Spiritual Health Victoria

REVIEW OF LITERATURE

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Introduction

Spiritual (or Pastoral) Care occupies a unique place within the health care system. Spiritual Care:

"Provides a supportive, compassionate presence for people at significant times of transition, illness, grief or loss. This care is most often delivered through attentive and reflective listening and seeks to identify the person's spiritual resources, hopes and needs. Care is provided from a multi-faith and spiritual perspective offering support, comfort, spiritual counselling, and faith based chaplaincy and religious services to patients and their families. Spiritual care is a collaborative and respectful partnership between the person and their health care provider and is an integral component of holistic care" (Spiritual Health Victoria, 2015, p. 2).

Originally arising out of the Christian faith, the profession now needs to present itself in the clear terms of science and to define what exactly it is doing that is of benefit to patients, staff and families. It needs to report on its activities and outcomes; What works? What doesn't? Who is most in need of spiritual care? How do healthcare staff make assessment and refer appropriately? What is the specific domain of spiritual care within the broader spiritual care that is (or should be) offered by all health care practitioners? How can the profession articulate its unique and necessary contribution to health care?

Many of the above concerns are allayed if spiritual care staff are able to report their interactions with patients in meaningful and representative ways, and to capture data on the outcomes of those interactions.

This review seeks to understand how data relating to spiritual care is recorded, including that within hospital reporting systems such as progress notes, and research reporting spiritual interventions and outcomes. It acknowledges that spiritual care may be provided by all members of the healthcare team (and particularly nursing staff), however this review focusses predominantly upon research that speaks to the spiritual care provided by spiritual care professionals (pastoral care or chaplaincy staff members and volunteers). It also looks at the relationship between spiritual care and other healthcare staff.

While this review does not specifically address the quality of spiritual care research, it must be noted that many authors cite the need for more rigorous research in the area of spiritual care, and/or advocate training for spiritual care staff to increase confidence in this practice (Derrickson & Hise, 2010; Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014; Kevin J. Flannelly, 2010; Kevin J. Flannelly & Jankowski, 2014; Galek, Flannelly, Jankowski, & Handzo, 2011; Jacobs, 2008; Jankowski & Flannelly, 2015; Kestenbaum et al., 2015; Murphy & Fitchett, 2010; K. M. Piderman & Johnson, 2009; Proserpio, Piccinelli, & Clerici, 2011; Selman, Young, Vermandere, Stirling, & Leget, 2014; Tartaglia, Dodd-McCue, & Murphy, 2012; Weaver, Flannelly, & Liu, 2008; U. Winter-Pfandler & Morgenthaler, 2010).

A note on terminology: In the Australian context, there is a move toward the use of the terms Pastoral Care or Spiritual Care, as a recognition of an increasingly multi-cultural, multi-faith and secular society. In the UK and US, the preferred term is chaplaincy. When referring to articles within this review, the authors' preferred terminology is utilised.

Methodology

Search terms (both key words and MeSH headings) were used in four databases (Medline, CINAHL, PsychINFO, & PubMed). Each of the groups was paired with the Spiritual care terms.

Pastoral care; spiritual care; chaplain; hospital chaplaincy service; pastoral counselling

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Intervention; outcome; measurement; assessment; evaluation; treatment outcomes	Charting; progress notes; documentation; medical records; data collection; reporting; recording	Patient; consumer; perception; views; attitudes; perspectives	Ethics; morals Organisation; organization; workplace	Spiritual health; spiritual wellbeing; wellness; wellbeing; spirituality

Abstracts were screened for relevance and downloaded using EndNote software.

A search was also conducted in Google, looking particularly at articles relating to pastoral care and reporting. Search terms included pastoral care, progress notes, and reporting.

Results

The search results are listed in table one below.

Search Terms	Medline	Cinahl	PsychINFO	PubMed	Total
Pastoral Care	4870	3424	3332	10377	
Intervention	3448019	905862	897645	3612772	
+ Pastoral Care	869	708	634	1879	
Limit 2000-Current	621		402	1495	
Limit Full Text	271	364	86	289	
Abstracts downloaded	45	31	20	16	112
Charting	2634771	506963	94160	2629826	
+ Pastoral Care	675	666	58	2225	
Limit 2000-Current	495	596	44	1802	
Limit Full Text	225	314	9	336	
Abstracts downloaded	28	31	2	15	76
Patient attitudes	66079	587662	18494	205116	
+ Pastoral Care	61	1024	40	1493	
Limit 2000-Current	48	850	22	1126	
Limit Full Text	24	475	6	166	
Abstracts downloaded	8	34	0	3	45

Ethics	182045	98326	59544	198118	
+ Pastoral Care	480	192	142	1133	
Limit 2000-Current	276	165	96	565	
Limit Full Text	98	93	21	81	
Abstracts downloaded	11	7	2	4	24
Workplace	936746	54601	87508	2077857	
+ Pastoral Care	924	43	86	3128	
Limit 2000-Current	490	38	65	2004	
Limit Full Text	248	16	12	251	
Abstracts downloaded	19	2	0	10	31
Wellbeing	21561	7811	45375	3160571	
+ Pastoral Care	883	66	787	6040	
Limit 2000-Current	848	48	692	4176	
Limit Full Text	406	29	165	693	
Abstracts downloaded	23	3	17	20	63
					351

Table 1. Search Strategy

From the database search, 351 articles were downloaded to EndNote.

A further 33 documents were added to EndNote from other sources including the google search, bringing the total to 384 entries.

Duplicates were removed (n=56) and the remaining articles were read for relevance to the review.

