

SPIRITUAL CARE POLICY AND GUIDELINES

POLICY STATEMENT

The spiritual needs of patients and their carers / family members are to be addressed as part of their care and action documented.

All staff should be sensitive to spiritual needs and issues and training is offered to encourage this.

Chaplains work as specialists in the area of spiritual and religious care, acting as a resource for patients and families of all faiths and none and also as a support to other staff in their spiritual care-giving.

The specific religious needs of patients will be facilitated wherever possible.

INTRODUCTION

From the beginning of the Hospice movement, spiritual care has always been recognised as an important element in the care of patients and their families/carers alongside their physical, psychological and social needs. This is re-emphasised in the NICE guidance on Supportive and Palliative Care¹ and in the Government's End of Life Care Strategy².

Pilgrims Hospices have always taken this aspect of care very seriously. For most hospice staff, attention to spiritual need is intuitive and much excellent spiritual care has always occurred without those giving or receiving it necessarily recognising it as such.

These guidelines aim to enhance and encourage what is already happening and to set out clearly how spiritual care is to be regarded and addressed within the organisation.

WHAT IS SPIRITUAL CARE?

Although widely considered to be of great importance, human spirituality is notoriously difficult to define! The following statement may help to grasp its essence without seeking to limit its scope too tightly:

“Within Western Palliative Care today, the spiritual dimension of human being is widely interpreted as that which gives transcendent meaning and aspiration to a person's life and may or may not include God or religion. Spirituality concerns all that makes for an individual's existence as a person with all that implies of our capacity as human beings for self-transcendence, relationship, love, desire and creativity, altruism, self-sacrifice, faith and belief: it is the dynamic of integration towards a person's unique identity and integrity”³

An important point to grasp is that, although spiritual care may include religious care, it is in fact a much wider concept. It can include whatever gives people's life meaning, their identity, their relationships, their thoughts and feelings and their faith if any. A religious faith is one way in which many people express their spiritual nature but this will not be true for everyone.⁴

WHO DOES SPIRITUAL CARE?

The NICE Guidance recommends that "Patients and carers should have access to staff who are sensitive to their spiritual needs" and also that, "Multidisciplinary teams should have access to suitably qualified, authorised and appointed spiritual care givers who can act as a resource for patients, carers and staff"⁵.

In Pilgrims Hospices it is recognised that all staff who have contact with patients and families/carers may be confronted with spiritual issues and should be aware of how to recognise and respond to these in a way that is appropriate to their role. Officially appointed hospice Chaplains have expertise in religious and spiritual care and are available for patients and families/carers and also as a resource for other staff and volunteers. Both of these are essential in an integrated spiritual care service.

There are three groups of workers within Pilgrims Hospices who may be involved in varying degrees in spiritual care: ⁶

- Group 1: Those who, in their work, have contact with patients and families/ carers but who are not responsible for their clinical care;
- Group 2: Members of the Multidisciplinary Team (MDT) i.e. clinical staff;
- Group 3: Those whose primary responsibility is for spiritual and religious care, i.e. Chaplains.

GROUP 1

This includes administrative and domestic staff, as well as volunteers working in Day Hospice, Reception or other contexts which bring them into contact with patients and families/carers. It is recognised that individuals may speak to any of these staff about spiritual issues which are concerning them.

Important skills for this group would be:

- Basic listening and communication skills
- An awareness of their own personal and professional limitations
- An ability to refer to members of the MDT
- An understanding of the relationship and difference between spiritual and religious needs
- A respect for the spiritual opinions of others especially where these differ from one's own.
- An ability to respect confidentiality but to understand the confidentiality of the team

GROUP 2

In addition to the skills mentioned above, it is hoped all members of the Multidisciplinary Team should have or be developing the following skills:

- Effective communication skills that demonstrate the ability to empathise and support individuals.
- An awareness of their own spirituality.
- An understanding of the nature of the individual's spiritual and religious needs within a palliative care context
- An ability to assess spiritual need (see below)
- An ability to encourage patients and families/carers to bring out their concerns at their own pace
- An understanding of the skills of others within the MDT
- An understanding of the importance of confidentiality and know when to disclose and document information.
- An ability to identify their personal educational need
- An ability to refer effectively to the Chaplain or other appropriate professional.

It is recognised that these staff work in a number of different settings both on site and in the community each of which makes particular demands in terms of spiritual care. Particular pressures are placed upon members of the CNS teams working in the community who may be confronted with demanding situations with no-one else around to help. It is important, therefore, that those working in the community feel themselves to be supported in spiritual care by the Chaplain and other members of the MDT. This support may be accessed at a number of levels:

- (a) Patients with complex needs may be brought to the Community MD meetings for discussion by the MDT including Chaplains.
- (b) CNSs may consult the chaplain individually about the spiritual needs of patients and families.
- (c) In some cases it may be appropriate for the Chaplain to meet the patient or family member either at an out-patient appointment or in the home.

