STANDARDS FOR NHSSCOTLAND CHAPLAINCY SERVICES:

SCOPING, STANDARDS AND CONSULTATION

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Abstract: A scoping group established by NHS Quality Improvement Scotland and the Healthcare Chaplaincy Training and Development Unit, (HCTDU, now part of NHS Education for Scotland (NES)) was asked to scope awareness and provision of Spiritual Care in NHS Scotland. The group produced a report covering a survey and literature research. Following a seminar May 2005 in which this report was discussed along with some current research, a further group began work on chaplaincy service standards. A consultation conference held on 27th June 2006 brought much support and many comments on the standards document. Despite some hesitation in trying to measure things spiritual, these standards should be a useful audit tool and an aid for future work on competencies and help development towards national standards or good practice statements on spiritual and religious care in NHS Scotland.

Key words: Spiritual Care, chaplaincy, scoping study, national standards, service standards, competencies.

Introduction

Standards for spiritual care have been seen both as 'Holy Grail' by enthusiastic promoters of a new service and a 'step too far' by those who fear that this is an attempt to domesticate that which by its very nature must be free and unmeasured.

It is not an entirely new argument. It is debated in the scripture of the lesser prophet Zechariah:
I saw a man with a measuring -line in his hand. "Where are you going?" I asked. "To measure Jerusalem," he answered, "to see how long and how wide it is". Then I saw the angel who had been speaking to me, step forward, and another angel came to meet him. The first one said to the other, "Run and tell that young man with the measuring-line that there are going to be so many people and cattle in Jerusalem that it will be too big to have walls" (Zechariah 2: 2-4).

One of NHS Quality Improvement Scotland's (NHS QIS) key roles is to work in partnership with healthcare professionals and members of the public to set standards for clinical and non-clinical services, assess performance throughout NHSScotland against these standards, and publish the findings. The standards are based on the patient's journey as he or she moves through different parts of the health service. On the whole, standards have been developed to address the delivery of care for people with specific conditions or needs, such as diabetes, stroke and coronary heart disease. However, non-clinical aspects of care are also addressed so that a holistic and well-rounded approach is given to patients, their family/carers. Spiritual need and care is understood as an essential part of this holistic approach, and is increasingly described as an integral part of health and well being. (WHO 1998) The Healthcare Chaplaincy Training and Development Unit (HCTDU) is working to enable this integration both through the training of chaplains and the development of a better understanding of spiritual care within each Health Board.

Scoping study

A scoping group was set up which included project officers from the standards development unit of NHS QIS, the healthcare chaplaincy training and development unit, chaplains, academics, clinical leads and representation from the SEHD's involving people team. The group surveyed a sample of health board areas to find out how aware health service staff were of the provision of spiritual and religious care. They also undertook a literature search to look at research which considered the ways in which spiritual care can be evaluated and can be seen to affect patient, carer, and even staff outcomes.

The project followed work undertaken by health boards in line with NHS HDL 76 (2002) Spiritual Care in NHS Scotland. The project also sat alongside elements of Scottish Executive Health Department policy including the documents: Fair For All (SEHD, 2002), Patient Focus Public Involvement (SEHD, 2001), Partnership for Care (SEHD, 2003), and Equality and Diversity Impact Assessment (SEHD, 2004) its purpose being to enable spiritual care services to be more sensitive, compassionate and effective in dealing with a community of diverse individuals.

With the publication of 'Report of the Scoping Study Group on the Provision of Spiritual Care in NHS Scotland' (NHS QIS, 2005) and the first NHS QIS seminar on spiritual care policy and research developments, the organisation had taken a further step towards establishing a baseline of spiritual care provision across NHS Scotland. This built on existing spiritual care policies in place across every board area, and the legislation and guidance received from the Scottish Executive Health Department (SEHD).

