

A QUESTION OF FAITH - THE RELEVANCE OF FAITH AND SPIRITUALITY IN HEALTH CARE



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Foreword

This report charts new territory for the HSE and gives visibility to issues which have not been to the fore in health service practice, planning and policy. Faith, spirituality and religion are not issues which are openly discussed or considered to any great extent by health planners and providers and yet this research shows that all of these issues are very relevant in particular health settings for a great number of patients.

This project was enabled through the support of the Donegal Peace and Reconciliation Partnership and the PEACE III programme. This funding programme was a catalyst for the project team to focus on the faith, spiritual and culture needs of all patients and service users in two healthcare settings in Co. Donegal. In a time of scarce resources, it provided the team with an opportunity to undertake an important piece of research, the findings of which have significant value for local practice and national policy. They will also contribute to an important body of work on religious and cultural diversity and tolerance in a post-conflict society.

The report documents the relevance and role of faith and spirituality within two healthcare settings in HSE West. It specifically explores how faith and spirituality needs are currently catered for within a healthcare context in two sites - Donegal Hospice and Letterkenny General Hospital. It explores a range of understandings of religious, spiritual and cultural diversity within a healthcare context. It examines how diverse and complex needs are understood and what supports may enable greater inclusive practice on faith, and spirituality for all communities.

The report draws on key evidence in Irish and international research which documents the relevance of faith and spirituality in healthcare and how these issues are managed in other jurisdictions.

The findings highlight the importance of these issues for patients, service users and staff across a multiplicity of settings. They indicate that there is an absence of a cohesive, unitary approach in addressing these issues and that training and further supports are necessary in addressing some existing gaps. They also indicate that while faith and spirituality are not explicitly addressed as part of a care-givers practice, there is evidence of great sensitivity and a tacit understanding of the importance of this issue for patients in particular settings.

I am grateful to the research team from the Departments of Nursing & Health Studies and Education at St. Angela's College, Sligo for their commitment and professionalism in undertaking this work. I am also grateful to the project steering committee who oversaw this work from the outset. Particular thanks must be extended to all patients, service users, families, advocates and staff who generously gave of their time and their stories.

I look forward to supporting a visible and effective response to the recommendations in the coming months and years at both local and national level.

Dr. Anne Flood

Project Chairperson

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Glossary of Terms

Caregiver	Members of the health care team who deliver direct or indirect care to patients and their families.
Chaplain	A person from a particular faith community with special training to meet the religious needs of persons. A chaplain in health care maybe ordained or non-ordained.
Chaplaincy team	A team of ordained and non-ordained Chaplains, employed by a health service provider to meet the spiritual and religious needs of persons in the health care setting.
Culture	The set of shared attitudes, values, goals, and practices that characterises an institution, organisation or group.
Faith	Faith is the confident belief or trust in the truth or trustworthiness of a person, concept or thing.
Faith affiliation	Belonging to or associated with a particular faith.
Faith community	A group of people who share a sense of belonging to a particular religious tradition.
Holistic Care	Holistic care focuses on the whole person and recognises a unity of body, mind, emotion, spirit and environment.
Religious faith	Belief and trust in a transcendent higher power which provides a framework in which life is experienced, understood and lived. Such a faith exists at both an individual and communal level and is shaped by and contributes to a historical tradition(s).
Resident chaplain	A chaplain from one of the established Christian communities in Ireland employed by the Health Service Provider.
Spirituality	Awareness of and response to transcendence within and beyond physical reality which influences how life is experienced, understood, and lived.
Spiritual Assessment	A formal way of identifying spiritual needs or the potential spiritual needs in health care.
Spiritual Needs	Issues arising out of situations which make one question one's personal meaning of life.



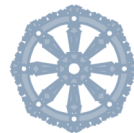
Executive summary

BACKGROUND

The vision for the Donegal Peace Partnership as stated in the Donegal County Development Board Peace III plan is *'Donegal, a county where there is no sectarianism or racism and where all feel equally valued and confident that they belong'*. This PEACE 111 funded project aimed to explore the relevance and role of faith, spirituality and culture within two healthcare settings in the Health Service Executive West, in order to develop greater tolerance and understanding of religious, spiritual and cultural diversity, and increase the capacity of healthcare organisations to respond to the faith, spiritual and cultural needs of patients. It specifically sought to explore how faith, spirituality and cultural needs are currently catered for within a healthcare context across two sites - Donegal Hospice and Letterkenny General Hospital (LGH). The central drivers for this project were the need to ensure equality, promote increased tolerance and understanding in addition to facilitating a greater accommodation of difference. The requirements of the project were underpinned by a number of key publications, namely the HSE National Intercultural Health Strategy 2007-2012 (2008); Health Service Intercultural Guide (HSE, 2009); Planning for Diversity: the National Action Plan against Racism (Dept. of Justice, Equality and Law reform, 2005); Equal Status Acts 2000/2008 and Donegal's Donegal Peace and Reconciliation Plan 2008-2010 (Donegal County Development Board, 2008). The project was also in line with strategic goals 4 and 5 of The Equality Authority Strategic Plan, 2009-2011.

PROJECT AIMS

1. Identify models of good practice in other jurisdictions regarding faith, spirituality, culture and healthcare.
2. Undertake research into how faith, spiritual and cultural needs are currently catered for within a healthcare context in two sites - Donegal Hospice and Letterkenny General Hospital.
3. Facilitate a discussion across churches and religious organisations regarding best practice in meeting faith and cultural needs in a healthcare setting.
4. Identify and implement practical actions aimed at increasing greater tolerance and understanding of religious diversity, faith, spirituality, culture and healthcare.



METHODOLOGY

A comprehensive, systematic review of the literature was conducted. The researchers searched a wide variety of electronic databases; identified relevant grey literature; undertook hand searches of various paper based publications; consulted pertinent websites and personnel in the area. The empirical aspect of the project which addressed aims 2 and 3 of the project was achieved through the employment of an exploratory descriptive design. A combination of data collection tools were utilised to ensure that a comprehensive appreciation of the subject matter was yielded and that all stakeholders had an opportunity to contribute in a manner conducive to them. Two hundred and eighty three persons, comprising of 169 caregivers (registered and non-registered health care professionals); 78 patients; 18 administrative personnel and 18 faith leaders contributed to this phase of the project. A multi-pronged data generation strategy was employed, utilising structured and unstructured modes of data collection. Data analysis was conducted in accordance with the type of data generated. The findings from both the literature review and the empirical phase were considered in unison to form the basis of the emerging recommendations.

KEY FINDINGS

The literature review demonstrated that there is a lack of consensus on the relationship between spirituality, faith and religion in healthcare. While there is an argument that the three are distinct there is a growing awareness that all these aspects need to be addressed within the health care setting as society becomes more diverse. The need to provide spiritual care that is cultural and religiously sensitive is recognised within the holistic, patient-centred approach to care. Evidence suggests that, while chaplains or spiritual leaders may have primary responsibility for faith/spiritual care within the multi-disciplinary team, all staff responsible for providing care have a role in responding to faith/spiritual needs. This requires a certain levels of competencies and skills in providing this care, most importantly the ability to recognise spiritual needs and communicating with patients on these issues. Education and training are seen as essential in ensuring that staff are aware and able to respond to cultural, faith and spiritual needs. Internationally, there have been a number of models put forward to identify, assess and respond to these needs more effectively. The UK and the Irish model of health care chaplaincy differ radically particularly in terms of management, structure and philosophy. Health care chaplaincy in Ireland is still principally framed within the Roman Catholic Church tradition and there are no common standards of health care chaplaincy across the main Christian churches in Ireland. In addition, individual healthcare institutions appear to develop their own chaplaincy policy. The UK system appears to possess a more multi-faith perspective. The most striking aspect of the provision of chaplaincy services and spiritual healthcare in the UK is that it is considered to be an essential and holistic dimension of the healthcare for which the National Health Service sees itself as responsible and accountable.

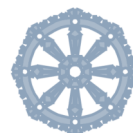


It was evident that the majority of caregivers recognised that they had a role in attending to patients' faith, cultural and spirituality needs. Caregivers and patients appeared to be comfortable with what was their or a patient's faith tradition and could deliver or receive care to varying degrees within the boundaries of the predominant Christian faith traditions encountered on a daily basis in the healthcare institutions. However, it was clearly evident that there was no common conceptualisation of spirituality in the healthcare institutions or among caregivers. Caregivers had difficulty at either the comprehension or articulation level when spirituality was being explored. Care givers and patients identified easier with some of the dimensions alluded to in the literature, than the concept of spirituality, as a distinct entity in itself. The ability or desire to separate religion from spirituality was clearly problematic for patients and some caregivers. Patients had an inherent difficulty conceptualising the concept of spirituality as distinct from their faith allegiances. Caregivers who had not a clear conceptualisation of spiritual needs/care framed the meeting of patients' spiritual needs within the boundaries of their faith tradition.

The perceived scope of chaplaincy referral was narrow in both content (which focused primarily on the sacramental dimension of their role), and in the breath of patients referred to them. Presumptions on the part of caregivers in relation to the different cohorts of patients and their need for chaplaincy care to meet their faith and spirituality needs meant that it was the very ill or the dying who that the chaplaincy team interacted with most frequently.

A number of barriers were perceived and existed which marginalised the quality and nature of faith/spiritual care delivery. They can be categorised them into individual, professional and organisational factors. The research unearthed exemplars of all three. The principal individual factor that emerged was participants' perceived restricted knowledge in relation to some faith/ spiritual issues. Participants own professional bodies (Nursing; Medicine; Physiotherapy) marginalised the value of such care by not providing or limiting such education within their under-graduate/post graduate curricula. Various organisational factors emerged such as perceived lack of time; inadequate staffing; lack of privacy/space; and the perceived domination of the medical model as the primary mode of patient assessment in the hospital.

Evidence suggests that, while chaplains or spiritual leaders may have primary responsibility for spiritual care within the healthcare setting all staff responsible for providing care have a role in responding to patients' faith, cultural and spiritual needs. This requires a certain level of competency and skills and most importantly the ability to recognise such needs and communicate with patients on issues related to identified needs. A clear



deficit in knowledge and perceived skill was identified by all cohorts of caregivers. The instigation of further education and training will be essential in ensuring that caregivers in these organisations are aware and able to respond to faith, cultural and spiritual needs.

A significant number of chaplains and faith leaders cater for the faith, cultural and spiritual needs of patients in both institutions through recognised sacramental duties; instrumental and emotional support and spending time with patient and their families. While the role of chaplains/faith leaders is recognised and respected by caregivers they are not perceived as a member of the multi-disciplinary team in that they do not attend MDT rounds/meetings. The increasing diversity of faiths and resulting need to deliver culturally sensitive care will require dialogue and ecumenical generosity.

RECOMMENDATIONS

The following recommendations were developed from the review of literature and the research conducted. There are a series of recommendations for the Health Service Executive which have a policy and/or process remit; a number of local recommendations that will require direction from the H.S.E. and finally a number site specific recommendations.

Recommendation	Area of Responsibility
Consider the development of faith/cultural and spiritual care strategy. This should contain a vision; core values; make reference to relevant policy/legislation; implementation priorities and time lines.	H.S.E. in conjunction with faith/spiritual leaders; Service user groups/patient forums
Construct a vision for the future of faith/cultural/spiritual care at local level that includes all of the care settings for all populations that the H.S.E caters for.	H.S.E.
Make explicit the role, expectations and outcomes of chaplaincy provision from the perspective of ordained and non-ordained healthcare chaplains.	H.S.E. in conjunction with faith/spiritual leaders
Consider conducting a review of the current model of healthcare chaplaincy in the context of the proposed model of healthcare delivery.	H.S.E.
Consider the development of guidelines on the identification and evaluation of visiting faith/community leaders (non-chaplaincy team members) to healthcare settings.	H.S.E.
Consider the development of a quality standard for meeting faith/cultural and spiritual needs in the organisations	H.S.E.- Office of Nursing & Midwifery Services Director (ONSD)



Agree an effective framework for assessing, planning, implementing and evaluating patients' faith/cultural and spiritual needs.	H.S.E.- Office of Nursing & Midwifery Services Director (ONSD)
Consider the introduction of a spiritual screening tool that is appropriate for all patients, irrespective of their faith affiliation.	H.S.E.
Agree a process for chaplaincy referral and a mechanism for documenting the outcome of referral.	H.S.E. and at local level
Consider mechanisms for raising the profile of healthcare chaplaincy as a distinct discipline and an integral member of the multidisciplinary team delivering holistic care.	H.S.E. and at local level
Provide training /education on faith/cultural/spiritual care at different levels for different cohorts of staff.	H.S.E and at local level
Consider the current practice of recording and distributing patient information in relation to faith affiliation.	H.S.E. with implementation at local level
Consider a process to develop a "reflective space" for persons aligned to the non-dominant faith traditions or for persons of no faith tradition in sites where such provision is absent.	Local level
Consider the introduction of a mentor system for junior staff in order for them to acquire the skills required to deliver faith/spiritual care	Local Level
Provide on-going unit based staff development in relation to faith/cultural/spiritual care	Local level
Consider multi-media strategies for informing other disciplines (health care/non health care) and patients/families about the multi-dimensional nature, vision, and services of the chaplaincy team.	Project Site specific
Standardise the implementation of a process for documenting faith/cultural/spiritual care identification, delivery and evaluation	Project Site specific
Harness the expert knowledge of the current visiting faith/ community leaders outside of the chaplaincy team to advice on meeting specific faith/cultural/spirituality needs and in the education of staff.	Project Site specific
Develop mechanisms to raise the profile of existing staff support services (e.g. Critical incident debriefing to assist caregivers deal with patient's faith/spiritual distress).	Project Site specific
Consider the development of an information booklet on the provision of faith/cultural and spiritual care resources.	Project Site specific

Chapter 1 - Background, Project Context and Structure of Report

INTRODUCTION

In 2010 the Health Service Executive commissioned an independent team of researchers from St. Angela's College, Sligo to carry out a project that sought to explore how faith, spirituality and cultural needs are currently catered for within a healthcare context across two sites - Donegal Hospice and Letterkenny General Hospital (LGH) and to identify models of good practice in other jurisdictions regarding faith, spirituality, culture and healthcare. Data collection, analysis, and drafting of the final report took place between June 2010 and March 2011. Mixed methods of data collection were employed concurrently, which included surveys to two distinct cohorts of caregivers and administrative personnel; various types of interviews and guided discussions with patients; caregivers (registered and non- registered health care professionals) and recognised chaplains and faith leaders. In this chapter an outline of the background of the project, project context and the structure of the report are provided.

Background

This project was undertaken in Co. Donegal in two principle health care settings. It is pertinent to give some historical perspectives to enlighten the reader prior to detailing the project. The first Irish health services date to the 18th century when hospitals were established by doctors, concerned citizens and philanthropists and funded through public subscriptions, donations and legacies for the poor and infirm (Scanlon, 1991) Catholic religious orders provided a range of hospitals and other services to help the sick and the poor in the 19th century. In County Donegal, health care provision was provided in the town of Lifford in the "Lifford County Infirmary" and was administered by a Board of Governors. In 1932, a County Hospital was opened on the current site of Letterkenny General Hospital and served as a hospital until 1960's when the current Letterkenny General Hospital was opened. Letterkenny General Hospital was governed by a Board of Governors until the implementation of the 1947 Health Act (Department of Health, 1947) when it was managed by the North Western Health Board (Department of Health and Children, 2001). Since 2005 health service provision in Co. Donegal is managed nationally through the Health Service Executive. Health policy is guided by the Department of Health and Children.

Co. Donegal has over the centuries experienced conflict both from internal and external sources. Additionally the famine (1842-1845) reduced the population further through emigration or death. These factors have all impacted on the people of Donegal and resulted in loss of life and property or developing resilience and strength to deal with issues encountered. Geographically, the country is surrounded by the Atlantic Ocean to the West and to the East by the counties of Northern Ireland. The influence of the Atlantic on the weather in Donegal and the



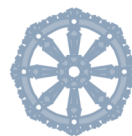
mountainous terrain mean that provision of gainful employment was a challenge. Hence, people have through the centuries emigrated to find work.

While over the centuries people have emigrated, it is true also that people immigrated and settled into Donegal mostly from the U.K. These individuals would have brought with them their own cultural and religious diversity. The dominant religion in Donegal is Roman Catholic. However, there has always been other religions present. Some of these religions were organised in parishes which crossed the county boundaries into the North of Ireland and may have made it easier for these people to feel part of their own religious community. Immigration to Donegal in more recent years has resulted in more cultural diversity with people immigrating especially from Poland, Romania, Latvia, and various African nations. The only Hindu temple in Ireland is situated in Letterkenny. To what extent immigrants have been able to integrate into the culture is not known. However there is some indication that there are challenges (DCDB, 2008).

PROJECT CONTEXT

Ireland witnessed a paradigm shift in relation to multi-culturalism and accompanying multi-faith practices in the past decade. Primarily, this paradigm shift was a result of greater freedom of movement for E.U. citizens and the favourable economic climate and associated work/habitual opportunities that attracted a significant number of immigrants to the country. This change in population profile was mirrored across each county; albeit to different extents. The 2006 Census identified that Donegal was less ethnically diverse when compared to the general national figures but a higher proportion were another stated religion (Catholic being the stated religion) when compared to the general population (10.5% compared to 7.1%) and a smaller proportion stated “no religion” (2.4% compared to 4.4%)(Central Statistics Office, 2008). One could surmise therefore that there may be a greater degree of religious diversity in Donegal when compared to rest of the country.

The relevance and role of spirituality, religion, and culture in health care has gained prominence over the last number of years. Today, spiritual and faith/religious care is recognised as an integral component of holistic patient care. Indeed, there is a growing body of evidence emerging that is demonstrating the positive role faith/spirituality can have on health outcomes. There is also a growing recognition that there is heterogeneity within all faiths, and that is incumbent on care givers not to assume homogeneity among their patients in relation how they wish their faith/spiritual needs to be addressed based on the traditional conceptualisation of their faith tradition. Spirituality as a concept is becoming increasingly relevant for people - those affiliated to faith traditions and those with no recognised faith tradition. Indeed there is consensus in the literature (Noble and Jones, 2010) that religion and spirituality are not synonymous - some would view spirituality as a core component of the more broadband concept



of religion while others consider that they fit together under the umbrella concept of spirituality. Regardless, of how one views' spirituality as a concept, caregivers must recognise their patients as spiritual beings and attend to their spiritual needs. Despite the acknowledgement that cultural, spiritual, and faith/religious needs are important in health care provision, it is not known what education or knowledge caregivers have to engage with patients to identify needs, or what provision is made by health care providers to assist their staff in gaining this knowledge/competence.

In order to ensure that care is being provided in a manner respectful and accommodating to the diversity of patients' cultural, spiritual, and religious needs it is timely to explore current provision and draw on exemplars of good practice in the literature to support patient care.

STRUCTURE OF THE REPORT

- Chapter 2:** outlines a comprehensive review of literature.
- Chapter 3:** summarises the methodological approach to the empirical phase of the project and the practicality of data collection and analysis.
- Chapter 4:** provides the main findings from the quantitative phase of data collection: surveys of caregivers and admission clerks and interviews with patients.
- Chapter 5:** provides the main findings from the qualitative phase of data collection; interviews with caregivers.
- Chapter 6:** provides the main findings from interviews and guided discussions with the healthcare chaplaincy team members and other non-Christian faith leaders who tend to patients' faith, cultural and spiritual needs in the healthcare institutions.
- Chapter 7:** presents a discussion on the triangulation of the emergent findings and recommendations for practice and policy.



Chapter 2 - Literature review

INTRODUCTION

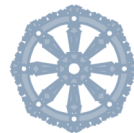
The purpose of this chapter is to review all relevant national and international literature on the importance and role of faith, religion, spirituality and culture within the healthcare setting. This will involve defining spirituality, religion and culture in terms of health care and giving an overview of spiritual care and chaplaincy services in Ireland. A discussion of the benefits of spiritual care in a health care setting and the role of healthcare practitioners is also outlined. Next, there is an outline of patients and practitioners perceived barriers to providing this care. Finally, there is an overview of national and international practice in relation to the delivery of spiritual, religious and culturally sensitive care.

Background

DEFINING SPIRITUALITY, RELIGION AND CULTURE IN RELATION TO HEALTH CARE

There is a wealth of literature discussing the difficulty in defining spirituality, religion and culture. Some would argue that spiritual, religious and cultural beliefs are distinct (Gordon and Mitchell, 2004; Timmins and Kelly, 2008; McSherry and Ross, 2002; Maire Cure Cancer Care, 2003; Koenig et al. 2003) whereas others would view them as intersecting concepts or belief systems (Mazzula et al. 2009; Reimer-Kirham, 2009; Reimer Kirham et al. 2004; Benson and Roehlkepartain, 2008). In terms of the distinctions, in particular between religion and spirituality, many see spirituality as an individual's understanding of the meaning and purpose of life (Koenig et al. 2003). According to Gordon and Mitchell (2004, p.646) "Everyone has a spirituality - it is seen in the uniqueness of values, beliefs, attitudes, relationships and practices; and involves purpose, meaning and hope in life". Religion is seen as the organised community based on a similar beliefs, practices and symbols (Koenig et al. 2003). Gordon and Mitchell (2004) believe spirituality can be distinct from religion but religion should always be spiritual, this is particularly true when speaking about spiritual and religious care. Culture is a broader term that might encompass both religious and spiritual beliefs (Reimer Kirkham et al. 2004). According to Allen (2009, p.315) culture is defined as "attitudes, values, beliefs and life practices learned and shared by people of a particular social group which are passed down generations affecting individuals thinking and actions". The purpose of this review is to explore how spirituality, religion and culture are recognised and responded to within a health care setting both nationally and internationally.

The relevance and role of spirituality, religion and culture in health care has gained prominence over the last number of years. According to Curlin et al. (2005) interest in religion, spirituality and culture stems from the movement towards a more humanistic approach to medicine from the traditional biological/medical framework.



This approach focuses on cultural competence, patient-centred, narrative and holistic medicine. Therefore spiritual and religious care is an increasing part of holistic care plan for patients, particularly in palliative care and intensive care (Timmins and Kelly, 2008). Once again, Gordon and Mitchell (2004) make the distinction between religious and spiritual care. Religious care is provided in the context of shared religious beliefs and the “lifestyle of a faith community” while spiritual care is provided on a one-to-one personal basis (Gordon and Mitchell, 2004, p.646). Greater diversity in terms of ethnicity, nationality and religion has meant that care should be provided in a manner respectful and accommodating to diversity of patients’ cultural, spiritual and religious needs (Black, 2009). This review will explore international best practice on assessment of spiritual, cultural and religious needs in a health care setting, who should provide this, how it should be provided and what competencies are necessary to provide this care.

ETHNIC, RELIGIOUS AND CULTURAL DIVERSITY IN DONEGAL

The focus of this project is on how faith, spirituality, and cultural needs are currently catered for within a healthcare context in two sites: Donegal Hospice and Letterkenny General Hospital. It is therefore important to give an overview of the ethnic, religious and cultural diversity in county Donegal using the Census Small Area Population Statistics (Central Statistics Office, 2006). Between 2002 and 2006, the number of non-Irish nationals in Donegal rose from 6.7% to 8%. In 2006, 92.3% of people in Donegal identified as White Irish, with a further .3% (or 363 people) identified as White Irish Traveller, this is compared to 87.4% and 0.5% of the general population. Therefore, in 2006, Donegal was less ethnically diverse when compared to the general national figures. However, a higher proportion were another stated religion (Catholic being the stated religion) when compared to the general population (10.5% compared to 7.1%) and a smaller proportion stated “no religion” (2.4% compared to 4.4%). Therefore there may be a greater degree of religious diversity in Donegal when compared to rest of the country. It also shows that ethnic and racial diversity has increased over the last number of years.

Role and Relevance of Spirituality, Religion and Culture in Health Care

BENEFITS OF SPIRITUAL, RELIGIOUS AND CROSS CULTURAL CARE

Many studies have explored the relationship between spiritual care and religious care and its relationship with health and health outcomes (Cotton et al. 2005; Mok et al. 2009; Diddle and Denham, 2010; Lanzetta, 2010; Curlin et al. 2005; Koenig et al. 2004; Anandarajah and Hight, 2001). In Curlin et al. (2005) study they found that physicians’ who emphasised religion helped patients to understand and cope with their illness, and the

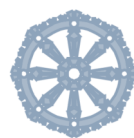


social support that stemmed from their religious community has many positive effects on the patient. However, in some cases the beliefs of the religious community sometimes conflicted with medical recommendations (Curlin et al. 2005, p.763). More specifically some studies have demonstrated that religious affiliation/spirituality may have positive health benefits such as reducing the risk of mortality (Schnall et al. 2010). Others have found that religious and spiritual beliefs can have a positive effect on health behaviours such as substance abuse and sexual activity among adolescents (Cotton et al. 2006). This study also found that it was associated with better mental health, and to some degree physical health.

According to Diddle and Denham (2010) the link between spirituality and health is weak due to the lack of empirical evidence and any studies are dated without any practical application to practice. Anandarajah and Hight (2001) state that it will take much more complex studies to understand exactly the aspects of spirituality and spiritual care that interact with health and well-being. In most cases spirituality and faith have been seen as positive in terms of a coping mechanism for patients (Curlin et al. 2005; Lanzetta, 2010; Yardely et al. 2009; Strang and Strang, 2001; Government of the UK, 2009; NHS Scotland, 2002). According to Lanzetta (2010) the holistic integrated model of medicine that addresses mind, body and spirit has a more positive impact on patient well-being than traditional models. Indeed there has been growing recognition and evidence that providing spiritually holistic care is key to quality care (Mauk and Schmidt, 2004; Curlin et al. 2005). The World Health Organisation's (1998) definition of holistic care also recognises the increasing importance of spiritual aspects of care as well as physical, emotional, social and mental care. However there is no consensus on who should provide this care and how it should be provided (Sinclair et al. 2006; Timmins and Kelly, 2008).

ROLE OF PRACTITIONERS IN PROVIDING THIS CARE

Internationally, there has been growing recognition of the role of nurses and other health care professionals providing spiritual and cultural competent care (Allen, 2009; Reimer-Kirham, 2009; Henery, 2003; van Loon, 2005). Reimer-Kirkham et al. (2004 p.148) state that there is a 'need for health care professionals to cultivate an internal space in which to provide spiritual care and to seek spiritual points of connection amidst diverse faith and cultural traditions'. This has implications for caring competencies, education and training for health care professionals. Some argue that all healthcare practitioners should have a role in providing spiritual care, in particular nurses (McSherry and Ross, 2002). The importance of a spiritual care practitioner leading within the multi-disciplinary team on more complicated matters of spiritual care has also been highlighted (Government of the UK, 2009; NHS Scotland, 2002; Gordon and Mitchell, 2004; Lawrence et al. 2008). Under the NHS guidelines in Scotland (2002 p.4), they identify the need for the "distinctive contribution of caregivers who are trained in spiritual and religious care and have time to give it'. They advocate the need for a spiritual care



manager at each site and the appointment of a number of spiritual caregivers. Similarly, Burkhart et al. (2008) found the need for spiritual leadership within a healthcare setting as staff and middle management often do not have the support to provide spiritual care. Education and spiritual development for frontline staff is essential (Burkhart et al. 2008; Yardely et al. 2009). The Marie Curie Cancer Care (2003) model assumes that all those involved in the care of patients have some role in providing spiritual care.

According to Anandarajah and Hight (2001) medical practitioners must not only recognise and assess patients' spiritual needs they must also provide therapeutic interventions. This includes consideration of patients' spirituality when making medication recommendations and that elements of general spiritual care should be incorporated into "routine medical encounters" (Anandarajah and Hight, 2001, p.84). They also stress the importance of the patient/practitioner relationship. Van Loon (2005, p.267) also makes this point with reference to nursing 'care of the human spirit is more about how we interact and use ourselves in the nurse/patient relationship, which it is about specific nursing actions or words'. It therefore may be important for the medical practitioner to recognise their own beliefs and values as it may help them to identify others beliefs (van Loon, 2005). This is what Anandarajah and Hight (2001, p.84) call "spiritual self-understanding and self-care". They argue that it is important for practitioners to understand their own spiritual beliefs and bias in order to provide patient-centred care. Being non-judgemental has been seen as a vital to delivering spiritual care (Anandarajah and Hight, 2001; Yardley et al. 2009).

BARRIER TO PROVIDING SPIRITUAL, RELIGIOUS AND CULTURAL CARE IN A MULTI-CULTURAL/MULTI-FAITH SOCIETY

A number of barriers could present themselves when trying to provide spiritual and religious care that recognises diversity and cultural difference. This may include lack of understanding and knowledge of religious and cultural backgrounds (Curlin et al. 2005; Allen, 2010; Fawcett and Noble, 2004), conflict between practitioners beliefs and that of the patients' (van Loon, 2005), conflict between medical recommendations and religious/cultural beliefs (Curlin et al. 2005) and a lack of resources and supports within the health care setting to address these needs (Reimer-Kirkham et al. 2004; Carroll, 2001; McSherry, 1998). Reimer-Kirkham et al. (2004) point out that heavy workloads of nursing staff and the relative invisibility attached to spiritual care means maintaining awareness of this aspect of care is difficult within the practice environment. In terms of culture, some studies have illustrated that a lack of knowledge among health care practitioners can have a negative impact on the health and well-being of ethnic minorities (Allen, 2010; Mazzula, 2010; Reimer-Kirham, 2009). This may lead to difficulties in accessing health services which can impact negatively on health (Ransford et al. 2002). Allen (2010, p.314) states that cross-cultural education and anti-racism is necessary in promoting effective cultural



care among nurses. Key to overcoming many of these barriers is to increase awareness, education and training to improve staff competency in providing spiritual and religious care (Allen, 2010).

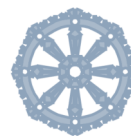
Many studies have set out to explore the cultural, religious and spiritual needs of different ethnic and religious groups (Black, 2009; Abu-Rayya et al. 2009; Mok et al. 2009; Reimer-Kirkham et al. 2004; Mazzula et al. 2010; Koffman et al. 2008). According to Black (2009, p.793) “health-care professionals need to recognise the values, beliefs and health practices of different faiths and cultures”, if this is not catered for it could cause distress in ethnic minorities. The NHS in the U.K. has developed a number of guidelines for cultural and spiritual awareness. The key areas that they focus on are diet, hygiene, modesty, family planning, childbirth, blood transfusion, dress/jewellery, organ transplantation, care of the dying/death, names, special consideration and post mortems (Government of the U.K. 2000). In this document they address the cultural and religious needs of a number of ethnic and religious groups. However, they stress that it is intended to encourage staff to consider and be aware of the needs of the individual patient. In Ireland, the Health Service Executive have also outlined the cultural and spiritual needs of 25 religious groups, 3 ethnic groups, and people without religious belief (H.S.E., 2009). The guide was developed based on the needs identified by Irish healthcare staff, needs of minority ethnic staff, profile of religious affiliations in hospitals and analysis of the census 2006. This further represents the changing nature of patient population and the need for the system to respond. It also represents a shift in health policy and a growing recognition of the diversity of patients’ needs.

ASSESSMENT AND AUDIT TOOLS

Many studies have been conducted on assessing and developing spiritual and religious assessment tools (Amanadarjah and Hight, 2001; Timmins and Kelly, 2008; Catterall et al. 1998; Hodge, 2001; Gordon and Mitchell, 2004). According to Anandarajah and Hight (2001, p.86):

“A spiritual assessment should include the following: determination of 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.”

Spiritual assessment has also been seen as a component to formulating care plans for patients (Timmins and Kelly, 2008). Following a review of spiritual assessment tools, Timmins and Kelly (2008, p.129) concluded that spiritual assessment should not be carried out by one professional but is a shared role for all health care practitioners, while informal assessments have their merits, formal ‘tick box approaches’ are more effective. They also concluded that a tool should not be time consuming, be easy to use, flexible and promote patient participation and involves family members. One such tool is the H.O.P.E. assessment, a set of questions used to



assess patients spiritual needs. It is based on 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 care (Anandarajah and Hight, 2001). Timmins and Kelly (2008) found that this tool was useful in its assessment of spiritual need. However, they concluded that none of the tools had been examined in relation to their reliability or validity. McSherry and Ross (2002) argue that the use of tools is contextualised and should be adapted to the particular beliefs of the area and their understanding of spirituality. Timmins and Kelly (2008) concluded that this was the most useful approach to spiritual assessment.