A total of 203 were included in the review.

The results of the review are outlined under a number of themes:

- What is the role of pastoral care and what do chaplains actually do? This part looks at pastoral care roles in a variety of settings and programs, a range of intervention types, and how pastoral care is provided for people experiencing a range of health conditions (n=61).
- How is spiritual health measured? This section focuses on screening and assessment tools utilised in clinical practice and in research contexts (n=54).
- What are the outcomes of spiritual care? This section describes a number of review articles and then addresses research using quantitative and qualitative methods, in more detail (n=37).
- What is the relationship between pastoral care and other health care professionals? This section particularly focuses upon referral pathways and the relationship between pastoral care and nursing professions (n=29).
- What is relationship between spiritual care and organisations, and overall well-being? (n=18)
- How do pastoral care staff report their activities? This section reports on peer reviewed and grey literature and includes discussion of ethical considerations (n=30).

Please note that all of the cited articles with abstracts are available in the appendices.

What do Spiritual Care practitioners do?

There is great diversity in how spiritual care interventions are measured and outcomes reported. This section outlines research relating to pastoral interventions, and then describes quantitative and qualitative studies that have articulated outcomes. All articles are included in table form in Appendix 1.

Research exploring spiritual care roles and interventions reveals a diversity of activities. Lawrence et al. (2008) speaks to the diversity of the chaplain role as dictated by the range of work circumstances. Hummel, Galek, Murphy, Tannenbaum, and Flannelly (2008) reviewed spiritual care interventions in 28 articles and grouped their results under the themes: religious, spiritual, counselling, emotional support, and advocacy interventions. Chaplains provide support to families and to the dying, they explain what is misunderstood, provide presence, debrief staff, and participate in ethics committees (Jacobs, 2008). They provide spiritual assessment, tend to religious and spiritual needs, hold religious services, and support decision making at end of life (Koenig, 2012). Chaplains in hospice settings provide spiritual care to patients, relatives and staff/volunteers, bereavement support, funeral and memorial services (Lloyd-Williams, Wright, Cobb, & Shiels, 2004) and also participate in interdisciplinary team meetings (Wittenberg-Lyles, Oliver, Demiris, Baldwin, & Regehr, 2008). They also provide family support following family witnessed resuscitation (James, Cottle, & Hodge, 2011). Pastoral Care may be delivered through group work (Hirschmann, 2011).

The chaplain role is undergoing changes in the context of secularization and individualization (Zock, 2008). A number of authors report the role of narrative approaches (including life review) in chaplaincy interventions (George, 2010; Grossoehme, 2015; Jansen & van Saane, 2006; Kruizinga, Scherer-Rath, Schilderman, Sprangers, & Laarhoven, 2013; Mundle, 2014; Risk, 2013; Ziegler, 2007). Other interventions include listening presence/mindfulness (Cooper-White, 2006; Parameshwaran, 2015), decision making (L. Carey & Newell, 2007; L. B. Carey & Cohen, 2008; Carlson, Simopolous, Goy, Jackson, & Ganzini, 2005; Clemm, Jox, Borasio, & Roser, 2015), prayer (Maddox, 2012), advocacy (Morgan, 2010) or dreams (Stranahan, 2011). Research is also seen as a chaplaincy intervention, drawing on the power of narrative in healing (Grossoehme, 2015).

Chaplains may also support specific programs in healthcare settings, including suicide prevention (Kopacz, 2013), smoking cessation (Van Voorhees, Hamlett-Berry, Christofferson, Beckham, & Nieuwsma, 2014), alcohol screening in trauma centre (Overton, Williams, Shafi, & Gandhi, 2014), or treatment adherence in cystic fibrosis (Cheng, Purcell, Dimitriou, & Grossoehme, 2015). Other settings in which chaplains play a key role are in paediatric palliative care (Fitchett et al., 2011; Lyndes et al., 2012).

Chaplaincy may also address particular conditions including generalised anxiety disorder (Koszycki, 2010), pain (Lindsay B. Carey, Newell, & Rumbold, 2006; L. B. Carey, Polita, Marsden, & Krikheli, 2014), divine struggle (Fitchett, Winter-Pfandler, & Pargament, 2014), cancer (S. D. King, 2012; K. M. Piderman et al., 2015; Sinclair & Chochinov, 2012; Zullig et al., 2014), heart failure (Ross & Austin, 2015), cardiac surgery (Rosendahl et al., 2009) or mental health/psychiatric conditions (Hirschmann, 2011; Nieuwsma et al., 2014). Chaplaincy also attends to the intensive emotional and spiritual need presented in ICU, where Hughes, Whitmer, and Hurst (2007) aimed to integrate spiritual care assessments into the ICU setting.

Chaplaincy has a strong role in end of life care, providing support to the dying and the bereaved (T. P. Daaleman, Usher, Williams, Rawlings, & Hanson, 2008; Kevin J. Flannelly et al., 2012; Johnson et al., 2014; Koenig, 2012; Lahaj, 2011; Pugh, Smith, & Salter, 2010) or providing dignity therapy (Fitchett, Emanuel, Handzo, Boyke, & Wilkie, 2015). Chaplaincy also takes place in settings outside of

healthcare, including court (L. B. Carey, 2015), prison (L. B. Carey & Del Medico, 2014) and disaster areas (Swain, 2011). Research exploring pastoral interventions has also included spiritual care interventions with multiple elements (Candy, 2012), moral distress (Guthrie, 2014) and a range of others (Handzo et al., 2008; Kevern & Hill, 2015; S. King, 2011; McClung, Grossoehme, & Jacobson, 2006; K. Piderman et al., 2014).

