

DO PRACTICE AND SERVICE MODELS HELP TO IMPROVE PATIENT ACCESS TO SPIRITUAL CARE? 1.2.07

How can the spelling out of practice and service models contribute to improving patient access?

As chaplains, we become aware of patient needs through many channels which depend upon our relationships and presence in the hospital environment. There also remains the feeling that we fail to make contact with many people we could support and help. It is for this reason that the issue of “patient access to spiritual care” is of very real concern. It is perceived that Trust systems for informing chaplains of patient needs do not work well and that patients may experience difficulty in obtaining the spiritual or pastoral help they may need. Efforts we may take to improve this situation are often frustrated by a lack of knowledge on the part of management about our philosophy of care, our objectives and methods.

This situation can be addressed by presenting what amounts to a chaplaincy or spiritual care policy, and inviting our respective Trusts to embrace such an approach. Such statements of policy may suffer from being far too vague to serve as the basis for implementing changes in facilitating patient access. This can be avoided if we put forward models of service and practice with clarity.

Making Models

We felt that such “model making” can, to a large extent, be an articulation of what we in fact think and do. However the process of formulating the models would help us to reflect on our actual practice and service in ways which might well be creative and possibly, self-critical. Service models depend not simply upon present implicit styles and philosophy but also upon the particular environment of the organisations in which we work. Here some of the opportunities given to mental health chaplains currently can also be taken up for certain categories of patient in an acute setting, i.e. those who are longer term or recurring in-patients.

We considered that what might be finally written down could read as rather “cold and clinical” since in reality everything interlinks and interrelates. For example an encounter with a patient may well have a religious focus such as a sacramental need, yet in reality we care for the whole person so that the “religious becomes the pastoral”. Could models reflect the organic nature of chaplaincy work as we experience it? In response to our own question we felt that would always be something of “*shop window*” in the presentation of models. This was a means of communicating with our respective Trusts to achieve certain aims. At the same time, the rather “objective” language used in models may help us to think clearly about the issues.

Models must reflect the philosophy shared by the particular chaplaincy team. There would be variation between Trusts even if they are in the same sphere of work, since philosophies and emphases evolve in ways particular to Trust chaplaincy teams.

Service Models

To some extent the pastoral tradition of the Church continues to shape chaplaincy. The provision of worship, sacramental ministry and the exercise of pastoral care in which we consider the well being of the whole person reflect the *parochial model*, except that one is ministering to a transient community rather than a more permanent entity. However in model making one is drawn to make distinctions by using such terms as “religious”, “pastoral” and “spiritual” to express what the chaplains are about.

Pastoral care is characterised by a faith-based understanding of the human person. This applies even if one is ministering to someone whose grasp of faith is somewhat ambivalent or limited. Thus whilst not denying a working distinction between the “religious” and the “pastoral”, it is not an absolute distinction. To some extent the nature of the care given depends upon the chaplain’s perception of the person to whom he or she ministers. A service model must provide some clarity if these distinctions are to be used while truly expressing what the chaplains concerned intend by their exercise of differing types of care. The key words used within a model to express the local philosophy will depend to some extent on the local Trust culture.

The most difficult defining word is “spiritual”. One acute sector chaplain saw dangers in its use in models whereas another felt it was useful in a Trust where much was made of the concept of holistic care. In Mental Health the word was increasingly used in Psychiatry and Psychology, which suggested that mental health chaplains should use the term to communicate their service model.

There appeared to be two ways to avoid pitfalls in the use of “spiritual” the worry is that if you define spirituality in a very broad sense (for example the need of every human being for meaning, purpose and identity) whilst staff may be alerted to the idea, that everyone and not just the “religious” have spiritual needs, chaplains may lose their specialism to other staff. One answer is to ensure that the model defines levels of responsibility for spiritual care within the local workforce. The other is to promote a concept of spirituality, which relates to religion and faith. For example it is possible to say that our common human search for meaning and identity is a search for what transcends the obvious, for those beliefs and values which give us hope and purpose.

In the Mental Health field the interest is in the therapeutic value of spiritual care so that models must relate to health, well being and recovery. There might also be something about the harmful effects of skewed spiritual beliefs and values which prevent healing and wholeness. This consideration might also be of interest to chaplains in the acute sector when chaplains minister to longer term or recurring patients.

Making Practice Models

Practice models can be derived from full descriptions of our actual work. Below is CS.s practice model based upon a categorisation of activities into three parts. CS however adds that he is not entirely comfortable with rigid labelling as “I think we move from one to another as needed.” There is an accepted debt of gratitude here to

the parochial model in that it is a faith based but flexible response to “all sorts and conditions”.

CS's PRACTICE MODEL

‘To meet the religious, spiritual and pastoral needs of patients, their relatives and staff’

‘Religious/Parochial’

- 24/7 on-call availability of a chaplain plus a voluntary rota of local RC priests for sacramental/priestly ministry as required for Catholic patients, Sacrament of Sick, Confession etc.
- Regular Sunday Services of Holy Communion
- Monthly Communion Service for staff
- Tuesday Evening Informal Service
- Bedside Communion
- Prayers for Dying/Dead
- Confession/Anointing
- Emergency Baptism
- Thanksgiving for Birth of a Child
- ‘Sensitive disposal’ of NVFs, Stillbirth Funerals, ‘Contract’ funerals.
- Occasional Services/Special Services. E.g. Carols, Ash Wednesday, Baby Memorial Service, Memorial Services for members of staff