STAFF COMPETENCIES, EDUCATION AND TRAINING

One of the most well-known competency frameworks was developed by a multidisciplinary (MDT) team from five Marie Curie Hospices (Gordon and Mitchell, 2004). Marie Curie Cancer Care standards (2003) set out core competencies for spiritual care at four different levels. At the first level all staff and volunteers who have causal contact with patients should understand basic spiritual needs and distinguish them from religious needs. This requires a basic awareness and communications skills. At level 2 all staff and volunteers who have direct contact with patients and their families are expected to have increased awareness of spiritual and religious needs and how they can be responded to. At level 3 staff who are members of the multidisciplinary team are expected to assess spiritual and religious need, develop care plans and recognise complex spiritual, religious and ethical issues. Finally level 4 staff or volunteers whose primary responsibility is for the spiritual and religious care of patients are expected to manage and facilitate this care. Staff at this level are expected to provide education support and training to those operating at other levels (Marie Curie Cancer Care, 2003). They clearly outline the knowledge skills and actions required of staff in meeting patients' spiritual needs. Some actions included building relationships with patients, using active listening skills (level 1), document perceived spiritual needs (level 2), refer difficult needs to a member of the MDT (level 2), document assessments (level 3), make referrals following spiritual assessment to chaplaincy (level 3), help patients articulate their spiritual needs and identify resources to address them (level 4) and delegate tasks to other chaplaincy team members (level 4).

Gordon and Mitchell (2004), initiated a pilot study to understand staff and volunteers reflections on their own skills and competencies in relation to this framework. They found that staff saw the competencies as a means of quantifying the work they were already doing. It was not considered burdensome but non-threatening. They concluded that it was useful in affirming good practice, setting personal skills and limits and helped identify training and development needs. In conjunction with the Marie Curie Cancer Care organisation (2005), Mitchell and Gordon developed a specialist tool of assessment and self-assessment to be used as part of a Personal Performance Review and Development Process (PPRD) to help identify training and development needs. Those at



level 3 could act as reviewer for those at level 1 and 2. It was envisaged that those at level 3 and 4 could complete a self-assessment. Review at level 1 and 2 could include observation of practice and/or oral assessment. Level 3 and 4 self-assessment could include observation, written reflective accounts, MDT meetings and review.

In an alternative view of developing staff competency and improving training and development, Yardley et al. (2009) advocate the inclusion of service users in the research and service development in spiritual care. They argue that this can be useful particularly when needs are difficult to define. This study also made reference to the Marie Curie Model and found that patients' validation supports the increased use of this model (2009, p.605). However they advocate that patients are involved in discussions and practice assessments before skills are developed and incorporated into daily practice.

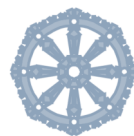
In Ireland, the National Association for Hospital Chaplains make some recommendations surrounding supervision, education and training. They recommend that chaplains take responsibility for one to one or peer supervision, participate in relevant professional courses, seek funding and study leave from their healthcare employer for these purposes and be members of professional bodies or associations (N.A.H.C., 2006). They also advocate that chaplains are involved in the education of staff through in-service and induction courses on an on-going basis.

Under a cultural competence model of health care, religion and spirituality can be an integral part of one's racial-cultural world view (Mazzula et al. 2010). Therefore in terms of health care, practitioners need to have cultural awareness, cultural knowledge, cultural sensitivity and cultural competence (Papadopoulos, 2006). Cultural competence includes assessment skills and clinical skills and challenging and addressing discrimination in nursing (Allen, 2010). Allen suggests that cross-cultural care training needs to encompass the specific cultural diversity and the social and political structures that underpin racism and discrimination.

Overall this suggest that all staff and volunteers require some level of training, education, skills and competencies when providing spiritual, religious and cross-cultural care. Studies have shown that the Marie Curie Cancer Care model is an effective framework for assessing staff competencies, and training and development needs (Gordon and Mitchell, 2004; Yardely et al. 2009).

OVERVIEW OF HOW SPIRITUAL, RELIGIOUS AND CULTURAL NEEDS ARE CURRENTLY CATERED FOR IN IRELAND

Before an outline of international best practice is presented it is important to give an overview of how spiritual/religious and cultural needs are currently catered for in Ireland. Very little research has been carried out on this topic in the Republic but there has been some studies conducted in Northern Ireland (Kernohan et al.



2007) and the UK (Black, 2009; Power, 2006; Gordon and Mitchell, 2004). In Ireland and the UK, spiritual and religious care is primarily carried out by the chaplaincy service. Chaplains are members of a clergy and usually provide spiritual, psychological and emotional support to patients to whom they are ministers (Healthcare Chaplaincy Board, 2009). In Ireland and the UK national standards have been developed to clarify the role and function of the chaplain within the multidisciplinary team (Kernohan et al. 2007). These standards include the patient's access to chaplaincy services, assessing and addressing the patient's spiritual and religious needs, the chaplain's participation in a multidisciplinary team to provide support to patients, carers and staff, chaplaincy contributions to the hospice professional educational programme, provision of adequate resources for chaplains to fulfil their role and assessing and addressing occasions for a communal recognition and reaction (Kernohan, et al. 2007). In this study of the effectiveness of these standards in Northern Ireland it was found that they were useful for assessing and addressing spiritual needs (Kernohan et al. 2007).

In the Republic of Ireland, the National Association of Hospital Chaplains have developed guidelines and clearly defined the role of Hospital Chaplains as professionals "committed to the spiritual well-being of those in their care" (National Association of Hospital Chaplains, 2006, p.1). Pastoral Care Workers, as they are sometimes known, are members of a multidisciplinary team and provide emotional and spiritual support to their patients. Pastoral care is provided in general hospitals, hospices/home care teams, hospitals for the elderly, nursing homes, orthopaedic hospitals, paediatric hospitals, intellectual disability services, mental health services, maternity hospitals, private nursing homes and rehabilitation services (N.A.H.C., 2006). The key role of the Chaplain, under these guidelines, are; accompaniment, bereavement, liturgy and ritual, pastoral support and interfaith chaplaincy. Both accompaniment and interfaith chaplaincy stress the importance of providing care and support that is respectful of the dignity, culture, beliefs, practices and spiritual needs of each person within a multi-faith society (N.A.H.C., 2006). This includes being knowledgeable of all faiths and traditions, knowing how to access a minister of other denominations or faiths and providing appropriate spiritual support in a sensitive manner. This reflects the growing need to provide spiritual care in a culturally sensitive approach in Ireland due to changing demographics and increased secularisation. The HSE (2006) developed job descriptions to support the elements of chaplaincy outlined above as well as a co-ordinator of chaplaincy services for the larger hospital groups within the Republic of Ireland.

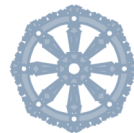
The Healthcare Chaplaincy Board sets the Standards for Certification of Catholic Healthcare Chaplains in Ireland (2008). HCB is a sub-committee of the Catholic Healthcare Commission, which is composed of representatives of the Bishops Conference and Conference of Religious in Ireland (CORI). The Church of Ireland has its own certifying body, and has standards almost identical with HCB Standards. The Methodist and Presbyterian



churches in Ireland appoints ministers to hospitals and other caring facilities to provide pastoral care to patients and staff alike. They also provide a link between the patient and their home church during their stay in hospital. The Health Research Board (HRB), the Adelaide Hospital Society (AHS), the Adelaide and Meath Hospital, incorporating the National Children's Hospital, Tallaght (AMNCH) and the Irish School of Ecumenics commissioned the Irish School of Ecumenics (ISE) to research healthcare provision and policy formation for religious minorities within the Christian culture. The study found that there was a tendency for healthcare providers and practitioners to assume a one-size-fits all approach in the accommodation of religious belief, which does not reflect diversity and cultural sensitivities within individual faith communities; that many service users and healthcare providers identified the need for adequate training for all those working in healthcare settings to ensure informed understanding of how religious belief and practices impact on areas of birth, death, diet and ritual behaviour; the majority of facilities relating to religious worship currently available through the HSE cannot be seen as shared spaces promoting inclusivity (Radford 2008, p.4,5).

Recent conference proceedings of the European Network of Health Care Chaplaincy report that the structures for chaplaincy since the launch of the Guidelines for Best Practice in Healthcare Facilities in 2006 are happening on an ad hoc basis. Hospitals are slow to take responsibility for the chaplaincy service; the role of the service is still seen as primarily a sacramental function; generally the Roman Catholic Priest is the head chaplain; other denominations visit, some as part of the chaplaincy team and others with no connection to the service. Two hospitals have full time Church of Ireland chaplains who are part of the chaplaincy team and in one of these hospitals a Methodist chaplain is also a team member (O'Connor, 2010).

Individual hospitals are responsible for creating their own policies on chaplaincy services and the provision of pastoral care. A random review of a number of hospital websites within the Republic of Ireland offer varying levels of information about chaplaincy services offered within the individual healthcare organisations. There is no evident standard with regard to the amount or type of information provided. Most of the information provided relates to the timetable for religious services (mainly Roman Catholic services), availability over the 24 hour day, ward visiting, pastoral care and support to patients and staff within the hospital. A number of sites provide more detail on the role of chaplaincy from the perspectives of pastoral and spiritual care. Other sites provide details of the team members including contact details. Two sites identify that the Hospital Chaplaincy Department operates on an inter-denominational basis and is staffed accordingly. One of these sites states that the Hospital Chapel is inter-denominational, with Muslim needs catered for within a Mosque in a nearby area on the same floor. A recent visit to a Dublin inter-denominational hospital chapel reveal how an inter-denominational space can operate from a religious service delivery perspective. It is important to state that the chapel area is a very



large room that incorporates the religious symbols of the different Christian community faith needs in one space.

The review and discussions with various parties has concluded that healthcare chaplaincy in Ireland as a service is in transition-moving incrementally from the concept of “Chaplaincy of ministry” to a new chaplaincy of professional healthcare that is integrated with the other healthcare professionals in delivering services. Currently, there is no ideal model. However, patient choice is now driving the development/delivery of chaplaincy services. There is evidence of chaplaincy becoming more open to meeting the needs of patients other than those of their own faith tradition. There is a growing recognition of the need to establish links with all faith traditions in the community. There is evidence of ad hoc integration of chaplaincy into the recognised multi-disciplinary team structure. Some chaplains record their visit with patients notes. The role of the nurse in spiritual assessment is being reflected upon with a train of thought that their role should be solely screening and that assessment should be carried out by a certified healthcare chaplain (O'Donavan, 2011).

MODELS OF GOOD PRACTICE REGARDING FAITH, SPIRITUALITY, CULTURE AND HEALTHCARE IN THE UNITED KINGDOM

This section of the literature review deals with models of good practice in spiritual healthcare with particular reference to principles, policies and practice within the United Kingdom. This choice is based on the potential of exploring the fundamental difference between the provision of chaplaincy services and spiritual healthcare within the U.K. and the Republic of Ireland. In the U.K., the ultimate responsibility for the provision of chaplaincy services and spiritual healthcare resides with the National Health Service itself whereas within the Republic of Ireland as alluded to above is provided by various Christian churches, most significantly the Roman Catholic Church, within a series of informal arrangements with individual hospitals. An exploration of the relevant responsibilities of the health providers and the various faith traditions within the two jurisdictions can provide a useful alternative perspective in identifying and implementing ‘practical actions aimed at increasing greater tolerance and understanding of religious diversity, faith, spirituality, culture and healthcare’ within the Irish context.

THE NATIONAL HEALTH SERVICE AND PROVISION OF CHAPLAINCY SERVICES AND SPIRITUAL HEALTHCARE

The most striking aspect of the provision of chaplaincy services and spiritual healthcare in the UK is that it is considered to be an essential and holistic dimension of the healthcare for which the National Health Service sees itself responsible and accountable. In its document, ‘NHS Chaplaincy; Meeting the religious and spiritual needs of patients and staff – Guidance for managers and those involved in the provision of chaplaincy-spiritual care’



(2003) the forward is written by the Chief Nursing Officer who states unequivocally, 'All services, including spiritual ones, should be delivered appropriately to service users and NHS staff. One of the key aims of this guidance is to enable chaplaincy services to meet the need of today's multi-cultural and spiritually diverse society' (p.3) In a further introduction, the Chair of the UK Multi-Faith Group for Healthcare Chaplaincy, quoting from a document produced by The Association of Hospice and Palliative Care Chaplains (2006) provides a rationale for an inclusive form of spiritual healthcare by stating his understanding of the relationship between religion and spirituality.

"It is important to be aware that all human beings are spiritual beings who have spiritual need at different times in their lives. Although spiritual care is not necessarily religious care, religious care, at its best, should always be spiritual." (p.4)

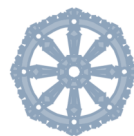
In relation to the key issue of worship and sacred spaces, the guidelines suggest that the Hospital Trust should provide accessible and suitable spaces for prayer, reflection and religious services which are open 24/7. In relation to the provision for religiously diverse needs, it states: 'Different religions have different requirements and more than one space is likely to be required with flexibility of furnishing and use of religious symbolism to allow for use by different faiths.' (p.17) (Appendix 1).

A MULTI-FAITH APPROACH TO HEALTHCARE CHAPLAINCY

The most prominent expression of multi-faith co-operation within healthcare chaplaincy in the UK is the establishment of the Multi-Faith Group for Healthcare Chaplaincy whose object is 'the advancement of multi-faith healthcare chaplaincy in England and Wales'. In pursuance of this objective the group succeeded in 2010 in drawing up Draft Standards for Spiritual Healthcare which were acceptable to all members of the multi-faith group and then distributed to all relevant stakeholders for consultation, which is still in progress. These standards are based on an underlying shared understanding of chaplaincy-spiritual care.

"There is a chaplaincy-spiritual care service that is equal, just, humane and respectful, and which meets the spiritual and religions needs of people of all faiths and people of no faith. Users of the service receive holistic spiritual care which conforms to best practice and is delivered in a seamless way across seamless boundaries." (2010 p.1)

There are 34 standards proposed which were circulated for consultation in 2010. These are grouped according to different dimensions of healthcare chaplaincy provision, service delivery and training, care environment, food and dietary requirements, management and staffing, audit and review and research governance (Appendix 2). Some of the key standards call for clear lines of accountability, chaplaincy appointments made by the Hospital



Trust in partnership with the appropriate faith communities, provision of sacred space for all faith communities and training of, and support for the whole chaplaincy-spiritual care workforce.

CHAPLAINCY TEAMS

Throughout both documents above there is continuous reference to the chaplaincy-spiritual healthcare team. It appears that good practice within the UK seems to take as a given that this dimension of the provision of healthcare will be provided by a functioning multi-faith team which is led by a chaplaincy team leader who, in turn, is accountable to a Board-level director of the Hospital Trust whose job description is the oversight of the provision of the chaplaincy-spiritual care services. In addition, The Churches Together in England through its Churches Committee for Hospital Chaplaincy has issued 'Guidance on Working in Chaplaincy Teams' (2008) which emphasises the importance of partnership between the chaplaincy team itself, the hospital as employer and the Faith Community Employers. It also proposes a 'close and formal way of working' by the chaplaincy team, including sharing in the conduct of worship where permitted and sometimes taking joint responsibility for the provision of pastoral care. While recognising that working within chaplaincy teams can be difficult due to diversity of theological and operational perspectives, they suggest that the process of working towards an agreed philosophy of spiritual healthcare would value the contribution of each member of the team (Appendix 3).

CHAPLAINCY SERVICES AND PALLIATIVE HEALTH CARE

In the UK the Association of Hospice Palliative Care Chaplains seeks to:

- work with a multidisciplinary team committed to providing holistic care
- be proactive in assessing and meeting the complex spiritual and religious needs of patients, their families and carers
- discern and respect the cultural, spiritual and religious diversity of all patients, their families and carers
- ensure that all spiritual and religious care is patient led and focussed on the needs of individuals, their families and carers. (2010 p.1)

In 2006, the Association produced its second edition of 'Standards of Hospice and Palliative Care Chaplaincy'. These highlight universal accessibility to chaplaincy services regardless of religious affiliation, the chaplain as a core member of an interdisciplinary and holistic healthcare team, the contribution of the chaplain to the Unit's education, training and research and to any events that require communal recognition and action (Appendix 4). These standards are accompanied by a Self-Assessment Tool as a practical aid to assess and audit a chaplaincy service using the Standards.

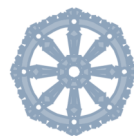


The Catholic Bishops' Conference of England and Wales commissioned 'A Practical Guide to the Spiritual Care of the Dying Person' (2010) to assist healthcare staff in the provision of spiritual care by helping them 'in identifying spiritual needs in their patients and to feel confident in their ability to provide it'. (p.5) The rationale behind this publication is that spiritual care is not the exclusive domain of chaplains and chaplaincy teams as everyone involved with the care of the dying has something to offer. It challenges the medical model of healthcare by claiming ***'if we only focus on the illness, consciously or unconsciously, then we distort, instrumentalise and thereby devalue a life'***. (p.5) While firmly rooted in the Catholic Christian tradition and theological perspective it is addressed to all involved in the end of life care in an inclusive manner which, 'tries to keep the whole person in view, in their spiritual, physical and psychological reality and it respects that there are many different ways and traditions, religious and non-religious, in which these aspects find expression in a person's life and care', (p.5,6).

The central thesis of the Guide is that, 'the key is to consider spirituality as a contributing factor to any patient's overall wellbeing' (p.11) and proceeds to suggest possible symptoms of spiritual distress under the categories of the physical, the emotional, questioning and questioning of faith (p.11,12). The next section suggests the importance of the practical forms of communication to help address the spiritual distress of patients. Most of these refer to attentive presence, listening and expressing care in small and sensitive ways. In relation to asking about the spirituality of the patient, the experience, awareness and insights of the working group which produced the Guide lead to some very specific suggestions based on our ultimate common humanity.

"Many people do not know how to start talking about spirituality or spiritual distress. This may be because they see it as synonymous with faith based beliefs or rituals and may feel unfamiliar or uncomfortable with this personally. Alternatively it may be due to hesitation to broach a personal topic, fear of being disrespectful or upsetting someone, or a lack of shared language to express spirituality. If however we see spirituality as the 'essence' of someone, their values, sense of self and self-worth, then we can begin by getting to know them as a person. Some opening questions that could help are, 'Tell me a bit about yourself.', 'How are you in yourself?', 'How has this illness affected you or your family?', 'Are there particular things that are on your mind at the moment?', 'Is there anything or anyone that you find helpful in times of trouble?', 'Is there anything that makes it more difficult to cope with (the pain, to sleep) at the moment?'" (p.15).

The Guide suggests that members of the multi-disciplinary palliative care team usually ask the patient or their family if they have a specific religious faith and then pass this information on to the chaplain. This reassures the patient and their family that their religious and spiritual needs are central to their care. In referring to the increasingly multi-faith nature of chaplaincy teams it understands chaplaincy as 'more than a last-minute



resource for religious ritual' because it can support all involved as the patient nears the end of life and the family and friends with on-going spiritual care. (pp. 19-21) Death and the process of dying require all the resources available to us including the resources of religious faith and spirituality. In asking that we, 'come to this moment without prejudice' it claims that, 'every person has a right to their faith and their community not just in the moment of death but especially in the time before it. It is the right of every person that their faith is acknowledged, provided for and treated with respect' (p.39,40).

EUROPEAN NETWORK OF HEALTH CARE CHAPLAINCY

The European Network of Health Care Chaplaincy was founded in November 2000 and consists of representatives from churches, faiths and national associations across Europe; Ireland is a member of this network.

It is rooted in Christianity, as expressed in European Cultures. Its purpose is:

- to **enable** its participants, who serve in the area of the multi-disciplinary field of healthcare
- to **share and learn** from one another
- to work for the **development** of professional guidelines required to minister to the existential and spiritual needs of patients, relatives and staff, drawing on personal, religious, cultural and community resources
- to **promote** a high quality standard of Health Care Chaplaincy in Europe

In 2002, Standards for Health Care Chaplaincy in Europe were agreed. They are viewed as a collective statement, which expresses the caring work of faith groups in the area of health care throughout Europe. They are meant to be a point of reference and a guide for all faiths and denominations in shaping spiritual care offered in the area of health care. The title of the person who offers spiritual care varies from faith to faith, denomination to denomination, tradition to tradition, nation to nation. The terms chaplain and pastoral are considered as generally accepted terms, but are not restrictive. They encapsulate 5 main areas namely the conceptualisation of healthcare chaplaincy; the organisation and development of chaplaincy services; areas of activity of chaplains; theological, pastoral, ethical matters and education; formation and supervision of healthcare chaplains. Some of the issues addressed by the network include the differing conceptualisations of spirituality; intra-church tensions; the secularisation of health care and palliative care. The newly appointed coordinator of the network (Dr. Anne Vandenhoeck) quoted from unpublished work of Robert Mundle, a chaplain in the Toronto Rehabilitation Institute in January 2011 to encapsulate how health care chaplaincy must move forward:

"... chaplains can contribute much more ambitiously to healthcare teams. To do so they must embrace the ambiguity of their split professional identities and the essential insecurity that characterizes the history of pastoral care. They also require more transparency, accountability,

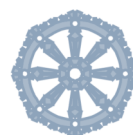


and a much bolder affirmative vision for the future of pastoral care....

.... I think there are at least three steps to a bolder vision for the future of pastoral care. The first step is to expand the ethnography of hospital chaplaincy. At its heart pastoral care is a reflective practice and I think chaplains can investigate further and describe in more detail what it is like. The second step is to raise the profile of hospital chaplains in the medical literature so that chaplaincy is no longer seen as an absent profession. And the third step is to think more ambitiously, and dare I say even prophetically, of chaplaincy as social action that contributes to the broader paradigms of political and public theologies.”

A review of the literature on chaplaincy and spiritual healthcare suggests a consensus regarding good policy and practice in chaplaincy services and spiritual care particularly in relation to faith and cultural accommodation within an inclusive healthcare context.

- Chaplaincy and spiritual care are best provided within a conceptual framework which considers them to be an essential and integral dimension of holistic healthcare.
- Responsibility for healthcare within hospitals and other institutions caring for the sick and dying should include management responsibility for the provision of chaplaincy services and spiritual care.
- Spiritual care should be accessible by all patients and staff because of the spiritual dimension of all humans whether they adhere to a religious faith or not.
- Chaplaincy services should acknowledge, respect and provide for the religious needs of patients and staff from all religious traditions.
- Chaplaincy and spiritual care is provided most effectively and most inclusively by a highly functioning chaplaincy team which shares the ministry of chaplaincy within the hospital/care institution and represents the various faith and spiritual faith traditions within the local community.
- A hospital chaplaincy team should have a team leader who is responsible for the functioning of the team and accountable to the hospital management for the quality of the service and the professional training, development and support of team members.
- Volunteers within the chaplaincy services should be given letters of appointment and job descriptions and trained by the chaplaincy team.
- Sacred space or spaces should be provided within the hospital or care institution which is appropriate and adaptable for worship, prayer and reflection by patients and staff of all religious traditions and non-religious traditions.
- The sacred space or spaces within the hospital or care institution should be planned in dialogue between the



hospital authorities, the chaplaincy team members and the relevant authorities within the local faith traditions.

- All patients and staff should be fully informed and kept up to date on the provision of chaplaincy services and spiritual care provided by the hospital/care institution through the chaplaincy team and other forms of care.
- The development of chaplaincy services and spiritual care should respond to the religious and spiritual needs of all patients and staff through on-going consultation and dialogue with all relevant individuals and groups.
- All staff members within hospitals and palliative care need to be trained in identifying spiritual distress and how to respond appropriately either personally or through relevant referral.

CONCLUSION

In conclusion, this review has demonstrated that there is a lack of consensus on the relationship between spirituality, faith and religion. While there is an argument that the three are distinct, there is a growing awareness that all these aspects need to be addressed within the health care setting as society becomes more diverse. The need to provide spiritual care that is cultural and religiously sensitive is recognised within the holistic, patient-centred approach to care. Evidence suggests that, while chaplains or spiritual leaders may have primary responsibility for spiritual care within the multi-disciplinary team, all staff responsible for providing care have a role in responding to spiritual needs. This requires certain levels of competencies and skills in providing this care, most importantly the ability to recognise spiritual needs and communicating with patients on these issues. Education and training are seen as essential in ensuring that staff are aware and able to respond to cultural, religious and spiritual needs. Internationally, there have been a number of models put forward to identify, assess and respond to these needs more effectively. Evidence suggests that, these tools and models are environment/setting specific and highly contextual. The U.K. and the Irish model of health care chaplaincy differ radically particularly in terms of management, structure and philosophy. Health care chaplaincy in Ireland is still principally framed within the Roman Catholic Church tradition and there are no common standards of health care chaplaincy across the main Christian churches in Ireland. However, a transition is occurring with patient centred care driving the development and delivery of the service. In addition, individual healthcare institutions appear to develop their own chaplaincy policy. The U.K. system appears to be more multi-faith in perspective. The most striking aspect of the provision of chaplaincy services and spiritual healthcare in the U.K. is that it is considered to be an essential and holistic dimension of the healthcare for which the National Health Service sees itself as responsible and accountable.



Summary points:

- There is no consensus on what constitutes faith/cultural and spiritual care in a healthcare environment.
- Attending to patients' faith/cultural and spiritual needs can impact positively on patients' physical and mental well-being.
- The role of healthcare practitioners in providing faith/ cultural and spiritual care appears to be person and context dependent.
- A number of barriers exist to the provision of faith/cultural and spiritual care in a multi-cultural/multi-faith healthcare environment.
- Healthcare practitioners need to have the knowledge and competence to address patients' faith/cultural and spiritual needs.
- There are different models of healthcare chaplaincy practice in relation to the provision of faith/spiritual care.
- Healthcare chaplaincy provision in Ireland is currently in a state of transition but striving to deliver patient-led care in an increasing multi-cultural/faith environment.

Chapter 3 - Research Methodology

This chapter details the empirical aspect of the project and addresses objective 2 and 3:

Conduct research into how faith, spiritual and cultural needs are currently catered for within a healthcare context in two sites - Donegal Hospice and Letterkenny General Hospital.

RESEARCH DESIGN

The research design adopted for the study was an exploratory descriptive design using a mixed methods approach. The research design is both descriptive and exploratory as it seeks to ascertain the views on current provision of faith and spirituality care and views for the future delivery of such care in an ever changing health care environment. Both quantitative and qualitative data were collected using different, but complementary, methods:

- Three anonymous surveys tailored to specific populations
- Individual face to face interviews (structured and semi-structured) with key informants
- Focus group interviews.

TABLE 1 *PROFILE OF PARTICIPANTS - NUMBER, STATUS AND MODE OF DATA COLLECTION*

Participants	Mode of data collection	Number of participating persons/responses
Staff Nurses/Midwives/Clinical Nurse Manager/Clinical Midwifery Manager	<ul style="list-style-type: none">● Structured survey● Face to face interview	108 9 (6 hospital; 3 hospice)
Acting Director of Nurses/Midwives	Focus group interview	6
Chaplaincy team members and community faith leaders [8 Christian churches and 4 other faiths]	Face to face interview (incl. one telephone interview)	18
Health Care Assistants	<ul style="list-style-type: none">● Focus group interview (hospital)● Individual interview (hospice)	15 rep. 12 clinical areas 1
Patients	<ul style="list-style-type: none">● Structured interview● Guided conversation	78 incl. 3 hospice
Support staff	Face to face individual interview	3
Health care professionals (excl. nurses and doctors)	Face to face individual interview	1
Admission clerks	Structured survey	18
Non consultant hospital doctors	Structured survey	24
Nursing students	Face to face interview	2



NOTIFICATION OF STUDY

Prior to any data being collected both institutions were furnished with posters for display and information cards so that all caregivers and potential patients were aware of the impending study (Appendix 5). Care givers were also informed by e-mail of the study.

SURVEY DEVELOPMENT

Three different anonymous survey instruments were developed for three distinct cohorts: nurses/midwives; admission clerks and non-consultant hospital doctors (NCHDs). In total, data was collected from one hundred and forty-nine persons via surveys.

ADMISSION CLERKS SURVEY

The population this survey was aimed at was admission clerks in Letterkenny General Hospital as they were acknowledged by the project steering team as the first person that requests a patient's faith affiliation. This survey instrument was initially designed by the research team and then approved by the project steering group. This instrument comprised of 6 closed questions affiliation (Appendix 6).

- Q.1.** Sought to ascertain if the admission clerk always recorded or reconfirmed (if returning patient) patients faith affiliation.
- Q.2.** Sought to determine the reasons why the admission clerk did not record or reconfirm faith/religious affiliation.
- Q.3.** Sought to determine if patients question why this information is required.
- Q.4.** Sought to determine if the admission clerk had ever encountered a negative response from patients as a result of asking about faith/ religious affiliation.
- Q.5.** Sought the admission clerk's degree of comfort seeking this information.
- Q.6.** Sought to ascertain how important the admission clerk perceive the recording of this information.

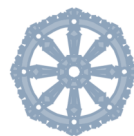
The survey was accompanied by an information sheet (Appendix 7). Consent to participate was implicit on return of completed questionnaire.

SAMPLE

Twenty surveys were distributed in September 2010. Nineteen surveys were returned with 18 suitable for analysis yielding a response rate of 90%.

NURSES/MIDWIVES SURVEY

The population this survey was aimed at was nursing and midwifery staff working in Letterkenny General Hospital



and Donegal Hospice. The instrument was developed initially by the research team and then modified following consultation with the project steering team. It was also piloted with 14 registered nurses working in a community hospital in the Sligo/Leitrim area. Small modifications were made as a result of the pilot study findings. The survey was chiefly comprised of a series of closed questions in a variety of formats. A number of Likert type scales were utilised to explore reasons for the conduction or not of faith/spiritual assessment. With the exception of two questions the responder was only required to tick the answer they deemed appropriate to the question being asked. The survey instrument was compiled in booklet form with a question and answer format used on the second page to inform potential respondents about the study; what participation required; how they had been selected; how their ethical rights would be upheld and the contact details for the research team and the named link person in the hospital/hospice. The final survey instrument comprised of six sections. Respondents were provided with an explanation of how faith and spiritual needs were being contextualised for the survey (Appendix 8).

Section A: The aim of this section was to obtain the respondent's profile in terms of status, age, education etc.

Section B: The aim of this section was to ascertain if faith and spirituality needs were assessed or not and if not to explore the underlying rationale for non-assessment. Some of the questions used in earlier research by Swift, Calcutawalla and Elliot (2007) were modified used in this section.

Section C: The aim of this section was to determine how comfortable nurses/midwives felt in relation to a number of faith related/spiritual encounters they could meet in practice.

Section D: The aim of this section sought to ascertain nurses/midwives perception of the significance of faith/spirituality issues in their interactions with patients/relatives.

Section E: The aim of this section was to ascertain the education/training nurses/midwives have received in relation to faith/spirituality and their perceived future needs.

Section F: The aim of this section was to determine their perceptions of sources of support available to them in the delivery of faith/spiritual care.

The survey was accompanied by an information sheet (Appendix 9). Consent to participate was implicit on return of completed questionnaire. The actual survey was distributed for the first time in July 2010. Prior to distribution, each ward area/hospice was issued with a poster for display in their office area and staff were made aware of the forthcoming study via the Director of Nursing's office and their linked Assistant Director of Nursing. Boxes were left in all clinical areas to facilitate potential responders returning the questionnaires. The boxes were collected and emptied after one month.



SAMPLE

A non-probability sampling strategy was employed; with all nurse/midwives working in the hospital/hospice at the time of survey distribution invited to participate. It was a challenge to obtain the exact number working at the time of distribution due to the multiple shift patterns (part-time; job sharing) on-going maternity leave and annual leave. In order to be as accurate as possible, the CNMs were requested to inform a member of the research team of the number that was required for his/her area at time of distribution. In total 278 were distributed initially. However, it was noted when the research team collected the surveys that over a hundred copies of the survey had not been collected by staff. As a consequence of the initial poor response; copies of the survey instrumented were reissued on two subsequent occasions to targeted clinical areas where the response rate was noted to be poor. Questionnaires were also given out at a meeting of nurse/midwives in October, yielding a further 19 completed surveys. The response rate eventually achieved was 40% (n=114).