How is Spiritual Health Measured?

There are many assessment and screening tools and ways of measuring spiritual health (a list of spiritual care assessment, inventories and screening tools are found in Appendix 2). Spirituality is seen as notoriously difficult to define, and therefore to assess or measure. It is clear that asking a patient's religious affiliation is not enough to assess spiritual health or spiritual care needs. Glenister and Callopy (2013) present examples of congruence and incongruence with the religious identifier through a series of case studies, and argue for more thorough assessment procedures to enable appropriate spiritual care. Fitchett (2012) argues that we no longer need to develop new models of assessment, but instead critically review existing models to inform best practice. Many of the articles below are from nursing literature.

A paper in 2012 reviewed existing spiritual assessment tools, describing 17 instruments (Draper, 2012). It outlined implications for nursing practice. Monod et al. (2011) also conducted a systematic review of instruments, finding 35 tools that measure general spirituality, spiritual well-being, spiritual coping and spiritual needs. They found the FACIT-Sp and Spiritual Wellbeing Scale were used most frequently. Timmins and Kelly (2008) reviewed assessment tools for ICU and CCU settings. Selman, Harding, Gysels, Speck, and Higginson (2011) completed a systematic review of cross-culturally validated tools in spirituality, palliative care and outcome measurement. Selman, Siegert, et al. (2011) conducted another review of spiritual care outcomes for palliative care, cancer and HIV populations. Gijsberts et al. (2011) conducted a systematic review of instruments measuring spirituality to help to conceptualise spirituality in end of life settings. Power (2006) discusses the ethics of spiritual assessment and screening tools. She defines a range of methods utilised including direct questioning, indicator-based tools, audit tools and value-clarification tools that utilise Likert scales (for example, the Spiritual Index by T. Daaleman, Reed, Cohen, and Zimmerman (2014)) which are more appropriate to research than spiritual care.

There are comprehensive tools that have been developed to measure, map or assess spiritual health. These include the FICA Spiritual History Tool, (Borneman, Ferrell, & Puchalski, 2010), the FACIT-Sp-Ex , (Delgado-Guay et al., 2011; Haugan, 2015; Nakau et al., 2013; Whitford & Olver, 2012; Whitford, Olver, & Haley, 2008), Spiritual Health Scale (Dhar, Chaturvedi, & Nandan, 2011), Spiritual Health Scale Short Form (Hsiao, Chiang, Lee, & Han, 2013), Pastoral Intervention Codings (L. Carey, Robinson, & Cohen, 2009), spiritual health locus of control scale (Holt, Clark, & Klem, 2007), Spiritual Health Inventory (Gray, 2011) and Spiritual Health Profile in psychiatric setting (McGee & Torosian, 2006).

There are indicators for specific spiritual states or illnesses such as spiritual distress (Blanchard, 2012; Robinson, 2013), a measure for spiritual wellness in depression (Briggs, 2006), spiritual pain in cancer (Delgado-Guay et al., 2011), Beliefs and Values Scale (M. King et al., 2013), the Spiritual Experience Interview, which measures spiritual maturity (Teal, 2007), and interest in spiritual care (Schultz, Lulav-Grinwald, & Bar-Sela, 2014).

A number of measures have been developed for palliative care contexts. Cobb, Dowrick, and Lloyd-Williams (2012) undertook a review of literature to identify spiritual need in palliative care. Other measures include the European Organisation for Research and Treatment of Cancer (EORTC) measure of spiritual wellbeing in cancer (Vivat et al., 2013), Palliative Care Specific Spiritual Assessment (Galchutt, 2013), and Quality of Spiritual Care Scale for use in palliative care settings (T. Daaleman et al., 2014), the Spiritual Life Map for use in palliative care (Hodge 2005, in Bushfield, 2010) and Spirit 8 (Selman et al., 2012; Selman et al., 2013). Others have been developed specifically for oncology; Basic Spiritual Assessment model in cancer (Jones, 2006), and the Spiritual Needs and Assessment Scale in oncology setting (Dedeli, Yildiz, & Yuksel, 2015).

In support of staff working with spiritual health, a number of tools have been developed including one to measure spiritual care (Burkhart, Schmidt, & Hogan, 2011), another to describe a spiritual care pathway (Cook, 2012), and another for social workers (Hodge, 2006). Another tool has been developed to support nursing staff who have difficulty performing spiritual assessment (Hoffert, Henshaw, & Mvududu, 2007). One tool has been developed to assist chaplains in assessing who most needs pastoral care and why (Ledbetter, 2008). Another measures patient satisfaction with chaplaincy (Beardsley, 2009). Another, developed by U. Winter-Pfandler and Morgenthaler (2011), assists chaplains in identifying which patients have the greatest need for chaplaincy.

Spirituality is also included as one aspect of larger tools, for example; as a component of care plans (Kevern, Walsh, & McSherry, 2013), part of the Service User Recovery Evaluation Scale (Barber, 2012), and within Liverpool Care Pathways in hospice settings (2004, in Power, 2006).

What are the outcomes of Spiritual Care?

This section outlines a number of review articles and then specific studies relating to outcomes.

Spiritual care as a profession faces the challenge of providing feedback to funding bodies concerning outcomes of intervention. This is linked with a need for more rigorous research practice within the profession. Handzo et al (2015) provide a discussion concerning the difficulties of articulating outcomes in chaplaincy and the need for more rigorous research. Handzo et al (2015) also discuss clinical versus personal outcomes and ask ‘What is important for chaplaincy outcomes?’ The profession has a process oriented rather than outcome oriented focus, which makes evaluation difficult, but also speaks to the value of the practice for individuals in an outcome driven environment. This is part of spiritual care’s unique contribution in health care.

