Assessment tools: are they an effective approach to implementing spiritual health care within the NHS?

C. P. Johnson

Over the last 25 years, many nursing and palliative care journals have carried articles on the subject of 'spiritual' health care. The following is a review of National Health Service (NHS) guidelines and the work of various writers who have contributed to the debate on 'spirit' and 'spiritual needs' from within sociology, palliative care and nursing studies.

However, 'spiritual' in the current usage should not be confused with 'religious' and is part of an understanding of what is known as holistic nursing (Dossey et al. 1995). This paper will examine what is meant by 'spiritual' and religious needs and what is indicated by the words 'spiritual' and 'spirit'; and some of the implications for a health care team will be considered. The place of assessment tools in 'spiritual' health care, and the role of the NHS chaplain in the assessment and provision of 'spiritual' health care will be examined. © 2001 Harcourt Publishers Ltd

Introduction

Under the heading ‘Measurable Outcomes’, the writers of the Framework for Spiritual Faith and Related Pastoral Care (NHSE 1995, p. 7) document state:

... patients’ spiritual and religious needs should be assessed and clearly recorded by a member of staff at some appropriate stage during the delivery of care. Ideally this should be done on admission... the information obtained is then available to the Department of Spiritual Care or at the patients’ request to their own religions/spiritual leader. Yet it must be stressed that the assessment of a patient’s spiritual need should be ongoing and any plan of care evaluated and reassessed accordingly.

In the past the religious care in a hospital was left to the Chaplain or other religious representatives and Baum 1988 (cited in Walter 1997, p. 24) comments: ‘the needs of the dying patient can be divided up into the spiritual and physical...a religious person should be allowed the peace of mind provided by prayer and allowed every opportunity of visits by the clergy’.

Here ‘spiritual’ is equated with ‘religious’, which applies only to a small number of patients, therefore indicating that non-religious and non-clerical members of staff are not equipped to deal with ‘religious’ needs. This approach is supported by two Government documents: The Patient’s Charter (DOH 1991, 1995) explicitly states that a patient can expect the NHS to respect ‘your privacy, dignity and religious and cultural beliefs’ (p. 6) and the NHS Guidelines (DOH 1992) (Meeting the Spiritual Needs of Patients and Staff) suggest that spiritual needs are met if patients and staff have access to chaplains or leaders of their particular faith and access to a non-denominational chapel and freedom to observe their religious practices. ‘Spiritual’ in these documents is firmly identified with religious.

This understanding is noted within some nursing studies (Nightingale 1857; Henderson 1966; Hull 1969 [cited in Cawley 1997], whilst
others (Labun 1988; Carson 1989; Emblen & Halstead 1993 [cited in Cawley 1997] describe religion or transcendence as a component part of spirituality but not equated with it. Furthermore, Narayanasamy (1991), recognizing the differences of definition cites Murray and Zentner’s (1989, p. 3) understanding:

A quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any god. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite and comes into focus when the person faces emotional stress, physical illness or death.

Ross (1997), arguing from a similar base, identifies ‘spirit’ as the ‘vital principle’, the ‘essence’ or ‘energy’ of what it is to be human and ‘that which gives real meaning’. ‘Spiritual’ needs are understood as the need for meaning and purpose, to receive and to give, hope, creativity and forgiveness. Therefore Cawley, reviewing the literature which explores some of the concepts of spirituality (1997, p. 34), concludes ‘spirituality does not necessarily have to include a religious component, although religion may be one method by which patients can perceive meaning to their lives’.

Saunders (1988) popularized this philosophy when drawing on the work of Simsen (1986) (cited in Saunders 1988, p. 2). She saw ‘the search for meaning to things that includes oneself has recently been shown to be the major concern of a group of hospitalised patients’. The work of Austrian psychiatrist Victor Frankl (1987) was also a resource for her thinking: his concept of logo therapy – the therapy of meaning, was developed in his book *Man’s Search for Meaning*. Reflecting on his Nazi labour camp experience during World War II, Frankl states ‘the hopelessness of our situation did not detract from its dignity or meaning’ (cited in Saunders 1988, p. 2).