GROUP 3

Whilst Chaplains are recognised and authorised by their faith communities they do not work exclusively as officials of the church or of any particular religious group but are entrusted by Pilgrims Hospices to address the whole range of spiritual and religious need.

They will be well-versed in religious issues and their work will sometimes involve religious activities such as services or prayers but they will also be constantly updating their knowledge and training over the full range of spiritual care.

As well as their direct care of patients and families/carers, therefore, they are also available to other staff and volunteers both for their own spiritual needs and to support their care of others.

Chaplains will also be aware of the resources of faith groups in the community and be able to make contact with leaders of particular religious groups when requested by the patients.

The following is a helpful summary of the Chaplain's role:

(Chaplains) ... "are expected to be able to manage and facilitate complex spiritual and religious needs in patients, families/carers, staff and volunteers. In particular they will deal with the existential and spiritual needs arising from the impact on individuals and families from illness, life, dying and death. In addition they should have a clear understanding of their own personal beliefs and be able to journey with others focussed on that person's needs and agenda."⁷

In Pilgrims Hospices, Chaplains also form part of the team providing bereavement services under the leadership of the Counsellor.

It is expected that Pilgrims Hospice Chaplains will be members of the Association of Hospice and Palliative Care Chaplains and work to its Standards⁸ and Code of Practice.⁹ They will also be registered with the United Kingdom Board of Healthcare Chaplains' register or working towards registration.¹⁰

ASSESSMENT OF SPIRITUAL NEED

Pilgrims Hospices accept, as part of these guidelines, the Kent Guidelines on the Assessment of Spiritual Need. These are set out in Appendix A. In addition the acronym F.I.R.M. may be helpful in assessing patients' spiritual needs. The initials stand for:

- F - Faith
- I - Identity
- R - Relationships
- M - Meaning.

The use of F.I.R.M. does not involve asking particular questions but seeks to identify the ways in which a person's belief system, sense of themselves, relationship with others or the meaning which they ascribe to life and the world, are being affected by illness, approaching death or bereavement. It requires the skills of active listening and attentiveness to direct statements, metaphors and "off-the-cuff" comments. ¹¹

COMMUNICATION

Members of Group One should speak to any member of the MDT concerning spiritual needs being expressed by patients or families/carers.

The MDT has a number of opportunities during the regular working week of each hospice (MDT meetings, ward rounds, handovers etc) to discuss the spiritual needs of patients and families/carers and to make plans accordingly. Chaplains themselves do not operate on a referral only system but will be meeting most patients in the course of regular ward rounds. However, the Chaplain may be approached verbally or in writing at any time concerning the spiritual needs of patients.

TRAINING

Training in spiritual care will be offered to all staff at least every two years at a level appropriate to their responsibility. This will normally be facilitated by members of the Spiritual Care Group and it is expected that Chaplains will play a major role.

Staff wishing to attend these sessions will be allowed to do so within their working time.

Chaplains are expected to update their knowledge of issues related to spiritual care through external courses and conferences.

THE CHAPELS

As well as the support of trained staff to help them in their spiritual needs, many patients and families/carers also require time, privacy and space for their own spiritual and emotional reflection.

Each hospice has its own chapel which, in addition to services of worship, is also constantly available for private prayer, meditation and quiet. These areas should remain open to patients, families/carers, staff and volunteers and not be used for other purposes unless absolutely necessary.

The chapels are not consecrated for the use of any particular faith group and should, as far as possible, be acceptable for the use of people of any faith or none.

Services of worship will be regularly available for patients and families/carers and these will always be open, informal and ecumenical in style.

DOCUMENTATION

Spiritual care is documented in the following areas of Inflex

- Information about the patient's spiritual needs and issues as well as religious beliefs and affiliations are recorded in the Spiritual and Religious Care page of the Patient Profile. This is an ongoing document which may be added to over time.
- Assessment and delivery of spiritual care is documented in the Notes and Evaluations for Patients (10) and Carers (11) thus forming part of the continuous narrative of the patient's and family's care.
- The Religious/Spiritual Support section of Section 1 of the Liverpool Care Pathway should be filled in whenever a patient is put on the LCP and variations, whenever they occur, should be recorded on the LCP B section which is completed twice daily.
- Chaplains record all their contacts with patients and carers in the Community (30) and IPU (41) Episodes. They may also keep their own confidential work notes in line with the Guidance for Chaplains and Counsellors.

Lead and Author	Lead Chaplain
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APPENDIX A

GUIDELINES FOR SPIRITUAL ASSESSMENT KENT AND MEDWAY PALLIATIVE CARE NETWORK

THE NATURE OF SPIRITUAL CARE

Spiritual care is an integral part of palliative care and requires some understanding of the nature of spirituality. This is concerned with the beliefs and values that determine what is important in our life and what gives meaning and purpose to living. It is a quality common to all humanity and yet is expressed in a unique way by each individual. Common spiritual needs may include the following:

- relationships with significant others
- the need to give and receive love
- making sense of what is happening to me – both now and in the past
- maintaining hope in the face of adversity
- an ability to transcend oneself and one's life experiences

Spirituality may incorporate, but goes beyond, religious affiliation. It may be a source of strength for those who are dying or challenged by fear of approaching death.

