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Evaluating the Effectiveness of Frameworks Benchmarking for Quality Spiritual Care in Victoria, Australia

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Abstract: The Spiritual Health Association[2] has developed two frameworks for use by spiritual care management across health services in Victoria (Australia), namely, the "Spiritual Care Minimum Data Set Framework" (SHV, 2015) and second, the "Spiritual Care in Victorian Health Services: Towards Best Practice Framework" (SHV, 2016a), hereafter referred to as "the frameworks." For the first time, the frameworks have provided a consistent way of collecting data in Victoria, and of benchmarking spiritual care services in several areas including governance, credentialing, and quality improvement processes. The evaluation was conducted by surveying 36 spiritual care managers/co-ordinators in Victorian hospitals. The results were used to report to chief executive officers in Victorian health services. The results of the evaluation showed that the frameworks were effective tools for auditing, benchmarking, and improving quality in spiritual care departments within health services in the State of Victoria, Australia. These frameworks were found to support spiritual care departments in undertaking continuous improvement initiatives in their local health services. The results have informed the development of future frameworks and guidelines for the spiritual care sector.

Keywords: spiritual care, pastoral care, chaplain, spiritual care managers/co-ordinators, evaluation, data set frameworks, standards, quality assurance, benchmarking

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2. Spiritual Health Victoria changed its name to Spiritual Health Association on July 1, 2019. The two frameworks were developed and evaluated by Spiritual Health Victoria.

Introduction

The Spiritual Health Association is a Victoria State Government funded body in Australia. The organization liaises with government, faith organizations, health services, peak bodies, and other stakeholders to promote and advance the quality and availability of spiritual care in health services.

With the professionalization of the industry and the need to gather accurate evidence of spiritual care to support professional employment and research, the Spiritual Health Association has developed several frameworks to strengthen the quality of spiritual care in health services. This article addresses the evaluation of the two frameworks described below and the outcomes from the evaluation. The results will inform the review and development of further frameworks and guidelines for the sector.

Background

In 2014, a project reporting spiritual care activity to the Victorian Department of Health and Human Services (Victoria, Australia) highlighted the need to improve data quality and education about data collection within the spiritual care sector (SHV, 2014). A consultative committee of senior spiritual care managers and Spiritual Health Association staff reached a consensus on data collection for spiritual care provision in the Victorian sector based on current standards and procedures used in health services (Hennequin, 2020). Feedback was also received from health service executives and the Victorian Healthcare Association (VHA) via the Health Service Spiritual Care Advisory Group, which was made up of health service executives and a policy advisor from the VHA. The Spiritual Health Association developed a new framework, the "Spiritual Care Minimum Data Set (SCMDS) Framework" (SHV, 2015), to promote a consensus approach. The framework was based upon the current national data collection standards in Australia (ACSQHC, 2012; SCA, 2013).

In 2016, the Spiritual Health Association developed an additional framework titled "Spiritual Care in Victorian Health Services: Towards Best Practice Framework" (SHV, 2016a), in consultation with spiritual care managers and a number of executives from Victorian health services. The National Health Service (England) "Chaplaincy Guidelines 2015," subtitled "Promoting Excellence in Pastoral, Religious and Spiritual Care" (NHS England, 2015), provided the impetus for Victoria (Australia) to develop its own best practice framework, which also assisted with the recognition of spiritual care as an allied health discipline by the Victorian Department of Health and Human Services (SHV, 2016b).

The Spiritual Health Association also collaborated with the Health-Care Chaplaincy Network in developing quality indicators, titled "What Is Quality Spiritual Care in Health Care and How Do You Measure It?" (HCCN, 2016). A National Consensus Conference held on June 1–2, 2017 in Melbourne further supported the recommendations for the provision of spiritual care within healthcare using integrated, accountable, and evidence-based models by a credentialed and professional spiritual care workforce (Holmes, 2017).

In early 2016, SHA sent printed copies of both the SCMDS Framework and the Towards Best Practice Framework to health services' chief executive officers and to their spiritual care management. In addition, email copies of the frameworks were sent to spiritual care management to further promote best practice. Copies were also posted on the Spiritual Health Association's website. The frameworks were based on current Spiritual Care Australia's (SCA) national standards (SCA, 2013)[3] and the minimum data collection standards for admitted patients in Victorian public and private hospitals.

