Barriers/Facilitators to deliver spiritual care

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AIMS

1. Misconceptions & barriers
2. MERVIC model: attributes to spiritual care
3. Priority to personal spirituality

Target: MDT approach to spiritual care

o Spiritual care is the provision of interventions which assess and address clients' spiritual needs in collaboration with the multidisciplinary team (Hospice & Palliative Nurses' Association (HPNA), 2007; Smith, 2006).

Challenge! Controversy!

o Spiritual care should NOT be given by nurses at all (Paley 2007).

o In contrast, patients perceive spiritual needs as part of the overall care given by the health care professionals and the pastoral team (Baldacchino, 2003; Saliba & Baldacchino, 2010).
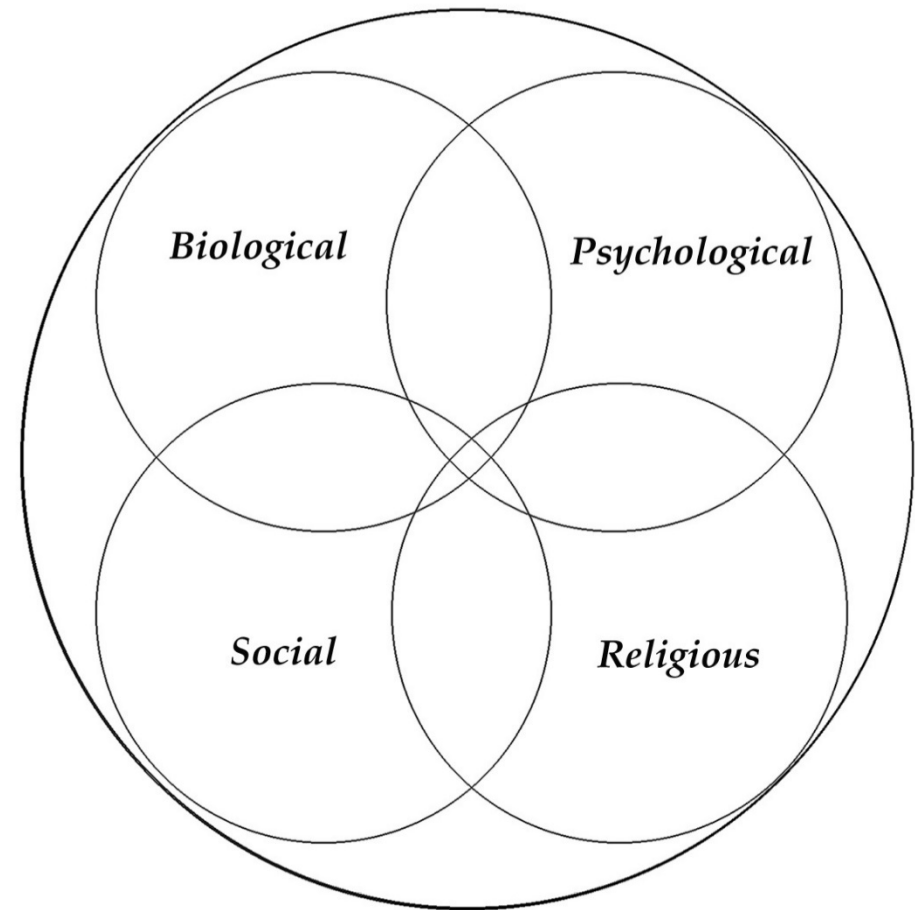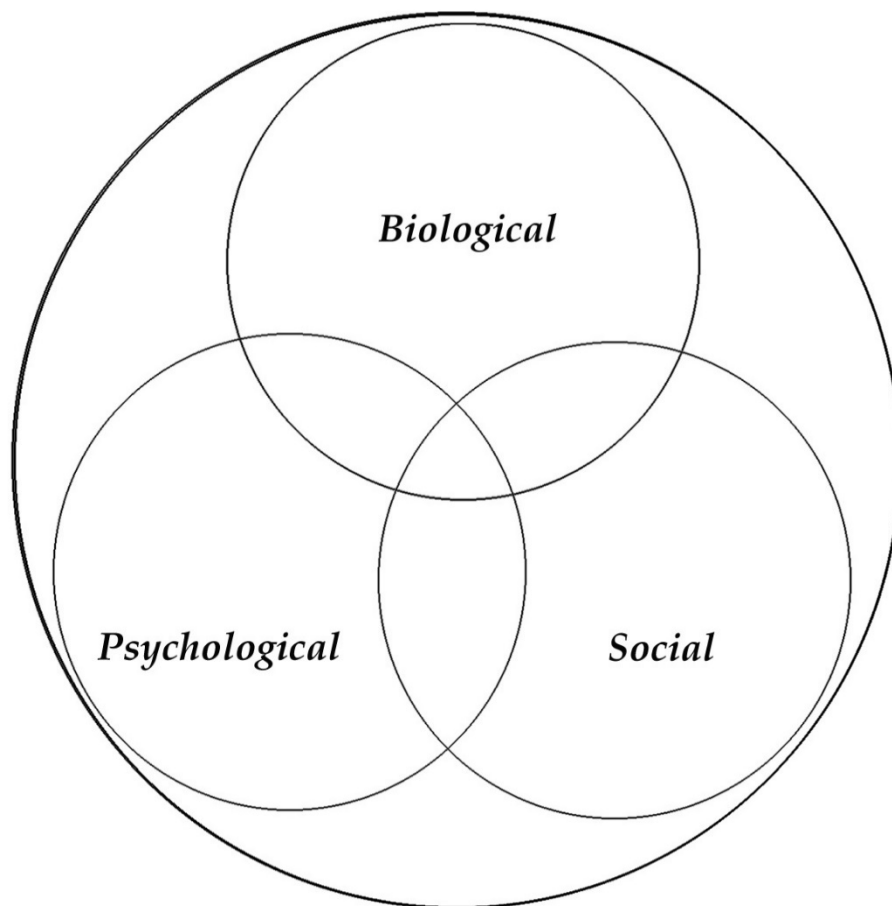
Florence Nightingale