Chaplaincy outcomes have been measured in simple terms by the number of interactions taking place. In a brief report, Flannelly et al (2005) estimated the proportion of patients who received visits from chaplains to be 20% (+/-10%). Others have mapped changes in chaplaincy services over time in the US (Cadge, Freese, & Christakis, 2008; Vanderwerker, Handzo, Fogg, & Overvold, 2008), and internationally (Orton, 2008). Cramer and Tenzek (2012) examined the chaplain role via review of chaplain job advertisements.

Jankowski et al (2011) provide an overview of literature to date, exploring spiritual coping, spiritual needs, spiritual struggle, and whether needs are being met. They then outline what chaplains actually do, describing care for patients, and for families. A review of patient satisfaction studies concludes that “studies that have evaluated patient satisfaction with chaplaincy care have found that patients, in general: (1) were very satisfied with chaplains, and (2) believed that chaplains have met their emotional and spiritual needs, thereby improving their health care” (Jankowski et al., 2011, p. 111). However, the authors write that “…it is not clear what chaplains did or what patients

found most helpful or satisfying. Nor is it clear if, or how, chaplain activities and patient satisfaction impact on patient health outcomes" (Jankowski et al., 2011, p. 112). They reiterate the need for ongoing research in chaplaincy.

Lichter et al (2013) also outline major research in the area of chaplaincy. The authors refer to Jankowski et al (2011) and quote, "Research into Chaplaincy outcomes falls roughly into two general categories: studies of patient satisfaction with chaplaincy care and studies of actual chaplaincy interventions and their relationship to health outcomes. The patient satisfaction studies are generally stronger methodologically than the intervention studies and tend to show the chaplain visits have a positive effect on overall patient satisfaction … The outcome studies are very few in number and most have serious methodological shortcomings" (Lichter, 2013, p. 63). They recommend further research, in particular replication of original studies and identify a range of gaps to be addressed; "religious and spiritual needs and resources; who chaplains are, what chaplains do and the desired outcomes of chaplain interventions; the efficacy of chaplains (where, when, how are they helpful?); and research methodology" (Lichter, 2013, pp. 63-64) .

In the UK, Snowden et al (2013a) developed a patient reported outcomes measure (PROM) for spiritual care. Their article details a review of literature, the development of the tool, and subsequent tests with patients. In their earlier report, there is also some discussion exploring congruence between chaplain and patient experiences of interventions which reveals "…the majority of the pairs were clearly in agreement as to the purpose and outcome of the encounter, suggesting considerable coherence between chaplain and patient in these cases" (Snowden et al., 2012, p. 35). The report includes table of previous research relating to patient outcomes.

Proserpio et al. (2011) reviewed 98 articles concerning pastoral care in hospitals. They concluded that the profession needs to focus on a range of areas: relationship with organizations, scientific research evaluating the efficacy of pastoral activities, development of procedures, protocols on ethical issues, respect for diversity in customs, culture and faith traditions, involvement in interdisciplinary teams and specific training and professional certification.

K. J. Flannelly, Oettinger, Galek, Braun-Storck, and Kreger (2009) compared two sets of measures and found that measures of effectiveness may be more useful than patient satisfaction measures in assessing pastoral care outcomes.

Quantitative Studies

Some studies have explored pastoral care outcomes via quantitative tools. Areas of exploration have included religious coping (Bay, 2008), enrolment in hospice (Kevin J. Flannelly et al., 2012), family satisfaction (Johnson et al., 2014; Wall, Engelberg, Gries, Glavan, & Curtis, 2007), mental wellbeing (Kevern & Hill, 2015), old age psychiatry (Lawrence et al., 2008) and patient satisfaction (Marin et al., 2015; Nichols, 2013; Winter-Pfändler & Morgenthaler, 2011).

A randomised controlled study examined the effect of pastoral care on coronary artery bypass graft patients. The study examined an intervention and control group, where patients received pastoral care by one hospital chaplain in the hospital setting. The chaplain engaged in four behaviours as part of their intervention: initiated conversation, identified as non-denominational chaplain, protocol of reflective listening and providing context for the patient to verbalise their concerns, and asking one existential/religious question. The study found that pastoral care may increase positive religious coping and decrease negative religious coping (Bay, 2008).

Another study reviewed data for deaths and enrolment in hospice. They found that health services employing chaplains had higher rates of enrolment to hospice. This speaks to the role of chaplaincy

to assist in end-of-life decision making (Kevin J. Flannelly et al., 2012). Johnson et al (2014) examined family satisfaction with care in an ICU setting and found particularly strong outcomes with end of life decision making support. Another study identified determinants of family satisfaction with spiritual care in ICU setting and found that younger families, and those visited by pastor or spiritual advisor in last 24 hours of the patient's life, had stronger association with overall satisfaction (Wall et al., 2007).

In the UK, Kevern & Hill (2015) found that chaplaincy intervention increased scores in patient mental wellbeing, particularly for those with the lowest baseline measures. Another study showed clinically significant reductions in patient depression scores following a 15 month chaplaincy intervention (Risk, 2013). Nichols (2013) reports on the three phase development of a pastoral care program in an aged care setting. Patient and staff satisfaction surveys revealed an overall increase in quality of life, meaning making, spiritual awareness and satisfaction in communities.

