Spiritual Health Association

NATIONAL MODEL FOR SPIRITUAL CARE IN HEALTH

2023

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INTRODUCTION

This document presents a contemporary and inclusive model for spiritual care in Australian health services, with a focus on hospitals. The model was developed through a co-design process that involved key stakeholders in the healthcare industry, academic scholars and consumers, as well as experts in allied health, spiritual health and wellbeing.

Our aim was to respond to the growing diversity of worldviews in Australia and the increasing evidence that shows the connection between spirituality and health. Under this model, spiritual care will be delivered by a professional spiritual care workforce that is employed by health services and fully integrated into the organisational structure. These professionals will work alongside community-appointed spiritual care providers, who will be able to respond to specific needs that arise. To ensure that spiritual care is fully integrated into the healthcare system, the model places an emphasis on collaboration between spiritual care providers and other healthcare professionals.

DEFINING THE PROBLEM – INCONSISTENT QUALITY AND SAFETY OF CARE PROVIDED TO CONSUMERS

Australians have a right to receive high-quality and safe spiritual care that is trauma-informed and culturally sensitive, and to have equitable access to best-practice services. Health services have the responsibility to minimise risk to consumer safety by implementing quality, best-practice care. However, the delivery of services differs greatly across the Australian healthcare system and unwarranted variations in the provision of care have been identified as a risk to both quality and safety[1]. Spiritual care operates in the context of complex histories which may include experiences of religious or spiritual trauma. In many cases, the delivery of spiritual care in health services continues to be based upon historic models of funding and administration, and the quality of such services is inconsistently monitored or evaluated.

Key studies have demonstrated that when appropriate spiritual care is available to consumers, the quality and safety of their care increases as measured in both patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs).[2]

SPIRITUALITY IN HEALTH

The spiritual dimension of health is internationally recognised (WHO, 1998).[3] More recently, the World Health Organization (WHO) has included spiritual health in the four dimensions of wellbeing.[4] There is a growing body of research on the connection between spirituality and health outcomes, and the subsequent benefits of spiritual care for patients, families, and healthcare workers.

The meaning of spirituality is evolving and diversifying in Australia. Spirituality has long been a critical factor of wellbeing for First Nations and religious Australians and, more recently, for growing numbers of "spiritual but not religious" Australians.[5] While there are several definitions of spirituality, at its core spirituality plays a central role in creating meaning, purpose, and connectedness.

> *"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"* [6]

WHAT IS SPIRITUAL CARE?

Spiritual care is the provision of

assessment **counselling** **support** **ritual**

in matters of a person's beliefs, traditions, values and practices enabling the person to access their own spiritual resources.

Spiritual Health Association

In Australian health policies, reference to spirituality is limited. Current policies often recognise the importance of spirituality for Aboriginal and Torres Strait Islanders but miss the significance of spirituality in the lives of many other Australians (McCrindle, 2021).[7] How spirituality is expressed may depend on the lens through which a person finds meaning, purpose and connectedness. Spirituality offers Australians peace, values, purpose, morality, and love (McCrindle, 2021). Australians consider a range of experiences to be spiritual.

> *"To me spirituality is caring for the environment, nature, others. I tell my kids if you can be anything in life, be kind."* [8]

In caring for the whole person, health professionals may become aware of a person's spiritual identity or world view through informal dialogue or formal screening processes. All health professionals can provide spiritually informed care. Spiritual care provided by the professional spiritual care workforce refers to the identification and assessment of a person's beliefs, traditions, values, and practices, to support a person to access spiritual resources that meet their needs. Spiritual care also responds to the needs of the organisation including a focus on staff support.

Having identified the place of spirituality as a dimension of health and the contribution of spiritual care, there is a gap in delivering a consistent high-quality model of spiritual care in Australian health services.

