

Supporting UASC who are experiencing spiritual distress Briefing Paper

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Context

Spiritual care is often defined as seeking to help people (re) discover hope, resilience and inner strength in times of illness, injury, transition and loss. Yet although spiritual care is a quality marker for UASC the current literature suggests that spiritual health is often addressed only as part of in-patient care and yet rarely met in primary care health settings. There is therefore a substantial concern within the literature about unrecognised and inadequate treatment that addresses the spiritual concerns for many patients which would include the UASC population. The need for NHS trusts and those commissioned by the NHS to provide appropriate spiritual care both within a multi-faith framework and beyond into a secular adaptation is fundamental to the care the NHS provides.

Added to this, contextually there has been a fundamental shift in the health care economy where integration in the delivery of care is high on the agenda. This is driven by quality measures around clinical excellence demanding identification as well as equitability and competency led levels of interventions for all patients. Integration demands that the whole person is supported and the body, mind and soul requirements of a patient sustained. The NHS Chaplaincy Guidance from the department of health (2003) state that access and spiritual care support should be equal, just, humane and respectful. This links to the Human Rights Act (2000) which gives right for the individual to religious observance.

The UASC project has recognised through its aspirations that the emotional health and well-being of patients is integral to the care that UASC receive. The literature and evidence shows that spiritual care is a key component in the delivery of emotional health and well-being for all patients which include this cohort. To address concerns and to enable an integrated approach to function across all agencies for all UASC, an EH&WB Network is being developed that has a mandate to deliver the aspirations from which a work plan has been devised and agreed.

The constraints of the current working model are equitability and capacity. UASC's ability to access spiritual support is ad-hoc and the formulation of interventions has no clinical governance from which quality and safety can be measured. There is no nationally recognised or validated generic screening tool from which the identification of need can be made.

Currently no formal screening is taking place and a UASC is reliant on a clinician to identify any spiritual distress they may be experiencing

This briefing sets out to develop a potential validated screening tool for UASC within primary care, to marry this into competency measurers that support clinicians to deliver spiritual care for UASC.

Dr Ana Draper, UASC project



Framework

The NHS Chaplaincy Guidance from the department of health (2003) should work within a suggested framework from which the following best practice issues should be considered.

- The chaplaincy service is headed by a designated member of the chaplaincy–spiritual care team.
- Chaplaincy provision is made available across the organisation out of normal hours and staffing levels take account of this.
- In order to respond in the most appropriate way to the distinctive religious needs of patients and staff, each member of the chaplaincy-spiritual care team retains the religious responsibility for his/her own faith community.
- Adequate arrangements are made for the spiritual, religious, sacramental, ritual, and cultural requirements appropriate to the needs, background and tradition of all patients and staff, including those of no specified faith.
- Suitable and authorised persons are appointed to chaplaincy-spiritual care posts in partnership with representatives of the appropriate faith community.
- All appointments are made in partnership with the appropriate faith community/ies (some open posts involve more than one community).
- Standard human resource procedures are followed, with the involvement of the panel of assessors as necessary.
- Clear lines of management/accountability are established to enable a consistent standard and quality of service for all patients and staff.
- Sufficient staff are available for the size and scope of the Trust's overall responsibility for all patients and staff.
- Appropriate and timely access to services from smaller faith communities is provided (as well as minorities within faith groups). It is important to know the faith needs of the patient and staff population.
- Resources and opportunities for training and professional development are provided.

To enable this framework to start to be delivered for UASCs there is a need to consider how staff can integrate the identification of spiritual distress into the current Initial Health Assessment, which links into a competency framework from which they have a pathway of resources that supports the delivery of spiritual care.



Screening Tool

Current tool availability

The current literature focuses on assessment tools for clinicians who are competent at a higher level to undertake care formulation of spiritual dilemmas. The search of the literature has shown that there is no validated screening tool that would identify spiritual distress in UASC and therefore to support staff to identify this aspect of UASC care. There is therefore a need to consider the development of a tool that would support identification.

Tool Development

It is our belief that without a screening process there is a lack of ability to fully integrated spiritual care into the integrated delivery model. When physical health concerns are a primary focus, without prompts or operational frameworks the emotional and spiritual are often disregarded. There is therefore a need to develop a tool that is part of a wider operational framework from which these aspects of holistic care can be identified and needs met.

The use of tools is well documented and there are often barriers to their generic use in primary care settings. The most effective tools are embedded in a relevant health assessment and are quick and simple to use.

Suggest development process

Dr Ana Draper and Jason Dermant have been reviewing the evidence in respect of signs and symptoms of spiritual distress and looked at well used validated tools that work well as triggers in identifying clinical need. They have formulated a potential screening tool that is based on identification via a cluster of questions from which the clinician can recognise if there is likelihood of spiritual distress.

The questions are:

- a) Do you have hope?
- b) Do you have practices that support your well-being?
- c) Are you attached to a community that supports your well-being?
- d) Are you happy with how you live your life?
- e) Are you at peace?

If a patient answers no to three or more of the five questions then a referral should be made for Spiritual support.

A pilot in the use of this screening tool is required and an evidence base linked to the pilot would need to be formulated to enable validation to take place.



Way's forward

The EH&WB UASC Network need to add spiritual care to the development work that is required in integrating health and well-being models into the wider health and care systems supporting this cohort. To enable this to happen there is a need to:

1. Develop a sub-group to take this work stream forward.
2. Pilot and evidence the use of screening to identify spiritual distress.

