

## THE INTRODUCTION AND EVALUATION OF A SPIRITUAL ASSESSMENT TOOL IN A PALLIATIVE CARE UNIT.

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*Abstract: A study was undertaken to determine if individualised, formal spiritual assessment could impact on and optimise patient care within a Palliative Care Unit (PCU). The authors write on the benefits of formal spiritual assessment as undertaken by chaplaincy services. The Spiritual Assessment Tool (SAT) selected, introduced and evaluated for the PCU was the HOPE tool. The authors share the results of research into the effect and benefits that formal spiritual assessment had on members of the PCU's interdisciplinary team. The results highlight a positive impact, of the SAT, upon the various team members. The article explores and expresses the staff's enhanced understanding of the nature and extent of spiritual and religious needs and resources.*

*Key words: Spiritual assessment tools; palliative care; chaplaincy; interdisciplinary team*

### Introduction

Within healthcare, the sources of most patient plans are based upon standard assessment tools used by the various members of the team. An assessment is a statement of perception and a process of information gathering and interpretation. In the fullest picture of patient care, the patient plan should therefore be rooted in a variety of diverse assessments that cover the multiplicity of patient care. As a recently appointed palliative care chaplain, two specific questions arose for me related to the role and contribution as a member of an active interdisciplinary team. Firstly how is the unique contribution of chaplaincy services expressed and viewed? Secondly, and of equal importance, how is the chaplaincy assessment shared for the benefit of patient care? To address these two fundamental questions the following research was undertaken in the Palliative Care Unit (PCU) and presented for review to the Canadian Association of Psychosocial Oncology (Pierce, Vander Berg and Koning 2004).

### The Setting

The PCU is an integral part of the care provided by Princess Margaret Hospital, which is a constituent of the University Health Network, located in downtown Toronto. It is a 12-bed acute unit, with a strong commitment to caring for patients coming from the

community for either symptom management or terminal care. The range of Toronto's cosmopolitan nature is reflected within the unit with a diversity of faiths and cultures. The largest faith group is Roman Catholic.

Given the relative small size of the unit a significant contribution, on the part of chaplaincy services, has been made to the PCU with a dedicated 0.5 position. The chaplain is a fully integrated member of the interdisciplinary team. A number of roles are fulfilled and these include patient and family care, staff support and staff education.

### Spiritual Assessment

Spiritual assessment is the process by which health care providers can identify a patient's spiritual needs pertaining to medical care. Spirituality is multidimensional in character with three of its leading aspects seen to be pertinent in spiritual assessment. The cognitive aspect includes the individuals search for meaning, purpose and truth within life. The experiential aspect includes the feelings of hope, peace, love, comfort and connection that undergird the diversity of relationships that individuals engage in. Finally the behavioural aspect involves the man-

ner in which a person expresses their individual spiritual beliefs and spiritual identity.

Koenig (2001) has noted the importance of spiritual assessment in the medical profession, relating it to the desire of patients to have their religious and spiritual needs acknowledged and addressed by the medical profession. Three components have been noted as crucial in a spiritual assessment:

- Determination of patient's spiritual needs and resources
- Evaluation of the impact of beliefs on medical outcomes and decisions
- Discovery of barriers to using spiritual resources and encouragement of healthy spiritual practices.

An appropriate spiritual assessment allows a chaplain or other healthcare professional to identify the religious and spiritual needs, resources and coping mechanisms of a patient. Specifically it can be a useful tool in the identification of spiritual distress and spiritual crisis. With the benefits that could accrue from such a spiritual assessment, one might assume that their usage would be common amongst the chaplaincy profession. O'Connor et al (2003) explored this in a survey of 325 Canadian chaplains. Of note is the fact that only 28% of chaplains contacted actually replied. Half of those who replied had never heard of the spiritual assessment tools listed in the survey. Of interest was that 30% of those who replied had developed their own spiritual assessment tool.

### **Spiritual Assessment Tool – HOPE**

Spiritual Assessment Tools (SAT) exist with a great variety and degree of complexity from simple tools such as FICA and HOPE to the more complex research tools of the Spiritual Well-Being Scale (Paloutzian 1982) and INSPIRIT - Index of Core Spiritual Experiences (Kass 1991). In this context, a decision was made to choose the simplest of the tools on the premise that it would be quickly assimilated and used across the interdisciplinary team. Though consideration was given to using the work of both Paul Pruyser and George Fitchett, the tool selected for implementation and evaluation was the HOPE tool. The authors acknowledges, that in correspondence using the Internet chaplain's forum on Yahoo, it was observed that a number of chaplains

expressed a view that the HOPE tool was more about discernment than assessment.

