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Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference

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Abstract

A Consensus Conference sponsored by the Archstone Foundation of Long Beach, California, was held February 17–18, 2009, in Pasadena, California. The Conference was based on the belief that spiritual care is a fundamental component of quality palliative care. This document and the conference recommendations it includes builds upon prior literature, the National Consensus Project Guidelines, and the National Quality Forum Preferred Practices and Conference proceedings.

Introduction

IN THE EARLY 1990s, academic medical centers, medical and nursing schools, residency programs, and hospitals began to recognize the role of spiritual care as a dimension of palliative care. A growing body of literature^{1–5} as well as attention from the lay press^{6–8} raised awareness of and questions about the role of spirituality in health care. Surveys have demonstrated that spirituality is a patient need,^{9,10} that it affects health care decision-making,^{11, 12} and that spirituality affects health care outcomes including quality of life.^{13–18} Spiritual and religious beliefs can also create distress and increase the burdens of illness.^{19,20}

Studies have raised critical issues including the need for a commonly accepted definition of spirituality, the appropriate application of spiritual care in palliative care settings, clarification about who should deliver spiritual care, the role of health care providers in spiritual care, and ways to increase scientific rigor surrounding spirituality and spiritual care research and practice. These issues and the current variability in delivering spiritual care as a component of palliative care raised awareness of the need for guidelines for ensuring

quality care. To this end, a Consensus Conference sponsored by the Archstone Foundation of Long Beach, California, was held February 17–18, 2009, in Pasadena, California. The Conference was based on the belief that spiritual care is a fundamental component of quality palliative care. According to the National Consensus Project (NCP) for Quality Palliative Care,²¹ “The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies.” Palliative care is viewed as applying to patients from the time of diagnosis of serious illness to death. In this way, the principles of spiritual care can be applicable across all phases and settings for the seriously ill, without regard to culture, religious tradition, or spiritual frames of reference.

The goal of the Consensus Conference was to identify points of agreement about spirituality as it applies to health care and to make recommendations to advance the delivery of quality spiritual care in palliative care. Five literature-based categories of spiritual care (spiritual assessment, models of care and care plans, interprofessional team training, quality improvement, and personal and professional development)

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were identified and provided the framework for the Consensus Conference. The resulting document and conference recommendations builds upon prior literature, the NCP Guidelines²¹ and National Quality Forum (NQF) Preferred Practices²² and Conference proceedings. This article represents the final Consensus Report. An expanded description of the Conference content and each section of this article is currently in preparation and will be published as a book.

Palliative Care Guidelines and Preferred Practices

The first clinical practice guidelines for palliative care were released in 2004 by the NCP²³; the guidelines were revised and a second edition was published in 2009.²¹ These guidelines are applicable to specialist-level palliative care (e.g., palliative care teams) delivered in a wide range of treatment settings and to the work of providers in primary treatment settings where palliative approaches to care are integrated into daily clinical practice (e.g., oncology, critical care, long-term care). Specifically these Clinical Practice Guidelines are intended to

1. Facilitate the development and improvement of clinical palliative care programs providing care to diverse patients and families with life-limiting or debilitating illness.
2. Establish uniformly accepted definitions of the essential elements in palliative care that promote quality, consistency, and reliability of these services.
3. Establish national goals for access to quality palliative care.
4. Foster performance measurement and quality improvement initiatives in palliative care services.

The guidelines address eight domains of care: structure and processes; physical aspects; psychological and psychiatric aspects; social aspects; spiritual, religious, and existential aspects; cultural aspects; imminent death; and ethical and legal aspects.

The successful dissemination of the NCP guidelines led next to collaboration with the NQF. Building on the NCP Guidelines, the NQF released a set of preferred practices for palliative care in 2006.²² This was a major advancement in the field of palliative care given the status of NQF as the nation's major private-public partnership responsible for identifying and approving evidence-based quality measures linked to reimbursement in all parts of the health care system. NQF involvement also was crucial in attracting the interest of policymakers in this field. Using the 8 NCP domains for its framework structure, the NQF identified 38 preferred practices to operationalize the NCP Guidelines and to set the foundation for future measurement of the outcomes of care. These practices are evidence-based or have been endorsed through expert opinion and apply to both hospice and palliative care. The 2009 NCP Guidelines²¹ and the NQF Preferred Practices²² (Table 1) served as the foundation for the recommendations for the Consensus Conference.

Consensus Conference Design and Organization

Achieving a consensus on spiritual care, both conceptually and pragmatically, requires engagement, deliberation, and dialogue among key stakeholders. Conference participation was by invitation. Invitees included a representative sample

of 40 national leaders, including physicians, nurses, psychologists, social workers, chaplains and clergy, other spiritual care providers, and health care administrators (Table 2). Participants agreed to develop a consensus-driven definition of spirituality, make recommendations to improve spiritual care in palliative care settings, identify resources to advance the quality of spiritual care to be made available through the George Washington Institute for Spirituality and Health SOERCE website,²⁴ and help with dissemination of the final documents. Prior to the conference, participants received a written overview of spiritual care as a dimension of palliative care drafted by Christina Puchalski, M.D. and Betty Ferrell, Ph.D., R.N., Principal Investigators. This document was, in effect, the first draft of this Consensus Report and incorporated feedback from an advisory committee and conference participants. It provided a common base from which the group could identify recommendations to improve spiritual care.

The conference began with an overview of the purpose of the conference, its structure, and its relation to the existing NCP guidelines and NQF preferred practices. This was followed by an overview of the developing Consensus Report, its structure, and areas of agreement and disagreement based the participants' reviews. The conference was facilitated by a consultant who established "ground rules" to create a safe environment for discussion and disagreement, for sharing all ideas, and for respect and the opportunity to speak without fear of judgment about diverse views.

At the conclusion of the first plenary session, participants attended one of five preassigned working groups each with an assigned facilitator. Each working group developed a proposed definition of spirituality and identified the key components of spirituality. After the first working group session, participants reviewed all the definitions and components and, using a consensus process, reached initial agreement on a definition and its important components.

The second plenary session began with a brief overview of the literature in spirituality and spiritual care. This was followed by a second working group session in which participants (in their same preassigned groups) were asked to focus on one of five key areas of spiritual care: Models and Treatment Plans, Assessment, Interprofessional Team/Training, Quality Improvement, and Personal and Professional Development. Facilitators asked each group to consider the following questions according to their specific group topic:

1. What are the issues identified in addressing the topic in spiritual care?
2. What are the barriers in implementing the topic?
3. What are the recommendations for the topic in applying spiritual care as a dimension of palliative care?
4. What resources or implementation strategies are available for the topic?
5. The conference facilitator received all of the written notes from the working groups, synthesized all the comments, and prepared a compilation for all participants to discuss on Day 2.

On Day 2, using a consensus process, conference participants finalized the definition of spirituality within the context of a health care environment. Critical elements of the definition included meaning, connectedness to spirituality as an aspect of humanity, and the search for the significant or sacred. In addition, spirituality was defined as being inclusive

TABLE 1. NATIONAL CONSENSUS PROJECT GUIDELINES²¹ AND NATIONAL QUALITY PREFERRED PRACTICES FOR SPIRITUAL DOMAIN²²

National Consensus Project Guidelines spiritual domain

National Quality Forum preferred practices

Guideline 5.1 Spiritual and existential dimensions are assessed and responded to based upon the best available evidence, which is skillfully and systematically applied.

Criteria:

- The interdisciplinary team includes professionals with skill in assessment of and response to the spiritual and existential issues common to both pediatric and adult patients with life-threatening illnesses and conditions, and their families. These professionals should have education and appropriate training in pastoral care and the spiritual issues evoked by patients and families faced with life-threatening illness.
- The regular assessment of spiritual and existential concerns is documented. This includes, but is not limited to, life review, assessment of hopes and fears, meaning, purpose, beliefs about afterlife, guilt, forgiveness, and life completion tasks.
- Whenever possible a standardized instrument should be used to assess and identify religious or spiritual/existential background, preferences, and related beliefs, rituals, and practices of the patient and family.
- Periodic reevaluation of the impact of spiritual/existential interventions and patient-family preferences should occur with regularity and be documented. Spiritual/existential care needs, goals, and concerns are addressed and documented, and support is offered for issues of life completion in a manner consistent with the individual's and family's cultural and religious values.
- Pastoral care and other palliative care professionals facilitate contacts with spiritual/religious communities, groups or individuals, as desired by the patient and/or family. Of primary importance is that patients have access to clergy in their own religious traditions.
- Professional and institutional use of religious/spiritual symbols is sensitive to cultural and religious diversity.
- The patient and family are encouraged to display their own religious/spiritual or cultural symbols.
- The palliative care service facilitates religious or spiritual rituals or practices as desired by patient and family, especially at the time of death.
- Referrals to professionals with specialized knowledge or skills in spiritual and existential issues are made when appropriate.

