

STANDARDS AND COMPETENCIES FOR SPIRITUAL CARE AND CHAPLAINCY IN PALLIATIVE CARE

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Abstract: Spiritual care and chaplaincy have come under considerable focus in recent years in Scotland and especially so within the field of Specialist Palliative Care. A combination of National Guidelines, Clinical Standards, Professional Standards, and a Competency Framework have come together to engender considerable discussion and an impetus for developing a framework for spiritual care, religious care and chaplaincy services and practice. The author reflects on the development of the standards and competencies, their format and integration and considers their impact on chaplaincy & spiritual care services in palliative care in Scotland.

Key words: chaplaincy, competencies, palliative care, religious care, spiritual care, standard.,

Introduction

Spiritual care and chaplaincy have been the focus of considerable attention and development in Scotland in recent years. The publication of the Guidelines on Chaplaincy and Spiritual Care in the National Health Service (NHS) in Scotland has engendered considerable debate and planning in all NHSScotland Trusts (NHS HDL 2002 76). They encourage consideration of the breadth of spiritual and religious care in a multicultural society, the depth of experience, professionalism and provision of chaplaincy services, and encourage consideration of the practical resources required to offer a consistent approach to spiritual and religious care. The perceived impact of the guidelines has been widely explored in the Scottish Journal of Healthcare Chaplaincy (SJHC 2003). However, it will not be until 2004 and beyond that we will be able to assess what practical impact the guidelines have had as Trusts seek to implement the plans they are currently preparing in response to the NHS Health Department Letter (2002) 76.

Within the field of Specialist Palliative Care many of the elements of the new NHSScotland Guidelines have been common practice for a considerable time. However, within the specialty, spiritual care and chaplaincy have seen considerable recognition and development with the formation of national stan-

dards and competency frameworks for specialist palliative care, chaplaincy, and spiritual care. In this process, hospice chaplains have contributed to the development of three significant documents:

1. **Clinical Standards for Specialist Palliative Care.** These are now mandatory for Hospices and Hospital Specialist Palliative Care Teams and are audited by the independent group NHS Quality Improvement Scotland (CSBS 2002).
2. **Standards for Hospice and Palliative Care Chaplaincy.** These seek to define the role of chaplaincy within the multidisciplinary palliative care setting and have been published by the Association of Hospice and Palliative Care Chaplains (AHPCC 2003).
3. **Competencies for Spiritual and Religious Care.** These are currently in press within Marie Curie Cancer Care, and are likely to be launched in partnership with other palliative care organisations (MCCC 2003 a).

Although each document stands on its own merit and has a particular area of focus, put together they show a consistency of approach that helps elucidate a profession and area of care that is often criticised for a lack of clarity and definition. While readily acknowledging and supporting the belief that spiritual care can be provided by all healthcare profes-

sionals, all three documents enable a greater understanding of the particular gifts of chaplaincy and help define and distinguish the role of all in the proper provision of spiritual care.

Clinical Standards for Specialist Palliative Care

The Clinical Standards for Specialist Palliative Care (CSBS 2002) were launched in June 2002 and are now mandatory for all Specialist Palliative Care Units and Hospital Palliative Care Support Teams in Scotland. The standards were published by the former Clinical Standards Board for Scotland, now incorporated into NHS Quality Improvement Scotland (NHS QIS).

There are eight standards in total, each accompanied by a standard statement, a rationale, and a list of criteria. At first reading the inclusion of chaplaincy and spiritual care is not obvious, there being no individual standards for spiritual care or chaplaincy. This, however, reflects the holistic approach to the standards set out in the opening philosophy statement which includes the basic assumption that Specialist Palliative Care is by nature multidisciplinary, and is as a consequence discerning and respectful of religious and cultural needs and traditions. However, on closer reading, chaplaincy and spiritual care are integrated throughout the standards. Examples of this inclusion are seen in the following standards:

Key Elements of Specialist Palliative Care (2a)

This standard defines the range of integrated service components and facilities required of a palliative care unit. Included in the list of facilities that comprise a dedicated environment are:

- quiet/private areas
- chapel/prayer room

Both must be in place for the standard to be met.

Managing People and Resources (3)

The multidisciplinary team is clarified in this standard. A core team is identified with this team having ready access to a number of other professionals. In a Specialist Palliative Care Unit the core team includes seven professions (and its alphabetical listing makes the order interesting):

- chaplain
- doctors

- nurses
- occupational therapist
- pharmacist
- physiotherapist
- social worker

In a Hospital Palliative Care Support Team the core team is doctors and nurses with chaplaincy included in the list of professions to which the core team of doctors and nurses should have ready access. However, the chaplain should have a specialist interest in palliative care and an agreed service level input (dedicated time).

