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A Health Services Framework of Spiritual Care

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Abstract

Aims—To introduce a health services framework of spiritual care that addresses the empirical and applied issues surrounding spirituality and nursing practice.

Background—Despite over 20 years of study, the concept of spirituality is still under development, which limits application to nursing practice.

Methods—Three studies using a health services framework are reviewed: (1) a survey study of dying patients and family that describes the providers, types, and outcomes of spiritual care; (2) an exploratory study of the process of spiritual care; and (3) a multi-level study of the structure and outcomes of spiritual care in long-term care facilities.

Results—Spiritual care recipients identify family or friends (41%), clergy (17%), and health care providers (29%) as spiritual care providers. The most frequently reported type of spiritual care was help in coping with illness (87%). Just over half (55%) of spiritual care recipients were very satisfied or somewhat satisfied with the care that they received. The processes of spiritual care involved: (1) presence, or the deliberate ideation and purposeful action of providing care that went beyond medical treatment; (2) opening eyes, or the process by which providers became aware of their patient's storied humanity and the individualized experience of their current illness, and; (3) co-creating, which was a mutual and fluid activity between patients, family members, and care providers that began with an affirmation of the patient's life experience and led to the generation of a holistic care plan that focused on maintaining the patient's humanity and dignity. In long term care facilities, decedents who received spiritual care were perceived as receiving better overall care in the last month of life, when compared with those decedents who did not receive spiritual care. In addition, among those receiving support for their spiritual needs, care was rated more highly among those who received support from facility staff, such as nurses, than those who did not; no differences were observed based on the presence of other sources of support.

Conclusions—A health services framework provides a holistic view of spiritual care, one that is consistent with integrated nursing models.

Implications for Nursing Management—By focusing on the structure, process, and outcome elements of spiritual care within organizational settings, nursing management can develop feasible approaches to implement, improve, and evaluate the delivery of this unique type of care.

Keywords

Nursing practice; spirituality; spiritual care; health services

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INTRODUCTION

Over the last 2 decades, nursing has seen a rise in research that has examined the relationship between religion, spirituality, and health-related outcomes, with a particular focus on clinical applications in practice (McSherry, 2000, Watson, 1999, Roper et al., 2000). In recent years, however, progress in this area remains hampered by methodological challenges, such as the use of small, non-generalizable samples, and more importantly, the lack of plausible conceptual models (Sloan et al., 1999). A concept analysis, for example, operationalized spirituality within nursing as the search for meaning and purpose, which is transcendent and distinct from religion (McBrien, 2006). However, an earlier review of the nursing literature reported that spirituality encompassed multiple constructs including: the relationship between self, others, and God; the quest to find meaning; hope, and; relatedness and connectedness(Dyson et al., 1997).

These conceptual shortcomings significantly limit empiric research and subsequent evidence-based approaches to incorporating spirituality within nursing practice. A recent systematic review concluded that the concept of spirituality is still under development, and that until a common understanding of this concept is brought forth, applications within nursing will be difficult to implement (Pike, 2011). The absence of such common understanding contributes to the lack of plausible models that depict mechanism and causality, which in turn, inform research and practice. In addition, prior approaches to the examination of spirituality and health-related outcomes have been largely confined to the individual level of hypothesis, research design, and implementation and evaluation (Koenig et al., 2001). If spirituality is to be integrated in nursing care, how can it be conceptually understood in clinical contexts?

Health services research offers an orientation to integrating spirituality in nursing practice. This multidisciplinary field takes a multi-level view – individuals, families, organizations, institutions, communities, and populations – to examine how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors impact outcomes such as access to health care, the quality and cost of health care, and ultimately health and well-being (Lohr and Steinwachs, 2002). Quality is a particular focus within health services research and a common framework classifies quality under 3 categories: structure, process, and outcome (Donabedian, 1988). Structure examines the characteristics of the care setting, such as capital resources (e.g., facility, equipment), human resources (e.g., personnel), and the organizational structure (e.g., staffing). Process describes what actually transpires during the delivery and receipt of care, incorporating both patient and provider activities and perspectives (Donabedian, 1988). Finally, outcome examines the effects of care on patient-centered outcomes including satisfaction with care, quality of life, and spiritual well-being.