NEED FOR AN INCLUSIVE, CONTEMPORARY SPIRITUAL CARE MODEL

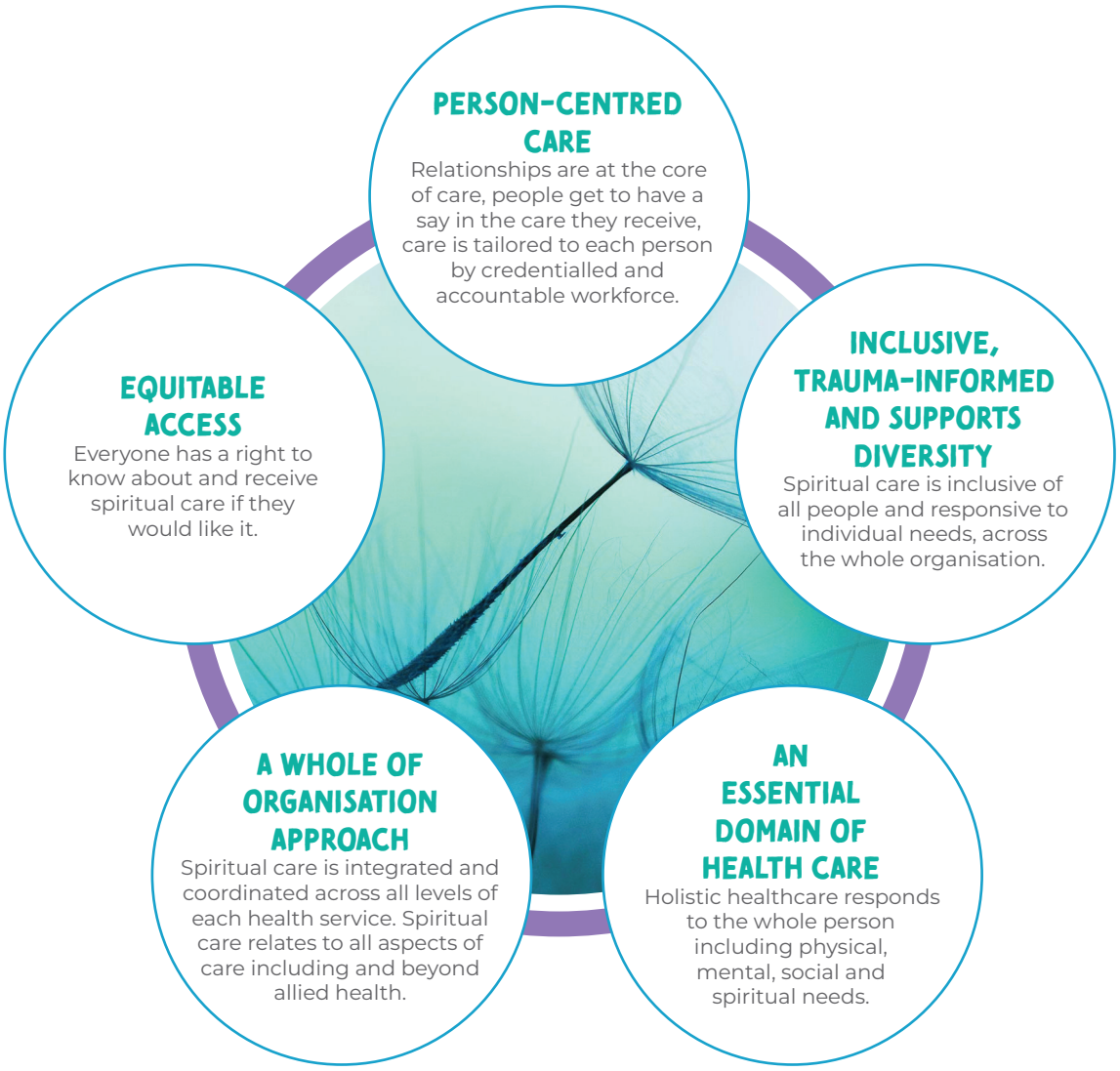
The Australian Charter of Healthcare Rights[9] has determined a person's right to have their "culture, identity, beliefs and choices recognised and respected". Healthcare that limits a person's right to receive cultural or spiritual care may impact the quality of a patient's experience and adversely affect health outcomes.

Quality spiritual care services have been shown to enhance patients' experiences of care during hospital stays as measured in higher patient satisfaction scores and resulting in the improvement of the health service's reputation as a provider of safe, high-quality care. There is a need for an inclusive, contemporary spiritual care model fit for purpose in the Australian context.