DOMAIN 5. SPIRITUAL, RELIGIOUS, AND EXISTENTIAL ASPECTS OF CARE

PREFERRED PRACTICE 20

Develop and document a plan based on assessment of religious, spiritual, and existential concerns using a structured instrument and integrate the information obtained from the assessment into the palliative care plan.

PREFERRED PRACTICE 21

Provide information about the availability of spiritual care services and make spiritual care available either through organizational spiritual counseling or through the patient's own clergy relationships.

PREFERRED PRACTICE 22

Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care.

PREFERRED PRACTICE 23

Specialized palliative and hospice spiritual care professional should build partnerships with community clergy and provide education and counseling related to end-of-life care.

of philosophical, religious, spiritual, and existential issues that arise in the clinical setting. These elements were grounded in theological, philosophical, empirical, and clinical literature.^{25,26} The agreed upon definition is as follows:

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.

The participants then reviewed the Consensus Document considering their work from the previous day. Participants were asked to identify areas in the document that were missing or required further elaboration or clarification and, once again, to comment on all aspects of the document. Verbal and written comments were collected.

Over the following 2 months this Consensus Document was revised yet again to incorporate the feedback from conference participants. This version of the document was sent to a panel of 150 expert reviewers for additional comments. All participants of the Consensus Conference and the 6 project advisors have reviewed this Consensus Report and agreed to its content.

Conference Recommendations

Recommendations for improving spiritual care are divided into seven keys areas that were developed from the original five focus groups from the Consensus Conference. The seven areas are

- Spiritual Care Models
- Spiritual Assessment

TABLE 2. CONSENSUS CONFERENCE LEADERS AND PARTICIPANTS

<i>The Project Team</i>	
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<p>M. Brownell "Brownie" Anderson, M.Ed. Senior Director, Educational Affairs Association of American Medical Colleges Washington, D.C.</p>	
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(continued)

TABLE 2. CONTINUED

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(continued)

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- Spiritual Treatment/Care Plans
- Interprofessional Team
- Training/Certification
- Personal and Professional Development
- Quality Improvement

Spiritual Care Models

Spiritual care models offer a framework for health care professionals to connect with their patients; listen to their fears, dreams, and pain; collaborate with their patients as partners in their care; and provide, through the therapeutic relationship, an opportunity for healing. Healing is distinguished from cure in this context. It refers to the ability of a person to find solace, comfort, connection, meaning, and purpose in the midst of suffering, disarray, and pain. The care is rooted in spirituality using compassion, hopefulness, and the recognition that, although a person's life may be limited or no longer socially productive, it remains full of possibility.²⁷

Spiritual care is grounded in important theoretical frameworks, one of which is the Biopsychosocial-Spiritual Model of Care.^{28,29} Another is a patient-centered care model in which the focus of care is on the patient and his or her experience of illness as opposed to a sole focus on the disease.³⁰ Integral to both of these models is the recognition that there is more to the care of the patient than the physical.

Biopsychosocial-spiritual model of care

The work of Engel³¹ and White³² proposed a biopsychosocial model for care that can readily be extended to encompass the spiritual²⁹ (Fig. 1). This approach is based on a philosophical anthropology, a cornerstone of which is the concept of the person as a being-in-relationship. Jonas³³ said, "Life is essentially relationship; and relation as such implies 'transcendence,' a going-beyond-itself on the part of that which entertains the relation." Disease can be understood as a disturbance in the right relationships that constitute the unity and integrity of what we know to be a human being. Humans are intrinsically spiritual since all persons are in relationship with themselves, others, nature, and the significant or sacred.

To know a thing is to grasp the complex set of relationships that define it, whether that thing is a quark or a human being.³⁴ This is especially true of living things.

Contemporary scientific healing retains the same formal structure that informed prescientific cultures—healing is still about the restoration of right relationships. Illness disturbs more than relationships inside the human organism; it disrupts families and workplaces, shatters preexisting patterns of coping, and raises questions about one's relationship with the significant or the sacred.²⁹ According to the biopsychosocial-spiritual model, everyone has a spiritual history. For many people, this spiritual history unfolds within the context of an explicit religious tradition; for others it unfolds as a set of philosophical principles or significant experiences. Regardless, this spiritual history helps shape who each patient is as a whole person. When life-threatening illness strikes, it strikes each person in his or her totality.³⁵ This totality includes not simply the biologic, psychological, and social aspects of the person,³⁶ but also the spiritual aspects as well.^{37,38} The biologic, psychological, social, and spiritual are distinct dimensions of each person. No one aspect can be disaggregated from the whole. Each aspect can be affected differently by a person's history and illness and each aspect can interact and affect other aspects of the person.

Interprofessional spiritual care model

The spiritual care model that underpinned the work of the Consensus Conference is a relational model in which the patient and clinicians work together in a process of discovery, collaborative dialogue, treatment and ongoing evaluation, and follow-up. The model, developed prior to the conference and then presented and discussed at the conference and subsequently modified, is different for inpatient (Fig. 2) and outpatient (Fig. 3) settings but the overall goals are similar. All parties in the spiritual care model have the potential for being transformed by interaction with one another. Based on examples in the literature³⁹⁻⁴¹ and the input from consensus participants and advisors, a model was developed for implementing spiritual care. Health care professionals should

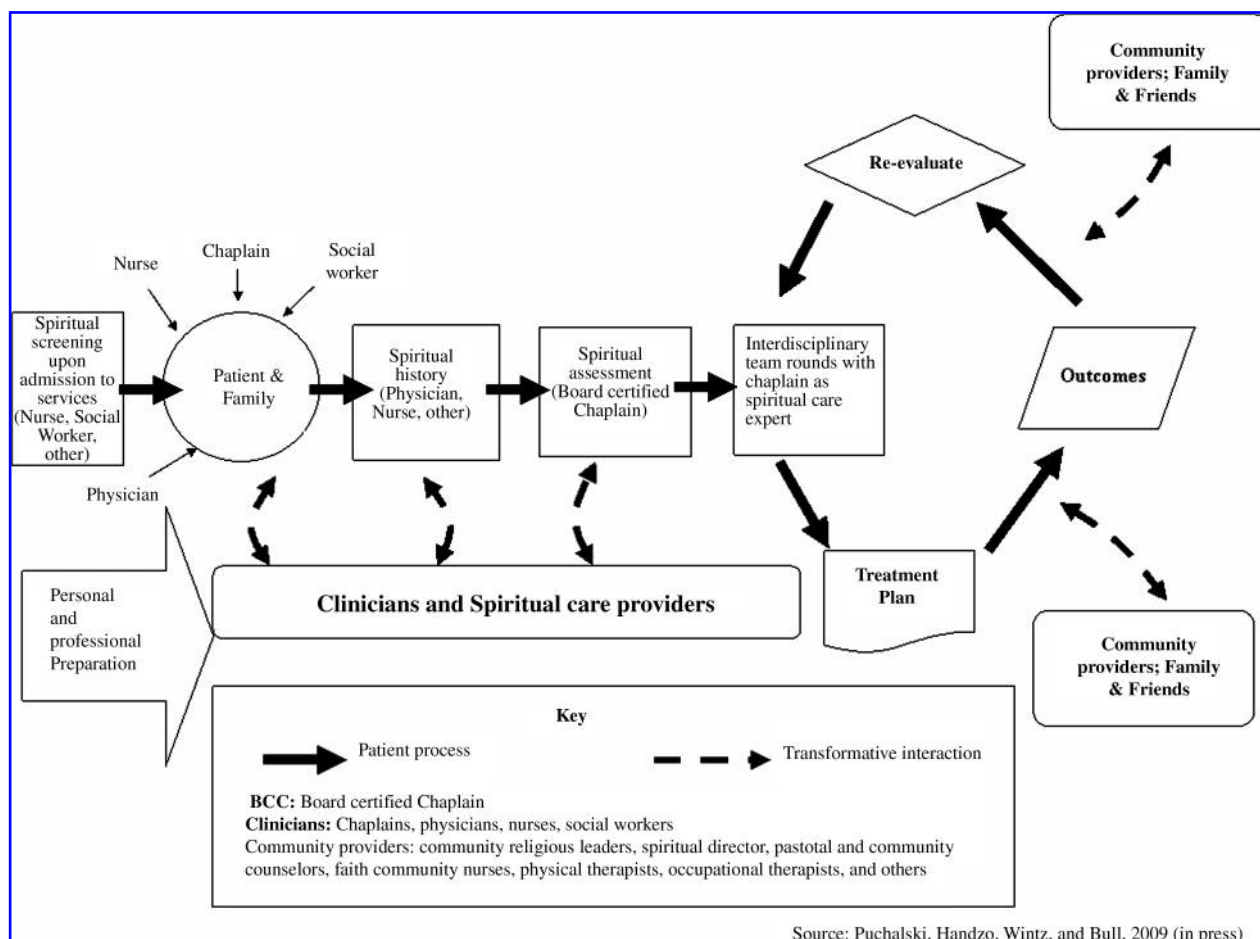


FIG. 1. Inpatient spiritual care implementation model.