To ground an understanding of spiritual care using a health services framework, our research group conducted a series of mixed method studies, which were approved by the University of North Carolina at Chapel Hill Institutional Review Board, and provided data on who provides spiritual care, what is provided, and how well spiritual care satisfies the needs of seriously ill patients and family caregivers (Hanson et al., 2008, Daaleman et al., 2008a, Daaleman et al., 2008b). This paper reviews three studies from this research and suggests several applications to nursing management.

METHODS

Providers, Processes, and Outcomes of Spiritual Care at the End of Life(Hanson et al., 2008)

Study Subjects—Study subjects were recruited from palliative care, family medicine or geriatric medicine inpatient services and oncology clinics in a university tertiary care health system. They were eligible if they were capable of understanding and responding to interview questions, and if their attending physician judged that it would not be surprising if the patient died within the year. Family caregivers for patients who were determined to have this prognosis were also eligible for interview, regardless of the patient's capacity.

Data Collection—Data was collected using in-person structured interviews. One investigator contacted treating physicians each week to identify patients who met the prognostic criterion. Eligible patients and family caregivers were given introductory written information about the study. Those who expressed willingness to participate were approached by one of several trained interviewers who explained the study and asked for informed consent. These same interviewers conducted the interviews, which were usually completed in person during hospitalization; however, some interviews were completed by telephone if requested by the study subject.

Study Measures—We designed a series of interview questions using Donabedian's quality of care framework, described above, to describe the structure and process of spiritual care and its potential outcomes (Donabedian, 1988). Spiritual care recipients provided information on demographics, and answered items about their own religiosity, spirituality, and related practices. Interviewers then asked each person to identify up to 3 individuals who provided spiritual care to them during the last few months. For each spiritual care provider, recipients were asked to recall that person's age, gender, race, relationship or role in care, and whether or not they shared the recipient's faith tradition.

To describe the process of spiritual care, interviewers first asked an open-ended question about what types of activities or care the recipient experienced. Next, the interviewer read a list of 18 possible types of spiritual care, such as "helping you be at peace with those that you love," and asked the recipient whether or not they received this care. Investigators coded responses to the open-ended question within one of these 18 spiritual care activities, or as an additional activity or type of spiritual care.

Finally, interviewers asked structured, Likert-scaled questions about satisfaction and perceived value of spiritual care. Recipients of spiritual care rated their satisfaction with this care on a 5-point Likert scale from very satisfied (5) to very unsatisfied (1). They also rated how valuable spiritual care was to help them meet spiritual needs, to find peace, and to make meaning during this time of illness. These 3 items used a 4-point Likert scale with responses ranging from "it got in the way"(1) to "it helped greatly (4)." These items were summed for a perceived value score ranging from 4–12.

Analysis—We used standard descriptive statistics to report who provided spiritual care, what types of activities were included in spiritual care, and recipients' satisfaction with this care. We used Pearson correlation coefficients to examine bivariate associations between satisfaction and perceived value of spiritual care, and the characteristics of the spiritual care providers and types of spiritual care. All analyses were conducted using SPSS software, Version 15.

Qualitative Study of Spiritual Care at the End of Life(Daaleman et al., 2008a)

This qualitative study design used semi-structured interviews. Our sampling strategy was purposeful since we focused on health care providers who were recognized as providers of spiritual care. Dying patients and family caregivers who participated in a survey study of spiritual care were asked to nominate providers of spiritual care. We then used these nominees to select participants from several disciplines for maximum variation in our sample.

A semi-structured interview guide explored participants' experiences with end-of-life care encounters. Participants were asked to describe 2 patient interactions: one where spiritual care was a core element and the provider was confident in delivering this care and one where the provider had difficulty in providing spiritual care. The guide included prompts about approaches and strategies regarding ethnic, racial, and religious differences, and factors that facilitated or impeded the provision of spiritual care.

