Offering spiritual support to dying patients and their families through a chaplaincy service

Spiritual care involves giving time and compassionate attention to dying patients and their families. A trust explains how an innovative chaplaincy service was set up.

AUTHORS Edwin J Pugh, MBBS, FRCP, is professor in palliative care, University of Teeside, and consultant in palliative medicine, North Tees and Hartlepool Foundation Trust; Susan Smith, MSc, BSc, RN, is executive director of nursing; Paul Salter, DipCoun, DipSW, is chaplaincy coordinator; both at North Tees and Hartlepool Foundation Trust.


Despite its importance in end of life care, spiritual care is poorly addressed. This article presents the results of an innovative service in which nurses notify hospital chaplains of all patients placed on the Liverpool Care Pathway and the chaplains then visit to offer spiritual support to both patients and their carers.

The national end of life care strategy for England said that “spiritual care and support for both the person and their carers is integral to the end of life care pathway” (Department of Health, 2008). The Liverpool Care Pathway (LCP) provides an agreed plan of care to facilitate good practice (Ellershaw and Ward, 2003), and has been accepted as an evidence-based tool to improve care of the dying. The LCP ensures a holistic view of care, including the assessment of spiritual needs, and is audited in the national care of the dying audit led by the Marie Curie Palliative Care Institute Liverpool. The results of the second round of this audit revealed that only 30% of dying patients and 50% of their families/carers had their spiritual and religious needs assessed (MCPCiL and Royal College of Physicians, 2009).

In North Tees and Hartlepool Foundation Trust, around 1,600 patients die each year, of whom around 40% receive care on the LCP. The trust has two hospitals in two separate locations. Results of the 2008-09 national care of the dying audit at the trust showed that 59% of patients in one site and 13% in the other who were on the LCP had their spiritual needs recorded as assessed.

In response to this and in collaboration with key nursing staff, an innovative service was piloted in which hospital chaplains, as “spiritual advisers”, routinely visited all patients on the LCP to sensitively offer spiritual support to them, their carers and indirectly to clinical staff caring for them.

This article presents the results of the pilot project, which ran for six months from July to December 2009 in both sites.

NEW SERVICE PROTOCOL
When a patient is placed on the LCP a nurse informs the chaplaincy service, leaving a voice message on a dedicated hospital telephone extension. In an emergency, the call chaplain is paged. The nurse leaves the following details:
- The caller’s name;
- The ward;
- A telephone contact;
- The patient’s name;
- Date and time of message.

The chaplains access the referral voicemail at least twice daily including weekends and then make an initial sensitive visit to offer support. Where possible, patients asking for repeat visits are visited by the same chaplain to maintain continuity. An information card about the services offered is left with the patient (if appropriate) or carers. The chaplains record the outcome of their visit in the LCP documentation as a multidisciplinary team member. Follow up visits are made as requested by the patient and carers.

SERVICE EVALUATION
Each clinical department within the trust has nurses with extra training and responsibility for end of life care (known as “nurse key workers”). An electronic questionnaire was emailed to these staff at the beginning of December 2009, five months after the pilot study had started. They were asked whether:
- They had personally referred patients to the service;
- There had been any complaints or compliments from patients or relatives;
- The service had given them more time to spend with other patients;
- Patients or relatives appeared less distressed after the visit.

Respondents were also asked to mark on a five point Likert scale how they rated the value of the new service to patients and their families, and for them and the clinical team. Non-responders were followed up with another email two weeks later.

This research received no specific grant from any funding agency in the public, commercial or not for profit sectors.

RESULTS
Before the initiative, a workload review showed the hospital chaplains saw around four patients on the LCP each month. Over the six months of study, 223
new contacts were made, representing 37 per month. Of these 141 (63%) received more than one visit. Overall 18 (8%) patients/relatives declined intervention by the chaplains.

Eighteen (55%) out of 33 nurse key workers completed the questionnaire. Of these, 15 (83%) had referred patients to the chaplaincy service, and none had received any complaints from patients or families. Thirteen had received positive comments about the service from patients and relatives, while in 10 cases the service had given nursing staff more time to spend with other patients. Eleven said relatives were less distressed after the chaplaincy visit, and the same number also said the service supported the emotional needs of clinical staff. All said they wanted the service to continue.

The service was rated “valuable” to patients and their families by 16 (89%) nurse key workers; of these, 10 rated it “very valuable”. Box 1 shows individual comments from key workers.

Fourteen (78%) rated the value of the service to them and the clinical team as “valuable”; of these nine rated it “very valuable”. In one case the service was not seen as of value. Box 2 shows individual comments.

**DISCUSSION**

For all patients, regardless of whether they have specific religious needs, spiritual care involves giving time and compassionate attention to them and their families. It may involve simply being with them and listening. Are there issues which need to be dealt with beforehand? Are there important issues that the patient and relatives would like to talk about, or say at this important time?

