SPIRITUAL OUTCOMES

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Spirituality/ spiritual care

- **1980s (พ.ศ. 2523)** — started to explore spiritual dimension
- **1982 (พ.ศ. 2525)** — regarded as the important aspect of the care
- **1999 (พ.ศ. 2542)** — wrote the spiritual policy in palliative care
- **2004 (พ.ศ. 2547)** — should be provided by the multi-disciplinary team
Topic--Spirituality/outcomes

Spirituality—spiritual care → Outcomes

Religious beliefs

one part of holistic care

Results of care (Quality of care)

Patient’s spirituality
Outcomes

- the end results of care
- foundation of nursing professional accountability
- tremendous potential to be translated into powerful health care decision
- outcome data helping to improve clinical practice or patient care

Outcomes/nursing outcomes → Quality of nursing care
Outcome—clinical value value compass

- Quality of care
  - Functional
  - Clinical
  - Satisfaction
  - Cost
Donabedian’s Classic Framework

Structure, Process, & Outcomes (1966)

Structure → Process → Outcomes

- Organizational structures
- Nursing intervention & Process
- Patient, Nurse, & Organizational outcomes
**Structure**—resources in the health care setting
- physical facilities
- staff mix
- Qualification of staff etc.

**Process**—how care is delivered—the means to the ends

**Outcome**—the results or consequences of care
(Donabedian, 1966)

In the past, outcomes focused on negative measurement—5Ds:
deadth, disease, disability, discomfort, & dissatisfaction—adverse outcomes

Cost, LOS, Patient mortality, Patient satisfaction, adverse events---Outcomes
Outcomes

Cost, LOS, Patient mortality, Patient satisfaction

Factors (: functional, social, psychological, physical-physiological factors)

- Achievement of appropriate self care,
- Demonstration of health promoting behaviors,
- Health-related quality of life,
- Patient perception of being well
Quality Health Outcome Model
Patient-focused outcomes — diagnosis, holistical outcome

Provider-focused outcomes — complication rate

Organization-focused outcomes — adverse events: falls, deaths, or unplanned readmission

- Nurse staff mix outcomes
- Nursing job satisfaction, Job stress, or Role tension
- Patient diagnostic-related groups (DRGs)
- Complications
- etc.
Outcomes

- the end results of care--changes
- Foundation of nursing professional accountability—VALUE of nurses/nursing care
- tremendous potential to be translated into powerful health care decision
- Outcome data helping to improve clinical practice or patient care

Jennings & Staggers (1998)

Results from Performance—Outcomes (or interchangeable)
Outcome research/Outcome management

by **Outcome research**—a mean to systemically evaluate the effectiveness of interventions relative to their cost and outcomes

**Outcome management**—be driven by pragmatic force within the health care deliver environment as a means of examining the results of care—research

- Efficacy
- Effectiveness
- efficiency
Nursing-sensitive patient outcome

--**sufficient sensitivity** to measure outcomes

Qualifying (levels)

Indicators

Consisting 6 components:
1. Prevention of complications (such as injuries)
2. Clinical outcomes (such as symptom control)
3. Knowledge of dz, its treatment, & management of side effects
4. **Functional health outcomes (holistic outcomes)**
5. Satisfaction of care
6. Cost

Each is of better care, not quality of care.
Definitions of spirituality:

1. : as an individual’s philosophy, value, and understanding of the meaning of life (Chan, 2009)

2. : an innate component of an individual’s basic structure, facilitating optimal wellness, health, and stability (Villagomeza as cited in Chan, 2009)

3. : as a possession of human beings, enabling self-awareness, heighten consciousness and providing the strength to transcend the usual self (Watson as cited in Chan, 2009)

4. : a quality that goes beyond religious affiliation and strives for inspiration, reverence, awe, meaning and purpose, even for those who do not believe in any God (Fawcett & Noble as cited in Chan, 2009)
5. as seeking harmony with the universe and striving for answers about the infinite, during facing emotional stress, physical illness or death (Nagai-Jacobsen, & Burkhardt as cited in Chan, 2009)