Survey Results

The survey results recorded in the scoping report were encouraging and not totally unexpected:

- A large majority of staff (80%) thought access to spiritual care 'important';
- Most (75%) knew how to go about contacting a chaplain;
- The majority (70%) equated chaplaincy with religion;
- A majority (60%) knew where the Quiet Room was;
- 40% had heard of a religion and cultures manual;
- Only 6% had been asked to comment on draft spiritual care policies or information;
- Around half (55%) had gathered that spiritual care was also for staff.

The literature search on Research identified a few key ideas could be reported e.g. the work of 'Hunt et al' (2003) which shows that active religious or spiritual beliefs are significant in an individual's ability to cope with illness. Spiritual Care was shown to be an effective element in helping those with physical and mental difficulties (Mueller et al 2001; Culliford 2002). The reasons why spiritual care was not better recognised or evaluated were "lack of audit", "lack of effective documentation" and a "shortage of good well articulated research." (Hunt et al, 2003; Brocollo and Van de Creek 2004).

Scoping study seminar

In May 2005 NHS QIS hosted a seminar to report the work and findings of the scoping study. The seminar included the presentation of the findings of the scoping study along with the history of how it came into being, how it related to other initiatives of the SEHD, an explanation of work on standards in spiritual care already in place in palliative care, and a series of workshops focused on examples of local research projects undertaken by academics, medics, chaplains and managers.

The plenary discussion session towards the end of the seminar brought out the two possible outcomes to take the scoping study findings forward; either a statement of good practice could be produced which could be widely shared round the health board spiritual care service or the development of standards which would become part of a review and peer review process. The recommendation of the scoping group, presented on an earlier occasion to the Board of NHS QIS, was for standards if possible, as the most practical way of developing a competent and understood spiritual care service throughout the entire breadth and depth of NHS Scotland.

A summary of the workshops was added to the original report which has now been published by NHS QIS and is available from their offices or from the HCTDU (NHS QIS, 2005).

Beyond the scoping study

Following the scoping study the following action points were developed:

- Future events of a similar nature would be arranged which would chart and inform NHS Scotland on progress and developments in spiritual care practice and thinking;
- Ongoing work encouraging the process of audit should be supported so that issues such as access, equity, meeting the needs of users and standardisation of the spiritual care services would be addressed;
- Developing further guidance in the delivery of spiritual care in NHS Scotland. The HCTDU was to convene a group to work on such guidance and prepare for any potential future work with NHS QIS.

Standards for NHSScotland Chaplaincy Services

A group was brought together in accordance with the results and recommendations of the Scoping study to develop the work. This group consisted of the HCTDU of NHS Education for Scotland (NES), the representatives of the three professional chaplaincy associations, service representatives, the Scottish Interfaith Council and occasional contact with a senior project manager of NHS QIS. It was decided early on that the already ratified 'Association of Hospice and Palliative Care Chaplains *Standards for Hospice and Palliative Care Chaplaincy (AHPCC, 2006) 2nd edition',* could be used as a base line for the service standards and modified to suit chaplaincy within the NHS.

Essential to understanding the context of these Standards for NHS Chaplaincy Services is to recognise where they sit in the three tier process of National Standards, Service Standards and Competencies:

- National standards set the criteria for what patients, carers, staff and volunteers can expect from Spiritual Care Services in NHSScotland. This kind of guidance is usually developed and supported by NHS Quality Improvement Scotland;
- Service standards set the criteria for how spiritual care services will be put into practice by the service primarily responsible for delivering spiritual care – i.e. Chaplaincy Services (these standards as prepared through the HCTDU, part of NES, in conjunction with chaplaincy associations);
- Competencies in Spiritual Care which describe and assess the competence of individual health care professionals, including chaplains, to provide spiritual care (these would be developed through the HCTDU within NES).

Service standards – bullet point two, provided the agenda for this working group. Seven standards were written and presented for consultation to a conference on 27th June 2006 (NES, 2006). Each standard consisted of a statement, a rationale, references, criteria and self assessment questions which would elicit an accurate and valid response and be useful as an audit tool. This continued the work as envisaged in the scoping document with service standards seen as a necessary prerequisite to the development of competencies.

