

CHAPLAINCY AND SPIRITUAL CARE POLICY

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1. INTRODUCTION

- 1.1. This policy complements information available on the intranet and our website, setting out how Somerset Partnership NHS Foundation Trust (hereafter referred to as "the Trust") ensures that Spiritual Care is embedded in all our service delivery.
- 1.2. Alongside meeting the spiritual care needs of staff, patients and carers, it also sets out our policy on Pastoral, Religious and Cultural care.
- 1.3. **This policy recognises that every human being has a 'spiritual' dimension relating to the meaning of life *for them*, whether or not they view this in terms of a faith or belief system.** The Trust is committed to ensuring that all patients and carers receive competent and compassionate care that takes their spiritual needs seriously, irrespective of any religious affiliation or belief held by patient or staff. This is given particular attention at times of great need, such as when end of life care is being offered.
- 1.4. **Failure to comply with this policy could result in disciplinary action.**

2. PURPOSE AND RATIONALE

- 2.1. The purpose of this policy is to set out how the Trust will deliver Spiritual Care to the population it serves. This includes providing support to staff, patients and carers. It recognizes that Somerset Partnership NHS Foundation Trust provides care in very different settings, including Community Hospitals, Mental Health inpatient units, Outpatients, Day hospitals, as well as in the community. Spiritual Care is at the heart of person-centered care, which necessitates that all staff in every setting need to be aware of the importance of Spiritual Care, have basic skills to deliver this, know when to make a referral to chaplaincy and how to access support, guidance and advice for themselves.
- 2.2. This policy sets out how the Trust will meet NHS Chaplaincy Guidelines 2015 "Promoting Excellence in Pastoral, Spiritual & Religious Care".
- 2.3. In addressing religious, cultural and spiritual needs, it is also supporting our delivery of the Equality Act 2010 and the Public Sector Duty 2011, (Equality and Human Rights Commission, 2015).

3. DUTIES AND RESPONSIBILITIES

- 3.1. The **Chief Operating Officer (Mental Health and Community Services)** has executive responsibility for religious and spiritual care within the Trust, ensuring compliance with duties and guidance.
- 3.2. The **Chaplaincy Team Leader** is responsible for advising the Trust and supporting spiritual care across all services, and ensuring delivery of spiritual, pastoral and religious care is adequate and appropriate, including liaison with external faith and belief communities.
- 3.3. **All staff** are responsible for ensuring all patients, carers and visitors receive appropriate spiritual care at all times. Certain professions such as nursing and medicine have a particular responsibility for ensuring competent spiritual care is delivered, and appropriate referrals for cultural and religious care is made when

required.

4. DEFINITIONS

- 4.1. **Challenges defining ‘Spiritual Care’.** There is no agreed definition of ‘Spiritual Care’ other than that it normally encompasses a broad field of practice including spiritual, religious and pastoral care. The Trust has chosen to use the following definitions, acknowledging that this is not everyone’s way of speaking, but to provide simple terms enabling consistent patient care along with any corresponding data collection and/or analysis.
- 4.2. **Further challenges with terms ‘spiritual’ and ‘religious’.** ‘Spiritual Care’ and ‘Religious Care’ are very differently understood by many. They should neither be artificially separated nor assumed to be interchangeable. These terms are sometimes presumed to have the same meaning, but this can lead to confusion and the needs of individuals being overlooked. Some will understand *spiritual* to be an aspect of religious life; others will understand religion as one particular expression of the *spiritual* life; and others would like to see them as entirely distinct. Indeed, some people do not consider themselves to be religious or spiritual.
- 4.3. **‘Spiritual’ (for the purpose of this policy)** describes the way in which people make sense of their human experience. It includes all those aspects of life that enable us to be human e.g. uniqueness, dignity, worth, conscience, values, attitudes, beliefs and relationships. Spirituality is a universal human experience that centers on the capacity to find purpose and meaning in life and explores existential questions.
- 4.4. **‘Religious’ (for the purpose of this policy)** describes a range of beliefs and practices, often incorporating specific ritual and tradition, and for many individuals it is the way in which they find expression for the spiritual. It might be described as the outward working of an inner belief.
- 4.5. **‘Spiritual Care’ (for the purpose of this policy)** describes a *response* provided to support a patient, member of staff or visitor in making sense of their human experience. It may include responses to those who show signs of spiritual pain or distress such as:
- **Anger:** Directed at their God, other people or self.
 - **Bitterness:** What have I done to deserve this?
 - **Regret:** I should have been a better person!
 - **Guilt/punishments:** I must have done something wrong.
 - **Doubt:** Is there a purpose/meaning for existence?
 - **Fear:** I am not sure there is anything after death. I no longer have the capacity for resilience and acceptance in the face of suffering and/or death.
 - **Isolation:** My family/neighbours, friends/God etc. have abandoned me.
 - **Loss of hope:** I see no future/ a negative future stretching endlessly ahead. I have lost the capacity to determine my life and my future.
 - **Loss of identity:** Who am I?

