

Caring for the Spirit: Implementation plan
Guidance Note

A MINIMUM DATA SET FOR SPIRITUAL HEALTHCARE

This paper forms part of the guidance for chaplains arising from the Caring for the Spirit NHS project. A listening exercise on this subject was undertaken in 2004 and this paper sets out the conclusions therefrom to inform future development.

November 2005

CONTENTS

Background	2
Defining what we mean	2
Attributes of spiritual care	3
Initial and continuing episodes of spiritual care	3
What is the data used for and what is it not used for ?	4
Future data development	5
Conclusion	5
ANNEX - Minimum Data Set	6

Background

1. As part of the *Caring for the Spirit* NHS project, South Yorkshire SHA undertook a listening exercise on proposals for a minimum data set for spiritual healthcare (MDS) during the summer of 2004. The comments on that exercise were collated and considered by the project board in January 2005. Subsequently, the proposals have been updated in accordance with comments made during the listening exercise; in response to further work commissioned from the North Bristol NHS Trust¹ and through contributions by members of the project board. The project Board is grateful to the North Bristol team and especially to Revd. Alison Bucknall for their help with this work.
2. There is no limit to the considerations which can go into defining the MDS. There are differences of opinion about whether data is relevant to the chaplaincy service and about how best to define the work which chaplains do and about a raft of other data issues. The project board has therefore taken the view that this guidance is part of a long-term intention to improve data collection and analysis about chaplaincy and that a clear start should be made with these proposals. Reference is made within the body of the report to the proposed next steps.
3. Despite the temptation to advocate for sophisticated collection, analytical and coding systems, the project board considers that it should continue to suggest only a minimum data set. The majority of chaplains are part-time and their commitment is properly to the offering of spiritual care to patients and staff. The project board considers that this work should be underpinned by the MDS rather than driven by it. The proposals herewith have this as their guiding principle.

Defining what we mean

4. Because of the difficulty in encapsulating any element of spiritual healthcare, the MDS neither sets out to establish a definition of healthcare chaplaincy nor to be the final descriptor of the various nuances of healthcare chaplaincy (its theological foundation, ethos and style as expressed within a particular healthcare setting) and the essential ontological nature of both the role and the task. Instead, the MDS provides an objective means of ensuring that core elements of the work of healthcare chaplaincy are set down in commonly identified ways.
5. This approach ensures that nothing is being omitted and also provides an objective means of assessment both of a client's care and of the service provided within a Trust. Viewed in this way a data set could be used in conjunction with both the chaplaincy occupational standards² and the chaplaincy quality standards³ to provide benchmarks for the professional standards of individual chaplains, as well as the spiritual healthcare service and provision as a whole.

¹ Healthcare Chaplaincy for the Twenty-first century - developing a contemporary model of care; North Bristol NHS Trust Chaplaincy; August 2005

² The chaplaincy occupational standards are accessible on the website of the Multi-Faith Group for Healthcare Chaplaincy at www.mfghc.com

³ Draft quality standards are being proposed for consideration by NHS Trusts by the Multi-Faith Group for Healthcare Chaplaincy. The draft standards can be accessed at www.mfghc.com

- The MDS proposed by the project board (annex 1) is intended to allow for adaptation to the shape (ethos; work pattern; resources; other emphases) of a Trust and of the chaplaincy service within it. When the MDS is used flexibly not every section will need to be utilised and local factors will influence some of the content. Additionally, and because there is already a variety of record keeping undertaken by chaplains, the design of data collection and summary material is omitted.

Attributes of spiritual care

- Spiritual Healthcare has received considerable attention in relation to a search for a broad definition. The nursing community in particular has been instrumental in assisting the development of working definitions of this particular type of care. The following table (Swinton 2001) sets out attributes of spirituality:

Meaning	The ontological significance of life; making sense of life situations; deriving purpose in existence
Value	Beliefs and standards that are cherished; having to do with truth, beauty, worth of a thought, object or behaviour; often discussed as 'ultimate values'.
Transcendence	Experience and appreciation of a dimension beyond the self, expanding self boundaries
Becoming	An unfolding of life that demands reflection and experience; includes a sense of who one is and how one knows.
Connecting	Relationship with self, others, God/higher power, and the environment

- In setting out any definition of spirituality, attention must also be given to the spirituality inherent within a religious faith and practice. Current patterns sometimes place religious care and religion as marginal to spirituality, whereas a religious faith, with its various expressions and practices, is an articulation of spirituality in a particular form. Religious care therefore must be regarded as an expression of spirituality even though the language used will be specific to a particular religion along with any denominational and/or cultural emphases.
- The project board has therefore set out data items in relation to both spiritual care and religious care as rite or ritual. Such judgements will need to be confirmed locally.