In addition, all Associated Health Professionals (AHPs) should be active members of their profession's specialist interest group (for chaplaincy this is the Association of Hospice and Palliative Care Chaplains), and the professionalism of the AHPs is further supported by the recommendation that all AHPs should have a post graduate qualification in palliative care.

Professional Education (4)

Each unit must provide an evidence based programme of education for professionals addressing the physical, psychological, social and spiritual aspects of palliative care, ethical issues, and communication issues.

Inter-professional Communication (5)

This standard gives further detail on the working of the multidisciplinary team which should meet regularly and review the care of all new and existing patients. All members of the core team (including chaplains) should attend these meetings. It also states the importance of professionals recording their patient and family contact in the patient's records.

Therapeutic Interventions (7)

This standard contains a specific reference to spiritual care and sets a standard for Spiritual Intervention. The criteria of intervention are:

- Evidence exists that patients and those important to them have had the opportunity for their spiritual needs to be assessed and addressed.
- Evidence exists that religious needs have been assessed and addressed
- There is evidence of referral to specialist spiritual support services according to identified need

The specialist here would be the chaplain.

This last standard seems very broad and begs the question as to how such things can be evidenced. It is a question that can and should be asked of any standards. In this case the answers are found in the detailed Self Assessment Tool that accompanies the standards, a tool that forms the basis of the peer review visit by NHS QIS which highlights the strengths and challenges arising from the self-assessment and visit, and decides whether standards are met or not met.

Evidencing the assessment and addressing of spiritual needs is enabled by the following audit question:

How do you ensure that patients and those important to them have had the opportunity for their spiritual needs to be assessed and addressed (see examples below)?

- *exploring the individual's sense of meaning and purpose in life;*
- *exploring attitudes, beliefs, ideas, values and concerns around life and death issues;*
- *affirming life and worth by enabling reminiscing about the past;*
- *exploring the individual's hopes and fears regarding the present and future for themselves and their families/carers;*
- *exploring the 'WHY' questions in relation to life, death and suffering.*

(CSBS 2002, 7.10.1.)

To be able to answer the audit question chaplains need to record their *therapeutic interventions* in the patient information systems (notes and/or electronic records) and by doing so they also contribute to standard 5 on inter-professional communication, an example of the integration within standards.

The impact of the Standards

Although the first round of visits by NHS QIS was completed in August 2003 with the public reports due early in 2004, there is already anecdotal evidence that the standards are having a profound influence on practice, with specialist palliative care units (hospices) and hospital support teams embracing the spirit of the standards and striving to meet them.

Hospice chaplains report that where no chapel/prayer room was available plans are now in

place to create them, and the multi-faith nature of their use is being embraced. Within palliative care units chaplains are included in the core multidisciplinary team and attend regular multidisciplinary team meetings. They also record their interventions in the patient records and in this the standards have proven to be a useful tool in expressing their interventions. Chaplains are not trained in note-writing and the issue of confidentiality has long been a struggle.

Although the standards will inevitably be revised following the completion of the first round of peer review visits, it is clear they have been embraced. Their integrated format is welcomed and understood and has the potential to be a positive influence on the provision of Specialist Palliative Care Services which includes spiritual care, religious care, and chaplaincy.

Standards for Hospice and Palliative Care Chaplaincy

Where the clinical standards for specialist palliative care set standards within this specialist area of healthcare, the Association of Hospice and Palliative Care Chaplains Standards for Hospice and Palliative Care Chaplaincy seek to take the next step of setting standards within the profession of hospice and palliative care chaplaincy (AHPCC 2003).

It is no accident that the standards follow the format of the CSBS clinical standards. Given that the clinical standards are mandatory in Scotland, it was common sense to follow a format that works and to include the relevant clinical standards within these professional standards. This enables chaplains working in Scotland to have both consistency and continuity within their clinical and professional standards, and offers an example of good practice that can be shared in the United Kingdom as a whole.

There are seven standards identifying the core elements of a chaplaincy service. While the introduction supports the view that all healthcare professionals can provide spiritual care the standards give a description of the specialist expertise that defines chaplaincy.

Access to Chaplaincy Services (1)

The first standard seeks to evidence the information available to patients and their families/carers about local chaplaincy services and how they can be contacted. It also states that there should be a written protocol for referral to chaplaincy services: The actual system may be a verbal one, but it is necessary that the process (protocol) should be written down.