Ross née Waugh (1995, p. 458) therefore maintains that ‘spirituality’ in recent writing ‘has been regarded as the central ‘artery’ which permeates, energises and enlivens all other dimensions of an individual’. She continues, ‘without spiritual well-being the other dimensions, i.e. the bio-psycho-social, can never function or be developed to their fullest capacity and hence the highest quality of life is unattainable’. On the basis of these arguments, questions of meaning are significant to an understanding of health, illness and healing.

However, what is meant by health? Moltmann (1985), in a discussion on the World Health Organization’s definition of health as ‘a state of complete physical, mental and social well-being, not merely the absence of sickness and handicaps’, describes it is an idealistic, utopian description, implying that health means the absence of suffering and pain, results in fear of illness, and excludes the sick and handicapped and the old close to death. He argues for the restatement and humanizing of health.

Health then becomes a term for the process of adaptation, the ability to cope with pain, sickness and death. It is the strength to live with malfunctionings, the strength to be human as displayed in ‘the person’s capacity for happiness and suffering, in his acceptance of life’s joy and the grief of death’ (Moltmann 1985, p. 273).

Moltmann’s understanding of health is useful in the understanding of ‘spiritual’ health care. A sick person is best viewed not as a set of malfunctioning organs but as a person. In words reminiscent of ‘spirituality’ Moltmann states that sickness affects a person’s relationship to himself, to society, to life history and to the transcendent. Healing (or health) must take all of these into account.

Although the understanding of ‘spirit’ and ‘spiritual’ have received widespread acceptance amongst writers, there are some who express reservations. Walter (1994, 1997) understands ‘spirituality’ as almost impossible to define and in everyday thought as being tied up with religion. He observes how writers on the subject state, without connecting argument, that ‘spirituality’ is different from religion and he perceives difficulties in differentiating these concepts from psychological care or from a humanist approach. Finally, he notes in practice the concern not to offend a minority religion overwhelms the definitions of ‘spirituality’ (Walter 1997).

Hogan et al. (1999, Unit 7, 1–3), in a deconstruction of Ross’s (1994b) definition note that spirituality is individualistic, arising from a ‘consume and feel good’ world view. The patient chooses or possesses a ‘spirituality’ rather like the consumer of a product. The various communities of which a patient is part are not considered important, and there is no reference to
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Development and change brought about by maturity, age and social circumstances. Finally, they observe if a patient is a contributor to their ‘spiritual’ community then nurses might be encouraged to include other experiences in their perception of the ‘spiritual’ care provided, such as maintaining family relationships and supporting communication with adult children and other relations.

If the Framework for Spiritual, Faith and Related Pastoral Care (1995) document expects the health care team to assess religious and ‘spiritual’ needs, it is important to understand what is being assessed. Reflecting on the definitions provided by Narayanasamy (1991) and Ross (1997), the usefulness of their work is overshadowed by the ambiguous, subjective and often intangible nature of spirituality. Cawley (1997, p. 31) states:

It remains a personal and individualistic concept which frustrates the development of a simple, standard definition...it may be more appropriate for future nursing research...to explore nursing practices such as interpersonal interaction and communication.

Spiritual health care and some of the implications for a health care team


Hogan et al. (1999, Unit 7,1) state ‘partial and potentially misleading views of spirituality are common in health care literature and this leads to limitations in recommendations for nursing practice, organisation of medical procedures and health care delivery in general’. This is reflected in the research carried out by Ross (1994), who concluded that, although a majority of nurses perceived that they were able to identify a patient’s ‘spiritual’ needs, in practice their understanding was vague and ambiguous. As a result patients’ ‘spiritual’ needs go unrecognized or inadequately or inappropriately dealt with. The conclusion drawn from the available understandings of ‘spirit’ and ‘spiritual’ is that any nurse can listen to patients and help them identify and articulate what is important to them (Ross née Waugh 1995, 1997; Bradshaw 1997). The advantage of this approach is that ‘spiritual’ care can be provided by anyone, for anyone, regardless of religious faith because its focus is on helping patients find their own meaning (Walter 1997). It assumes all patients are treated holistically, recognizing that they are physical, social, emotional and ‘spiritual’ persons.