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#### **FICA**

- F - Faith, Belief, Meaning
- I - Importance and Influence
- C - Community
- A - Address / Action in Care

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#### **HOPE**

- H – Sources of hope, meaning, comfort, strength, peace, love and connection
  - O- Organised Religion
  - P - Personal spirituality and practices
  - E – Effects on medical care and end of life issues
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The tool selected, devised by Anandarajah and Hight with medical students and physicians in mind, is based upon the mnemonic HOPE. The article in which its two authors present the HOPE tool is readily downloadable and recommended. (<http://www.aafp.org/afp/20010101/81.html>) Rather than reproduce the contents of the article I proffer a brief summary of the tool.

The HOPE assessment moves from a patient's basic spiritual resources without an immediate concentration upon religiosity or spirituality. It acknowledges how many patients today operate outside the realm of traditional perceptions of spirituality and religion. It then can inquire about a patient's understanding and practice of their spirituality and religion through the O and P phases. Finally it moves to the E section, which elicits information of how these expressed beliefs may interact with the medical and nursing care. As such the tool is geared towards end of life care.

#### **Method**

A two-stage survey was proposed with an intervention between surveys being the introduction and implementation of the HOPE tool. The first survey assessed how spiritual and religious needs were understood and addressed by staff. A subsequent survey was post intervention and took place 10 weeks

after the introduction of the tool into the patient chart.

The HOPE tool consisted of a two-sided A4 sheet. On the first page there were details on the patient – name, location, date of admission, faith tradition. The nature of chaplaincy interventions were noted as was any specific faith/denominational care requested. Given the large Roman Catholic population, details were recorded on the sacraments administered. On the reverse side, the HOPE tool was set out allowing the chaplain to record the findings of his four stage spiritual assessment.

Prior to the introduction of the tool in the patient chart, the chaplain explained the concept of spiritual assessment and the distinctiveness of the HOPE tool to the team. In each patient encounter the assessment form was completed and inserted into the patient's chart by the chaplain. In over 90% of the encounters the assessment was completed within two working days of the patient's admission into the Palliative Care Unit. In a small number of cases the assessment was undertaken with the assistance of the translation services provided by the hospital. Given the nature of the unit some of the assessments were undertaken in dialogue with the family members and this was noted on the assessment form. Over half of the assessments took place on the first visit to the patient. Other information discerned from subsequent encounters was added to the form and dated as appropriate.

### **First survey**

The first survey involved 18 members of interdisciplinary team - (Nurses =11, Physicians = 3, Allied Health Care = 3). Questions were asked around the frequency with which patients raised issues of spiritual need with staff. Of those surveyed 28% stated that such discussions occurred on a weekly basis and 11% stated they occurred on a daily basis. In meeting these needs, 44% of staff did not always feel comfortable in these encounters while the remainder felt comfortable in engaging with patients as spiritual issues were raised.

The survey revealed that staff sought to understand and address spiritual need by using primarily the chaplain's notes in the nursing chart (50% used these notes frequently) or consultation with the chaplain (61% availed of this frequently). The denominational chaplains and the pastoral visitors

were shown to be used infrequently. (16% of staff frequently consulted - in both cases)

### **Second survey (Post introduction of SAT)**

The second survey took place after 10 weeks. In this survey 21 staff members of the interdisciplinary team were included - (Nurses = 13, Physicians = 3; Allied Health Care = 5). By this stage, 75 spiritual assessment forms had been completed by the chaplain and placed in the patient charts.

The results indicated a positive experience on the part of the staff. The SAT had been seen by all the staff, was deemed easy to locate and found to be universally straightforward to comprehend. In terms of the SAT giving a better understanding of patient's spiritual needs/coping mechanisms and resources, the tool was viewed as a source of pertinent spiritual information across the team with 90% stating that it had enhanced their personal understanding

93% expressed a view that it did lead to changes in the patient care plan, with a frequency of sometimes or more. Changes in the care plan of families were also acknowledged as occurring sometimes or more by all the staff. In terms of a perceived improvement in patient care due to the use of the SAT, 80% of replies stated that it had a positive effect sometimes or more. The results also universally stated that it had enhanced the provision and fulfilment of patients religious needs.

