CHAMPIONING SPIRITUAL CARE-PART II

Out of the Mystery: Education Pulls Nurses Into Spiritual Screening

By **Jeremy Hudson, MA, BCC**

In health care, spirituality and spiritual care have the perception of being cloaked in the mysterious. Patients, family members, and health care professionals don't always have a solid grasp of what spiritual care is and what chaplains can offer. The confusion and lack of understanding are challenges for spiritual care providers who are trying to further integrate the discipline of spiritual care into the fabric of their institutions.

The Department of Spiritual Care at the University of Iowa Hospitals and Clinics (UIHC), Iowa City, Iowa, tackled this scenario—and, having done so, is now experiencing greater visibility and integration than previously, and is serving more people in need.

UIHC recently introduced a hospital-wide spiritual screening as a part of the nursing assessment to identify patients and family members who desire spiritual support while in the hospital. The initiative is an outgrowth of a collaboration with other disciplines and education about spirituality and spiritual care to all levels of the organization.

The multiple definitions of spirituality, religion, spiritual care, and religious care often add to the mystery and confusion surrounding chaplaincy. Even when chaplains themselves are asked how they define these terms, varied responses emerge. If spiritual care providers struggle to have consistent explanations and definitions of these concepts, then how do we expect other health care providers and administrators to know, understand and explain them to patients and their families?

Yet, the hands-on patient care staff are among spiritual care's strongest advocates if they are equipped with and give a consistent and concise message.

Chaplains need to be the champions, promoters and educators for spiritual care in their institutions. They must be open to and engage in opportune situations that present themselves and actively seek out other chances to collaborate at their organizations if chaplaincy is to continue to gain visibility and greater integration.

At UIHC, this process began when a nurse manager and social worker asked, "How do we identify patients and family members who might benefit from spiritual care?" This was an opportunity ripe for cultivation.

To move this forward, educating colleagues about spirituality and spiritual care was a key building block. And it was necessary to start with the very basics. We began with using the definition of spirituality drawn from the Greek, *pneuma*; the Hebrew, *ruach*; and the Latin, *spiritus*. All three words are defined as breath or spirit. Therefore, spirituality is that which gives breath to life. A person's spirituality can consist of such things as relationships, art, music, vocation, and even, but not always, religion. Spiritual distress is looking at how the present challenges impact the things that give breath to the life of a patient or family member.

This education created a better understanding of what spirituality is, how illness impacts spirituality, and why it is an important component of holistic care.

With the foundation set, UIHC undertook an initial pilot project for spiritual screening in which the unit social workers administered the screening. During a three-month period in 2015, 62 percent of patients screened requested spiritual care.

The goal was to implement the spiritual screening hospital-wide in

the social work assessment. However, understanding that a social worker does not visit every patient during a hospital stay, it was evident that this would only be a start, although certainly more than spiritual care providers can screen on their own.

From the social work screenings, the hope was to generate enough data to make the case for adding a spiritual component to the nursing assessment. Social work and chaplaincy aren't able to see every patient, but nursing does. If nursing did the initial screening as a part of their assessment, it would mean 100 percent of patients are screened for spiritual distress in the first 24 hours of admission and offered spiritual care.

The screening includes a scale for the patient/family to rate their level of distress from one (no distress) to 10 (extremely distressed). Chaplains use this scale to determine acuity and which patients should be visited first.

Through collaboration with and education of key leaders in administration, nursing, information technology, and social work, the project gained overwhelming support. As other disciplines heard about the screening or got involved, momentum and buy-in grew, along with the scope of the project. It went from a small pilot to implementation on four units to being incorporated in the nursing assessment hospital-wide within months of the initial pilot.

Now, at UIHC, every patient is

screened and offered spiritual care upon admission to the hospital.

Once the screening was added to the nursing assessment, it was taken out of the social work assessment. There have been discussions about the possibility of adding it back into the social work protocol. Having it in both offers different perspectives: since the social work assessment typically takes place later in a patient's hospital stay, circumstances may look much changed from the nurse's initial evaluation within the first 24 hours of admission.

The project was not without bumps in the road. For one, its scale was challenging. As a spiritual care department, we were walking into an unknown, and we wrestled with many questions. Among them: How many referrals would be generated? Do we have the staff to meet the potential needs? If we don't take the opportunity to have the screening in the nursing assessment, will the window ever present itself again? We chose not to look at the challenges as barriers, but, instead, view them as further opportunities for education and collaboration.

It has been a year since the spiritual screening went live in the nursing assessment. During that time, the initiative has produced an average of 264 additional requests for spiritual services per month, and a total of 3,100 additional requests for the year.

Many of the requests have come from units that do not have dedicated chaplains. The project provided data to ask for—and obtain—more staff for the Department of Spiritual Care in order to meet all of the requests received through the screening. Moreover, the data demonstrates that patients and their families, and health care team members desire and value spiritual care.

In addition, the screening has allowed for a greater presence and collaboration with hospital units where chaplains weren't as visible before. There have been requests from staff at outpatient clinics to add the screening tools to their assessments so those settings can offer spiritual services as well.

This endeavor has allowed UIHC's spiritual services a pathway to increase the presence and integration of spiritual care into the overall institution. As chaplains, there are opportunities throughout health care to educate and collaborate with colleagues to make our institutions better, further our craft, and, most of all, improve the care of those we serve.

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