take an appropriate spiritual history from the patient upon admission to the clinical setting. Based on information from the spiritual history, clinicians can identify the presence of a spiritual issue (including spiritual distress or spiritual resources of strength) and make the appropriate referrals to chaplains in the inpatient setting or to other appropriate spiritual care providers in an outpatient setting. Clinicians should distinguish when the patient presents with emotional or psychosocial issues, spiritual issues, or both and make the appropriate referral. This model is based on a generalist-specialist model of care in which board-certified chaplains are considered the trained spiritual care specialists. These board-certified chaplains serve as a resource to identify other spiritual care providers who might be appropriate for the patient.

Recommendations

1. Spiritual care should be integral to any compassionate and patient-centered health care system model of care.
2. Spiritual care models should be based on honoring the dignity of all people and on providing compassionate care.
3. Spiritual distress or religious struggle should be treated with the same intent and urgency as treatment for pain or any other medical or social problem.
4. Spirituality should be considered a patient vital sign. Just as pain is screened routinely, so should spiritual issues be a part of routine care. Institutional policies for

spiritual history and screening must be integrated into intake policies and ongoing assessment of care.

5. Spiritual care models should be interdisciplinary and clinical settings should have a Clinical Pastoral Education-trained board-certified chaplain as part of the interprofessional team.

Spiritual Assessment of Patients and Families

Failure to assess spiritual needs may potentially neglect an important patient need; it also fails to consider patients as whole persons. Communication with patients and families about spiritual issues ranges from preliminary screening in order to identify potential spiritual issues to a spiritual history taken by trained health care providers to a spiritual assessment by a board-certified chaplain.^{42,43}

Spiritual screening

Spiritual screening or triage is a quick determination of whether a person is experiencing a serious spiritual crisis and therefore needs an immediate referral to a board-certified chaplain. Spiritual screening helps identify which patients may benefit from an in-depth spiritual assessment. Good models of spiritual screening use a few simple questions that can be asked in the course of an overall patient and family screening. Examples of such questions include, "Are spirituality or religion

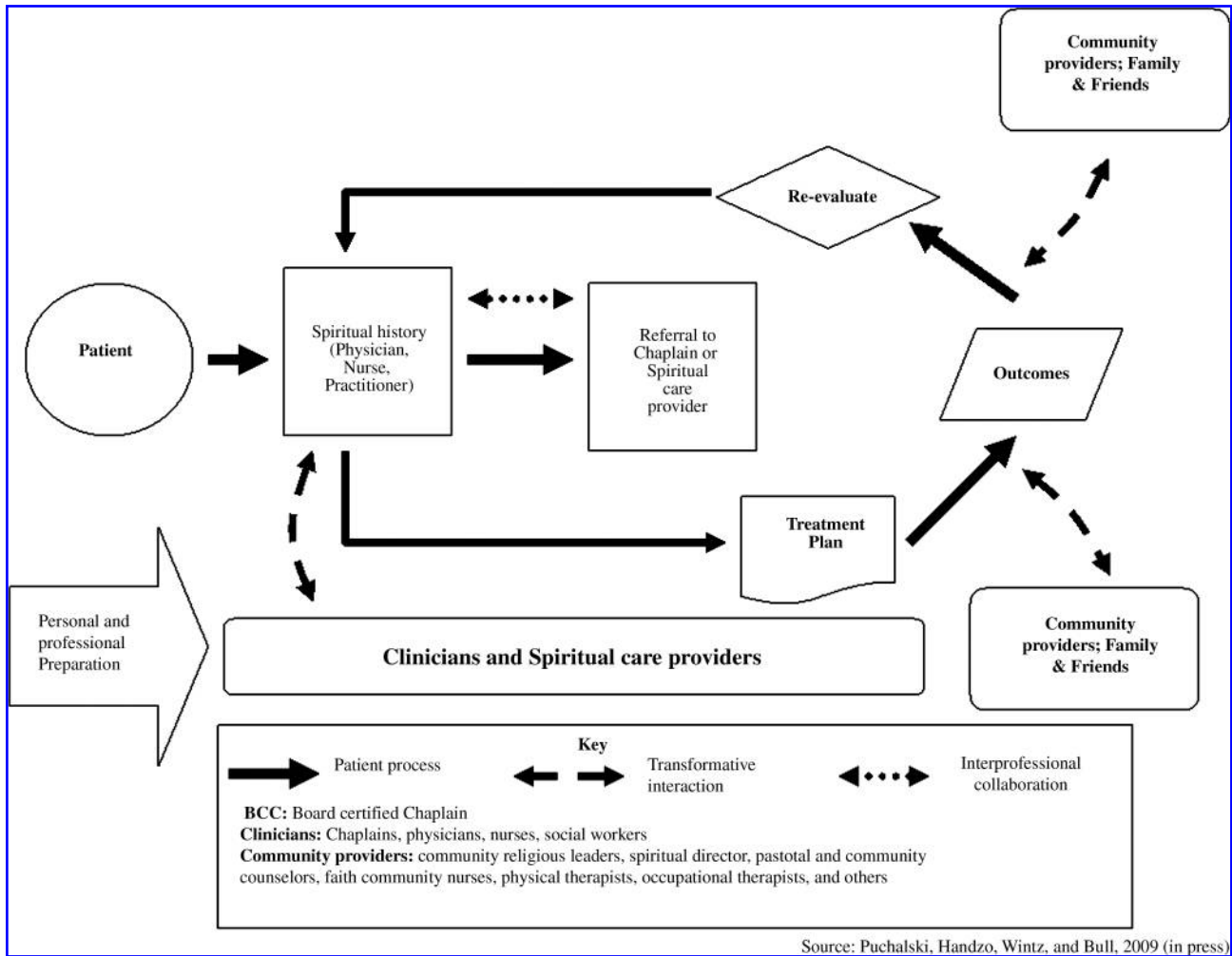


FIG. 2. Outpatient spiritual care implementation model.

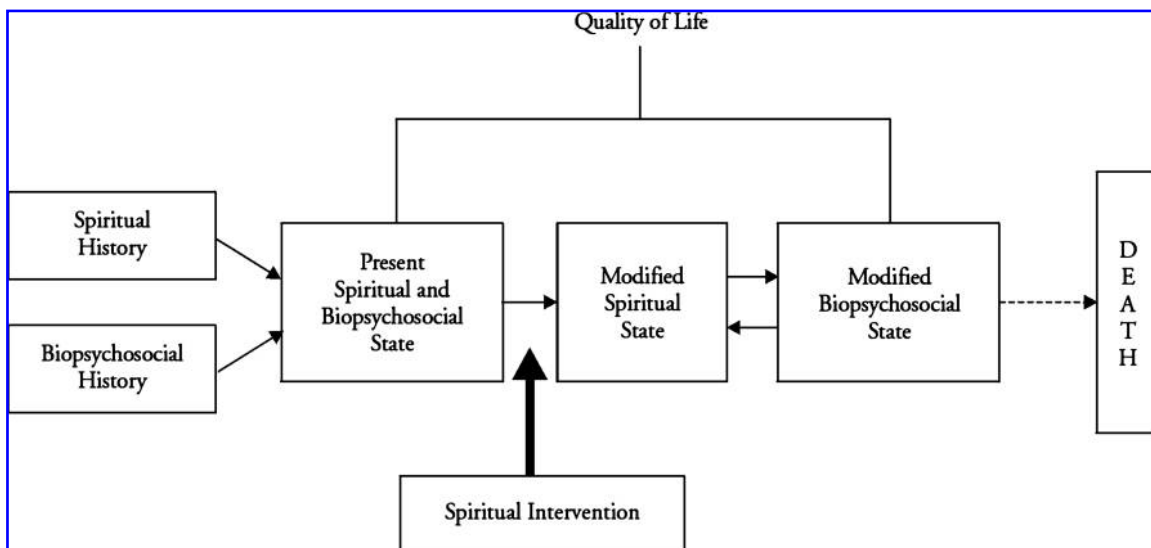


FIG. 3. The biopsychosocial-spiritual model of care. From Sulmasy DP: A biophysical-spiritual model for the care of patients at the end of life. Gerontologist 2002;42(Spec 3):24-33. Used with permission.

important in your life?" and "How well are those resources working for you at this time?"