Supportive/Counselling/Spiritual

- Much supportive talking/listening at bedside by referral or by ward visiting
- Listening Ear and Counselling if required
- Support for relatives
- One to One staff Support
- Critical Incident Debriefing for Staff
- Part of Palliative Care Team and involved in Integrated Pathway of Care

Professional

- Teaching Sessions for staff e.g. ethics, bereavement
- Membership of working parties committees etc. e.g. Trust Ethics Forum, Mental Capacity Act Implementation Group, working party on sensitive disposal of NVFs
- Directorate Meetings
- Own professional development and learning
- Advice on religious, ethical and multi-faith issues
- Members of relevant Case Conferences and MDTs (e.g. palliative care, stroke)
- Participation in management/leadership of Team as appropriate to team member

Comments:

CS's draft practice model may suggest the need for a detailed referral system supported by the Trust to enable good patient access to complement the usual less formal means of contact the chaplains have.

In the CS model the term “spiritual” relates to support and counselling and is not used in a wider sense. In JP’s mental health trust the term is firstly used as an umbrella term complementing other aspects of patient centred care. For example it has this use in the Trust’s “Care Plan Approach”. It is also has a more precise use in the following notes which are preparatory to the making of a Practice Model where it is related to the health, well-being and recovery of the mental health service user.

JP’s PRACTICE MODEL

Religious Ministry

The provision of worship

The Sacraments: Holy Communion, Anointing, Confession etc.

All support given to help people practice their faith.

All support given to help people interpret their faith, apply it to themselves, and search for meaning in a faith context.

Locating support for service users in the community.

Pastoral

Care which given according to principles of faith but also given with respect for the patient’s beliefs.

Friendly supportive contact, listening and encouraging.

Spiritual

(The details here reflect the view that all persons have spiritual needs based upon the search for meaning, purpose and identity and that this aspect of being needs attention in the sphere of mental health. This philosophy embraces all aspects of chaplaincy work but certain types of work can be here headed “spiritual” to distinguish from the other two aspects.)

Making as an assessment of a service user’s spiritual needs and difficulties.

Suggesting an approach to support health, well being and recovery.

Working with the service user to resolve difficulties and find ways forward.

Chaplaincy to Staff

Core Training to support improved patient access and CPA

Spiritual Care and Self-Awareness courses.

Staff Counselling

Consultancy for staff working with service users.

Comments: There is a feeling that certain traditional types of chaplaincy work of a sacramental and pastoral nature needs to be defined and safeguarded in a Trust which holds a very inclusive concept of the “spiritual”. In the necessary service model there has to be some clear definition of the terms used such that the spiritual and the religious are not seen as completely distinct. There also needs to be definition

of levels of responsibility for spiritual care within the trust. The work described above under “Spiritual” necessitates a robust CPA policy and willingness for multi-disciplinary working. Spiritual ministry has a therapeutic nature to complement the work of clinicians and other professionals involved in each case.

JA’s PRACTICE MODEL

The Chaplaincy Department is concerned with meeting the spiritual and pastoral needs of patients, their relatives, and staff with The Rotherham NHS Foundation Trust and Rotherham Hospice. The service is for those of all faiths or none. The Trust’s Service Development Strategy Documents states “We aim to meet your spiritual, clinical and physical needs, and to support those who care for you in any way that we can”.

Availability

- Chaplains are available 24/7 via the Paging system to offer confidential, non-judgemental support to patients, relatives and staff. The Roman Catholic and Muslim Chaplains have their own pagers and all other enquiries are directed through to the departmental pager.
- The Chapel is situated on C level and is open at all times
- The Muslim Prayer Room is situated on C level and is open during the day. At other times access can be gained by contacting the Portering Department.
- The Whole time Chaplains visit the Hospice regularly and are also available to be called into the Hospice 24/7 via the paging system.

Areas of Work

1. Patients and their Relatives

- Ensuring any specific religious requests are met e.g. sacramental ministry
- Specific visiting via referrals
- General ward visiting
- Offering spiritual and pastoral support
- Providing weekly worship services (Sundays – Christian, Fridays – Muslim)
- Special Services e.g. Annual baby memorial service
- Organizing and conducting hospital contract funeral services.
- Liaising with ministers and other faith leaders at the specific request of patients

2. Staff

- Offer spiritual and pastoral support to all staff both individual and group
- Offering training opportunities dealing with issues of spiritual care
- Advising on religious, spiritual and multi-faith issues and contacting appropriate religious groups.
- Membership of inter-departmental committees, forums, and working parties

- Membership of MDTs

3. Departmental

- Promoting the work and availability of Chaplaincy via publicity material and speaking to local groups
- Staff and Volunteer development and learning
- Recruiting and supporting Chaplaincy Volunteers
- Professional Development Reviews.
- Administration
- External meetings and maintaining faith based links

Comments:

The range of services detailed in JA's model is supported by the Trust's Service Development Strategy. This raises the question as to how the Trust is going to ensure that its commitment to spiritual care for all patients translates into delivery. How does this SDS relate to care plan documentation and the referral system for chaplains? Here is an example of model making to support a Trust philosophy which might lead on to Trust initiatives to improve patient access.

CONCLUSIONS?

The group must stress that these are simply early thoughts on Practice models. It is thought that their presentation and content would depend greatly on the service models. The latter can only be agreed through some clear thinking on appropriate local philosophies. However clarity and definition are needed in both models if they are to support Trust initiatives in improving patient access.