Domain 5: Spiritual, Religious, and Existential Aspects of Care

Reference to spiritual care within the NCP Guidelines also refers to religious and/or existential depending on the context.

Spirituality is recognized as a fundamental aspect of compassionate, patient and family-centered palliative care. It is a dynamic and intrinsic aspect of humanity through which individuals seek meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices. Palliative care interdisciplinary teams (IDT) serve each patient and family in a manner that respects their spiritual beliefs and practices. Teams are also respectful when patients and families decline to discuss their beliefs or accept spiritual support.

Guideline 5.1 Global

Patient and family spiritual beliefs and practices are assessed and respected. Palliative care professionals acknowledge their own spirituality as part of their professional role and are provided with education and support to address each patient’s and family’s spirituality.

Criteria:

5.1.1 The IDT has clearly defined policies and processes in place to ensure spiritual care is respectful of patient and family age, developmental needs, culture, traditions, and spiritual preferences.

5.1.2 Either directly, through referral, or in collaboration with the professional chaplain, the IDT facilitates spiritual and cultural rituals or practices as desired by the patient and family.

5.1.3 IDT members respect patient and family beliefs and practices, never imposing their individual beliefs on others.

5.1.4 The spiritual needs of family members may differ from those of the patient and are recognized and supported.

5.1.5 Care of children, adolescents, and their family members recognizes that spirituality is integral to coping with serious illness and is provided in a developmentally appropriate manner.

5.1.6 In all settings, the IDT includes professional chaplains who have evidence-based training to assess and address spiritual issues frequently confronted by pediatric and adult patients and families coping with a serious illness.

5.1.7 The professional chaplain is the spiritual care specialist, conducting the assessment and addressing the spiritual aspects of the care plan.

5.1.8 Professional chaplains develop community partnerships to ensure patients have access to spiritual care providers trained and supervised by a professional chaplain. The IDT and community spiritual care providers share information and coordinate services.

Note: Words bolded in red are defined in the Glossary.
Domain 5: Spiritual, Religious, and Existential Aspects of Care

5.1.9 The IDT integrates the patient’s and/or family’s faith community into the care plan when requested.

5.1.10 Led by the professional chaplain, opportunities are provided to engage staff in self-care and self-reflection regarding their own spirituality.

5.1.11 Every member of the IDT is trained in spiritual care and recognizes the importance of the spiritual aspects of care.

5.1.12 Members of the IDT receive training to cultivate an openness to the spirituality of patients and families through empathic listening.

Guideline 5.2 Screening and Assessment

The spiritual assessment process has three distinct components – spiritual screening, spiritual history, and a full spiritual assessment. The spiritual screening is conducted with every patient and family to identify spiritual needs and/or distress. The history and assessment identify the spiritual background, preferences, and related beliefs, values, rituals, and practices of the patient and family. Symptoms, such as spiritual distress and spiritual strengths and resources, are identified and documented.

Criteria:

5.2.1 All aspects of the screening, history, and assessment are conducted using standardized tools.

5.2.2 Spiritual screening is completed as part of every clinical assessment to identify spiritual distress and the need for urgent referral to a professional chaplain. Screening is designed to evaluate the presence or absence of spiritual needs and spiritual distress.

5.2.3 IDT members also include a spiritual history as part of the clinical evaluation in the initial assessment process. A spiritual history identifies patient preferences and values that may affect medical decision-making.

5.2.4 A spiritual assessment is triggered based upon the results of the spiritual screening and history. It is an in-depth and ongoing process of evaluation of spiritual needs, results in a plan of care, and is conducted by a professional chaplain as the spiritual care specialist, in collaboration with the faith community, based upon patient wishes.

5.2.5 The spiritual assessment explores spiritual concerns including, but not limited to:

a. Sources of spiritual strength and support

b. Existential concerns such as lack of meaning, questions about one’s own existence, and questions of meaning and suffering

c. Concerns about relationship to God, the Holy, or deity, such as anger or abandonment

d. Struggles related to loss of faith, community of faith, or spiritual practices

e. Cultural norms and preferences that impact belief systems and spiritual practices

f. Hopes, values and fears, meaning, and purpose
Domain 5: Spiritual, Religious, and Existential Aspects of Care

g. Concerns about quality of life
h. Concerns or fear of death and dying and beliefs about afterlife
i. Spiritual practices
j. Concerns about relationships
k. Life completion tasks, grief, and bereavement

Guideline 5.3  Treatment

The IDT addresses the spiritual needs of the patient and family.

Criteria:

5.3.1 Spiritual elements of the plan of care are based on needs, goals, and concerns identified by patients and families, recognizing and maximizing patient and family spiritual strengths. The care plan, including religious rituals and other practices, details the expected outcomes of care.

5.3.2 Patient and family spiritual needs are addressed according to established processes, documented in the interdisciplinary care plan, and emphasized during transitions of care, including identification of significant practices which bring strength and comfort to the patient.

5.3.3 Professional and institutional use of symbols and language are inclusive of patient and family cultural and spiritual preferences.

5.3.4 The patient and family are supported and accommodated in their desires to display and use their own spiritual and/or cultural symbols.

5.3.5 Palliative care teams serving pediatric patients have expertise in honoring and meeting the spiritual needs of children and adolescents, including in situations where children or adolescents have differing values, beliefs and needs from their parents or designated decision-makers.

Guideline 5.4  Ongoing Care

Patient and family spiritual care needs can change as the goals of care change or patients move across settings of care.

Criteria:

5.4.1 Throughout the trajectory of the patient’s illness, the IDT performs spiritual screening to identify new or emergent issues, identifying services and supports to help navigate these transitions. Changes in prognosis and other significant transitions prompt reassessment of spirituality.