Spiritual history

Spiritual history-taking is the process of interviewing a patient in order to come to a better understanding of their spiritual needs and resources. A spiritual history can be integrated into existing formats such as the social history section of the clinical database. Compared to screening, history-taking uses a broader set of questions to capture salient information about needs, hopes, and resources. The history questions are asked in the context of a comprehensive examination by the clinician who is responsible for providing direct care or referrals to specialists. The information from the history permits the clinician to understand how spiritual concerns could either complement or complicate the patient's overall care. It also allows the clinician to incorporate spiritual care into the patient's overall care plan. Unlike spiritual screening, which requires only brief training, those doing a spiritual history should have some education in and comfort with issues that may emerge and knowledge of how to engage patients comfortably in this discussion.

The goals of the spiritual history are to

- Invite all patients to share spiritual and religious beliefs, and to define what spirituality is for them and their spiritual goals.
- Learn about the patient's beliefs and values.
- Assess for spiritual distress (meaninglessness, hopelessness) as well as for sources of spiritual strength (hope, meaning, and purpose).
- Provide an opportunity for compassionate care.
- Empower the patient to find inner resources of healing and acceptance.
- Identify spiritual and religious beliefs that might affect the patient's health care decision-making.
- Identify spiritual practices that might be helpful in the treatment or care plan.
- Identify patients who need referral to a board-certified chaplain or other equivalently prepared spiritual care provider.

There are clinical history tools available that can be used to collect and document clinical information. Several tools have been developed for this purpose including FICA (Faith/Beliefs, Importance, Community, Address in care or action),^{41,43} SPIRIT (Spiritual belief system, Personal Spirituality, Integration, Rituals/restrictions, Implications, and Terminal events),⁴⁰ HOPE (Hope, Organized religion, Personal spirituality, Effects of care and decisions),³⁹ and Domains of Spirituality (developed for use by social workers).⁴⁴ Generally, these tools include more objective data (e.g., religious affiliation, spiritual practices) while touching upon deeper and more subjective spiritual aspects (e.g., meaning, importance of belief, sources of hope).

Spiritual assessment

Formal spiritual assessment refers to a more extensive process of active listening to a patient's story conducted by a board-certified chaplain that summarizes the needs and resources that emerge in that process. The chaplain's summary should include a spiritual care plan with expected outcomes

that is then communicated to the rest of the treatment team. Unlike history-taking, the major models for spiritual assessment are not built on a set of questions that can be used in an interview. Rather, the models are interpretive frameworks that are based on listening to the patient's story as it unfolds. Because of the complex nature of these assessments and the special clinical training necessary to engage in them, this assessment should be done only by a board-certified chaplain or an equivalently prepared spiritual care provider.

When each level of evaluation occurs depends on the setting and who is asking the questions. In hospitals, nursing homes, or hospices, spiritual screening should be done by the nurse or social worker upon triage or admission in order to assess for spiritual emergencies that may require immediate intervention. In outpatient settings, a spiritual screening might not take place as an event separate from the clinical encounter. Rather, if the patient comes to the physician's office in distress, a spiritual screening might be done as part of the initial conversation with the physician, advanced practice nurse, or physician assistant. A spiritual history could be done by the physician, nurse, social worker, or other clinician responsible for developing and assessment and treatment plan. The spiritual assessment would be done by a board-certified chaplain.

Recommendations

1. All patients should receive a simple and time-efficient spiritual screening at the point of entry into the health care system and appropriate referrals as needed.
2. Health care providers should adopt and implement structured assessment tools to facilitate documentation of needs and evaluation of outcomes of treatment.
3. All staff members should be vigilant, sensitive, and trained to recognize spiritual distress.
4. All health care professionals should be trained in doing a spiritual screening or history as part of their routine history and evaluation; unlicensed staff members should report all witnessed pain or spiritual distress.
5. Formal spiritual assessments should be made by a board-certified chaplain who should document their assessment and communicate with the referring provider about their assessment and the plans of care.
6. Spiritual screenings, histories, and assessments should be communicated and documented in patient records (e.g., charts, computerized databases, and shared during interprofessional rounds). Documentation should be placed in a centralized location for use by all clinicians. If a computerized patient database is available, spiritual histories and assessments should be included.
7. Follow-up spiritual histories or assessments should be conducted for all patients whose medical, psychosocial, or spiritual condition changes and as part of routine follow-up in a medical history.
8. The chaplain should respond within 24 hours to a referral for spiritual assessment.

Formulation of a Spiritual Treatment Plan

Integrating spiritual issues into the treatment plan

Health care professionals determine how to integrate information from the spiritual assessment into the patient's

TABLE 3. SPIRITUAL CONCERNS

<i>Diagnoses (Primary)</i>	<i>Key feature from history</i>	<i>Example statements</i>
Existential concerns	Lack of meaning Questions meaning about one's own existence Concern about afterlife Questions the meaning of suffering Seeks spiritual assistance	"My life is meaningless." "I feel useless."
Abandonment by God or others	Lack of love, loneliness Not being remembered No sense of Relatedness	"God has abandoned me." "No one comes by anymore."
Anger at God or others	Displaces anger toward religious representatives Inability to forgive	"Why would God take my child . . . it's not fair."
Concerns about relationship with deity	Desires closeness to God, deepening relationship	"I want to have a deeper relationship with God."
Conflicted or challenged belief systems	Verbalizes inner conflicts or questions about beliefs or faith Conflicts between religious beliefs and recommended treatments Questions moral or ethical implications of therapeutic regimen Expresses concern with life/death or belief system	"I am not sure if God is with me anymore."
Despair/Hopelessness	Hopelessness about future health, life Despair as absolute hopelessness No hope for value in life	"Life is being cut short." "There is nothing left for me to live for."
Grief/loss	The feeling and process associated with the loss of a person, health, relationship	"I miss my loved one so much." "I wish I could run again."
Guilt/shame	Feeling that one has done something wrong or evil Feeling that one is bad or evil	"I do not deserve to die pain-free."
Reconciliation	Need for forgiveness or reconciliation from self or others	"I need to be forgiven for what I did." "I would like my wife to forgive me."
Isolation	Separated from religious community or other	"Since moving to the assisted living I am not able to go to my church anymore." "I just can't pray anymore."
Religious-specific	Ritual needs Unable to perform usual religious practices	
Religious/spiritual struggle	Loss of faith or meaning Religious or spiritual beliefs or community not helping with coping	"What if all that I believe is not true."

overall treatment plan. Using the language consistent with practice in most health care settings, this includes identifying or diagnosing the spiritual problems/needs; identifying spiritual goals (if appropriate); and determining, implementing, and evaluating the appropriate spiritual interventions (Tables 3 and 4). Health care professionals involved in assessing and referring patients should identify spiritual issues or make spiritual diagnoses if applicable. Some spiritual diagnosis labels currently exist but these may be limited in scope (e.g., to patients with cancer) and also are not presently used for reimbursement. Thus a clinician may identify a spiritual issue or a patient's sources of strength or the clinician may identify a spiritual diagnosis. In general a spiritual issue becomes a diagnosis if the following criteria are met:

1. The spiritual issue leads to distress or suffering (e.g., lack of meaning, conflicted religious beliefs, inability to forgive).
2. The spiritual issue is the cause of a psychological or physical diagnosis such as depression, anxiety, or

acute or chronic pain (e.g., severe meaninglessness that leads to depression or suicidality, guilt that leads to chronic physical pain).

3. The spiritual issue is a secondary cause or affects the presenting psychological or physical diagnosis (e.g., hypertension is difficult to control because the patient refuses to take medications because of his or her religious beliefs).

