**The Ability of Hospital Staff to Recognise and Meet Patients’ Spiritual Needs: A Pilot Study**

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### *Objectives:* We conducted an online cross-sectional survey to determine the understanding of spirituality and spiritual care among clinical and non-clinical staff caring for people with chronic and terminal conditions

### *Background:* As health-care moves towards a more person-centred approach, spiritual care has become more important in patients’ care. Recent evidence shows positive associations between addressing patient spiritual needs and health outcomes.

### *Methods:* We administered an adapted Spirituality and Spiritual Care Rating Scale (SSCRS), used by the Royal College of Nursing, to hospital and community-care staff (n=191) in Sydney, Australia. This survey examines perceptions of spiritual care and participant abilities to meet patients’ spiritual needs.

### *Results:* The response rate to the SSCRS survey was 84 of 191 eligible participants (44%). Agreement was high on items describing talking to and observing patients and their loved-ones to identify spiritual needs (mean–90%). However agreement was low concerning items describing the use of data collection tools and talking with colleagues to identify patients’ spiritual needs (mean–43%). Participants recognised patients’ spiritual needs (mean-86%), but when asked if they were able to meet these spiritual needs, only 13% (n-11) stated they were always able to do so. Hence, there was strong agreement on actions for guidance and support for staff dealing with patients’ spiritual and religious issues (n-71, 85%) and that spiritual care education and training is required (n-64, 76%).

### *Conclusion:* We have identified strong agreement of the importance of delivering spiritual care but uncertainty in the ability to recognise and meet spiritual needs of patients by clinical and non-clinical hospital staff. Our results also show that spiritual care training for hospital staff is now required. Therefore, evidence-based models of spiritual care education and training require further study.

### Keywords Spiritual care, Hospice care, Patient-centred care, needs assessment

## Introduction

Spirituality is becoming more relevant to effective healthcare as it moves towards a more patient-centred approach (Sterwart. M et al. 1995). Indeed there is growing evidence for positive associations between spirituality and health outcomes (McSherry 2007). The definition of spirituality varies but it is suggested that religion should be situated within the broader category of spirituality (Speck. P 2004). Current literature describes broad definitions (Unruh, Versnel, and Kerr 2002, Berry 2005, Roudsari, Allan, and Smith 2007), such as:

Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices (Puchalski and et al 2014, p 63).

Mitroff suggests that workplace spirituality involves finding one’s ultimate purpose in life, connecting with colleagues and having alignment between one’s core beliefs and the organisation’s values (Mitroff. I and Denton. EA 1999). Healthcare is a vocation that creates greater meaning in the workplace (Moore. T 1992). Indeed, the connection between workers and their work organisation are understood as a match between an employee’s personal beliefs and values and the organisation’s values, mission and purpose (Milliman. J, Czaplewski. AJ, and Ferguson J 2003).

 This study took place within a hospital that serves people with complex health or aged care needs, regardless of circumstance. This is done by listening and relating, enabling choice, tailoring care, ensuring a sense of belonging, partnering with loved-ones, engaging with community and ensuring the nurturing of the whole person. Koenig describes ‘spiritual care as the heart of what whole-person care encompasses' (Koenig. H 2014, p 1162, Hutchinson 2011, Mitchell 2008). Koenig also suggests that to provide whole person care, health professionals must be whole persons themselves. Thus, health professionals must also have the emotional, physical, social and spiritual resources to carry out their work.

 Whole person care is mandated internationally in end-of-life and hospice care (World Health Organisation 2002) and encouraged in other areas of health care. Spiritual care interests patients, particularly near the end of life. Phelps and co-workers found that patients, physicians and nurses showed strong agreement that routine spiritual care would benefit patients (Phelps and et al 2012). However, few patients reported receiving spiritual care. Timmins and McSherry stress that spirituality is embedded within the core values of nursing practice. Recently, McSherry & Jamieson showed that 'nurses recognise that supporting patients with their spiritual needs has the potential to enhance the overall quality of nursing care' (McSherry and Jamieson 2011, p 1764). However, many respondents felt more guidance and support from governing bodies is necessary to enable more confidence with spiritual care. We hypothesised that these views affect all staff involved in spiritual care. Thus, we applied the Royal College of Nursing Spirituality and Spiritual Care Rating Scale, developed by McSherry and colleagues to identify the nature of understanding about spirituality and spiritual care among all staff in a hospital setting.

## Methods

### *Participants*

The hospital in which the survey was conducted provides rehabilitation, palliative and supportive care, pain management, mental health care for older people, and community care. All clinical and non-clinical hospital staff (n-191) were eligible to participate in the survey. Areas of employment included health care staff (including managers) working both in the hospital and within the community. We also invited clinical researchers, pharmacists and those working in cleaning and patient transport to participate.