Literature Review

Benchmarking and quality improvement are the foci for both the SCMDS Framework and the Towards Best Practice Framework. The spiritual care sector had national Standards of Practice developed by Spiritual Care Australia (SCA, 2013). Some work had also been done previously in Victoria to establish standards in data collection (SHV, 2012). In 2015 and 2016, the frameworks provided a new way to benchmark, utilizing two audit tools (SHV, 2016a) and a means of evaluating various components in establishing or assessing the quality of service provision and performance (Hobson et al., 2008; Rees & Leahy-Gross, 2012).

Key components identified in the frameworks focused on quality improvement in governance, consumer, and carer involvement (McDonnell & Jones, 2010); advocacy and integration with the multidisciplinary team, including education of health professionals about spiritual care (Abu-El-Noor, 2012; John et al., 2001); as well as improving data quality in spiritual care to communicate effectively with other staff (Thiru et al., 2003). The inclusion of these features in service provision could improve spiritual care as part of person-centered care in health services.

The literature search confirmed the importance of using validated spiritual care assessment tools as part of best practice (Borneman, Ferrell, &

3. SCA: Spiritual Care Australia is the Australian national professional association for spiritual care practitioners for various sectors including health and welfare.

Puchalski, 2010; Fitchett, Murphy, & King, 2017; Monod et al., 2010; Peterman et al., 2002). Existing research has shown that these interventions can assist practitioners in assessing for spiritual distress, but they can also be used to communicate across a multidisciplinary team (Monod et al., 2010). Other significant aspects identified were training and education about spiritual care for staff in health services (Yang et al., 2017), for allied health students (Hodge & Hovarth, 2011), and raising public awareness. The manual *Collecting Evaluation Data: Surveys* (Taylor-Powell & Hermann, 2000) provided a good framework to conduct an effective telephone survey of health services' spiritual care managers.

Aim

The SHA wanted to evaluate whether (a) spiritual care and health service managers found the frameworks effective and (b) useful in assessing (i) best practice and (ii) spiritual care documentation, and (c) for improving the quality of spiritual care provided.

Method

Context

On March 8, 2016, the SHA conducted a workshop to educate spiritual care managers about the two new frameworks, and to encourage participants to explore opportunities for gap analyses and quality improvement projects in their health service. Twenty spiritual care managers and faith community leaders participated in the workshop. The new frameworks were also promoted at the annual SCA conference on May 3, 2016 in Melbourne, Victoria (Holmes & Hennequin, 2016). Further, a poster of the two frameworks was presented at the Palliative Care Victoria Conference on July 28–29, 2016 in Melbourne (Hennequin, 2016).

Key messages focused on continuous quality improvement and embracing change management to align with best practice and current standards in healthcare and spiritual care. Spiritual care management in 36 Victorian health services were emailed information about the evaluation of the frameworks via a survey on October 26, 2016 and invited to participate in the survey. Only health services with an employed spiritual care director, manager, or co-ordinator were contacted. Contact was made by telephone. Only one practitioner was unable to respond to the invitation to participate in a telephone survey; 35 accepted at the first or second invitation (n = 35/36: 97.2% response rate).

Questionnaire

The questionnaire was developed by SHA staff. Feedback on the draft questionnaire was obtained within the organization from two staff members with research skills. The questionnaire was then trialed by the telephone interviewers and updated before the telephone surveys were conducted. As the questionnaire was administered purely as a quality assurance measure among personnel from existing SHA affiliate organizations, and as it did not request any personal or organizational details, ethics approval was not required.

Spiritual care service managers were telephoned at a prearranged time and surveyed using the questionnaire. Although time consuming, telephone interviews were considered by the researcher to be an effective means of ensuring responses to the questionnaire, particularly given the increasing online workload and the number of online surveys, which can be easily ignored due to excessive emails. Each telephone interviewer surveyed approximately half the number of participants (19 and 16: $n = 35$). Participants were given an estimated time of 20 minutes for the survey. Participants were asked about both frameworks initially, whether they had read one or both framework(s) fully or partially, and if not, why not. Participants then answered questions on the individual frameworks that they had read. They were invited to make final comments on any aspect of the frameworks or the implementation process. Responses were handwritten by the interviewers on a hard copy of the survey questionnaire and then transcribed to Survey Monkey, which is an online survey tool (Survey Monkey Inc.).