The interviews were conducted in-person, tape recorded, professionally transcribed, and checked for accuracy by a single investigator. Initial coding was performed by the interviewer and the principal investigator. The interviews were read to identify emerging patterns using editing analysis, in which meaningful segments of text were coded (Miles and Huberman, 1994). All investigators subsequently met and iteratively reviewed the codes to reach consensus; themes were compared within and across interviews. The final categories were reviewed by three participants in a process known as member checking (Miles and Huberman, 1994). The data were analyzed using qualitative research software (OSR, N6).

Spiritual Care Provided in Long-Term Care(Daaleman et al., 2008b)

Study Population—A total of 230 residential care/assisted living [RC/AL] facilities and nursing homes [NHs] from four states (Florida, Maryland, North Carolina, New Jersey), participating in the Collaborative Studies of Long-Term Care (CS-LTC), identified decedent deaths for this project. Details and an overview of the CS-LTC are described elsewhere (Zimmerman et al., 2001). At the time of facility recruitment, a facility liaison was identified and was contacted monthly by telephone to determine if any residents had died in the preceding 30 days. To be eligible, residents had to have died in a participating CS-LTC facility, or within three days of leaving the facility by transfer or discharge. If the decedent was eligible, the facility liaison was asked to provide the name and contact information of a family member or responsible party who was most familiar with the decedent's care in the last month of life.

Data Collection—Once eligibility was determined, a condolence letter and consent form introducing the study was mailed four weeks after the date of death to the deceased resident's identified family member. Interviewers followed up at least six weeks after the date of death to obtain verbal consent and conduct a telephone interview with family members; interviews lasted approximately 45 to 90 minutes. We also collected facility-level data from participating facilities via telephone interviews with facility administrators.

Study Measures—The facility liaison reported demographic information about the decedent resident, including gender, race, and age. Family members provided demographic information about themselves and their relationship to the decedent. They also reported whether or not the resident received support for his or her spiritual needs, and the providers of spiritual support (i.e., family/friends, clergy, facility staff). Family members also responded to an open-ended question that asked them to describe what the staff did to meet the resident's spiritual needs. These open-ended descriptions were coded into either group service activities or individual devotional activities by two of the study investigators. Family

members also rated their impression of the overall care that the resident received in the last month of life (on a 4-point scale ranging from 1=Poor to 4=Very good).

Facility administrators reported organizational characteristics (e.g., bed size, proprietary status) of their facility, in addition to services that their facility directly provided or contracted to provide on-site for residents. These services included one-to-one religious advice or counseling by clergy, religious services, hospice services, and a hospice unit. Administrators were also asked if their facility was affiliated with a religious organization.

Data Analysis—To identify characteristics that were associated with receipt of support for spiritual needs, we used Generalized Estimating Equations (GEE)(Diggle et al., 2002) applied to logistic regression, controlling for within-facility clustering using GEE empirical standard error estimates and exchangeable correlation. A similar strategy was used to test the association between resident and facility characteristics and specific sources of spiritual support and process elements of spiritual care within facilities (e.g., individual devotional activities); these latter analyses were limited to those residents who received support for their spiritual needs.

For facility-level analyses examining the relationship between facility type and structural elements of spiritual care, exact logistic regression models were used. Finally, in analyses aimed at determining the association between overall impression of care and receipt of spiritual care, as well as sources of spiritual support and the structure and process elements of spiritual care, we used linear mixed modes with a random effect for facility and impression of overall care as the dependent variable. All analyses were conducted using SAS software (version 9.1, SAS Institute, Cary, NC).

RESULTS

Providers, Processes, and Outcomes of Spiritual Care at the End of Life(Hanson et al., 2008)

The age of spiritual care recipients ranged from 34–98, and patients were significantly older than family caregivers (72.9 vs 61.1 years, $p<0.001$). Participants had relatively high educational attainment with 45% achieving college graduation. One third of recipients described themselves as very religious, and 41% described themselves as very spiritual. All reported they had received some form of spiritual care, and half of these reported 3 or more people who provided them with spiritual care.

The Experience of Spiritual Care—The 103 recipients of spiritual care reported 237 people provided this care. Spiritual care providers visited frequently, and 63% shared the faith tradition of the recipient. Of the 237 spiritual care providers identified by recipients, 95 (41%) were family or friends, 38 (17%) were clergy, and 66 (29%) were health care providers. Fifteen recipients also named God or a higher power as one of their sources of spiritual care.