If there is an interprofessional team involved then a board-certified chaplain, as the expert in spiritual care, provides the input and guidance as to the diagnosis and treatment plan with respect to spirituality. In situations where there is no interprofessional team, health care professionals identify the issues or make the diagnoses and develop the treatment plan. These clinicians are responsible for referring complex spiritual issues to a board-certified chaplain. For simple issues, such as a patient wanting to learn about yoga, meditation, or art or music therapy, the health care professional can make the appropriate referral or implement a course of action. For

TABLE 4. EXAMPLES OF SPIRITUAL HEALTH INTERVENTIONS

<p>Therapeutic communication techniques</p>	<ol style="list-style-type: none"> 1. Compassionate presence 2. Reflective listening, query about important life events 3. Support patient's sources of spiritual strength 4. Open-ended questions to illicit feelings 5. Inquiry about spiritual beliefs, values and practices 6. Life review, listening to the patient's story 7. Continued presence and follow-up 8. Guided visualization for "meaningless pain" 9. Progressive relaxation
<p>Therapy</p>	<ol style="list-style-type: none"> 10. Breathing practice or contemplation 11. Meaning-oriented therapy 12. Referral to spiritual care provider as indicated 13. Use of story telling 14. Dignity-conserving therapy
<p>Self-care</p>	<ol style="list-style-type: none"> 15. Massage 16. Reconciliation with self or others 17. Spiritual support groups 18. Meditation 19. Sacred/spiritual readings or rituals 20. Yoga, tai chi 21. Exercise 22. Art therapy (music, art, dance) 23. Journaling

the more complex spiritual issues, referral to a board-certified chaplain or other spiritual care provider is critical. Use of decision tree algorithms may facilitate the care process. Figure 4 is an example of one such algorithm.

Several surveys have demonstrated that some patients would like to be able to pray with their physicians and nurses.^{45,46} A survey conducted by Stanford University Medical Center, ABC News, and *USA Today* in 2005⁴⁷ reported that prayer is the second most commonly used method that hospitalized patients rely upon for pain control, after opioid analgesics. Astrow¹ and Lo⁴⁸ have developed guidelines for praying with patients that could be adapted *a priori*. Regardless, prayer requests from patients should be handled sensitively and compassionately.

Tables 5 and 6 are examples of how spiritual care can be incorporated into a treatment plan. These plans should include input from the interprofessional team and be updated on a regular basis based on appropriate follow-up and reevaluation.

Evaluation and follow-up

NCP Guidelines²¹ call for periodic reevaluation of the impact of spiritual/existential interventions and patient and family preferences. Any time a diagnosis of a spiritual nature is made or a need is identified, whether related to pain, nutrition or a psychosocial or spiritual distress, it is of utmost importance to determine the impact of the interventions and adjust the plan of care as needed.⁴⁹

Documentation

Documenting the provision of spiritual care allows for communication about the intervention and the corresponding desired outcomes. Documentation should occur in the social history section of the intake history and physical of the patient's chart, as well as in the daily progress notes as applica-

ble. Documentation of the intervention showing its value and effectiveness is key to quality care and provides knowledge to other members of the interprofessional team who share in the care of the patient. Health care professionals could consider documenting spiritual issues as part of a comprehensive biopsychosocial-spiritual assessment and plan. Sound clinical judgment should govern how much detail is provided in the documentation. Private content or information offered in confidence should be documented only to the extent that it directly affects the patient's clinical care of patients and is critical for other members of the interprofessional team to know.

Recommendations

1. Screen and assess every patient's spiritual symptoms, values, and beliefs and integrate them into the plan of care.
2. All trained health care professionals should do spiritual screening and history-taking. These caregivers should also identify any spiritual diagnoses and develop a plan of care. Detailed assessment and complex diagnosis and treatment are the purview of the board-certified chaplains working with the interprofessional team as the spiritual care experts.
3. Currently available diagnostic labels (e.g., National Comprehensive Cancer Network [NCCN] Distress Management guidelines,⁵⁰ *Diagnostic and Statistical Manual [DSM]* code V62.89,⁵¹ NANDA nursing diagnoses⁵²) can be used, but further work is needed to develop more comprehensive diagnostic codes for spiritual problems.
4. Treatment plans should include but not be limited to:
 - a. Referral to chaplains, spiritual directors, pastoral counselors, and other spiritual care providers including clergy or faith-community healers for spiritual counseling

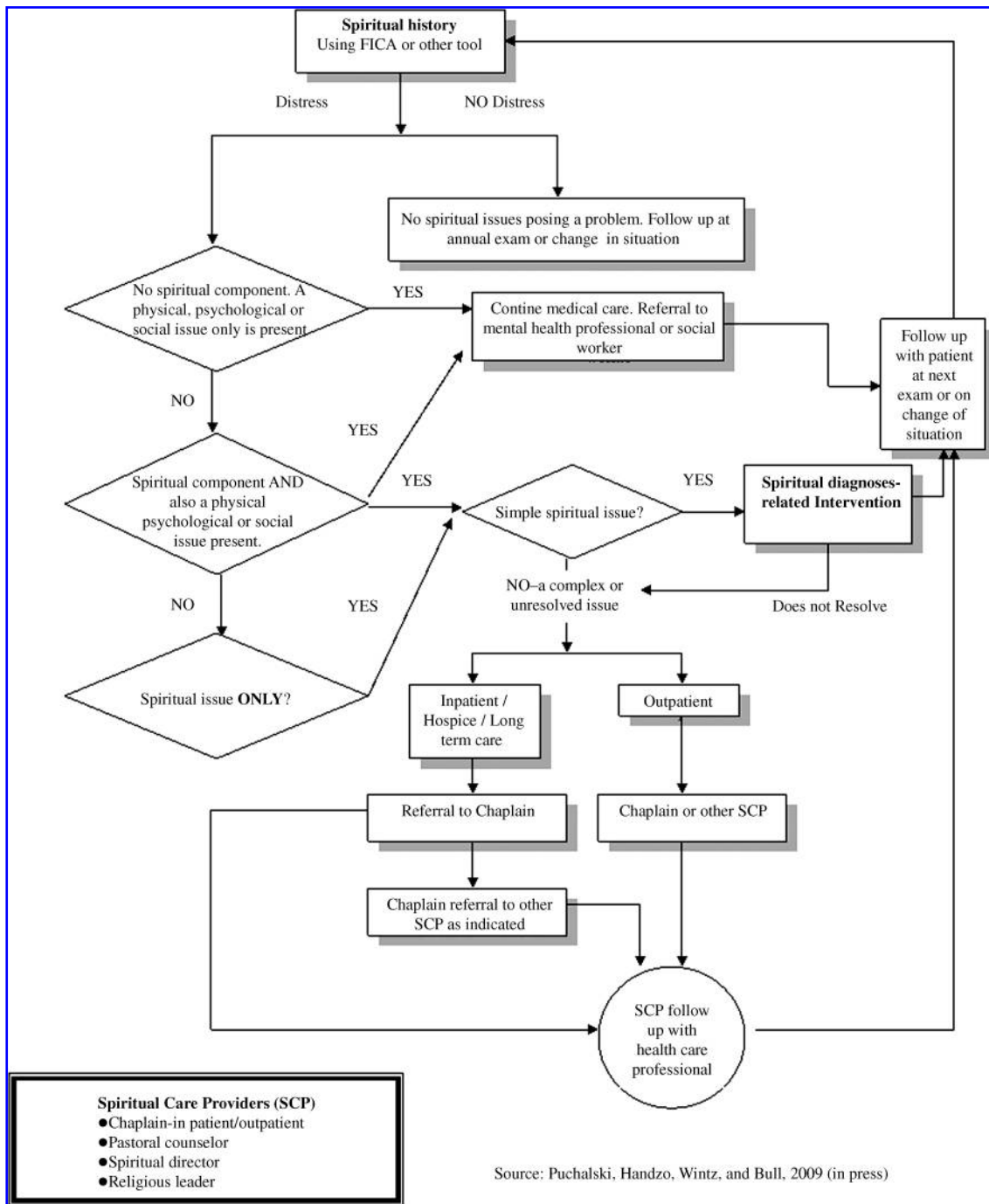


FIG. 4. Spiritual diagnosis decision pathways.

- b. Development of spiritual goals
 - c. Meaning-oriented therapy
 - d. Mind-body interventions
 - e. Rituals, spiritual practices
 - f. Contemplative interventions
5. Patients should be encouraged and supported in the expression of their spiritual needs and beliefs as they desire and this should be integrated into the treatment or care plan and reassessed periodically. Written material regarding spiritual care, including a description of the role of chaplains should be made available to

- patients and families. Family and patient requests specifically related to desired rituals at any point in their care and particularly at the time of death should be honored.
- 6. Board-certified chaplains should function as spiritual care coordinators and help facilitate appropriate referrals to other spiritual care providers or spiritual therapies (e.g., meditation training) as needed.
 - 7. Spiritual support resources from the patient’s own spiritual/religious community should be noted in the chart.