Results from the evaluation survey were exported from Survey Monkey to Excel worksheets. Standard descriptive statistical analysis was utilized for assessing the survey quantitative data, and the qualitative data were thematically categorized independently by each interviewer. According to Ezzy (2002), "Thematic analysis aims to identify themes within the data. Thematic analysis is more inductive than content analysis because the categories into which the themes will be sorted are not decided prior to coding the data." After discussion and further examination of any themes where differences occurred, the final themes were agreed upon. Some of these themes arose from the information gathered from participants regarding the effectiveness of the frameworks. Other themes, such as "Key areas and components," arose from the wording of questions. Responses were color coded in Excel worksheets according to the identified categories, and graphs were produced to show the results.

Demographics

Participants from 35 health services completed the survey (n = 35). The majority of these participants were from Melbourne metropolitan public hospitals (54.3%) (see Table 1). Irrespective of the locality or type of hospital, all participating services had at least one spiritual care practitioner or spiritual care manager employed.

It is important to note that across Victoria health services have different models of spiritual care (SHA, 2019a; SHV, 2016a). While specific employment data on spiritual care practitioners were not collected as part of this research, 7 of the 36 health services which were invited to participate (n = 7/36: 19.4%) had an employed sole practitioner who provided spiritual care with or without the assistance of volunteers. However, most of the regional and rural health services surveyed relied on trained volunteers to provide the human resources necessary for spiritual care.

Both metropolitan and regional health services included spiritual care practitioners who visited on behalf of faith communities. Some faith community practitioners were employed by the faith community and worked as part of the hospital spiritual care team in an inclusive way, as well as regularly visiting patients who identified as part of their faith. Employed faith community practitioners would usually have a "Memorandum of understanding" with the hospital where they worked. Other faith community representatives visited in a volunteer capacity.

Table 1: *Summary of participant healthcare services – evaluation survey*

Location of health service – metropolitan or regional	n = *35: 100 (%)*
Metropolitan public hospitals	19 (54.3%)
Regional public hospitals	6 (17.1%)
Metropolitan private hospitals	6 (17.1%)
Regional private hospitals	3 (8.6%)
Regional community health center	1 (2.9%)
Total	35 (100%)
Type of health service – public or private	
Public hospitals: metropolitan and regional	25 (71.4%)
Private hospitals including one private mental health hospital	9 (25.7%)
Community health center – regional	1 (2.9%)
Total	35 (100%)

Results

Detailed results of the evaluation are listed separately under each of the two frameworks. All results were calculated based on the total number of participants (n = 35), irrespective of whether or not participants actually provided a response to a specific question.

Spiritual Care in Victorian Health Services: Towards Best-Practice Framework

Nine key areas and components were listed in the framework for the delivery of effective spiritual care (see Table 2). The majority of participants (n = 32/35: 91.4%) identified that the list of "Key areas and components for effective spiritual care in Victorian health services" was useful for their work (SHV, 2016a).

Individual Responses Questions

The frameworks were read by the majority of participants: Towards Best Practice Framework (n = 25/35: 71.4%); SCMDS Framework (n = 30/35: 85.7%). Eight participants partially read the Towards Best Practice Framework (n = 8/35: 22.9%) and two partially read the SCMDS Framework (n = 2/35: 5.7%). Summary findings of individual responses to each question are presented below relating to both the Towards Best Practice Framework (Questions 4–12) and the SCMDS (Questions 14–20).

Table 2: *Key areas and components – Towards Best Practice Framework*

	Key areas and components
1	Governance
2	Quality service delivery and accountability
3	Integration
4	Resources
5	Staffing (recruitment and appointment)
6	After-hours on-call service
7	Data collection and record keeping
8	Staff and organizational support
9	Professional development
10	Good practice for the management of spiritual care volunteers
11	Good practice for the management of spiritual care students
12	Research and innovations for spiritual care in health services
13	Audit tool 1: setting up a spiritual care service
14	Audit tool 2: gap analysis evaluation of an existing spiritual care service

Q4: Let's start with the Towards Best Practice Framework. If you have partially read the framework, which key components did you read?