Between 66–78% of participants reported various types of spiritual care that helped with relationships with loved ones or God. Somewhat smaller percentages of participants reported types of spiritual care that helped with understanding self and illness (45–73%). Spiritual care helped with specific religious or spiritual practices for 34–66% of recipients. In response to the open-ended question about spiritual care activities, participants also reported help with insight into dying, comfort, and intercessory prayer. The most common type of spiritual care was help in coping with illness (87%), and the least common was intercessory prayer (4%).

Just over half (55%) of spiritual care recipients were very satisfied or somewhat satisfied with the care that they received. Most recipients (72%) felt that the spiritual care they had experienced was very valuable to meet their spiritual care needs, but smaller percentages felt it was very valuable as a resource to find inner peace (54%), or to help them make meaning (52%). An overall score for perceived value was created by summing the Likert scale ratings of perceived value for meeting needs, inner peace, and meaning. The average score for perceived value of spiritual care was 10.2 (s.d. 1.9) out of a possible score from 4 to 12. Patients and family caregivers did not differ significantly regarding their satisfaction with or perceived value or care. Satisfaction and perceived value were well correlated with one another ($r=0.497$, $p< 0.001$).

Are Providers and Types of Care Associated with Satisfaction with Care?—In initial bivariate comparisons, most provider characteristics showed no correlation with the recipient's report of satisfaction and their perceived value of spiritual care. Specifically, these outcomes did not differ according to the spiritual care provider's age, race, gender or frequency of visits, and did not differ if the provider was family or friend, clergy, or a health care provider. Satisfaction tended to be lower if the spiritual care provider shared the recipient's faith tradition ($r= -0.138$, $p=-.046$). We found that satisfaction with care was greater when spiritual care included helping with understanding ($r=0.251$, $p=0.001$) or helping to cope with illness ($r=0.168$, $p=0.012$). The perceived value of care was higher if spiritual care included help with understanding ($r=0.483$, $p<0.001$), spiritual care practices ($r=0.460$, $p<0.001$), relationships ($r=0.371$, $p<0.001$), or with coping with illness ($r=0.273$, $p<0.001$).

Qualitative Study of Spiritual Care at the End of Life(Daaleman et al., 2008a)

The average participant age was 44 years (range 27–60 years); half were women, and 9 self-identified as white and 1 each as African-American, Asian-American, and Hispanic/Latino, respectively. The professional backgrounds of the participants were as follows: 8 physicians, 2 chaplains/pastoral care providers, 1 nurse, and 1 facilities services/housekeeping. Most participants considered themselves to be not religious or slightly religious (N=7) and not or slightly spiritual (N=9) persons. There was heterogeneity in self-reported faith traditions: non-denominational (N=1), Hindu (N=1), AME Zion (N=1), atheist (N=1), Catholic (N=2), Jewish (N=2), and Christian (N=3). Our analyses identified three domains of spiritual caregiving, in addition to barriers and facilitators affecting the delivery of spiritual care. These themes were validated post-hoc by 3 participants and we achieved data saturation, that is, no new themes emerged.

Domain 1: Presence—Presence was a dominant theme among participants, one marked by intentionality, or the deliberate ideation and purposeful action of providing care that went beyond medical treatment, giving attention to emotional, social, and spiritual needs.

… I would say spiritual care is sort of care of the whole person, you know, or just being aware that it's more than just the physical body and the pain … [Interview 4]

Physical proximity to the patient was a key element, facilitating communication on the provider's part that was fully attentive to the patient, sometimes transcending verbal and nonverbal communication.

Domain 2: Opening Eyes—Opening eyes was the process by which care providers recognized and became aware of the patient's storied humanity, and the individualized experience of their illness. This involved understanding the patient's perspective of his or her illness, incorporating viewpoints from family and close friends. Although the patient's

perspective was central, opening eyes was a bidirectional process, whereby patient and provider recognized the uniquely human dimension in each other.

I always think of spiritual care as trying to open my eyes to what the patient sees about what's happening to them, as well as opening the patient's eyes to see that I care about what …they … is going on with them … [Interview 3]

Domain 3: Co-Creating—Co-creating was a mutual activity among patients, family members, and care providers that generated a wholistic care plan focusing on maintaining the patient's humanity and dignity in the face of death.

