

A COMPARATIVE ASSESSMENT OF HOSPICE CHAPLAINCY SERVICES

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Abstract: Marie Curie Cancer Care undertook a comparative assessment of its ten Marie Curie Hospices using the Association of Hospice and Palliative Care Chaplains' Standards for Hospice and Palliative Care Chaplaincy (AHPCC 2003). This article discusses the findings of the assessment process and considers the value of the assessment for Marie Curie Cancer Care as a charity committed to multidisciplinary team working. The article demonstrates the practicality of the standards and the accompanying self assessment tool in assessing the service providing expertise in spiritual and religious care in hospices. It features examples of good practice and identifies areas that need further research and development.

Key words: Assessment, chaplaincy, hospice, standards, palliative care.

Introduction

Since the start of the millennium there has been considerable activity at a national level with regard to spiritual and religious care. Part of that ongoing process has been the publication by the Association of Hospice and Palliative Care Chaplains of *Standards for Hospice and Palliative Care Chaplaincy* (AHPCC 2003). These standards sit within the context of two other areas of assessment within palliative care: National Guidelines and Standards for Hospice and Palliative Care Services, and the individual competence of all members of staff providing spiritual and religious care.

The relationship between these three areas of service and assessment has been detailed in depth by Mitchell (2003) and may be summarized as follows:

- National Clinical Standards and Guidelines which apply to hospices in the United Kingdom (UK) set the standards by which hospice and specialist palliative care services can be assessed (CSBS 2002, NICE 2004).
- Marie Curie Cancer Care's publication of *Competencies for Spiritual and Religious Care in Palliative Care* sets the individual practice of healthcare professionals, and chaplains in particular, in context (MCCC 2003).

- The AHPCC standards were compiled to sit in between and to assess 'a chaplaincy service'. The standards therefore include the mandatory elements of the national standards and flow towards the development of competence for the individual healthcare professionals providing the service.

Assessment of chaplaincy services

The AHPCC standards were published with a self assessment tool to enable hospices to assess their chaplaincy services. They suggest assessment can be either internal or external, and that categories of met, not met, partially met, or working towards can be applied.

Marie Curie Cancer Care has ten hospices in the UK and Northern Ireland. In preparation for a chaplains' workshop, and to enable the charity to compare the chaplaincy services in its Marie Curie Hospices, an assessment of the chaplaincy services was undertaken using the AHPCC Standards for Hospice and Palliative Care Chaplaincy. Although the standards and self assessment tool had been piloted prior to their publication this was acknowledged as the first comparative assessment of chaplaincy services across the United Kingdom.

Method

Nine of the ten Marie Curie Hospice chaplains completed a self assessment of their chaplaincy service one hospice had no chaplain in post. The assessment was internal: an experienced chaplain on secondment to Marie Curie Cancer Care's Education Department agreed to act as reviewer, the chaplain had also been a member of the AHPCC working party that prepared the standards and assessment tool. The assessments were submitted in December 2003, a summary of the assessment was prepared and a report was presented to the chaplains at their workshop in January 2004.

Findings

General findings

When the standards were launched at the AHPCC National Conference in May 2003 they were described as being *aspirational yet achievable*. This claim is borne out by the review of the nine Marie Curie Hospices: With the exception of Standard 4 and the recording of incidences of staff support, each element of the standards is being met in one or more of the charity's hospices, although no one hospice was able to meet all standards at the time of the review.

A number of standards are dependant upon resource decisions at local and national level that are not in the control of the chaplaincy service being assessed. The practicalities of building design and use, the centralization of printing, and the hours available for chaplaincy are all factors that have an impact on whether or not the standards can be met. In addition a number of standards are 'not met' or 'partially met' due to insufficient evidence. Unless information and process is being recorded it is difficult to evidence and assessment. However, alongside these difficulties, the review of the standards elicited a number of innovative examples of good practice which were documented in the reviewer's report of the assessment.

Standard 1 Access to Chaplaincy Service

Of the nine participating hospices 8(89%) were able to meet the criteria of giving patients information on admission that there is a chaplaincy service. However, the charity wide booklet used did not give the information on why, how or when patients and their

families/carers could contact the chaplaincy service. Therefore the number meeting the criteria dropped to 4(44%) in response to giving information of when and how to contact the chaplaincy service.