Of the eight participants who partially read the framework, six read audit tool 2 – "Gap analysis evaluation of an existing spiritual care service" (*n* = 6/8: 75%). Other areas of interest included the management of spiritual care students (*n* = 3/8: 37.5%) and the management of volunteers (*n* = 2/8: 25%).

Q6: How effective did you find the Towards Best Practice Framework in identifying gaps in best practice?

Approximately 77% (*n* = 27/35: 77.1%) found the Towards Best Practice Framework effective in identifying gaps in their service. Approximately 17% (*n* = 6/35: 17.1%) found the framework neither effective nor ineffective.

Q7: Which areas did you find useful in the Towards Best Practice Framework?

Of the 35 participants, 62.8% (*n* = 22/35) found the audit tools useful, and 51.4% (*n* = 18/35) checked their overall alignment with the Towards Best Practice Framework. Quality service delivery and accountability (*n* = 13/35: 37.1%), credentialing (*n* = 13/35: 37.1%), and governance (*n* = 9/35: 25.7%) were also identified as useful aspects of the framework. The credentialing of professional practitioners, volunteers, and faith community representatives was identified as useful, even though credentialing was not identified specifically as one of the "key components."

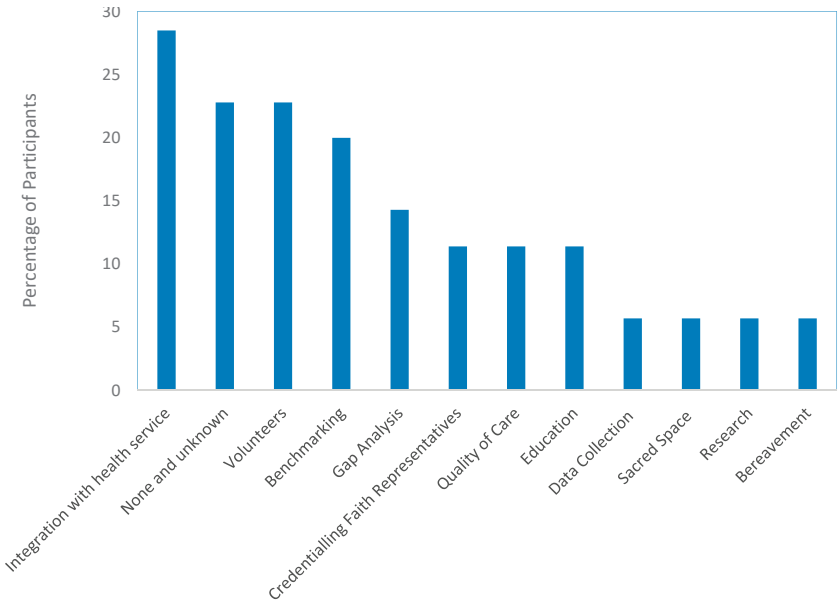
Q8: What specific changes did you make in your department as a result of using the Towards Best Practice Framework?

Thirty-one participants (*n* = 31/35: 88.5%) made specific changes in their spiritual care departments as a result of using the Towards Best Practice Framework (Figure 1). These covered improvements across a range of areas, including integration with the health service (*n* = 10/35: 28.5%), improving volunteer services (*n* = 8/35: 22.8%), benchmarking services against the framework (*n* = 7/35: 20%), using audit tool 2 to conduct a gap analysis (*n* = 5/35: 14.3%), quality of care (*n* = 4/35: 11.4%), and credentialing faith representatives (*n* = 4/35: 11.4%) (see Figure 1).

Q9: How did you involve your line manager?

