

MEASURING THE EFFECTIVENESS OF CHAPLAINCY:

WHAT TO AUDIT

James Duffy and Gillian Munro

Abstract: The authors introduce a form of audit as a response to the question 'What should be audited in spiritual care?' Using a Systems pattern already established in other departments, focus groups were held to indicate needs and wants of the client group. This led to an examination of methods already in use and a comparison of the two. The biggest challenge revealed was access and referral to the service. Assessment of client satisfaction should take into account clients' needs. Some forms of measure are helpful others may be harmful. All information must then be used. The department now has clarity on what should and should not be measured to provide an effective service.

Key Words: Systems Audit, method, challenge, measures.

Introduction

The newly formed Spiritual Care Department in NHS Tayside had placed on them an expectation that they would audit their service. However, it was unclear what this meant. Obviously, some kind of measure would be involved, but what should be measured, why should it be measured, and what would the measures tell us? All this before considering how to show it measured.

The Head of Department contacted the Clinical Governance Department for some help, guidance and advice with these questions. The response was an introduction to a systematic approach to Clinical Governance, based on quality management principles. This approach had been implemented in a number of departments, covering clinical and non-clinical services. The advice was not to measure anything about the service, until enough work had been done around identifying and implementing the Clinical Governance system for it to be clear what should be measured and to ensure that there was something to measure.

This article sets out the clinical governance system, describes its application to the Department of Spiritual Care, outlines progress in implementing the

system, and discusses the types of meaningful measures which flow from its introduction.

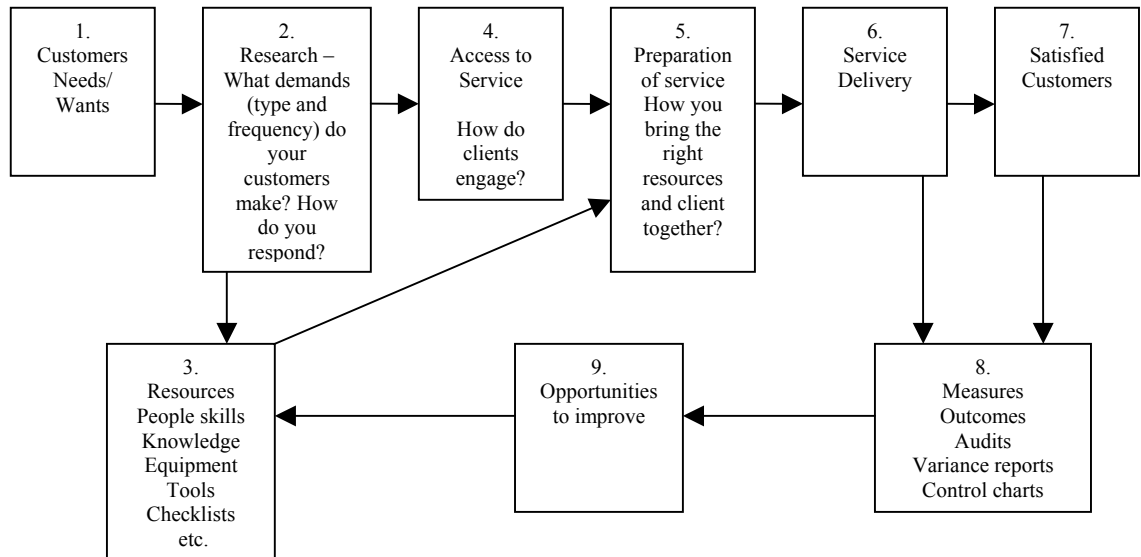
The system

The Clinical Governance staff in Dundee pulled the system together following successful introduction to a number of departments and service areas, as described by Duffy and Irvine (2004). The system represents a model based on research into various quality systems, such as the King's Fund Organisational Audit Programme (KFOA), the European Foundation for Quality management (EFQM) and the International Organisation for Standardisation (ISO) ISO 9000.

The system can be represented as a diagram, with 9 interlinked steps (see figure 1).

Once this model had been presented to and accepted by the Department of Spiritual Care we had to work out how to fill in each of the boxes for this department. Experience has shown that while the model is generally applicable to all types of department, the detail of how it is applied is unique to each department.

Figure 1. Systems Diagram



Box1

The start point was to find out and quantify what customers’ needs and wants were (Box 1). If there are no identifiable needs and want, there is no justification for providing a service. Equally, there is no justification for providing a service which does not address needs and wants. This is not to say that every need and want must be responded to. Not every want is a need. In a world of finite resources it may be necessary to decide which needs are to be responded to.

To establish needs and wants, focus groups were held. This included people from a wide variety of faith backgrounds, and people who professed no faith. A clear picture began to emerge of the circumstances under which people would identify a spiritual need and the type of response they would hope for. This amounted to a mixture of predictable and less predictable needs. The good news about the predictable items was that there existed within the department knowledge of how to respond.