However, it is necessary to recognize some of the implications for a health care team. Ross (1994b, p. 37) stresses the importance of a suitable ward environment appropriate for patients to reflect on their search for meaning. She suggests having a routine rest hour – having set visiting hours – ensuring provision of chapel or reading/quiet room facilities – providing privacy for bed bound patients by screening their areas. These quiet spaces would allow a nurse more opportunity to ‘be with’ a patient rather than ‘doing for’. On the other hand, Hogan et al. (1999, Unit 7,3) point out this private provision would provide inadequate support for a patient whose ‘spirituality’ is tied up with family, friends, political associates or professional colleagues. They maintain this sort of privacy should be available as a fundamental requirement for all nursing and not as extra provision, ‘ensuring privacy is an essential part of nursing care’ (p. 3).

Illness, suffering and death challenge every human being and negative ways of coping can be damaging to the nurse and patient alike (Hogan et al. 1997, Unit 7). Ross therefore identifies nurses most aware of a patient’s ‘spiritual’ needs as being those who demonstrate a personal awareness of the ‘spiritual’ dimension, who are themselves searching for meaning, have experienced a life crisis, recognize ‘spiritual’ care as part of their role and are particularly sensitive and perceptive people.

An understanding that ‘spiritual’ care is fundamental to nursing practice is then essential to its delivery. Bradshaw (1997, p. 57) states, ‘The best way to teach nurses to meet their patient’s spiritual needs is by showing them how to care’. Writers on the philosophy of nursing (Bradshaw 1994, 1997; Hunt (cited in Hogan et al. 1999)) argue that historically nursing is holistic and consequently a ‘spiritual’ discipline. This tradition is traced back to Florence Nightingale, who made no distinction between the physical, psychological and ‘spiritual’ aspects of being.

human. Indeed, Hogan et al. (1999, Unit 2, 14) identify the word nursing as coming from the Latin verb ‘to nurish’ and conclude ‘this is analogous to the nurturing mother who provides a secure and nourishing environment for the meeting of physiological or physio-social needs’.

However, nursing has often been eroded by secularization (Bradshaw 1994 (cited in Hogan et al. 1999, Unit 7, 7–9); Bradshaw 1997). The modern problem lies in the tension between the professionalism of medicine or treatment and traditional nursing values of caring. ‘The key issue here is that caring implies the presence of the spiritual dimension of life, whilst treatment does not’ (Hogan et al. 1999, Unit 7, 7).

The reflections made by Ross (1994) on suitable ward environment appear to contribute little to the debate on ‘spiritual’ health care because her proposals suggest aspects which should be basic to ward ethos. Her understanding, with Hogan et al. (1999), of the personal ‘spiritual’ awareness of the nurse is helpful, although this questions the premise that all nurses can be providers of ‘spiritual’ health care. However, Bradshaw’s (1997) and Hogan et al.’s (1999) work on the correlation between ‘spirituality’ and care is useful, for it suggests all patients can be beneficiaries of ‘spiritual’ care. All good nursing care is therefore considered to be ‘spiritual’, conveying to a patient that they have value and are cared for regardless of their illness, colour or creed.