A documented protocol for referral to chaplaincy services was available in 6(67%) of hospices however, the availability of the protocol varied.

Examples of Good Practice

- Additional Social & Pastoral Care Leaflet including information on how when and why patients and families/carers would contact the Chaplaincy, Social work and Bereavement Services is included with the generic admission leaflet.
- Documented protocols are available in the wards, in in-patient notes, and the local computer network.

Standard 2 Spiritual & Religious Care

Given that this is arguable the most readily identifiable area of chaplaincy activity it is not surprising that 8(89%) hospices could meet the standard for providing inclusive worship reflecting the faith groups present in the hospice, and 9(100%) hospices were facilitating ceremonies and sacraments for individual patients when requested by patients and their family/carers.

In terms of the process of assessment 5(56%) hospices met the standard, however that increased to 8(89%) when including those partially meeting the standard. The difficulty is a lack of evidence standard is being met

The rare but recognized need to protect patients from unwanted visits from spiritual or religious leaders was met in 4(44%) hospices, however, only those who had experience of an incidence had been able to evidence the standard.

Examples of Good Practice

- A directory of local contact numbers for other spiritual/religious/faith resources is held in the chaplain's office, and in-patient areas.
- A directory of national contact numbers for spiritual/religious/faith resources (local numbers can change)
- The location of the directory of spiritual/religious/faith resources is detailed in the documented protocol for referral to the chaplaincy services.

- Where an unwanted visitor is identified a chaplain/staff member informs the visitor of the patient's decision
- Reception Staff are made aware of unwanted visitors and given guidance to contact the chaplain/staff member when an unwanted visitor arrives

Standard 3 Multidisciplinary Teamworking

Chaplaincy services are clearly involved in the multi-disciplinary team with 9(100%) of chaplains receiving and responding to referrals from members of the team, 9(100%) referring to other members of the team and 8(89%) attending multi-disciplinary team meetings. However, evidencing these figures is difficult: 4(4%) record attendance at team meetings, 1(11%) has an agreed response time for referrals, and 6(66%) record their response to referrals and interventions in the patient information systems. It was clear from additional detailed information given in the self assessment that most referrals were responded to well within the nationally agreed time-scale of two working days (CSBS 2002) and the documented protocol enabled patients and their families/carers to be seen the same day, often immediately.

Examples of Good Practice

- Responses to referrals are all documented in the patient notes.
- All chaplaincy activity is entered into the patient information systems (written and electronic)

Standard 4 Staff Support

This is clearly perceived as a difficult standard to evidence. While 9(100%) of chaplaincy services were able to meet standards of providing personal and professional support, and spiritual and religious support to other member of staff and volunteers it could not be evidenced. None of the services kept a log of such support. Likewise with providing evidence of good working relationships: 2(22%) could give supporting evidence of such relationships however the remaining 7(78%) partially met the standard, suggesting good relationships without evidence. The self-assessment tool does provide a method for gathering the required evidence, confirmed by the following suggestion for practice:

- Chaplains keep a log of incidences and time spent on staff support. It could be a permanent log or one taken over a month or more as an audit. Such

a log would enable chaplains to evidence all the sections of standard 4.

Standard 5 Education & Training

There was strong evidence of involvement in education and training: 7(78%) of services participated in staff induction and in-service training with 8(89%) contributing to their hospice's education programme. The responses clearly detailed chaplaincy services providing resources for members of staff participating in education and training however, the resources were not made known to the education department.

Examples of Good Practice

- Chaplaincy has a dedicated session in the induction program for all new staff
- All new members of staff spend time with the chaplain arranged by their line manager

Standard 6 Resources

All services, 9(100%), had access to quiet/private areas, and 7(78%) had access to a chapel/prayer room. Those without a chapel gave additional information stating there was no available space in the hospice to provide a chapel at present. While 8(89%) services had access to patient information systems, all 9(100%) recorded their interventions in the patient information systems. The question of attendance at multi-disciplinary team meetings is duplicated in this standard and the answer differed from that given in standard 3 - 8(89%). In this format 6(67%) chaplains were able to meet the standard with two partially meeting the standard. The difference is accounted for by some services being unable to attend **all** regular multi-disciplinary team meetings due to other work commitments or insufficient hours. All 9(100%) of those completing the self assessment were subject to an annual appraisal and commented it was a very worthwhile and positive experience.