TABLE 5. CASE EXAMPLE: ASSESSMENT AND TREATMENT PLAN

An 80-year-old man dying of end-stage colon cancer with well-controlled pain, some anxiety, unresolved family issues, and fear about dying.

<i>Dimension</i>	<i>Assessment</i>	<i>Plan</i>
Physical	Well-controlled pain Nausea and vomiting, likely secondary to partial small bowel obstruction.	Continue current medication regimen. Evaluate treatment options to relieve nausea associated with bowel obstruction.
Emotional	Anxiety about dyspnea that may be associated with dying Anxiety affecting sleep at night	Refer to counselor for anxiety management and exploration of issues about fear of dying. Consult with palliative care service for treatment of dyspnea and anxiety.
Social	Unresolved issues with family members as well as questions about funeral planning and costs	Refer to social worker for possible family intervention as well as assistance with end-of-life planning.
Spiritual	Expresses fear about dying; seeks forgiveness from son for being a "distant dad."	Refer to chaplain for spiritual counseling, consider forgiveness intervention, encourage discussion about fear of death Continue presence and support.

- 8. Follow-up evaluations should be done regularly, especially when there is a change in status or level of care, or when a new diagnosis or prognosis is determined.
- 9. Treatment algorithms can be useful adjuncts to determine appropriate interventions.
- 10. The discharge plan of care should include all dimensions of care, including spiritual needs.
- 11. Spiritual care must extend to bereavement care. Palliative care programs should institute processes to ensure that systematic bereavement support is provided. Referral to bereavement counselors or services should be available as appropriate for loved ones and families after the death of the patient. Structured bereavement

- assessment tools should be used to identify needs for support and those at greatest risk for complicated grief.
- 12. Health care professionals should establish procedures for contact with family or loved ones following the death of a patient. This may include sending condolences, attending funerals, holding memorial services, or other rituals to offer support to and connection with to the family.

**Interprofessional Considerations:
Roles and Team Functioning**

Collaboration among the members of interprofessional teams has become a central component in health care delivery

TABLE 6. CASE EXAMPLE: DISCHARGE PLAN

A 65-year-old woman admitted for repair of hip fracture; surgery went well, without complications. Now being discharged to a rehabilitation facility. Noted anxiety, separation from religious community. Has strong spiritual beliefs, good level of hope, strong family support. Her spiritual goals include deepening her relationship with God. Expressed interest in learning meditation.

<i>Domain</i>	<i>Problem</i>	<i>Plan</i>
Physical	Status post-hip fracture	Physical and occupational therapy Ensure adequate pain management
Emotional	Anxious about not being able to work; has panic attacks at night	Evaluate options to treat anxiety and sleeplessness Counseling with social worker
Social	Isolation in new facility	Encourage family to visit at new facility Contact rehabilitation facility to get information regarding activities, volunteers, support available
Spiritual	Isolation from church community; desires deepening of her relationship with God	Refer to chaplain Refer to spiritual director once discharged from rehabilitation facility Provide list of meditation centers and teachers in patient's community or refer to social work for basic instruction

Puchalski, C. (2006a). Spiritual assessment in clinical practice. *Psychiatric Annals* 2006;36:150. Used with permission.

systems.⁵³⁻⁵⁶ No one clinician can possibly meet the combined physical, psychosocial, spiritual, and personal needs of patients. While all team members have some responsibility for spiritual care, board-certified chaplains play a key role as the team member most directly responsible for spiritual care. As The Joint Commission⁵⁷ has asserted: "The emerging prominent role of clinically trained, professional board-certified chaplains working with health care organizations in completing spiritual assessments, functioning as the 'cultural broker,' and leading cultural and spiritual sensitivity assessments for staff and physicians can be of great value. Organizations that employ board-certified chaplains are able to focus directly on the significance and incorporation of cultural, spiritual, and religious practices into the plan of care." In the outpatient setting, having an interprofessional team is more challenging. Physicians and advance practice nurses can consult with social workers and outpatient chaplains or other equivalently trained spiritual care professionals.

Despite the advantages, however, interprofessional team care raises a number of issues. The team must decide how patient-care responsibilities are to be apportioned. The team leader must strike a balance between the role of "captain" and the role of facilitator or convener. Each team member must be aware of and respect the professional ethics of other team members. Any team member who cooperates in, or fails to

object to, any harmful act is a moral accomplice. Team dynamics also can raise ethical issues. In the interest of harmony, team members can become too compliant or be too eager to be seen as "good team-players." It is important that all members of the interprofessional team be respected and valued as integral participants in the care of the patient. Finally, patients and family members also have roles to play as members of the palliative care team.

Interprofessional communication/confidentiality and spiritual care

Communication is a critical element of interprofessional care. Whether in the hospice, hospital, outpatient, or long-term care setting, interprofessional rounds may offer the best way to optimize communication. Documentation in the patient record is essential to communicate spiritual concerns. Practice principles are important to foster interprofessional collaborative spiritual care (Table 7).

Interprofessional functioning in the outpatient setting

Incorporation of a full interprofessional team in the outpatient setting may present challenges. There are no generally accepted guidelines or practices for spiritual care in this arena.

TABLE 7. GUIDE FOR INTERPROFESSIONAL COLLABORATIVE SPIRITUAL CARE

Preamble: The goal of this guide is to promote meaningful, compassionate care that addresses the spiritual dimension of an individual. The spiritual dimension is an essential part of the individual's personal striving for health, wholeness, and meaning of life. Each person's definition of spirituality is individualized and may or may not include a religious preference.

This is a guide to the ways in which health care professionals can honor, integrate, and bring to light the spiritual underpinnings of a wide variety of professional ethical codes for a mutual goal of achieving the highest possible level of health and healing for all.

Collaborators: Patients, families, and a variety of health and spiritual care professionals: such as health care chaplains/clergy persons/spiritual and religious leaders, culturally based healers, mind-body practitioners, nurses, physicians, psychologists, public health researchers, social workers, and community health educators.

Shared Values: Autonomy, compassion, competence, confidentiality, courage, dignity, equality, generosity, humility, integrity, justice, respect, reverence, trust, and worth.

Guiding Documents: American Psychological Association's Code of Ethics, American Medical Association's Principles of Medical Ethics, American Nurses Association's Code of Ethics, Association of Professional Chaplains Code of Ethics, National Association of Catholic Chaplains Code of Ethics, National Association of Social Workers Code of Ethics, Public Health Leadership Society's Principles of the Ethical Practice of Public Health, and the Unified Code of Ethics for Healers.

This guide affirms the following for health care professionals in the provision of spiritual care:

1. Recognize spirituality as an integral component to the human experience of illness, healing, and health.
2. Perform spiritual inquiry in a patient-centered, confidential, and respectful manner.
3. Elicit the patient's ongoing spiritual concerns/issues/needs.
4. Be sensitive to the ways in which a patient describes spiritual beliefs, practices, values, meaning, and relationships.
5. Respect patient autonomy to address or not address spirituality.
6. Practice spiritual self-care as a provider of spiritual care.
7. Collaborate with qualified interdisciplinary professionals.
8. Provide competent and compassionate spiritual care.
9. Work in partnership in the study, application, and advancement of scientific knowledge regarding spirituality and health care.
10. Perform only those services for which one is qualified, observe all laws, and uphold the dignity and honor of one's profession.

Prepared as the final class project, for Practical Tools in Spiritual Care, a course in the Online Graduate Certificate Program in Spirituality and Health, George Washington University and George Washington University Institute for Spirituality and Health, 2008, D. Kreslins, S. Alvarez-Baez, M. Hardee, M. McCahill, L.J. Peterson; C. Puchalski, M.D., Course Director.

It is easy to assume that patients or family member who desire spiritual care or who would find it useful have access to spiritual or religious resources and a community to provide for that need. However, Balboni⁹ found that 49% of patients with advanced cancer were not finding their religious and spiritual needs met by their faith communities.

It is often the case that the patients and caregivers in outpatient settings will not have a regular chaplain available to them. The Joint Commission⁵⁷ only requires that accredited institutions “accommodate” spiritual and religious needs. There is no requirement that a chaplain or spiritual care provider of any kind be available. Many hospitals and long-term care facilities provide for spiritual needs with volunteer community clergy or religious leaders. As more and more health care is shifted to the outpatient setting because of economics and as burdens on the health care system increase, opportunities to provide spiritual care to patients and families will increase and may also set the stage for requiring board-certified chaplains or equivalently prepared spiritual care providers in the outpatient setting.