NON-CONSULTANT HOSPITAL DOCTORS SURVEY

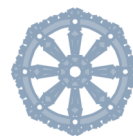
The population this survey was aimed at was non-consultant hospital doctors serving Letterkenny General Hospital and Donegal Hospice during the research period. A ten question structured questionnaire was developed to ascertain their views on assessing the spiritual and faith needs of patients. The researchers purposefully developed this questionnaire in as succinct manner as possible to gather the necessary information required but encourage participation. The clinical director approved the survey for distribution (Appendix 10).

- Q1-4:** The aim of this block of questions was to ascertain if medics consider a patient's faith or spirituality needs in two specific contexts - conducting patient assessment and communicating a diagnosis.
- Q.5.** Sought to ascertain if NCHDs believe doctors have a role in assessing patients' faith/spirituality needs.
- Q.6.** Sought to ascertain if NCHDs perceived faith/spirituality issues important in their interactions with their patients.
- Q. 7, 9 and 10.** Sought to address NCHDs education and training needs.
- Q.8.** Sought to ascertain NCHDs' awareness of the HSE Intercultural Guide.

All surveys were accompanied by an information sheet which detailed the same specifics addressed in the information sheet accompanying the other surveys.

SAMPLE

Census sampling was utilised with all 102 NCHDs mailed a questionnaire in December 2010 following receipt



of permission from the Clinical Director. Twenty-four surveys were returned yielding a response rate of 24%. All were suitable for descriptive analysis.

Interviews

INDIVIDUAL INTERVIEWS

Face to face interviews were conducted with a variety of key informants so that a more in-depth appreciation of the phenomenon under exploration could be garnered. The content of the interview guides were informed by the literature review, the status of the interviewee within the organisations and the findings being generated from the surveys which were undergoing analysis concurrent to the conduction of the interviews (Appendices 11-13). Both structured and semi-structured interviews were used.

Structured interviews were used with the patient population in light of the restraints that the environment where data collection had to be conducted placed on the process, and the awareness of the researchers that the interviews needed to be succinct in order not to induce patient fatigue or interrupt the patient routine to any great extent. Interview questions were developed from the literature. Field work was conducted in the Sligo/Leitrim area with a small number of people known to the researchers who had experience of being patients in similar type health care institutions. This enabled the researcher to gain skills in phraseology to engage with the patient population and gain the information requested. For example, the word spirituality was used cautiously and frequently replaced by words such as vision, hope, and support which are recognised in the literature as being associated with spirituality. Closed questions were used to elicit specific biographical data. For the remainder of the interview the format was open questions. This enabled participants to expand and also where appropriate for the researcher to explore fully the meaning intended. Interviews varied in length and were participant dependent. A loosely guided discussion was held with three hospice patients to compliment the structured interviews. This discussion was kept very informal given the patients compromised health status.

Semi-structured interviews were used with all participants (excluding the hospital patient cohort) as they combine the flexibility of unstructured interviews with some of the structure and agenda, are sufficiently flexible to allow participants to raise issues not on the topic guide but of personal relevance to them and permit flexibility in the order and phrasing of questions. The interviews took place from August 2010 to January 2011 and involved 133 persons-patients/health care professionals; non-health care professionals; nursing students; nursing personnel (clinical and management); chaplains/faith leaders and support staff across both organisations. One interview was conducted via telephone. All interview participants were fully informed about the purpose of the study and their



role therein. Their oral consent to participate was ascertained prior to the interview commencing.

FOCUS GROUP INTERVIEWS

The majority of health care assistants (n=15) and nursing administration personnel (n=5) participated in two separate focus group interviews. According to Kitzinger (1995) focus groups are particularly useful when exploring people's knowledge and experience of certain issues and are also useful at engaging those who may not otherwise agree to participate due to shyness or a perception that they have nothing to contribute. The interview schedule was refined and finalised by the research team. The focus group interview schedule was semi-structured, allowing participants to discuss the topic openly and in detail. This mode of data collection was efficient in gathering the views of two distinct but important cohorts of persons in meeting the faith and spirituality needs of patients.

INTERVIEW PROCESS

Participants were interviewed at a time and location convenient to them with refreshments being provided as appropriate. A small number of interviews were conducted off-site at the request of participants. Ground rules were established with the focus group interview participants in relation to group confidentiality and respect of other participants during the interview itself prior to data collection commencing. The researchers approached the interview format in an informal manner so participants felt at ease. This format enabled the interaction to flow freely and allowed participants the opportunity to raise issues not identified in the interview schedule. Depending on participants responses to questions asked, the interviewer employed other types of questions if required to gain a better appreciation of the participants' perspective on meeting patients' faith and spirituality needs such as experience/example questions, simple clarification questions, structural/paradigmatic questions, and compare/contrast questions.

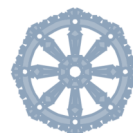


TABLE 2 SAMPLING STRATEGIES

Participants	Mode of data collection	Sampling strategy
Staff Nurses/Midwives/Clinical Nurse Manager/Clinical Midwifery Manager	Face to face interview	Volunteer
Acting Director of Nurses/Midwives	Focus group interview	Volunteer
Chaplaincy team members and community faith leaders [8 Christian churches and 4 other faiths]	Face to face interview (incl. one telephone interview)	Purposeful
Health Care Assistants	<ul style="list-style-type: none"> ● Focus group interview (hospital) ● Individual interview (hospice) 	Volunteer
Patients	<ul style="list-style-type: none"> ● Structured interview ● Guided conversation 	Convenience
Support staff	Face to face individual interview	Purposeful
Health Care professionals (excl. nurses and doctors)	Face to face individual interview	Volunteer
Nursing students	Face to face interview	Volunteer

A variety of sampling strategies were utilised: volunteer, purposeful and convenience. Purposeful was employed where it was deemed necessary that the research team gathered the views of identified key personnel such as faith/community leaders, mortuary technicians and the catering manager as they were the only persons who could give their unique but highly valuable perspective on the phenomenon under exploration. The majority of the participants were generated via a volunteer sampling strategy. The patient population was comprised of patients who met the following criteria outlined below and were in-patients in the Letterkenny General Hospital the during the data collection period. All clinical nurse managers were informed of the inclusion criteria and the proposed data collection period. As a consequence they served as both a research gate keeper and an adjudicator of patients' fitness to participate in the research.

- Aged > 18years
- Be an in-patient for a minimum of 48 hours
- Be competent to give consent
- Be able to speak English or their carer/relative able to speak English
- Deemed well enough to participate in the research by the Clinical Nurse/Midwife Manager on the morning of researcher's visit to ward area.



Data Analysis

SURVEY DATA

The quantitative data generated from the survey was analysed using SPSS (Version 17). Descriptive statistics were employed. The qualitative data was entered into Microsoft word; categorised and analysed in relation to the questions where supplementary comments were requested. Where appropriate, relevant quotations from the respondents were used to support and complement the quantitative data. Percentages were rounded up or down as appropriate to the nearest whole integer. Findings are presented in both tabular/graphical and written form.

INTERVIEW DATA

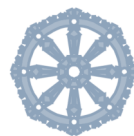
All face-to-face interviews were tape-recorded and transcribed in full. The computer software package NVivo 8 was used to assist in the organisation, management and retrieval of the majority of the qualitative data. The exception was that generated from the chaplaincy team or community faith leaders; which was hand coded and manually analysed. The researchers became immersed in the data by reading the transcriptions and listening to the digital recordings. Thematic analysis was subsequently carried out. The researchers were aware of personal experiences in relation to faith/spirituality/cultural issues and the impact a researcher may have on the research process. Rather than bringing an increase of bias to the analysis this enabled the researchers to ask questions of the data and look for evidence in the transcriptions and recordings. This added to the validity of the analytical process.

CREDIBILITY OF THE DATA

The credibility of the data has been attained as a result of the following: prolonged engagement in the field; multiple but complimenting modes of data collection; the perspective of multiple persons/cohorts on the topic; the maintenance of an audit trail and the inclusion of multiple excerpts from the data generated clearly indicate how the findings advanced were developed. The credence of the findings is further substantiated by concurring with previous research.

ETHICAL ISSUES

Ethical approval was received from the Research Ethics Committee of Letterkenny General Hospital in June 2010. The ethical rights of all participants were upheld in relation to autonomy, beneficence/mal-beneficence; confidentiality and privacy. All participants were fully informed about the study either orally or in written format. The consent of all participants to partake was ascertained. Consent was assumed on completion of the surveys. Participants who were interviewed had the freedom to stop the process at any time and make explicit what



information they wanted to be utilised. The data was stored in accordance with the Data Protection Act (2003).

CONCLUSION

The methodology employed to generated data to address objective two and three of the project has been clearly detailed. Complimentary modes of data collected were used to ensure that the phenomenon under exploration was portrayed comprehensively.

Summary points:

- The research design used was exploratory-descriptive using a mixed methods approach.
- Participants included patients; health care-givers; nursing students; ordained healthcare chaplains; non-ordained healthcare chaplains and other faith leaders (n=283).
- Data was collected via structured questionnaires; focus group interviews and individual interviews.
- Data was analysed both statistically and thematically.
- A number of measures were put in place to ensure the rigour of the findings.

Chapter 4 - Quantitative Findings

This chapter provides an overview of the findings of the quantitative aspect of the study. Two methods of data collection were used; surveys and a structured interview. Three separate surveys were conducted which involved nurse/midwives; admission clerks and non-consultant hospital doctors. The survey data was collected during a six month period from July to December 2010. The surveys were predominately very structured. The structured interviews were conducted in August 2010 with 75 in-patients in Letterkenny General Hospital.

ADMISSION CLERKS SURVEY

In total, 18 admission clerks responded to this survey which represents 80% of the total population of admission clerks in Letterkenny General Hospital. All figures reported are percentages.

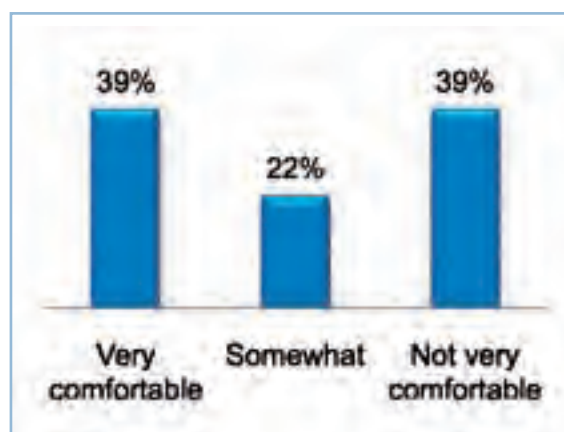
RECORDING OF RELIGIOUS/FAITH TRADITION ON ADMISSION

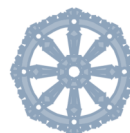
The majority of admission clerks reported (83 %, n=15) that they record a person's faith/religion on admission with the remaining admission clerks admitting they record it *sometimes*. This high recording rate was not unexpected and reflects the findings of a statistical review of the records conducted in March 2010 for the research team which revealed religion/faith is almost always recorded on admission. Some of the reasons advanced for only recording it *sometimes* related to embarrassment and perceived intrusiveness. However, these must be treated cautiously as only three participants were eligible to complete the section on potential reasons.

The admissions clerks were subsequently asked if patients question them about the reason their faith/religious status was required by the hospital or abuse them as a reaction to requesting information. The majority of admission clerks (83%, n=15) reported that they are questioned sometimes about the rationale for this data being collected. Only one admission clerk reported never being questioned. Eleven of the admission clerks (61.1%) reported having encountered a negative response (e.g. verbal abuse) from patients as a result of requesting their religious/faith status.

In order to assess the admissions clerks' perceived comfort around asking this information, they were asked to select if they were either *very comfortable*; *somewhat* or *not very comfortable*.

FIGURE 1
PERCEIVED
'COMFORT' WITH
RECORDING OF
RELIGIOUS/
FAITH TRADITION

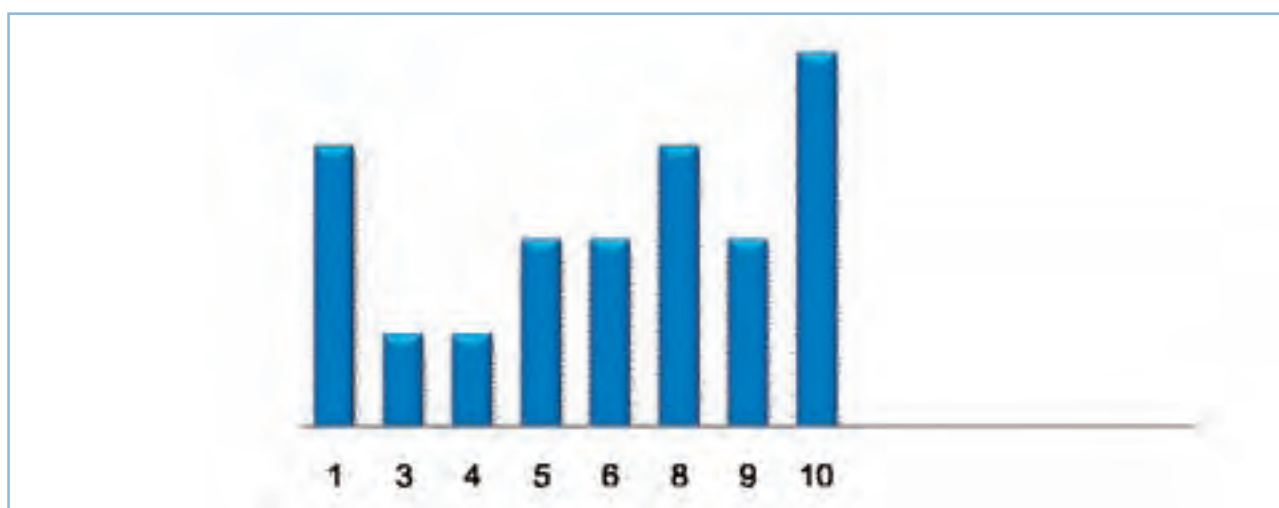




The responses were varied with 39% perceiving themselves as *not very comfortable* and an equal amount perceiving them as *very comfortable*.

The admission clerks were asked to rate on a scale of 1-10 how important they perceived the gathering of information regarding a patient's faith/religion was. As Figure 2 illustrates, the perceived importance of this data being collected varies widely among the admission clerks. However, fifty percent gave it a score of eight or higher indicating they do perceive the gathering of it is important.

FIGURE 2 PERCEIVED IMPORTANCE OF RECORDING FAITH/RELIGIOUS INFORMATION



SUMMARY

The majority of admissions clerks record patients' faith affiliation on admission and perceive the gathering of such information as important. The majority are comfortable asking this information of patients and are frequently questioned by patients about the rationale for this data being collected. A significant proportion of the admission clerks have encountered a negative response from patients as a result of requesting their religious/faith status.

NURSES/MIDWIVES SURVEY

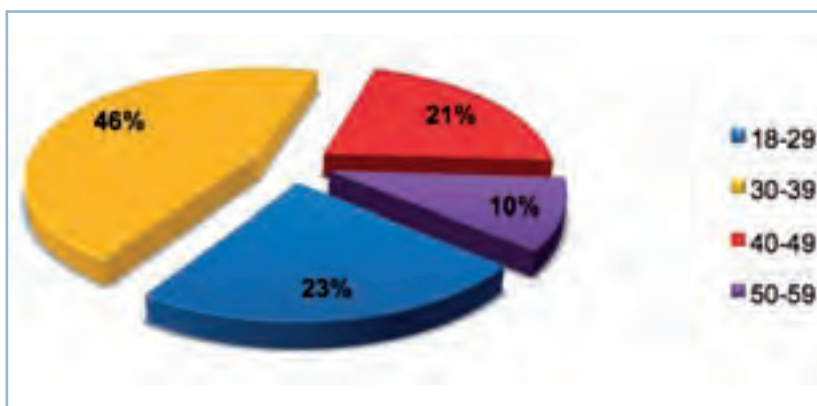
In total, 108 nurses and midwives responded to this survey. Six other completed surveys were received but they were excluded from the final dataset as respondents were not registered nurses or midwives. Thus, the final response sample for analysis was 108. Due to the sample number, it was decided to include questionnaires that had some missing data. The number of respondents who answered each question is indicated and percentages are calculated out of the number of responses.



DEMOGRAPHIC PROFILE

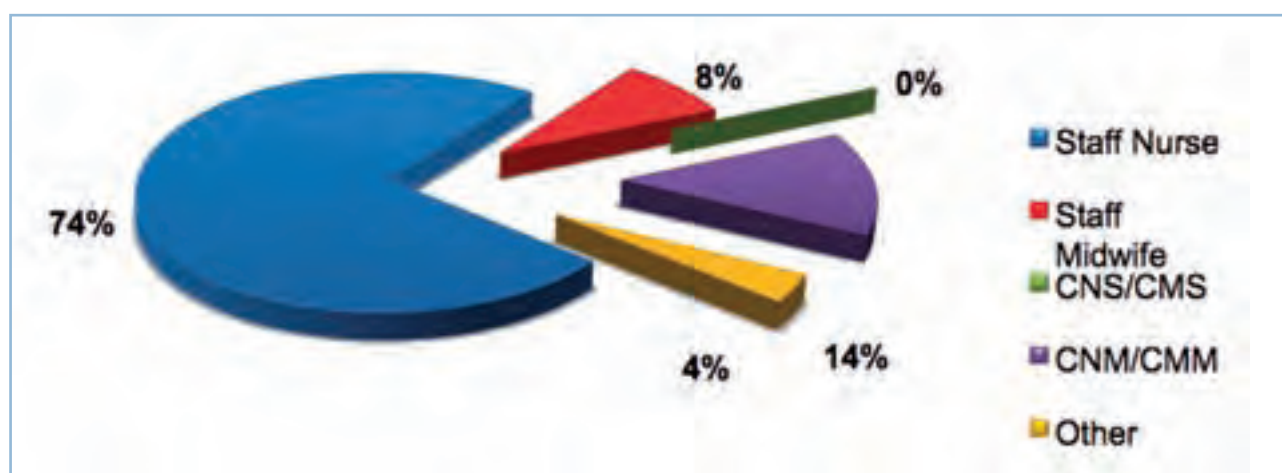
This section provides an overview of the profile of the respondents. The majority of the respondents were female (93%, n=108); with the greatest number aged between 30-39 years (46%; n=49). Only 10% of respondents were over the age of 55.

FIGURE 3 DEMOGRAPHIC AGE PROFILE



The majority of respondents were either staff nurses or midwives (88; n=89%). The remaining respondents were clinical nurse/midwife managers or in acting managerial positions. There was no clinical nurse/midwife specialist respondent (Figure 4).

FIGURE 4 NURSING /MIDWIFERY POSITIONS

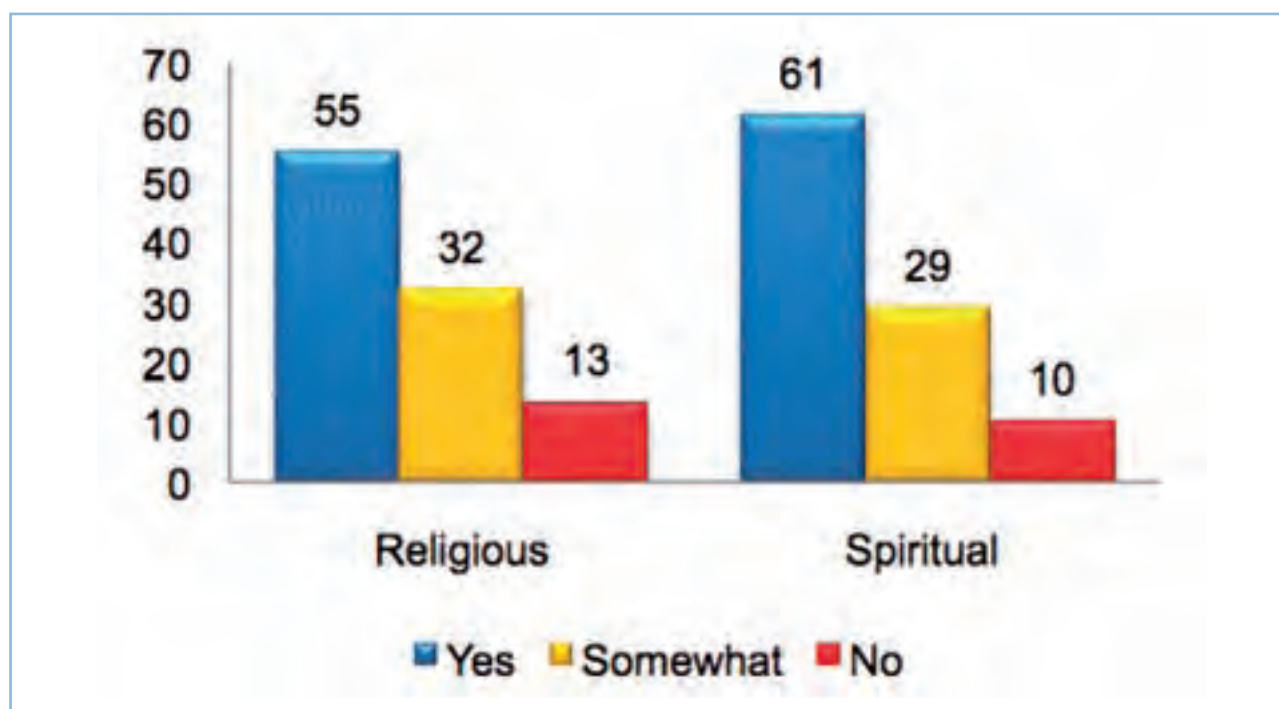


Respondents' academic qualification on initial registration as a nurse or midwife varied among the sample. The highest proportion of respondents (47%, n= 48) had a primary degree on registration; followed by certificate (31%, n=32). Twenty-three respondents possessed a diploma on registration. Sixty-four (n=68) of respondents hold a post-registration/graduate qualification with twenty five of those in possession of a post-graduate diploma. Three respondents possess a higher degree, namely a Master degree.

Respondents were subsequently asked how they would categorise their religious and spiritual stance. 87% of respondents answered that they would consider themselves *religious* or *somewhat religious*. A higher proportion (90%, n=96) responded that they would consider themselves *spiritual* or *somewhat spiritual*. The remaining respondents did not consider themselves as either religious or spiritual (Figure 5).



FIGURE 5 RESPONDENTS' PERCEPTIONS OF THEIR OWN SENSE OF RELIGIOSITY/SPIRITUALITY



RECORDING OF RELIGIOUS/ FAITH TRADITION

63% (n= 69) of respondents reported they always record or reconfirm (if previously documented) a patients religious/faith tradition on admission to their ward/unit. A further 16% (n= 18) responded that that they *sometimes* recorded or reconfirmed with only a small minority (16%, n=17) indicating they did neither. Respondents who indicated that they *sometimes* do *not* record or choose to record this information - were asked to reveal why they took these decisions through responding to a series of statements which gave them 4 options - strongly agree; agree; disagree and strongly disagree. Due to the relatively small number - who were in a position to respond to the statements the responses were collapsed into two categories: strongly agree/ agree and strongly disagree/disagree. The exact number who responded to each statement is detailed beside the statement. The mean and standard deviation for each statement is also reported. The range was 1-4 with 4 reflecting the strongest level of disagreement with the statement.

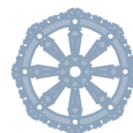
The leading reasons for not recording or reconfirming patients' faith tradition was the perception that it was an unnecessary, intrusive and that possession of this information would make no difference to the care received. Other reasons which over half of the respondents gave were in relation to lack of time, clinical factors making it impossible to record/reconfirm, belief that a patient's religion is their own private affair, staff embarrassment asking it and a perception that patients might be offended by being asked their religion (Table 3).



TABLE 3 *REASONS FOR NOT RECORDING/RECONFIRMING FAITH TRADITION*

	Mean (SD)	Strongly agree/ agree	Strongly disagree/ disagree
I think for some patients it is an unnecessary question (n= 29)	2.10 (.77)	72	28
I sometimes feel embarrassed to ask it (n= 29)	2.59 (.86)	52	48
I think it can be an intrusive question (n=29)	2.41 (.73)	66	34
Clinical factors make it impossible (n=30)	2.33 (.84)	57	43
Religion doesn't mean much to me (n=29)	3.21 (.67)	7	93
I sometimes feel it's a kind of "death" question (n= 29)	2.83 (.65)	31	69
Asking it won't have an impact on their care (n=30)	2.23 (.81)	67	33
Sometimes I don't understand the answer they give(n=31)	3.48 (.72)	52	48
It's something I can skip, and there are more important things to record (n=29)	2.69 (.85)	41	59
The hospital/hospice isn't bothered whether I record it or not (n=27)	2.89 (.93)	26	74
Sometimes I don't have time (n=30)	2.57 (.89)	50	50
I don't feel confident asking this question (n=30)	2.77 (.67)	37	63
I don't know why the information is being asked (n=30)	3.03 (.61)	17	83
The patient doesn't look like he/she would be religious (n=32)	3.28 (.77)	6	94
I am afraid I will offend/annoy a person by asking it (n=32)	2.50 (.76)	53	47
I don't know enough about religious faith traditions other than my own (n=30)	3.0 (.64)	20	80
I feel it is the patient's own private affair (n=29)	2.52 (.63)	52	48
I feel it makes patients feel uncomfortable (n=30)	2.60 (.67)	50	50

* Responses collapsed from four to two



ASSESSMENT OF RELIGIOUS/ FAITH NEEDS

Respondents' practice in relation to assessment and subsequent intervention in relation to patients faith needs was explored further through a series of questions. Three response options were available: always, sometimes, never. The majority of respondents (61%, n=63) reported that they ascertain if their patients are part of a particular religious/faith community. However, the number of respondents who reported they always explored or acted on this information further was substantially less (Table 4). The leading action that 41% (n=41) of respondents reported that they undertook was informing appropriate personnel (e.g. catering manager/medics etc.) if patients' cultural needs linked to their faith tradition required modifications to 'usual' care provided. Over 30% of respondents reported that they never ascertain from patients if they would like their faith/religious/ community leader informed of their admission, inform patients of the name of hospital chaplains (if appropriate), inform patients of the services that the chaplaincy team offer or inform patients of the location of religious space in the institution.

TABLE 4 *EXPLORATION OF PATIENT FAITH NEEDS*

	Always	Sometimes	Never
Do you always ascertain if your patients are part of a particular religious/faith community? (n=103)	61	24	15
Do you ascertain how important their faith/religious tradition is to them? (n=103)	21	53	26
Do you ascertain what their specific faith/religious needs are (including cultural aspects)? (n=101)	23	55	22
Do you ascertain how they would like their faith/religious needs met while in hospital? (n=100)	25	51	24
Do you ascertain if they would like their faith/religious/community leader informed of their admission? (n=103)	22	43	35
Do you inform patients of the name of hospital chaplains (if appropriate)? (n=102)	27	40	33
Do you inform patients of the services that the chaplaincy team offer? (n=103)	23	41	36
Do you inform patients of the location of shared/religious space in the hospital? (n=101)	24	40	36
Do you inform appropriate personnel (e.g. catering manager/medics etc.) if patient's cultural needs linked to their faith tradition will require modifications to 'usual' care provided (n=95)	41	38	21



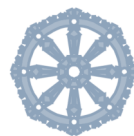
ASSESSMENT OF PATIENT SPIRITUAL NEEDS

Five questions sought to gain an appreciation of respondents' assessment of spiritual needs. Three response options were given: always, sometimes, never. In direct contrast to the assessment of religious needs, assessment of spiritual needs is conducted always by only 18% (n=19). 27% responded that they never assess patients' spiritual needs. Only 11% reported that they used a specific assessment tool *always* or *sometimes*. However, over 60% reported that they ascertained always or sometimes how important their spiritual needs were to their patients, ascertained what their specific spirituality needs were, and how they would like their spirituality needs met while in hospital/hospice. It is apparent that the assessment of spiritual needs is a practice that is possibly nurse/midwife or context dependent. Approximately 1/3 of participants reported they never ascertain what their patients' spiritual needs are or how they would like them addressed in the health care setting (Table 5).

TABLE 5 ASSESSMENT OF SPIRITUALITY NEEDS

	Always	Sometimes	Never
Do you assess patients' spiritual needs? (n=104)	18	55	27
Do you use a specific spiritual assessment tool? (n=102)	4	7	89
Do you ascertain how important their spiritual needs are to them?(n=103)	16	51	33
Do you ascertain what their specific spirituality needs are? (n=104)	12	53	35
Do you ascertain how they would like their spirituality needs met while in hospital? (n=104)	14	47	39

Respondents who reported they never or only undertook spiritual assessment sometimes were asked to share why they took these decisions through responding to a series of statements which gave them 4 response options: strongly agree; agree; disagree and strongly disagree. The responses were subsequently collapsed into two categories - strongly agree/ agree and strongly disagree/disagree. The exact number who responded to each statement is detailed beside the statement. The mean and standard deviation for each statement is also reported. The range was 1-4 with 4 reflecting the strongest level of disagreement with the statement. Similar to the leading two reasons for not recording or reconfirming religious affiliation; the perception that spiritual assessment is unnecessary and intrusive emerged with over 63% (n=60) perceiving it as an unnecessary. A lesser but significant percentage (59%, n=55) perceive it as intrusive. Clinical factors, lack of time and the perception that is the patient's own private affair was reported by over 50% or more of respondents. Interestingly, a smaller



percentage of respondents (38%, n= 35) reported embarrassment as a reason for not assessing spiritual needs compared to over 50% who cited embarrassment in relation to recording religious needs/affiliations. Over 30% of respondents responded that they believed assessing their patients' spiritual needs would not make a difference to the care they would receive (33%, n=31); don't feel confident asking the question (31%, n=29) or believed they didn't know enough about spirituality needs to assess patients (35%; n=33) (Table 6).

TABLE 6 REASONS FOR NOT ASSESSING SPIRITUALITY NEEDS

	Mean (SD)	Strongly agree/ agree	Strongly disagree/ disagree
I think for some patients it is an unnecessary question (n=94)	2.33 (.64)	64	36
I sometimes feel embarrassed to ask it (n=93)	2.75 (.76)	38	62
I think it can be an intrusive question (n=93)	2.42 (.63)	59	41
Clinical factors make it impossible (n=94)	2.32 (.72)	55	45
Spirituality doesn't mean much to me (n=94)	3.12 (.63)	15	85
Asking it won't have an impact on their care (n=94)	2.73 (.67)	33	67
Sometimes I don't understand the answer they give (n=92)	3.09 (.58)	13	87
It's something I can skip, and there are more important things to record (n=94)	2.94 (.65)	25	75
The hospital/hospice isn't bothered whether I record it or not (n=93)	2.96 (.77)	24	76
Sometimes I don't have time(n=94)	2.62 (.70)	50	50
I don't feel confident asking this question (n=93)	2.84 (.69)	31	69
I don't know the reason for collecting this information (n=94)	2.90 (.67)	23	77
The patient doesn't look like he/she would be spiritual (n=92)	3.17 (.56)	6	94
I don't know enough about spirituality needs (n=94)	2.76 (.69)	35	65
I feel it is the patient's own private affair (n=85)	2.51 (.72)	53	47

* Responses collapsed from four to two

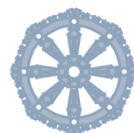


COMFORT DEALING WITH FAITH/SPIRITUAL ENCOUNTERS

Respondents' perceived degree of comfort dealing with ten various faith/spiritual encounters was explored. Degree of comfort could range from **not at all** to **very comfortable** (Table 7). A non-applicable option was also possible. 43% of respondents (n=46) reported they are very comfortable in supporting the patient's need to practice their religion/faith and 40% are very comfortable supporting patients in their religion/faith rituals/traditions (e.g. diet/prayer times). However, only 20% (n=21) reported being very comfortable performing a culturally sensitive assessment of faith/religious needs and 17% (n=18) reported being very comfortable interpreting different cultural expressions of faith. It was evident that supporting patients in meeting their spiritual needs; recognising signs of spiritual distress and subsequently supporting patients in distress were areas where respondents felt less than comfortable engaging in with their patients.