To the question as to staff discomfort levels, as noted in the first survey, the results indicated an increase in the comfort level for staff with a figure of 75% now recorded. The importance of location of the SAT was acknowledged with 72% stating that it should be in the nurse's notes, which lies in the heart of the patient's chart.

A number of reflections were offered on how the SAT might be improved which focused on clarity of layout and quality of handwriting on the part of the chaplain. Three specific suggestions, from the staff, were introduced into the revised SAT. These additions were a section on the patient and families current comfort level with death, a tick box indicating patient/family consent to chaplaincy service and a reference box with contact name and number for specific faith ministry if required. In the next review

of the SAT, staff will again be consulted and its efficacy will be again reassessed

## Evaluation

The introduction of the SAT into the patient's chart has been shown to have a positive experience upon the members of the interdisciplinary team. The second survey has demonstrated an enhanced staff understanding around patients religious and spiritual needs and the resources available to the palliative care patients of their unit. As an example of this the following encounter is proffered. A patient who had no listed faith affiliation seems to be very unsettled each morning with the caring staff. Following a spiritual assessment, it was discerned that the patient had previously practiced morning meditation but felt uncomfortable in expressing his frustration with the many interruptions. What followed was a negotiation with all parties that agreed that for 90 minutes each morning the patient would not be disturbed and a notice was posted to that effect on the door. For staff it was a positive encounter with the spiritual resources used by patients.

The introduction of the SAT has had a number of positive implications to the PCU. It has enhanced staff understanding of the nature and breath of spiritual needs. It improved the comfort level of staff in engaging with patient's spiritual issues. Spirituality has become more integrated into the patient care plan with a heightened awareness of the role of chaplaincy within the team. It has led to increased referrals for chaplaincy services as some of the less experienced staff became more aware of the issues around spiritual distress.

It led to a number of teaching seminars led by the chaplain on the nature of spiritual distress, death ritual across the faith and cultural traditions and also the diverse nature of cultural communication styles. Reflecting over the whole experience the introduction of a SAT gave staff a framework to meet the Palliative Care Quadrangle (Physical, Social, Psychological and Spiritual) in a more fruitful and empowering manner.

## Future plans

At present the SAT is going to be introduced into three other specific units in the University Health Network with a proposed re-evaluation date of the

end of 2004. It continues to be used in the PCU and this has now become part of unit practice. The chaplain on their arrival on the unit introduces new staff members, especially medical residents, to the SAT. The use of the HOPE tool has also become part of the practice of the C.P.E. (Clinical Pastoral Education) residents. This will allow a larger scale reflection on its value and impact from the perspective of chaplaincy services.

## Summary

The introduction and implementation of a specific SAT has been shown to enhance the meeting of the spiritual and religious needs of patients and their families within a specific PCU. It has enlarged the understanding of the needs of patients by staff who provide their prime care. It has facilitated a growing interest and understanding as to the unique role and contribution that chaplains can make to patient care. It has set up a forum for education around the holistic needs of palliative care patients. Finally it has helped chaplaincy services to gain further inroads into the crucial language of assessment and treatment plan.

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## References

- PIERCE B, VANDER BERG A, KONING F. 2004 'Impact of Formal Spiritual Assessment of Patients for Staff in a Palliative Care Unit (PCU) Presented at CAPO (Canadian Association of Psychosocial Oncology) Annual Conference Toronto May
- KOENIG H. 2001 Spiritual Assessment in Medical Practice American Family Physician Jan 1
- O'CONNOR T, O'NEILL K, PENNER C, VAN STAALDUINEN G, DAVIS K, MEAKES E. (2003) 'Chaplaincy Experiences of Assessment Tools' Presented at EPIC Conference. Toronto. February 2003
- ANANDARAJAH G, HIGHT E. 2001 Spirituality and Medical Practice: Using the HOPE Questions as

a Practical Tool for Spiritual Assessment American  
Family Physician January 1. 63:81-8,89.  
PRUYSER P.1976 The Minister as Diagnostician  
The Westminster Press, Philadelphia

FITCHETT G.1993 Assessing Spiritual Needs - A  
Guide for Caregivers Augsburg Fortress, Minneapo-  
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