Community spiritual leaders: Members of the team at large

In addition to social workers, chaplains, physicians, and nurses, there are other spiritual professionals who can participate as part of the larger palliative care team. These include community clergy, religious leaders, community elders, spiritual directors, pastoral counselors, parish nurses, lay religious professionals, culturally-based healers, and other spiritual care providers of diverse religious, spiritual, and culturally diverse backgrounds including humanistic nonreligious leaders.

When building relationships with community religious or spiritual care providers, it is important for the interprofessional health care team to determine what training the person has, since this can vary widely. It is also important to determine the person’s beliefs about how medical decisions should be made and how end-of-life care should proceed, especially with regard to the use of pain medicines and life-sustaining treatments.

Recommendations

1. Policies about effective and appropriate communication channels between health care professionals and spiritual care professionals in a variety of health care settings are needed.
2. Policies should be developed by clinical sites to facilitate networking, communication, and coordination among spiritual care providers. Board-certified chaplains can function as spiritual care coordinators to facilitate this communication.
3. Health care professionals should work to create healing environments in their workplace.
4. Respect for the dignity of all health care professionals should be reflected in policies (e.g., a hospital code of ethics could include respect for fellow workers and treating all with compassion).
5. Spiritual care providers should document their assessment of patient needs in the patient record and contribute to the treatment plans as appropriate as part of interprofessional communication and collaboration.

6. Given the significant shift in health care to outpatient settings, there is a need for board-certified chaplains in these areas. Initial screening and some treatment of spiritual issues may be done by health care professionals such as physicians, counselors, parish nurses, and social workers. More complex spiritual issues need to be attended to by a board-certified chaplain or equivalently prepared spiritual care provider.
7. Activities and programs to enhance team spirit and system-wide compassion and respect can be introduced into the workplace. These can include retreats, opportunities for reflection, team-building experiences, and service recognition awards for compassionate care.

Training and Certification

Since 2000 there has been a significant increase in formal education in spirituality and health in the health care professions. Over 85% of medical and osteopathic schools have topics related to spirituality integrated into the curriculum.²⁵ Nursing has integrated spirituality into baccalaureate education.^{58,59} Social work programs have spirituality integrated into their undergraduate and masters program.⁶⁰ The Marie Curie Cancer Center in London has developed a set of competencies for health care providers for spiritual care.⁶¹

Chaplains (whether ordained, commissioned, or otherwise set aside by their religious-tradition community) are identified leaders who have acquired an extended education in pastoral care. All board-certified chaplains have at least 1600 hours of clinical pastoral education. Clinical Pastoral Education (CPE) is interfaith professional education for ministry. It brings theological students and ministers of all faiths (pastors, priests, rabbis, imams, and others) into supervised encounters with persons in crisis. At the conclusion of this course of study CPE students are considered competent in pastoral formation and providing spiritual support to people of diverse spiritual, religious, and cultural backgrounds. In North America, chaplains can receive certification from a number of the national organizations that are accredited by the COMISS Network Commission on Accreditation of Pastoral Services.⁶² They include the following:

- Association of Professional Chaplains (approximately 3700 members).
- The Canadian Association for Pastoral Practice and Education (approximately 1000 members).
- National Association of Catholic Chaplains (approximately 4000 members).
- National Association of Jewish Chaplains (approximately 400 members).

In addition to spiritual care training, there also needs to be palliative care training for all disciplines including chaplains. Palliative care education is increasing in the clinical disciplines but there is still an increased need for this education. Since 1990 these educational initiatives as well as research have given rise to the field of spirituality and health. While there have been significant advances, there is still a need for increased and more formalized training in spirituality and health in undergraduate health care professions curricula, as well as graduate, postgraduate, and continuing education.

Chaplains have certification in spiritual care; it would be important to also have accountability measures for health care professionals involved in spiritual care based on their professional education.

Recommendations

1. All members of the palliative care team should be trained in spiritual care. This training should be required as part of continuing education for all clinicians. At a minimum, content of these educational programs should include:
 - a. All team members should have training in spiritual care commensurate with their scope of practice in regard to the spiritual care model. Health care professionals should be trained in doing a spiritual screening or history.
 - b. Health care professionals who care for patients are involved in diagnosis and treatment of clinical problems, and are involved in referring patients to specialists or resources should know the basics of spiritual diagnosis and treatment.
 - c. All team members should have knowledge of the options for addressing patients' spirituality, including spiritual resources and information.
 - d. Health care professionals should be trained in the tenets of different faiths and in different cultures in order to provide culturally and spiritually competent care.
 - e. As part of their training in cultural competency, all team members should have a broad minimum level of training in the spiritual/religious values and beliefs that may influence patient and family decisions regarding life-sustaining treatment and palliative care.
 - f. All team members should be aware of the training and differences in spiritual care providers and know when to refer to each.
 - g. All team members should have training in compassionate presence and active listening, and practice these competencies as part of the interprofessional team.
2. Team members should have training in self-care, self-reflection, contemplative practice, and spiritual self-care.
3. Health care systems should offer time for professional development of staff with regard to spiritual care and develop accountability measures in spiritual care for the interprofessional team.
4. Board-certified chaplains can provide spiritual care education and support for the interprofessional team members.
5. Clinical sites should offer education for community clergy members and spiritual care providers about end-of-life care, procedures in health care facilities, palliative care, patient confidentiality, self-care, and how to support health care professionals in their professional development. Education for seminary students regarding end-of-life care can be facilitated by collaborating with seminary accreditation organizations.
6. Development of chaplain certification and training in palliative care is needed.

7. Profession-specific (e.g., medicine, nursing, social work, psychology) competencies and training in spiritual care should be developed.
8. Spiritual education models should be interdisciplinary. Examples of educational programs that could be utilized include those from the Marie Curie Cancer Center⁶¹ in London and the George Washington Institute for Spirituality and Health²⁴ in Washington, D.C.

Personal and Professional Development

Spiritual care emphasizes the importance of relationships,⁶³ therefore, health care is an inherently spiritual profession. Inherent to the proposed spiritual care model is the transformation that occurs when a health care professional and a patient interact in a professional relationship. Caring for people who suffer opens up the possibility of personal transformation for the health care professional. To be open to that, the professional must have an awareness of the spiritual dimensions of their own lives and then be supported in the practice of compassionate presence with patients through a reflective process.

When considering professional development and spiritual formation, health care providers must overcome barriers to the idea of health care as a spiritual undertaking. Health care providers form deeper and more meaningful connections with the patients by developing an awareness of their own values, beliefs, and attitudes, particularly regarding their own mortality. Many physicians and nurses speak of their own spiritual practices and how those practices help them deliver good spiritual care, which, in turn, helps in their ability to deliver good physical and psychosocial care to the seriously ill and dying patients. Reflective work is required in order to gain insight into one's own sense of spirituality, meaning, and professional calling in order to have the capacity to provide compassionate and skillful care. By being attentive to one's own spirituality and especially to one's sense of call to service to others, the health care professional may be able to find more meaning in his or her work and hence cope better with the stresses.

Ethical considerations

While advocating for the health care professional's attention to the spiritual needs of patients, it is recognized that certain special characteristics of the relationship between the health care professional and the patient help to shape how this is carried out in practice. The first important characteristic to note is the marked power imbalance between the professional and the patient. The sick, and especially those who are dying, often feel they have little control over their lives. All the power and control is perceived as belonging to the health care professional who must never exploit a patient's weakness or vulnerability. Health care professionals have a profound moral obligation to be trustworthy and to use their power in the interests of their patients.^{1,64}

Second, there is a deep sense of intimacy regarding the spiritual aspects of a person's life. The one granted such access must exercise care, restraint, and confidentiality. Finally, it is important to recognize that while spiritual concerns can assume a particular importance at the end of life, attention to the spiritual needs of patients is not something to be reserved

only for patients approaching death. Consistent with the philosophy of the NCP Guidelines and NQF Preferred Practices, palliative care is appropriate regardless of disease status, can begin at the time of early diagnosis, and attention to spiritual needs should be integrated across the trajectory of illness.

Boundaries. In order to ensure appropriate therapeutic relationships with patients and families, boundaries need to be recognized for the benefit of all concerned. Boundaries are mutually understood, unspoken physical, emotional, social, and spiritual limits for the health care professional and patient. The health care professional-patient relationship is often a one-way relationship that lacks equality and reciprocity. Boundaries allow for compassionate presence in the healing encounter. Health care professionals are more vulnerable to crossing these boundaries when they are overworked, stressed, or have experienced chronic losses or grief. Thus, it is critical that institutions and individual professionals make opportunities for appropriate self-care and reflection to avoid these risks.

