Mid Essex Hospital Services NHS Trust

| SPIRITUAL CARE POLICY | **Type: Policy**<br>**Register No: 15001**<br>**Status: Public** |
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| Developed in response to: | CQC End of Life Action Plan |
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| **Consulted With:** | **Post/Committee/Group:** | **Date:** |
|---|---|---|
| Dr. Srirupa Gupta | Palliative Care Consultant | May 2018 |
| Rachel Roper | Human Resources | May 2018 |
| Dr. Ellie Making | Site Medical Director | May 2018 |
| Lynn Thomas | Head of Patient Experience | May 2018 |
| Clive Gibson | Lead Nurse Safeguarding Adults/Elderly Care | May 2018 |
| Matt Riddleston | Lead Nurse Cancer and Palliative Care | May 2018 |
| Charlotte Hoctor | End of Life Care Facilitator | May 2018 |
| Tabitha Stuthridge | Bereavement Midwife | May 2018 |
| Dr. Mandy Giles | Lead Psychological Services | May 2018 |
| Sue Poole | Head of Learning and Development | May 2018 |
| Elaine Chapman | Bereavement Services Officer | May 2018 |
| Robert Lee-Bird | Patient Council | May 2018 |
| **Professionally Approved By** | | |
| Lyn Hinton | Director of Nursing | May 2018 |

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| 1.0 | Julia Sheffield – Lead Chaplain | 4 March 2015 |
| 2.0 | Timothy Blake- Lead Chaplain | 23 July 2018 |
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**Contents**

## 1.0 Purpose

1.1 The document is designed to provide guidance to all Trust staff regarding the role of the Department of Spiritual Care and Chaplaincy and the extent of the services offered to support the diverse needs of Trust Patients, staff and families by the chaplaincy team and associated staff and volunteers.

1.2 The document also sets out to detail the responsibilities of all staff within the Trust in supporting the spiritual wellbeing of patients and their families and the staff within the whole Trust community.

## 2.0 Aims

2.1 To support the provision of spiritual, pastoral, religious and cultural needs (hereafter called Spiritual Care needs) for any patient, family, staff or visitor in the hospitals within the Trust.

2.2 To clarify definitions and create a working terminology, whilst acknowledging grey areas in perception and understanding of 'Spiritual Care'.

2.3 To describe the key roles of departments and staff in the assessment and delivery of Spiritual Care.

2.4 To describe key competences needed and professional boundaries to be observed by all staff.

2.5 To describe the specific responsibility of the Spiritual Care and Chaplaincy Department.

2.6 To describe training needs and identify responsibility for the provision of and access to Spiritual Care training

2.7 To describe communications and information resources to enable staff to meet Spiritual Care needs

2.8 To ensure that the Spiritual, Pastoral, Religious and Cultural needs of patients are addressed within a comprehensive framework of assessment, delivery, recording and auditing of care.

2.9 To ensure that all staff understand their role in the assessment and/or delivery and recording of Spiritual Care.

2.10 To enable managers to recognise and respond to the training and support needs of their staff in the field of Spiritual Care.

2.11 To ensure that provision is made to meet specific religious and cultural requirements of patients, family, staff, and visitors, under the terms of the Equality Act 2010.

## 3.0 Scope

3.1 This policy applies to all frontline staff, including volunteers, who meet, greet, or care for patients and visitors, and all managers with supervisory responsibility for staff and volunteers and their human rights and sensibilities.

3.2 This policy applies equally to persons of all faiths and beliefs

3.3 This policy addresses multicultural considerations regarding religious practices, end of life and bereavement care, and reference to barriers to medical treatment and tissue and organ donation, but excludes dietary, dress and modesty considerations as these are covered in other Trust Policies: specifically Catering Policy, Uniform Policy, Chaperone Policy.

3.4 This policy refers to aspects of, but does not cover, the Operational Policy of the Spiritual Care and Chaplaincy Department, which is to be found in a separate document.