Most participants (*n* = 29/35: 82.8%) involved their line manager in discussions about the Towards Best Practice Framework and potential initiatives for quality improvement. Some used audit tool 2 gap analysis (*n*

Figure 1: *Changes made in department and noted by participants as a result of using Towards Best Practice Framework (n = 31/35: 88.5%)*

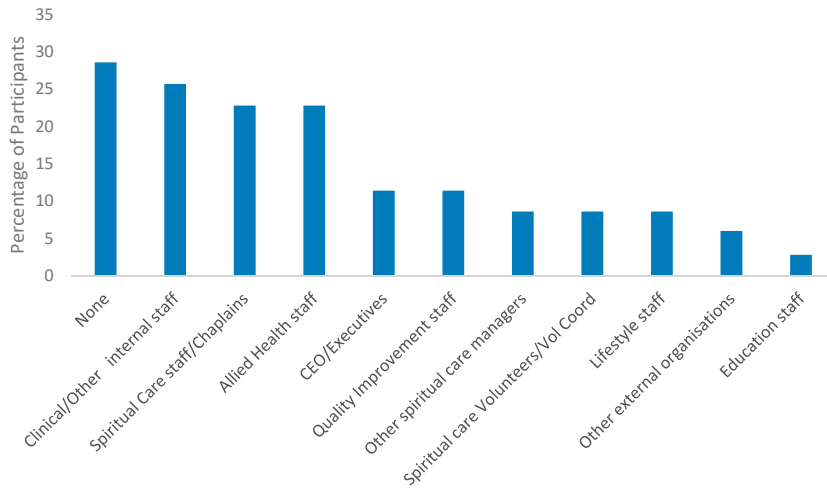


= 8/35: 22.8%) to benchmark their service at that time or as part of an annual review. Some health service line managers (*n* = 5/35: 14.3%) were very supportive and positive about aligning their service with the Towards Best Practice Framework. Spiritual care managers felt that the framework assisted them in raising quality and resource issues about their service, and it also provided a means to promote spiritual care (*n* = 5/35: 14.3%). Unfortunately, a number of line managers were not responsive in discussing best practice spiritual care (*n* = 5/35: 14.3%) and did not engage with a process for quality improvement for varied reasons.

Q10: With what other staff did you liaise?

Of the 29 participants (*n* = 29/35: 82.8%), the majority liaised with their own spiritual care staff and chaplains (*n* = 8/35: 22.8%), clinical/other internal staff (*n* = 9/35: 25.7%), allied health staff (*n* = 8/35: 22.8%), chief executive officers/executives (*n* = 4/35: 11.4%), quality improvement staff (*n* = 4/35: 11.4%), other spiritual care managers, and volunteers and the volunteer co-ordinator (*n* = 3/35: 8.6%). Ten participants did not liaise with any other staff (*n* = 10/35: 28.6%) (see Figure 2).

Figure 2: *Participants' liaison with staff by role – Towards Best Practice Framework (n = 29/35: 82.8%)*



Q11: What goals did you want to achieve by using the Towards Best Practice Framework?

Thirty-two participants (*n* = 32/35: 91.4%) identified five goals they wanted to achieve by using the Towards Best Practice Framework:

- to achieve best practice;
- to improve the quality of their service;
- to conduct a gap analysis of their service;
- to improve integration with the health service;
- to improve staffing and resourcing.

Q12: Did the outcomes meet your goals?

Twenty-eight participants answered this question (*n* = 28/35: 80%). Approximately 57% (*n* = 20/35: 57.1%) were progressing in meeting their goals, approximately 14% felt that their goals had been met (*n* = 5/35: 14.3%), and only about 9% (*n* = 3/35: 8.6%) had not yet met their goals.

Spiritual Care Minimum Data Set Framework

The SCMDS Framework provided a framework of guiding principles for data collection with consistent and agreed definitions for use in health services and other relevant contexts (see Table 3).

Table 3: *Key terms and definitions – SCMDS Framework*

Guiding principles
Episodes of care – admitted patient
Unit record number
Non-admitted patient/client
Spiritual care providers
Spiritual care contact
Definition of pastoral interventions: 96186-00 Pastoral assessment 96187-00 Pastoral ministry or support 96087-00 Pastoral counseling or education 96109-01 Pastoral ritual/worship 95550-12 Allied health intervention, pastoral care
Optional categories for internal health service reporting: Contact duration (time) Direct or indirect activities Outcomes Spiritual support of health service staff

Note: Pastoral interventions have been renamed "spiritual interventions codes" (IHPA, 2020a).