TABLE 7 PERCEIVED LEVEL OF COMFORT IN DEALING WITH NEEDS

	Not at all	A little	Some what	Quite a bit	Very comfortable	N/A
Performing a culturally sensitive assessment of faith/religious needs (n=107)	13	16	25	23	20	3
Interpreting different cultural expression of faith (n=106)	10	15	25	32	17	1
Caring for patients from diverse faith/religious backgrounds (n=107)	10	15	18	19	37	1
Supporting patients need to practice their religion/faith (n=107)	5	9	20	22	43	1
Supporting patients in their religion/faith rituals/traditions (e.g. diet/prayer times) (n=107)	6	13	16	23	40	2
Performing a culturally sensitive assessment of spiritual needs (n=108)	12	22	26	15	21	4
Interpreting different cultural expressions of spirituality (n=108)	10	20	30	16	21	3
Supporting patients in meeting their spiritual needs (n=108)	7	15	22	26	28	2
Recognising signs of spiritual distress (n=106)	15	21	26	23	13	2
Supporting patients in spiritual distress (n=106)	8	21	25	25	19	2



PERCEIVED IMPORTANCE OF FAITH/SPIRITUALITY ISSUES IN INTERACTING WITH PATIENTS AND RELATIVES

This section explored respondents' perceptions of the importance of faith/spirituality issues in general in their interactions with patients and relatives. They were also asked to reflect on how important their own faith was to them in their interactions with patients and families. Respondents' perceived importance could range from **not at all** to **very important**.

The majority of respondents considered that faith/religious issues are either 'quite a bit' or 'very important' when dealing with patients and their relatives. They also considered their own faith/religious issues are important in their interactions with patients and families. In relation to spirituality the same weight of importance was not reported although this difference was only small (Table 8).

TABLE 8 *PERCEIVED IMPORTANCE OF FAITH/SPIRITUALITY ISSUES IN INTERACTIONS WITH PATIENTS/FAMILIES*

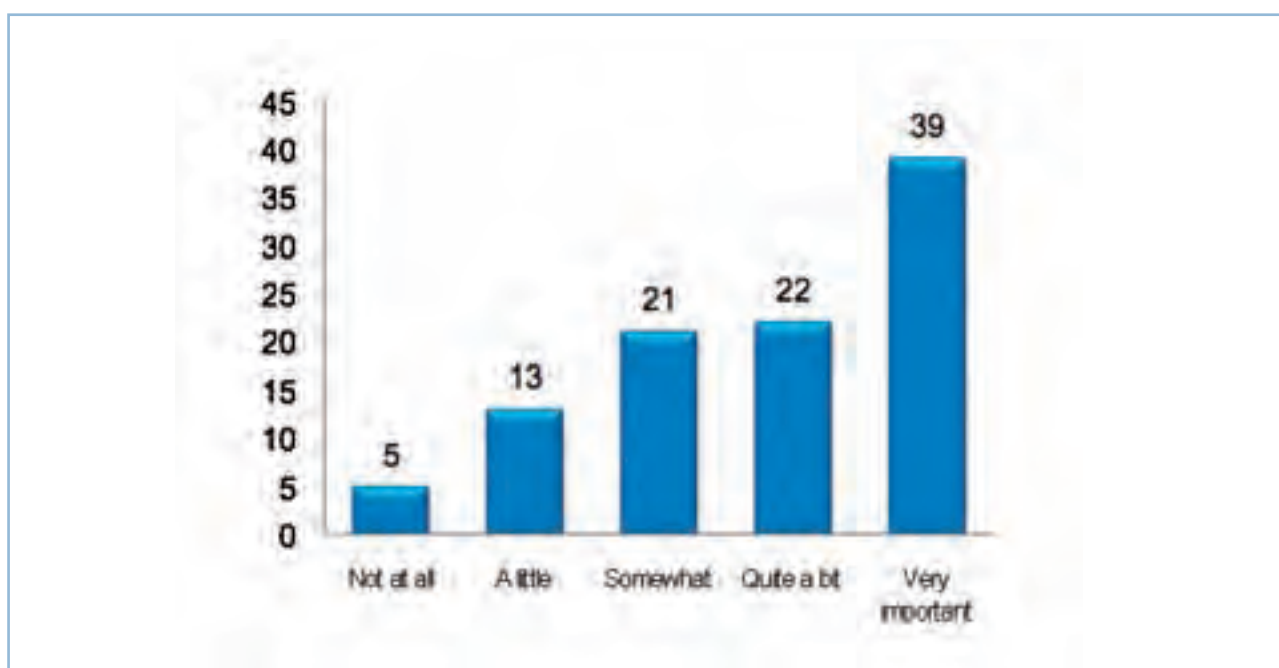
	Not at all	A little	Some what	Quite a bit	Very Important
How important do you believe <u>faith/religious</u> issues are in your interactions with patients/clients? (n=105)	5	6	25	25	39
How important do you believe <u>faith/religious</u> issues are in your interactions with relatives? (n=105)	5	10	16	36	33
How important do you believe your own <u>faith/religious</u> issues are in your interactions with patients/clients? (n=106)	17	6	13	29	35
How important do you believe your own <u>faith/religious</u> issues are in your interactions with relatives? (n=105)	17	11	9	31	32
How important do you believe spiritual issues are in your interactions with patients/clients? (n=102)	10	9	21	34	26
How important do you believe spiritual issues are in your interactions with relatives? (n=106)	11	13	26	28	22
How important do you believe your own sense of spirituality is in your interactions with patients/clients? (n=106)	13	14	14	30	29
How important do you believe your own your own sense of spirituality are in your interactions with relatives? (n=106)	13	17	14	29	27



TRAINING/EDUCATION IN FAITH AND SPIRITUALITY CARE

This section explored the training and education of health care professionals in the area of religion and spirituality. Respondents (n=107) were asked how important they felt it was that health care professionals received training in religious/faith diversity. Over 61% consider it very important/quite a bit. Only 18% (n=19) believe it is not important (Figure 6).

FIGURE 6 *PERCEIVED IMPORTANCE OF FURTHER TRAINING/EDUCATION IN RELIGIOUS/FAITH DIVERSITY*



Only 26% (n=28) of respondents reported that they had received education/training on caring for persons from diverse faith/religious backgrounds. The majority (66.9%) reported that they had received such education in their pre-registration education. Other sources of education were post-registration education courses (12.5%); via the Centre for Nursing and Midwifery Education (4.16%); in-house education (4.16%). Just over 12%, reported other sources of education. The majority (53.8%) had received such education over 10 years ago with only 15.3% receiving it in the past five years. Only 25% of participants felt sufficiently educated /trained to care for persons from diverse faith/religious backgrounds.

Respondents were subsequently asked how important they felt it was that health care professionals received training in caring for patients spiritual needs (Figure 7). 65% consider it very important/quite important to have such training with only 4% believing it was not important. These findings mirror those that emerged in relation to training on religious/faith diversity.

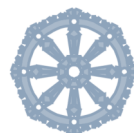
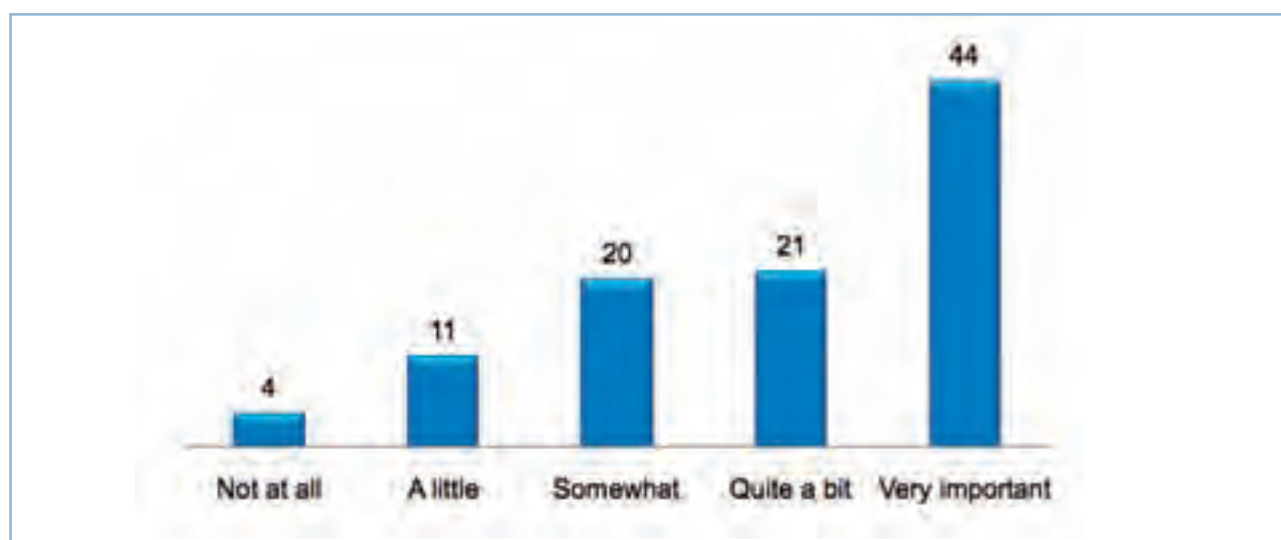


FIGURE 7 PERCEIVED IMPORTANCE OF FURTHER TRAINING/EDUCATION IN SPIRITUAL CARE



Only 29% (n=30) of respondents reported that they had received spirituality education/training. Similar to training in the area of religious/faith diversity; pre-registration education programmes were the main source of this education with over 48% citing it as a source. Other sources were post-registration programmes (37.9%); the CNME (3.4%); in-house training (6.8%) and other sources accounted for just over 3%. Only 24% (n=25) of respondents feel sufficiently educated on caring for patients' spiritual needs.

SUPPORT AND SOURCES OF SUPPORTING THE DELIVERY OF FAITH AND SPIRITUALITY CARE

Only 28% of all respondents (n=30) reported that they were aware of the H.S.E. Intercultural Guide and only 15% were aware whether their ward area had a copy of it. Eighty per cent of respondents (n=84) feel supported by the chaplaincy team. However, only 37% of respondents (n=39) reported that they were aware of all of the services that the chaplaincy team offer. Analysis of the supplementary qualitative comments revealed a small number of respondents felt the chaplaincy team could:

".....[make us] more aware of services they provide."

"... have more input with relatives."

"... become more involved in patient care without being called to ward."

"...be more supportive."

"...provide contact numbers."

However, it was also alluded to that the chaplaincy team are not always invited to become involved in patient care but invited in at the patient's request:



"People coming in for day surgery probably would be very frightened if they were asked if they wanted to see their priest or minister. Therefore I do not mention it. If a person was having a major procedure or operation this is a different scenario. I treat all patients with respect and if they request to see a chaplain I would facilitate this."

"I feel that religion is a very personal issue for most people and unless they request support in this area this is not something I would be imposing on them unless in an emergency situation."

In addition, it was felt that there was a need for education on other religions as the hospital /hospice evolve into a more multi-cultural institution and that this could be provided by other faith leaders.

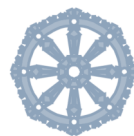
"We do our best, but Letterkenny/Donegal is a diverse community and it is only a matter of time before we have to care for more multi-faith patients - Hindu; Muslim; Jewish. It would be nice to have regular updates from these religious leaders into how best we can care for their communities."

Fifty nine per cent of respondents (n=60) feel adequately supported by the organisation in relation to their delivery of faith/spiritual care to patients and their families. Analysis of the supplementary qualitative comments revealed that time, staffing issues and lack of knowledge were the main factors that hindered the delivery of faith/spiritual care and the suggestions for assisting them in meeting patients' needs centred chiefly on the rectification of these factors. Respondents believe they could be supported in the delivery of faith spiritual care by the development of a policy or guideline on meeting patients' faith/spirituality needs; in-house education training; provision of related literature; provision of an abridged version of the H.S.E. Intercultural Guide with a specific focus on rituals in relation to death; provision of space for certain religions to engage in prayer rituals; provision of more patient time through enhancing staffing levels and overt support to staff in relation to meeting faith/spiritual needs.

"I feel in today's society it is not politically correct to talk about spirituality needs. There is a pressure on you not to talk about them. I feel it is part of the person and should not be ignored. As long as we have the support of the HSE and the knowledge that we can talk to them about their cultural/spiritual needs without the fear of family or co-workers getting upset..."

SUMMARY

Assessment of faith and spiritual needs is not a routine aspect of patient care. Nurses/midwives address faith needs more than patients' spiritual needs. Members of the chaplaincy team are not routinely involved in patient care but invited following a patient's request. This has implications for both chaplain and patient. Faith and



spiritual needs are considered very important in nurse/midwives interactions with patients and their families. There is lack of knowledge about the HSE Intercultural Guide and further education/training in relation to faith diversity and meeting patients' spiritual needs is warranted. There is a perception that both chaplaincy and hospital management could provide additional assistance to nurses and midwives in the provision of such care.

NON CONSULTANT HOSPITAL DOCTORS SURVEY

In total, 24 non-consultant hospital doctors responded to their survey which was 24% of the total population of NCHDs serving both Letterkenny General hospital and Donegal Hospice in the study period. 62% of respondents reported that they considered patients' faith as part of their assessment always or sometimes. Slightly less (54%) reported that they did likewise in relation to patients' spiritual needs. Only 18% of nurses/midwives reported they always assessed patients' spiritual needs in contrast to 29% of the medic respondents. However, spiritual needs were considered more by NCHDs when communicating with patients in relation to their diagnosis. 67% reported that they always or sometimes consider patients' spiritual needs at this time. In comparison, only 59% considered a patient's faith needs at this interaction (Figure 9).

TABLE 9 *CONSIDERATION OF FAITH AND SPIRITUALITY NEEDS*

	Yes (%)	Sometimes (%)	No (%)
Consideration of patients' faith needs when conducting patient assessment	29	33	38
Consideration of patients' spiritual needs when conducting patient assessment	29	25	46
Consideration of patients' faith needs on communicating diagnosis	38	21	41
Consideration of patients' spiritual needs on communicating diagnosis	38	29	33

However, a notable number of NCHDs did not consider either need upon assessment, or when imparting a diagnosis. The comment of one respondent may reflect why this finding emerged:

"Patients' faith/spirituality [needs] are important in their response to illness but should not affect [medical] assessment /management."

MEDICS' ROLE IN ASSESSING FAITH/SPIRITUAL NEEDS

42% of respondents reported that they felt doctors have a role in assessing patients' faith/spirituality needs. 33% did not consider that doctors had a role with the remaining participants undecided. Analysis of the



supplementary qualitative comments revealed that respondents varied hugely in their perception of the value of possessing any knowledge about a person's faith/ spirituality needs as the following comments illustrate:

"Medical needs assessment is more important."

"I believe in the separation of church and state."

"Knowing about the patient improves communication."

"People from 3rd world countries where I come from tend to attribute their medical problems to spiritual causes. So being at peace spiritually is a huge placebo and also enhances adherence to treatment plan... this is very important in a multicultural Ireland."

Others reported that although they were aware of the importance of religion to their patients, they do not actively seek such information on assessment or were of the opinion that faith/ spirituality care should not affect assessment/management. The sensitivity of addressing patients faith/spirituality needs was also alluded to. Patient circumstance also dictated whether such assessment took place.

"I am religious myself and know how important religion is to many of the patients, but I don't make any effort in assessing this."

"Patients faith/spirituality care are important in their response to illness but should not affect assessment/ management."

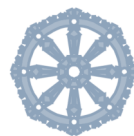
"Only if the patient is terminally ill."

"...Breaking bad news will depend on knowledge regarding the faith of the patient."

The majority of respondents consider that faith/spirituality issues have an influence on their interactions with their patients. The import they attributed to same is illustrated in table 10.

TABLE 10 PERCEIVED IMPORTANCE OF FAITH/SPIRITUALITY ISSUES IN INTERACTIONS WITH PATIENTS AND PERCEIVED IMPORTANCE OF TRAINING IN FAITH/SPIRITUALITY ISSUES FOR DOCTORS

	Not at all	A little	Some what	Quite a bit	Very Important
Perceived importance of faith/ spirituality issues in interactions with patients	12	17	17	29	25
Perceived importance of training in faith/spirituality issues for doctors	37	13	21	4	25



Over a third of respondents do not believe that it is important for doctors to receive training in faith/spirituality issues. In contrast, close to 30% hold the opposing view and believe that such training is very important or quite a bit. This is in direct contrast to nurses/midwives' perception of the need for training for health care professionals in this area (Figure 7). Only 21% of respondents reported that they were aware of the H.S.E Intercultural Guide. This was similar to nurses/midwives where only 28% of this cohort knew about the existence of the guide. Only two respondents reported that they had received education/training in this area. However, 46% of respondents reported they would welcome further education/training in the care of a patient's faith/spirituality needs.

SUMMARY

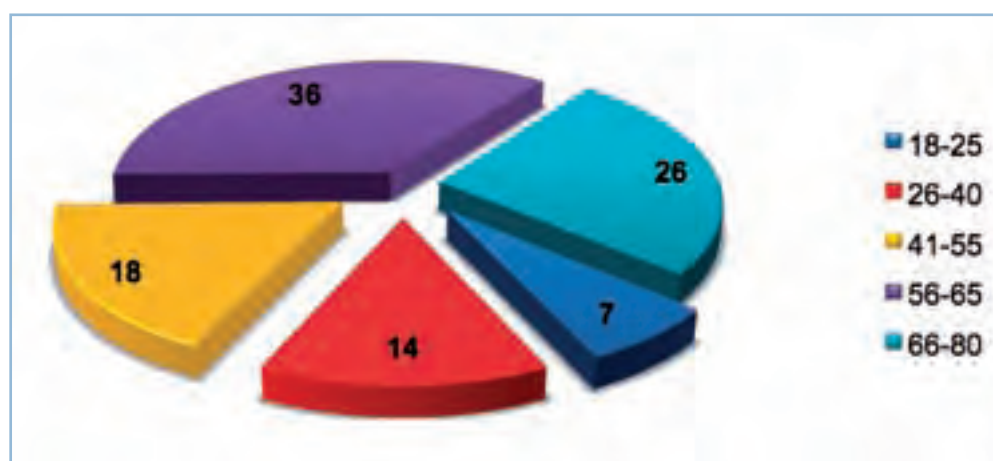
In summary, the assessment of faith/spirituality needs is not included as routine in medial assessment or considered when imparting a diagnosis. The need for such appeared to be context dependent (terminally ill patient) and physician dependent. However, the majority did consider that such information was important in their interactions with patients. The majority of the respondents had not received training in the area of faith/spirituality needs and the import on receiving such training in the future was not as acute as that reported by the nurse/midwife respondents. Similar to the nurse/midwives the majority of respondents were not aware of the existence of the H.S.E. Intercultural Guide.

STRUCTURED PATIENT INTERVIEWS

Three hospice patients participated in a loosely guided discussion on faith/spirituality needs in July. Their impressions were subsequently added to by the interviewing, in a structured manner of seventy five hospital in-patients on an individual basis over a seven day period in August 2010. Of the hospital in-patient population the majority of the participants were female (63%, n=45). The age profile of the participants (n=73; data not available on two participants) was broad and all age categories were represented. 62% of the participants were aged over 55 years old as Figure 8 illustrates.

FIGURE 8

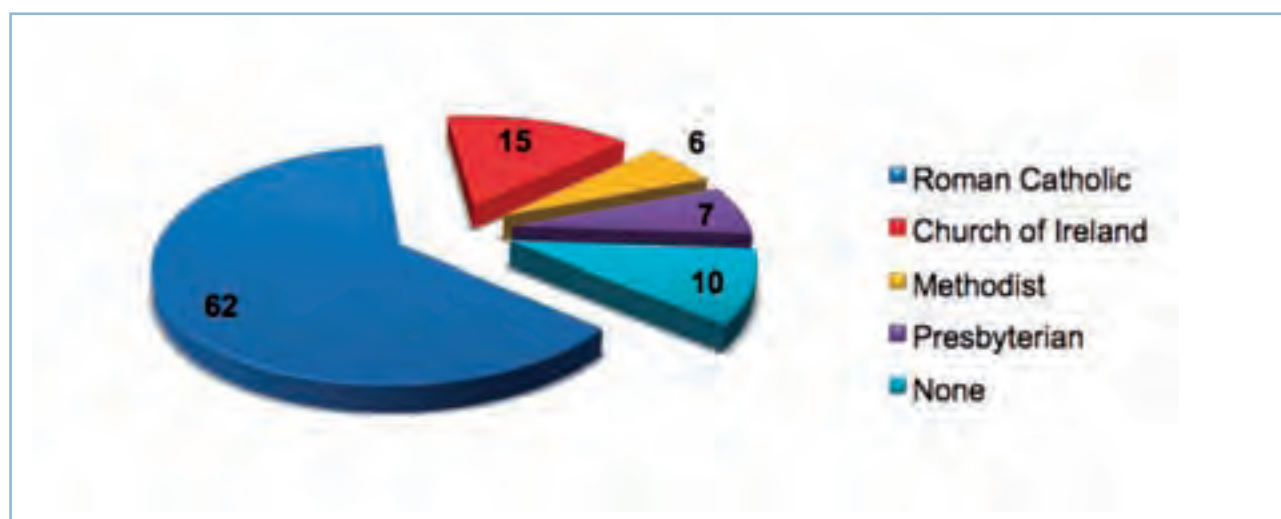
**AGE PROFILE
OF
PARTICIPANTS**





The majority of the participants that furnished their faith tradition (n=72) aligned themselves to a Christian faith tradition with the Roman Catholic faith tradition being the commonest (62%, n=45) (Figure 9). However, within the Roman Catholic tradition 13% reported that they were non-practising Catholics. A small minority reported that they belonged to no faith tradition. The participant faith profile is a good representation of the normal composition of patients attending the hospital as was confirmed by a record review of patients' religious status from January to March 2010.

FIGURE 9 FAITH TRADITION OF PARTICIPANTS



46% of participants reported that they had been asked their associated faith tradition on admission to hospital. A further 3% indicated that it had been recorded on a previous admission. The majority of these participants were not surprised that their faith tradition was ascertained from them. However, the majority could not recall who requested this information from them. Only one participant reported that they felt uncomfortable responding to the request for their faith tradition.

The majority of participants (93%) who responded to questions on services were not made aware of the availability of a chaplain/minister of faith on admission; or made aware how to contact the aforementioned; or made aware of the services of the chaplaincy team or the designated chapels within the hospital since their admission as Figure 10 details.

Just over half of the participants reported that their faith was either very important or important to them. Participants reported that faith based traditions and rituals such as prayer; mass attendance; reading the bible; reciting the rosary; holy water and praying to saints was particularly meaningful to them during their current admission.

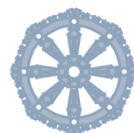
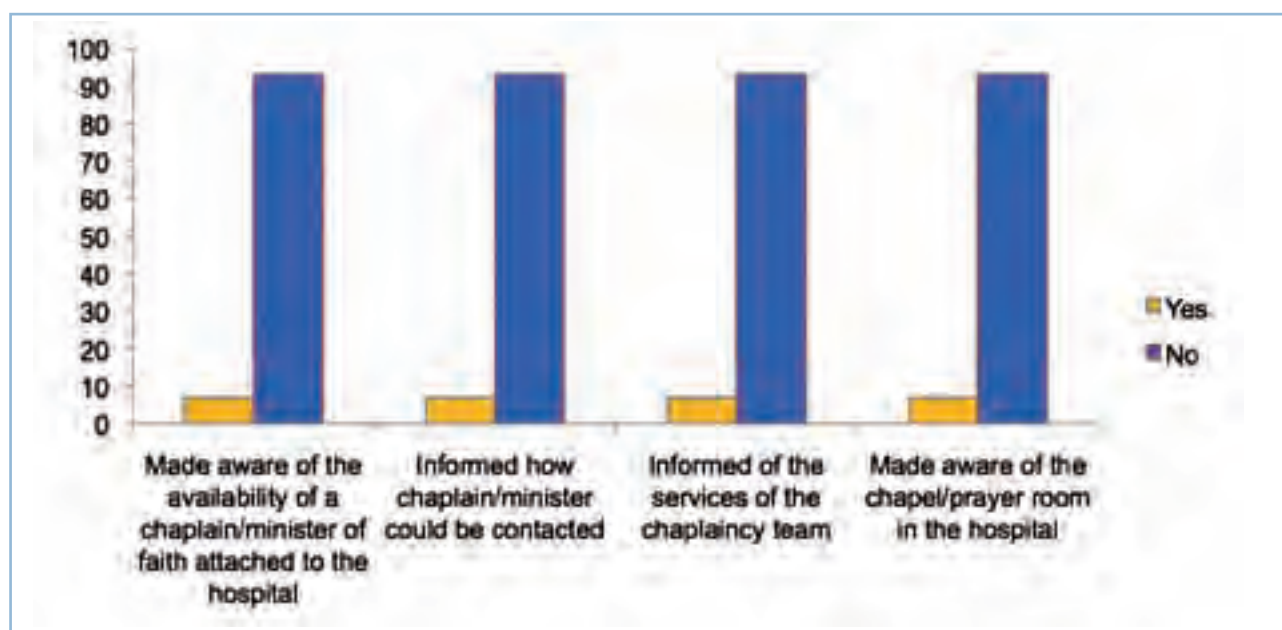


FIGURE 10 INFORMATION RECEIVED REGARDING AVAILABLE FAITH SERVICES/SUPPORTS



“Oh I pray to Padre Pio and various saints....there's hardly one of them I don't be talking to...”.

“No I'd just pray that day that they would do the right thing for me, that they'll give me the right treatment or do the rightwhatever...”.

“Oh yes I like to see the priest for Holy Communion...”.

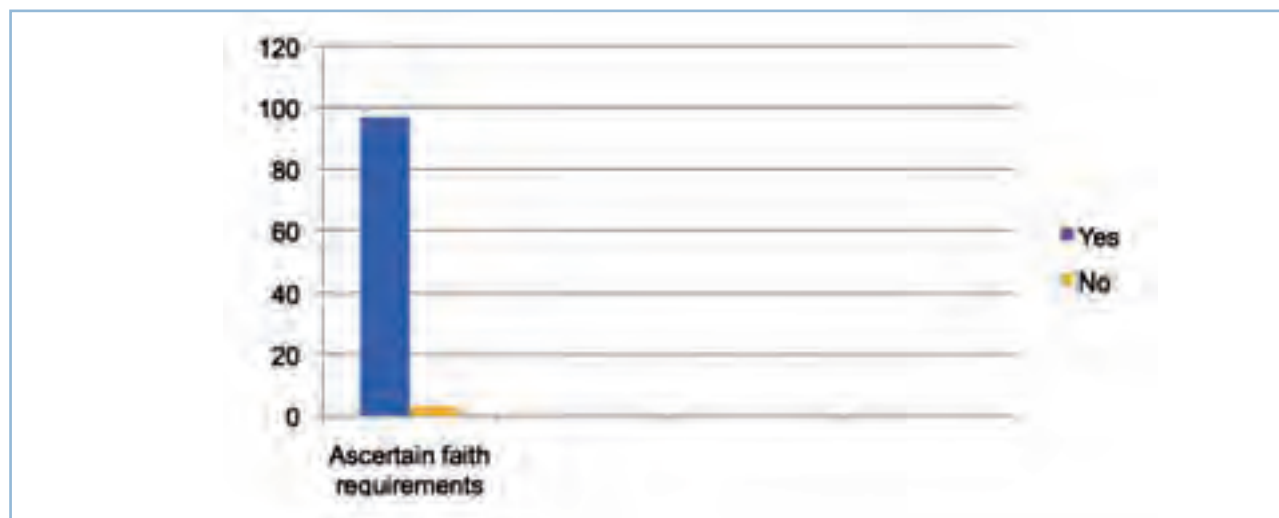
However, approximately one third of participants reported that such traditions or rituals were not meaningful to them. Indeed they reported that nothing was.

The majority of participants (97%) reported that their faith needs in relation to their faith tradition (e.g. Mass attendance; Holy communion etc.) was not ascertained from them since admission (Figure 11).

Nevertheless, all participants felt the hospital/hospice environment permitted them to follow their faith traditions as required. Acknowledged services offered by chaplaincy can be grouped into sacramental based and supportive. Exemplars of tailored made faith and spirituality based services in maternity and the hospice highlighted the institutions and chaplaincy's commitment to providing sensitive care to their patients/families. There was also evidence of the ability of the chaplaincy service to reach out and make a difference to patients with no faith affiliations. One woman in such a situation shared out she valued the chaplain's visits and found her interactions with them thought provoking. Participants relished both the tangible resources to support their



FIGURE 11 ASCERTAINMENT OF FAITH REQUIREMENTS



faith such as the availability of the church and the services performed therein and the intangible supports such as quietness and caregivers' presence.

"..they have a lovely chapel here with a Mass on a Sunday evening."

"You've peace and quiet."

Another intangible support valued by patients, was the time nurses spent with them. Participants who had been patients of both the hospice and the hospital were aware of the impact of the differing environment contexts on how their needs were met. They believed this was due to a lack of time available to nursing staff.

"It's different [hospital] because they don't have the time" (hospital and hospice difference)".

SPIRITUAL ASSESSMENT

No participant reported they were assessed in relation to their spiritual needs. However, only 16% of the participants considered themselves as spiritual with the majority (78%) unsure about whether they were spiritual or not, as they had no conceptualisation of spirituality, outside the boundaries of their faith tradition. Of those who did (n=19) the majority related the concept to "God". In light of this lack of conceptualisation regarding spirituality among participants; they were asked a series of questions that tapped into recognised spiritual needs such as sources of hope and strength during their current illness and what gives their lives purpose and meaningfulness. The same responses surfaced for all of these dimensions of spirituality. The leading source of hope/strength/purpose/meaningfulness for the cohort of participants interviewed was faith based; rituals and symbols featured predominately. Exemplars of same, included Quiet time with God; Bible; Mass attendance; rosary beads and saints. It would appear that majority of the patient cohort followed the channels laid down by their faith tradition to sustain their spirit. 19% reported that they relied on no sources of hope or strength during

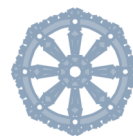


TABLE 11 SOURCES OF HOPE AND STRENGTH DURING ILLNESS

Source	No. of Responses	Source	No. of Responses	Source	No. of Responses
Prayer	23	Nothing	14	Friends	12
Quiet time with God	13	Walking	9	Talking	8
Bible	6	Reading	4	Desire to get better	2
Mass	2	Saints	2	Thinking	2
Shopping	2	Nature	2	Beads	1
Live life to the full	1	Staff	1	TV	1
Singing	1	Gardening	1		

* Participants could give more than one answer

Faith-based sources Interactive/interpersonal sources

their current illness. While twenty five participants were unsure of what gave their lives purpose and meaningfulness. Other sources of hope/strength reported were interactive/interpersonal based (Table11).

In times of spiritual distress (need), turning to God was the chief way that solace was sought by participants (n=24). Participants' friends (n=17) and families (n=15) were other sources of solace. One other participant reported that they would rely on their faith leader. As previous, a small number of participants believed they could call on nothing or nobody to assist them in times of distress.

SUMMARY

It is evident from the patient participants' perspective that while their faith needs were very important to them, their specific faith needs were not explored by staff. However, they still felt that the environment did not hamper their needs being met. Spirituality as a distinct concept is not something the majority of the participants comprehended. The dimensions of spirituality explored were intrinsically linked to their faith tradition. It was noteworthy there is a small but professionally significant cohort of patients who do not rely on faith based or other sources of support during their illness experience.



CONCLUSION

The meeting of patients' faith (associated cultural) and spirituality needs appears to be both caregiver and context dependent. There is a recognition that such needs exist but not a mirroring of the exploration or instigation interventions to meet identified needs taking place in a uniform manner. It is evident that caregivers require and would be receptive to further training/education in this area to assist them in their daily practice. Patients' overwhelming identification with their faith tradition to help them cope with their illness trajectory may be shaping how caregivers respond in meeting their faith/spirituality needs. It would appear that the manner in which the healthcare institutions currently address their faith needs (availability of faith rituals such as mass/space/chapel) is also sufficient to feed their spirit.

Summary points:

- The recording of faith affiliation on admission to the healthcare institutions is standard practice.
- Nurses, midwives and doctors do not conduct the assessment of patients' faith/spiritual needs in a uniform manner.
- Factors that preclude assessment include perceived lack of time; clinical factors and a belief that it is the patient's own private affair.
- A need for further training and education in relation to meeting patients' faith/cultural and spiritual needs was identified.
- The majority of patients reported they were not informed of the availability or breadth of the chaplaincy service in the hospital.
- Patients' perceive their faith needs are addressed effectively within the healthcare institutions.
- Patients were not familiar with the concept of spirituality but were with recognised dimensions of the concept.