## 4.0 Introduction

*"At its best, our National Health Service is there when we need it, at the most profound moments in our lives. At the birth of our children. At the deaths of our loved ones. And at every stage in between - as we grapple with hope, fear, loneliness, compassion - some of the most fundamental elements of the human spirit."* [1] *(NHS Chaplaincy Guidelines)*

4.1 This policy is therefore based on this assertion that every person has a human spirit. Under normal circumstances the human spirit is vital and interactive but in certain situations e.g. stress, loss, illness and trauma, people may need spiritual support and have special needs, for example:

- To give and receive love
- To be listened to with empathy
- To be understood
- To be valued as a human being
- To have forgiveness, hope and trust
- To explore beliefs and values
- To express feelings honestly
- To find meaning and purpose in life

4.2 'Spirituality 'means the beliefs and values that determine what is important in one's life, a sense of connectedness which gives meaning and purpose to living. This policy underlines the responsibility of all staff to support spiritual care in its broadest sense, respecting the dignity, humanity, individuality,

independence and diversity of the people whose cultures, faiths and beliefs are represented in the Trust population.

4.3 The policy recognises the growing body of evidence that many of the behaviours associated with faith and belief can be shown to be beneficial to the well-being of patients; that spiritual, emotional and physical wellbeing are interconnected in the role they play in holistic care

4.4 This policy also asserts the evidence of relationship between spirituality and staff wellbeing; that the roots of stress, burnout, and disenchantment lie in spiritual issues, such as meaning, purpose, relationships, and connectedness at work, and are as important as other conditions, if not more so, in producing a happy and contented workforce.

4.5 This Policy supports an amendment to the NHS constitution proposed by the Executive of the Chaplaincy Leadership Forum, in relation to a patients' right to receive spiritual, religious and pastoral care, with rapid access at end of life.

## 5.0 Definitions

5.1 **Spiritual Care**:

*"The care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness… and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires"*

For the purpose of this document, it is care provided in the context of illness which addresses the expressed spiritual needs of patients, staff and service users. These needs are likely to include one or more of the following:

- Personal dilemmas
- Religious convictions and practices
- Relationships of significance
- The exploration of faith or belief.

5.2 **Pastoral Care:** Care to support the daily personal and emotional needs arising from health issues and the hospital environment.

5.3 **Religious/Cultural Care**: Is that given where specific religious belief, and /or custom and practice is identified, to meet an individual's human rights and to give spiritual support.

5.4 **Psychotherapeutic Care**: Specialised care where there are complex or adverse emotional and psychological behaviours.

5.5 **Spirituality**: The beliefs and values that determine what is important in one's life, a sense of connectedness that gives meaning and purpose to living. This may or may not include a belief in God or a higher being.

5.6 **Spiritual Distress/Crisis**: When individuals are unable to find sources of meaning, hope, peace, strength and connection in life or when conflict occurs between their beliefs and what is happening in their life. Often triggered by illness and impending death, this distress can have a detrimental effect on physical and mental health in patients and family members.

5.7 **Family**: Any person who has a significant relationship with the patient. This maybe a relative, partner, close friend and or carer.

5.8 **Chaplain**:

Chaplains in the Mid Essex Hospitals Trust can be identified in three distinct roles

- **Trust Chaplain** A registered spiritual and religious care specialist employed by the Trust.
  These chaplains are recognised as being in good standing with their faith communities and accredited by the United Kingdom Board of Healthcare Chaplains (UKBHC)[2]. Whilst currently drawn for reasons of demographics from the Christian community, they are required to provide care to patients of all faiths and beliefs; drawing on other faith communities and resources as necessary.

- **Ward Chaplain** A volunteer drawn from local faith communities to provide spiritual care under the supervision of the Trust Chaplains. The Ward chaplains usually operate on one ward and have extensive training and support.

- **Associate Chaplain** A local faith Community leader in good standing with his faith community, providing specific religious support to patients and their families. They are required to undergo all the necessary mandatory training as well as being supervised by the Trust Chaplains.