Spiritual & Religious Care (2)

In this standard the wording of the CSBS standards in is reflected with regard to spiritual needs and assessment. However, an addition here is the inclusion of the element of protection for patients from unwanted visits from spiritual or religious groups or representatives. The standard supports the position that the patient has the right to see their relevant spiritual or religious representative and also has the right to decline a visit. All referrals to other agencies should be with the patient's consent. The standard also draws on the clear definition of spiritual care and religious care as it appears in the NHS Scotland Guidelines (NHS HDL 2002):

Religious Care is given in the context of the shared beliefs, values, liturgies and lifestyle of a faith community.

Spiritual Care is usually given in a one to one relationship and is completely person centred and makes no assumptions about personal conviction or life orientation. Spiritual Care is not necessarily religious. Religious Care, at its best, should always be spiritual.

Multidisciplinary Teamworking (3)

The criteria section of this standard sets out the essentials of multidisciplinary team working including: attending and contributing to team meetings, responding to referrals and referring on to other team members, and the recording of relevant information in patient information systems (notes and /or electronic). There is at present considerable debate in the NHS, in England & Wales in particular, around data protection and the whether or not chaplains should have access to patient records. These standards adopt a common sense approach, they assume that if chaplains are recognised members of the care team and contribute to team meetings there is no issue over access to patient records, indeed not to have access would leave chaplains unable to meet these professional standards and the clinical standards. This view is supported by hospices e.g.

Marie Curie Cancer Care is producing a patient information leaflet for use in their hospices. The leaflet makes clear that spiritual care is part of the holistic approach of palliative care and that chaplains are members of the core multidisciplinary team and all members of the team have access to patient notes (MCCC 2003 b).

Staff Support (4)

Following on from teamwork the importance of good working relationships is stressed. The confidentiality of the chaplaincy relationship with staff and volunteers is developed with chaplaincy offering personal and professional, spiritual and religious support to all staff and volunteers and the multidisciplinary team in particular.

Education & Training (5)

This standard addresses the need to raise awareness among other healthcare professionals about the provision of spiritual and religious care through staff induction, in-service training and a programme of education for all healthcare professionals. It stresses that the chaplain's remit is not only to provide the specialist input to spiritual care but also to encourage others to develop their skills in a holistic approach to care.

Resources (6)

Here the resources required for chaplaincy to function are described are drawn together including the elements contained in the clinical standards: e.g. access to a chapel/prayer room, quite private areas, patient records, sufficient hours. It also introduces personnel issues such as regular appraisal, professional development, and external professional supervision.

Taking into account the need for a multi-faith approach to spiritual care and chaplaincy, the criteria for chaplaincy appointments is not faith or ordination specific e.g. Minister, Rabbi, Imam etc. Rather the focus is on the individual with the criteria being membership of the Association of Hospice and Palliative Care Chaplains and holding a recognised status within a mainstream faith community.

Chaplaincy to the Unit (7)

The wider aspects of chaplaincy are addressed in this standard including responding to the unexpected and unusual events that impact of staff in particular

but may include patients and their family/carers. E.g. the illness or death of a colleague or a national disaster, anniversary or world event. There is a recognition that in such times there is a need for someone with experience to organise an event that reflects people's feelings and, as a result, seeks to bring meaning and meet their needs

A baseline for chaplaincy.

The standards were warmly embraced at their launch with many chaplains acknowledging they were under pressure locally to develop chaplaincy and spiritual care standards. The publication of professional standards complete with a Self Assessment Tool not only enables palliative care chaplains to be fully engaged with the world of healthcare standards, but they also provide a way of auditing their service and identifying the resources currently being used and those required to move forward to achieve the standards. The Association of Hospice and Palliative Care Chaplains has distributed the standards through Help the Hospices to all its members and all palliative care units in the UK. There is for the first time the potential for a UK wide baseline audit for chaplaincy services in hospices and palliative care.

Although these standards are particular to the specialty of hospice and palliative care chaplaincy, they have the potential to be used as a basis for developing broader healthcare standards for chaplaincy services in other areas of healthcare.

Spiritual & Religious Care Competencies for Specialist Palliative Care

While standards can be used to audit clinical provision and services when it comes to individuals and their professional practice, *competence* is the current healthcare model. Competence levels offer a framework to enable individuals to enhance their skills and to develop professionally. They also provides a tool for those responsible for administering and encouraging their local Personal Performance Review and Development process. Marie Curie Cancer Care has taken forward the work of competence in spiritual and religious care with the development of Spiritual & Religious Care Competencies for Specialist Palliative Care.