Q14: Are there any areas in the SCMDS Framework which you found particularly useful?

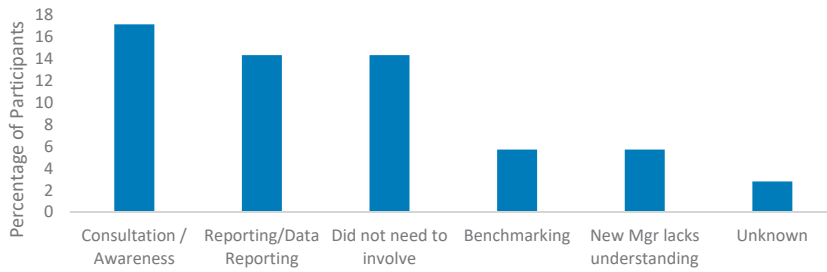
Spiritual care managers identified these themes as being most useful: definition of terms such as "episodes of care – admitted patient", "unit record number," "non-admitted patient/client," "spiritual care providers," and "spiritual care contact" (n = 21/35: 60% each); benchmarking (n = 16/35: 45.7%); definition of pastoral intervention codes (n = 15/35: 42.8%); quality improvement (n = 13/35: 37.1%).

Changes made as a result of using the SCMDS Framework included reviewing data collection (n = 16/35: 45.7%), improving integration of the data collection (n = 9/35: 25.7%), improvement in the recording of data by volunteers and visiting faith representatives (n = 5/35: 14.2%), transitioning to an electronic medical record (n = 4/35: 11.4%), and the ongoing education of staff about data collection (n = 4/35: 11.4%).

Q15 and Q16: Did you involve your line manager and if so how?

Nearly half of the participants (n = 14/35: 45.2%) involved their line manager in quality improvement initiatives related to the SCMDS Framework. These included improving consultation about the SCMDS Framework (n = 6/35: 17.1%); using the framework in reporting interventions (n = 5/35: 14.3%); benchmarking their service and demonstrating improvement to meet best

Figure 3: *Line manager involvement in continuous improvement – SCMDS Framework (*n = *14/35: 45.2%)*



practice (*n* = 2/35: 5.7%). Some participants, however, believed there was no need to involve their line manager (*n* = 5/35: 14.2%). Two managers did not feel supported by their line manager as they demonstrated a lack of understanding about the information being discussed (*n* = 2/35: 5.7%) (see Figure 3).

Q17: Which other staff in your health services did you liaise with?

Twenty-nine participants answered this question (29/35: 82.8%). The highest response was in liaising with spiritual and pastoral care team and staff (*n* = 15/35: 42.8%). This included visiting faith representatives. An additional three responses identified liaison with peer spiritual care managers individually or as part of a management steering committee. Allied health management and staff comprised the next highest number of responses (*n* = 8/35: 22.8%). This was followed by health information staff (*n* = 6/35: 17.1%), an electronic medical record (EMR) project team (*n* = 3/35: 8.6%), and information technology staff (*n* = 2/35: 5.7%). Executive and clinical staff were also approached (*n* = 3/35: 8.6%), as well as volunteer co-ordinators and volunteers (*n* = 3/35: 8.6%). Liaison with quality improvement staff occurred in two instances (*n* = 2/35).

Q18: What goals did you want to achieve by using the SCMDS Framework?

Thirty spiritual care managers responded and identified quality improvement (*n* = 19/35: 54.3%), best practice (*n* = 13/35: 37.1%), and reporting to management (*n* = 7/35: 20%) as the top three goals that they wanted to achieve.

Q19: Did the outcomes meet your goals?

Twenty-seven participants answered this question (*n* = 27/35: 77.1%). Ten participants answered "Yes" (*n* = 10/35: 28.5%), 14 answered "In progress" (*n* = 14/35: 40.0%), and 3 answered "No" (*n* = 3/35: 8.6%).