## 6.0. Roles and Responsibilities

6.1 **The Board, Site Managing Director and Chief Executive** have ultimate responsibility for ensuring that all Spiritual, Religious and Pastoral Care is:

- Offered to patients, relatives and staff in accordance with current equality and diversity legislation
- That it meets recommendations laid down by the DH, NICE, and NHS England guidelines
- Is delivered in accordance with Trust Values and Behaviours statement
- Is championed and underpinned by a competent and adequately established and resourced team of Healthcare chaplains

- Has specific provision in the estate in accordance with DH guidelines for provision of Multifaith prayer rooms and facilities

6.2 **The Site Medical Director, Director of Nursing and all Medical and Nursing staff with line management responsibility**

- Are responsible for ensuring that health professionals are aware and adequately trained in the initial and ongoing assessment of the holistic health needs of patients
- To ensure spiritual, religious, and cultural needs are identified, recorded by consent, and
- Are appropriately addressed by ward staff and/or by referral to the Spiritual Care and Chaplaincy Team.

6.3 **Department for Spiritual Care and Chaplaincy** is responsible for:

- The development, reviewing, and promotion of the Spiritual Care Policy;
- For providing a resource of expert knowledge on religious and cultural care;
- For providing, managing, and monitoring a 24/7 professional spiritual and pastoral care service for patients, family, and staff;
- For resourcing the Spiritual Care aspect of staff and volunteer training programmes;
- For the day to day management of the Faith Centre at A209;
- For assessing, sign-posting and referring on any pastoral needs which would be better met by another discipline or department i.e End of Life care, Palliative Care, Psychological Services, PALS etc.

6.4 **Department of Human Resources** is responsible for:

- Ensuring that Spiritual Care is included in staff health and well-being policies.
- That recruitment and employment practices eliminate discrimination on the grounds of religion and belief.
- Ensure patient assessment and care policies, and staff employment and welfare policies comply with the Religion and Belief aspects of the Equality Act 2010.

6.5 **Department of Learning and Development**

- To work with the Department of Spiritual Care and Chaplaincy to ensure that Spiritual Care awareness is appropriately included for new staff at induction and subsequently at appropriate levels as required.

6.6 **Switchboard Staff**

- All switchboard operators should be conversant with protocols and procedures to enable contact with the 24 hour on-call Chaplaincy Service

from a monthly rota provided by the Chaplaincy Service (refer to Appendix 1)

6.7 **Staff involved in Critical Incident Debriefing**

- Should be able to recognize and address spiritual distress in staff following critical incidents.

6.8 **Bereavement Team**

- Responsible for daily engagement with bereaved families to ensure that the spiritual needs are recognised and addressed.
- To be aware of the support offered by the Department of Spiritual Care and Chaplaincy for families around bereavement listening and viewing of bodies.
- To be familiar with chaplaincy referral procedures

6.9 **Patient Experience Team**

- To ensure there is a patient feedback tool to measure patients' satisfaction with their Spiritual Care and an adequate complaints procedure.

## 7.0 How We All "Care for the Spirit"

7.1 Informal Spiritual Care begins with the desire to treat others as we would wish to be treated i.e. make a connection with, to have unconditional regard for, and a concern for the wellbeing of the other person. Spiritual Care at this level is embodied by eye contact, a welcome facial expression, open, calm body language, and a willingness to listen.

7.2 These attitudes and behaviours are in common with the Trusts values and behaviours statement and its policy on Dignity in Care.

## 8.0 Assessment of Spiritual Care Needs

8.1 A Spiritual/Religious Needs section should be included in all admissions and general nursing assessment documentation.

8.2 A comprehensive Spiritual Needs Assessment should be included in all assessment and documentation related to the care of the dying.

8.3 A basic spiritual assessment will involve a conversation which shows concern for how a person will cope with their hospital stay and may include the following lines of enquiry:

- Do you have any worries about your stay in hospital?
- Will you have enough support while you are here?
- Do you like to practice any particular religion or faith?

- Would you like support from our Chaplaincy Team?