Spiritual Care, therefore, is important to all people, not just those who express a religious belief. Patients often have a strong need to make sense of their circumstances, to find meaning in events, their relationships and their life during

periods of illness and hospitalisation. Spiritual aspects of care, therefore, recognise the humanity, uniqueness and the personhood of all patients, relatives and staff.

- 4.6. **'Pastoral Care'** is a term often used to describe the response provided when a patient, member of staff or visitor needs support and care to meet personal and emotional challenges. This care includes the giving of time, listening and respect to whatever the patient or user presents, as well as dealing with practical problems and their resolution. Advocacy of all types could fall within this category, as might supporting a patient who has just received bad news.
- 4.7. **'Religious Care'** broadly describes support or advice given to a patient, member of staff or carer specifically related to their religious belief or custom. This can be of particular significance at key moments such as birth or death.
- 4.8. **'Cultural Care'** is not always distinguishable from religious care in some traditions, but includes the wider cultural needs and expectations of individuals, such as dietary traditions, rituals relating to rites of passage, issues of modesty and so on. Whilst these are not a 'protected characteristic' when it comes to equality legislation, as a Trust we aspire to deliver holistic and sensitive care which is responsive to cultural needs whenever possible.
- 4.9. **'End of Life'**. Spiritual, religious, pastoral and cultural care are particularly significant at the end of life. Rather than the more general term 'palliative care', the phrase 'End of Life' refers specifically to the last few days of life, when an individualised plan of care is normally in place.

5. IMPLEMENTING THE POLICY

5.1. Recording

- 5.1.1. The religious affiliation of all patients (inpatient and outpatient) must be accurately recorded on Rio by the admitting nurse to support effective religious and cultural care when required, in line with our responsibilities under the Equality Delivery System 2.
- 5.1.2. The chaplaincy department will request a yearly report on inpatients' religious affiliation to ensure that the services we provide, broadly meet the patient profile.
- 5.1.3. As a patient's spiritual needs emerge all members of staff are required to sensitively respond by either providing support themselves or making appropriate referrals to chaplaincy. A patient's spiritual needs and how staff are planning to meet them need to be recoded on Rio in the patient's progress notes or in the patient's care plan.
- 5.1.4. Chaplains document their visits and interactions with patients, carers and significant others in the patient's progress notes so that the spiritual dimension is included in the patient's holistic and multi-disciplinary care.
- 5.1.5. Every chaplain maintains an up-to-date "to-do list" on Rio, which functions as the chaplain's caseload.
- 5.1.6. The chaplain who is responsible for a ward/unit is also responsible for the work carried out by the chaplaincy volunteers on that site and for appropriately documenting their work.
- 5.1.7. All members of staff who have access to Rio can start or contribute to the patient's Spiritual Care assessment by filling in the page under
 - "Core Assessments":

- Personal History/Social Circumstances:
- Cultural and Spiritual Needs
- Ticking the box that the patient would like to see a chaplain will generate a referral to the Rio “To-do list” of the lead chaplain.
For patients who are re-admitted the page needs to be renewed or edited, so that a new referral to chaplaincy is triggered.

5.2. **Assessing & Delivering**

- 5.2.1. The Trust understands that spiritual care is a core component of patient-centered care, and as such is delivered in part by all staff. It is crucial that staff recognize when a referral to chaplaincy is required, so that specialist advice and support can be provided. Therefore staff who have regular contact with patients and carers are required to recognize spiritual distress, be confident on how to respond and make appropriate referrals.
- 5.2.2. The chaplains benefit from some background information, before they visit. Complex situations are best referred via email, so that the chaplain can contact the referrer to gain a better understanding of why the patient is seeking chaplaincy support.
- 5.2.3. The chaplains are guided by the Trust’s values of “working together” by adopting a collaborative, multi-disciplinary approach. “Everyone counts” manifests in the chaplaincy’s commitment to inclusivity. “Making a difference” is the chaplains’ core ethos to help individuals gain a new perspective, which encourages recovery, healing and wellbeing. The chaplains are committed to creatively seek ways to engage with everybody cared for by the Trust.
- 5.2.4. To provide holistic care chaplains seek a multi-disciplinary approach and dialogue.
- 5.2.5. Referrals to chaplaincy can be made by any member of staff, patients, carers, family or friends. Referrals can be made by email to the generic email account: chaplains@sompar.nhs.uk or via the Chaplaincy Telephone number.
- 5.2.6. Information on how to make a referral can be found on the Trust’s Intranet and Internet site.
- 5.2.7. The chaplaincy has also produced a generic information booklet for inpatients about the service and how to access support.
- 5.2.8. Staff can refer patients via Rio, see 5.3.1.
- 5.2.9. When a patient has been identified as receiving ‘end of life’ care, an individualised care-plan is drawn up with a specific assessment of the individual’s psychological, spiritual and emotional needs. This is particularly important as the chaplaincy team is not available out-of hours, even in emergency situations. All members of staff are responsible to recognize a patient’s religious needs and to identify these early, so that together with the patient and their family, support from their local faith community can be accessed and provisions made for end-of life care. If the patient has received religious or spiritual support this must be documented in the patient’s progress notes. Chaplains are not the sole providers of spiritual care, as providing individualized, person centered-care is the responsibility of all. Patients should be referred to chaplaincy for specialized support.
- 5.2.10. Staff may benefit from contacting the chaplaincy to discuss a patient’s spiritual, religious or cultural needs, as it may aid them to provide better support and care.