We believe this model will help to ensure that all patients receive the spiritual care they need, in line with their worldview or religious beliefs. By working together, healthcare professionals and spiritual care providers can deliver care that is truly person-centred.

GUIDING PRINCIPLES

The principles of care informed the development of this model and describe what is valued in this model. The following principles were influenced by the engagement process as well as from the Charter of Health Care Rights, principles resulting from the National Consensus Conference in 2017 and the four principles from the National Guidelines for Spiritual Care in Aged Care.



SCOPE AND USE OF THIS DOCUMENT

Through a co-design process we have produced a model for spiritual care that outlines four priority areas of focus and details quality indicators and clear expectations of what the model looks like in practice. The scope of the project focused on the hospital component of a person's health service journey, however, this model may be used to improve integration between hospitals and other parts of the health service. The model may also be adapted for use in other contexts. This document may be used to design a new spiritual care service, to develop or enhance an existing service, and to review the efficacy of services provided within a healthcare setting.

DEVELOPMENT OF THE MODEL

As a peak body for spiritual care in the health sector, Spiritual Health Association led an engagement process to co-design a consistent and contemporary spiritual care model.

The core project team includes representatives from SHA, Alfred Health, Australian Commission on Safety & Quality in Health Care, and the Anglican Diocese of Melbourne. MosaicLab, an independent engagement and facilitation consultancy was contracted to support the project.

The model has been developed through a desktop review to draw upon research, particularly focused upon consumer feedback about spiritual care preferences, and a series of interviews, focus groups and leadership workshops. We involved a diverse cohort to help identify changes to the way spiritual care operates to ensure quality, safe, contemporary spiritual care services.

The model will be trialled in selected health services in 2023 and will enable health care services to build capacity for providing high-quality and safe spiritual care.

CO-DESIGN STEPS

1. PLANNING (AUG 2022)

Project planning with the co-design team, including academic and Safer Care Victoria representatives

Desktop review of research and relevant documents

→ Strategic Engagement Plan

2. ENGAGING WITH IDEAS (SEPT – OCT 2022)

Engaging with leaders, practitioners and researchers to generate ideas for the model

6 interviews **26** forum participants

→ What was said report

3. DRAFTING THE MODEL (NOV – DEC 2022)

First draft based on the desktop review and results of the co-design phases 1 & 2

→ First draft of model

4. IMPROVING THE DRAFT (DEC 2022 – FEB 2023)

Engaging with leaders, practitioners and researchers to identify the strengths and gaps in the draft model

9 interviews **59** survey responses **23** forum participants

→ Summary reports of the engagement

5. READY TO IMPLEMENT (MAR 2023)

Refining the model based on the engagement findings

→ Model ready for piloting in health services

INTENDED AUDIENCE

This document is intended for health service leaders and professionals who guide the development and improvement of spiritual care services, including:

- State, Territory and Commonwealth Departments of Health
- Hospital Executives/Directors/Managers
- Spiritual care management and practitioners
- Allied Health Directors/Managers
- Safety and Quality Managers
- People and Culture Managers
- Educators and training providers

CONTEXT – EXISTING FRAMEWORKS AND STANDARDS

The model operates within a context of existing standards, frameworks and guidelines.

- Australian Commission on Safety and Quality in Health Care
  - National Safety and Quality Health Service (NSQHS) Standards
  - Australian Charter of Healthcare Rights
- Australian Government Department of Health and Aged Care
  - National Aboriginal and Torres Strait Islander Health Plan 2021-2031
- Australian Institute of Health and Welfare
  - Australian Classification of Health Interventions (ACHI) 12th edition
- Meaningful Aging Australia
  - National Guidelines for Spiritual Care in Aged Care
- Palliative Care Australia
  - National Palliative Care Standards (2018)
- Spiritual Care Australia
  - Standards of Practice
  - Code of Conduct
- Spiritual Health Association
  - Guidelines for Quality Spiritual Care in Health
  - Capabilities Framework for Spiritual Care Practitioners in Health 2020
  - Spiritual Care in Medical Records: A guide to reporting and documenting spiritual care in health services
  - Spiritual Care Providers (Community Appointed) Credentialling Framework
- World Health Organization
  - Geneva Charter for Well-being
  - ICD-11 Spiritual Care Intervention Codes

PRIORITY AREAS

The four priorities below identify the major areas of focus for the model. These are described in further detail from page 9 under the heading “Quality Indicators”. The intention is to define what each of the priority areas looks like in practice within a range of ‘not meeting the standard’ to an ‘exemplar standard for the model’.