6. an individual’s search for meaning of life, wholeness, peace, individuality, and harmony (Bown & Williams; Burkhardt as cited in Chan, 2009)

7. defined by 5Rs (Chan, 2009):
   1. Reason & Reflect—the search for meaning in the life experiences
   2. Religion—a vehicle for expressing spirituality through a framework of values, beliefs, and ritual practices, providing answer for life & death
   3. Relationship—relationship with ourselves, others, & God
   4. Restoration—the ability of spirituality to have a positive influence on the physical aspect of a person

8. FIRM (Walter & Fisher, 2012)
   F—Faith, I—Identity, R—Relationship, & M—Meaning
From "How to establish a palliative care program: Application to patient at risk" by V. Gunten, F.S. Ferris, R.K. Portenoy, & M. Gla; Chen 2001, Center to Advance Palliative Care p.1. Copyright 2001 by the Center to Advance Palliative Care.
Religion & spirituality

I. Spirituality is broader than religion

II. as a way to obtain the spirituality

Persons with no religion still have spiritual need.
# Religion & spirituality

<table>
<thead>
<tr>
<th>Religion</th>
<th>Spirituality</th>
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<tr>
<td>• Focusing on rites &amp; practice, using worship</td>
<td>• Personal relationship with God/supernatural things</td>
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<td>• Support mechanism to suffering chronic disease with optimism &amp; a fighting spirit in the face of life challenging changes</td>
<td>• Producing successful outcomes during dying, death, &amp; bereavement</td>
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<td>• Provided by palliative care, mostly</td>
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Spiritual need: an experiencing disharmony of mind, body, spirit such as facing physical illness, emotional stress, or death to enhance their personal spiritual coping strategies. (Tyler & Raynor, 2006)

Spiritual care: as the activities and ways of being that bring spiritual quality of life, well-being, and function—all of which are dimensions of health—to clients (McEwan, 2005)
Spiritual needs (McSherry & Jamieson, 2011)

Expressed by the need for:

1. Meaning or purpose
2. Love & harmony relationship
3. Forgiveness
4. Trust
5. Personal beliefs/values
6. Spiritual practices or concept of God/supernaturalism
7. Creativity
Advantages of Spiritual Care

- Active religious/spiritual beliefs help patients and family increase ability to cope with their illness, symptoms, and dying (Hunt, Cobb, Keeley, & Ahmedzai, 2003)

- Spirituality has a positive influence on health & well-being. (Tyler & Raynor, 2006)

- Spiritual care provides prevention of disease, enhances recovery following illness, & fosters composure for the ill. (Culliford as cited in Tyler & Raynor, 2006)

- Spiritual care promotes spiritual health & an individual’s sense of well-being and wholeness. (Tyler & Raynor, 2006)
Roles of Nurses for spiritual care

- As both a science & an art, anointing (การทานน้ำมัน) has been integrated into nursing, serving as basic practice to care for others: “providing for physical needs as well as for emotion and spiritual needs” (Carson as cited in Tyler & Raynor, 2006, p. 64.)

- Taking actions: **listening**, being present, prayer, use of religious objects, talking, conveying a benevolent/merit attitudes, validation of clients’ feelings & thoughts, facilitation, & instilling **hope**—**assessment & care**

- Taking **holistic assessment** to identify spiritual needs of individual patients and spiritual care

- Having the **accountability** to provide spiritual care—fundamental nursing care
Who do take the role for spiritual care?