Another study explored inpatient's experiences of spiritual care, assessing "how frequently these patients identified spiritual concerns during their hospitalization, the manner in which spiritual questions were addressed, patients' desires for spiritual interaction, and patient outcome measures associated with spiritual care" (Ellis, Thomlinson, Gemmill, & Harris, 2013, p. 1306). While the focus of the study was on spiritual care as provided by physician, it included patient outcome measures associated with spiritual care by using the 'religious coping and religious struggle scale'. Of patients visited by chaplains, clergy or church members, 94% found the visits helpful.

A Swiss study explored patient satisfaction with chaplaincy interventions (Winter-Pfändler & Morgenthaler, 2011). Six hundred and seventy-nine patients were surveyed following discharge from 32 general hospitals and psychiatric clinics. A range of aspects of pastoral care were evaluated including relationship, intervention and religiosity. The authors found that patients showed high satisfaction with chaplaincy services. "Whereas the patient–chaplain relationship was significantly associated with the patient's age and religiosity, the apprehension of pastoral intervention was significantly associated with the patient's religiosity and denomination, length of stay, admission to hospital, and the patient's health status. The results suggest that chaplains have to take account of the situational circumstances and personal characteristics of patients in order to optimize their service" (Winter-Pfändler & Morgenthaler, 2011, p. 146).

Marin et al. (2015) found that patients who had been visited by chaplaincy staff were more willing to recommend the hospital and to endorse that staff met their spiritual needs, and were more satisfied with their healthcare on a number of instruments. Pearce, Coan, Herndon, Koenig, and Abernethy (2012) found that attention to spiritual care would improve satisfaction ratings, and that a significant number did not receive the care they desired with hospitalized.

Qualitative Studies

Other studies have showed the outcomes of chaplaincy via qualitative methodology. Many of these are by case study design (Ai & McCormick, 2010; Risk, 2013; Shields, Kestenbaum, & Dunn, 2015).

Chaplains not only provide listening presence to patients, but also assist in discerning beliefs and values that impact health care decision making (Ai & McCormick, 2010). The authors offer a number of case studies showing how chaplains have successfully supported end of life decision making, and suggest that chaplains will need to rise to new challenges in the future as the Baby Boomer generation ages.

In an Australian study, Calder (2011) examined the role of pastoral care in road trauma survivors. Interviews with found that pastoral care was seen as a valuable and supportive intervention with

nine core themes: talking and listening, friendliness and interest, availability, choice and control, distinctiveness and independence, understanding and reassurance, connection to outside world, spiritual support and connection, and motivating rehabilitation.

Given the difficulties of determining outcomes for measurement in palliative care interventions, a 2013 Delphi study investigated the outcomes of patient experience and found key themes of: being heard and understood, feeling there is a place for insoluble, and feeling there is a place for that which cannot be said. The Delphi study was with experts including physicians, spiritual care providers and researchers (Vermandere et al., 2013).

A number of studies have explored the reasons why patients seek pastoral support and what they expect. Piderman's (2010) study found that patients desired a reminder of God's care and presence, support for family, presence in times of anxiety, and to pray or read scripture. Winter-Pfandler & Flannelly (2013) sought to identify what patients seek pastoral support for. The findings revealed three domains: emotional support, help to cope with illness and religious/spiritual assistance. In identifying patient expectations, pastoral care providers are more able to meet those needs and therefore patient satisfaction is increased. It would be interesting to see follow up studies relating to this data. McCormick and Hildebrand (2015) analysed data from interviews to discover what patient's look for from a chaplain and why. They propose an assessment model incorporating psychological theory, faith development and autonomy.

Halm, Myers, and Bennetts (2000) interviewed and surveyed patients who received pastoral care and found that patients perceived a range of interventions as helpful. Comparisons were made with patients who had not received pastoral care, and staff who were involved in care. In general, those who had received pastoral care perceived it as more helpful than staff members or those who had not received pastoral care.

Lyndes, Fitchett, Thomason, Berlinger, and Jacobs (2008) conducted focus groups with chaplains to determine what constitutes quality spiritual care. They focused upon context-specific projects and ideas to support future practice.

Spiritual Care – A Team Approach

This section describes studies from nursing and other literature. It reviews referral pathways, spiritual care provision by healthcare staff and the relationships between pastoral care and other spiritual care providers. Abstracts for these articles are provided in Appendix 3.

Referrals to spiritual care by other healthcare staff

Referral pathways may be of consideration as they may impact outcomes in terms of number of chaplaincy interventions. They are also important to consider as they provide a reflection on why staff refer to chaplaincy (Jankowski et al., 2011).

In a 2009 study, of 15,655 pastoral visits, 78% of referrals were met on the day, and 94% within 2 days. The most frequent source of referrals were nurses, followed by self-referral from patients or family members (Galek et al., 2009). Referrals occurred in response to patient request, problems with illness or treatment, end-of-life issues, and concerns about death.

Winter-Pfandler et al (2011) surveyed head nurses to discover in which situations they would refer to a chaplain. They found nurses often refer when patients are dying or need religious/spiritual support, but rarely where there are negative feelings or other psychosocial needs. They found that

the religiosity of nurses determined whether the nurse would refer or not and conclude that there is a need to reduce subjective factors in the referral process. Another study reported surveys with 133 nursing staff and found the main reason why nurses refer to chaplaincy services to be family issues relating to death or trauma (Weinberger-Litman, Muncie, Flannelly, & Flannelly, 2010).