<table>
<thead>
<tr>
<th>Box 1. NURSE COMMENTS ON THE VALUE OF THE CHAPLAINCY SERVICE TO PATIENTS AND FAMILIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=nurse</strong></td>
</tr>
<tr>
<td>N1: “Allowed relatives to express feelings.”</td>
</tr>
<tr>
<td>N2: “Very valuable. Chaplains are able to give the support that nursing staff and doctors can’t always give.”</td>
</tr>
<tr>
<td>N3: “Provided comfort and support when we [clinical staff] are sometimes very busy.”</td>
</tr>
<tr>
<td>N4: “It gives patients and their families a special link for their needs allowing time to be spent with them in a usually busy environment.”</td>
</tr>
<tr>
<td>N5: “This is a very valuable service as communication has improved. Families feel supported by people who are not medical. Ward X had a patient who had no living relative but the valuable time given to this patient at the end of his life was impeccable.”</td>
</tr>
<tr>
<td>N6: “The relatives of patients were more content after the visit by chaplains.”</td>
</tr>
<tr>
<td>N7: “Feel this is the first steps to improving spiritual needs of patients and relatives.”</td>
</tr>
<tr>
<td>N8: “Helps patients and families express their fears and wishes.”</td>
</tr>
<tr>
<td>N9: “Families are comforted after visit.”</td>
</tr>
<tr>
<td>N10: “Giving support spiritually.”</td>
</tr>
<tr>
<td>N11: “It makes the family members feel more at peace having spoken to your staff.”</td>
</tr>
<tr>
<td>N12: “With it being a busy ward, [I am] aware that when talking to relatives we tend to finish the conversation. They [chaplains] have more time and would not be rushed.”</td>
</tr>
<tr>
<td>N13: “Provides comfort and support.”</td>
</tr>
<tr>
<td>N14: “Extra support is always a benefit.”</td>
</tr>
<tr>
<td>N15: “Depends if family are religious; some families welcome spiritual support, others feel they are being intruded upon.”</td>
</tr>
<tr>
<td>N16: “Very valuable.”</td>
</tr>
<tr>
<td>N17 and N18: no comments.</td>
</tr>
</tbody>
</table>

Chaplains are specialists in offering spiritual care, respecting patients’ personal beliefs, whether these are specifically religious or more general (agnostic, atheist, humanistic). They can offer time to patients and families at this critical time and also offer support to staff. In addition, they can help patients from different faith traditions. The new service was introduced in July 2009 to support clinical staff and ensure that all dying patients and their families have the chance to discuss their spiritual needs. As members of the multidisciplinary palliative care team, the chaplains record their intervention in the LCP documentation.

Myers (2009) suggested that spiritual care should be regarded as an important part of nursing care and that this need is more prominent in times of emotional stress, loss, bereavement and death. Nurses do indeed give spiritual care as part of good nursing care, which includes touch, listening, valuing patients and simply being present. Although ideally nursing staff would provide all spiritual care to dying patients, the current reality in acute hospitals is that clinical staff, including nurses, often do not feel they have the expertise or time to assess and manage spiritual needs (Baldacchino, 2006; Milligan, 2004; Kuppelomaki, 2001).

During consultations before the service was introduced, nurse key workers initially expressed concern that spirituality would be imposed on patients and their families. The results show that this concern has proved to be unfounded. Almost two thirds of patients or families requested a follow up visit, while fewer than one in 10 refused a visit. Neither staff nor chaplains have received any complaints from patients or families. Indeed, anecdotally, families who are not religious have praised intervention by chaplains. All nurse key workers said the service should continue, and the majority said they had heard positive comments from relatives. Most felt relatives were less distressed following intervention from the chaplains. In general key workers felt supported and over half felt the service had given them more time to attend to the needs of other acutely ill patients.

**Ethical issues**

Is it ethical for chaplains to visit without being invited by patients or families?
Increasing literature supports the view that attending to patients’ spiritual care is an integral part of good palliative care, particularly at the end of life (Sinclair et al, 2006; Chochinov and Cann, 2005). It appears that, at the very least, good practice will create a climate or opportunity for patients and families to discuss spiritual matters.

It could be argued that it would be unethical to address spirituality proactively in two specific circumstances. First, if any spiritual visit was used as a pretexts for another end, such as proselytising and forcing belief or non-belief; and second, if any patient were truly "aspiritual". We argue that, on balance, not offering spiritual support would constitute a failure to provide good care at the end of life. The routine visiting by chaplains fulfils this care.

A patient is put on the LCP for the last few hours or days of life, and may be comatose at that point. This leaves little, if any, opportunity for the chaplain to establish a relationship with the patient, which is vital if spiritual needs are to be fully addressed. This initiative has been well received to date by patients, families and staff. This is perhaps a timely indicator suggesting that chaplains' involvement at an earlier stage in the palliative care process would afford time to ensure an even better model for appropriate assessment of patients' spiritual care.

This innovative service model addresses the current deficiency in spiritual care for patients and families at the end of life. While meeting a need, and helping to fulfil the requirements of the LCP to assess and address spirituality, we recognise this is only a first step to ensure that spiritual needs are appropriately addressed in palliative and end of life care.

The trust's strategic aim for the new service is for chaplains to support nursing and other clinical staff by passing on their skills, through mentoring and active education in spiritual care. An educational approach using the LCP with clinical staff has been shown to be effective in an acute hospital (Witton, 2008). Dedicated educational sessions on spirituality for clinical staff are under way. In addition, the trust has worked with the University of Teesside to produce an accredited degree level module (30 credits) on practical spiritual care for health and social service professionals. The first cohort of 15 students completed the module in January 2010. An independent evaluation of the impact of this course is being carried out and a final report is due in August 2010.

CONCLUSION

This innovative service provides a model of chaplaincy care to address inadequacies in spiritual care for dying patients and their families.

Nurses feel the service has been valuable for patients and relatives. In addition, many have felt supported and also had more time available for other patients. Fears about imposing spirituality and causing distress to patients and families have not proved founded. All patients placed on the Liverpool Care Pathway and their families are now offered support for spiritual needs and the majority accept the offer. The use of this model could be explored on a wider scale, such as for patients in critical care or those recently diagnosed with a terminal illness.

The chaplains’ role now includes the mentoring and education of clinical staff in end of life care. Over time the strategic aim is to give other clinical staff the skills and confidence to address patients' spiritual needs. As this competency evolves, the current chaplaincy model may change to one where chaplains provide a more educative and mentoring role to clinical staff in the future, as they become more skilled and competent in addressing spiritual needs.

REFERENCES