Let the environment do no harm to patients

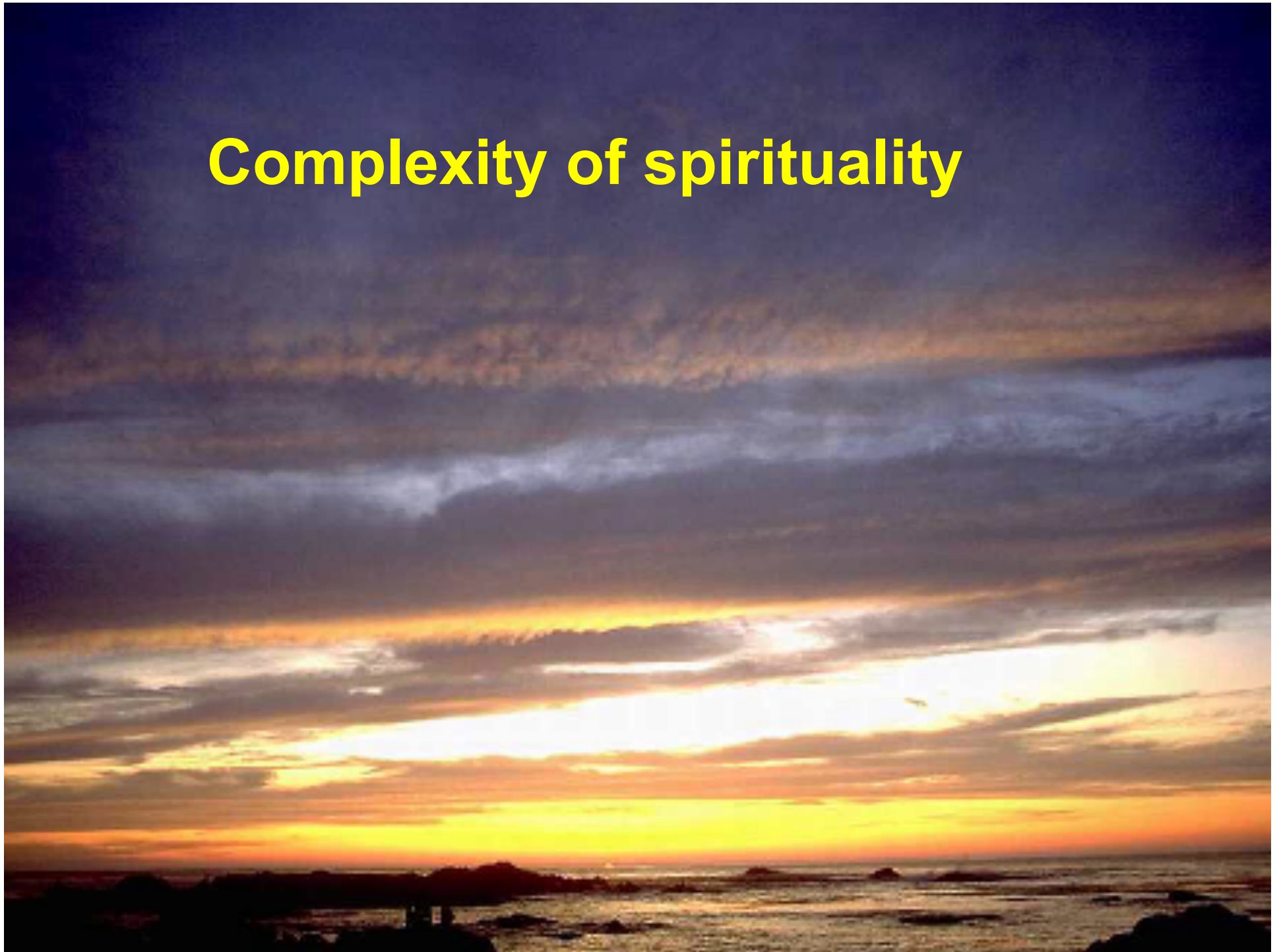'All the results of good nursing, ... may be spoiled ... in petty management'