- 5.2.11. All sites should have information about the Chaplaincy service displayed in public areas.
- 5.2.12. The chaplaincy is committed to recruiting “Chaplaincy Champions” amongst staff on inpatient units to promote spiritual care awareness, act as a bridge between the ward and chaplaincy and to assist patients and carers to access appropriate spiritual care.

6. TRAINING REQUIREMENTS

- 6.1.1. In order to support this wider understanding of spiritual care, the Trust both enables and strongly encourages relevant clinical staff to develop their competency in delivering spiritual care (for example through training provided by the Chaplaincy Department).
- 6.1.2. The Trust is clear that spiritual care is a dimension of all care, and therefore all patients have a reasonable expectation to receive it. This includes patients who are affiliated to a religious tradition and those who are not. There are particular challenges with identifying, assessing and being able to address the needs of the non-religious patient with pastoral or ‘spiritual’ needs, but the Trust is committed to develop this provision. It is similarly committed to developing appropriate assessment and provision for patients under the age of 18 or who have a diagnosis of Learning Disabilities, who have a reasonable expectation of spiritual care that is appropriate and right for them as an individual as well as for their family.
- 6.1.3. Whilst the majority of patients have an expressed religion of ‘Christian’, this relates to a very broad range of beliefs and practices. Further, there are a wide number of individuals who identify with other beliefs such as Buddhist, Hindu, Humanist etc. In order to support the cultural, religious and spiritual needs of all, the Chaplaincy service is required to have effective relationships with a wide number of faith and community leaders.
- 6.1.4. Alongside the spiritual needs assessment carried out for patients receiving end of life care, a clear record of the spiritual care delivered needs to be made of all significant interventions in patient care.
- 6.1.5. The Trust is committed to providing high quality Chaplaincy support following the guidelines set out in [NHS Chaplaincy Guidelines 2015 Promoting Excellence in Pastoral, Spiritual & Religious Care](#) and in response to end of life situations as expected within ‘[One Chance to get it Right \(2014\)](#)’.
- 6.1.6. Because the Trust does not operate an out-of-hours emergency, on-call system for chaplains, there is a clear need to identify early if a patient and/or their family has specific spiritual and religious needs and to develop a personalized care plan on how to meet those needs, especially if the patient is receiving end-of-life care. If the patient has links to a faith community they may be able to offer the required religious and pastoral support. It is vitally important to always gain the patient’s consent before making a referral to their faith community or faith leader.
- 6.1.7. All in-patient sites should make provision for a space for quiet and reflection. Prayer rooms should be welcoming and inclusive. All wards have access to a range of sacred texts and literature, further copies can be obtained from the chaplaincy department.
The chaplaincy intranet page contains additional resources on how to provide care in a multi-faith context.

- 6.1.8. Alongside care for patients and their families, the Trust takes seriously the spiritual needs of its staff and chaplaincy support is available to staff on request. Chaplains also work with individual staff and their managers to support staff with particular religious or cultural needs in the workplace (e.g uniform policy / leave policy). After a death of a member of staff chaplains work closely together with HR and the well@work team to provide support to managers and the units they lead.

7. MONITORING COMPLIANCE AND EFFECTIVENESS

An annual review of chaplaincy services will be undertaken by the Chaplaincy Team Leader, to ensure their continued effectiveness in supporting the needs of patients, families and staff.

The review will consider:

- staffing provision
- direct patient/family and staff support activity undertaken
- appropriateness of physical resources
- information provision about chaplaincy services.

The report of the Review and accompanying Action Plan and any recommendations will be considered by the Regulation Governance Group.

8. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

- 8.1. *Equality Act (2010)*. London: Stationery Office. Available at: <http://www.legislation.gov.uk/ukpga/2010/15/contents>
- 8.2. Equality and Human Rights Commission (2015). *Public Sector Equality Duty*. Available at: <http://www.equalityhumanrights.com/private-and-public-sector-guidance/public-sector-providers/public-sector-equality-duty>
- 8.3. NICE 2004 Guidance on Cancer Services: Improving Supportive and Palliative Care for Adults with Cancer <http://www.nice.org.uk/guidance/csgsp/resources>
- 8.4. Accessible Information Standard
- 8.5. DOH: Chaplaincy best practice.

9 APPENDICES

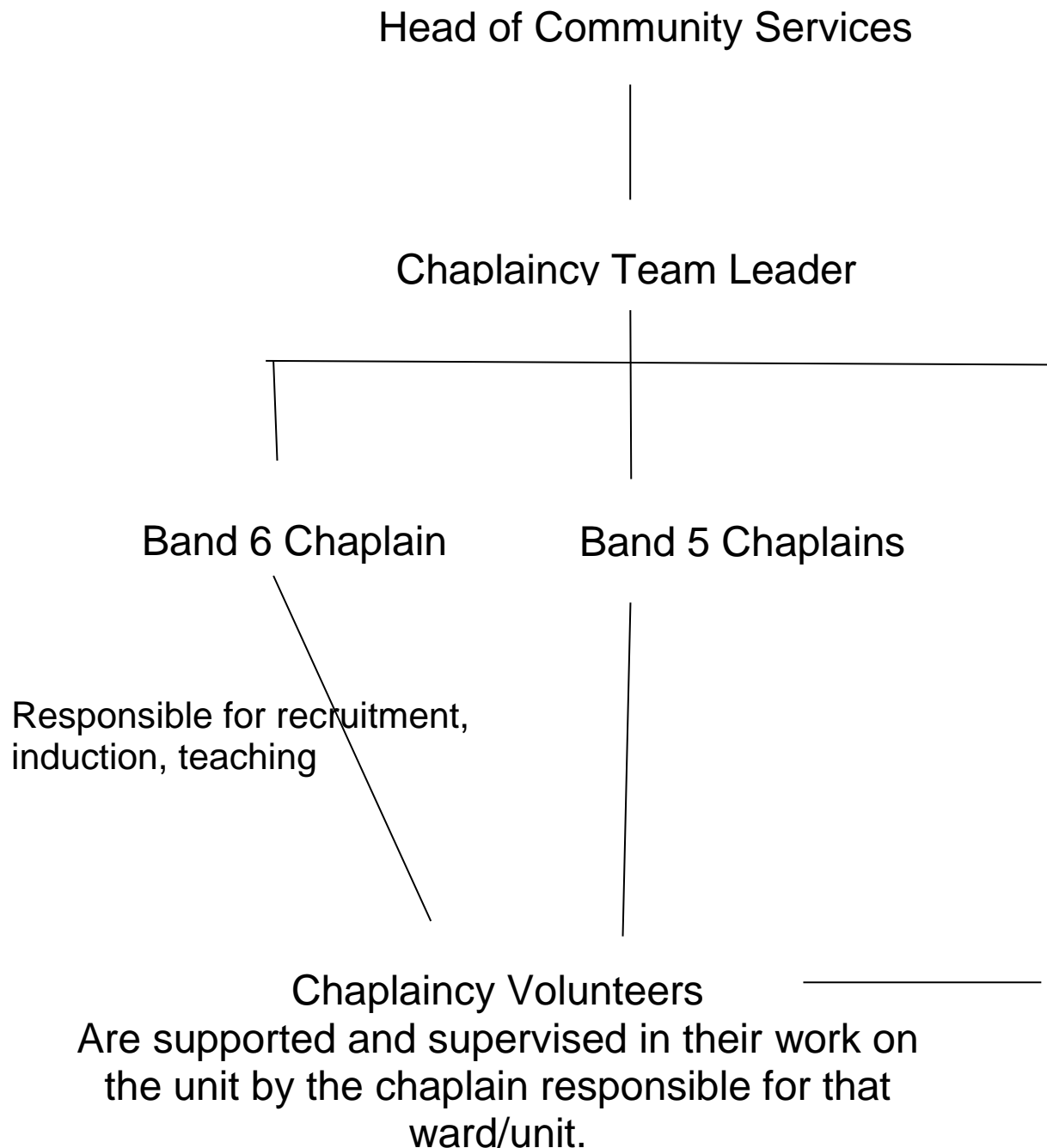
- 9.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

CHAPLAINCY RESOURCES

For current resources, like sacred literature, prayer mats, contact the chaplaincy or visit the chaplaincy website. The chaplains are donated various items by religious charities to support patients during an inpatient stay.

The chaplaincy website also has links to information about major faith groups and how religious and cultural beliefs and practices impact healthcare. There is a particular section on multi-faith End-of-Life Care.

CHAPLAINCY STRUCTURE



Every chaplain will develop and foster links with key staff on each site, in particular with the chaplaincy champion.