As spirituality is an intimate aspect of self, spiritual assessment and care are best achieved in the context of a good rapport where trust has been established.

EXPRESSIONS AND RESPONSES

Spiritual issues often come into focus when people face critical life changing events such as the diagnosis of a life threatening disease or impending death. This may have a profound effect on people who are ill and on their family and friends. Unsettling questions often arise such as “why me?”, “why is this happening to me?”, “what is the cause of this – is it my fault?” and “how will I cope?”. Some individuals may express their needs in religious terms and may be helped by such things as prayer and ritual.

However, spiritual needs may not always be expressed openly, but may be observed as a change in behaviour, either positive or negative. Using open questions may help a person to explore the wider spiritual issues. Below are some examples of questions that may be useful:

- What is important to you? / in life? / at this time?



- Is there anything that is worrying you at the moment?
- Can you tell me anything that gives you comfort when you're troubled?
- What helps lift your spirits?
- How are you feeling in your spirit(s)? / inside?

BEING THERE

The most important element in spiritual assessment and care is allowing patients to talk about their hopes, fears, joys and sorrows. Patients should be given the opportunity to test their own beliefs, express painful emotions or struggle with questions of faith and fear within a supportive relationship. Health professionals often avoid such conversations because they “don’t know what to say”, not realising that simply “being with” and listening to patients may be the most important spiritual care they can offer.

Feeling helpless and being unable to solve a problem or “do anything” can be a very difficult experience for a health professional. However, attentive presence is one of the most precious gifts we can offer our patients and their families.

RECORDING INFORMATION

The question may next arise about what needs to be recorded and what just needs to be retained by the health professional. Certain information could be of benefit to the rest of the members of the multi-disciplinary team, and give them a better picture of the patient.

- If the matter could impact on the rest of patient care, some note needs to be made.
- Where personal details have been disclosed which the patient would like to remain confidential, it may still be helpful simply to indicate that a conversation has taken place.
- If there is a specific religious request (e.g., to see a Rabbi or to receive communion), or if it is appropriate to refer to another professional, this should be noted and action taken.

WHO CAN I REFER TO?

Here are some colleagues who may be able to help both you and the patient or carer to explore spiritual issues.

The Multi-disciplinary Team: If you are a member of a multi-disciplinary team (MDT) which meets regularly, it may help to talk issues through within the confidentiality of the team. Members of the MDT may include: consultant, registrar, nurse specialist, chaplain, social worker, counsellor and other allied health professionals.

Chaplain: Remember that chaplains, particularly in palliative care, are available to address the whole range of spiritual issues described above and not only the religious ones. Most chaplains are not representatives of a particular faith group but are employed by the hospice or hospital for the spiritual care of patients, their carers and staff.

LOOKING AFTER YOURSELF

Listening to spiritual concerns can be personally demanding. You need to make sure that you take care of yourself. Regular supervision is helpful but sometimes it may be necessary to find someone you trust to talk to at the time.

References

¹ National Institute for Clinical Excellence, *Improving Supportive and Palliative Care for Adults with Cancer*. London, 2004, "Spiritual Support Services", pages 95-104.

² Department of Health, *End of Life Care Strategy*, 2008, paras. 98-109
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

³ Association of Hospice and Palliative Care Chaplaincy, *Chaplaincy in Hospice and Palliative Care*, page 2, "The Nature and Scope of Palliative Care".

⁴ C.f. Appendix A. The Kent Guidelines for Spiritual Assessment offers a complementary account of the nature of spiritual care.

⁵ N.I.C.E. op. cit. page 10, "Key Recommendation 11".

⁶ This division and the following three sections are adapted from:
Marie Curie Cancer Care, *Spiritual and Religious Care Competencies for Specialist Palliative Care*, 2004; www.mariecurie.org.uk/healthcare.
In the context of Pilgrims Hospices we have reduced the four sections to three and prefer to speak in terms of "groups" of staff rather than "levels" of competence. Although we have not followed this document in its detail it is recommended as a helpful aid to personal reflection on knowledge and skills.

⁷ Marie Curie, op. cit. page 6

⁸ Association of Hospice and Palliative Care Chaplaincy, *Standards for Hospice and Palliative Care Chaplaincy*, 2006.

⁹ AHPCC, CHCC and SACH, *Health Care Chaplains Code of Conduct*, 2005

¹⁰ www.ukbhc.co.uk

¹¹ Stanworth, Rachel. *Recognizing spiritual needs in patients who are dying*, OUP, 2004