The Statements

These statements reflect the insight gained from the consultation in June 2006 and should be read with reference to the conference draft version of the standards (NES 2006).

Standard 1 *Patients and their carers have their spiritual and religious needs assessed and addressed.* Comments were largely positive and showed a concern to share best practice in assessing spiritual and religious need.

Standard 2 *All patients and carers have information about and access to the chaplaincy service.*
There was considerable discussion about awareness of what the service is and how it can better be accessed. Some groups reported genuine difficulties of access.

Standard 3 *Chaplaincy services should work in partnership with faith community and belief groups to ensure the appropriate provision of religious and spiritual care for patients and their carers.*
Points raised included the importance of the patient's choice and permission as to who visited, the need for a written protocol as only such can be audited and the way in which the multi faith manual

might be referred to or used (a NES manual is currently being prepared).

Standard 4 *As part of the hospital or unit's provision of support for staff and volunteers the chaplain offers personal and professional support.*

It was suggested that chaplains offered support which was unique although often using counselling skills. The awareness to refer on to other agencies or services was added.

Standard 5 *The chaplaincy service is committed to supporting continuing professional development and contributes to the healthcare team's professional education, training and research programmes.*

Comments raised the examples of reflective practice and the possible need to include "diversity" as part of education. The need for awareness of research and best practice was added.

Standard 6 *The unit ensures the chaplaincy service is provided with the resources to fulfil service standards, supervision and training needs.*

The original statement was changed to describe chaplaincy service needs rather than those of an individual chaplain. Much discussion about professional association membership, patient information and data protection, sufficiency of hours and external supervision.

Standard 7 *In addition to inclusion in the hospital or unit's major incident plan, there are events that need a communal recognition and action. The chaplain is a resource to assess and facilitate these needs.*

This statement is already more inclusive than the original as was reflected in the general desire for a revamped first paragraph of the rationale. Major incident procedure has been added to the statement, rationale and criteria. Discussion took place over the word 'advocacy' which some felt does not help clarity.

The next steps

The group has now to finalise the standards in the light of such comments and discussion prior to publication. Once published, hopefully in the autumn/winter of 2006/7, it is hoped that these standards will enable the carrying out of audit by chaplaincy managers and give a realistic picture of where chaplaincy services are going and how they will develop. They will have the backing of the professional chaplaincy associations and should become a useful tool in planning ahead. They are not mandatory but as such they will help the development of a service in different parts of the country which is consistent and based on the continuing development of good practice. They will facilitate the writing of competencies and may form a basis for future work and discussion on national NHS standards for spiritual and religious care in NHS Scotland. At present, there is no plan for NHS QIS to produce national standards of this type. However, NHS QIS is supportive of the group which is undertaking this development on behalf of chaplains and spiritual care providers to assist in delivering a consistent, high quality service.

Throughout this process there is an awareness of the hesitation on the part of some, to the whole idea of standards for spiritual care. This is healthy and it is important to recognise that there are aspects of spiritual care that do not lend themselves to measurement and not devalue them on that account. However, if we are serious about the provision of holistic care which takes into account the centrality and integrity of the spiritual as part of the indivisible whole, which also includes the physical, the social and the psychological, then it is incumbent on us to state a standard of care wherever that is possible.

The angel of our initial story from Zechariah was right to suggest that you can't build walls around spiritual care and say, "*that it is contained within*", because spiritual care is never hard bound at the edges and there is always more to it than we can see and measure. However, it is entirely possible that we can lay a foundation, nourish the soil, or create the atmosphere and conditions, in which spiritual care is more likely to flourish. Standards have the potential to raise awareness of compassion, the quest for meaning and understanding and the need for empathetic accompaniment. All of which are important elements in the well being of people as they face the challenges which illness, suffering or sadness bring.

Standards can be seen to be an interim aid to the provision of something of ultimate importance. However, in the quest for well-being we should not be hindered because there are some areas we cannot measure and some things which we cannot do. Standards for spiritual care in NHS Scotland will help patients, carers and staff and that is why they are worth pursuing.

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