The Competencies were prepared by a multi-professional group, and, from the beginning, ac-

knowledge the difficulties of definition and language within Spiritual care in particular. They also acknowledge the difficulty of evidencing an area of care where *awareness* of skill can clearly be evident though hard to measure. The Competencies follow the familiar three column format headed Knowledge, Skills and Actions. There are four levels of competence relating to different aspects of patient & family/carer contact:

- Level 1. All staff and volunteers who have casual contact with patients and their families
- Level 2. Staff and volunteers whose duties require contact with patients/families
- Level 3. Staff and volunteers who are members of the multi-professional team
- Level 4. Staff and volunteers whose primary responsibility is for the spiritual and religious care of patients, visitors and staff

The competence each member of staff and volunteer should be able to demonstrate is set out at each level and includes:

- an appropriate understanding of the concept of spirituality at that level,
- an awareness of their own personal spirituality,
- recognition of personal limitations,
- when to refer on,
- documenting perceived, needs, referral and intervention.

Levels 1 to 3 encourage an increasing level of competence through awareness and practice with a protocol for referring on to the professional with expertise in spiritual care: the chaplain. Level 4 gives a competency framework for the chaplain or director of spiritual care which includes: how referrals are responded to and recorded, the depth of intervention, and knowledge of other external spiritual and religious resources. The *actions* column for level 4 also includes acting as a resource for staff support, education and training, and influencing the development of national initiatives. At first reading level 4 seems very detailed and daunting. However, it needs to be borne in mind that competencies should be challenging if they are to encourage the development of personal skills, and, as with standards, they are designed to be aspirational but achievable.

The weakness in the competence framework is measurement. However, the competencies come

with suggestions for audit at each level. There are two key elements for audit with a third at Level 4:

- Reviewing documentation
- Personal Performance Review and Development process (PPRD).
- Review of training and education delivered (Level 4)

Documentation can be used to show referrals are being made and give some measurement of skill. PPRD can be used to discuss competence and identify training needs. The review of training and education is by evidencing evaluation of education and training sessions and showing how evaluation has been used to improve future sessions.

At present Marie Curie Cancer Care is preparing the competencies' document for publication. However, once published its impact within the charity will be profound. There will be a requirement for all staff to meet or be working towards achieving competence in spiritual and religious care. This provision of spiritual care has long been recognised by other healthcare professions, nursing in particular, as an integral part of the caring role. Not only is that provision acknowledged by the development of competencies in Specialist Palliative Care, there is the potential for it to be clarified and evidenced, and for the natural skills of all healthcare professionals to be enhanced and developed.

Conclusion

These three documents have the potential to have a profound impact on the provision of spiritual and religious care in hospices and palliative care teams. The order of publication provides a striking continuity and process to encompass all aspects of spiritual care, including service provision, integration into the care setting, service definition, and individual competence. The *national standards* set service levels and audit process for units; *professional standards* focus on the professional service responsible for the provision of spiritual and religious care; and the *competencies* support and enhance the breadth of spiritual care offered by individual healthcare professionals at all levels, and the expertise of chaplaincy in particular.

A considerable advantage in the ordering of the process has been the integration of the different documents. There is a continuity of format, and the inclusion of self assessment audit tools makes

evaluation and comparison achievable. Although the documents readily acknowledge the difficulty of definition and measurability of spiritual care, they offer tools and pointers to allow the process in which audit can at least begin and develop. As the standards and competencies are introduced locally and the process of audit begins, ways will be found to plug the acknowledged gaps in evidencing care and, as a result, there is the potential for a measurable improvement in service provision and care.

There is a danger with the two standards documents in particular there of chaplains becoming disheartened by the fact that they are not able to achieve all the standards at present. Although they set at a level that *should* be achievable, they are by nature aspirational and designed to develop care,. The greatest challenge will be that the standards will raise resource questions, most especially in terms of facilities and time. However, they are also the best argument in support of resources: all healthcare providers should be committed towards achieving standards in care and practice, and that includes chaplaincy and spiritual care.

There is no doubt spiritual care has seen a remarkable development in Scotland since the turn of the millennium. Although growing, the field of specialist palliative care is still comparatively small, and its holistic and multidisciplinary focus positively encourages openness and trust. There is considerable advantage to Scotland having its own Health Department. The country is small enough to allow people to think creatively, to know each other personally, and to encourage working together across traditional boundaries and barriers.

The first three years of the millennium have seem remarkable developments in spiritual care and chaplaincy. As the NHS Guidelines move on to "plans for implementation", as the CSBS and AHPCC standards influence practice and change, and as the competencies engender a broader understanding of spiritual care and how it is practiced by all healthcare professionals and chaplains in particular, there is a real sense of excitement that will carry us into the next few years: How will it all develop?

References

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merly the Clinical Standards Board for Scotland), Edinburgh.

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