Q20: Final comments

All 35 participants made final comments which covered a multiplicity of themes including:

- the value of both frameworks, great resources as reference documents, for gap analysis, and valuable regarding governance issues (*n* = 21/35: 60%);
- affirmation of the work done by Spiritual Health Association (*n* = 7/35: 20%);
- professionalization of the sector and benchmarking (*n* = 7/35: 20%);
- suggestions when reviewing the frameworks, including consumer input and more information regarding the ICD-10-AM/ACHI/ACS codes (*n* = 6/35: 17.1%);
- request for continued advocacy from Spiritual Health Association with health service executives and the Department of Health and Human Services, especially as an allied health profession (*n* = 3/35: 8.57%);
- affirming the importance of data collection, including to assist with research (*n* = 3/35: 8.57%).

Discussion

The qualitative information provided some interesting insights into how the frameworks were used and the issues that managers faced in their particular health service regarding best practice or data collection for spiritual care. Overall, most of the participants had engaged with one or both frameworks. Of the 35 health services which participated, the majority found that the frameworks were effective: Towards Best Practice (*n* = 27/35: 77.14%); SCMDS Framework (*n* = 24/35: 72.7%).

Spiritual Care in Health Services: Towards Best Practice Framework

Many were very positive about this framework (*n* = 24/35: 68.57%):

> Generally, the frameworks are valuable as agreed points of reference. They are clear and well set out. They are valuable to have. (Q20: Final comments)

> Working with the frameworks has exceeded our expectations in what we could achieve in goals setting. We fall short in representation in multidisciplinary teams, some areas are not as well integrated. We have other goals to set for the future! (Q20: Final comments)

Responses to Q7 listed most of the areas covered under the "Key areas and components for effective spiritual care," indicating that the framework had covered essential areas for effective service provision. Audit tools 1 and 2 for gap analysis and benchmarking provided a way to assess best practice. This is evident from the results in Q7, where 22 participants had used the audit tools (n = 22/35: 62.8%). "Good practice for the management of spiritual care volunteers," where faith representatives were credentialed, also showed a high result (n = 12/35: 34.2%). Improving the credentials of faith community representatives in health services was a concurrent goal of the Spiritual Health Association at the time of this evaluation, and this was also taken up by many as a quality improvement initiative.

Changes to service provision within spiritual care departments, which were addressed in Q8, demonstrate high engagement with quality improvement by the majority of participants (n = 30/35: 85.7%), although a few of those who answered did not make or identify any changes (n = 8/35: 22.8%).

Twenty-two participants in Q9 stated that the framework encouraged discussion with line managers (n = 22/35: 62.8%). It highlighted spiritual care provision in the health service and invited engagement with discussions about quality improvement and benchmarking. This framework assisted in raising awareness with management about the issues being dealt with by the department to achieve best practice. Participants consulted with their line manager regarding undertaking a gap analysis (n = 8/35: 22.8%); plus they consulted and raised awareness about the framework and current best practice in spiritual care (n = 5/35: 25.7%). Responses indicated, however, that some line managers were not seen as being supportive (n = 5/35: 25.7%), while others did provide support (n = 5/35: 25.7%) as indicated by the following statement:

> Very pleased that the frameworks have come out and we have a gold standard. Our hope is that we continue to reach for the current gold standard. (Q20: Final comments)

Some felt that while the frameworks were very valuable, more advocacy was needed at a higher executive level to recommend their use (n = 3/35: 8.57%) and to support the professionalization of the sector. Although spiritual care had been recognized as an allied health discipline by the Chief Allied Health Advisor, Department of Health and Human Services in Victoria

(SHV, 2016b), some wanted more formal recognition of this fact in state government documents and on websites.

Spiritual Care Minimum Data Set Framework

The SCMDS Framework was an important step in establishing consistent practices in data collection by spiritual care practitioners within Victorian health services. While many health services used the ICD-10-AM-ACHI/ACS codes to document spiritual care interventions for admitted patients (IHPA, 2020b), practitioners did not do so according to common and consistent guidelines for data collection (Hennequin, 2020; SHV, 2014). Some documented more than one intervention per visit, others did not. Data collection was often not integrated with the health services' data system or was not aligned with documentation standards used by Victorian health services (DHHS, 2017a).

The SCMDS Framework provided definitions of terms and clear guidelines for data collection. During the implementation of this framework, the Spiritual Health Association raised awareness by promoting best practice for data collection at conferences and provided education at meetings and seminars. This has continued to be an important aspect of quality improvement since the framework was launched by the Spiritual Health Association in late 2015. Participants found that the SCMDS Framework was effective in identifying gaps in the collection of data (n = 24/34: 72.7%).