Chapter 5 - Qualitative Findings 1

This chapter presents the qualitative findings in relation to how caregivers meet the faith (associated cultural) and spiritual needs of patients. The status of caregivers was detailed in Chapter 3. Thirty-five care givers contributed to this section. It was evident that there are distinct but interlinked elements to meeting patients' faith/spirituality/cultural needs. The findings are therefore presented in five discrete sections which although interrelated have distinct components and are co-dependent on each other. Perceived challenges to care delivery are subsequently presented.

CARE GIVERS CONCEPTUALISATION OF FAITH AND SPIRITUALITY

Caregivers had no difficulty in conceptualising patients' faith needs and aligned it to their affiliated religious tradition. There was recognition that they were not familiar with all of the different faith traditions of patients. In contrast, no common conceptualisation of spirituality emerged from the care givers. A number of different perspectives were given on the meaning of the concept and exemplars were shared with the researchers as a means of illustrating their understanding of the concept. The majority of caregivers described spirituality as a fusion of religious perspectives with some wider perspectives. Others articulated the difficulty in defining spirituality. It was evident that some caregivers' conceptualisation was restricted to the perceived boundaries of a particular faith tradition and/or religious practices. All caregivers recognised the need to have a holistic perspective of patients' needs inclusive of spirituality. When the meaning of spirituality was limited to a religious practice there was caution expressed in relation to not pushing spirituality onto a patient. The findings suggest that for some caregivers there is difficulty with the identification of areas of spiritual discomfort and spiritual distress.

The majority of caregivers perceived spirituality as something personal and driven by the patient but facilitated by the caregiver when required.

"..spirituality [a] personal thing to a patient ... not something we can force ...but something [if] they express, we facilitate - something that is offered particularly when people are unwell - up to them to decide."

According to caregivers the issue of religion or religious practices is foremost in the minds of patients coming into hospital. Where a patient is seriously ill caregivers offer them the opportunity to have a visit from the chaplaincy team. At other times, it would appear that the patient needs to articulate their particular spirituality requirements before the caregiver will address them. With no clear definition forthcoming on spirituality it was difficult to determine how a spiritual need might be expressed by a patient. While the quotation above suggests a religious type of expression, the following quotation identifies that it may be more in the approach of the



caregiver giving the patient time so that other needs may be forthcoming:

“...(Patient) not going to put a religious context into their .. concerns, ..psychological needsquestions that need to be answered - you treat them that way..... - not forcing some sort of spirituality on them - they will express their needs and how they want to be treated - if someone asks for a Chaplain...” .

Some caregivers giving direct care are not aware of the religious status of their patients and make assumptions based on icons and religious symbols that patients possess:

“You know you’re average catholic person because they’ll have their Rosary beads.....” .

Caregivers subsequently use these assumptions based on faith based cues to respond to patients’ questions or incorporate their presumptions into their care practices. Caregivers identified that the Roman Catholic religion was the most prominent religion in Co. Donegal. Caregivers who follow this faith tradition may be influenced and limited in perceiving a clear meaning of spirituality, and perhaps view spirituality through the lens of a religious practice. One caregiver alluded to this:

“....sometimes interpreted from religion - don't have to be religious to be spiritual ...it may incorporate religion and in Ireland probably does.”

There may be a fusion of perception between spirituality and religion. However, exploration of the meaning of spirituality revealed that some caregivers found it difficult to comprehend:

“hard to understand the word spiritual .. everyone has their own ...” .

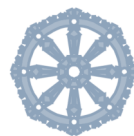
Some caregivers considered the wider dimensions of spirituality as demonstrated below.

“There is just somebody there looking out for me. I suppose there is a God but he's one God, he's not divided into all these different places. That, to me, would be spiritual.”

“..what gives purpose to their life or what they believe in.”

“...something about hope something I can connect with ---related to aspects of a higher power or higher being - something about how I feel .”

The above quotations demonstrate that some caregivers considered spirituality as broader than a particular religion or religious practices per se and considered elements such as vision, and hope. While identifying these meanings, caregivers considered how their conceptualisation may have been influenced in their formative years and experience in practice as epitomised in the following quotations:



"I would say probably a lot of it started from my own upbringing,.. "

"I've changed as a person remember the patients you've met along the way and their slant on life and you've taken that on board reflecting back on something somebody else said about the same thing."

"the more you're exposed to things, the more you think about things, then it makes a bit more sense,..., you're trying to,, reason why that's happening to someone with the same condition and the same symptoms, it's not happening to someone else, ...how that's impacting on a person....".

For some caregivers, there was also an awareness of how of their own personal life events influenced their present ability to be receptive and present to patients in relation to faith/spirituality needs:

"You start reflecting on life and what things mean thinking I suppose what is it all about really. You really start looking at..... how you deal with sickness even in terms of your emotions, your spirituality."

A hospice based nurse shared her conceptualisation of spirituality that guides her practice.

- S** Sense of who we are as individuals;
- P** Path we are on – our own journey;
- I** What is in us – how we were made;
- R** Respect for beliefs;
- I** Incorporate religious beliefs;
- T** Time out - take time;
- U** Us together;
- A** Always think of others;
- L** Love we share the lives we live."

For caregivers being able to describe how they might recognise a spiritual need as distinct from a religious need was a challenge. Some offered examples encountered with patients to demonstrate their description of a spiritual need. A spiritual need was viewed as different for each patient and was context related in terms of the patient journey. The following quotations suggests that the expression of a need may not be obvious or expressed in a categorical statement, rather the expression might be couched in another way which may seem trivial initially. The professional responds to this expression or cue in a way that permits further sharing by the patient as exemplified in the following:



“(patient) offload anything but..... It's more my legs aren't working; I'm not able to walk. It's not I'm dying or I'm not....It's very subtle” .

“gauge - body languageyou will get the vibes - body language a big one - responding to that with the patient -example way they inhalechecking it out with the patient ...” .

In contrast to a religious need, which the patient can articulate clearly and caregivers automatically understand, the articulation or interpretation of a spiritual need can be concealed at times, requiring further exploration by a skilled caregiver. Furthermore the spiritual need may be entangled with other aspects of the patient's life:

“- it is a personal thing and unless you have sat down with someone you would not have true insight into what is going on for them(their concerns, fears search for meaning).....”.

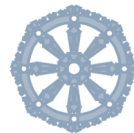
If the identification of a spiritual need requires exploration how can a spiritual need of a patient who is unable to communicate or has difficulty in expressing themselves be identified? The identification of spiritual needs requires an ability to assess a patient holistically and be quizzical when something is not “quite as it should be” as one example given by a caregiver identifies:

“Patients ... and required more and more pain reliefand others accept the fact and needed far less medication – “.

The previous quotation suggests that not all caregivers may be skilled in identifying a spiritual need, and subsequently failing to address a need has the potential to exacerbate further patient distress. One caregiver shared a graphic description of what she perceived to be a patient in spiritual distress and how the attentiveness and skill of a chaplain enabled the patient to find peace:

“(Patient)..... was like a battle axe. (grumpy, very angry) ... and XXXX came and ...(talked) it out and she was saying I've been religious and I've done this and why is thisHe brought her to peace. He helped her with her anger in the last week or two weeks of her life...”.

The previous quotations demonstrate not only the skilled identification of spiritual distress but also the skill required to deal with such distress. Such distress as exemplified in the previous quotation also suggests that spiritual distress takes time to address. Some caregivers believed that chaplains are not always alerted to a patient situation early enough, therefore they may not be able to address such issues as spiritual discomfort or spiritual distress. This suggests that there is a lack of understanding of spiritual discomfort or spiritual distress and its manifestation in a patient.



In summary, it appears that caregivers can relate to faith needs easier than spiritual needs, however, there is no common conceptualisation of this concept to base practice upon. Practice in relation to spiritual care appears to be context, patient and care giver dependant.

DELIVERY OF HOLISTIC PERSON CENTRED CARE

All caregivers expressed the view that spiritual, faith and cultural care was part of their role and an integral part of caring for the whole person. All caregivers spoke of how they attended to patients' spiritual, faith and culture needs as they perceived them, and to the best of their ability. Knowing the particular religion of a patient was important so that religious needs could be addressed. While engaging with patients of no particular religious persuasion or belief, caregivers expressed the view that they still believed that they had a role to perform. The next quotations demonstrate how the caregiver perceives she has a specific task to give information to the patient but also gives the patient the opportunity to speak about matters that are significant to them at that moment. The caregiver is therefore intuiting that there may be a need but does not want to force her personal perspectives on the patient:

"We have a job to do - deliver the facts, the information --- let you know you are there if they want to talk."

This quotation identifies that there is a dependency on the patient responding to the invitation to express a spiritual need and being able to express that need. As identified earlier, not all patients are able to do any or all of the latter. All caregivers expressed the view that as part of their role in health care delivery, all care should respect the faith, spiritual or cultural perspectives of patients and should endeavour to meet those needs in collaboration with the chaplaincy team. There was an emphasis on keeping the patient at the centre of care delivery and in responding to perceived or expressed needs while respecting their different wishes as captured in the following quotation:

"...and to be listened to and to consider that they're the only one person there at that time. ... very important, ..their needs are paramountmaybe they're not interested in religion; that's respected too.....".

PERSON CENTRED CARE

Keeping the patient central, meant anticipating that they might have a need and encouraging them to speak about how things are for them. The next quotation illustrates how the caregiver continued to invest time and energy in the person. Prolonged engagement, in addition to interpersonal skills are identified as the basis for faith/spiritual care.



“some people more willing to talk about how they are feeling inside -.....you might have to draw them out a wee bit - by asking people how are you? have you any concerns? just to talk and have time to listen - with some people harder to deal with.... they don't want to talk or express themselves...it is the interaction and the time you spend with them and the talk that you initiate and it can come from there.”

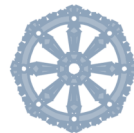
“they would want to stay,.... We would try and give them as much time as possible.”

Time was identified by many caregivers as an essential element to understand and identify spiritual relatedness for a patient. Caregivers also identified that the personal nature of spirituality requires time to probe a particular situation with a patient to help them with their spirituality issues. Yet other caregivers consider spiritual care delivery as simultaneously occurring with other aspects of care delivery contradicting the position that focused patient time is required. Spiritual care delivery involves being connected with the patient to permit identification and exploration of issues of a spiritual nature to emerge. On occasions, this requires prolonged engagement with the individual. Addressing a spiritual need; be it a discomfort or distress requires further uninterrupted time. To address spiritual health issues simultaneously while attending to other aspects of care may limit the level of care delivered. As identified earlier, patients who do not have a particular religious need may have spiritual needs. Keeping the patient central and giving time, enabled caregivers to pick up signs or cues that the patient wished to talk or needed time with the caregiver. In reality, some caregivers do have more time to be present with patients. This seems to be context dependent or role dependent. Caregivers whose role involves more direct patient care used intuition to respond to potential patient cues. How these cues were subsequently responded to depended on the caregivers knowledge/skill base in the area of faith/spirituality.

In the following quotation the caregiver is in a situation and relies on her own experience to be able to deal with the situation but still at the end of the interaction is left wondering if she had done the right thing:

“One lady.... on night duty and I went down with a cup of tea to her and she caught me by the hand and she started cryingand she said “I know I’m dying but I don’t want to hear that I’m dying; I don’t want to hear it out loud.” And her and I had a long chat a whole lot of things going on personally for her I gave her a hug and said...”There is nothing I can say to you except to say that I really feel for you.” and you think you are not saying the right thing or you might be worrying that you are not saying or doing the right thing”.

In this situation the caregiver had the courage to give time to the patient and listen. She responded to the cues emitted and engaged with the situation; while the cues were obvious there were other choices that she could



have made. The caregiver identified with the distress of the patient and assessed there was a need. Albeit an informal assessment, the caregiver nevertheless was measuring what she was seeing in her patient against some personal standard and in the process identified that something was wrong. She utilised her own knowledge base to discern what she should do. However, at the end the caregiver was left wondering if she had done the right thing. Having had no formal instruction on how to deal with such a situation she questions her own knowledge base as a basis for her action.

ASSESSMENT AND RECORDING

It is evident that caregivers were engaging in some form of faith/spirituality assessment and were endeavouring to address identified needs in a somewhat individually informed way. However, no formal structure to record written evidence of assessment, plan of care or other detailed information appears to be used.

“... done on admission never look back at it again - kind of put to the bottom of your list in recording yet it is part of everything you do”.

“no record you will see elements in the communication (midwifery/nursing notes) e.g. anxiety 4am”.

However some ‘sacramental’ specific religious practices were recorded at times:

“we record religion and if they were anointed but not otherwise - at times if you had sat with patient you would write this in nursing notes”.

Non recording of interventions in care records in relation to faith/spirituality care could be due to the historical emphasis of accounts in relation to medical type interventions. For nursing and midwifery, the care records constitute the paperwork which the professional uses to document the patient care and also consult to have a detailed insight into the patient’s needs and the plan of care to meet those identified needs. These notes also convey how the patient is progressing toward their optimal health function with identified health care needs. One caregiver stated that the records do not adequately address the many interventions carried out with the patient:

“I don't thinkwhat we document gives full credit of the care we give.”

For many caregivers being able to articulate spiritual, faith or culture needs was challenging. Therefore in relation to using a problem solving and patient centred approach there would be an additional problem of not knowing how to record or what to record. Some caregivers alluded to these types of difficulty when they stated:

“hard to write down.”

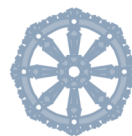


“the only way is responsesee the patients.”

The first quote relays the difficulty caregivers have in writing the detailed assessment, planned interventions and setting some goals in relation to spirituality. The second quote refers to the identification of evidence to measure care given to meet a spiritual need. Non-recording of these aspects, leads to a lack of continuity in care of the patient and subsequently a lack of focus on holistic health outcomes. Caregivers referred to writing key information in relation to on-going treatment and recovery from a medical perspective but not from a faith/cultural/religious perspective. No caregivers referred to the use of any assessment tools to assist them with the process of identifying faith/culture/spiritual needs or planning care to meet specific needs; however as highlighted earlier, an individual informal assessment is carried out and in this process caregivers are alert to any cues that might indicate a spiritual, or faith need. However this approach is dependent on having quality time with the patient. One caregiver recognised that a spiritual assessment tool might be useful for teaching caregivers in situations where the patient does not have a belief in any specific religion. Using an assessment tool for all patients would increase the probability of identifying spiritual and cultural needs of all patients. The limitation of recording an affiliated religion only, leads to the non-identification of spiritual needs, which may have implications for aspects of care delivery.

Caregivers spoke with passion about the care they strived to give caregivers/families. In some areas, there was a legislative requirement for detailed records to be kept. There were also policies to be followed. Caregivers from these areas took a different view to recording than other caregivers. Documenting was seen as a mechanism for clarity, and a way of being clear about instructions in relation to aspects of the care. In addition, to the formal required records, other information was gained through surveys in an effort to improve the quality of the service. These surveys were carried out on the initiative of the caregiver and the information gathered was discussed to see what implications the findings revealed for the service provided and the caregiver involved. This also gives feedback to caregivers on how they are performing and can serve as a motivator to meet the faith/cultural needs of patients.

Holistic person centred care identified that all the caregivers spoke of the importance and centrality of the needs of the patients. There was no formal mechanism of assessment or recording of the spiritual/faith needs or the interventions that might be undertaken to address these. It is not clear who is responsible for ensuring that faith/spiritual needs are met. Some specific faith affiliated activities are recorded. No evaluation of interventions to address the faith/spiritual needs is carried out. The decision making process in relation to referral to the chaplaincy services is unclear. Caregivers endeavour to meet the needs of the patients; however the abilities, capacity and support of the caregiver needs some focus.



COMMUNICATION: A KEY SKILL IN ATTENDING TO SPIRITUAL, CULTURAL AND FAITH NEEDS

Ways of attending to faith, cultural and spiritual needs involve the art of communication. Communication is important between caregivers, with individual patients and with families or significant others. This communication was unidirectional, therefore the opening of a relationship with a patient was important and perceived to be the open invitation to the patient. The following quotation highlights this quite well:

“having an open friendly manner...this encourages the patient”

This open friendly manner is the basis of the relationship and the continued communication with the patient. It includes the overall appearance of the caregiver and their corresponding body language which indicates openness to the presence of another. In the real situation of health care delivery, this requires personal awareness and insight into the personal perspectives that may influence an encounter in addition to making a deliberate effort to be totally present to another. One caregiver recognised that being able to be totally present to another requires one to let go of previous encounters and to see each patient afresh. The caregiver acknowledges that this may not be easy:

“...sometimes it can be difficult- have to have ways of overcoming that before I go to the next patient.”

The approach to a patient exhibiting total attention permits the identification of aspects from the patient communication that indicates something is not quite right for them. Engaging with the patient through this approach and having appropriate information regarding a patient or family situations made it easier for some caregivers to fulfil their role in attending to spiritual, faith, and cultural needs; however the informal communication mechanisms utilised in the hospital might make this difficult. Caregivers who are in possession of knowledge about patients and who are skilled in communication are able to modify their way of working so that the environment remains calm and pleasant for those around them. This following quotation demonstrates how through their use of knowledge the caregiver engaged with all members of the family to meet their spiritual needs:

“.... we try and get them in ... before the other family members would arrive. there might be someone else in the family ... had a disagreement or whatever with them ...”.

Here the caregiver identifies that previous knowledge of a particular family situation is beneficial; this gives caregivers the opportunity to consider other ways that would be respectful in meeting the needs of all family members. Communication between caregivers is important.



“a lot of the time we would depend on XXXX telling us as soon as possible....” .

In the midst of every day practice, caregivers become aware of incidents where other caregiver's communication skills may be questionable. This was more evident in situations where communication content was disappointing or of a shocking nature as identified in the following quotation:

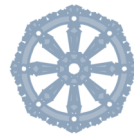
“...I remember,there was a woman inand ...XXX. opened the curtain, and told her that she was dying.. “ And she said “I’m not dying.” ...XXX .said “you are and you will die within....” And she says but can you not just take it out?” XXX.....said “no, you will die within the six to eight months.” And we went in and she just sat there, she had no expression, she had nothing and I put my arms around her and ...”.

In the previous quotation the caregiver was identifying some insensitive practice issues as a consequence of poor communication skills on the part of the person imparting the diagnosis and how she used the verbal distress of the patient as her cue to respond to the patient's spiritual distress. This identifies that in the midst of the work environment there is an attentiveness and openness to others who may need support and help. Some caregivers alluded to the fact that it is part of their philosophy of care:

“that's part of our philosophy of care, it's part of our ethos”.

Being able to empathise was an important element of communication and the part of the art of responding to faith, cultural and spiritual needs of patients and families as caregiver perceived them. Empathising enabled the caregiver to pick up on subtle cues that there was a need. The possession of empathetic skills enabled them to engage with the patient and respond intuitively to where the patient was at in their life journey as exemplified in the following quotation:

“.... Indirectly you might get a question about do you think I'll get any bettermore spiritual or wondering. You'd get a lot of that in physio and they think of physio and hope and getting better. So you've to build up your rapport with them, see where they are at on their journey and work with that. If they are at a certain stage it's not my place to pull them back unless it's something unrealistic or unsafe.answering it as they're able, to manage at that time but honestly.... Anything I was uncomfortable with in terms of faith, that I didn't feel I would be able to answer, ... feed through the nurses to the chaplaincy or if they wanted a minister or a priest,... I suppose it's very much an informal, very much as the patient needs it. ...But it came up quite subtly on days you're not expecting it and from patients sometimes that you're not expecting either.But I always try to be honest but I suppose not detrimentally



honest, with some hope, because that is part of my role. It's not a false hope as such. I suppose it's where you are the minute, ..."

"getting to know the patient, you kind of know who wants an honest answer and who wants a kind of a nice answer."

In the previous quotations, caregivers engaged with patients sufficiently to be able to empathise with their situation. Using finely developed listening skills and analytical abilities, they were able to discern what exactly the patient is looking for or wanting without stating it. Such conversations are context dependent and require very skilled practitioners to engage. Yet as was evident previously, not all caregivers possess these skills and caregivers that do possess these skills have a multitude of other tasks that minimises their direct care time with patients. Such conversations do not occur in a once off meeting, but rather within a relationship built on trust, confidence and mutual respect. Again in the acute care setting, many patients have a shorter hospital stay and this further erodes time that could be gained in conversation with caregiver. However, some caregivers do not perceive this situation as a disadvantage:

"...you may not get the depth with those patients but sometimes it is easier for them to open to a stranger ..."

Caregivers were cognisant of the potential impact that a reduction in the length of stay in hospital would have on their ability to establish the bedrock of giving time to meet the patient's needs. For the most part, the development of the therapeutic relationship is contingent on the time it takes to develop a relationship. However, caregivers are open to the possibility of patients communicating on difficult matters with someone in a professional role whom they have not had the time to build a relationship with. A decrease in duration of hospital stays further supports the development of written based evidence of the assessment of spiritual care needs and the subsequent interventions that are employed.

Engagement with patients to meet their spiritual needs requires good interpersonal skills including self-awareness, open attitude, ability to be totally present to another, empathy and confidence. What was difficult to ascertain from caregivers was what strategies or techniques they used to help a patient with their spiritual needs. For some caregivers praying was appropriate. The caregiver had established a relationship with a patient and engaged sufficiently to establish that given other factors praying was appropriate:

"I prayed a few times - I would with the dying. I'm not catholic but if somebody's dying...I remember... I was off at 12.30 and I remember I sat until 1.30 praying.. did what catholic prayers I know, ... her family couldn't get there on time. So I sat for that half hour until



somebody else came didn't like pulling the curtains and leaving them. And then the other people (patients) can be uncomfortable there as well."

It was clearly evident that caregivers listened actively to patients and used empathy. However, caregivers were also conscious of the extent of their own skills and ability to deal at times with patients' faith/spirituality issues, and sought assistance when required.

"Anything I was uncomfortable with in terms of faith, that I didn't feel I would be able to answer, feed through the nurses to the chaplaincy I suppose it's very much an informal, very much as the patient needs it. But it came up quite subtly on days you're not expecting it.... , and sometimes you're sort of thinking "oh, what's the best way to answer this?" You can be taken off guard and. ...".

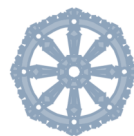
The chaplaincy service was also requested to deal with patients of no religion if deemed appropriate and acceptable to the patient.

The art and skill of communication was deemed very important in addressing spiritual/faith /cultural needs. Relating to another and being totally present requires uninterrupted time combined with refined and developed interpersonal skills. The supports for the caregiver to continue to develop and refine these skills into therapeutic interventions needs addressing.

KNOWLEDGE TO CARE

This importance of knowledge to assist caregivers to meet the faith, cultural and spiritual needs of patients and families in health care was very evident. There was an emphasis on gaining knowledge through experience and practice with sources of knowledge including patients and colleagues. Some practical knowledge was gained from reflecting on experiences. This was satisfactory from the caregiver's viewpoint when the religious or faith practices were those they were familiar with. Other religions were more challenging. Some caregivers were familiar with the H.S.E. Intercultural Guide.

It was evident that caregivers strived to deliver quality care in relation to meeting patients' faith and related cultural traditions. For non-health care professionals such as catering and mortuary caregivers this meant adhering to the relevant legislation, regulations and local policies. This is particularly important in the correct preparation of dietary requirements for some patient populations such as Jews and Muslims. However, the existence of legislation and policy guides for practice did not preclude openness to new ways of doing things or finding other ways of recognising and meeting the needs of service user/patients. Caregivers strove to maintain



a balance between doing what was right according to legislation, regulations and policies and endeavouring to meet needs of service users in ways that were respectful of their culture and faith expressions as encapsulated in the following quotations:

“We have a cultural book (HSE Intercultural Guide) up there in the Chapel of Rest and all of that information is in it. ... we would try and accommodate them as best we could..... But if there is any special requestwe would make sure it was carried out. “

All caregivers identified the need for knowledge in relation to faith, culture, and spirituality. A variety of sources were used to gain the knowledge and to continue to update that knowledge as illustrated in the following:

“ we would be led by the xxxxx (other professional) and the ward” “if we get or receive a request we will do our utmost But we asked her (patient) and she told us what to do and we did it.”.....we would ask others to see if they would be aware of it, or we would ask our colleagues in xxxxxxx (another location).”

In one area they recognised the need for regular updating in relation to cultural practices:

“we have half hour sessions for training sessions”

Some caregivers recognised the resources available to them while others consulted with their colleagues in an effort to gain knowledge. What is evident is that not all caregivers are aware of all the resources available to them:

“intercultural training – voluntary”

“It’s the inter cultural guide and it goes through every single religion.(HSE Intercultural Guide)and it tells you exactly what you should be doing and in terms of death rituals and the cleaning and touching of the body”

“I remember... I don't know what religion...face them to the sunrise or something must have been a Muslim...we rang a doctor in the middle of the night. ... “we don't know what to do here.”

One caregiver recognised that possessing knowledge in itself was not enough; it was exposure to experiences of different culture that gave opportunities for learning from practice and to enhance knowledge already gained.

“worked with and never understood until I worked in it - preconceived ideas that people have learned and what they are hearing from the media etc ... that unfortunately transfers in the way we treat people -...”.

The previous quotation identified that there was a personal interaction and engagement with the knowledge to



enable the practice to be respectful of another culture. Other caregivers shared this perspective when they spoke of how this knowledge is gained:

“remember one patient getting her off the ventilator relationship with her - she was content - she comforted me -she talked to me - she was so in tune with herself - experiences like that have helped me cope and deal with other people - you cannot teach someone....different things you do - some of it is experience or people you work with or courses you done ...- in general we do very little of anything like that - recognise it in your own life with your own situations - life gives you that, you realise as you progress - when you are very young you don't realise it and you don't get it in your (first professional course) something that develops --- further education does help.”

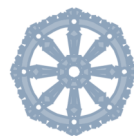
“education around the subjects - learn by experience - the longer you work at things the better you become.....your faith and spiritual care is no different to other aspects of careit depends on people's make up how you approach - think it is nurtured through experiences - more and more diverse culture -with different beliefs I think listening to patients and their different needs and expectations..... until you encounter you will not remember - and with that exposure you have to be open you have to be willing to accept these people with their own beliefs.”

“role play not something you can read from a book it is very difficult ...only with confidence would you be able to ask these questions or pick up on these things some education some theoryneed education ..regularly particularly in relation to communication within that.”

There was a general consensus that knowing was not enough, experience was included but required other interaction with the knowledge as identified in the following:

“reflect on our own spirituality - self-reflection help meet needs of patients.”

Caregivers recognised that they gained a lot of knowledge through practice and engaging in reflective practice. In the context of the current working environment, with a decrease in length of hospital stay and an increase in the acuity levels of patients, the opportunities to reflect on experience may be very much reduced. Reflection is best engaged in with others who can challenge your assumptions on aspects of the experience. It is not clear who the caregiver would be able to engage with for reflection. Reflection would be important for developing the application of the knowledge gained from other sources to individual patient situations. It would also be beneficial in helping to identify aspects of spiritual and cultural care delivery which require change and also identifying what would be required to change aspects of care. All caregivers identified that they gained



knowledge about faith, spirituality and culture from working in health care and endeavoured to increase this knowledge from other sources including the HSE Intercultural Guide, the internet, patients and other colleagues in the health care environment.

There was emphasis on gaining spiritual/faith/cultural knowledge through experience and practice with sources of knowledge including patients and colleagues. However, for the most part these sources of gaining knowledge were individualistic and could be capitalised upon to increase the knowledge base of many other caregivers. There was an acknowledgement that more formal education was necessary in addition to experiential knowledge.

RECOGNISING ROLE AND EXPERTISE OF CHAPLAINCY

All caregivers were familiar with the chaplaincy team and viewed their role as very important in meeting or helping to meet the needs of patients. Caregivers appreciated the chaplains and the many ways in which they contribute to the provision of health care. An element of familiarity with the chaplains was evident. For some caregivers, there was evidence of an on-going relationship; however other caregivers viewed the role of the chaplaincy team as solely patient-focused. Caregivers acknowledged the presence of the chaplains within both environments. Within Letterkenny General Hospital their presence was very evident:

“very lucky with the ministers that we have - we all know them - everyone has a relationship with them - they are very visible - here all the time.”

Within the Hospice no dedicated chaplaincy team is on site. However, the chaplaincy team from Letterkenny General Hospital fulfil this role. Hospice caregivers felt that while they would like more presence of chaplains on site they are very happy with the service the Hospital Chaplains provide:

“they’re very good, they do their absolute best, they’re very involved. They’re very supportive of the caregiver ,we can bleep them at any stage if someone becomes very ill or a family want prayers said. ... we are quite lucky ...”.

Some caregivers expressed the view that they could involve the members of the chaplaincy team at any time and this was found to be extremely necessary but also very much appreciated by caregivers.

“yes on-going all the time - make time for you - they are part of the team.”

“Chaplains a big role... I would contact them ... need for more lay involvement (as lay chaplains).”

What is evident for caregivers is that the Chaplaincy Service is recognised in both the hospital and the hospice.



Where caregivers have a relationship with the chaplains this is viewed as valuable and really appreciated. Chaplains are involved in different ways in both the hospital and the hospice; remembrance services, reflection services, blessings in addition to one to one with caregivers and patients.

Some caregivers felt that the chaplains provided an important role for caregivers also:

“we know we can talk to the chaplains at any time and they are very open to that. I mean, if I had an issue with something in the morning, I'd have no problem picking up the phone and asking one of them to come and speak to me about it.”

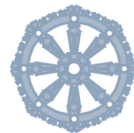
Other caregivers in the hospital did not consider the chaplains had a role in meeting their own faith/spirituality needs. Caregivers spoke of their understanding of the role of the chaplaincy team and the importance of this role in assisting patients to meet their needs. Caregivers within the hospital did not automatically furnish patients with information on the chaplaincy service. All caregivers identified that the chaplaincy team were marvellous and could not imagine being able to provide for patients needs without them. Some caregivers viewed the chaplaincy team as part of the wider multi-disciplinary team to be called upon while others viewed the chaplains as being very closely linked to meeting the patient needs on a daily basis. Some caregivers acknowledged that when they identify a patient as ill they will call upon the chaplain as a support for the patient:

“very ill focusing on faith needs – would call the chaplain.”

Other caregivers felt that the chaplains needed to be involved in patient care from an early stage and not when patients are very ill or dying when effective engagement cannot occur between patient and chaplain. This further supports the view of a recording of spiritual assessment and the detailing of interventions. These would need to include information from all caregivers working with the patient, as alluded to earlier some caregivers who spend more time with the patients are not involved directly in decisions about alerting chaplaincy services.

The next quotation identifies where a caregiver was aware of the spiritual distress of a patient and was able to identify that other interventions such as being present with the patient and speaking with the patient had not been successful in enabling her to find peace. The expertise of the chaplain is very obvious in the view of the caregiver:

“.... And he just came inHe was just brilliant.was dying and she was a young woman and she was so angry. She was only 50 she was like a battle axe. And I remember.. her and XXX fought it out and she was saying I've been religious and I've done this and why is this



and he was just so helpful to her.He brought her to peace. He helped her with her anger in the last week or two weeks of her life.”

In non-acute areas of the hospital the chaplains also were deemed to have a very important role with either caregivers or relatives. Caregivers identified with confidence that they would call on the services of the chaplains at any time.

“...we would get the Chaplain out to say prayersand that would bring it to a conclusion...”.

The presence of the chaplaincy services within the hospital enabled some caregivers to engage with the chaplains about personal issues. For others they just did not consider that the chaplains could be there for them as well as patients.

“(support of chaplains for you) Noprobably not their fault never thought about that.”

For all of the caregivers, there was an appreciation for the work and effort of the chaplains and the valuable service that they provide. However within the hospital, caregivers identified that some customs and religious practices could be considered insensitive to patients not affiliated to that particular religion or to those of no religion. Exemplars of same included the distribution of Holy Communion and ward prayers.

“I don't mind [Holy Communion distribution] but I must say there is a bit where I do feel embarrassed. People do feel awkward about it (the patients).”

In summary, the chaplains are well known to caregivers. There is an obvious appreciation for the role overall, however greater clarity in relation to the role with caregivers and the decision making process around referral needs attention. Some faith practices may conflict with the needs of all patients in some areas therefore this too needs attention.