Why is it difficult to deliver spiritual care to the patient?
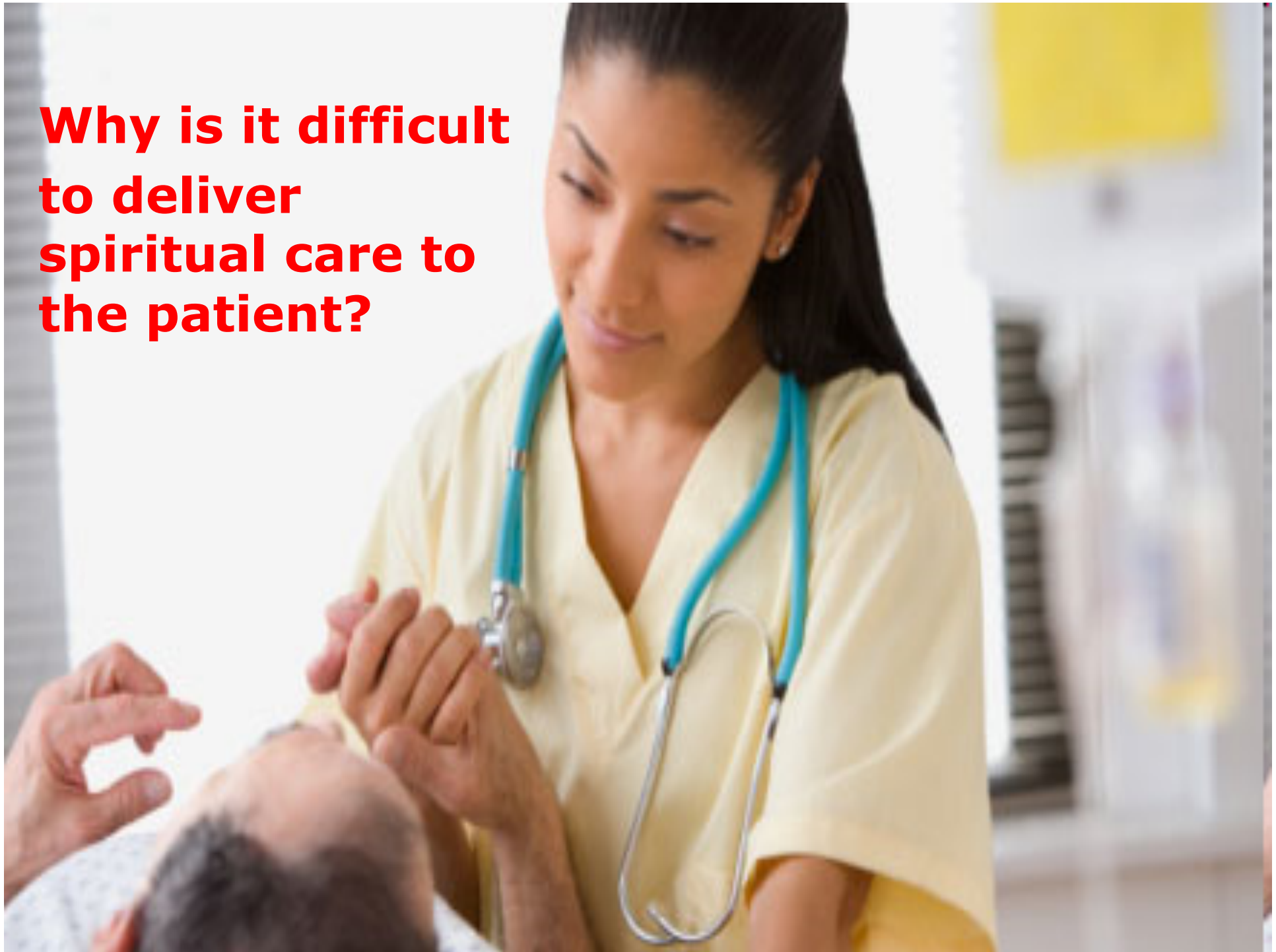
Spirituality is applicable to the believers and non-believers (Baldacchino 2003)

Complexity of spirituality

Definition of Spirituality

The **power within a person** which motivates the person to find meaning, purpose and fulfilment in life, suffering and death and fosters hope to one's will to live. (Renetzky 1979, Golberg 1998, Dreyer 1996)

Definition of Spirituality
(Stoll 1989)

o **My being, my inner person. It is me expressed through my body, my thinking, my feelings, my judgments and creativity.........**
(Stoll 1989)

Definition of Spirituality (Stoll 1989 cont)

Through my spirituality ……. I give and receive love; I respond to and appreciate God, other people, a sunset, a symphony and spring (Stoll 1989)

A taxonomy of Spirituality (McSherry 2004)

DESCRIPTORS							
Theistic: Belief in a supreme being, cosmological arguments not necessarily a 'God' but deity	**Religiou:** affiliation – belief in a God, undertaking certain religious practices, customs and rituals	**Language:** Individuals may use certain language when defining spirituality such as inner strength, inner peace	**Cultural; Political; Social ideologies:** an individual may subscribe to a particular political position or social ideology that influences governs their attitudes and behaviours. dependent upon world faith – religious tenants	**Phenomenological:** one learns about life by living and learning from a variety of situations and experience both positive and negative	**Existential:** a semantic philosophy of life and being, finding meaning, purpose and fulfilment in all of life's events	**Quality of Life:** although quality of life is not explicit in definitions it is implicit	**Mystical:** relationship between the transcendent, interpersonal, transpersonal, life after death

LEFT…….RIGHT

CONSIDERATION

The order or sequencing of the descriptors present in the taxonomy are individually determined depending upon ones beliefs, values and life experience or worldview.

The taxonomy is restrictive in that it implies the ability to intellectualise supporting the position that such definitions are exclusive and restrictive.

The taxonomy implies that an individual's worldview will determine their definition of spirituality.

The descriptors listed in the taxonomy are not exhaustive because they may well be infinite.

The taxonomy suggests two form of spirituality the 'old' and the 'post modern'. The old = religious and theist while the 'The post-modern' = Phenomenological and existentially focused.