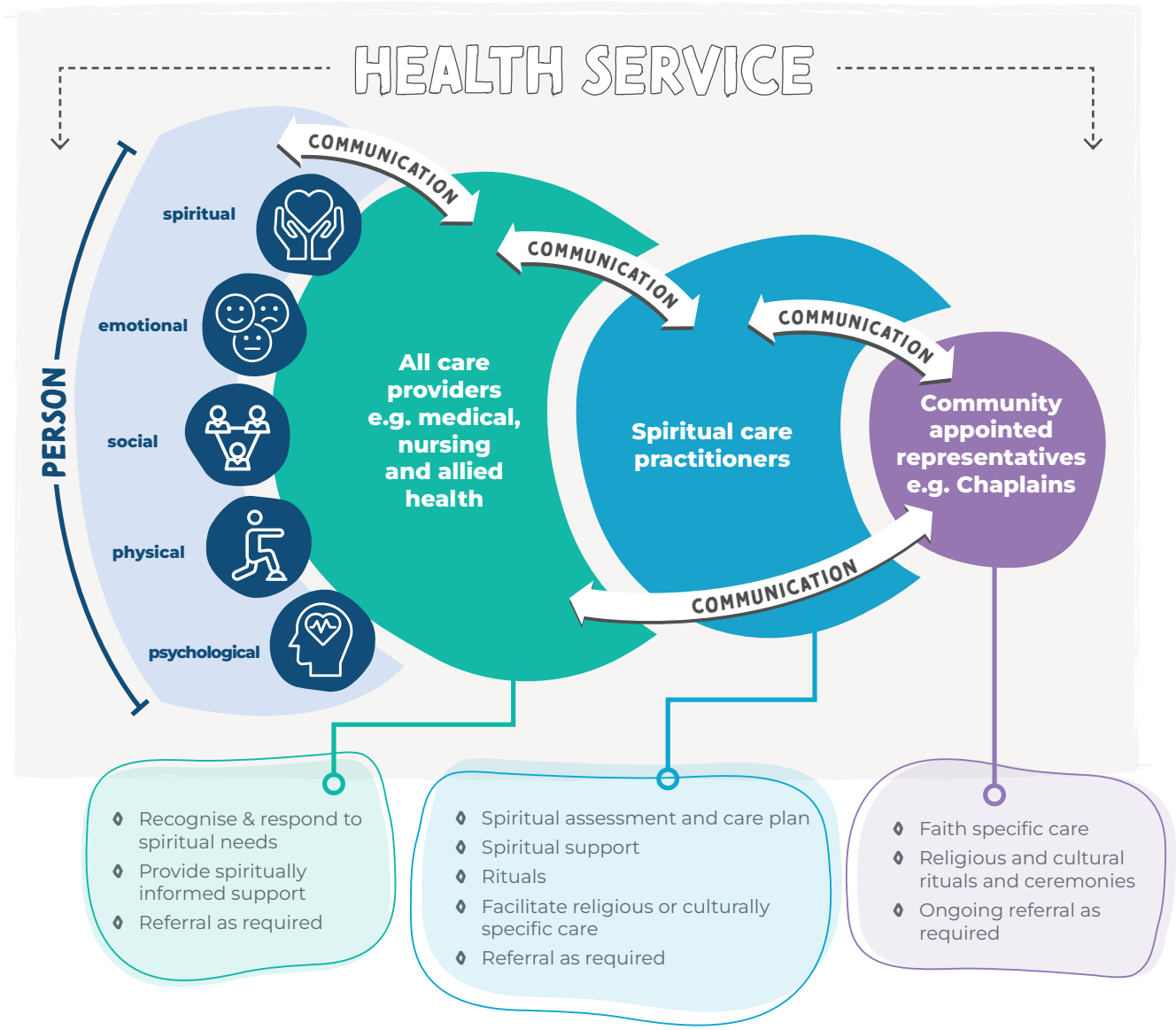
1. **Holistic person-centred care**
   Applying the biopsychosocial-spiritual model to person-centred care enables care to be truly holistic.