8.4 Where a patient requests or consents to support from the Chaplaincy Team, ward staff are responsible for making a referral to the Department of Spiritual Care and Chaplaincy, in a timely manner see Appendix 1.

8.5 Spiritual Care referrals can also be accepted on behalf of patients without consent, from concerned staff or family, in which case a chaplain will make an introductory visit.

8.6 Caring staff should recognize that a person's Spiritual Care needs may arise or change at any point in their hospital visit in response to changes in a person's condition, prognosis, or personal support system.

## 9.0 Meeting Every Day Religious Needs

9.1 Every patient should have the opportunity to declare or to withhold information about their faith or beliefs, and to give or withhold consent to have this recorded on any assessment or data collection form.

9.2 Managers should ensure that staff responsible for patient assessment and essential data collection are confident to include, rather than omit, questions about religious affiliation, and any need for support. This may require specific training.

9.3 Religion or belief sections on forms should always be completed with the consent of the patient or their advocate. If consent is withheld, this should be recorded as 'Not applicable' A blank entry will be considered an incomplete assessment.[See also paragraph 10.1.2]

9.4 Religious practices are highly personal. Where a person declares a particular religious faith or affiliation, always clarify with the person, rather than assume to know, if they need assistance to carry out practices important to them.

9.5 If religious assistance is required, first ask the person to be specific. .If resources are needed, e.g. sacraments, sacred texts, prayers, prayer mats, or other religious artifacts, refer immediately to the Spiritual Care and Chaplaincy Department who will assess for and supply resources as far as possible

## 10.0 Spiritual Care in the Last Days of Life

10.1 It is recognized that spiritual and religious needs often come to the fore around the end of a life, and for the dying person and their family.

10.2 In a person of faith, religious rituals may be highly significant and contribute to the peaceful ending of a person's life and the family's experience of a good death. This may also be so of individuals who have previously ceased to practice their religion.

10.3 In accordance with the Care of the Dying Policy the spiritual, religious and cultural requirements of the dying person must be included in a Last Days of Life care plan. The Department of Spiritual Care and Chaplaincy is available to support all staff in the completion of Last Days of Life Care Plans. Some examples of good practice in the completion of Last Days of Life care plans are shown in appendix. 6

10.4 Some religions require specific rites and rituals to be carried out in a specific timeframe. It is therefore essential that as far as possible the resources for rites and rituals are prepared in advance of the death, and that staff are aware of out-of-hours procedures, including how to access the Trust's 24 hour on-call Chaplaincy Service.

10.5 Critical Care staff need to be aware that spiritual and religious issues for the family may suddenly arise where the withdrawal of life support or organ donation is proposed.

10.6 Sources of information for the specific religious requirements at the end of life are:

- The person and/or their family
- Multi-cultural resources for staff' on the Chaplaincy intranet page
- 24 hour on-call Chaplaincy Service

**10.7 Emergency Marriage or Registration of Civil Partnership** There are situations that arise in the End of Life that require particularly sensitive handling, Emergency marriage ceremonies and similar blessings are an example of these. Staff are encouraged to consult with the Department of Spiritual Care and Chaplaincy who can provide advice and facilitate these occasions.

## 11.0 Spiritual Care in Maternity and Baby Loss

11.1 **Baptism or Christening** Ideally, in all Christian traditions, baptism takes place within the context of a worshipping Christian community. However, where an adult, child, or baby is gravely ill, the chaplains have a responsibility to facilitate a request for baptism. Following this baptism the Department of Spiritual care and Chaplaincy recognises the importance of helping the family to connect with their own Christian community for ongoing pastoral care and support**.**

11.2 **Baby Naming and Blessing** Following a miscarriage or stillbirth, the Bereavement midwife offers parents the opportunity to have their baby named and blessed. (This service is available whatever the beliefs of the parents.) Following such a request chaplains will consult with the parents and provide a suitable simple service of blessing, and provide a certificate following the service.

11.3 **Memorial Service for those who have suffered the death of a baby or child.** Every six months the Department of Spiritual Care and chaplaincy

holds a service to provide those affected, a means to mark and remember the loss of a baby or child through miscarriage or infant death. This service is largely non-religious and particularly helpful to families still grieving their loss.