Our job is really kind of an outline. 'This is exactly where you are. This is what's happening. These are the potential problems down the road and this is what we will do.' [Interview 7]

Barriers and Facilitators to Spiritual Care—The lack of sufficient time was the major barrier to spiritual care voiced by most participants.

… these were really tough issues that take a lot of time, and in my mind that they would take some time to sort these things out, and I don't think that there is sufficient time in clinic to really have these types of discussions with people and so I think time was a barrier. [Interview 9]

Social, religious, or cultural discordance between providers and patients sometimes created an atmosphere of mistrust, and was another obstacle to care. Finally, institutional obstacles, such as the absence of privacy and lack of continuity, were also highlighted.

Having ample time, which was unencumbered by competing clinical demands and which fostered relationship, was noted as a facilitator by many participants. The second factor, which was time-dependent, was effective communication, in which providers were able to gather information and craft a coherent clinical narrative for patients and/or family members. Finally, participants reflected on their own personal experiences with serious illness and death as a facilitator of their spiritual caregiving.

Spiritual Care Provided in Long-Term Care(Daaleman et al., 2008b)

We completed interviews with 451 family members of decedents (44.2% of eligible decedents, 67.6% of those for whom we were able to identify and contact an eligible family member) from 128 facilities. Most respondents were children of decedents (69%) however some were other relatives (20%), spouses (7%), or other non-relatives (5%). Family respondents were predominantly white (89%) and female (74%) with a mean age of 61.1 years. A large majority of decedents (87%) received support with their spiritual needs. Residents in RC/AL facilities with fewer than 16 beds were less likely to receive spiritual support (71%) when compared to residents of new-model RC/AL facilities (94%, P=0.005) and those in NHs (89%, P=0.010). There was little difference between religiously affiliated and non-affiliated facilities regarding the receipt of spiritual support among their decedent residents (86% vs. 91%, P=0.210). None of the decedent characteristics were strongly associated with receiving spiritual care (all P>0.15).

Source, Structure, and Process of Spiritual Support—Decedents received spiritual support from multiple sources including clergy (85%), family and friends (62%), facility staff (37%), and others (17%). Residents who were younger than 85 years of age were more likely than older residents to receive spiritual support from family and friends (75% vs 55%, P=0.006) and other sources (24% vs 14%, P=0.019) than residents age 85 and older. Clergy

were more likely to be identified as a source among female decedents (88% vs 75% for male decedents, P=0.006) and in facilities with a religious affiliation (96% vs 82%, P=0.012). Staff were reported as a source of spiritual support more often among non-white decedents (43% vs 36%, P=0.033), for those in religiously affiliated facilities (63% vs 30%, P<0.001), and in NHs when compared to new-model RC/AL facilities (42% vs 21%, P=0.004).

Although a small number of LTC facilities have a hospice unit (7%), most facilities reported 1:1 counseling by clergy (70%), on-site religious services (93%), and hospice services (88%). Religiously-affiliated facilities were more likely to provide 1:1 clerical counseling (94% vs 65%, P=0.019), but were comparable to non-affiliated facilities in providing on site religious services (100% vs 91%, P=0.344) and hospice. Hospice services were more prevalent in NHs when compared to small RC/AL facilities (100% vs 72%, P=0.006) and traditional RC/AL facilities (100% vs 73%, P=.036), and more prevalent in new-model compared to smaller RC/AL facilities (97% vs 72%, P=0.026). Two spiritual care process elements were reported by family members: group service activities (e.g., worship services) were used by 16% of residents and individual devotional activities (e.g., private prayer) by 19%. Religiously-affiliated facilities were more likely to assist in individual activities when compared to non-affiliated sites (37% vs 14%, P=0.012), as reported by family members

Spiritual Care, Spiritual Support, and Perception of Overall Care—Family members of decedents who received spiritual care rated overall care in the last month of life more highly, when compared with those decedents who did not receive spiritual care (3.59 vs 3.23, P=0.002). Among those receiving support for their spiritual needs, care was rated more highly among those who received support from facility staff than those who did not (3.76 vs. 3.49, P<0.001), but no differences were observed based on the presence of other sources of support. Also, individual devotional activities were associated with higher overall care ratings (3.87 vs. 3.53, P=0.001), but care ratings did not vary substantially based on other structure or process elements.