### *Survey instrument*

The survey used the Spirituality and Spiritual Care Rating Scale (SSCRS) to gather data (McSherry and Jamieson 2011). The SSCRS shows consistent reliability and validity across different populations and languages (Fallahi Khoshknab and et al 2010). The five-part questionnaire was delivered electronically, while hard copies of the survey were distributed amongst staff that did not have hospital email accounts. The survey was developed using Survey Gizmo survey software (SurveyGizmo 2014). Online survey tools allow easy access to survey responses and descriptive data analysis. Additionally, such tools allow data to be exported to statistical analysis software for further analysis.

### *Data Analysis*

Data were analysed using descriptive statistics to characterise participants taking part in this study. Kruskal Wallis one way analysis of variance test was used to compare survey answers between different demographic groups as all data gathered were considered both nominal and ordinal. Pearson’s correlation coefficient was used to measure relationships between scores from the survey sections and between survey scores and different demographic groups located in the survey.

## Results

### *Demographics*

Of the 191 questionnaires distributed, 84 (44 %) were returned. Most respondents were female (n=60 - 73.2%) and the mean age of all respondents was 41.9 years (SD ± 12.2 years) (Tables 1-2). Most respondents worked in palliative care (n=25 - 29.8%) and rehabilitation (n=17 - 20.2%). The largest group were medical specialists (n=12 - 14.3%) and registered nurses (n=10 - 11.9%). Most participants described themselves as Australian (n=61 - 73.5%), followed by South-East Asian (n=7 - 8.4%) and European (n=6 - 7.2%). Most stated their religion as Christian (n=54 - 70.1%) while 19.5% (n=15) of staff described themselves as having no religious affiliation.

 Table 1 Demographic characteristics of participants

 **Table 2** Location of practice and work experience -

### *Levels of agreement toward provision of spiritual care*

Strongest agreement lay with the respect from staff for privacy and beliefs of patients (96 %), the showing of kindness and concern (94%) and supporting and reassuring patients at times of need (94%). Listening to and talking with patients about their fears and anxieties was considered important (93 %), as was visits by the hospital chaplain or other religious leaders (92 %).

 We found that staff not practicing religion showed stronger agreement that spirituality is not concerned with a belief or faith in a higher being compared to practicing staff (*p*-0.004). Participants practicing religion reported stronger agreement with the need to forgive and to be forgiven (*p*-0.03) and patient requests for meetings with religious persons (*p*-0.02).

 Younger participants, especially those between 20 and 40 years-old reported stronger agreement for personal friendship and relationships within spiritual care compared with older age groups (*p*-0.015). We also found one difference in agreement between gender with male participants showing more agreement toward the need to forgive and be forgiven (*p*-0.03).

### *Identifying patients’ spiritual needs*

Most participants stated that they would identify spiritual needs from the patients themselves (96%), through listening and observing patients (91%) and by talking to loved-ones (81%). However, between only 40 and 50% of participants used health records or discussion with colleagues, while 26% of participants said they used spirituality assessment tools (Figure 1).

Figure 1 How participants identify patients’ spiritual needs (% - n)

Only two participants described using specific tools (Highfield & Casson Assessment Tool and the organisation's own Pastoral Care Assessment tool). When asked how often participants encountered patients with spiritual needs, 49% said they did so on a daily basis while a further 27% said they did so on a weekly basis.

### *What are spiritual needs?*

Participants showed strong agreement that spiritual meaning and purpose (98%) and hope and strength (94%) were spiritual needs. Creativity as a spiritual need received the lowest agreement at 69% (Figure 2). Only 15% of participants added their own descriptions of spiritual needs with examples such as the need for belonging in the community, a relationship with God and the need for peace when facing death.

Figure 2 What participants consider as patients spiritual needs (% - n)

### *Who is responsible for spiritual care?*

Most participants agreed (87%) that all healthcare professionals should be responsible for providing spiritual care (Figure 3). Participants also agreed that chaplains (79%) and family and friends (76%) should help to provide spiritual care. However, participants agreed less with the role of the patient providing their own spiritual care (57%), while there was virtually no agreement that spiritual care should be provided by a combination of all of those people stated in the other items (2%).

Figure 3 Who participants believe are responsible for providing spiritual care (% - n)

Concerning provision of spiritual needs, 26% more female than male staff agreed that the patients themselves are responsible for providing their own spiritual care (*p*-0.023) while 21% more female than male staff agreed that chaplains are responsible for patient spiritual care (*p*-0.048).

### *Ability to meet the patient’s’ spiritual needs*

Only 13% of participants stated they were always able to meet patients’ spiritual needs. Most participants (79%) stated that they were able to do so sometimes, while 8% said they were never able to meet patients’ spiritual needs.