Box 2

However, completion of the first box led into box 2. Here we tried to identify what methodologies were needed to respond appropriately to the needs. This involved bits of research to examine the skills and knowledge bases required dealing with the various types of demand which the Department’s staff would face. It also involved identifying any supporting materials which staff would use in delivering the service. The Department made clear decisions about who was responsible for ensuring this work was undertaken, and had the necessary skills in relation to literature searches and reviews available.

Box3

Moving into box 3, the department started to compare its resources with the resources identified in box two. In terms of addressing any knowledge and skills gap, the existing Personal Development Plan process proved satisfactory. A checklist could now also be drawn up of support material, reference leaflets, artefacts and so on which would be required in the various locations. Again, clear responsibility was assigned to making good any gaps.

Box 4

When we considered box 4, we were looking at how clients (patients, relatives and staff) accessed the service. This has presented one of the biggest challenges. Traditionally as part of the admission process in many areas patients would be asked if they wished to see the chaplain. This immediately singled out the Department of Spiritual Care and referral arrangements as different from any other care team. For all other services, patients would be assessed and referred on the basis of assessed need. Clearly, nobody gets asked if they want to see a radiologist or a phlebotomist. These arrangements may lead to people with complex spiritual needs not being identified while others with less need identify themselves immediately affecting the process of prioritisation of visits by the chaplain. We drew two conclusions from this. Staff are not confident at assessing whether people have spiritual needs, and there is poor understanding among staff and patients about the kind of issues the Department of Spiritual Care can help with.

Those difficulties notwithstanding, the referral arrangements led to problems in relation to timescale. Unless a request was regarded as urgent, where quick and effective processes alerted the chaplain, referrals could take some days to arrive as in one hospital these were written and had to be collected from each ward. This resulted in what appeared to be a slow response from the chaplain, although the chaplain had responded quickly on receipt of the referral. This arrangement also led to a significant number of missed visits, as the patient had been discharged or transferred or the spiritual crisis had passed. Referral by phone call has been encouraged which brought practice in line with referral arrangements to other departments. This has gone a long way to resolving the difficulty of response times.

Box 5

Box 5 is about preparing the service delivery, so that the service provider turns up at the right time with the right equipment and gets access to the patient. In the acute setting in particular the chaplain was often not high in the pecking order of who gets to see the patient. So the chaplain would defer to a host of others, whether or not, to the patient, their spiritual need was paramount. This led to wasted visits, with

obvious consequences for the use of scarce staff resources

In contrast, in the palliative care setting, the role of the chaplain in delivering spiritual care was understood to be of great importance and the place of the chaplain recognised.

Additionally, there remained problems associated with getting information about the kind of spiritual need the chaplain would meet in responding to the referral. Potentially the chaplain with better information could plan visits in an appropriate way and be better prepared generally meeting the person.

Box 6

Box 6 covers the activities of delivering the service, and normally takes place when the chaplain, or other person providing the spiritual care, is together with the person or people receiving spiritual care. The care that is transacted here clearly needs to be tailored to each individual circumstance, but should be recognisably based in the methodologies identified in box 2.

Box 7

Box 7 is concerned with measuring client satisfaction. Clearly it is important to know that the service is being delivered in a way which is acceptable to clients. The main issue here is that measures should be related to those things identified in boxes 1 and 2 which the clients said were important to them. There is an easy trap to fall into of asking clients about those things which appear important from the service providers' perspective, but which may be different from the things which really matter to the client.

Box 8

Box 8 is about measurement. It is only at this point that there can be meaningful consideration of what to measure, and what to audit. We consider there to be four kinds of measure, one of which is of paramount importance, and one of which is at best of no use, and at worst can be harmful. The four measures are:

- Customer centred outcomes (also referred to as end-to-end measures)
- System measure
- Process measure
- Activity count

The **customer centred outcome** measure is of paramount importance. This is a measure of the department's success in meeting the client demand. It is an expression of the department's capability, given the system within which it operates. What we mean by this measure is this:

- People bring a variety of issues to the department.
- For each of these issues they want help.
- The spiritual care department's purpose is to provide that help (around those types of issues which the department has agreed it should respond to).
- The success of the department in doing that is the extent to which people consider their issues to have been addressed.

It is only by demonstrating that the service actually performs a function of moving people along the way to resolving issues that it can demonstrate its worth. However, making this measurement should not be regarded as a simple task. It is necessary to identify the various types of problem which people bring, and how to quantify the problems. This is inevitably subjective and will vary from person to person. Two people faced with similar circumstances will feel the problem and express it differently. The same intervention will have different degrees of success for different people. This variation is natural and normal. But it does tell us that this measure becomes meaningless if we try to reduce it to one figure. To properly describe the capability of the system of spiritual care delivery we need for all categories of problems (starting with the most common and/or the most serious) a way of expressing the mean and the range of the changes brought about with the client in relation to the problem. The methodology for doing this is a technique called statistical process control (SPC) which is described in many texts, (e.g. Shewhart, 1931, who pioneered their use, and Lloyd and Carey, 1995). It is important to realise that this is a measure of system capability, it is not a measure of individual performance. Individuals perform within the system and, therefore, within the constraints of the system.