Examples of Good Practice

- Multi-faith chapel with separate prayer room for Moslems (meeting a clear local need)
- External supervision
- Annual Appraisal

Standard 7 Chaplaincy to the Unit / Institution

While 8(89%) services could evidence communal responses to events impacting on staff, it reduced to 6(67%) when responding to events out with the unit

affecting staff, and further reduced to 4(44%) in response to events affecting the morale or functioning of the unit. The detail of evidence given suggests that those individuals with a greater length of service had stronger working relationships with staff and more examples of past experiences to describe and therefore evidence this standard.

Examples of Good Practice

- Chaplaincy exercises a 'ministry of presence' around the hospice.
- Memorial Services for the families/carers of deceased patients.
- Acts of reflection/worship (following the death/illness of member of staff/volunteer).
- Acts of reflection/worship at national events (e.g. Anniversary of September 11th, Gulf War, death of the Queen mother.)
- Advocacy role for representing staff concerns without breaking confidence.

Discussion

The aim of the standards that they should be *aspirational yet achievable* is demonstrated by this assessment. That all but one of the standards is being met in at least one hospice demonstrates their practicality, while at the same time there is clear evidence of future developments that can be made.

The comparative nature of the assessment has contributed to general findings in areas such as: evidence and assessment, confidentiality, protecting patients, the chaplains' role as a resource, and also identifies areas for further research.

Evidence and assessment

The most obvious weakness in the findings is the inability of present structures to provide evidence to meet the standards. However there are examples of simple measures that would help provide the evidence required. For example, keeping a register of attendance at multidisciplinary team meetings would evidence the two standards that cover this element: standard 3 – multidisciplinary teamworking, which explores inclusion in principle within the multidisciplinary team, and standard 6 – Resources, which explores the practice and availability to attend multidisciplinary team meetings.

Using the patient information systems, patient notes and electronic systems, can provide evidence for the standards relating to chaplaincy contact with patient

and referrals and response to referrals to and from members of the multidisciplinary team. The review has shown that by adding a few specific chaplaincy codes to the generic electronic information system all chaplaincy activity can be recorded and assessed easily and quickly thus evidencing the standards.

It may be that specific audit is needed to evidence standards such as standard 4.1 – building relationships with members of staff and volunteers. However an alternative to a specific assessment may be the integration of the Marie Curie Cancer Care Competencies for Spiritual and Religious Care in Specialist Palliative Care (MCCC 2003), which have the potential to provide the level of evidence required.

Clearly evidence and assessment is a challenge, but one that is already being successfully achieved in part.

Confidentiality

There is no doubt from the detailed responses to the standards that confidentiality is an issue particularly in regard to recording chaplaincy activity with patients and carers, and recording incidences of staff support. When individual healthcare professionals are in possession of very personal and sensitive information of a patient and/or their family/carers, what do you record in the patient notes without breaking what is felt to be a personal confidentiality while maintaining and supporting the essence of a shared confidentiality within the multidisciplinary teamwork. There is also the issue of patients having the right of access to their notes where sensitive family information the patient might not be aware of could be recorded?

In terms of staff support, it is the very fact that chaplaincy is perceived to be 'completely confidential' that enables it to function as a support mechanism, if it was known that information was being recorded would that stop people seeking support? These are clearly real and genuine concerns. However there is evidence that the standards themselves provide solutions to the difficulties.

Standard 2 offers a list of meaningful phrases that enable those providing spiritual and religious care to document the nature of the patient or family/carer contact without the intimate personal detail:

2.a.1 Spiritual needs are assessed and addressed and may include the following:

- *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 encouraging reminiscing of 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.*

(AHPCC 2003)

These phrases form part of the mandatory standards assessed by NHS Quality Improvement Scotland (CSBS 2002) and the Scottish hospices working within this system and using these phrases to record sensitive information were able to meet and evidence the standard.

In terms of standard 4 - Staff Support, the standard that no hospice was able to meet, the wording of the standard itself holds the key to meeting this standard without breaking confidentiality: "are incidences (not content) of support recorded" (AHPCC 2003, 18). It is the number of incidences that is required to be evidenced not the confidential content of the support. The AHPCC could consider giving additional information to that effect to guide and reassure those seeking to complete the self assessment form and assess the standards.