## 12.0 Whole Trust Community Support

12.1 Any hospital develops its own community character. The health and wellbeing of that community can be encouraged by the celebration of community events and challenged, for example, by the unexpected death of a colleague, or the internal and external stresses that are part of the everyday life of a busy hospital.

12.2 The Department of Spiritual care and Chaplaincy has a responsibility to respond with sensitivity to circumstances that impact on Trust community wellbeing. Some of these responses are as part of the continuity of community life, Christmas Carol singing in the Atrium or on the wards, events from other faith groups and national celebrations.

12.3 Other responses will include the provision of appropriate contexts to express individual or corporate grief, pain or loss at the death of a colleague, national or international tragedy and both during and in the aftermath of a major incident.

## 13.0 Safeguarding and Professional Boundaries

### 13.1 Persons who are Vulnerable, have Special Needs, or who lack capacity

13.1.1 The holistic approach to care, including spiritual needs assessment, is key to the safe and effective care of vulnerable persons.

13.1.2 All reasonable adjustment must be made, where required, to address the spiritual and or religious needs of vulnerable people, which may involve the considered view of a named person to be consulted in matters of the person's welfare.

13.1.3 Communications and information regarding spiritual care should be provided, as far as possible, in an accessible format, according to need.
The use of '**This is Me'** or similar communication tools can support Trust Chaplains as well as Ward Chaplains in their Spiritual Care; particularly when these make reference to any faith based practices.

13.1.4 There is much evidence to show the beneficial role of remembered faith practices, such as prayer, hymns, and receiving of sacraments in people living with organic mental health condition such as dementia.

13.1.5 It is also recognized that some functional mental health presentations contain an element of religious fervour or delusion. If this suspected during a spiritual assessment the case should be referred on to the Psychological Services, who will reassess for the most appropriate management.

13.1.6 Trust chaplains can help to support ward staff and psychological services in Spiritual and Religious Care where it forms part of a psychiatric or psychological presentation.

## 13.2 **Unsolicited Religious Attention**

13.2.1 It is recognized that vulnerable people must be protected from the imposed beliefs of others. The development of a professional Healthcare Chaplaincy service is founded on the premise that persons in hospitals must retain freedom of choice regarding their engagement, or not, in faith base practices.

13.2.2 All reasonable efforts need to be made to protect vulnerable patients,

- from unwanted visits from religious representatives, especially from persons seeking to evangelise or convert, and
- from distribution of unwanted religious literature claiming knowledge of cause and cure of medical conditions.
- From unsolicited/unwelcome visits from pastoral visitors or religious leaders from the patient's own faith community. Where possible staff should be guided by the patient.

## 13.3 **Professional Boundaries - "who can pray with patients?"**

13.3.1 Codes of conduct prohibit all healthcare professionals from imposing their values, beliefs or practices on those in their care; or failing to respect their beliefs, values or spiritual interests. This is includes Healthcare Chaplains.

13.3.2 Prayers, religious rites and rituals, and the supply of religious material should, therefore, be provided only at the request, or with consent of the patient.

13.3.3 It is permissible for a medical or nursing staff to pray with a patient:

- Where there is recognition of mutual religious belief,
- Where it will not compromise the patient/professional relationship, and
- Where it is considered to be in the best interests of the patient.

13.3.4 When engaging in religious practices the dignity and respect of the person, and in a ward environment, the surrounding patients, must be safeguarded.

13.3.5 The chaplaincy service is there to provide a safe, high quality and authorize service for the assessment and provision of spiritual and religious needs to patients, families and staff.

## 14.0 Record Keeping, Audit & Monitoring

14.1 Issues arising from failure to meet Spiritual and religious needs will be monitored and reported through Datix and the complaints channel.

14.2 The Department of Spiritual Care and Chaplaincy will conduct audits into patient admission and assessment data to monitor staff compliance and identify training needs.