 More nursing assistants and spiritual carers stated that they were always able to meet their patients’ spiritual needs compared to all other job descriptions (*p*-0.025). Due to religions other than Christianity being so poorly represented, comparisons were made between the ability of practicing Christian staff and staff not practicing religion to meet patients’ spiritual needs. Overall, differences were not significant (p-0.054), although, 20% of non-practicing staff said they were never able to meet patients’ spiritual needs compared to 7% of practicing Christian staff. However, while only 12% of practicing Christian staff stated they were always able to meet patients’ spiritual needs, no non-practicing staff stated that they were able to do so (Figure 4).

Figure 4 Comparisons of attitudes between participants practicing Christianity and those not practicing religion on the frequency in the ability to meet patients’ spiritual needs (% - n)

### *Actions required to improve spiritual care of patients*

Most participants agreed that spiritual care and spirituality are fundamental to health care (85%) and that institutions (care providers) should provide guidance and support for staff to deal with spiritual and religious issues (85%). Participants also agreed that, presently, staff do not receive sufficient spiritual care education and training (76%).

### *Further comments about spirituality and spiritual care*

Twenty-eight participants made additional comments about their understanding of spirituality and spiritual care. Most stated that carers must show kindness, compassion and be respectful of individual patients’ spiritual needs. Others suggested that staff must be consistently prepared to deliver spiritual care to those in need. Some suggest that spiritual care guidelines are too prescriptive so that patients are treated the same way regardless of beliefs. However, another commented that, where pastoral care services are informed of a patient’s spiritual needs, feedback from patients is generally good.

## Discussion

### *Support and Guidance*

Our findings show participants agree that spirituality and spiritual care are fundamental to healthcare, and that hospital organisations should provide guidance and support for staff dealing with patients’ spiritual and religious issues. These results support recommendations for the benefit of routine spiritual care (Puchalski and et al 2014p646, Timmins and McSherry 2012). However, while this and previous studies support the need for such guidelines, some participants expressed caution. They stated that implementation of spiritual care guidelines may become too prescriptive resulting in patients being assessed and cared for using the same approach, regardless of their beliefs. This caution was reflected by very few participants in this present study using formal spirituality assessment tools to evaluate patients.

### *Assessment of spiritual needs*

While participants support the provision of spiritual care, there was little familiarity with how spiritual needs are assessed. Apart from talking to patients and loved-ones, only one quarter of participants used structured assessment tools. While these actions may help to identify spiritual needs, studies recommend that structured assessment tools should be adopted to address spiritual needs, and to improve documentation and of their spiritual needs effect on outcomes of treatment (Puchalski and et al 2009). Rieg, Mason & Preston (2006) state that guidelines facilitate competent spiritual care and suggest that guidelines allow care-givers to recognise patients’ spiritual needs and, more importantly, that care-givers become comfortable with questions that elicit spiritual assessment data. We suggest that staff should be educated on the use of valid spiritual assessment tools that elicit multidimensional aspects of spirituality. Current examples of clinical spiritual history tools include FICA, HOPE, SPIRIT, and Domains of Spirituality (Puchalski and Romer 2000, Anandarajah and Hight 2001, Maugans 1996, Nelson-Becker and et al 2006, Puchalski and Ferrell 2009).

### *Ability to meet the patient’s spiritual needs*

Participant subgroups responded differently concerning their ability to meet patients’ spiritual needs. Here, respondents practicing religion felt they were more able to do so than those not practicing. Given these differences, it is important to determine who is best suited to meet patients’ spiritual needs; ideally, healthcare workers with similar worldviews and spiritual beliefs to their patients. However, religiosity is one of many factors that form an individual’s worldview. For example, complementary needs or therapies such as literature and music that are compatible with patients’ worldviews should be considered by hospital staff. Rieg and colleagues suggest a four-tier assessment of spiritual care based on standardised assessment of religious preferences, culturally defined spiritual practices, their spiritual interactions with available therapies, and subsequent transformational interaction between spiritual knowledge and compassionate care (Rieg, Mason, and Preston 2006).

 One limitation of our study was that participants were not asked why they were not able to meet patients’ spiritual needs on a regular basis. Previous reviews describe the need for non-religious clinicians not to underestimate the importance of patients' belief systems and the anxiety of non-religious care-givers when requested to pray by religious patients (McCormick 2014). However, there has been little investigation into differences and levels in spiritual care between religious and nonreligious healthcare staff or between different ethnic or cultural groups. Future studies would benefit from such follow-up questions.