2. **Integrated governance**
   High quality governance of spiritual care in the health service that enables the health service to provide for consumer needs more effectively and holistically.

3. **Professionalised workforce**
   A professional, credentialled workforce to provide holistic, person-centred spiritual care.

4. **Sustainable resourcing**
   Health services provide resources that support implementation of the biopsychosocial-spiritual model of care.

The required workforce according to the model of spiritual care



MODEL OF HIGH-QUALITY, SAFE SPIRITUAL CARE

Holistic person-centred care

Multidisciplinary clinical care teams
Medical, nursing and allied health staff

Health service employed SCP
Credentialled spiritual care practitioners

Community appointed SCP
Religious and cultural representatives + volunteers

Screening, Assessment & Referral
Spiritual care plan developed in collaboration

Spiritual care interventions & procedures
Culturally or religious specific care, support, rituals, ceremonies

IMPACT
increased quality and safety of spiritual care in health services

Self-advocacy
Patients are engaged, empowered and supported to advocate for their spiritual needs

RESOURCES

- Organisation wide leadership
- Adequate funding allocation
- Qualified spiritual care practitioners
- Multidisciplinary teams
- Partner organisations
- Spiritual care policies, standards, guidelines and codes
- Evidence-based research
- Spaces and material resources for spiritual practice
- Education and training

CORE ACTIVITES & PROCESSES

- Coordinated synergistic teamwork
- Spiritual care referrals to support a person's needs
- Self-advocacy for spiritual needs
- Culturally safe, trauma-informed care
- Collaboration between teams and partner organisations
- Discharge care plans or referral to other services

QUANTIFIABLE OUTPUTS

- Information about spiritual care services provided to all consumers
- Consumers referred to spiritual care service
- Needs-based assessments
- Regular feedback between care team and consumer
- Consistent use of standardised codes

OUTCOMES

- Improved patient reported experience (PREM)
- Improved patient reported outcomes (PROM)
- Healthcare service meets quality and safety standards
- Culturally safe practices
- Optimal patient, family, and community experience and participation
- Planning in place for key stages - treatment, recovery and palliation

AIMS

Healthcare services contribute to the holistic care needs of Australian consumers and communities, providing access to high-quality and safe spiritual care in hospitals, enhancing consumers' experience and measurable outcomes of their care.

ASSUMPTIONS

- Spiritual care is included in health service governance structures
- Spiritual care practitioners comply with industry standards
- Healthcare staff recognise and respond to spiritual needs, provide spiritually informed support and refer consumers to spiritual services as required

QUALITY INDICATORS

PRIORITY 1: HOLISTIC PERSON-CENTRED CARE

Description: Applying the biopsychosocial-spiritual model to person-centred care enables care to be truly holistic.

Connection to the NSQHS Standards:

- The Clinical Governance Standard requires health services to ensure the workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients. The Clinical Governance Standard includes actions to recognise the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.
- The Partnering with Consumers Standard requires health services to have systems to support patients to be partners in their own care to the extent that they choose. Systems should support patients and consumers to be partners in healthcare planning, design, measurement and evaluation.
- The Comprehensive Care Standard requires health services to establish systems to provide comprehensive care aligned with the patient's expressed goals of care, values and preferences which include relevant screening processes to identify clinical and social issues and other risks of harm.