System measure would normally be done by audit. This is simply a check to find out if the system is working as designed. For example, if in box 3, a decision had been made that PDPs would be done annually with quarterly reviews, the system measure would establish whether this is happening. System

measure is an important type of measure. It establishes whether a department is doing all the things which it decided were important to achieve the best outcomes for people using the service. But this kind of measure is internally focussed, and can never take the place of measuring customer centred outcomes.

Process measures are also normally done by audit. This would consist of taking processes identified as critical, or historically problematic, and examining them in detail to ensure they are working adequately. There is a note of caution about this kind of audit. While this is a valuable tool, there can be a temptation to sort out a troublesome process without sufficient thought to the effect of that solution on other parts of the system.

The last measure is **activity counts**. This is what Deming (1986) describes as degeneration into counting. How many of this did we do, how many did we refer to this department, how many clients did we see, and so on. The danger is that upping the quantity becomes the goal or the target and unintended nonsensical consequences result. For example, John Seddon (2003) discusses the ambulance service response to a national target of meeting 75% of category A calls within 8 minutes.

There is one further type of measure we would advocate. It is well worth measuring the type and frequency of demands coming into the department. In boxes 1 and 2 research will have provided a theoretical understanding of this, but measuring actual demand will allow this information to be refined, and for the department to anticipate and deal with changes which occur over time in the demand it has to respond to.

Box 9

Finally box 9 is the box where the data from all the measures, including the satisfaction measures must get used. If it doesn't get used, there was no point in collecting it. Where the information suggests that something is not going as well as it should, we need to have a recognised way of dealing with that. This links back into box 3, because the only way to improve the outcomes which the service is capable of achieving with its clients is to change the system of delivery. Inevitably this means changing the way people access the service, or the way the service responds, or both. The service responds with its resources, which are the knowledge and skills and materials available to it. If the changes made are

effective, positive differences in outcome measures will start to follow.

Conclusion

By adopting a systems approach to service delivery, the Department of Spiritual Care in Tayside has developed an understanding of what is important to service users which has gone beyond the expectations of conventional knowledge. This has been accompanied by a wider understanding of the types of responses people would be hoping for.

The department now has clear insights regarding what to measure, how to measure it and how to use the information gathered. Just as importantly, there is now clarity about what should not be measured.

What should be measured

- what customers' needs and wants are
- the skills and knowledge bases required to deal with the various types of demand which the Department's staff face and what is available at present
- any supporting materials required for staff to deliver the service and what is available at present
- information requested by staff on spiritual requirements of patients and the appropriate communication of this
- reasons for 'failed' visits
- success in meeting client demand
- what has been planned has been carried out
- the results of problem solving

What should not be measured

- how many of this did we do
- how many did we refer to this department
- how many clients did we see

The outward looking client centred outcomes will be the main measure used, and there will be no attempt to reduce these to one figure. They will be considered as a range of outcomes to reflect the variance achieved with different people.

NHS Tayside Spiritual Care Policy states *Audit is central to the process of Spiritual Care within NHS Tayside*. The challenge was how to implement this

in a new department. In Tayside we did not have a large team but we had firm foundations in the acute and community hospitals. We felt it would not help us to know how many people were visited or for how long because each person must have their needs dealt with in an individual way. What we did want to know was how effective our care was in supporting patients, carers and staff and how we could improve our service. Working with our colleagues in Clinical Governance allowed us to use their expertise in their specialist field as well as their local knowledge of Tayside. As we sat writing issues on *post-its* and organising them into priorities and ways of working we had to reflect on why we did things that way and was there a better answer. Working with people who began with little knowledge of spiritual care but developed a great interest helped us to stand back and look at our own practice so that we can now develop a department which delivers care which people want, not what we think they need.

Acknowledgement

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REFERENCES

- DUFFY J., IRVINE E. 2004 *Clinical Governance: The Role of Measures Quality in Primary Care* 12:283-8
- DEMING W. E. 1986, *Out of the Crisis*, MIT Press Massachusetts
- SEDDON J 2003, *Freedom from Command and Control*, Vanguard Press, London
- CAREY R.G., LLOYD R.C. 1995, *Measuring Quality Improvement in Healthcare: a guide to statistical process control application* Quality Resources, New York
- SHEWHART W 1931, *Economic Control of Quality of Manufactured Product* Van Nostrand Reinhold, New York.

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