Protecting patients

Occasions when patients need protection from unwanted spiritual or religious representatives are rare. The assessment process showed examples of proactive and reactive responses to this issue. The reactive approach would only raise the issue with the visiting representative if they returned to the hospice to visit, and it was acknowledged it is difficult to protect patients during busy visiting times. The proactive approach of informing the visitor of the patient's request appears to be more effective, though it is not an easy option for staff. This proactive approach can also be recorded and evidenced, hence its inclusion as an example of good practice.

The resource role

There are two clear aspects to resourcing: the resources required to enable chaplaincy services to meet the standards, and the chaplain themselves as a resource to the hospice. In terms of resourcing chaplaincy, the issues are around access to quiet & private areas, a chapel/prayer room, and the hours worked being sufficient to meet the standards in general and the multidisciplinary team meetings in particular. None of these are in the direct control of the chaplaincy service and therefore require management support to enable them to be met. In terms of the chaplaincy service as a professional resource there is anecdotal evidence to support the role in providing personal and professional spiritual and religious care however it would require a log of incidences to evidence. There is also anecdotal evidence in the self assessment forms detailing one to one academic support and lending personal copies of books and specialized journals to staff and particularly those undertaking formal study in palliative care. These resources being lent could be recommended to the hospice education department and library, enabling others to benefit from the knowledge and experience.

Further research

Taking the findings and discussion into consideration there are a number of areas that point towards the opportunity for further research, developing audit tools to evidence chaplaincy services and spiritual and religious care.

Staff support

The standards give anecdotal evidence of staff support and recommend keeping a log of incidences to evidence the standard. The nature of that support and the percentage of chaplaincy time spent on staff support needs to be evidenced. Expanding the log to include time spent and the nature of the support given could offer valuable insight not only into the value or otherwise of chaplaincy in providing staff support but also in terms of the issues raised by staff working in specialist palliative care.

Patient information systems

Evidence has shown that recording chaplaincy activity in electronic patient information systems is effective in enabling evidence for assessment. A detailed assessment of chaplaincy activity could be used to

more clearly define the role of chaplaincy and the breakdown of how much time is spent on the various activities. This may elicit other areas of chaplaincy that are not currently included in the AHPCC standards and could be used for future review and revision.

Baseline assessment

This comparative assessment has provided Marie Curie Cancer Care with a baseline for its chaplaincy services that can be used for comparative purposes with future assessment. The standards provide the opportunity for a baseline assessment of hospice, or hospice and palliative care chaplaincy in the United Kingdom. In an area of care that is difficult to define and evidence a national assessment of chaplaincy services offers the potential to provide evidence of current chaplaincy provision, activity and function within the field of hospice and palliative care.

Conclusion

This comparative assessment of the Association of Hospice and Palliative Care Chaplains' standards for Hospice and Palliative Care Chaplaincy has given Marie Curie Cancer Care insight into an aspect of its care that is hard to define and assess. The assessment has delivered:

- A baseline for chaplaincy services in the charity that can be used as a comparison for future assessment.
- A baseline for individual Marie Curie Hospices from which they can develop their chaplaincy services, drawing on the examples of good practice already in place in other Marie Curie Hospices.

In addition, the assessment has confirmed the statement of the Association of Hospice and Palliative Care Chaplains that the standards are *aspirational yet achievable* is accurate. No one Marie Curie Hospice is able to meet the standards in their entirety, yet all but one of the standards is being met in a Marie Curie Hospice.

The assessment has also highlighted areas for future debate and research:

- Determining the incidence and content of staff support provided by chaplaincy services
- The use electronic patient information systems to enable the audit and assessment of chaplaincy activity.
- A baseline for hospice chaplaincy services in the UK

This comparative assessment of hospice chaplaincy services within Marie Curie Cancer Care has shown that chaplaincy services within the charity are committed, professional and working towards meeting the AHPCC standards for hospice and palliative care services. Inevitably the individual self assessments reflect the geographic spread of the Marie Curie Hospices and their local ethnic and cultural differences. However, for the first time hospice chaplaincy services have been comparatively assessed and shown to be measurable.

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