QUALITY INDICATOR	WHAT THIS LOOKS LIKE IN PRACTICE		
The extent to which...	***Not meeting the standard***	***Minimum standard for the model***	***Exemplar standard for the model***
A. Consumers are empowered to request spiritual care support.	Consumers are not informed about the availability of spiritual care services.	Consumers are informed about the availability of spiritual care services.	All staff in the health service are aware of the importance of spiritual care services and inform consumers of their availability.
B. Specific referrals that relate to consumer needs beyond what can be provided by the spiritual care team are documented and followed up, e.g. for specific religious or cultural care and other supports.	Spiritual care assessments are not made or do not document the need/request for tradition specific care, and appropriate referrals are not made.	Spiritual care assessments are completed and the need/request for religion or cultural specific care is documented, and appropriate referrals made.	Spiritual care assessments are completed, the need/request for religion or cultural specific care is documented, appropriate referrals are made, and followed up to determine whether care request was met, and the outcome documented.
C. Spiritual care is provided in a culturally safe, trauma-informed and linguistically appropriate manner, according to the person's values and beliefs.	Health service staff, and particularly spiritual care practitioners, do not make themselves aware of consumers' values and beliefs and/or do not take them into account and hence not provide culturally safe, trauma-informed and linguistically appropriate care.	Health service staff, and particularly spiritual care practitioners, make themselves aware of consumers' values and beliefs, take them into account and hence provide culturally safe, trauma-informed and linguistically appropriate care.	Health service staff, and particularly spiritual care practitioners, are highly inter-culturally competent, make themselves aware of consumers' values and beliefs, take them into account and hence provide high-quality, culturally safe, trauma-informed and linguistically appropriate care. First Nation's spirituality is recognised. Spiritual care is trauma-informed and highly culturally sensitive. The spiritual care team collaborates with Aboriginal Liaison Officers.

PRIORITY 2: INTEGRATED GOVERNANCE

Description: High quality governance of spiritual care in the health service that enables the health service to provide for consumer needs more effectively and holistically.

Connection to the NSQHS Standards:

- The Clinical Governance Standard requires leaders of health services to have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person-centred, safe, and effective.
- The Partnering with Consumers Standard requires health services to partner with consumers in the design and governance of the organisation.
- The Comprehensive Care Standard requires health services to have systems in place to support clinicians to deliver comprehensive care.

QUALITY INDICATOR	WHAT THIS LOOKS LIKE IN PRACTICE		
The extent to which...	***Not meeting the standard***	***Minimum standard for the model***	***Exemplar standard for the model***
A. Spiritual care is integrated into the health service multidisciplinary teams (MDTs) or MDT equivalents.	No established working relationship between spiritual care and the MDTs.	Routine contact between spiritual care and the MDTs.	Consistent spiritual care representation at MDT meetings.
B. Spiritual care has a clear line of management and reporting from executive level through to the spiritual care manager or equivalent.	No clear lines of reporting or accountability from the spiritual care manager through to executive.	Routine reporting from the spiritual care manager through to executive.	Spiritual care manager reports to the person with oversight to Allied Health and attends Allied Health team meetings. Spiritual care data are routinely reported to executive.
C. A spiritual care procedure is in place outlining reporting relationships, reporting expectations and referral pathways.	There is no procedure or policy for spiritual care.	There is a policy or procedure within the department for spiritual care, but it isn't integrated within the health service.	The spiritual care policy or procedure is integrated and well understood and used by MDT staff.
D. Spiritual care quality measures are reported as part of the health service's overall quality and safety review and are used to improve practice.	No quality measures for spiritual care included in the organisation's review processes/tools.	Some spiritual care measures are not included regularly as part of the quality reporting.	Spiritual care is included annually and equally in the quality and safety reviews with other disciplines as part of an integrated model of person-centred care.
E. Organisational wide leadership understands, values and fosters quality provision of spiritual care.	Spiritual care is not recognised sufficiently as part of the organisation.	Spiritual care is valued inconsistently and not fostered at high levels in the system.	Spiritual care is recognised and fostered at all levels, actively invited, and involved in executive-led initiatives.

PRIORITY 3: PROFESSIONALISED WORKFORCE

Description: A professional workforce to provide holistic, person-centred spiritual care.

Connection to the NSQHS Standards:

- The Clinical Governance Standard requires health services to ensure the workforce has the right qualifications, skills, and supervision to provide safe, high-quality health care to patients.
- The Comprehensive Care Standard requires health services to establish systems to provide comprehensive care aligned with the patient's expressed goals of care, values and preferences which include processes to support multidisciplinary teamwork and collaboration.