Misunderstanding of spirituality
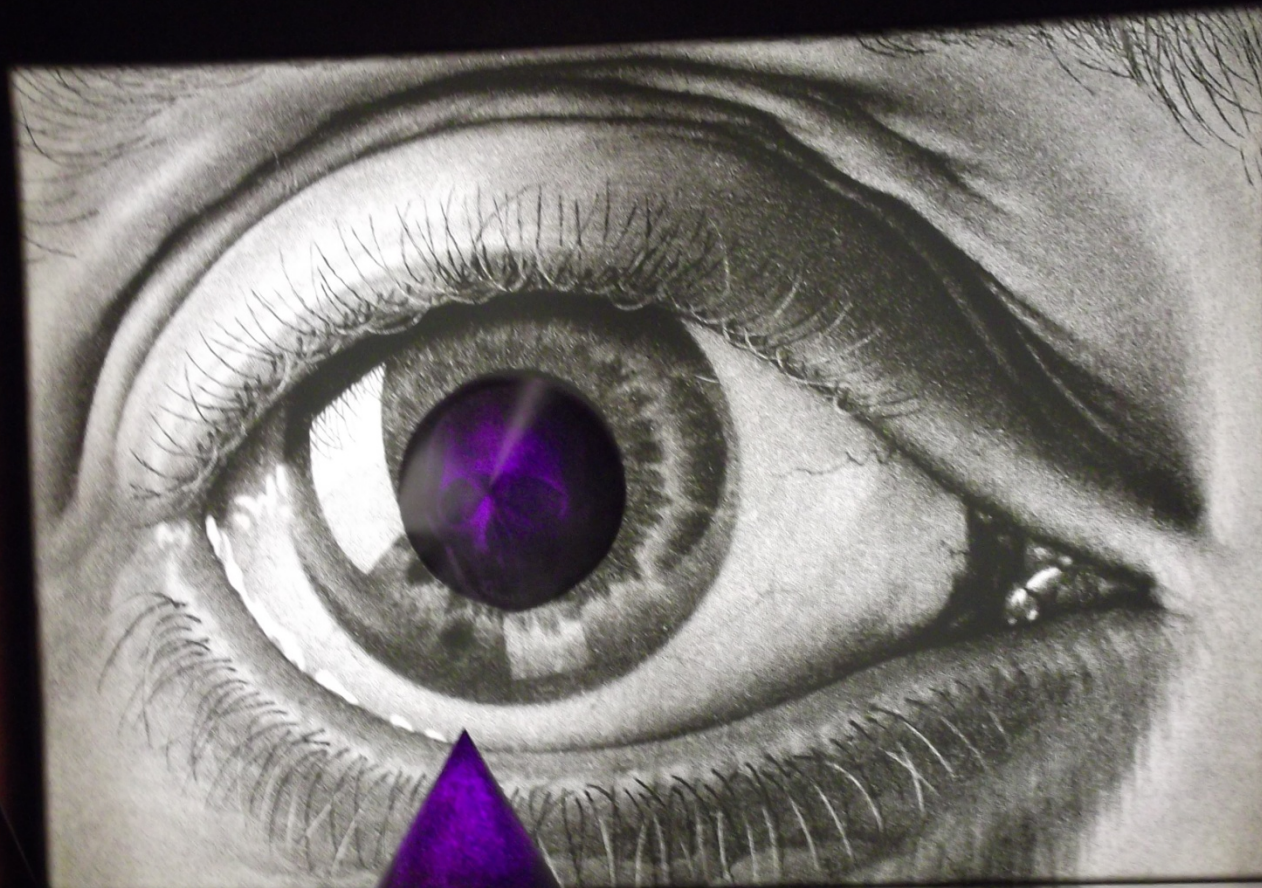
The spiritual dimension "comes into focus when the person faces emontional stress, physical illness or death" (Murray & Zentner 1989, Baldacchino et al 2012)

Spirituality associated with dying….