Prohibition on Proselytizing in the Clinical Setting. Some clinicians may be motivated to proselytize by virtue of a zealous devotion to their own faith or spiritual commitments. A health care professional is never justified advising patients to “get religion” even if his or her intent is beneficent. Proselytizing within the clinical relationship is a violation of the trust the patient has given to the health care professional and inappropriate in the context of the professional relationship between the patient and the clinician.

Importantly, the prohibition on proselytizing should not be construed as a prohibition on asking patients about their spiritual or religious beliefs and practices. Skillful spiritual screening, history-taking, and assessments should not be threatening to patients or specific to one denomination, faith tradition, or philosophical orientation. Encounters regarding spirituality should not imply a particular answer that the patient can presume the health care professional considers “correct” but rather should open a dialogue that can be tailored to the specific needs of the individual patient.

Recommendations

1. Health care settings should support and encourage the health care professional’s attention to self-care, reflection, retreat, and attention to stress management.
 - a. The role of spirituality in the health care professional’s health, well-being, and resiliency to stress, as well as their ability to be compassionate, should be included in training and orientation for new staff members.
 - b. Reflective processes should be integrated into regular staff meetings and educational programs using rituals and care resources used for patients.
 - c. Environmental aesthetics should encourage reflection and foster self-nurturing behaviors.
2. Professional development should address spiritual development especially as it relates to the health care professional’s sense of calling to their profession, the basis of relationship-centered care, and provision of compassionate care.
 - a. Provide staff with the resources for basic spiritual care and for addressing spiritual and cultural issues of patients

recognizing how the clinician’s own spiritual and cultural background may influence how they provide care.

- b. Integrate spirituality and self-care concepts into each profession’s curriculum and continuing education programs.
 - c. Provide opportunities and resources for health care professionals in their life-long professional and spiritual growth within the clinical context, recognizing that intimate professional relationships can be transformational for health care professionals and patients.
3. The interprofessional team should be encouraged and given time for regular and ongoing self-examination (e.g., providing a safe, confidential space for compassionate listening at the work site, offering opportunities for off-site retreats, providing resources for referrals [spiritual directors, therapists] as needed).
 4. Health care settings should provide opportunities to develop and sustain healthy teams and a sense of connectedness and community. Opportunities may include:
 - a. Structured interprofessional teams that honor the voice of all members and value a sense of mutual support.
 - b. Ritual and reflections in team meetings.
 - c. Provision of onsite staff support for team-building.
 5. Institutions should provide opportunities for the interprofessional team to discuss ethical issues as they arise.
 - a. Health care professionals must be reminded and cautioned regarding the power imbalances that characterize the health care environment. Spirituality should be defined broadly to be inclusive of religious, philosophical, and existential or personal beliefs, values, and practices and centered on patient preferences.
 - b. Discussions should include a virtues-based ethics approach to address complex spiritual concerns.⁶⁵
 - c. Health care professionals should be afforded the opportunity to discuss spiritual and ethical conflicts and issues they encounter in working with patients and other health care professionals.

Quality Improvement

The process of quality improvement is widely recognized in all health care settings. There is an increased emphasis on improving the quality or performance of health care services through application of standard approaches adapted from business and industry. Well-established quality improvement efforts in health care have addressed common and costly patient care concerns such as safety, infection control, relief of common symptoms, patient adherence, and other aspects of patient care delivery. While quality improvement approaches vary, common features include assessment of the current status of care, planning of strategies for improved care, implementation of these strategies, and ongoing evaluation of outcomes with continued refinement of care.⁶⁶

As hospice and palliative care have emerged as major aspects of health care delivery, these settings have adapted quality improvement methods from acute care settings. Hospices have been increasingly pressured to demonstrate effectiveness and pioneering, hospital-based palliative care programs have also applied quality improvement strategies to design, implement, and evaluate their services. Common aspects of hospice and palliative care targeted for improvement

have included relief of pain and symptoms, delivery of bereavement services, patient and family satisfaction with care, use of advanced directives, avoidance of life-prolonging therapies, the ability of these programs to achieve patient goals of care, and attention to desires about place for death.^{67,68}

Application of quality improvement to spiritual care

The domain of spiritual care has received less attention than other aspects of palliative care within quality improvement efforts⁶⁹ in part because there are many challenges to application of quality improvement efforts in spiritual care. The well-defined guidelines for spiritual care that have been advanced by NCP, NQF, and this Consensus Report can provide an established standard of quality that can be targeted for improvement. Nevertheless, it is important to acknowledge that the existential quality of spiritual care makes quantification of outcomes a challenge. Assessing relief of suffering, forgiveness, meaning in life, and other abstract aspects of spiritual care require approaches that exceed the capacity of the usual quantitative metrics applied to other aspects of health care. Therefore, spiritual experts need to have creative input into developing measures that will adequately assess spiritual care. Spiritual metrics that reflect the goals of spiritual care need to be developed. These metrics might include an increase in chaplain referrals, improved patient satisfaction, and lower scores on a spiritual distress scale as a result of attention to patients' spiritual concerns.

Improving the quality of spiritual care as a function of quality improvement processes will require attention to the unique aspects of this domain of care. Some quantitative approaches may be applicable. For example, hospice and palliative care programs can adapt quantitative methods for assessing referrals to chaplaincy, rates of completion of spiritual assessment, and the incorporation of desired rituals into the treatment plan. However, qualitative approaches also will be needed to capture the unique aspects of spiritual care. Data derived from patient or family interviews, staff focus groups, and reflections on patient care can inform palliative care programs in their quest to improve the quality of spiritual care.

Quality improvement frameworks

The NCP Guidelines,²¹ NQF Preferred Practices,²² and recommendations from this Consensus Report provide a shared framework for palliative care programs. There is tremendous opportunity for the palliative care community to advance the critical aspect of spiritual care. Application of these recommendations followed by meaningful evaluation can improve the quality of spiritual care delivered to patients and families. Attention to spiritual care by accrediting bodies, such as The Joint Commission, can further advance spiritual care in the knowledge that without quality spiritual care, quality palliative care will not be achieved.

Recommendations

1. All palliative care programs should include the domain of spiritual care within their overall quality improvement plans. Spirituality should be a component of electronic medical records. Clinical settings should monitor the quality of care specifically with regards to spiritual care at the time of death. Measurable outcomes can include pa-

tient and staff satisfaction and quality of life. Process measures can include rates of chaplain referral and timelines of completion of routine spiritual assessment among other metrics.

2. Assessment tools should be evaluated to determine which are most efficacious and clinically relevant. Tools and measurement techniques across palliative care settings should be standardized.
3. Quality improvement frameworks based on NCP Guidelines that relate to structure, process, and outcomes of spiritual care need to be developed.
4. Building on tested quality improvement models (e.g., pain management), quality improvement efforts specific to spiritual care should be tested and applied.
5. Research that will contribute to improving spiritual care outcomes to palliative care patients should be supported. Recognizing the complex definition of spirituality and its difficulty in measurement, studies should use multiple quantitative and qualitative methods for evaluation.
6. Funding to evaluate the current state of the science, establish a research agenda, and facilitate research opportunities for spiritual care research should be sought.

Conclusion

Spiritual care is an essential domain of quality palliative care as determined by NCP and NQF. Studies have indicated the strong desire of patients with serious illness and end-of-life concerns to have spirituality included in their care. There is a strong empirical and scholarly body of literature to support the inclusion of spiritual care as part of a biopsychosocial-spiritual approach to care. Based on the position that palliative care encompasses the care of all patients from the time of diagnosis of spiritual illness, the principles in this Consensus Report can be applied to the care of most patients. In this report, practical recommendations are provided for the implementation of spiritual care in palliative, hospice, hospital, long-term, and other clinical settings. Critical to the implementation of these recommendations will be interprofessional care that includes board-certified chaplains on the care team, regular ongoing assessment of patients' spiritual issues, integration of patient spirituality into the treatment plan with appropriate follow-up with ongoing quality improvement, professional education and development of programs, and adoption of these recommendations into clinical site policies.

By utilizing the recommendations set forth in this document, clinical sites can integrate spiritual care models into their programs, develop interprofessional training programs, engage community clergy and spiritual leaders in the care of patients and families, promote professional development that incorporates a biopsychosocial-spiritual practice model, and develop accountability measures to ensure that spiritual care is fully integrated into the care of patients.

Tools and resources for implementation of spiritual care can be submitted to SOERCE, an online resource center on gwish.org

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