EMBRACING DIVERSITY IN CARE DELIVERY

Caregivers acknowledged that Ireland is becoming a multi-cultural society and in Donegal there has been an increase in the population of people from different cultures. Caregivers recognise that there are challenges in becoming familiar with this changing context of health care delivery. There was an acknowledgement that each patient is different and that practices within health care should respect this, and caregivers expressed an openness to adapting practices to embrace a variety of different cultures.

Caregivers expressed the desire to familiarise themselves with these cultures, but they perceive that this will be



difficult as for some the only exposure they have had to different cultures is within the healthcare environment. Therefore they have to rely on information from other caregivers or from the HSE Intercultural Guide. Some caregivers perceived that exposure to different cultures outside of the health care environment would help them to come to a better understanding of that culture:

“increase in different cultures...takes time to get to know them -sometimes keep to themselves in the community and you don't have a background knowledge..... you don't decide -take the lead from the patient.”

Without the valuable source of gaining cultural knowledge by exposure to different cultures outside of the health care environment, caregivers are dependent on written sources of information, gaining knowledge from colleagues and then ultimately checking practice out with the patient. There was recognition that many of the caregivers would have done professional courses in another country or have professional experience in another country prior to being employed in Donegal. For some caregivers the knowledge gained from this exposure was viewed as valuable in helping them understand the many different aspects that need to be considered when attending to the needs of individuals from different cultures:

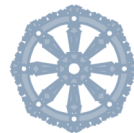
“meet a lot of people.....international..... it was a great base.”

“(have training)...don't go in deep enough - worked with travellers and never understood untilAfrican culture will breast feed but not for the 1st 3 days -they formula feed for 1st 3 days ..worked in Saudi - the Muslim community don't know enough about their culture ...- media influence -its perhaps we don't know enough - really should be - should come in with an open mind ...” .

In the second quotation, the caregiver recognises that it is exposure that gives the full understanding of the culture. The caregiver acknowledges the influence of the media in developing an understanding of a culture in the absence of experience. The practice of taking a lead from the patient is important as media exposure may give the incorrect vision of a particular culture or may influence the development of an attitude which is not respectful of a particular culture. Caregivers acknowledged a lack of in-depth knowledge on the majority of cultures but were open to finding out the information and gaining knowledge. The work of groups and specific training to increase cultural knowledge was acknowledged:

“a lot done through the cultural diversity group”

“.....intercultural training but it is voluntaryalthough they do have reduced sessions



(time) to help uptake.....”.

Some caregivers were not familiar with the H.S.E. Intercultural Guide and used colleagues to help identify how a different belief system should be embraced in care giving. While it is good that caregivers would source such knowledge, a wider understanding may enable them to have more insight into other ways of being respectful to other needs.

For these caregivers it was not just the different cultures but knowledge of the practices of some religions. As Roman Catholic faith is the dominant religion in Donegal it is taken for granted that all caregivers would know what elements of the faith practices would impact on care:

“...this thing where you've eaten an hour before..” .

Some caregivers consult with the HSE Intercultural Guide, the internet, colleagues and specific individuals to help them understand and apply that understanding into their work practices. This knowledge gives them a confidence to consider how they might be respectful in their work practices. This confidence also enables them to liaise with families in order that their practices are inclusive and respectful.

*“With the travelling community ask who is in charge. There's no easy way around it.
...you deal with that person and that person only. They have control over everyone else...”.*

Caregivers illustrated that the healthcare environment had an open attitude to meeting diverse needs. Exemplars of trying to meet patients' needs were shared:

“.....we asked her (patient) and she told us what to do and we did it.”.....we would ask others to see if they would be aware of it, or we would ask our colleagues in xxxxxx (another location).”

Being aware of a lack of knowledge is important but having the interest to do something about this requires energy and time. One caregiver acknowledged that sourcing particular products to meet a need was important. Applying cultural and faith knowledge in respecting those beliefs were important and required applying knowledge to specific details:

“...Halal prepared and cooked in a particular way...”.

There is openness to embracing the cultural needs of patients. For some caregivers previous exposure to different cultures supported them to be able to identify and meet needs of patients. Within County Donegal there is limited



and infrequent exposure to different cultures therefore all sources of knowledge need to be capitalised upon. The HSE Intercultural Guide and personal experiences of some caregivers could be utilised in the continuous development of knowledge.

CHALLENGES TO CARE DELIVERY

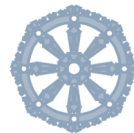
While it is evident that caregivers are respectful of the spiritual, faith and cultural needs of patients', challenges are encountered in the facilitation of same. Limited exposure to different cultures and faith traditions increases the challenge of gaining knowledge and insight into practices. However, it is apparent that all the resources available to support caregivers in relation to the latter could be utilised more. Not all caregivers are familiar with the H.S.E. Intercultural Guide which is a resource which is available within all areas. The majority of caregivers have worked in other countries and have in-depth knowledge of cultures, sub cultures and faith traditions. It would be useful to ascertain the numbers of caregivers from different cultures, and the numbers who have worked in another country as this may be a resource on which to capitalise knowledge. There is the probability that some informal sharing is already taking place but there is an indication that this is not as widespread as it could be, as shared by one caregiver:

"..not really a little but not as much as it could be ...".

Where informal sharing is taking place this may also be limited to one location. Additionally gaining knowledge of another culture or faith tradition includes gaining an appreciation for the beliefs which underpin or influence why certain ways of practising are important. Working with different faith traditions which have views which are in opposition to the philosophy of health care can be very difficult to reconcile with as identified in the following:

*"hard to comprehend the rationale, Jehovah Witness and blood products –could save life ...
and to think they will not take it."*

The respect for the different faith and culture traditions and the openness of caregivers to be adaptable and support specific aspects was obvious, however, the understanding of spiritual needs for patients of different faith traditions were viewed only through the lens of that faith. Because a patient may be affiliated to a religion it is assumed that their spiritual needs will be subsumed in that religion or faith tradition. Therefore, patients may have spiritual needs which go unidentified or unmet. This may be further challenged when the patient does not speak English. While there is access to language translators this makes discussion of such specific personal issues quite difficult and it would appear that families who are not able express those needs will attempt to deal with some areas themselves:



“ ...Difficult with non-nationals - we will try and be sensitive timesdifficult - difficulty around assessment of needs - particularly with language barriers sometimes families just do their own thing.”

Caregivers identified that they dealt with situations and some of these situations were more stressful to deal with due to a perceived lack of practical supports. Caregivers recognised that the space provision to meet with patients and relatives in private was important to assist them giving non-intrusive time to listen and allow patients and families opportunities to share. Caregivers also recognised that such a space would be important for caregivers themselves to be able to reflect on experiences in practice.

“nowhere on the ward, there is nowhere to go fortold terrible news that day, theinto that officethey're in and out the door (other Caregiver). There's actually nowhere ...”.

Caregivers identified that they had a role to fulfil in relation to meeting the spiritual, faith and cultural needs of patients and their families. Some did acknowledge the demands that this placed on them personally and identified some situations as being more difficult than others to deal with:

“But young childrenwould affect youwhen you have kids of your own and everything it really brings it home to you...”.

The location of both Letterkenny General Hospital and Donegal Hospice means that inevitably caregivers have either direct contact or indirect contact with patients and relatives who are in traumatic situations. The uniqueness of both these locations means that caregivers do not change location or careers at the same pace as other city institutions. Therefore they have acquired knowledge of each other which enables them to anticipate how a caregiver colleague might be affected by a situation and be able to give support. Other caregivers acknowledge that only people you work alongside will be able to appreciate the situations of health care. Therefore it is not surprising that they acknowledge colleagues as the principle form of support:

“...peer supportable to share just to say to them is enough .. not looking for answer I think this is the big thing - at work this is the only thing.....”.

The increase in the pace of health care delivery means that caregivers have less time to give this support. However they point to the significance of maintaining this support and identifying time for this to occur:

“tough on junior caregiver - they do need support from senior caregiver ...everything else gets time so why not for them? ..” .



Caregivers identified that outside of the immediate work environment there was a lack of a formal structure of support or debriefing. They identified that there were notable times in their work experiences when it is evident a formal debriefing would be appropriate. They also felt however that if they expressed a need this would be met:

“if we went seeking it there would be... we’re not offered it.”

Within the hospice environment there was a clear identification with a variety of support mechanisms. Within the hospital environment there are informal support mechanisms but not all the caregivers were aware of how to access or when. Therefore there is a need for information regarding informal support mechanisms that can be used by all caregivers. Support mechanisms are useful to help caregivers become more self-aware and increase their ability to deal with aspects of life that emerge in the process of working with individuals on an ill health journey experience. Caregivers emphasised the importance of being able to keep one’s own life in perspective and to switch off after a day working with others. They shared how they do various activities to attempt to switch off but add that realism is important:

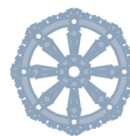
“....Unless there is another professional that's in the same as yourself, it's very hard not to take your work home with you.....” .

“ but at home go for a walk --do something to take your mind off or do somethinggood to talk to someone else some days worse than others.....”.

“.....your own spirituality does affect - your own wellbeing - be in a better place one day that you are another day.....”.

Caregiver sharing indicates that they are open to the diverse needs of patients and to embracing this in the delivery of care. While caregivers strive to keep patients at the centre of care and make every effort to attend to their needs it would appear that some needs may not be identified and unmet for the reasons outlined in the themes. The ability to attend to spiritual cultural and faith needs requires key skills and caregivers gave good insights into how these skills can be developed. There are opportunities for learning that could be utilised better and the education should involve all caregivers.

From this study it is evident that there are challenges for the caregiver in relation to the faith, spiritual and cultural needs of the patient that necessitate being attended to. Adequate record keeping of all aspects of care delivery in relation to faith, spiritual and cultural needs attention. More formal structures would be beneficial for all aspects of faith, spiritual and cultural health care.



CONCLUSION

It was evident that caregivers strive to deliver quality patient care. However issues such as a lack of conceptualisation or varying conceptualisations of the phenomenon under exploration made care delivery difficult. Care for a patient's faith and the associated cultural and spiritual needs is considered part of the role of all engaged in health care delivery. Chaplaincy plays a key role in meeting patients' needs and a lesser role in supporting the caregiver to do so. Lack of structure in relation to assessment; recording and evaluating of faith/spiritual care is marginalising it. A need for knowledge enhancement is required to assist in sensitive care delivery.

Summary points:

- All caregivers strive to deliver person centred care which includes meeting patients' faith/cultural and spiritual needs.
- The manner in which patients' faith/cultural and spiritual needs are addressed by caregivers is person and context dependent.
- It is not standard practice to document the interventions employed to meet patients' faith/cultural and spiritual needs
- All caregivers recognise and value the role of the healthcare chaplain in meeting patients' faith/cultural and spiritual needs.
- Addressing patients' faith/cultural and spiritual needs in the healthcare environment is challenging.

Chapter 6 - Qualitative Findings 2

INTRODUCTION

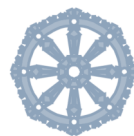
Twenty-one leaders from 14 religious groups were invited to participate in this study; of those 18 were interviewed¹. These represent 12 groups – eight Christian (*Roman Catholic, Baptist, Methodist, Anglican,, Presbyterian, Reformed Presbyterian, Kingdom Praise Fellowship and Church of Pentecost*) and four other world religions (*Islam, Bahai, Sikh and Hindu*).

Of these 12 religious groups three have resident chaplains – Roman Catholic, Anglican and Presbyterian. These are people paid by the hospital to function as chaplains and are part of the hospital staff. There are four full-time Roman Catholic chaplains (two priests and two lay people), a part-time Church of Ireland chaplain and a part-time Presbyterian chaplain (both ordained ministers). Along with these there is a de facto Baptist chaplain, a lay man, who works on a voluntary basis. These chaplains form the chaplaincy team in the hospital and share a chaplaincy office. They see chaplaincy in the hospital as an integral part of their work, and they have structures for meeting and working together. But the majority of the religious leaders interviewed do not see themselves as chaplains as such. They are ministers in their own communities, and as part of that ministry will visit members of their communities in the hospital and hospice. Some of these would have little or no contact with the resident chaplains. As can be seen in the table below the appointed chaplains represent between them the religious affiliation of 95% of the population of Donegal. (Central Statistics Office, 2006)

TABLE 12 COUNTY DONEGAL – RELIGIOUS AFFILIATION

Religion	Number	%
Roman Catholic	127,258	86.41%
Church of Ireland	6,583	4.47%
Presbyterian	5,830	3.96%
Methodist	702	0.48%
Other Christian	666	0.45%
Muslim	375	0.25%
Orthodox	141	0.10%
Other	1137	0.77%
Not stated	1098	0.75%
No religion	3474	2.36%
Totals	147,264	100.00%

¹ The Jewish community in Ireland was contacted but reported no Jewish community in the Letterkenny vicinity. The Letterkenny Christian fellowship agreed to participate but cancelled the appointment and didn't respond to further requests. One Roman Catholic chaplain declined to be interviewed.



PERCEIVED FAITH AND SPIRITUALITY NEEDS

There is a common understanding of faith care across the churches and faiths. It consists of both an explicit religious dimension (prayer, scriptures, rituals) and personal caring (friendship, counselling, crisis support). While this human caring may have no explicit religious content it has strong religious meaning for all the leaders. For them such caring represents faith in practice. All of the Christian chaplains/leaders spoke about the key role expected of them in this faith care.

“My main role would be visiting my own folk as and when they are in the hospital for whatever period. I don’t have that many in the hospice, thankfully. In the hospital you never know, you could have one or you could have three, it just depends on the situation and I would generally try to visit them on a regular basis for as long as they are in, irrespective of what other Chaplains might be visiting them at the time.”

They see themselves as providing a service wanted and expected by their respective congregations. Among the eastern religions the formal religious leader is not seen as playing a key role in this – that is the work of family and friends within their particular religious traditions.

The predominant desire expressed by most of the religious leaders is for faith care to be provided within individual denominational/faith structures and delivered by their own people. There was very little sense of a common religious/spiritual framework within which faith care could be uniformly administered. The religious leaders understand that the specifics of their respective religious traditions are important to the patients, particularly in times of illness, and their primary hope is that the hospital and hospice will recognise and accommodate religious difference in a framework that is respectful of and friendly towards all.

ADDRESSING PATIENT NEEDS

While all of the religious leaders share the same broad view on the faith care needs of patients, there is a range of approaches to providing a response, from proactive and structured among the appointed chaplains to reactive and informal among the visiting chaplains/leaders.

APPOINTED CHAPLAINS

All the chaplains see the two elements of pastoral care (religious support and personal care) as part and parcel of an overall spiritual care.

“My vision is to bring the patients nearer to God through showing them care and compassion,



helping them to experience God's love."

The chaplaincy service of all of these to both hospice and hospital includes an explicit religious dimension (prayer, sacraments) and a broadly counselling role (building inter-personal relations, crisis support). This service is offered to patients, their families and staff. As noted above, the Roman Catholic chaplaincy is by far the largest and is the only one that has full-time staff. The Roman Catholic team is composed of two priests assigned by the bishop and living in on-site accommodation provided by the diocese, and two lay people appointed by the HSE. The team as a whole visit assigned wards every day. They speak to each person in the ward and follow up with those who want to engage further or refer them to their respective religious leaders. They do communion rounds, attend removals, including for relatives of staff and lead the prayers. The priests have sacramental duties including daily mass, confessions and administration of the sacrament of the sick. The Catholic chaplains have their own chapel in the hospital.

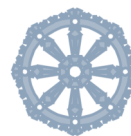
The Presbyterian and Anglican chaplains are part-time and share a chapel. Their activities include pastoral visitation, conducting of prayer services and responding to emergency calls. They share a chapel in the hospital providing services on alternative Sundays. As with the other chaplains they include families and staff as part of their brief. They do this both reactively (engaging with them informally) and proactively (responding to them in times of need).

The volunteer chaplain from the Baptist tradition is a retired layman who had an interest in ministering to those in hospital; his role gradually expanded. At this point he functions effectively as a member of the chaplaincy team. With the support of other chaplains he was verified as a chaplain and received a chaplain's badge, which has given him the same access to staff and patients as any of the other recognised chaplains.

OTHER RELIGIOUS LEADERS

All the other leaders interviewed have full-time roles outside of their engagement with the hospice and hospital. They function on behalf of their respective religious communities and their focus is on visiting their own faith community members. They do this in an informal, reactive way, responding as the need arises. They hear by word of mouth from within their own communities if there is a patient in need of visitation. Some of the Christian leaders are contacted by official chaplains. Some will come during official visiting hours on the same basis as any other visitor. Others will come outside of hours if the need arises, and generally find that the hospital staff are accommodating.

By and large, they do not consider their work as part of the hospital or hospice response to the care needs of



patients. They see it as a response of their respective faith communities. Their only real concern is to be able to access the patients. Here the feedback in relation to the hospital and hospice is uniformly positive. None of the religious leaders raised any issue in regard to feeling restricted, or excluded within either institution.

As above their visits have two inter-related elements - prayer and scripture sharing on the one hand, to very practical personal supports on the other.

With the Christian churches, there is an emphasis on the role of the designated leader in visiting the patients. With the other world religions the emphasis is on the role of family and friends in visitation. According to the Muslim participants there is not a strong tradition of the Imam visiting hospitals in the same way as religious leaders in the Christian churches do. The Imams will offer prayers in the Mosque but it is the Muslim family and friends who visit and support the patients, including providing spiritual support through reciting the Koran. In any event there is no resident Imam in Letterkenny. A similar point was made by the Hindu participant. As with the Muslims, the visitation of the sick by religious leaders is not part of the Hindu tradition. This is carried out by family and friends.

The Baha'i have no clerical caste and one of their core principles is to mix with other religious groups in a spirit of friendship. Baha'is visit members of their faith in the hospital or hospice on the same basis as any other visitor to the hospital.

RELATIONSHIP BETWEEN STAFF AND RELIGIOUS LEADERS

There is obviously a major difference here between appointed chaplains and visiting religious leaders. The appointed chaplains are members of staff, have an assigned role within the hospital as part of the overall service delivery, and have working spaces in terms of an office and chapels. The others are essentially visitors; some come within regular visiting hours and would not seek to be distinguished in any way from other visitors. Others come sometimes outside of regular visiting hours as chaplains on behalf of their churches, and have become known and accommodated by staff.

APPOINTED CHAPLAINS

The appointed chaplains as staff members interact with the staff to a much greater degree than the visiting religious leaders. There was unanimous feedback from them in relation to staff. The chaplains feel welcome, included and appreciated.

“Well the staff have a very high respect for Chaplaincy. Unbelievable! Way beyond anything



you'd ever expect. That's a great motivation, that's a great motivation to commit yourself to all the areas of the hospital and hospice and the psychiatric unit."

There is a very definite sense that faith care is not marginal to what is going on in the institutions, that staff and management are part of a wider culture that appreciates the role of faith, particularly in times of illness, crisis and death.

"Our role is recognised and valued by patients, staff and management in both institutions. They will take the initiative to call us in as we are needed. We don't feel marginalised. There are strong, personal relationships with staff at all levels across both hospice and hospital."

The chaplains are also quite clear that their pastoral care remit extends to the staff. Just as the chaplains are there to provide personal, crisis and religious support to patients so also they are there to provide the same for staff. And the chaplains see that this is understood and welcomed by staff.

"My overall comment about Letterkenny General is that I've been - I think I'll say, overwhelmed really, with the sense of appreciation for Chaplaincy and it permeates right down to canteen and maintenance and the cleaning staff and the lads that keep the grounds so beautifully clean and tidy. They think chaplains are great and they'd even ask, now that they know me, ' You look very tired, are you alright?'"

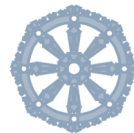
One of the chaplains referred to a meeting between chaplains and management some years back where the role of chaplaincy was explored. Management committed to supporting the chaplains and the full recognition of their role. The chaplains believe that the management have lived up to that commitment since then.

VISITING CHURCH LEADERS

The Reformed Presbyterian pastor generally visits outside of visiting hours and finds that he is accommodated by hospital staff. He also spoke about one of his congregation who died in the hospice.

"The staff asked me to provide a prayer service afterwards to bring closure. I was glad to be asked and glad to do that."

Another visiting church leader is a retired layman. His role gradually developed from his interest in ministering to people in hospital, he is now a regular visitor to the hospital. A third would generally visit during regular visiting hours, but occasionally he is called in outside of those hours. His experience of the hospital staff is that they recognise his role and are supportive of him. On his part he is anxious to accommodate the needs of the hospital and not be in anyway intrusive or disruptive.



A fourth church leader finds the hospital and hospice very positive environments to work in, with a strong culture of care and neighbourliness permeating staff at all levels. He will on occasion visit outside of standard visiting hours, and because he is not as well known to staff as the official chaplains, he is sometimes challenged by staff as to his business in the wards.

A fifth pastor has no concerns about the place of faith care in the hospital or hospice. He sees the visitation as an important part of his busy ministry. So his primary concern is simply to meet his own church members.

“I don’t generally engage with the staff or other chaplains, and I don’t even know the location of the chaplains’ office.”

A sixth church leader; a lay activist visits members in hospital as part of his church work; his experience is that the staff are welcoming and accommodating. The prayer style of their church is charismatic, involving dance and singing. They are conscious that this may not always be appropriate in a ward where other patients are ill or sleeping.

“The staff accommodate us. And we also accommodate them – we adapt to the culture of the hospital.”

OTHER WORLD RELIGIONS

“I am a regular patient at the hospital so I know what it is like there. There are no issues for us in the Hindu community. The care provided by the hospital is good. The Hindus do not require any particular consideration or religious services. Generally the Hindus are liberal in their ecumenism, and don’t have any difficulty or sensitivity about being visited by Christian chaplains.”

As noted earlier there is no formal chaplaincy system operating with Muslims, Sikhs, Baha’is and Hindus. None of those interviewed reported any areas of concern in regard the hospital or hospice.

“As Muslim’s we find the staff considerate, supportive and inclusive.”

Apart from a concern that the staff should be aware of cultural practices especially in regard to death and diet, there was no indication of any deficiencies in the hospital or hospice in regard to consideration of their needs. On the contrary, the consistent point being made is that the hospital and hospice present a welcoming, caring environment where people’s religious sensibilities are not violated. Bahai’s have no clerical caste.



“One of our core principles is to mix with other religious groups in a spirit of friendship. Our members have had no difficulties with the hospital.”

INTEGRATION WITH WORK OF OTHER STAFF

It was only seen as relevant to the appointed chaplains. They are part of the hospital ‘emergency response team’ which includes counsellors as well as chaplains, and represents the hospital care strategy at times of emergency. They are automatically contacted when there is an emergency.

“We have a bleeper system and are contacted automatically as part of the overall hospital response to emergencies etc. We are also contactable by mobile phone. The hospital is proactive in contacting us. Also individual staff members will approach us if they feel that a particular patient is in need of chaplaincy support.”

It seems very clear from the chaplains’ perspective that they feel part of the system. Their experience is that their role and the place of religious faith in the overall delivery of patient care, is appreciated and respected.

“No, I feel very, very much at home here, and an example of that would be if a cardiac arrest happened I am part of the team, I go there, I just ask the name from the nurses or the doctors, they give me the name and I do my work with them. I do feel part of the team; I’m very well received here.”

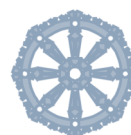
There is also a sense of a clear division of labour. While the caregivers see faith care as part of the overall package of patient care, they also see faith care as delegated to chaplains and not part of their core role. So they would be anxious to ensure that faith care happens as needed, and would call on the chaplains to provide it. For one chaplain this has negative consequences:

“In the hospital there is a tendency towards the separation of the medical and the spiritual. While the spiritual is highly valued there is a culture of confidentiality in regard to medical information that does not include the chaplaincy. So we do not take part in case conferences for instance, as chaplains would as a matter of course in some other hospitals. We may be asked to go and see a particular patient who is distressed, but would not be offered information as to the cause of that distress.”

That example of the complete separation of the medical and spiritual is not the experience of all the chaplain:

“Or they would tell me about the prognosis of the person, and ask me to keep an eye on the person.”

By and large the ‘division of labour’ did not emerge as a strong negative theme among the chaplains. They are



glad that the specific function of faith care is seen as their specialisation, and they are glad that that specialisation is welcomed within the wider system of patient care. They also see that while caregivers do not engage in faith care in an explicitly religious way, the culture of care and respect for patients is already implicitly constitutive of, and supportive of that care. This is very much in keeping with the overall vision of faith care among the chaplains, which includes practical caring as well as explicit religious support. Broadly, they see the staff as committed to the former, and delegating the latter to the chaplains.

CHALLENGES IN EXECUTING CHAPLAINCY ROLE

Mono-Cultural, Inter-Cultural and Multicultural Approaches to Religious Diversity

While the religious leaders are fundamentally positive about their role in the hospital and hospice, and about how that role is received, there are challenges and tensions. As might be expected these are stronger for those who are involved more, particularly the appointed chaplains. And broadly speaking, the main focus for these challenges and tensions is the growing diversity of churches and faiths. All the leaders were clear and strong on the need for respect for and accommodation of diversity. But there are some differences apparent in how this can best be achieved. It may be useful here to look at the concepts of monoculturalism, interculturalism and multiculturalism. Interculturalism is essentially about interaction between majority and minority cultures to foster understanding and respect. It is about exploring and expressing commonalities. Multiculturalism acknowledges the need for recognition and celebration of different cultures in a society (National Consultative Committee on Racism and Interculturalism, 2007). Both are essentially respectful of difference. The latter emphasizes the need for accommodating difference, creating space where each culture is given freedom to function according to its own lights. The former emphasizes the value of creating spaces where the different cultures can come together. These are not necessarily mutually exclusive.

Monoculturalism (Sue Wing and Sue, 1999) is an assumption about the normativeness of one's own culture or tradition and, in contrast to racism or sectarianism, is unconscious. It is predominantly a product of enculturation. Many people of a monocultural bent are well meaning. Monoculturalism is damaging to minorities especially where there is power with the predominant culture to impose standards.

Broadly speaking the challenges that arose could be viewed and understood within a framework of the three approaches. There are tensions evident between mono- and multi-culturalism on the one hand, and between multi- and inter-culturalism on the other.

It seems clear that the centre of gravity among the religious leaders is multi-culturalism. This includes an explicit



rejection of mono-culturalism. None of the religious leaders is proposing a mono-cultural approach. But because mono-culturalism is unconscious it is possible for it to continue in some forms, and some concerns were expressed on this point in the consultation.

Some of the religious leaders were anxious to go beyond multi-culturalism to inter-cultural encounters. But the different religious groups had different readings of the potential and desirability of inter-culturalism in the light of their own particular religious tradition, and this also resulted in some issues and tensions.

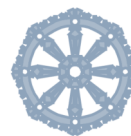


MULTICULTURAL PREFERENCE

The predominant desire among the religious leaders in the first instance, is for a multicultural approach. They believe this is also what their membership wants. Especially in times of illness, crisis, birth and death, members have a strong attachment to the particulars of their own faith tradition. In the case of the Christian churches, this includes a strong attachment to the place of the clerical leadership. For the other world religions, there is not the same emphasis on clerical leadership in the context of hospital or hospice, but there is a strong desire that the cultural practices particular to the religions be understood and respected. The following analogy is presented to illustrate the perceptions of the chaplains/faith leaders and their interpretation of their congregations' wishes. *All of the religious traditions fit under the broad category of spirituality, analogous to the way that apples, pears, oranges etc. all belong to the generic category of fruit. But fruit has no existence other than in the specific form of apples or oranges or pears. You can't eat fruit in general, only particular fruits. Predominantly the leaders want to supply the religious fruit of their respective traditions and believe that is what the patients want.*

MULTICULTURAL AWARENESS

The leaders of the Baha'i, Muslim, Hindu, Sikh all drew attention to particular cultural practices that are important to their members, and were anxious that the hospital staff and management be aware of and as far as possible accommodate.



The Hindus do not require any particular consideration or religious services. The only issue is that most do not eat meat, and would welcome this to be taken into account in their hospital care.

Religious Sikhs carry on their persons five symbols that are very significant for them, and insofar as possible should not be taken from them, at least without discussion first. These are the five K's - Kesh (uncut hair), Kanga (a wooden comb), Kara (a metal bracelet), Kirpa (a sword), and Kachera (an item of underwear). A number of Sikhs are strict vegetarians and prefer to eat food cooked in their own homes and brought in by family members. There are very strong prohibitions on the handling and keeping of the Sikh scriptures.

The Baha'i leader would welcome an initiative in the hospital to inform staff about the Baha'i community and in particular their religious practices around the death of a member. Baha'i dead must be buried within an hour's travel distance from the place of death. Baha'is do not embalm or cremate their dead. The dead body is washed and wrapped in a shroud. Baha'is are often buried wearing a Baha'i burial ring. The only ceremonial requirement of a funeral is the recitation of the Prayer for the Dead.

Two Muslim leaders were interviewed. One emphasized the closeness of Christians and Muslims and felt there was no need for any specific initiatives in regard to Muslims. The other was more conscious of the spectrum of views within the Muslim community, from conservative to liberal, and of the need to be sensitive to both. He spoke of the value of providing education for staff in regard to Muslim faith and culture. He would also welcome the inclusion of Muslim religious symbols in both institutions and the provision of a Muslim prayer space similar to what is available in the psychiatric hospital.

The leader in the African Church of Pentecost spoke of a desire for some designated space for prayer in Pentecostal style. The issue here is that the characteristic form of prayer of his church doesn't always fit in with the needs of the hospital. If people in a ward are sleeping or very unwell the loud prayer can be disturbing. The members also have some cultural practices mainly associated with birth that are especially relevant to his young church. They have some ritual practices around eating and cleaning at the time of child birth and would welcome if the hospital staff were aware of these and insofar as possible, could accommodate them.

The Catholic position has a strong emphasis on a multicultural approach. They believe that church and faith groups can pursue their respective chaplaincies in parallel to one another, each being faithful to its own tradition while being respectful of the others. In view of that, the Catholic leaders are committed to denominationally based chaplaincy. They believe that people want and would expect a chaplaincy service from within their own



church. They believe that the same holds true for the people in other Christian churches and for those belonging to non-Christian religions. They want a good relationship with all these groups based on mutual respect. They do not see that chaplaincy can operate under a broad 'spirituality' umbrella.

MONO-CULTURAL FEARS

As noted above mono-culturalism assumes the normativeness of a particular culture or tradition. Some examples of mono-cultural practices were named in the consultation. A very explicit one was the presence of a fixed crucifix in the mortuary area. The cross and crucifix represent different theologies in the Reformed and Catholic traditions. The fact that the crucifix was fixed was understood by some leaders of the minority Christian churches as an assumption of the normativeness or superiority of the Catholic position. An example was offered of how this issue was handled in a multi-cultural way in another hospital. The crucifix was present in the mortuary but not fixed. By the simple gesture of turning it around it became a cross.

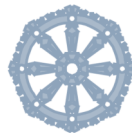
Other sensitivities around multi-culturalism were the manner in which some religious practices were conducted in public wards.

In a situation where one religious tradition is by far in the majority there are particular difficulties. How does it pursue its multi-cultural entitlement to enable its own particular practices without that pursuit being experienced as a mono-cultural imposition?

INTERCULTURAL INITIATIVES

The need to address the religious diversity issue was named by a number of the designated chaplains. There is openness to an intercultural approach, but there are different views on how far this can be brought. Some are supportive of the current arrangements in regard to joint services with other Christian churches, but recognise real differences between some of the churches in regard to theologies of death and the after-life, which in the context of a hospital and hospice take on a particular significance.

Some see no basis for joint prayer services with non-Christian religious groups, because of the belief that it is not the Christian God that these groups pray to. Others have a different view and sought to promote inter-faith prayer. An effort to include Muslims in a neo-natal service for stillbirths and miscarriages was rejected by the majority of the chaplaincy team, against the desire of one chaplain. Enquires showed that sharing worship with other faith groups had never been attempted in any HSE establishment or church setting in Donegal. Without such a reference and without the support of the superiors in each denomination, most chaplains were unwilling



to take the initiative as a first in this area. However, the chaplains were willing to disagree and go through a period of strained relations in their attempt to pursue the possibility of shared worship, aware of the H.S.E. policy on intercultural inclusiveness and human rights legislation.

While there was openness among many of the leaders of minority churches and faiths to intercultural possibilities there was also a note of caution arising from a sense that there is a spectrum of views within their respective memberships. While some of their members might be liberal and open others are more conservative and would be less comfortable in intercultural faith settings.