QUALITY INDICATOR	WHAT THIS LOOKS LIKE IN PRACTICE		
The extent to which...	***Not meeting the standard***	***Minimum standard for the model***	***Exemplar standard for the model***
A. Consumers receive care from qualified and credentialled spiritual carer practitioners, or via referral to health service approved religious or cultural representatives.	Consumers receive care from unqualified practitioners (employed or volunteer).	All staff in the spiritual care team are qualified and credentialled according to industry standards. Religious or cultural representatives are credentialled by the health service.	Workforce planning safeguards the current effectiveness and future provision of spiritual care.
B. Assessment, referrals, and interventions are documented in the healthcare records.	Spiritual care staff do not have access to patient medical records.	Spiritual care is not fully integrated into the Electronic Medical Records (EMR), and staff do not have sufficient training to record and document spiritual care effectively.	Spiritual care assessments, referrals, and interventions are fully integrated into the health service EMR.
C. Clinical and allied health staff are aware of the processes to refer to spiritual care.	There are no documented policies and procedures for referral, and referral practices vary considerably.	There are documented policies and procedures, but they are not clearly communicated to clinical and allied health staff. Referral practices vary.	There are documented policies and procedures for referral that are easily accessible and implemented.
D. Professional development programs in spiritual care are provided for clinical and allied health staff to improve their awareness of spiritual care, their role in providing spiritually-informed care and referral.	No information about spiritual care provided to staff. Spiritual care professional development is available by request for staff.	Spiritual care professional development is available and is led by the spiritual care team on a ward-by-ward basis, or equivalent.	Spiritual care professional development is integrated into the Clinical/Allied Health Education program for all clinical and allied health staff. Information is clearly available on the staff intranet.

PRIORITY 4: SUSTAINABLE RESOURCING

Description: Health services provide resources that support implementation of the bio-psychosocial-spiritual model of care.

Connection to the NSQHS Standards:

- The Clinical Governance Standard requires health services to implement a framework that ensures patients receive safe and high-quality health care. Safety and quality systems should be integrated with governance processes to actively manage and improve the care of patients in a safe environment.
- The Comprehensive Care Standard requires clinicians to use organisational processes to deliver comprehensive care and actively involve patients in their own care through shared decision making.

QUALITY INDICATOR	WHAT THIS LOOKS LIKE IN PRACTICE		
The extent to which...	***Not meeting the standard***	***Minimum standard for the model***	***Exemplar standard for the model***
A. The health service resources its spiritual care provision.	Spiritual care is an add on to Social Work with limited profile and scope to work within the health service. Religion-specific chaplains are able to visit consumers from their particular religious background.	The health service has a qualified and credentialed spiritual care practitioner that facilitates person-centred care and is able to refer to external spiritual care providers for specific needs and support of consumers.	The health service funds a spiritual care manager and care team integrated throughout health service delivery. Enables access to additional services by health service credentialled representatives funded by partner organisations and/or other religious and cultural representatives. Includes resourcing to support health service staff.
B. The health service has clear delivery and staffing expectations to support equitable access to spiritual care.	Health service relies on community religious and cultural representatives to support the spiritual needs of consumers without a clear governance structure.	A qualified and credentialed spiritual care practitioner is available for consumers who request spiritual care throughout their health service journey.	Qualified and credentialled spiritual care practitioner(s) are provided proportionate to the size and complexity of the unit served and officially recognised as integrated/embedded members of the clinical staff.
C. Dedicated spaces are available for spiritual practice and care (e.g., reflection, ritual).	No dedicated space available.	A single dedicated sacred space accessible to staff and public for reflection and ritual prayer.	Dedicated sacred space that allows for holistic spiritual practice and meeting places including but not limited to prayer and rituals, family gatherings, mourning spaces and reflection areas.

ACKNOWLEDGEMENTS

Spiritual Health Association would like to thank the many participants who engaged in the co-design process and generously shared their thinking, experience, insight, and research.

ENGAGEMENT PROJECT TEAM

- **Cheryl Holmes**, CEO, Spiritual Health Association
- **Cuong La**, Research and Policy Leader, Spiritual Health Association
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APPENDIX – GLOSSARY

Sources:

National Safety and Quality Health Service Standards (second edition)
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition

Spiritual Health Association – Guidelines for Quality Spiritual Care in Health
https://www.spiritualhealth.org.au/download/Guidelines-4-Qual-Spir-Care-Health-2021-1-190821-Web2021.pdf

assessment: a clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.