14.3 The Patient Experience Group will monitor the effectiveness of the implementation of this policy through periodical reports from the department of Spiritual Care and Chaplaincy.

14.4 The Department of Spiritual Care and Chaplaincy will make records of encounters with patients. This will ensure that the case load is appropriately managed by the team and that referrals are logged effectively for follow up. The volunteers will similarly log their encounters to enable continuity of care and referral to the Trust Chaplains as necessary.

14.5 Records will be held in accordance with Trust I.T. Governance policy, both electronically and where necessary on paper.

14.6 Records will be reviewed to assist with Chaplain deployment and for audit purposes.

14.7 Trust Chaplains will access Patient record systems e.g. Lorenzo and Vital Pac, to assist in identifying the location/status of patients referred to the Team.

## 15.0 Implementation and Communication

15.1 After ratified this policy will be placed on the intranet and website.

## 16.0 References

England – NHS Chaplaincy Guidelines 2015
Promoting Excellence in Pastoral, Spiritual and Religious Care
(Refer to link Appendix 2)

DoH Religion or Belief: A Practical Guide for the NHS

One chance to get it right - Improving people's experience of care in the last few days and hours of life.
June 2014 Leadership Alliance for the Care of Dying People

Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment GOWRI ANANDARAJAH, M.D., and ELLEN HIGHT, M.D., M.P.H, Brown University School of Medicine, Providence, Rhode Island. Am Fam Physician. 2001 Jan 1; 63(1):81-89.

**Appendix 1** **Chaplaincy Referral Procedure**

**Department of Spiritual Care and Chaplaincy**

# Chaplaincy Referral Procedure

## For Emergency/Urgent referrals 24hrs everyday

**Call the On-Call chaplaincy pager service via switchboard [0] 01245 362000**

Response times:

Working week Mon –Fri 0830 – 1630; pager 10 mins; attendance 20 mins

Out of hours; pager 10 mins; attendance on site within 1 hour

**Emergency/urgent referrals** are defined as when Religious/pastoral support is required **24/7**

- where end of life is imminent
- around end of life with family present
- where timely clinical/ethical decisions about care need to be made
- where there is significant spiritual or pastoral distress in patient, family or staff.
- In the event of a critical or major incident
- to supply time sensitive spiritual, religious or cultural care information or advice by telephone. [Please also refer to Spiritual and Multicultural care resource page on the Chaplaincy intranet pages]
- where a patients request for Sunday bedside ministry arise out of hours

**Note: please advise the operator if a Roman Catholic chaplain is required**

## Non urgent referrals or requests

**By Phone** x5244 / 01245 515244 [messages will be picked up within one working day]

**By email** MEHT.Chaplain@meht.nhs.uk

**NOTES**

Chaplains are normally on site Mon –Fri 0830 – 4.30; and Sunday 0900 – 1200

Switchboard are advised on variations in service

Chaplaincy Office situated in the Faith Centre at A209

The Faith Centre is open 24/7 for private prayer and reflection

Team Leader direct line x4069

## Appendix 2. Multifaith healthcare resource – link only

**This guide provides basic support in understanding the needs of different faith groups but our 'Golden Rule' is to always ask patients or their carer about their needs for religious or spiritual support.**

http://www.upmc.com/about/Documents/community-commitment/Center%20for%20Inclusion/Interfaith_Online_Guide.pdf

## Appendix 3. Equality Act of 2010 –Religion and Belief – link only

Part Two in particular relates to protected characteristics see Full Act here: http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

## Appendix 4. NHS England – NHS Chaplaincy Guidelines -Promoting Excellence in Pastoral, Spiritual & Religious Care; 2015– link only

https://www.england.nhs.uk/wp-content/uploads/2015/03/nhs-chaplaincy-guidelines-2015.pdf

## Appendix 5.

### Text Extracts

### 1. NHS constitution

The UK Chaplaincy Leadership Forum executive is at time of writing [Feb2015] in consultation with the authors of the NHS Constitution with the proposal that the following amendment is made :