5.4.2 The plan of care continues to evolve based upon the changing needs of the patient and family.
Clinical and Operational Implications

Clinical Implications

Spiritual care is an essential component of quality palliative care. Spiritual care services including screening, history, and assessment are performed on admission and regularly thereafter. Interventions using professional standards of practice are part of the basic provision of quality care available to all palliative patients.

Operational Implications

Specialist-level palliative care programs include salaried professional chaplains and related programmatic expenses. Clinicians serving seriously ill populations may develop affiliation agreements with spiritual care departments in health systems, hospitals, or hospice programs that can provide timely access to professional chaplain services. Even when these resources are available, partnerships with faith community leaders are encouraged and nurtured. The IDT has policies and procedures regarding spiritual care consultation and processes for referrals.

Essential Palliative Care Skills Needed by All Clinicians

The process and tools needed to conduct a spiritual screening and assessment for spiritual distress and spiritual needs can be learned by all clinicians. In addition, clinicians can learn to identify and utilize resources available on the team, within the patient and family, or in the community or care setting to ensure that spiritual needs are promptly addressed.

Key Research Evidence

The systematic review addressed the following key question: KQ5) What is the effect of a spiritual assessment and/or interventions on patient and family/caregiver spiritual and emotional wellbeing? Eleven systematic reviews were identified pertaining to KQ5. The evidence table in the systematic review describes the key findings of each included review. The summary of findings table in the systematic review describes the quality of evidence. The complete findings are published online in the Journal of Pain and Symptom Management (doi: 10.1016/j.jpainsymman.2018.09.008).

Practice Examples

Practice Example D5-A

A large health system includes several outpatient clinics and hospitals across a broad geographic area. Not every site has the same scope of services and staff resources and budgets are tight. The health system has committed to integrating palliative care as a component of patient-centered care and to align with the NCP Guidelines. The expanding service area and diverse patient populations reveal the need for expansion of spiritual care services across the system. A board-certified professional chaplain at one of the larger hospitals in the health system serves as a champion and convener of spiritual care resources across the health system. She and her team promote implementation of screening for spiritual distress for all inpatients, along with a template for this information in the medical record. This screening tool is integrated into the outpatient oncology clinics across the system. The central team creates educational
Domain 5: Spiritual, Religious, and Existential Aspects of Care

materials and procedures that help the regional hospitals and clinics to develop relationships with community spiritual care providers and local faith community leaders to meet the diverse needs of their local patient populations.

**Practice Example D5-B**

A rural hospital has no formal palliative care team, but the hospitalist physicians, physician assistants, advanced practice registered nurse, and hospital nurses, commit to developing and growing palliative care at their institution. They form a workgroup of interested hospital staff and community members. The hospital has seen a dramatic shift in the population served as its community has welcomed many Eastern European immigrants. Furthermore, the closure of the county hospital in the neighboring urban area has led to higher ethnic diversity than the hospital had known. Working through the NCP Guidelines, the palliative care workgroup recognizes that it should prioritize the diverse spiritual needs of patients who are seriously ill or dying in the hospital. The Ethics Committee also notes that many consultations have been related to cultural clashes involving spiritual beliefs and practices. The social work department works with the palliative care workgroup to identify spiritual care providers in the community who are available to come to the hospital as requested to meet the diverse needs of the patients. An educational series is held for all staff to increase understanding of the range of spiritual and religious traditions of community members. The hospital adopts a new policy on “Compassionate Care Near the End of Life” which incorporates key principles from the NCP Guidelines. The palliative care workgroup arranges to meet via videoconference with the palliative care specialty service at a regional hospital each quarter to discuss challenging cases.

**Practice Example D5-C**

A pediatric oncology program has recruited a physician dually boarded in oncology and palliative medicine, along with a pharmacist skilled in the pharmacology of symptom management. Staff and family caregiver education in symptom management improves rapidly. At the monthly staff meeting, several individuals acknowledge these improvements but request attention to the spiritual care of the children and families they serve. The staff feels poorly equipped to address the needs of parents and families from diverse religious traditions. They feel unsure of how to respond effectively to the spiritual experiences children may report, such as communication with deceased relatives, visits from “angels,” and awareness of their impending death. The pediatric oncology program adopts improved spiritual care as a goal for the next quarter, using the NCP Guidelines as a framework for its quality improvement plans. The 0.20 full-time equivalent (FTE) professional chaplain assigned to this unit leads these efforts, including the development of strategies to standardize spiritual assessment of all children and their families and a focus on incorporating spiritual care in the plan of care. While resources are stretched in this setting, the team believes that the combined efforts of all the staff, including child psychology, art and music therapy, and child life specialists, can make a major improvement in spiritual care.

**Practice Example D5-D**

A national company establishes specialty practices to deliver home-based palliative care in rural and urban settings. Spiritual distress screening during the comprehensive palliative assessment reveal that more than 90% report no unmet spiritual needs, as they are actively engaged with their own faith community. To meet the needs of the remaining patients, families, and the IDTs, the central office employs a professional chaplain to actively participate in all the IDT meetings by phone, with some site visits. The chaplain creates policies and procedures on the spiritual care of patients and families. He helps local practices facilitate connection with local faith community leaders and develops contracts with local hospices for...
Home-based spiritual care services when necessary. These visiting hospice chaplains are contracted to the local palliative care practices to provide patient and family visits. They identify themselves as part of the palliative care team, rather than their hospice employer. However, their connection with the local hospice is helpful when a hospice transition occurs to provide continuity and a familiar face for the patient and family.

Endnotes