DISCUSSION

As evidenced by these studies, a health services framework of spiritual care offers a dynamic, multi-level approach to further understanding within clinical nursing contexts. Nursing studies have already begun to map out the process domain of spiritual care by qualitatively describing nursing provider perspectives and reporting activities such as referring to others, facilitating religious rituals and practices, and being present to patients (Ross, 2006). For example, one exploratory study of nurses described the spiritual care of dying nursing home residents using five themes: honoring the person's dignity, struggling with end-of-life treatment decisions, wishing to do more, personal knowledge of self as caregiver, and intimate knowledge of the resident (Touhy et al., 2005). Other small survey studies of oncology nurses suggest that spiritual care involves several tasks: referring to pastoral care providers and clergy, acknowledging and supporting patients' spiritual or religious concerns, and being attentive to both patients and family members (Sellers and Haag, 1998, Taylor et al., 1995, Kristeller et al., 1999).

Several findings from these seminal studies support a health services approach to spiritual care as an organizing framework for implementing and evaluating spiritual care within nursing practice. First, spiritual care is provided to seriously ill patients from multiple sources; family, friends, and health care providers were more commonly identified as spiritual care providers than were clergy. Second, spiritual care activities are varied, but facilitating relationships and coping are more frequent than prayer, religious ritual, or services. Finally, outcomes of spiritual care are not uniformly positive – about half reported they were very or somewhat satisfied with care – and appear to be linked with specific types

of spiritual caregiving. If a health services paradigm provides a holistic view of spiritual care, one that is consistent with integrated nursing models (McSherry, 2000, Watson, 1999), are there programmatic examples for implementation and evaluation in clinical nursing?

Implications for Nursing Management

Nursing practice is primarily nested within organizational contexts (Watson, 1999). In this light, Peter Senge's concept of the learning organization, which focuses on the practice of "learning together" as a multi-level endeavor (Senge, 1990), can be an applicable model for managers who are seeking to implement spiritual care within clinical nursing. To begin, understanding how practice and team learning develop individuals within organizations, such as hospitals and outpatient clinical settings, entails mastering the learning disciplines around a shared vision. Each of the learning disciplines described by Senge – systems thinking, personal mastery, mental models, building shared vision, and team learning – can be considered on three levels: practices, principles, and essences (Senge, 1990). Practices are the tasks and work involved in an organization, a primary focus of both individuals and groups, and are the most conspicuous aspect of any discipline (Senge, 1990).

The most immediate and direct application of this framework may be found in hospice and palliative care programs, which are implementing quality improvement strategies and adopting quality measures in the US (Durham et al., 2011). In 2008, the Centers for Medicare and Medicaid Services (CMS) issued the Hospice Conditions of Participation Final Report in 2008, requiring all Medicare-certified hospices to implement Quality Assessment and Performance Improvement (QAPI) processes to monitor and ensure quality care (Centers for Medicare and Medicaid Services, 2008). These regulations require hospice providers to use a systematic, data-driven approach to measure the quality of care that they deliver, to identify areas of improvement and to develop strategies to enhance care (Schenck et al., 2010, Durham et al., 2011). Quality improvement involves a systematic approach to document, measure, and analyze quality indicators, such as the Plan/Do/Study/Act cycle (Institute for Healthcare Improvement, 2003). Unfortunately, existing clinical instruments for gauging end-of-life care do not include structured measures of important but "intangible" aspects of care, such as spiritual care (Durham et al., 2011).

CONCLUSION

A health services framework provides a relevant and informative model to determine the efficacy of innovative strategies that seek to enhance spiritual care in nursing practice. By focusing on the structure, process, and outcome elements of spiritual care within organizational settings, this framework can help nursing move from exploratory and descriptive approaches of individual-level spirituality to effective, meaningful, and sustainable ways of implementing and improving the delivery of this unique type of care.

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