The place of assessment tools in spiritual health care

In the small amount of research in this area, various systems of spiritual care assessment have been considered, although it is recognized these various approaches are still in their infancy (Labun 1988; Ross 1997; Catterall et al. 1998). Types of assessment have then been difficult to determine with any clarity. Three possible routes are described here:

First, ‘specific patient spiritual history guides’ (Stoll 1979 (cited in Labun 1988)). This approach recommends formal assessment for all patients on admission and is used to identify specific avenues to be explored. This ‘problem-solving’ approach is helpful if a patient exhibits evidence of an ‘altered spiritual integrity’ (Narayanasamy 1991, 1996). General areas are appraised to derive data about ‘spiritual’ concerns, i.e. concepts of God/deity, sources of strength and hope, ‘spiritual’ practices and the relation between beliefs and health. See Appendix 1.

Second, an ‘open, qualitative data collection’ approach (Ellis 1980 (cited in Labun 1988); Cressey & Wimbolt-Lewis 1999) using a similar ‘questions/answer’ technique as outlined above. The process is more adhoc and ongoing, noting the changing ‘spiritual’ needs of a patient (Ross 1997).

Third, a ‘supportive approach based on a pain measurement scale model’ (Catterall et al. 1998). This assessment tool is designed to enable nurses evaluate the ‘spiritual’ care given and allow patients to assess themselves. In contrast to a ‘problem-solving’ approach, this process is designed to support patients in their existing spiritualities and avoids offering interventions which might be inappropriate. See Appendix 2.

Whatever assessment tool is used, it is understood that it must be applicable to patients of any or no faith and should produce the same results when performed by a person of any or no faith. Communication concerning spiritual needs should be characterized by sensitivity and based on a relationship of trust. Questionnaires require an appropriate format with language comfortable for both patient and nurse. The patient’s objections and their desire to remain silent must be respected (Labun 1988). Appendix 3 describes an interesting example of a spiritual self-assessment plan developed by a hospice.

In addition, Catterall et al. (1998) suggest the necessity of using a questionnaire specifically designed for people with a religious faith. Working with Christian patients, questions include areas such as prayer, services of worship, laying on of hands and private religious discussions. In their conclusions, they note that for all patients the ‘spiritual’ side of life was of immense value. They explain (Berggren-Thomas & Griggs, 1995 (cited in Catterall et al. 1998, p. 165)):

When a patient questions the meaning of life this may not demonstrate a problem but signify the next step in his/her spiritual journey. Care in this case would not involve a problem solving approach to the treatment of problems but rather one in which the patient is offered support and help to cope with or develop his/her well-being.

Care planning and the use of care plans are understood as the next stage in attending to
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‘spiritual’ needs (Narayanasamy 1991, 1996). See Appendix 4. The patient information gained from the questionnaires is built into a programme appropriate to the individual. Such plans seek to address the patient’s ‘spiritual’ needs. (Narayanasamy 1991, 1996).

‘Spiritual’ care plans need careful implementation. Throughout this process, nurses are expected not to impose personal beliefs, to respond with a correct understanding of the patient’s background and be sensitive to the patient’s signals for ‘spiritual’ support. For a caring nurse–patient relationship is paramount for ‘spiritual’ care…it demands an attitude of helping, sharing, nurturing and loving. These actions fulfil the requirement for individualised spiritual care’ (Narayanasamy 1996, p. 415).

Evaluating a ‘spiritual’ care plan involves making a judgement about the outcomes of nursing intervention. O’Brien (1982 (cited in Narayanasamy 1996, p. 415)), summarizing the desired outcome, concludes that a patient ‘who has attained spiritual integrity demonstrates this experience through a reality based tranquillity or peace, or through the development of meaningful, purposeful behaviour’.

However, there are risks attached to ‘routinization of spiritual care’. Walter (1997, p. 27) warns of ‘spiritual’ care being taken over by ‘the flowchart language of the nursing process’ and just another patient care compartment, dehumanizing the whole process. He alerts nursing staff to ‘off-the-peg’ strategies that use textbook approaches rather than ‘watch-with-me vulnerability’. Equally, he questions whether or not all staff can offer ‘spiritual’ health care and the discernment required, asking ‘how are they to know when to stop busily doing and just to be with the patient?’ (p. 28).