Non-clinical group

Chaplains/religious persons

Clinical group**

(McSherry & Jamieson, 2011)
Evidences

- 50% of nurses rarely or never provide spiritual care
- Nurses (3,880) encountered spiritual needs of their patients (McSherry & Jamieson, 2011)
  - daily 1,639 (41.4%)
  - weekly 953 (24.2%)
  - monthly 816 (20.7%)
  - yearly 410 (10.4%)
- Need education, training [workshop]
  - 1658 (41.3%) agreed & 1523 938.0%) strongly agreed – did not receive sufficient education and training in spirituality (McSherry & Jamieson, 2011)
Comfort as Experienced by Thai Older Patients with Advanced Cancer

By Tanatwanit, Yupin

2011

The Catholic University of America
Barriers to provide spiritual care

1. Giving less importance to beliefs & faith in healing (WHO, 1998)
2. Lack of academic training--uncertainty
3. Inadequate of time & staffing
4. Belief that spiritual care is a religious service; should be provided by religious persons
5. Demographic of nurses: religious beliefs, marital status, working department, & past hospitalization experiences (Chan, 2009)
6. Feeling discomfort to assess or discuss about spiritual needs & care
Barriers to provide spiritual care

16 nurses in a 25-bed acute medical ward in a rural hospital (Smyth & Allen, 2011), found important issues:

1. Understanding spirituality—not clear
2. Assessment of spirituality—profound spiritual needs & no standardized assessment tool
3. Difficulties in meeting spiritual need—
   3.1 lack of privacy or appropriate space for discussing
   3.2 workload or time constraints
4. Education—insufficient skills & knowledge
Approaches to address spiritual care

1. Education & training (knowledge & skills)
2. Preparing nurses for spiritual care
3. Policy supporting spiritual care
4. Creating guideline for spiritual assessment & care

(Joint Commission on Accreditation of Healthcare Organization, 2005)

Assessment

- Question about support system, prayer, spiritual goals, religious/spiritual resources, & beliefs about life & illness
- Question about Hope
- Observe certain indicators: crying, anger, depression, God-talk, resentment etc.
- Characteristics of patients
Approaches to address spiritual care (contⁿ)

5. Promoting nurses’ competency:
   a) willingness,
   b) understanding,
   c) ability to assess, without forcing, &
   d) appropriate responses (promoting meditation, prayer, area for religious activities etc.)

Another one (Leeuwen, Tiesinga, Middle, Post, & Jochemsen, 2009):
1) Assessment
2) Professionalization
3) Personal support
4) Referral
5) Communication
6) Attitude

6. Attitude & Awareness
5 strategies to heighten awareness of nurses for spiritual care

(Backman, Boxley-Harges, Bruick-Sorge, & Salmon, 2007)

are the learning activities to self-explore in order to challenge nurses, promote critical and reflective thinking.

5 strategies:

1. Exploring one’s spirituality
2. End-of-life issues
3. Grief and loss
4. Living with chronic illness
5. Spiritual assessment of the client—spiritual dimension of the client—comfortable or difficult & its levels
Knowledge & Skills for spiritual care

• **Education**—better understanding knowledge & concepts (Pranee Lundberg & Petcharat Kerdonfag, 2010)—educated
• **Training or education training or workshop** on holistic care, encompassing the spiritual dimension (Chan, 2009)
• **Preparation nurses** for spiritual/palliative care
• **Awareness** to provide spiritual care (high level)
• **Communication/counseling**
  – Sensitivity to spiritual needs
• **Referral** (Walters & Fisher, 2010)
  – Counselors 36%
  – Complementary therapists + social worker 7%
  – Doctor 4%
  – Nurse colleagues + multiple team 17%
Spirituality care

Outcome measures:
- Clinical practice guideline
- Clinical pathway
- Algorithm (stepwise assessment & intervention)
- Protocol
- Professional organization
**Existing Assessment Instruments/Tools**

1. **The Spirituality Scale**: development and psychometric testing of a holistic instrument to assess the human spiritual dimension.