Australian Charter of Healthcare Rights: specifies the key rights of patients when seeking or receiving healthcare services. It was endorsed by health ministers in 2008.

clinical governance: an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the community and the healthcare organisation that systems are in place to deliver safe and high-quality health care.

community appointed representatives: accredited and authorised representatives from a specific community visiting members of their own community.

comprehensive care: health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate.

comprehensive care plan: a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, carers and families about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will depend on the setting and the service that is being provided, and may be called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.

credentialing: the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.

diversity: the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken, and sexual and gender identities [LGBTQIA+].

faith: trust or confidence in someone or something. For those with religious beliefs, faith may be related to hope, assurance and eternal existence or afterlife.

goals of care: clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process.

governance: the set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including patients and consumers). Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure for setting the corporate objectives (social, fiscal, legal, human resources) of the organisation and the means to achieve the objectives. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. In the NSQHS Standards, governance includes both corporate and clinical governance.

health care: the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.

healthcare record: includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.

leadership: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.

multidisciplinary team: a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[10] Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.)

palliative care: according to the World Health Organisation, palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness. It includes the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

person-centred care: an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients.[11] Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.[12] Also known as patient-centred care or consumer-centred care.

qualified and credentialled spiritual care practitioners: Spiritual Care Australia sets the industry standards for spiritual care practitioners in health care: https://www.spiritualcareaustralia.org.au/about-us/standards-and-policies/

Spiritual care practitioners are appointed and credentialled by the health service. They can be from a diverse range of beliefs, traditions, values and practices.

quality improvement: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[13] Quality improvement activities may be undertaken in sequence, intermittently or continually.

religion: according to the Australian Bureau of Statistics, a religion is regarded as a set of beliefs and practices, usually involving acknowledgment of a divine or higher being or power, by which people order the conduct of their lives both practically and in a moral sense. Religion is a mixture of beliefs, practices, and a Supernatural Being, and gives form and meaning to existence.

spiritual care (clinical definition): spiritual care is the provision of assessment, counselling, support and ritual in matters of a person's beliefs, traditions, values and practices enabling the person to access their own spiritual resources.[14]

spiritual care management: spiritual care is managed by different roles and at different levels depending on the complexity and size of the health service. Management can be at a director, manager or coordinator level.

spiritual screening and assessment: spiritual screening generally takes place on admission of a patient. Health care staff ask the patient questions regarding their spirituality, and whether the patient has any specific spiritual or cultural needs. The screening may include how important their spirituality is to their coping or as a source of strength, and whether this is currently supporting them. This screening may then generate a spiritual care referral.[15]

A professional spiritual care practitioner will then conduct a **spiritual assessment** of a patient by gathering and evaluating in-depth information regarding the patient's spirituality, cultural and emotional needs and resources.[16] Spiritual assessments are fundamental to a spiritual care practitioner's practice and delivery of quality spiritual care.[17] Spiritual care practitioners will assess patients to ensure spiritual care is provided in response to identified need.

Validated, evidence based spiritual assessment tools will be used. An example of an evidence-based quantifiable spiritual assessment tool is the PC-7 Spiritual Assessment Model.[18] Once a spiritual assessment has been conducted, the spiritual care practitioner will generate a plan of care with interventions and expected outcomes.[19]

spirituality: 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.[20] Spirituality is subjective and can be expressed in different ways by individuals and communities. Some people choose to express their spirituality through religion or religious practice, while others may not. Spirituality can also be described as the search for answers to existential questions, such as: Why is this happening to me? To whom do I belong? Does my life have meaning? What happens after we die?[21]

NOTES

1. Australian Commission on Safety and Quality in Health Care. (2017). National Safety and Quality Health Service Standards. Sydney: ACSQHC.
2. Karimi, L. and H. Tan (2020). "*Validation of the Patient Reported Outcome Measure of spiritual care (PROM) in an Australian setting.*" Health and Social Care Chaplaincy 8(1): 71-85.
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