Galek et al (2007) surveyed hospital directors in medicine, nursing, social services and pastoral care to determine importance of four areas; pain/depression, anxiety/anger, treatment issues, and loss/death/meaning. They found that "Directors in each of the surveyed disciplines (medicine, social work, nursing, and pastoral care) indicated that it was most important to refer patients to chaplains for issues related to loss, meaning, and death" (Galek et al., 2007, p. 370). The referrals were impacted by religiosity and spirituality, discipline, views on chaplain role, and other factors.

Other studies that show perceptions of pastoral care and/or referrals to chaplaincy are related to the subjects own religiousness or spirituality (Weaver, Handzo, & Smith, 2005). Outcomes in terms of referral may be impacted by the religiosity of nursing staff (Weaver, Koenig, & Flannelly, 2008). Egan et al. (2014) found that staff in some renal services had good relationships with chaplaincy services, whereas others did not refer at all. Another study looked at the ways in which non-chaplaincy staff engaged in spiritual care, and recommended collaboration with chaplains (O'Connor et al., 2012).

Iacono (2011) presents a case study elucidating the interaction between nursing staff and pastoral care, and highlights the important work of chaplaincy staff: "This was a profound experience for the nurses who were present. How did the chaplain find just the right words at the right time? The patient was comforted, and the nurses felt better too!" (Iacono, 2011, p. 417). Piotrowski (2013) also calls for education for nursing and other palliative care staff to enable more thorough spiritual screening and subsequent referral to pastoral care professionals.

Surveying 255 spiritual advisors in the UK, Lawrence et al. (2008) found that 39% of referrals came from nursing staff, 30% from patient's relatives/carers and 17% from patients.

Health Care Practitioners and Spiritual Care

It is clear in the literature that spiritual care is not only provided by pastoral care or chaplaincy staff, but delivered by the whole healthcare team. Nursing, in particular, has taken great interest in spiritual care and much research has been undertaken. This section highlights some of the literature that demonstrates the relationship between pastoral care and other health professions, and also some of the ways in which the nursing profession is approaching spiritual care in its practice.

For nursing staff in the ICU setting, a lack of access to pastoral care after hours was a cause for concern (Bloomer, 2013). In the neonatal environment too, pastoral care workers are seen as valuable in support of both parents and staff. Nursing researchers suggested that NICU's should have a dedicated pastoral carer to meet the intensity of need (Caldeira, 2012). Byrne (2007) has mapped a nursing understanding of pastoral care via an exploration of language. Another article reviews the role of spiritual care for nursing staff and acknowledges the role of chaplaincy as the team leaders in spiritual care (Battey, 2012).

Shields (2015) articulates a need to discern spiritual screening as a practice conducted broadly by any member of the healthcare team, from spiritual assessment which is best conducted in depth by chaplaincy staff. She provides a number of case studies outlining the AIM model of pastoral assessment and intervention, and speaks briefly to the outcomes of the method.

A number of articles have explored nursing spiritual care interventions, addressing experiences such as spiritual pain (Dolan, Paice, & Wile, 2011), and existential and spiritual concerns (Keall, Clayton, & Butow, 2014). Pugh et al. (2010) outlined the development of a chaplaincy service in end of life care and demonstrated the value of the service for patients and families, from a nursing perspective. Burkhart and Androwich (2009) discuss spiritual care documentation for nursing staff. Wong and Yau (2010) in their phenomenological study of nurses spirituality and spiritual care, outlined themes of meaning, benefits and difficulties in applying spiritual care.

In research from social work, Hodge and Horvath (2011) looked at spiritual need via a qualitative meta-synthesis of eleven articles addressing patient perspectives. They found that six core themes relating to spiritual need: meaning, purpose and hope; relationship with God; spiritual practices; religious obligations; interpersonal connections; and professional staff interactions.

In quantitative research, 179 clergy were surveyed regarding their experience of pastoral care with patients, and results showed that 55% are more likely to refer to hospitals with pastoral care department (Moran, 2005). Another study explored the perception of hospital directors and found that chaplains attending to grief and death, prayer and emotional support as very to extremely important. The authors found that in general, physicians and directors of smaller hospitals rated chaplain roles with less importance (Kevin J. Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005).

Interviews with paediatric physicians and chaplains found that physicians see chaplains as part of the interdisciplinary team and support patients and families with ritual, especially around death (Cadge, Calle, & Dillinger, 2011). Following a half day shadowing experience with chaplains, medical students reflected on the importance of spiritual care and the role of chaplains in the clinical setting. The study found that the shadowing positively influenced perceptions of chaplaincy (Frazier, Schnell, Baillie, & Stuber, 2015). Other medical students shadowed trauma chaplains to develop skills in engaging in difficult conversations and the role of chaplains (Perechocky et al., 2014)

Spiritual Health and Organisations

While much of the research here looks at spiritual health from the perspective of the individual, we also considered spiritual health in terms of organisation. There is very little available, and the available articles speak to spiritual health within the workplace, as opposed to the organisation itself being spiritually healthy. For future research, it may be worth looking at 'health promoting hospitals' or 'health promoting workplaces' as spirituality may be a component within these approaches.

Fisher describes spiritual health as "a, if not the, fundamental dimension of people's overall health (i.e. physical, mental, emotional, social and vocational). Spiritual health is a dynamic state of being, shown by the extent to which people live in harmony within relationships in the following domains of spiritual well-being:

Personal domain - wherein one intra-relates with oneself with regards to meaning, purpose and values in life. The human spirit employs self-awareness in its search for self-worth and identity.

Communal domain - as expressed in the quality and depth of interpersonal relationships between self and others relating to morality, culture and religion. These are expressed in love, forgiveness, trust, hope and faith in humanity.

Environmental domain - moving beyond care and nurture for the physical and biological to a sense of awe and wonder; for some people it is the notion of unity with the environment.