○ Synonymous with religiosity versus a broader perspective of spirituality in line with patient's culture (Holloway *et al*., 2011; Kalish, 2012)

○ Thus, focusing on religious needs and referral to chaplains / pastoral caregivers (Galek *et al*., 2007; Baldacchino 2009)

Definition:

o**Spiritual care:** 'that care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include 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. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires'. (NHS Education for Scotland (2009, p6; RCN 2011)

Different eyesights: Patient & MDT members
The MDT might NOT be in tune with patients' individual experiences

Let us come closer to what the patient sees!
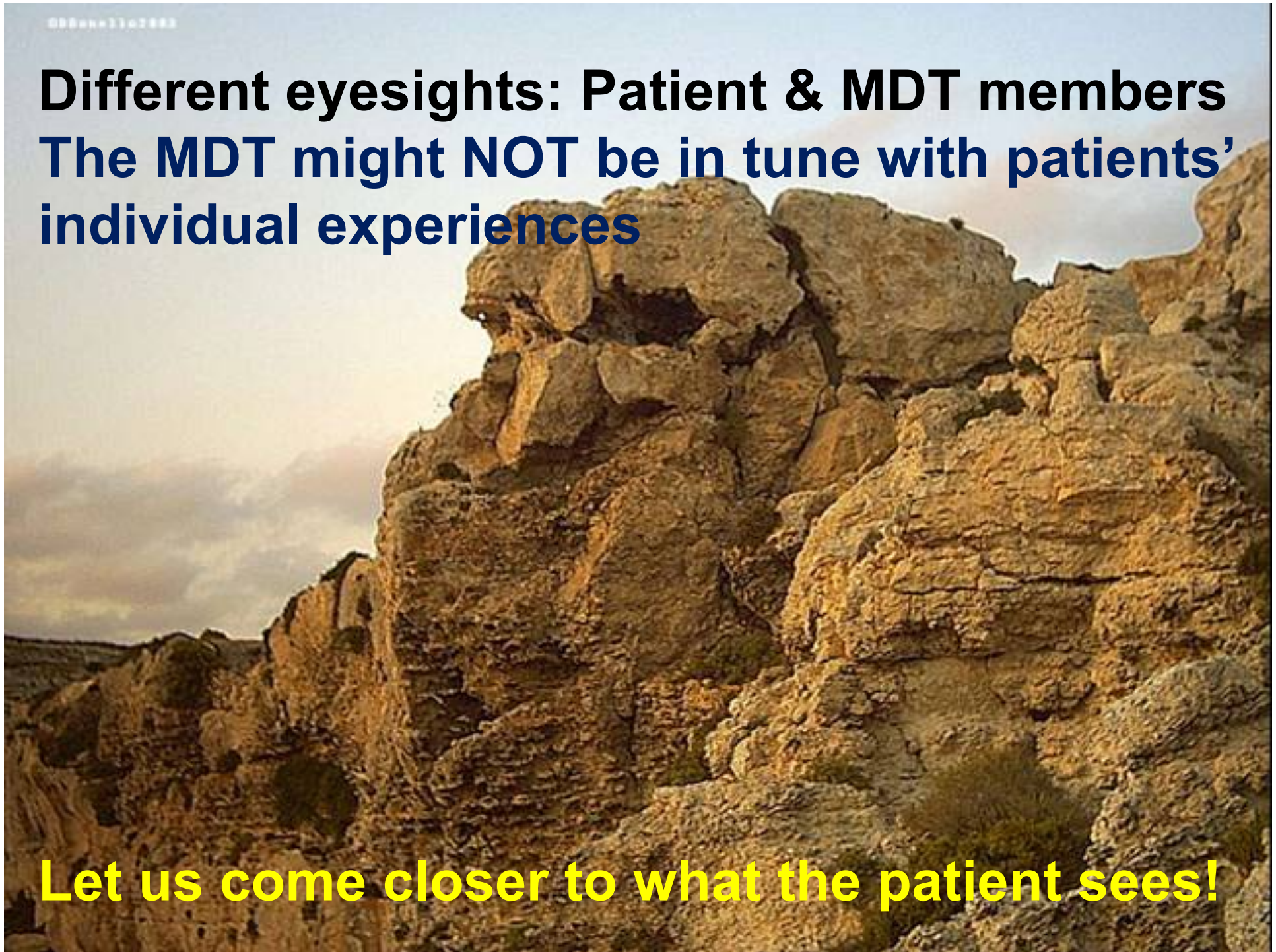
Controversy & Debate:
Overlap vs separation **between Spirituality and psychological / social care (O'Connel and Skevington 2010, Clarke 2009, Paley 2008).**