### *What are spiritual needs?*

Over 85% of participants agreed with all the items describing spiritual needs. This highlights the broad views and a lack of consensus regarding the nature of spiritual needs and may impact on the ability of staff to recognise spiritual needs and address them. Recently, Rushton (2014) commented that health professionals fail to provide adequate spiritual care due to the lack of an agreed definition of spirituality. Therefore, the nature of spiritual care and guidelines for training and implementation must be addressed. Spiritual care has been defined as: ‘That care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness. This includes the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. (Richardson 2010) sensibly suggests that ‘spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires’.

 Keall and co-workers address this issue in part where they investigated the facilitators, barriers and strategies for identifying and providing existential and spiritual care among Australian palliative care nurses. Using structured interviews, participants underlined the importance of the nurse-patient relationship, communication skills and cues to 'create openings' to facilitate care (Keall, Clayton, and Butow 2014). Their results also revealed barriers to spiritual care such as lack of required skills, privacy and fear of uncovering unresolved symptoms and/or differences in beliefs. Importantly, participants offered strategies for further education, care-giver awareness and interdisciplinary sharing of information for continuity of care.

### *Who is responsible for spiritual care?*

Who are the providers of spiritual care? Views are polarised with some advocating the role of the chaplain (Curlin and et al 2006) while others argue it is the responsibility of all those involved in care. Those who advocate for the central role of a chaplain may view spirituality within a religious context. However, there is growing consensus that spirituality is not necessarily located in a religious framework (Egan and et al 2011).

 Our findings reflect these conflicting views. While a substantial proportion (79%) identify a chaplain as one of the people responsible for the provision of spiritual care, a larger proportion (87%) indicate it is the responsibility of all health professionals as well as family and friends (76%).These results are consistent with the study by (McSherry and Jamieson 2011) showing that participants feel spiritual care should not be monopolised by one area of health care but shared by the whole care team. Rumbold (2003) supports this observation and further suggests that while spiritual care may be provided by the whole team, leadership of spiritual care should be given by specialist practitioners such as pastoral care workers.

 Studies exploring the responsibility for spiritual care among the nursing profession may in part answer the above finding. Presently, about 90% of nursing staff are women (United States Census Bureau 2013) where current research shows uncertainty regarding the role of nurses toward patient spiritual care. Here, two studies found that responsibilities for spiritual care are not clear cut among the nurses where care is affected by nurses’ own spirituality, their education, upbringing and the lack of time to attend to or converse with patients. Moreover, a recent study found that nurses perceive physicians as the obvious spiritual care provider (Rodin and et al 2015).

Several studies show how physicians respond differently to patients’ spiritual suffering. Some propose that dying patients whose existential suffering is resistant to treatment should be offered palliative sedation to unconsciousness (Morita 2004). Encouragingly, Smyre et al. (2015) found that when addressing the responsibilities of physicians treating terminally ill patients, most sought to relieve patients’ spiritual suffering as much as their physical pain(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015)(Smyre and et al 2015. Interestingly, the same cohort of physicians also agreed that patients with unresolved spiritual struggles had more intense physical pain.

### What next?

Findings from this and previous studies indicate that spiritual care training is currently required for health care professionals and ancillary staff (Cetinkaya, Dundar, and Azak 2013). Although efforts have been made to integrate spirituality into nursing and clinician curricula (Cone and Giske 2013), recent findings show that such training is surprisingly low for nurses but is increasing amongst physicians. It also appears that training remains voluntary and self- selecting (Rasinski and et al 2011). We recommend that spiritual care training be required for all staff in contact with patients. We further recommend the development of evidence-based models of spiritual care training as proposed by several authors including Balboni and Puchalski (Balboni and et al 2013). Recently, Morgan et al (2015) developed an educational program aimed at improving understanding of spirituality and spiritual care among palliative care staff. Importantly, the diversity of this course allows the consideration of the unique culture and spirituality of each individual(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015)(Morgan et al. 2015).

### Limitations

The response rate of 44%, for our study was low. While response rates among physicians and other clinical staff were high, they were particularly low amongst nurses where only 24% responded to the survey. Therefore attitudes shown by nurses participating in the survey may not truly reflect or be representative of those working throughout the organisation. Given this discrepancy, and the contact nurses have with patients, emphasis must be given to the recruitment of nursing staff for future studies. Additionally, many participants failed to complete the demographic questions in the survey. This may have been due to these items being placed at the end of the survey. Therefore, for future studies, all demographic items will be placed at the start of the survey.

## Conclusions

Our findings show that spiritual care training is needed for clinical and non-clinical staff caring for people with chronic or terminal conditions. While staff members can identify definitions of spiritual needs, their ability to recognise and meet these needs in their patients is uncertain. The findings support the need: (a) to gather further evidence to support our claims; and (b) in further studies to develop an evidence-based model of spiritual care training that considers both the unique culture and spirituality of the individual and the use of valid spiritual assessment tools.

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