Assessment of ‘spiritual’ needs is increasingly becoming part of health care strategies, particularly in a hospice setting. However, looking back at the usefulness of the question/answer technique, this approach must be considered to be long and complicated and fails to take into consideration a nurse’s own ‘spirituality’. The supportive approach is simpler and allows for the patient’s contribution. Nevertheless, it is still individually based. Walter’s warnings must be noted but he offers no alternative assessment tools to nurses who recognize that providing ‘spiritual’ care is part of their duties.

The role of the NHS Chaplain in the assessment and provision of spiritual health care

Peter Speck (1988) recounts the story of a family at the bedside of a teenage girl on an intensive care unit in an NHS hospital. The ward have ‘called in’ the Chaplain, who is faced with an angry and distressed father demanding a miracle healing. Speck’s account traces the route taken by the Chaplain in handling this situation and uses it to illustrate his chapter title ‘Distinguishing Needs – Spiritual and Religious’. In the event, the Chaplain opts for a ‘spiritual’ approach rather than a religious one. Speck (p. 29) explains ‘If we are focusing at the wrong level (e.g. religious) we may well miss the underlying search for meaning’. The Chaplain facilitating ‘spiritual’ care in a NHS context will be aware of this difference and will share this pastoral work with others who have related to the sick person and who have been invited by that person to join in their ‘search for meaning’.

It is still perceived by many in both society and hospital that the role of the Chaplain is to address the religious needs of the patient. Walter (1997) understands that this approach has several advantages, fitting well with British understanding of religion as a private matter and because it demarcates the role of the Chaplain.

However, in the ‘new’ climate of understanding, the Chaplain will see himself as a joint member of a multidisciplinary team offering ‘spiritual’ health care in a holistic setting. The Chaplain’s role in the assessing and providing ‘spiritual’ health care for patients and staff has many aspects:

- As a focus of reconciliation, i.e as the one who facilitates the language of forgiveness, love and hope into a situation. This moves the Chaplain beyond a psychotherapy or listening approach and draws from an understanding of love and forgiveness (Walter 1997). Clearly this role can be brought by nurses, but in practice because of personal understanding of ‘spirituality’ and of the lack of time, the nurse may choose to use the Chaplain as a resource. Bradshaw (1997, p. 56) states ‘it is important…that health care staff do not underestimate or dismiss the role of the clergy [Chaplain?], which is an overt and clearly
visible representative of the spiritual dimension.

- **As one who brings a religious resource to a care plan.** A patient may need time to talk to a Chaplain (or other minister) about religious matters such as anger against God. This may also involve prayer and Bible reading. Elsdon (1995) notes that a person who is deeply religious may suffer more ‘spiritual’ pain than someone who has little or no faith and this can require special understanding from a Chaplain or religious leader. It is also appropriate for the Chaplain to support nurses in a similar way.

- **As ‘one who can be there’ and be vulnerable.** Saunders (1988, p. 2) states ‘we are not there to take away or explain, or even to understand but simply to ‘watch with me’, as Jesus asked of his disciples in the Garden of Gethsemane’. The Chaplain, therefore, unlike most of the health care team, can be the one who doesn’t come along with a set of ‘off-the-peg’ strategies (Walter 1997) but because of his/her religious background brings vulnerability (Speck 1988; Nouwen 1979).

- **As one who functions as a facilitator or as a ‘consultant’.** The ‘Framework’ document (1995, p. 4) describes Chaplains as having ‘wide ranging experience and specialist knowledge which enables them to work with staff, patients and carers in exploring areas of need’. Being one step removed from day-to-day care enables the Chaplain to open up situations with patients with which the ward team have struggled (Stoter 1995). The Chaplain is also an important resource when the ward team feel uncomfortable with a situation or in need of reassurance and support (Harrison 1993).