Transcendental domain - the relationship of self with something or some-One beyond the human level (i.e. ultimate concern, cosmic force, transcendent reality or God). This involves faith toward, adoration and worship of, the source of mystery of the universe" (Fisher, 1998 in Fisher & Brumley, 2008).

There is very little research that attends to spiritual health in the workplace. In Puchalski, Vitillo, Hull, and Reller (2014), conversations at a conference developed a model of spirituality and compassion, and highlighted positive outcomes for healthcare staff including a sense of meaning and purpose in work, spiritual wellbeing, decreased burnout and compassion fatigue.

McSherry (2006, pp. 914-915) writes of the importance of spirituality being recognised at the organisational level; "If spirituality has a prominent feature within an organization then there will be investment in staff and resources, which in turn, will lead to improvements or better standards of spiritual care. In addition, these organizations may recognize a need for continuing professional development and research in the area to evaluate and advance practice".

Fisher and Brumley (2008) examined Spiritual Wellbeing in the Workplace, using the SHALOM measurement. They found that the beliefs of worldview of staff influenced spiritual wellbeing ideals, which in turn influence lived experience. In about ten percent of staff, there was spiritual dissonance for those with high ideals that did not match their lived experience, which affected their experience of the workplace.

Spiritual health in the workplace may also be related to training for staff to support their spiritual care of others; "Education is a way of raising professional carers' awareness of spirituality and promoting confidence in practice" (Byrne, 2007, p. 124). Research relating to spiritual care training includes that provided for spiritual care practitioners in ICU (Elliot Rodriguez, 2011), exploration of why spiritual care is infrequent in end-of-life settings (Balboni et al., 2013), a general overview of training (Lemmer, 2010), or a call for training (Egan et al., 2014), particularly in the aged care psychiatry setting (Lawrence et al., 2008). In the medical profession, Anandarajah (2008) reported on the development of models for teaching spiritual care in medicine.

Links between spiritual care and overall wellbeing

There is very little on how spiritual care is linked with overall wellbeing. Some articles refer to spiritual health or spiritual wellbeing as a concept, others to spirituality. This concept is then placed in relationship with illness or treatment experiences such as prognosis in cancer (Seyedrasooly et al., 2014), palliative care (Evans & Ume, 2012; Puchalski et al., 2014; Rabow & Knish, 2015), dementia care (Goodall, 2009) or mothers of children in cancer care (Bastani, 2014). Spirituality may be considered a component of quality of life, however this review did not include this search term.

Introducing the connection between spirituality and health, Puchalski et al. (2014, p. 642) writes that, "Data indicate that a focus on spirituality improves patients' health outcomes, including quality of life. Conversely, negative spiritual and religious beliefs can cause distress and increase the burdens of illness".

How do Spiritual Care and Chaplaincy staff report their activities?

Spiritual Care activities may be reported internally via documentation in medical records (paper or electronic), or externally via published research. This section of the review addresses both aspects and incorporates both published peer reviewed literature, and a range of grey literature sources including conference presentations. It addresses some of the concerns that spiritual care staff have with documentation, and issues arising in developing appropriate and reflective systems for reporting. A summary of existing reporting and documentation formats are found in Appendix 4.

Reporting of Spiritual Care Activities

Ethical Concerns with Documentation and Reporting

Charting is seen as problematic in spiritual care and numerous ethical issues are considered. With chaplaincy arising from a tradition that has the confessional as a core practice, there are understandable concerns about confidentiality and fears of transgressing trust following vulnerable conversations (Handzo & Wintz; McCurdy, 2012). Carey et al (2015) question, 'If I were this patient, what would I want disclosed to healthcare teams? How much should chaplains report in collaborative and multi-disciplinary environments?'

Documenting pastoral interactions may be seen as counter to the essence of pastoral practice: "As reported by the investigator in 2006, Baroody, Faber, Capps, Madison, Cusick and others have warned that spiritual care must not follow disciplines that objectify their practices, because it is not possible or even ethical to do so in matters of the spirit" (Gleason, 2013, p. 46).

Glenister (2011) outlines a number of concerns with the practice of charting for pastoral care practitioners, largely in comparison with existing charting formats of other healthcare practitioner groups. He questions chaplaincy professionalism, and reflects upon the 'nebulous' language of pastoral reporting that has resonance with the work of chaplains. He also questions how a patient might receive the notes if they were to read them. He concludes in wondering if a "more formal, interchangeable form of documentation and assessment might help in professionalising our role" (Glenister, 2011, p. 3). And also a wish to ensure that such reporting maintains the unique identity of chaplains as valuable and essential in the clinical environment.

There is a strong call for further research and evidence-based practice, and spiritual care is deemed evidence-based if chaplains are engaging with research literature and/or utilising measurement tools. A study of 773 chaplains showed that 35% (civilian), 52% (Veterans Affairs), 53% (Department of Defence) of chaplains reporting using measurement tools in their practice. A discussion of barriers to tool use included time, awareness of measures, access to measures, leadership support and seeing them as not appropriate for chaplain use. Scales most in use have been developed for use in the military context (George Fitchett et al., 2014).

Further concerns are related to misrepresentation of patient spirituality in care plans (Kevern et al., 2013). Most hospitals capture identifiers of religion in their patient history as the most commonly gathered spirituality-related data, but this really doesn't have depth of meaning without further engagement. There is the danger of generalization (Glenister, 2011). Even with spiritual assessment tools in place, practitioners may use these with varying degrees of care and competence. Further, individuals bring their own bias to the use of tools, depending upon their own experience of spirituality and religious connection.

