that align with those identified in the literature and from which a model for provision and governance of spiritual care begins to emerge. A national policy agenda will require:

1. Governance and policy structures that clearly define spiritual care and articulate its place within organisational structures and policy frameworks. This could include endorsement by State Health Departments and health services of the ICD-10AM ACHI/ACS Spiritual Care Intervention Codes for reporting in patient medical records and inclusion of spiritual care governance in the National Standards for Safety and Quality;
2. Clear role delineations and scope of practice for spiritual care provision. This could include endorsement of the Capability Framework for Spiritual Care Providers in Health Services by Spiritual Care Australia, and implementation of the Framework by health services to further this objective;
3. Collaboration between education providers, spiritual care professional bodies and policy makers to identify education and training models to support the different levels of spiritual care provision and to address the lack of understanding particularly at management levels; and
4. National standards of practice and accreditation processes for spiritual care providers to ensure best practice spiritual care delivery.

The Australian National Consensus Conference *Enhancing Quality & Safety: Spiritual Care in Health* June 2017 began the conversation towards the development of a national policy agenda to respond to these issues. This has the potential to influence policy development and the provision of spiritual care across Australian hospitals in some of the ways outlined above, with implications for other countries currently exploring these issues.

4.1. Limitations

The limited number of responses and the Australian focus means findings are not generalizable to other contexts. The method of questionnaire distribution is likely to have recruited those with an existing interest in the area of spiritual care, thus results may be skewed toward support for spiritual care. Extending this exploratory study through more targeted distribution methods to ensure a broad range of stakeholders would be helpful in developing a wider evidence base to support policy initiatives.

5. Conclusion

The stakeholders who participated in this study have positive views towards the role of spiritual care in hospitals. High levels of agreement with policy issue statements and policy objectives and the identified themes from free text responses all begin to identify the issues that need to be addressed to form a national policy agenda for the provision of professional spiritual care in Australian hospitals. These directions informed the June 2017 National Consensus Conference and may provide potential mod-

els for international colleagues exploring this area of health care. Clearly further work is needed to define the scope of practice for all spiritual care roles and to identify the education and training pathways required. Appropriate governance structures and policy development is needed to ensure safe and quality spiritual care services in Australian hospitals. The inclusion of spiritual care may provide a significant pathway for the provision of patient-centred care in health. The contribution of spiritual care to wellbeing, positive health outcomes and patient experience therefore warrants further exploration.

Conflicts of interest

None.

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