CONCLUSION

The faith, cultural and spiritual needs of patients attending both institutions are catered for by the recognised chaplaincy team and visiting faith leaders. The chaplaincy team meet faith/spiritual needs through the execution of sacramental rituals; support and 'presenting' with patients and their families. The chaplaincy team perceive they are a resource for staff needs also. Both institutions are perceived as being receptive and welcoming of the role that chaplains/faith leaders play in healthcare delivery. There is an opinion that in the main, caregivers perceive that the meeting of patients' faith/spiritual needs is the remit of the chaplaincy team. There is no formal acknowledgement of chaplains as members of the multi-disciplinary team although they are members of specific purpose teams. The increasing multi-cultural patient profile is challenging the chaplaincy team to reflect on their future response to these patients emerging faith/spiritual needs.

Summary points:

- A number of ordained; non-ordained health care chaplains and faith leaders provide faith and spiritual care to patients in the healthcare institutions.
- Healthcare chaplains perceive their contribution to patient care is valued and recognised by caregivers.
- Healthcare chaplains feel their role encapsulates religious support and personal care.
- Healthcare chaplains are not an established member of the multi-disciplinary health care team.
- The evolving multi-cultural/faith healthcare environment is challenging and requires healthcare chaplains to reflect on the appropriate mode of practice for the future delivery of faith/spiritual care.

Chapter 7 - Discussion and Recommendations

INTRODUCTION

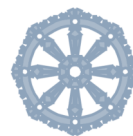
This chapter will discuss the key issues that emerged from the review of the literature and the research conducted to meet the objectives laid down. It will be presented under faith, spiritual; cultural needs and healthcare chaplaincy provision. When interpreting the findings, the study site profile requires consideration. The research was conducted in County Donegal - a principally rural border county which is recognised to be less ethnically diverse than the country as a whole but has a higher proportion of another stated religion (Catholic being the stated religion). A number of economic; political and social factors have shaped the culture and climate of the county. The care providers and patient are a microcosm of the wider county population.

The provision of holistic care includes the meeting of the psychological, social, cultural, and spiritual needs of individual people and their families; as a consequence it is incumbent on health care professionals to assess patients' faith/spiritual needs. Early nursing leaders, such as Florence Nightingale of the 19th century, Jean Mance of the 17th century, and Hildegard of Bingen of the 12th century, practiced and wrote about nursing with spiritual and religious inspiration (Carr, 2010). Furthermore, there is an increasing acknowledgement in the empirical literature of the role that faith and spirituality plays in patients/carers ability to comprehend and cope with their illness (Koffman et al. 2008; Allen and Marshall, 2010). Faith has been recognised for its ability to serve as a source of empowerment for active participation in care (Maliski et al. 2010) and that addressing persons' spiritual needs is emerging as useful intervention for persons with mental health issues (Lloyd and O'Connor, 2007). This growing body of research accentuates further the need to assess and meet patients identified faith and spiritual needs.

FAITH, SPIRITUAL AND CULTURAL NEEDS

Recording of faith tradition

It was clearly evident from both the admission clerks' responses and the earlier record review that patients' faith affiliation is predominately requested and recorded on admission. The very high percentage of recorded faith affiliation needs to be reflected upon - are patients told such information is mandatory or is it that the majority of the patient cohort are members of a faith tradition and are happy to volunteer such information when requested? If it is the former, the organisation needs to be clear about why the collection of such information is mandatory and reflect if, how, and to what extent it contributes to patient care. It is also recognised that such information is considered personal and private for many individuals and therefore the organisation needs to reflect on if the context of its collection is amenable to protecting individual's privacy. The significant percentage of admissions clerks who were either questioned or subject to verbal abuse as a result of initiating the question



about faith affiliation indicates that the general public are uncertain about either what the information is required for, how it contributes to their care or how it is deployed within the organisation. To counteract such uncertainty it is suggested that patients are informed about the need for such information, be given the opportunity to give their permission as to how this information will be used and given the choice as to whether or not their faith affiliation is recorded.

The conceptualisation of religion/faith tradition appears to be unambiguous in the literature with a general consensus that “it is an organized system of beliefs, practices, rituals, and symbols” in relation to the sacred (Koenig et al. 2000). Both caregivers and patients appeared to be comfortable with what was their or a patient's faith tradition and could deliver or receive care to varying degrees within the boundaries of the predominant Christian faith traditions encountered on a daily basis in the healthcare institutions. However, it was clearly evident that there is no common conceptualisation of spirituality in the healthcare institutions or among caregivers. Caregivers had difficulty at either the comprehension or articulation level when spirituality was being explored. This finding was not unexpected and mirrors the empirical literature where no common conceptualisation of spirituality emerges either. It is also evident in the literature that healthcare professionals mirror society's difficulty in defining and articulating what spirituality is or what constitutes spiritual care (Mc Sherry and Draper, 1998; Baley et al. 2010). Potential dimensions of spirituality found in the literature include *finding meaning; connectedness with self, others; or higher being; congruence of values and beliefs; love; hope and strength*; (Mc Sherry and Draper, 1998; Tanyi, 2002; Narayanasamy, 2004; Miner-Williams, 2006, Paley 2008). Care givers and patients in the study identified easier with some of the dimensions alluded to in the literature than the concept of spirituality as a distinct entity in itself. It is noteworthy that there is consensus in the literature (Noble and Jones, 2010) that religion and spirituality are not synonymous but also that they are not mutually exclusive and such an appreciation was evident. Some would view spirituality as a core component of the more broadband concept of religion while others would consider that they fit together under the umbrella concept of spirituality. The ability or desire to separate religion from spirituality was clearly problematic for patients and some caregivers. Patients had an inherent difficulty conceptualising the concept of spirituality as distinct from their faith allegiances.

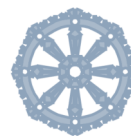
It was clearly evident from each of the different cohorts of caregivers that they considered patients' faith and spirituality issues important and incorporated them within their work practices to the best of their ability. Participants who had not a clear conceptualisation of spiritual needs/care framed the meeting of patients' spiritual needs within the boundaries of their faith tradition. Caregivers in the main believed that it was intrinsic to the care they delivered. The notable exception was the non-consultant hospital doctors who held mixed views on



whether it was part of their remit as medics. There was evidence that caregivers referred patients to the chaplaincy service when requested or when they perceived such a referral was necessary (dying or very ill patient) but also evidence that some care givers had not considered how the chaplaincy service could support them in their delivery of faith/spiritual care. The exemplars of referrals to the chaplaincy service appeared to be principally in connection with sacramental duties. Such a narrow focus was not surprising given the findings of the nurses/midwifery survey which revealed that only 37% of nurses/midwives reported they were aware of all the services the chaplaincy team offer. The literature would suggest that caregivers and members of chaplaincy/faith teams need to work together on establishing the parameters of chaplaincy referral and explicating the referral process to all caregivers and patients (Mc Clung et al. 2006; Galek et al. 2007)

The findings presented revealed that assessment of faith tradition is on-going with approximately 2/3 of nurses/midwives ascertaining or reconfirming patients' affiliated faith tradition on admission. However, a much lesser percentage of nurses/midwives conduct a deeper exploration of patients' faith identity/needs. Such activity indicates that the respondents fail to appreciate that religious identity is not homogeneous and that all faiths are sub-divided into groups that place a different emphasis on particular tenets of their religion. It is well recognised that all religions *comprise of individuals with multiple identities informed by a variety of factors including gender, age social class, and ethnicity*. Caregivers can only gain an appreciation of patients' particular interpretation of their faith, identify their particular needs and plan their care by engaging in a detailed discussion with patients about their faith. Expecting patients' to comply with the traditional conceptualisation of their faith tradition, based on a superficial assessment of religious identity is undermining the complexity of their faith and their associated value systems. The findings revealed that caregivers are relatively in tune with the cultural aspects to minority faith traditions such as diet etc. However, it would appear that a significant proportion of the caregivers do not appreciate the potential desire that patients may have for involvement of the chaplaincy service and/or faith leader during their in-patient stay. This was substantiated by patient participants whose responses clearly demonstrated that limited information is routinely imparted to patients about chaplaincy services or means to initiate contact with chaplains/faith leaders. This has consequences for both the patient and the chaplain/ faith leader. The patient is denied a potential source of support during their illness journey and the chaplain/faith leader is denied the opportunity to *journey with the patient* and possibly only become involved with some patients towards the end of their illness trajectory, when the potential to develop a strong inter-personal relationship is compromised due to the patients diminished health status.

There was limited evidence that patients' spirituality needs were assessed in a formal overt manner. Both personal and organisation factors were cited as reasons for not engaging in same. However, the interviews



revealed that informal assessment of spirituality did occur and good communication skills, particularly the ability to respond to patients' non-verbal cues appeared to be the cardinal way that caregivers tended to assess and address patients' spiritual needs. There was also substantiation of caregivers nurturing and feeding patients' (and their families) spirit within the boundaries of the patient's faith tradition, for example caregivers cited incidences when they prayed with patients and respected their religious icons irrespective of their own faith tradition/beliefs. It also emerged that the caregivers *own* sense of spirituality and their *own* life journey which had challenged their own faith/spirituality had an impact on the manner and quality of spiritual care these individuals delivered. Various researchers would contend that successful spiritual care is not dependent upon assumptions relating to spirituality but upon the caregivers personal spirituality, sensitivity, and empathy (Carroll, 2001; Swinton and Narayanasamy, 2002). This was very evident in the hospice staff. However it is was recognised by patients, hospice staff and the research team that the hospice environment is conducive to the delivery of such care - single rooms (privacy); time; space; quietness etc. Some caregivers felt that faith/spiritual care should be guided by the patient themselves (because of its uniquely personal status) not the health care professional. Such a perception has emerged in other research studies (Mc Sherry, 2006; Ross, 2006; Nobel and Jones, 2010).

The narrow faith/spiritual assessment and meeting of identified needs that emerged in this study may be as a result of a number of reasons. First, the current assessment documentation does not request an in-depth assessment to be conducted. This dearth could be construed by some caregivers that the organisations are not overtly committed to the provision of such care. Indeed, a quarter of the nurse/midwife respondents perceived the institution were not concerned whether they recorded a faith/spiritual assessment. There was also evidence that some medics perceived medical assessment as the leading assessment; that faith/spiritual care can be context dependent (palliative care setting; breaking bad news) and that church and state should be separate.

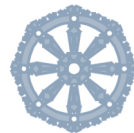
Secondly, while there is a strong believe that spiritual care should not be thought of as being separate from the other care needs, research has highlighted that nurses are uncertain about how to address spiritual needs (Ledger 2005, Bailey et al. 2010). This would appear to be a consequence of many nurses not knowing what interventions actually constitutes spiritual care and hence the difficulty in either articulating or documenting spiritual care. The nurse/midwife survey revealed that approximately a third of the respondents felt they did know enough about spirituality needs; only 13% were very comfortable recognising signs of spiritual distress and 19% supporting patients in spiritual distress. However, the qualitative strand of the research unearthed that a number of spiritual care interventions were been employed within the institutions by caregivers and appreciated by patients (albeit the latter not necessarily recognising them as spiritual care strategies). Exemplars of such strategies being utilised were being present; showing respect and compassion, empathy and the utilisation of non-verbal communication



skills such as listening compassionately. All of these strategies have been substantiated in previous research (Timmins 2011 cited by O Regan 2011). However, some caregivers did not realise they were responding to patients' spiritual needs through these strategies and hence undervalued their potential benefit to patients' sense of spiritual well-being. For some it was only through reflection with the researchers that such enlightenment occurred.

Thirdly, a proportion of caregivers in some clinical areas maybe engaging in what has been coined as making a pre-assessment about the need to ask about faith/spiritual needs. Narayanasamy and Owen (2001) refer to this as nurse 'stereo-typing' of the patient where a nurse may decide that the information is unnecessary; be put off asking by what is felt to be its intrusive nature; or is reluctant because of personal uncertainty about belief. These reasons were advanced by caregivers in relation to non-assessment of faith/spirituality needs. It was evident that assumptions about patients' faith/spiritual needs were being made by some caregivers in some contexts under the guise that the patients would be frightened if the subject matter was raised or alternatively a belief that their hospital stay was too brief to warrant such exploration. The view that it should be patient initiated was also held. The difficulty with 'pre-assessment' is that it is potentially open to the accusation of providing care differentiated by supposition (Swift et al. 2007). In order to counteract possible individual prejudices, an agreed and effective framework for faith/spiritual assessment is required. Catterall et al. (1998) would contend that spiritual assessment tools should be appropriate for all patients, irrespective of whether they have religious beliefs; be easy to use, flexible and take little time to assess the spiritual state of patients at different times and in different situations. The literature would also suggest (King and Wells 2003) it is not enough to just address patients' spiritual needs but that healthcare professionals should convey the patients' values and beliefs to other team members so a mechanism of sharing this information also needs to be considered. It is plausible also to suggest that the historical perspectives maybe influencing the courage of caregivers to approach what they felt were personal subjects for patients. This lack of courage to be open with the patient about personal matters in relation to spirituality may be influenced by the various religious elements of the conflict in the Northern counties. However, it may also be related to the lack of familiarity of significant pertinent knowledge in relation to different faith or no faith affiliation. A safe perspective would be to give the patient space to share and to exercise caution. However for some patients they may not be able to share the void that is experienced for example in spiritual distress.

Fourthly, it was evident that although caregivers were firmly committed to providing patients with the optimum faith/spirituality care a number of recognised barriers to such care delivery existed. Their existence (perceived or real) appeared to be marginalising the quality and nature of faith/spiritual care delivered. Several factors have



been identified in the literature has contributors to such marginalisation. Carr (2003) categorised them into individual, professional and organisational factors. The research unearthed exemplars of all three. The principal individual factor that emerged was participants' perceived restricted knowledge in relation to some faith/ spiritual issues. Participants' own professional bodies (Nursing, Medicine, Physiotherapy) marginalise the value of such care by not providing or limiting such education within their under-graduate/ post graduate curricula. Various organisational factors emerged such as perceived lack of time; inadequate staffing; lack of privacy/space; narrow conceptualisation of the parameters for chaplaincy referral and the perceived domination of the medical model as the primary mode of patient assessment in the hospital. Indeed exemplars of where chaplains and the care they provided were viewed by caregivers as the solution when the biomedical model of care had failed was evident. In some cases chaplaincy/faith care was not considered to complement care delivered through the medical model but perceived as subsequent to it. It is recognised that the majority of patients in Letterkenny General hospital in-patient stay is relatively short and hence reduces healthcare professionals' capacity to establish and develop a robust therapeutic relationships with their patients through spending time with them. Knowing the patient was identified in this study as a precursor to the provision of faith/spiritual care and concurs with a recent Irish study by Bailey et al. (2009). Bailey et al. (2009) also highlighted that this nursing time (to 'be with' the patient), while described as essential to spiritual caring, is largely under-represented in nursing documentation with consequent implications for staffing resources underscoring how some of the organisational factors are intertwined. Caregivers reported that they rarely recorded such interventions as spending time with patients and as a consequence are marginalising the care they give themselves, irrespective of organisational factors. Swinton and McSherry (2006) would caution that there is a very real danger that one dimensional, limited time to 'be with' patients, becomes accepted as the norm and staff are forced to rely on making a referral to the chaplain to provide spiritual support. This has the potential to deskill caregivers and make the provision of spiritual care viewed as a specialisation. Lack of space to deal with patients/families in spiritual distress was signalled by caregivers as restricting their ability to provide sensitive care in this area.

CAPACITY TO CARE

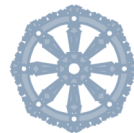
The delivery of faith/spiritual care has received increasing recognition over the last decade. Addressing patients faith needs did not appear problematic in either healthcare institution. Knowledge to meet patients' needs appeared to be derived from a number of sources - personal knowledge, experiential knowledge and theoretical/legislative knowledge. Personal and experiential knowledge emerged as the sources that guided practice to the greatest extent. Surprising low levels of education/training was received by caregivers in their professional training/education programmes and all cohorts of caregivers reported they would value training/education in the area of faith/spiritual care delivery. However, caregivers were relatively confident that



they could source information and inform their knowledge to care in relation to unfamiliar religions/faith traditions via the H.S.E. Intercultural Guide, colleagues or patients themselves. However, the nebulous concept of spiritual care was perceived differently. The antecedent to same, spiritual development has not been given the same import in the literature or indeed reflected on by many caregivers themselves. Currently, universally there is no assessment for the spiritual development of nurses, doctors, ministers of religion or patients (Graham 2008). Therefore anyone of the aforementioned cohorts of caregivers could be at any stage in their development, and as this study indicated those caregivers who perceived themselves as possessing a well-developed sense of spirituality were in a better provision to meet patients' needs. Gaining comfort with one's own spirituality is the initial step in developing awareness and sensitivity to patients' spiritual needs according to Graham 2008. Participants in this study concurred with this. In the current study, there appeared to varying degrees of perceived capacity to meeting faith/spiritual needs. Much of the spiritual care provided was based on caregivers' experiential knowledge. This reliance on experiential knowledge emerged in a recent Irish study by Timmins 2011 (O Regan 2011). It is contended that the lack of capacity for some was through a lack of appreciation of what constituted spirituality and spiritual care; for nurse/midwives it varied on context as the responses to the ten encounters in the survey revealed all participants perceived the need for further education/training in the area to support them in their practice. Gordon and Mitchell (2004) would contend that competencies are a viable and crucial first step in *'earthing' spiritual care in practice and evidencing this illusive area of care*. Such philosophies led to the development of a now well recognised and empirically support set of competencies - Marie Curie Cancer Care (MCCC, 2003) *Spiritual and Religious Care Competencies for Specialist Palliative Care*. The framework specifies four levels that should be achieved by all staff and volunteers, through those with increasing depth of contact with patients and their carers, to those whose primary responsibility is for spiritual and religious care – normally chaplains or spiritual-care co-ordinators (Smith and Gordon 2009). It is argued by Gordon and Mitchell (2004) that such an approach places spiritual care in a practical context by offering a model for spiritual assessment and care based on the individual competence of all healthcare professionals to deliver spiritual and religious care. They would contend that developing staff capacity to care is more important than seeking all-embracing definitions or the 'ideal' assessment tool.

HEALTHCARE CHAPLAINCY

As alluded to above there is an increasing acknowledgement in the empirical literature of the role that faith and spirituality plays in patients/carers ability to comprehend and cope with illness. This means that spirituality/faith care is a constituent of healthcare rather than an appendage. It seems clear that this is understood, at some level at least, by caregivers, patients and church leaders associated with the hospital and hospice. It should not be surprising, in view of broader patterns of religious history in Ireland, that this care is seen primarily through



denominational lenses and is also viewed to a significant degree, but not exclusively, as the specialisation of church ministers. This appears to be the predominant understanding of patients and staff in the hospital and hospice, and the understanding within which the chaplains and the wider community of visiting religious leaders are largely working.

It seems clear as well that the understanding of spirituality as described above - 'finding meaning; connectedness with self, others; or higher being; congruence of values and beliefs; love; hope and strength' – fits easily within all of the religious traditions, and all of the religious leaders would understand themselves as working within that framework as interpreted by their respective traditions.

It is not surprising then that the predominant 'default' position adopted by the religious leaders is the multi-cultural approach to chaplaincy – each tradition being given space to address the spiritual needs of its members according to its own lights. There is a shared understanding that a mono-cultural approach is not appropriate, and there is openness to but sensitivity towards inter-cultural approaches, based on the views within the different traditions on the extent to which inter-culturalism can be brought. A number of initiatives suggest themselves in the light of this. Firstly, that members of the chaplaincy team have a dialogue on their understanding of their chaplaincy roles utilising the multi-cultural/ mono-cultural/inter-cultural framework. This should enable them identify common understandings and genuine differences, and lay the foundations for a shared vision of their work. This dialogue could be extended to the other visiting religious leaders. On the basis of that shared understanding a dialogue could be developed with the hospital and hospice managements to explore how this vision can best fit and be promoted within a whole vision of health care. This should enable the full scope of chaplaincy to be articulated as well as the spiritual role of all of the staff. If spirituality is understood in terms of the depth issues above, and spiritual care as 'time with' and 'presence to' the depth of the person, then it will be understood that all staff have a role to play. But this role will be limited by the increasing operational pressures of their work. The role of chaplains, who are employed for their time and presence, may be more deeply understood and more fully appreciated.

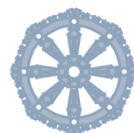
CONCLUSION

Both institutions strive to deliver holistic care inclusive of patients' faith, cultural and spiritual needs. Patients were content with the manner in which their faith needs were addressed. Patients' faith affiliation is secured on admission to the hospital but patients would appear uncertain about the necessity for its collection. Caregivers had no difficulty conceptualising the concept of faith, but had in relation to the concept of spirituality. Patients shared that they had the same difficulty regarding spirituality. There is conflicting evidence regarding whether a



deeper exploration of patients faith needs by care givers is conducted. Assessment and tending to patients' spirituality needs is very informal and appears to be caregiver and context dependent. However, it would appear, according to patients that recognised dimensions of spirituality were being addressed sufficiently through the boundaries of their particular faith traditions via sacramental rituals and prayer. At times, presuppositions about potential needs are made by caregivers in the absence of formal assessments and again are caregiver and context dependent. Caregivers rely on various sources of knowledge to underpin their practice but wish to be afforded the opportunity of further training/education in the area of faith, cultural and spiritual care. The role of chaplains/faith leaders is respected by both institutions. Meeting patients' faith/spiritual needs is perceived by caregivers and patients as primarily the remit of chaplains. Chaplains are not recognised members of the multi-disciplinary team, in that they do not go on ward rounds; participate in M.D.T. meetings. However they are invited by the team to assist them in delivering holistic patient care. The increasing diversity of patients in terms of their faith, cultural and spiritual needs, necessitates reflection by all caregivers and chaplains/faith leaders in terms of their knowledge and competence to meet such diverse needs and their ability to embrace diversity in this area. Management in both institutions need to articulate to all caregivers, their commitment to, and expectations surrounding care of patients faith/cultural/spiritual needs. The identified resources necessary to enhance the capacity and competence of caregivers to meet patients' faith, cultural and spiritual requirements need be provided by the management of both institutions. The literature review suggested that healthcare chaplaincy in Ireland and the UK is in transition and that the patients' needs are shaping its future development and direction. The findings of this report mirror this evolution.

The 2006 census provides evidence of a society which is significantly more diverse, religiously and culturally, that it has ever been (Central Statistics Office, 2008). The increase in cultural and religious diversity within the Republic of Ireland has therefore been relatively recent. In comparison Britain, has witnessed the diversification of their society since the 1970s. As increased numbers of members of ethnic and religious minorities began to use their public services, there was a growing awareness during the 1980's and 1990's of the need to develop culturally and religiously sensitive provision. Hence, this has been a feature of healthcare provision in Britain from the 1980's (Davies et al, 2000). The knowledge of and reflection upon the more extended period of adjustment to a multi-cultural society experienced in Britain may help Irish service providers in responding to their particular multi-cultural and multi-faith reality. The awareness of how the British health service has created a co-operative, inclusive system of chaplaincy and spiritual healthcare provision might be of assistance to Irish health service providers in being pro-active in developing a service addressing culture, faith and spirituality in an appropriate way.



RECOMMENDATIONS

The following recommendations were developed from the review of literature and the research conducted. There are a series of recommendations for the Health Service Executive which have a policy and/or process remit; a number of local recommendations that will require direction from the H.S.E and finally a number site specific recommendations.

Recommendations	Area of Responsibility
1. Consider the development of faith/cultural and spiritual care strategy. This should contain a vision; core values; make reference to relevant policy/legislation; implementation priorities and time lines.	H.S.E. in conjunction with faith/spiritual leaders; Service user groups/patient forums
2. Construct a vision for the future of faith/cultural/spiritual care at local level that includes all of the care settings for all populations that the HSE caters for.	H.S.E.
3. Make explicit the role, expectations and outcomes of chaplaincy provision from the perspective of ordained and non-ordained healthcare chaplains.	H.S.E. in conjunction with faith/spiritual leaders
4. Consider conducting a review of the current model of healthcare chaplaincy in the context of the proposed model of healthcare delivery.	H.S.E.
5. Consider the development of guidelines on the identification and evaluation of visiting faith/community leaders (non-chaplaincy team members) to healthcare settings.	H.S.E.
6. Consider the development of a quality standard for meeting faith/cultural and spiritual needs in the organisations.	H.S.E.- Office of Nursing & Midwifery Services Director (ONSD)
7. Agree an effective framework for assessing, planning, implementing and evaluating patients' faith/cultural and spiritual needs.	H.S.E. - Office of Nursing & Midwifery Services Director (ONSD)
8. Consider the introduction of a spiritual screening tool that is appropriate for all patients, irrespective of their faith affiliation.	H.S.E.
9. Agree a process for chaplaincy referral and a mechanism for documenting the outcome of referral.	H.S.E. and at local level
10. Consider mechanisms for raising the profile of healthcare chaplaincy as a distinct discipline and an integral member of the multidisciplinary team delivering holistic care.	H.S.E. and at local level



Recommendations	Area of Responsibility
11. Provide training/education on faith/cultural/spiritual care at different levels for different cohorts of staff.	H.S.E. and at local level
12. Consider the current practice of recording and distributing patient information in relation to faith affiliation.	H.S.E. with implementation at local level
13. Consider a process to develop a “reflective space” for persons aligned to the non-dominant faith traditions or for persons of no faith tradition in sites where such provision is absent.	Local level
14. Consider the introduction of a mentor system for junior staff in order for them to acquire the skills required to deliver faith/spiritual care.	Local Level
15. Provide on-going unit based staff development in relation to faith/cultural/spiritual care.	Local level
16. Consider multi-media strategies for informing other disciplines (health care/non health care) and patients/families about the multi-dimensional nature, vision, and services of the chaplaincy team.	Project Site specific
17. Standardise the implementation of a process for documenting faith/cultural/spiritual care identification, delivery and evaluation.	Project Site specific
18. Harness the expert knowledge of the current visiting faith/ community leaders outside of the chaplaincy team to advice on meeting specific faith/cultural/spirituality needs and in the education of staff.	Project Site specific
19. Develop mechanisms to raise the profile of existing staff support services (e.g. Critical incident debriefing to assist caregivers deal with patient’s faith/spiritual distress).	Project Site specific
20. Consider the development of an information booklet on the provision of faith/cultural and spiritual care resources.	Project Site specific

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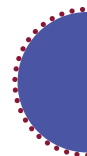
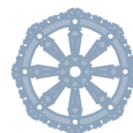
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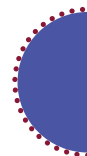
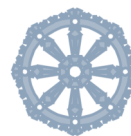
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Appendices



Appendix 1

Further key recommendations from the ‘NHS Chaplaincy; Meeting the Religious and Spiritual Needs of Patients and Staff – Guidance for managers and those involved in the provision of chaplaincy-spiritual care’ (2003)

- 1.1** The guidelines suggest that the provision of spiritual healthcare and chaplaincy services is most effective if led by a Board-level director and has a robust quality assurance system including user feedback.
- 1.2** Regarding the recording and distribution of patient information it is suggested that patients be given the opportunity to give their permission as to how information about them is used and given the choice as to whether or not their religious affiliation is recorded. Here Nottingham University Hospital is cited as an example of best practice. They rewrote their hospital admission leaflet to explain their chaplaincy service, provided this leaflet to all hospital staff, trained staff responsible for admissions in how to deal with questions of spiritual care and provided more information on the chaplaincy services on-line and through the hospital radio. (p.13)
- 1.3** Volunteers are considered an integral part of the chaplaincy team and, like the members of the paid chaplaincy team itself, should have proper selection, screening, training, appointment letters, and job descriptions. (Pp.15-16)
- 1.4** On a practical level, specific time allocation is indicated to the chaplaincy team leader for the management of chaplaincy- spiritual care. (p.28) The service must include those of no specific religious faith and training and professional development for all chaplains and spiritual care-givers needs to be properly resourced and provided. Most significantly, Chaplaincy appointment are Hospital Trust appointments which are made in partnership with representatives of the relevant faith communities with standard human resources procedures being followed and clear lines of management and accountability. (p.8)
- 1.5** Christie Hospital NHS Trust in Manchester conducted a small upgrading scheme ‘to make additional space within the chapel precinct’. This involved providing an evidenced-based argument to the Trust Board for the development, with ‘reference to any perceived or documented shortcomings in existing facilities...and reference to any relevant legislation’. They claim that the quality of the partnership



between all involved was the most important facet of the process. Some of the key points in relation to this sensitive area are:

- Good communication between all parties is established and maintained, particularly where spaces are to be shared
- A code of conduct on how to use the premises is drawn up

The processes of improving worship and sacred spaces are clear and an appropriate team is assembled to conform to Trust guidelines on accommodation changes, (p.18)

- 1.6** With specific reference to the responsibility of hospitals in time of bereavement, it sees that support and advice to families from a chaplaincy perspective is essential. All clinical areas need to have access to reliable guidance on the care of patients of different faith communities at and after death and of the needs of the bereaved.



Appendix 2

Consultation Draft; Standards for Healthcare Chaplaincy Provision from the Multi-Faith Group for Healthcare Chaplaincy (2010)

SERVICE DELIVERY AND TRAINING

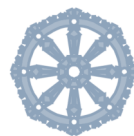
- SHS 1** Spiritual healthcare is delivered by appropriately authorised and practicing caregivers with clear lines of accountability. Chaplains are accountable to their Trust for their performance but represent their faith community. Their accountability is complex but both aspects need to be sustained appropriately.
- SHS 4** Chaplains have access to all levels of Trust Management for confidential briefing and/or feedback.
- SHS 9** The chaplaincy-spiritual care service meets spiritual, religious, sacramental, ritual and cultural requirements appropriate to the needs, background and tradition of the patients and staff including those with no specific faith.
- SHS 12** Appointments to chaplaincy-spiritual care service are made in partnership with the appropriate faith communities and representatives of the faith communities are involved in the selection of persons appointed to the service.

CARE ENVIRONMENT

- SHS 13** There is space(s) designated and suitable for worship and communal activities, including prayer and reflection, which are accessible by patients/users and staff 24 hours a day seven days a week. The Trust gives priority to achieving sacred spaces for all world faiths. It is likely that more than one space will be required, with flexibility of furnishing and use of religious symbolism to allow for use by different faiths. Where new locations are planned, the chaplaincy-spiritual care service should be involved at the earliest opportunity.
- SHS 18** There is information about the spiritual healthcare referral system in all clinical areas undertaking or managing emergency healthcare.

FOOD AND DIETARY REQUIREMENTS

- SHS 19** Chaplaincy-spiritual care services advise on the general dietary requirements for patients, staff and visitors of the major world faiths and for special dietary requirements related to sacraments and ritual. However, there is no standard currently proposed for patients and visitors to receive food of choice which meets their religious needs and also doctor's advice.



PROTECTION OF CHILDREN AND VULNERABLE ADULTS

- SHS 22** Clear and concise information about spiritual healthcare services is made available to all potential users.
- SHS 23** Leaflets and notices are updated regularly and reflect the world faiths of the chaplaincy-spiritual care workforce, the staff profile and the local community profile.
- SHS 25** Spiritual healthcare staff are trained in the implementation of Trust policies governing information usage, confidentiality and consent.

MANAGEMENT AND STAFFING

- SHS 29** The chaplaincy-spiritual care service is supported by a Board-level director who is responsible for monitoring and reviewing their effectiveness of the service.
- SHS 36** The spiritual healthcare workforce is led and directed by a chaplaincy manager who is qualified and appropriately trained for this task.
- SHS 33** Members of the chaplaincy-spiritual care workforce have access to appraisal, development review and team briefing. Chaplains also have access to spiritual direction and spiritual and professional supervision as necessary.

AUDIT AND REVIEW

- SHS 34** Chaplains and spiritual care-givers regularly review their skills, attributes and behaviours and audit their service for effectiveness.