Thus the risk of addressing spiritual needs and psychological needs separately (McSherry 2000)

Spiritual care: is it the role of nurse / MDT?

Rationale (i)

- Perception of spiritual care as an 'optional extra' (Baldacchino 2003; Ross 1997; Clarke 2013)

- Codes of conduct & research recommend the MDT to give holistic care thus: meeting spiritual needs (+/- religious needs) into their role (Baldacchino, 2009).

- Disappointingly the latest Nursing and Midwifery Council Code *excluded* spirituality in care but the guidelines still hold the spiritual dimension in care.

- Inability of nurses to identify patients' *spiritual* needs (non-religious) (Ross, 2006; Baldacchino 2009; Holloway *et al.*, 2011; Pike, 2011; Kalish, 2012).

Rationale (ii)

- Research in Palliative Care is abundant, mostly qualitative, exploring clients' spiritual needs in end-of-life care (Puchalski *et al*., 2009; Nixon & Narayanasamy, 2010; Cobb, Dowrick & Lloyd-Williams, 2012).

- Problem of generalization of results in qualitative studies. However, it sheds light on applicability of spirituality in care and generates further research (Polit & Beck 2004).

- Unpreparedness of nurses to deliver spiritual care (RCN 2010). Education on spiritual care: Predictor for perceived ability to deliver spiritual care (Attard et al 2014)

Barriers to spiritual assessment

Barriers to spiritual assessment (i)

(McSherry & Ross 2010; 2002)

o Complexity of the nature of spiritual assessment due to diversity in clients' & caregivers' spirituality (religious & non-religious) (Draper, 2011);

o Codes of Professional conduct tend to give less emphasis on the 'spiritual beliefs' by simply referring to 'beliefs';

o Spirituality in Nursing/Midwifery models of holistic care is either *implicit* (Rogers 1980; Roy 1980) or *explicit* (Watson 1985; Neuman 1995) (McSherry 2000; Ross 1997; Marstolf & Mickley 1998) rendering spirituality as an abstract concept!

Barriers to spiritual assessment (ii)
(McSherry & Ross 2010; 2002)

- 3.**Education guidelines** of what & how to teach spiritual assessment to health caregivers are still being developed (Baldacchino 2008);

- 4.Quantitative **design** vs qualitative method of the spiritual assessment method;

- 5.**Time** of spiritual assessment: on admission only? or continuous assessment? Just ticking data in less time than qualitative interview/observation!!

Ethical issues in Assessment

○ **Assumption** that ALL patients have spiritual needs;

○ **Competence** of health caregivers;

○ **Confidentiality in documentation** of spiritual distress & spiritual needs;

○ **Follow up** spiritual care of unresolved spiritual issues;

○ **Controversy**: Overlap vs Separation between spirituality & psychological dimensions;

Recommendations

- "Assessment tools should be easy to use **[non-intrusive]**, flexible, and take little time to assess the spiritual state of patients at different times and in different situations" (McSherry & Ross 2006 p.10)

- **Include chaplains,** clergy within the MDT: Research shows nurses' awareness about the need to collaborate with the MDT / chaplains to address spiritual needs (Nolan & Holloway 2014; McSherry & Jamieson 2011; King, 2012)

Personal spirituality was reported as the strongest predictor of perceived ability to provide spiritual care (van Leeuwen et al 2008).