Initial and continuing episode of spiritual care

- An initial episode of spiritual care refers to the first occasion during which spiritual care has been provided. A continuing episode of spiritual care refers to any ongoing spiritual care provided to the same individual/s. This might entail one further occasion in which spiritual care is provided, or it might entail a series of occasions during which spiritual care is provided.

11. Chaplains also spend time "loitering with intent" both in areas or situations where their care may be needed and also in terms of pastoring to the community by being present as part of the care that the institution offers. This visible and recognisable presence brings comfort and support to many to whom it is offered. The legitimacy of this work should not be ignored and the project board have therefore included an element of "being there" in their approach to chaplaincy work.

What is the data used for and what is it not used for ?

12. Collecting data about an activity when there is no automated system is an effort with no purpose unless there is an imperative to do this. The project board considers that the MDS should have the following uses which justify its collection:

- The MDS would relate essentially to **the role and task of chaplaincy** but would also enable the relationship with other healthcare professionals with whom healthcare chaplains work in the care of patients to be explained and would enable the creation of a body of material which could be subjected to analysis and provide the foundation for local research.
- The MDS would provide the foundation for a **client/patient pathway** which illustrates what kind of care has been provided; the duration of that care; any referrals onwards; and opportunity for comment/outcome. With careful planning and development it would be appropriate to develop an MDS which can be incorporated within the Electronic Patient Record (EPR) in order that spiritual care is logged into a patient's record of treatment.
- The MDS would provide **an objective means of assessment** both for the service as a whole and also for the individual patient when it is utilised in whole or in part as a care pathway. This is useful both as an aide to reflection upon working practice and also in order to present material in relation to service delivery to Executive and Senior Management staff whose understanding of the role and task of healthcare chaplaincy might benefit from a fresh approach.
- The MDS would enable chaplains to **share particular elements of the service with other disciplines**, especially in relation to patient care and to present collated data within a business or development plan to illustrate the practice emphases within a chaplaincy department and where such service falls short due to a shortage of essential resources
- The MDS would inform **local audit activity** by providing essential information that illustrates any gaps in the spiritual healthcare work pattern due to personal preference or a basic lack of resources.
- The MDS data can also be utilised within a **local research project** that may/ may not have regional and/ or national influence

- 13. The purpose of this data is not for any uninformed approach to cost-reduction and indeed may best be used to resist such approaches. Chaplaincy continues to carry an unique role in caring for all patients and all staff in addition to the whole organization. Not to be able to quantify such activity undertaken across the organization lacks management credibility.
- 14. Another concern has been at the uninformed use of the MDS to enable inter-chaplaincy comparison. Those concerned worry that their activity data will be used to suggest changes to their service following comparison with another which had "better" figures. The project board understands these concerns well and members have experienced them both in chaplaincy and in other services since the development of the Korner data review in the 1970s. The fears then were not realized and need not be today.

Future data developments

15. Improving the collection, definition and uses of data about spiritual healthcare will take time. The approach currently is to get data collection started across all chaplaincies and then to use collected data for common discussions between chaplains and other professionals. In due course, data about chaplaincy needs to be added to the dataset used for NHS performance management and the chaplaincy service included within the electronic patient record.

16. The current timescale for these strands of activity is set out below:

- Agreement to MDS for spiritual healthcare November 2005
- Inclusion of data collection as quality standard by all NHS Trusts June 2006
- Discussion about a national dataset for spiritual healthcare September 2006
- Use of local data to begin within chaplaincy audit activity December 2006
- Inclusion of chaplaincy within NHS performance management April 2007

These dates are provisional at present and will be updated within the stage planning process for the NHS project

Conclusion

17. The project board commends the minimum data set herewith to chaplains and other members of the spiritual healthcare workforce. Comments and concerns should be referred to Tim Battle, Project Officer at tim.battle@sysha.co.uk

A MINIMUM DATA SET FOR SPIRITUAL HEALTHCARE

MDS for a week of chaplaincy activity

- Number and duration of initial episodes of spiritual care categorized as being either routine or emergency
- Number and duration of continuing episodes of spiritual care categorized as being either routine or emergency
- Number and duration of religious services in ward/ prayer room/ chapel
- Number and duration of funerals
- Duration of time spent in multi-disciplinary team meetings
- Duration of time spent "being there" categorized by location within the hospital/ setting
- Duration of time spent in training Trust staff not members of the chaplaincy department
- Duration of time spent in activities categorized as continuing professional development
- Duration of time spent in staff/ chaplaincy team meeting
- Duration of time spent traveling between sites

Referrals for spiritual care

- Time and date of referral
- Name of referrer
- Identification as patient or staff or relative or Minister of religion
- Location of the patient
- Reason for referral categorized as death/ dying, bereavement, trauma, non-specific emergency, routine, other.

Nature of spiritual care offered

- Sacramental/ ritual care
- Prayer
- Non-specific spiritual care
- Specific spiritual care