Appendix 3

The Churches Together in England through its Churches Committee for Hospital Chaplaincy; 'Guidance on Working in Chaplaincy Teams' (2008)

(1) Partnership

There are always three partners in the satisfactory working of chaplaincy teams, the team itself, the NHS employer/service provider and the Faith Community authorities to which chaplains are answerable for religious and faith based matters. The relevant authority of Anglicans and Roman Catholics are the chaplains diocesan bishop and the Health Care Chaplaincy Steering Group, Free Churches Group for Free church Chaplains. (p.3)

(2) Commitment

The guidance states its basis assumption that 'all members of the chaplaincy team concur that agreeing a close and formal way of working would be an advantage both for them personally and for the chaplaincy service itself. The sense of partnership within the team needs to survive the individual ministry of any of its initiators. The success of these arrangements clearly also entails the goodwill, agreement and support of the employing NHS organisation together with the relevant faith community authorities' (p.4)

(3) Worship

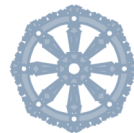
'The chaplains will share in the conduct of worship where permitted and should provide for the needs of patients, relatives and staff at each main site.' The concept of sharing in the conducting of worship by Christian chaplains also extends to sharing the space for worship which requires careful planning to make sure that all users are 'accommodated appropriately' (p.4)

(4) Pastoral Care

Interestingly the guidance suggests that 'members of the chaplaincy team share in the pastoral care of patients whilst allowing for each patient to receive the ministry of his/her own tradition'. Thus there is a sense of shared Christian ministry which also has specifically denominational dimensions. The chaplaincy team can co-operate in a range of practical ways including cross-referral, recognition of the faith needs of others and the training and supervision of volunteers.

(5) Team Relationships

They emphasise the need to 'maintain a strong sense of mutual commitment and sharing between all team



members'. This can be nurtured by planned periods of spending time together for prayer, lunch, team meetings and team building and theological and liturgical reflection. They claim that a mature team will have a leader to ensure effective working and where different beliefs cause problems, 'it is the element of dysfunctional team working and not the difference of conviction that must concern him or her'. (p.6)

(6) Developing a Shared Philosophy

The Churches Committee on Hospital Chaplaincy recognise that relationships within a chaplaincy team can be difficult and that, as a result, some members might not have the opportunity to exercise their full potential within the role or cause them to act independently of the team. It considers that the best approach to these problems is to ensure that all individual approaches should be shared in a manner which helps team formation especially a shared philosophy of hospital chaplaincy as a basis for its shared provision.

The Churches Committee considers that all chaplaincy teams should have the encouragement of their faith communities and NHS managers to formulate local Trust-based philosophies of spiritual care which are compatible with the theological positions represented within the chaplaincy team and have due regard to the local NHS Policy and Practice. Agreed philosophies can then provide the foundation of the models of care and practice which define the chaplaincy team's task within the NHS organisation and which relate to the stated needs of those benefiting from the services provided.' (p.6)



Appendix 4

Association of Hospice Palliative Care Chaplains

'Standards of Hospice and Palliative Care Chaplaincy' (2006)

Standard 1 Access to Chaplaincy Services

'All patients and carers have access to the chaplaincy services'.

Standard 2 Spiritual and Religious Care

Patients and their carers of all faiths and no faith have their spiritual needs assessed and addressed.

Standard 3 Multidisciplinary Team-working

The chaplain works as the core member of the multidisciplinary team to ensure the provision of holistic care for patients and their carers. (Clinical Standards in Scotland include chaplains as core members of the multidisciplinary team; this understanding may vary in other areas)

Standard 4 Staff Support

As parts of the unit's provision of support for staff and volunteers the chaplain offers personal and professional support.

Standard 5 Education, Training and Research

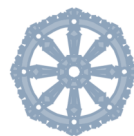
The chaplain contributes to the unit/team's professional education, training and research programmes.

Standard 6 Resources

The unit ensures the chaplain is provided with the resources to fulfil his or her job description, supervision and training needs.

Standard 7 Chaplaincy to the Unit (Institution)

Over and above the individual and group needs of the patients, carers, staff and volunteers, there are events that need communal recognition and action. The chaplain is a resource to assess and address these needs.



Appendix 5

Hospital Information Leaflet

Faith and Spirituality in Healthcare

Why is this study being done?

Letterkenny General Hospital wants to deliver a quality-inclusive service to all patients/service users. The patient population of the hospital has become more diverse over the last decade, in terms of their faith, spirituality and associated cultural needs, and it is not known how these needs are currently being catered for. Indeed, very little is known about how any hospital in Ireland caters for these needs.

Who is being asked to take part?

We are trying to involve as many groups of people as possible. Some of those who will be taking part are patients; healthcare professionals (e.g. nurses, doctors etc.); health care assistants; hospital chaplains and other community leaders.

How will the information be collected?

The information will be collected through questionnaires; group and individual discussions. Two members of the research team will talk to patients while they are in hospital. Healthcare professionals will be asked to complete a questionnaire and take part in focus group discussions. Chaplains and community leaders will be interviewed individually and as a group.

Will people know who has taken part?

No, all the information shared with the research team will be anonymous and confidential; no one will be able to link responses back to those who gave them. All information will be stored (in keeping with the Data Protection Act 2003) on a password protected computer, and only accessible to the researchers (who are not staff of the hospital).

What will happen to the information?

The research team will analyse all the information they receive to discover how patients' faith and spirituality needs are being met. Following this, they will write up their findings and suggest recommendations. This will be then given to the steering group who will decide if and how the recommendations can be met.

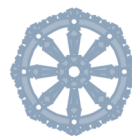


Who gave permission to complete this study?

Letterkenny General Hospital and Donegal Hospice received PEACE III funding to conduct this study. Dr. Anne Flood, the Director of Nursing of the Hospital, is the chairperson of the Research Study Steering Group. Ethical approval for the study was obtained from the Research Ethics Committee at Letterkenny General Hospital.

Who can I contact if I want further information?

You may contact either Michele Glacken, researcher, tel. 0868586774, email mglacken@stangelas.nuigalway.ie; or Mary Kelly, Health Promotion Officer, Letterkenny General Hospital, tel. 074 9225888.



Appendix 6

Admission Clerk Questionnaire

Faith and Spirituality in Healthcare

This questionnaire is asking you about the recording of patients religious/ faith tradition on admission to your ward/area. Circle the one that best fits your response to the question.

1. Do you always record or reconfirm (if previously documented) a patient's religious/faith tradition (e.g. Catholic/Presbyterian) on admission to your ward?

Yes

No

Sometimes

If you answered yes, please skip to question 3

If you answered **no or sometimes** above, we would like you to read each of the statements below and tick (✓) the one that best fits your reaction to the statement.

2. I don't always ask or record this information because:	Strongly agree	Agree	Disagree	Strongly disagree
I think for some patients it is an unnecessary question				
I sometimes feel embarrassed to ask it				
I think it can be an intrusive question				
Religion doesn't mean much to me				
I sometimes feel it's a kind of death question				
Collecting it won't have an impact on their care				
Sometimes I don't understand the answer they give				
It's something I can skip, and there are more important things to record				
The hospital isn't bothered whether I record it or not				
Sometimes I don't have time				



2. I don't always ask or record this information because:	Strongly agree	Agree	Disagree	Strongly disagree
I don't feel confident asking this question				
I don't know why the information is being collected				
The patient doesn't look like he/she would be religious				
I am afraid I will offend/annoy a person by asking it				
I don't know enough about religious faith traditions other than my own				
I feel it makes patients feel uncomfortable				

3. Do patients' question you about why this information is needed?

Always

Sometimes

Never

4. Have you ever encountered a negative response (e.g. verbal abuse) from patients when you ask this question?

Yes

No

5. How comfortable do you feel asking this information?

Very

Somewhat

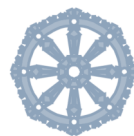
Not Very

6. On a scale of 1-10, (10 being very important and zero not important at all) how important do you rate the gathering of this information?

Thank you for taking the time to complete this questionnaire

Your participation is highly valued

Please put your completed questionnaire in the survey box on the ward



Appendix 7

Admission Clerk Information Sheet Faith and Spirituality in Healthcare

What is this study about?

This study aims to explore how faith; spirituality and associated cultural needs of all patients and service users of Letterkenny General Hospital are currently being met, and identify if there are further interventions/supports that could be introduced to make the service more inclusive and responsive.

Why is this study being done?

Letterkenny General Hospital wants to deliver a quality inclusive service to all patients/service users. The hospital's patient population has become more diverse over the last decade, in terms of their faith and spirituality needs, and it is not known, how these needs are being catered for currently. Indeed, very little is known, about how any hospital in Ireland caters for these needs.

Why am I being asked to participate?

Admission clerks play a key role as you are often the person who records the religious/faith tradition of the patient. We are asking all admission clerks to participate in the study so our findings are representative of your work.

What will taking part involve?

Taking part will involve you complete the short questionnaire overleaf. The questions just require you to tick a box or circle your response to a statement/question. It should take you about 5 minutes to complete. **Your consent to participate will be assumed on completion of the questionnaire.**

How will you ensure my privacy and confidentiality?

There are no identifying features on the questionnaire, so all the information you give us will be anonymous and confidential; no one will be able to link your responses back to you. All information will be stored in keeping with the Data Protection Act 2003. It will be stored on a password protected computer that is only accessible by the researchers who are not staff of the hospital.

Who gave permission to complete this study?

This study has received research ethical approval from Letterkenny General Hospital's research ethics committee.

Who do I contact if I have further questions?

You may contact Michele Glacken, researcher on 086 8586774 or via email at mglacken@stangelas.nuigalway.ie or Mary Kelly, Health Promotion officer on 074 92 25888.



Appendix 8

Nursing Staff Questionnaire

Faith and Spirituality in Healthcare

The following questionnaire is comprised of various sections. Section A is about you and the remaining sections have questions related to caring for patients religious/ spiritual and associated cultural needs.

In this questionnaire, questions will be asked about your patients' faith/religious needs. By this we are referring to the faith/religious traditions/communities they belong e.g. Roman Catholic; Islam.

There will also be questions on patients' spiritual needs. By this, we mean what gives patients' life a sense of meaning and purpose; what gives the patient a sense of peace and what are their sources of support/strength and hope.

A. From the choices available, circle the one that best fits your response to the question/statement:

1. Gender: Male Female

2. Age (yrs.): 18-29 30-39 40-49 50-59 60+

3. Current nursing position:

Staff Nurse Staff midwife CNS/CMS CNM/CMM

Other _____

4. Primary nurse education: (select only one)

Registered nurse (Certificate) Registered nurse (Diploma)
Registered midwife (Diploma) Registered nurse (Degree)
Registered midwife (Degree)

5. Do you hold a post-registration/graduation qualification?

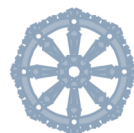
Yes No

6. Highest academic qualification:

Diploma Degree Post graduate certificate
Post graduate Diploma Master Degree Doctorate

7. Would you consider yourself to be a religious person? Yes Somewhat No

8. Would you consider yourself to be a spiritual person? Yes Somewhat No



B. This section will explore how Faith/Religion and spiritual needs are catered for.

Please tick (✓) the one that best fits your response to the question/statement:

9. Do you always record or reconfirm (if previously documented) a patient's religious/faith tradition on admission to your ward? Yes No Sometimes

If you answered yes, please proceed to question 11

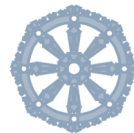
If you answered **no or sometimes** above, we would like you to read each one of the statements below and tick the one that best fits your reaction to each of the statements:

10. I don't always ask or record this information because:	Strongly agree	Agree	Disagree	Strongly disagree
I think for some patients it is an unnecessary question				
I sometimes feel embarrassed to ask it				
I think it can be an intrusive question				
Clinical factors make it impossible				
Religion doesn't mean much to me				
I sometimes feel it's a kind of "death" question				
Asking it won't have an impact on their care				
Sometimes I don't understand the answer they give				
It's something I can skip, and there are more important things to record				
The hospital/hospice isn't bothered whether I record it or not				
Sometimes I don't have time				
I don't feel confident asking this question				
I don't know why the information is being asked				
The patient doesn't look like he/she would be religious				



10. I don't always ask or record this information because:	Strongly agree	Agree	Disagree	Strongly disagree
I am afraid I will offend/annoy a person by asking it				
I don't know enough about religious faith traditions other than my own				
I feel it is the patient's own private affair				
I feel it makes patients feel uncomfortable				

11. As part of your nursing/midwifery assessment (Faith /Religious needs)	Always	Some-times	Never
Do you always ascertain if your patients are part of a particular religious/faith community?			
Do you ascertain how important their faith/religious tradition is to them?			
Do you ascertain what their specific faith/religious needs are (incl. cultural aspects)?			
Do you ascertain how they would like their faith /religious needs met while in hospice?			
Do you ascertain if they would like their faith/religious/ community leader informed of their admission?			
Do you inform patients of the name of hospice chaplains (if appropriate)?			
Do you inform patients of the services that the chaplaincy team offer?			
Do you inform patients of the location of shared/religious space in the hospice?			
Do you inform appropriate personnel (e.g. catering manager/medics etc) if patient's cultural needs linked to their faith tradition will require modifications to 'usual' care provided?			



12. As part of your nursing/midwifery assessment (Spiritual needs)	Always	Some-times	Never
Do you assess patients' spiritual needs?			
Do you use a specific spiritual assessment tool?			
Do you ascertain how important their spiritual needs are to them?			
Do you ascertain what their specific spirituality needs are?			
Do you ascertain how they would like their spirituality needs met while in hospice?			

13. If you **never or only sometimes assess patients spiritual needs**, we would like you to read each of the statements below and tick the one that best fits your reaction to **each of the statements**:

I don't always assess or record patients' spiritual needs because:	Strongly agree	Agree	Disagree	Strongly disagree
I think for some patients it is an unnecessary question				
I sometimes feel embarrassed to ask it				
I think it can be an intrusive question				
Clinical factors make it impossible				
Spirituality doesn't mean much to me				
Asking it won't have an impact on their care				
Sometimes I don't understand the answer they give				
It's something I can skip, and there are more important things to record				
The hospital/hospice isn't bothered whether I record it or not				
Sometimes I don't have time				
I don't feel confident asking this question				
I don't know the reason for collecting this information				
The patient doesn't look like he/she would be spiritual				
I am afraid I will offend/annoy a person by asking it				
I don't know enough about spirituality needs				
I feel it is the patient's own private affair				



C. Encounters: How comfortable are you in dealing with the following faith/spiritual encounters?
Circle the one that best fits your response to the question/statement:

14. Performing a culturally sensitive assessment of faith/religious needs

Not at all A little Somewhat Quite a Bit Very comfortable N/A

15. Interpreting different cultural expression of faith

Not at all A little Somewhat Quite a Bit Very comfortable N/A

16. Caring for patients from diverse faith/religious backgrounds

Not at all A little Somewhat Quite a Bit Very comfortable N/A

17. Supporting patients need to practice their religion/faith

Not at all A little Somewhat Quite a Bit Very comfortable N/A

18. Supporting patients in their religion/faith rituals/traditions (e.g. diet/prayer times)

Not at all A little Somewhat Quite a Bit Very comfortable N/A

19. Performing a culturally sensitive assessment of spiritual needs

Not at all A little Somewhat Quite a Bit Very comfortable N/A

20. Interpreting different cultural expressions of spirituality

Not at all A little Somewhat Quite a Bit Very comfortable N/A

21. Supporting patients in meeting their spiritual needs

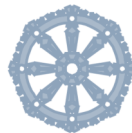
Not at all A little Somewhat Quite a Bit Very comfortable N/A

22. Recognising signs of spiritual distress

Not at all A little Somewhat Quite a Bit Very comfortable N/A

23. Supporting patients in spiritual distress

Not at all A little Somewhat Quite a Bit Very comfortable N/A



D. Perception of importance of faith/spirituality to your practice.

Circle the one that best fits your response to the question/statement:

24. How important do you believe faith/religious issues are in your interactions:

With patients/ clients?

Not at all A little Somewhat Quite a Bit Very Important

With relatives?

Not at all A little Somewhat Quite a Bit Very Important

25. How important do you believe your own faith/religious traditions are in your interactions:

With patients/ clients?

Not at all A little Somewhat Quite a Bit Very Important

With relatives?

Not at all A little Somewhat Quite a Bit Very Important

26. How important do you believe spirituality issues are in your interactions:

With patients/ clients?

Not at all A little Somewhat Quite a Bit Very Important

With relatives?

Not at all A little Somewhat Quite a Bit Very Important

27. How important do you believe your own sense of spirituality are in your interactions:

With patients/ clients?

Not at all A little Somewhat Quite a Bit Very Important

With relatives?

Not at all A little Somewhat Quite a Bit Very Important

E. Education and Training: Circle the one that best fits your response to the question/statement:

28. How important do you feel it is for health care professionals to receive training in religious/faith diversity?

Not at all A little Somewhat Quite a Bit Very Important



29. Have you received education/training on caring for persons from diverse faith/religious backgrounds?

Yes No

If yes, was it:

- Part of pre-registration education/training
- Part of post-registration education/training
- Via the CNME
- In-house training/education
- Other (please explain)_____

If yes, approximately how many years since you received this education/training (Please circle the appropriate answer)?

< 5 years 5-10years >10years

30. Do you feel sufficiently educated /trained on caring for persons from diverse faith/religious backgrounds?

Yes No

31. How important do you feel it is for health care professionals to receive training in caring for persons spiritual needs?

Not at all A little Somewhat Quite a Bit Very Important

32. Have you received education/training on caring for persons spirituality needs?

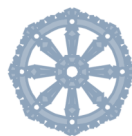
Yes No

If yes, was it:

- Part of pre-registration education/training
- Part of post-registration education/training
- Via the CNME
- In-house training/education
- Other (please explain)_____

33. Do you feel sufficiently educated /trained on caring for persons spirituality needs?

Yes No



F. Support: Circle the one that best fits your response to the question/statement:

34. Do you feel sufficiently supported by the chaplaincy team in the delivery of faith/spirituality care to patients/families?

Yes No

If No, how could the chaplaincy team support you in the delivery of faith/spirituality care to patients/families?

1. _____
2. _____
3. _____

35. Are you aware of all of the services that the chaplaincy team offer?

Yes No Don't Know

36. Do you feel adequately supported by the hospice (management/facilities/guidelines etc.) in the delivery of faith/spirituality care to patients/families?

Yes No

If No, how could the hospice management support you in the delivery of faith/spirituality care to patients/families?

1. _____
2. _____
3. _____

37. Are you aware of the HSE intercultural guide?

Yes No

38. Does the Hospice have a copy of the HSE intercultural Guide?

Yes No Don't Know

Please feel free to write any additional comments about this subject below:

Thank you for taking the time to complete this questionnaire

Your participation is highly valued

Please put your completed questionnaire in the survey box on the ward



Appendix 9

Nursing Staff Information Sheet

Faith and Spirituality Needs in Healthcare

What is this study about?

This study aims to explore how faith; spirituality and associated cultural needs of all patients and service users of Letterkenny General Hospital and Donegal Hospice are currently being met, and identify if there are further interventions/supports that could be introduced to make the service more inclusive and responsive.

Why is this study being done?

Letterkenny General Hospital and Donegal Hospice want to deliver a quality inclusive service to all patients/service users. The hospital's patient population has become more diverse over the last decade, in terms of their faith and spirituality needs, and it is not known, how these needs are being catered for currently.

Why am I being asked to participate?

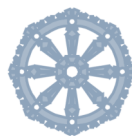
Nurses have a key role in caring for a person's faith and spiritual needs as part of the holistic care they give. We are asking all nurses allocated to in-patient wards/units to participate in the study so our findings are representative of the care been given.

What will taking part involve?

We are hoping to collection the information required in two ways- through a questionnaire and through a series of focus group interviews with staff/patients and the chaplaincy service. You are being asked to be involved in the initial part of the study, by completing the attached questionnaire. The majority of the questions just require you to tick a box or circle your response to a statement/question. It should take you about 10 minutes to complete. **Your consent to participate will be assumed on completion of the questionnaire. If you chose to complete the questionnaire, please return it to the designated study box on your ward.**

How will you ensure my privacy and confidentiality?

There are no identifying features on the questionnaire, so all the information you give us will be anonymous and confidential; no one will be able to link your responses back to you. All information will be stored in keeping with the Data Protection Act 2003. It will be stored on a password protected computer, which is only accessible by the researchers who are not staff of the hospital.



Who gave permission to complete this study?

This study has received research ethical approval from Letterkenny General Hospital's research ethics committee.

Dr Anne Flood, Director of Nursing, is the chairperson of the research steering committee.

Who do I contact if I have further questions?

You may contact Michele Glacken, researcher on 086 8586774 or via email at mglacken@stangelas.nuigalway.ie or Mary Kelly, Health Promotion officer on 074 92 25888 or Lucy McGettigan in the hospice.



Appendix 10

Non Consultant Hospital Doctors Questionnaire Faith and Spirituality Needs in Healthcare

We are using the terms 'faith needs' to describe the needs patients have in relation to their affiliated faith tradition/community such as dietary; service attendance etc. When reference is made to patients' spiritual needs we mean what gives patients' life a sense of meaning and purpose; what gives the patient a sense of peace and what are their sources of support/strength and hope.

Circle as appropriate:

- | | | | |
|---|-----|----|-----------|
| 1. Do you consider faith needs when conducting a patient's assessment? | Yes | No | Sometimes |
| 2. Do you consider spiritual needs when conducting a patient's assessment? | Yes | No | Sometimes |
| 3. Do you consider patients' faith needs when you're informing them of their diagnosis? | Yes | No | Sometimes |
| 4. Do you consider patients' spiritual needs when you're informing them of their diagnosis? | Yes | No | Sometimes |
| 5. Do you feel that doctors have a role in assessing patients' faith/spirituality needs? | Yes | No | Sometimes |

Please Comment:

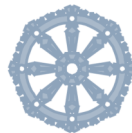
6. How important do you believe faith/spirituality issues are in your interactions with patients/clients?
Not at All A Little Somewhat Quite a Bit Very Important
7. How important do you feel it is for doctors to receive training in the area of faith and spirituality?
Not at All A Little Somewhat Quite a Bit Very Important
8. Are you aware of the HSE intercultural guide? Yes No
9. Have you received education/training on caring for a person's faith/spirituality needs?

If yes, was it:

- Part of pre -registration education/training
- Part of post-registration education/training
- In-house training/education
- Other (please explain) _____

10. Would you like to receive/training on caring for a person's faith spiritual needs? Yes No

Thank you for taking the time to complete this questionnaire



Appendix 11

Chaplin's Interview Schedule

Faith and Spirituality Needs in Healthcare

INTRODUCTION

Welcome, thanks, check with participant **re: consent**

The **purpose of this interview** is to explore their role in meeting the faith/spiritual needs of patients in Letterkenny General Hospital and Donegal Hospice; challenges they may encounter and an exploration of how they feel the hospital/hospice could meet the needs better.

- I am interested in your views and in what you think is important. I have a number of areas that I am interested in, but anything else you would like to say is even more important, so please do add it in.

- Shall we start with:

(Please note these are all potential questions but the participants responses and level of engagement will direct the interview not the schedule)

CURRENT ROLE

- Could you describe your current role in the hospital and hospice?
- How do referrals /communications between yourself and staff work currently in both institutions?
- Did you receive preparation for your role as hospital/hospice chaplain or visiting faith leader?
 - If yes, what format did this take? On reflection, was this preparation adequate?
 - If no, have you ideas for its enhancement?
- How inclusive do you consider the provision of faith/ spiritual care to be
 - a) Within the hospital?
 - b) Within the hospice?
- What are the things that facilitate you in your role
 - a) In the hospital?
 - b) In the hospice?
- What are the challenges facing you in chaplaincy / faith leadership?
 - a) In the hospital?
 - b) In the hospice?



STAFF

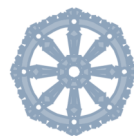
- How do you think staff perceives the chaplain/ visiting faith leader? (E.g. part of the multi-disciplinary team etc.)
- Do you feel staff have a robust knowledge of the various facets of your role?
- How do you inform staff of the dimensions of your role?
- How do you inform staff of the faith tradition that you represent?
- What are your perceptions of staff's knowledge of patients potential faith spiritual needs? What factors do you feel contributes to their knowledge base?
- Do you liaise with staff regarding the interventions you are employing to meet patients faith/spirituality needs?
- Do you assist staff plan the care they should give to patients in spiritual distress etc.? Do they ask you?
- From your own experience, how does the perception of chaplaincy and faith leadership among staff and patients differ for ordained and lay chaplains?
- What role, if any, do you see the staff in the hospital and hospice have in the provision of spiritual care to patients? Elicit what staff- nurses/ docs/ domestic staff etc..
- Have you be involved in any education/training of staff on faith/spirituality needs?
- If yes, explore further.
- If no, would they welcome the opportunity of being involved?

CHAPLAINCY TEAM

- What co-operation exists between the chaplains to the hospital and hospice?
- Do you perceive yourself as part of a chaplaincy/faith community leader team?
If yes; how does this team work? Is it effective?
- Who/what do you draw on for support in your role?
- How do you support other chaplains/ faith community leaders? Is this formalised or ad hoc?
 - If no, explore the reasons

ENVIRONMENT

- What physical space is currently available to you as a chaplain/faith leader
 - a) In the hospital?
 - b) In the hospice?
- How is this space used by yourself and patients? Do you feel the current space meets faith/spirituality



needs of all patients? Have you ever assessed its effectiveness from patients' perspective?

- What provision of space for you as a chaplain /faith leader would you consider to be ideal
 - a) In the hospital?
 - b) In the hospice?
- Are there other environment factors other than space that are required to meet patients faith/spirituality needs?

SUPPORT

- Do you have a role in supporting staff from a faith /spiritual perspective? If so, what does this role embrace
 - a) In the hospital?
 - b) In the hospice?
- Is this role formalised (e.g./ regular debriefing sessions with staff of ad hoc)
- Who initiates the need for support? (yourself or staff)
- How do you assess the effectiveness of this support?

FUTURE

- What are your personal hopes for the future of chaplaincy/faith leadership?
 - a) In the hospital?
 - b) In the hospice?

Interview is concluded
A debriefing period ensues



Appendix 12

Information Sheet

Chaplains/Faith Community Leaders Faith and Spirituality Needs in Healthcare

What is this study about?

This study aims to explore how faith; spirituality and associated cultural needs of all patients and service users of Letterkenny General Hospital and Donegal Hospice are currently being met, and identify if there are further interventions/supports that could be introduced to make the service more inclusive and responsive.

Why is this study being done?

Letterkenny General Hospital and Donegal Hospice want to deliver a quality inclusive service to all patients/service users. Patient populations have become more diverse over the last decade, in terms of their faith and spirituality needs, and it is not known, how these needs are being currently catered for.

Why am I being asked to participate?

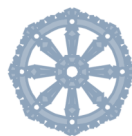
As a chaplain or faith community leader you play a key role in meeting the religious and spirituality needs of patients in both the hospital and the hospice. Therefore the information you can share with us on how you try to meet patients faith/spiritual needs; challenges you may encounter in tending to patients' needs and finally ideas you might have to enhance the meeting of these needs is central to the aim of this study.

What will taking part involve?

For you, taking part will involve both an individual interview with one of the research team and later in the autumn a group discussion with other chaplains/faith community leaders. At the autumn meeting we will be able to share with you other staff views on their role in meeting the faith and spirituality needs of patients and patients' perceptions of how their needs are being met. Both the individual interview and group discussion will be recorded for accuracy.

How will you ensure my privacy and confidentiality?

We will use pseudonyms in all information we share with others. All information will be stored in keeping with the Data Protection Act 2003. It will be stored on a password protected computer, which is only accessible by the researchers who are not staff of the hospital.



What will happen to the information?

The research team will analyse all the information they collect to discover how patients' faith and spirituality needs are being met. Following this, they will write up their findings and suggest recommendations. This will be then given to the research study steering group who will decide if, and how the recommendations can be met.

Who gave permission to complete this study?

This study has received research ethical approval from Letterkenny General Hospital's research ethics committee. Dr. Anne Flood, Director of Nursing, Letterkenny General Hospital is the chairperson of the research steering committee.

Who do I contact if I have further questions?

You may contact Michele Glacken, researcher on 086 8586774 or via email at mglacken@stangelas.nuigalway.ie or Mary Kelly, Health Promotion officer on 074 92 25888.

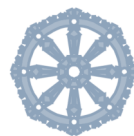


Appendix 13

Patient Interview Schedule

Faith and Spirituality Needs in Healthcare

	Yes	No	Don't know	N/A	Comments
Would you say that you have a faith?					
Were you asked on admission what your faith/religious tradition was?					
Can you remember who asked you?					
Were you surprised to be asked this question?					
Do you know why the hospital asks this question?					
How important is your faith to you?					
Did anyone ask you what your faith requirements were? (daily communion; mass; quiet time; speak to priest etc..)					
Did anyone ask how you would like your faith needs met in the hospital?					
Were you able to follow your faith needs as you wanted? (e.g. pray; have quiet time; diet etc..)					
Have you been made aware of the availability of a chaplain/ minister/ faith/community leader attached to the hospital?					
Were you informed of how the above person could be contacted?					
Were you informed of the services the chaplaincy team provide?					
Are you aware of the chapel/prayer room in the hospital?					



	Yes	No	Don't know	N/A	Comments
Do you consider yourself spiritual? (follow up what they mean by that)					
Were you asked if you had any spiritual needs on admission?					
What gives your life a sense of meaning and purpose?					
Is there anything especially meaningful to you now? What/who is your source of hope and strength during your illness?					
Does faith/religion/spirituality help you cope with your illness?					
Since admission, have you had concerns about such things as your beliefs, values and the meaning of life for you?					
Did you want any help with these concerns? Follow up if yes...					
Query received any of the following since admission: Therapeutic touch/ active listening/ clarify values/ acceptance and non-judgemental place/prayed with.					

Additional Comments:

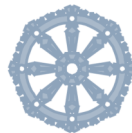


Appendix 14

General Interview Guide

Faith and Spirituality Needs in Healthcare

- How would you define spirituality?
- Do you think it is a part of your role to attend to spiritual and cultural needs?
- Where might it fit in?
- How would you define / identify a spiritual need?
- Do you think that every person has spiritual needs?
 - How would you know a patient's /family's needs?
- A patient or family who does not believe in anything an agnostic, atheist do they have spiritual needs?
- How would you identify these needs?
 - How might you meet these needs?
- Do other Caregivers have any role to play in meeting the spiritual needs of patients?
- Who or what can you offer to help patients spiritual needs – what do you do?
- Do you think that every person has cultural needs?
 - How would you know a patients / families cultural needs?
- What helps you to attend to patients / families spiritual needs?
 - What preparations do you have or on-going preparation?
- What are your sources of personal support?
- Who do you see as part of the team in looking after spiritual/faith/cultural needs?
- What role has the Chaplaincy team in relation to spirituality and culture?
- What is the relationship with the Chaplains?



- What part do they play in the multidisciplinary team?
 - How do you involve them?
- Do you undertake a spiritual assessment?
 - How have you developed your own knowledge?
- Some staff indicate that their own personal perspectives on spirituality and religion are important when attending to patients – would you expand on this
- What would be some of the suggestions you might have to help nurses develop a deeper understanding and appreciation of spiritual and religious perspectives as part of their nursing view of the patient?
- What supports have you for your own spiritual needs and development?
- What are the challenges in relation to spiritual/faith/culture needs assessment and delivery of care to meet these?

ADDITIONAL PROBE AREAS FROM A MANAGEMENT PERSPECTIVE

- Do you think it is a part of the staff to attend to spiritual and cultural needs? Elaborate on this please.
- Do you think staff perceive their role in the same way as you do?
- How would you know as manager that these needs were being addressed?
- How do you know the staff have the knowledge and skill to perform spiritual/cultural assessments?
- Do you think that staff have sole responsibility for meeting of these needs?
 - How do other team members work on these aspects?
- What would you expect to be happening in the team from a spiritual/faith cultural perspective?
- How do you know this is happening?
 - Are there any challenges to this?



- Do you think some of your staff may not be able to attend to these needs?
- Is there any on-going education/other inputs in relation to faith/spiritual/cultural?
- Do you think that staff have spiritual needs?
 - Would you have a part to play in supporting them – expand on this?
- What are the challenges in relation to this?
 - .. do they have spiritual needs -- What helps you to attend to your own spiritual needs?
- Have you had any preparation for this aspect of your role?
- What is the relationship with the chaplains?
- What part do they play in the multidisciplinary team?
 - How do they involve them?
- What would be some of the suggestions you might have to help staff develop a deeper understanding and appreciation of spiritual and religious perspectives of the patient / family?



Copies of this report are available on request in PDF, Word, Large Font and other accessible formats from: Blaithin.McPartlan@hse.ie. Tel: 071-9820266.

This report can be downloaded from www.hse.ie.

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