- **As a ‘spiritual’ support for all staff.** Lyall (1998) describes the many and varied pastoral situations that hospital Chaplains find themselves in. These can include a casual conversation with a sister about her own ability to cope with management changes, to a seminar with a group of nurses agonizing over issues of life and death. This demands sensitive listening, perceptive observation, careful response, emotional warmth and the ability to confront questions of meaning in life (McGregor 1987).

- **As a reminder to the institution of the importance of spirituality.** The hospital Chaplain has the unenviable role of being appointed by the institution to stand between the rock and the hard place’ (Hogan et al. 1999, Unit: 7,9).

In a modern health care setting, the pressures of delivering a service can lead to a fragmentation of care with a focus on different aspects of the body rather than the whole person, a moral distancing leading to responsibility which is limited to specific tasks, care as the delivery of a commodity and professional rivalry which undermines any interdisciplinary working (Hogan et al. 1999, Unit 7). This can result in an arid and barren ‘spirituality’ because the ‘institution and how it is organised...shapes and nurtures the ‘spirituality’ of all involved’ (Hogan et al. 1999, Unit 7,18).

The Chaplain then has a role in reminding the institution of the importance of the whole person and the vitality of ‘spiritual’ health care. This can be a reminder of the significance of vision and vocation, by regular reflections on areas of responsibility, by the development of procedures and codes which enable development of awareness and by reminding the organization of limitations. The Chaplain might be the only person suitably equipped for this huge task and as such he/she ‘will need to become aware of management as well as clinical needs and pressures in order to defend and support appropriate spiritualities’ (Hogan et al. 1999, Unit 7,6–7).

Speck’s (1988) contribution is significant as he is possibly the first NHS Chaplain to enter the ‘spirituality’/religion debate. However, his story has a religious conclusion (i.e. prayer with the girl’s father) so perhaps in practice Speck is unable to separate the two concepts? The Chaplain’s skills must also be questioned. Was he in reality exercising interpersonal and counselling skills rather than discerning ‘spiritual’ needs? On the other hand, Speck’s insights are useful in that they widen the role of the Chaplain within the NHS.

The other writers cited develop this role in the assessment and provision of ‘spiritual’ health care providing a job description that goes beyond that of providing for a patient’s religious needs.

**Conclusion**

This review of some of the understandings of ‘spiritual’ health care concludes that difficulties
remain in finding a simple acceptable definition. Cressey and Winbolt-Lewis (1999, p. 4) suggest
‘the art of giving and receiving love in the journey towards meaning, wholeness and health’
and Catterall et al. (1998, p. 163) propose ‘the lived experience that gives meaning to life and
death’. It is my view that these definitions are still confusing and do not do justice to the various
meanings of ‘spirituality’.

The crucial factor in ‘spiritual’ health care is the nurse–patient relationship. Having nurses
sensitive to the ‘cues’ patients display is of paramount importance (Ross 1997; Bradshaw
1997). Although anyone can be involved in assessing their spiritual needs, the nurse is
probably the health care professional who is best placed to recognize ‘spiritual’ issues. Chaplains
can be a useful resource in the assessment and provision but the nurse remains the key person
(Cressey & Winbolt-Lewis 1999). Ross (1997) suggests that, in addition to receiving help from
Chaplains, family, friends and colleagues, patients welcome help with ‘spiritual’ needs from
nurses.

The aims and ideals of ‘spiritual’ health care are in place but work needs to be done on
assessment tools. In conjunction with physical, psychological and social assessments, these
should be easy to use, flexible, take little time, enabling nurses to assess the ongoing
effectiveness of their ‘spiritual’ care (Catterall et al. 1998) and fulfil their obligation as outlined
by the International Council of Nurses (1973) ‘to promote spiritual health and alleviate spiritual
suffering’ (cited by Ross 1997, p. 42). Such tools are important, if ‘spiritual’ needs are not to be
overlooked. Not all patients will have ‘spiritual’ needs requiring intervention, but it is important
for nurses to be aware and sensitive to those needs should they arise (Ross 1997). Appropriate
assessment tools, as part of a care plan, will assist with this process.