"*You have the right to receive high quality spiritual, religious and pastoral carefrom a professionally trained NHS chaplain, with rapid access available to suchcare at the end of life."*

### 2. The Relationship between Spirituality and Healthcare

From Spiritual Care and Chaplaincy, Scottish Government Edinburgh 2009

1 "Health is not just the absence of disease, it is a state of physical, psychological, social and spiritual well-being" *World Health Organisation, Precis of discussion, 1948)*

2. "Among the basic spiritual needs that might be addressed within the normal, daily activity of healthcare are:

- the need to give and receive love
- the need to be understood
- the need to be valued as a human being
- the need for forgiveness, hope and trust
- the need to explore beliefs and values
- the need to express feelings honestly
- the need to find meaning and purpose in life."

3. “The need for spiritual care demonstrates that people are not merely physical bodies requiring mechanical fixing. People find that their spirituality helps them maintain health and cope with illnesses, traumas, losses and life transitions by integrating body, mind and spirit. People, whether religious or not, share deep existential needs and concerns as they strive to make their lives meaningful and to maintain hope when illness or injury affects their life.”

4. “Literature reviews show there to be a growing body of evidence as well as a healthy critical analysis of research in the realm of spirituality and religion. Many of the behaviours associated with faith and belief can be shown as beneficial to well-being.”

## The Relationship between Spirituality and Staff Wellbeing

“. . . there is a growing body of evidence that stress, burnout, and the disenchantment of professional carers with their work has its roots in issues more complex than pay and conditions. Issues such as meaning, purpose, relationships, and connectedness at work (the very stuff of spirituality) are just as important as other matters, if not more so, in producing a happy and contented workforce, and an organisation that does its job well.”
(Wright, 2005)

## Appendix 6. End of Life Support- Spiritual Care Possible Trigger Questions

These are all focused on asking the patient, but the same can apply to asking a carer and can be adapted for their support as well.

A. **Are there people that you would particularly like to see?**
   **People that are special just to be with you? Someone you have not seen for a while?**
   **Note and facilitate – If No family local?- Can we facilitate something?**
B. **Are there things that might support you at this time?**
   **Music, someone to read a favourite book, poems, Do the crossword**
   **Note and facilitate – If No family local? Can we facilitate something?**
C. **Are you someone who prays?**
   Would you like a prayer book or maybe some support in your praying?
   Have you a particular Faith community you are part of or were in the past?
   Would you like a visit from the chaplain or your faith community leader?
   **Note and facilitate – Chaplaincy can facilitate Faith Community Visits.**
D. **Are there conversations you need to have about dying?**
   Things that are particularly on your mind? Arrangements you would like to make or questions you have? Are there people you need to see about that?
   **Note and facilitate – If No family local- Chaplaincy Psychotherapy or others can facilitate some of these.**

**NOTES**

It may not be appropriate to make this assessment all at one time or particularly immediately after the diagnosis/news being broken to patient or family.
Please feel free to ask for support from the chaplaincy team with any aspect of this assessment.
Extension 5244 or if urgent page the On Call Chaplain through the operator.
MEHTChaplain@MEHT.NHS.UK

**What an initial assessment might look like.**

**Please <u>never</u> put N/A or just Not Religious**

Mrs Evan's family could not face talking about this, so we will discuss again when possible.
Mr Smith's family say that he is not someone who goes to Church, but he does pray and may value a chaplain visit/support.
Mrs Smith says that all she needs is the support of her family, and hopes that her son can come and visit, he lives in Nottingham. Chaplain support not needed
Mr Mohammed's family is concerned that after he has died they would like him to be returned to his home in Jordan to be buried. They also asked about a visit from an Imam.
Family very distressed and would value to talk with the chaplain.
Mr Steven's described his son as a very spiritual person but not religious, still unsure about a chaplain visit so will follow up.
Mrs Agnew loves classical music and particularly ballet as she was a dancer, would enjoy hearing this but not all night and day!
Mr Peter's family say that he is a very committed Catholic and would like the Priest to visit as soon as possible.

T.Blake April 2018