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Stakeholder views on the role of spiritual care in Australian hospitals: An exploratory study

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ABSTRACT

Research increasingly demonstrates the contribution of spiritual care to patient experience, wellbeing and health outcomes. Responsiveness to spiritual needs is recognised as a legitimate component of quality health care. Yet there is no consistent approach to the models and governance of spiritual care across hospitals in Australia. This is consistent with the situation in other developed countries where there is increased attention to identifying best practice models for spiritual care in health. This study explores the views of stakeholders in Australian hospitals to the role of spiritual care in hospitals. A self-completion questionnaire comprising open and closed questions was distributed using a snowball sampling process. Analysis of 477 complete questionnaires indicated high levels of agreement with ten policy statements and six policy objectives. Perceived barriers to spiritual care related to: terminology and roles, education and training, resources, and models of care. Responses identified the issues to inform a national policy agenda including attention to governance and policy structures and clear delineation of roles and scope of practice with aligned education and training models. The inclusion of spiritual care as a significant pathway for the provision of patient-centred care is noted. Further exploration of the contribution of spiritual care to wellbeing, health outcomes and patient experience is invited.

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1. Background

The international research exploring the contribution of spiritual care to patient experience, wellbeing and health outcomes continues to grow [1–3]. Correspondingly there has been increased attention given to identifying best practice models for the provision and governance of spiritual care in health care [4–7]. While spiritual care is currently provided in many Australian hospitals, the models and governance guiding this care are varied, as are the capabilities and competencies of the providers. This is not a situation unique to Australia. In both the United Kingdom and the Republic of Ireland, Government funded health departments (NHS and Health Service Executive respectively) have supported and funded initiatives to identify best practice spiritual care models across the countries' health services [5,6]. These moves to identify best practice spiritual care are significant as they come at a time when the contribution of spiritual care to safety and quality has

been acknowledged in Australian reports. This creates an opportunity and context for the identification of best practice spiritual care in Australia, as undertaken in both the United Kingdom and Ireland. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has identified patient-centred care that incorporates concern for the patients' beliefs and values as a key component of safe and high quality care [8]. The focus on quality in health care has raised questions about how quality is defined and measured with a commensurate move away from assessing volume and quantity to measures of value and outcomes [9–11]. Internationally, proponents of spiritual care responded to this move with a call to action [12] and the development of international quality indicators to assess the quality of spiritual care [13]. While the provision of spiritual care has increasingly been recognised in Australian State and Federal Government reports [14–17], little attention has been given to how it is understood in the Australian context, the policy needed to guide its provision, and how the contribution of this essential element of care is measured. Many of the definitions for spiritual care have come from the nursing literature [18], however a more recent study across nine countries (excluding Australia) explored patients and carers perceptions of spiritual care as 'providing a safe space, listening and counselling' [19].

In 2015 Spiritual Care Australia (SCA) and Spiritual Health Victoria (SHV) established a working group to plan for a national

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consensus conference held in June 2017 to influence the Australian policy agenda for spiritual care. Earlier conferences held in the USA and then internationally established a precedent for this initiative [4].

In setting the priorities and agenda for the conference, the working group recognised that little is known about the attitudes and views of those involved in Australian hospitals towards spiritual care, or about their perceived barriers to the inclusion of spiritual care. Published research has tended to focus on the attitudes and views of doctors and nurses to spiritual care in health [20–22]. Accordingly SCA and SHV instigated an exploratory questionnaire based study to investigate the views of a broader range of stakeholders in Australia on the role of spiritual care in hospitals.

Responses to the questionnaire informed the Australian national consensus conference and identified the issues that need to be addressed through a national health policy agenda for the provision of spiritual care in Australian hospitals. This paper reports on the results from the questionnaire.

2. Method

The working group established for the Australian national consensus conference developed a self-completion questionnaire comprising both open and closed questions. There were five sections to the questionnaire with 41 questions as outlined below.

Section 1 comprised introductory statements consisting of three general statements reflecting the growing body of research on the contribution of spiritual care to patient wellbeing, health outcomes and patient experience. Section 2 included 10 policy issue statements based on the international quality indicators for spiritual care [13]. Section 3 described six policy objectives which respondents rated for both their desirability and feasibility. Following Sections 2 and 3 respondents were able to add additional policy issue statements or policy objectives through a free-text facility.

In Section 4, seven general questions were included, five of which were Likert scales directed specifically to those working in a hospital setting and two were open-ended providing opportunity for respondents to identify barriers to the inclusion of spiritual care and provide any final comments or questions about spiritual care in hospitals. Finally, seven demographic questions were included in Section 5.

The survey was reviewed by the working group to ensure content validity and was then piloted with experts in either health care and/or spiritual care and final adjustments were made based on feedback received.

2.1. Sample

The working group reached consensus on a distribution list to reach a broad range of stakeholders across the health sector. This included the CEOs of national health organisations and peak bodies, national and state health ministers and key government personnel and state and national spiritual care organisations. Working group members also provided names of individuals with key roles within the health sector or names of health academics/researchers to be added to the distribution list. The survey was distributed by email via the online tool Survey Monkey. The invitation email included information about the survey, the proposed use of survey data and invited participants to distribute the surveys to other stakeholders and/or colleagues thus creating a snowball sampling process. Participation was voluntary and completion of the questionnaire implied consent.

2.2. Data analysis

All data were held in a de-identified database. Analysis of the quantitative data was completed using the Survey Monkey platform that provided percentage responses and basic statistics (median, mean and standard deviation). This analysis enabled cross comparisons of data across response fields and demographic categories. The qualitative data from open-ended questions were exported and analysed thematically and coded using NVivo11 (QSR International) software. Thematic analysis enabled the identification of emergent themes and sub-themes that were then applied so that data could be organised into these broad themes and sub-themes [23]. Emerging themes and initial analyses were presented and discussed with the working group to establish trustworthiness [23].

2.3. Ethics

Ethics approval to analyse the survey data was obtained by the author through La Trobe University College Human Ethics Subcommittee, Melbourne Australia (Reference S17-019), and approval to access the database for research purposes obtained from Spiritual Health Victoria.

3. Results

Data from 477 complete questionnaires were analysed.

3.1. Demographic information

The majority of respondents were female (70.6%) with 71.3% of respondents indicating an active religious affiliation. Participants indicated current areas of work and were able to select as many areas as were applicable to them. The top four areas were spiritual care (53.6%), management (20.4%), allied health (18.6%) and nursing (14.6%). The predominant place of work was the hospital setting (67.6%) with 'other' including mental health, community, disability, not-for-profit, church, and aged care, nominated by 22.3% of respondents. Respondents came from public (58.6%), private (26.2%) and 'other', including not-for-profit, both private and public, NGO and retired (15.2%) sectors. There was a wide range of responses to the question identifying the first discipline respondents trained in. The top four responses were nursing (22.9%), 'other' (16.3%), theology (13.7%) and education (10.9%). There were respondents from all eight states and territories in Australia.

3.2. Quantitative results

The quantitative results from Sections 1–3 demonstrate that the majority of survey respondents have positive views of spiritual care.

3.3. Positive effects of spiritual care

There was a high level of agreement from the 477 respondents with the three statements about positive effects as seen in Table 1.

3.4. Policy issue statements

There was a high level of agreement from the 477 respondents with eight of the ten Policy Issue Statements as shown in Table 2. With regard to the two statements with more variable response, the statement about 'faith representatives' was the only statement framed as a negative statement (to test for response bias) and elicited a range of responses. While there was support for the statement about patient assessments, this statement had a greater

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