MERVIC model:Attributes for delivery of spiritual care
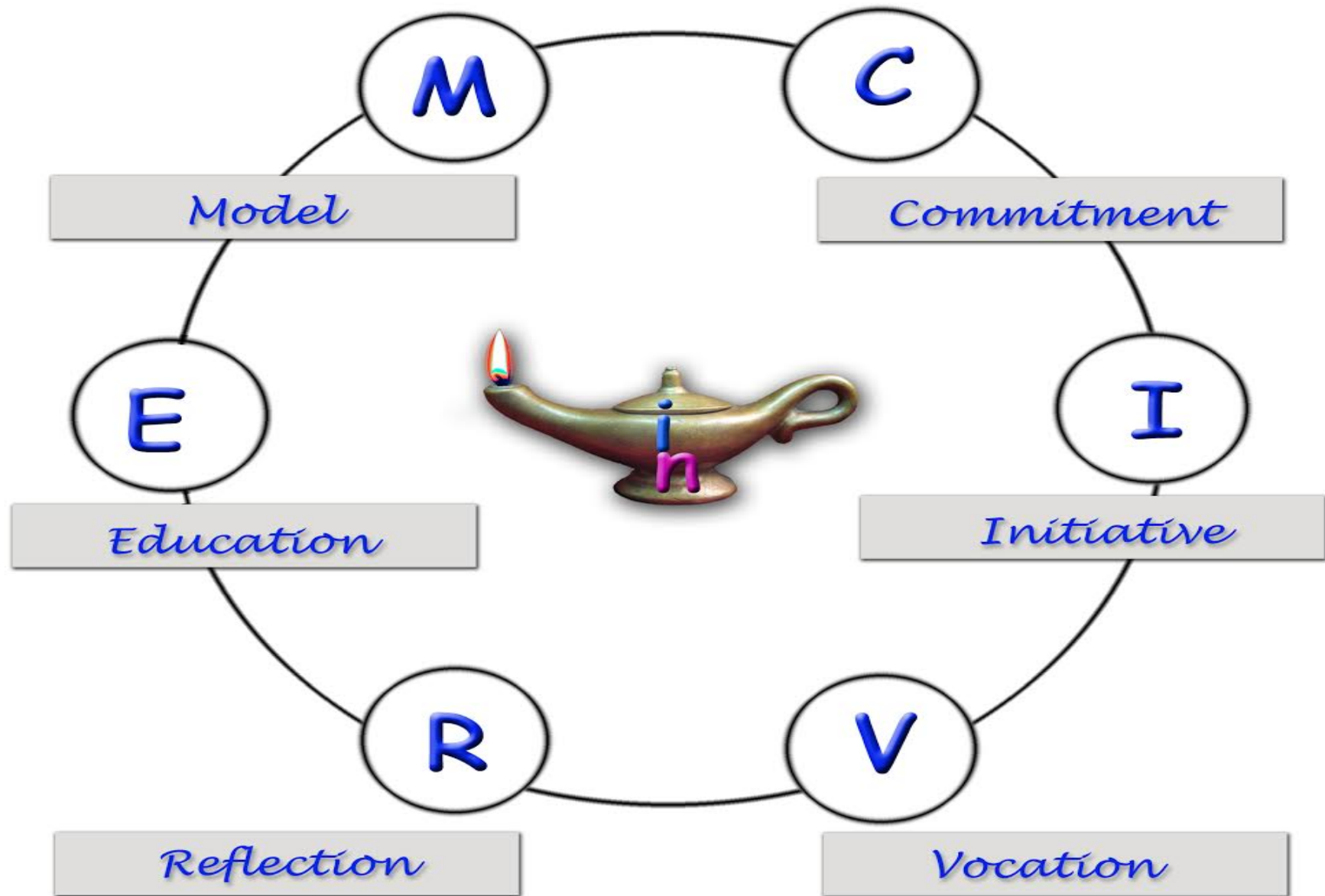
Being *in* Doing (Baldacchino 2010)

Being in **Doing**

○ ***Being* in doing** involves the ***spirituality*** of the caregiver which may be transformational for both the client and the caregiver.

(Baldacchino 2010, DiJoseph & Cavindish 2005).

Giving & receiving

In times of distress

The clients do not care how much you know unless they know how much you care!

Greetings from Malta!