2. **Spirituality and Spiritual care Rating Scale (SSCRS)**
   (McSherry, 2011)

3. **Spiritual Care Competency Scale** = 6 parts
   (Leeuwan, Tiesinga, Middel, Post, & Jochemens, 2009) at back

4. **Spiritual and Religious Care Competency for Specialist Palliative Care**
   (Marie Curie Cancer Care, 2003)
   1, 2, 3, 4, levels; Question about Knowledge, skills, & actions
Existing Assessment Instruments

1. **“Spiritual Well-Being Scale, SWBS”** Ellison.(9) The scale is focusing on religious well-being, reflecting on one’s perception and feeling of God, at the same Dhar, et al.: *Spiritual health scale 2011* 277 Indian Journal of Community Medicine/Vol 36/Issue 4/October 2011 time claiming to be an instrument to measure the spiritual well-being (of an atheist). It reflects the inbuilt contradiction in the scale.

2. **“Spirituality Assessment Scale”, SAS** Beazley.(10) This scale is limited to the organizational situations and dealing with impact of the individual’s spirituality on the growth of the organization and not on the growth of the individual.
3. “Spiritual Assessment Inventory, SAI” Edward.(5) It measures spiritual maturity and quality of life but the approach is limited in terms of Judeo-Christian emphasis.

4. “Index of Core Spiritual Experiences, INSPIRIT” Kass.(11) This scale has limited value having no application for an atheist. It is relevant only for the believers.

5. “Independent Spirituality Assessment Scale” Rojas.(12) The tool, however, is limited to serve the empirical research needs of the management and other disciplines.

6. “Myers-Briggs Type Indicator MBTI”, Richardson.(13) MBTI basically focuses on the already actualized and transcendent individuals, but its validity for the common worldly person, who is in the process of evolving spiritually, is questionable.
7. **Spiritual Health Scale (SHS 2011):**
   - cognitive (thinking level),
   - affective (feeling level) and
   - behavioral (action level).
   (Dhar, Chaturvedi, & Nandan, 2011)

8. **The popular Spiritual Well-Being Scale**
   The SWBS is a 20-item scale developed by Ellison (1983) to measure overall perceived spiritual quality of life.
   The SWBS is a general indicator of wellbeing which may be used for the assessment of both individual and congregational spiritual well-being.

9. **The Community Spirituality Scale**
   (Faith, Love, Relationship)
   The Community Spirituality Scale (CSS) was comprised of seven items developed by Rover & Kocum (2010) to capture the third domain of spirituality (relationship) suggested in the literature, namely the relationship with partner, family, significant others, and community

10. **Student Survey of Spiritual Care (SSSC)**
    (Mayer, 2003)
    9 items, 1-6 rating scale (knowledge, care, well being, ability to identify spiritual needs/distress)
    etc.
Evidence-based practice (EBP)—the conscientious use of best evidence in decision making for improving the quality of care.

In the past, nurses mostly applied research into practice via research utilization, which is based on a single study, while EBP greater relates to a deeper knowledge and a larger skill set, including: Best evidence from a thorough search and critical appraisal of all relevant studies, context, healthcare resources, practitioner or nurse skills, patient status and circumstances, and patient preferences and values.

(Melnyk & Fineout-Overholt, 2005)
5 critical steps of EBP

1. Asking the burning clinical question.
2. Collect the most relevant & best evidence
3. Critical appraise the evidence
4. Integrate all evidence with one’s clinical expertise, patient preference, & values in making a practice decision or change
5. Evaluate the practice decision & change
“Vicars [who] deal with spiritual things...doctor prescribed the drugs I take and the nurses, keep me comfortable, help me to have a wash or take me to the toilet”

(Walters & Fisher, 2010, p. 331)
Hope, importantly, Suandok hospital will be able to demonstrate the excellence of spiritual care soon.
References


References (cont’n)


References (contn)


Tyler, I. D., & Raynor, J. E. (2006). Spirituality in the Natural sciences and nursing: An interdisciplinary perspective. Association Black Nursing Faculty,