The "definitions of terms" used by the Department of Health and Human Services (DHHS, 2017a) and of the ICD-10-AM/ACHI/ACS codes were particularly useful for the sector, as this enabled a more consistent interpretation and documentation of the interventions as per current health standards. When answering Q18, most participants felt that improving their data collection and achieving best practice were worthwhile and positive goals: quality improvement (n = 18/35: 51.4%); best practice (n = 13/35: 37.1%). They also felt that the data could assist with reporting and discussions regarding staffing: reporting to management (n = 8/35: 22.9%); staffing and resources (n = 5/35: 14.3%). Only two participants did not identify any specific goals.

Many spiritual care managers stated in their responses to Q20 (final comments) that they appreciated the resources developed by the Spiritual Health Association and the work done: valuable resources (n = 24/35: 68.57%); appreciation for Spiritual Health Association's work (n = 7/35: 20%). Many felt that it assisted with quality improvement and best practice and the professionalizing of spiritual care (n = 13/35: 37.1%).

Limitations

The survey was conducted involving a small number of participants (n = 35) from a total of 36 health services where a spiritual care director/manager or co-ordinator was employed. The Department of Health and Human Services Victoria listed over 40 metropolitan public hospitals and over 60 public rural hospitals and health services (DHHS, 2017b). The same website also listed 83 private hospitals (DHHS, 2018). Currently, the Spiritual Health Association has no information or evidence as to how effectively spiritual care is being provided, if at all, in the majority of health services and hospitals in Victoria.

The survey does, however, offer some evidence of quality improvement or best practice for 35 health services in some of the essential components for effective spiritual care: governance, credentialing, quality service delivery and accountability, integration, resources, staffing, after-hours on-call service, data collection and record keeping, staff and organizational support, professional development, good practice for management of spiritual care volunteers and students, research and future innovations in spiritual care. It is also worth noting, as indicated earlier, that all results were calculated based on the total number of participants (n = 35), irrespective of whether or not participants actually responded to a specific question. Thus, the statistical results were quite conservative for a number of questions within this evaluation.

Another limitation was that there were no definitions provided to participants of terms such as "best practice" or "benchmarking". It is important to note, however, that good practice was discussed under the heading "Purpose of framework" and aligned with the current standards and policies for service provision in health services (SHV, 2016a). In hindsight, defining those terms under the "Key terms and definitions" section would have been helpful for clarifying the terms, both for people completing the survey and for staff analysing the results.

For the SCMDS Framework, listing the key headings, including "Definition of terms" and "Definitions of pastoral interventions," might have provided clearer responses for Q14, "Are there areas which you found particularly useful?" (SHV, 2015). However, there was a process to reach agreement using thematic analysis. Providing a list of the "key components" in addition to free text in Q7, "Are there areas which you found particularly useful (Towards Best-Practice Framework)?" would have meant that responses were received under identified themes.

Further work and research need to be done in Australia to demonstrate the contribution of spiritual care to person-centered care and health

outcomes (Holmes, 2018; Lobb et al., 2018), and to assess current documentation practices and evaluate whether these are consistent and efficient (Tartaglia et al., 2018). This is beyond the scope of this paper.

Conclusion

The Spiritual Care in Health Services: Towards Best Practice Framework and the Spiritual Care Minimum Data Set Framework, have been resources which generated audits and service evaluations in 35 health services in Victoria, Australia. The two frameworks provided an important platform in 2016 for spiritual care managers to assess best practice in essential areas of service provision. Their implementation has encouraged quality improvement in many of these areas.

Ongoing investigation of what is best practice in providing spiritual care and in data collection is essential. The ongoing development and review of guidelines and frameworks based on current evidence and research will continue to be an important aspect of the work of the Spiritual Health Association (SHA, 2019a) as a national peak body advocating and promoting compassionate, person-centered spiritual care in health services. Indeed, as a result of this evaluation, new quality assurance frameworks have been developed for the benefit of spiritual care provision within healthcare services (SHA, 2019b, 2020).

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