However, assessment tools are only one aspect of the solution. It is my opinion that society as a
whole will also have to ‘catch the vision’ of what is meant by ‘spirit’ and ‘spiritual care’ before many
of the aims are realized. The NHS not an island on

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Appendix 1

Concept of God or deity

Is religion or God significant for you?

Is prayer (or meditation) helpful to you?

What happens when you pray?

Does God or a deity function in your personal life?

If yes, can you describe how?

How would you describe your God or what you worship?

Sources of strength and hope

Who is the most important person to you?

To whom would you turn when you need help?

Are they available?

In what ways do they help?

What is your source of strength and hope?

What helps you the most when you feel afraid or need special help?

Spiritual practices

Do you feel your faith (or religion) is helpful to you?

If yes, would you tell me how?

Are there any religious practices that are important to you?

Has being ill made any difference to your practice of praying (or meditating) or to your religious practices?

Relation between spiritual beliefs and health

What has bothered you most about being sick (or in what is happening to you)?

What do you think is going to happen to you?

Has being sick (or what happened) made any difference to your feelings about God or the practice of your faith?

Is there anything that is especially frightening or meaningful to you now?


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Appendix 2

Assessment tool for evaluating appropriate ‘spiritual’ care for a patient.

A. Spiritual matters are the most important thing in life and give immense support. Score: – 2
B. I am interested in the meaning of life and spiritual matters and take comfort from this. Score: – 1
C. I am comfortable with my own philosophy and meaning of life, and spiritual matters do not affect me one way or the other. Score: 0
D. Spiritual considerations significantly interfere with my life. Score: + 1
E. I feel so troubled by spiritual matters that they are totally taking over my life. Score: + 2

In devising such a tool, the authors decided to add negative numbers to indicate the supportive element that spirituality may have on the well-being of the patient.

This assessment was designed to allow sequential comparison that would indicate whether the patient had improved in this area of his/her life or not. It was not designed to indicate how change could be achieved or to highlight difficulties.

One end of the scale, i.e. (A), may indicate that the patient needs some input, e.g. regular communion or contact with a minister in order to maintain their well being.

At the other end of the scale, i.e. (E), the patient may need to be supported through their spiritual journey.

Source: Catterall et al. (1998) p. 164

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Appendix 3

Spiritual assessment

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<th>Always</th>
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<th>Occasionally</th>
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<tr>
<td>1. I feel my needs are being met</td>
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<td>2. I am told everything I want to know</td>
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<td>3. I can talk about my feelings</td>
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<td>4. I feel there is meaning in my life</td>
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<td>5. I feel I am a burden to others</td>
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<td>6. I am afraid of the future</td>
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<td>7. I feel positive and hopeful</td>
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<td>8. I feel valued by other people</td>
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<td>9. I am able to practise my religion</td>
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<td>10. My dignity is respected</td>
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Devised by Kirkwood Hospice Huddersfield (based on work developed by Roger Cressey, Chaplain, Pinderfield Hospital, Wakefield) and reproduced with their kind permission.
Are assessment tools effective at implementing spiritual health care?

**Appendix 4**

**Nursing Care Plan**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Care plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeking purpose and meaning</td>
<td>Treat patient with respect and dignity.</td>
</tr>
<tr>
<td></td>
<td>Enable patient to review his plans and set new future plan.</td>
</tr>
<tr>
<td>Needs love and forgiveness</td>
<td>Encourage patient to talk and help him to ventilate his feelings, anger, bitterness and identify source of guilt.</td>
</tr>
<tr>
<td></td>
<td>Listen with empathy, without being judgemental.</td>
</tr>
<tr>
<td></td>
<td>If patient wishes, ask chaplain to visit.</td>
</tr>
</tbody>
</table>

*Source:* Narayanasamy A 1996 p. 415

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