There is also a problem of ‘translation’. A small study, in which 19 chaplains were interviewed, found translation challenges occurred in justifying the role to patients and families, determinations of what constitutes a "productive" employee, and effective collaboration with other members of the health care team (Cramer, Tenzek, & Allen, 2013).

So why chart?

Even with these concerns, charting is important in terms of professionalism, accountability, and communication with and relationship to other healthcare providers. One nurse writes, “…in this hospital Chaplains are allowed to chart but when I got here I realized they had all stopped charting so Chaplaincy is invisible. I think Chaplains have to be aware of themselves not only providing direct care to patients but providing, umm, presence in the hospital for staff as well and to be teachers to the whole staff what spiritual care is…” (Cavendish, 2007, p. 96).

Another speaks to the need for evidence based practice, “If spiritual treatments are to be recommended in secular settings, then their place and relevance need to be established. Although there is an emphasis in modern health services on so-called holistic care, the secular nature of health services means that the need or desire for such care on the part of patients and their families cannot be assumed. Thus, here we not only need evidence of effectiveness of spiritual and religious treatments but we also require data on their acceptability, the populations in which they are effective, exactly how they are effective and how they should be delivered” (Candy, 2012, p. 14).

“It seems likely that spiritual and religious experiences remain very personal. It is important therefore to continue to explore how they might be met to adopt a person-centred approach both to tailoring any intervention to individual need and making sure that it is available at appropriate times. Moreover, assessment tools alone may not be the best method to assess need in this area of care. Rather, need may be identified as a result of an interpersonal exploration in a non-judgemental and facilitating approach” (Candy, 2012, p. 14).

And how is it done?

Massey and others developed a 100-item taxonomy of chaplaincy to assist in the definition of outcomes and interventions in a palliative care setting. The team reviewed published inventories of chaplain activities and grouped these into ‘interventions’, ‘intended effects’ and ‘methods’. These were reviewed by focus groups and subject to further review before determining inter-rater reliability (Massey et al., 2015).

In forty-four top rated hospitals in the US, a brief survey indicated that standard practice is for chaplains to have access to medical charts and electronic records and to write in medical charts. There were no credentialing requirements (Goldstein, Marin, & Umpierre, 2011).

Pastoral care practitioners and researchers have utilised a range of methods to record their interactions with patients and subsequent outcomes. Montoyne & Calderone (2010) describe a brief history of pastoral intervention reporting, and outline a two-year study that concludes that chaplain interventions are often more related to chaplain orientation than patient need. Three forms of data collection were formed: patient needs, chaplain interventions and patient outcomes into an online database, however outcomes were noted by the chaplain and so do not therefore reflect the inner experience of the patient. Only a small number of chaplains were included in the study. Future research design calls for less reliance on chaplain self-reporting, including self-reporting by patients, and use of anchoring vignettes.

Another system of recording has drawn upon the WHO Pastoral Intervention codings. The development and utility of the WHO Pastoral Intervention codings is discussed in detail in Carey & Cohen (2014). The research outlines difficulties with terminology, whether staff used codings, and whether these were complete or incomplete. The authors recommend a revision of existing codes to be more inclusive of the variety of formats of pastoral, spiritual and religious care.

Grey Literature

A search was made in google to find articles and presentations relating to chaplaincy documentation, charting and progress notes, gleaning PowerPoint presentations, conference proceedings and online articles.

More concerns…

Many articles speak to the difficulty of charting; knowing what is appropriate to include in chart notes, what to communicate to other staff members and how to articulate chaplaincy's unique contribution to healthcare (Sergent, 2014). Bolejack (2012) acknowledges the struggle of recording, asking: "How does a chaplain enter a visit without an agenda when there is a form to be completed at the end of that visit? How to suspend judgment when clinicians are expected to solve 'problems'? How to report the spiritual in the clinical record"?

He writes on the inherent tension within spiritual care reporting, that "Spiritual care is not a science; yet, the spiritual caregiver must function and communicate in a clinical environment. And, this must be done without adopting the language & practice of the scientist *to the sacrifice of* the interpersonal and the mystery of the very nature of the "spiritual" (Bolejack, 2012, p. 2).

Mather (2012) observes charting in its various forms, articulating the simplistic, 'I was there', to a chaplaincy specific page in notes (that only chaplains are likely to see), to avoiding charting altogether. She suggests that charting should reflect the unique perspective that chaplains hold of wholeness, within a context that separates individuals into parts in order to heal. Peery (2008) writes on the system utilised at his medical centre, which incorporates a 5-point model.

While there are many concerns, many speak of the importance of charting, commonly commenting along the lines of, "If it isn't charted, it didn't happen" (Bolejack, 2012; Burkhart, Coglianese, & Kaelin, 2011; Hull, 2011; Ruff, 1996). "Many pastoral care professionals believe that presence and relationship are the alpha and omega of their work…. They hold that pastoral care cannot be measured; that to attempt it would be almost an affront to God… We say beware. Those who shun accountability should not be surprised if they are first in line for budget cuts" (Yanofchick, 2009, in Donovan, ND.).

Pastoral practitioners may make a range of errors in documentation, as listed by Donovan (ND.) and Bolejack (2012). These include confusing assessment with interventions, tools or goals, simplifying emotions or interactions to a checklist, simplifying the complexity of pastoral care, or reducing a person to membership with their faith tradition (Donovan, ND.). Further errors include lack of documentation of follow up or referral, vague, unclear or incorrect wording and lack of individualization (Bolejack, 2012).

Again, so why?

Burkhart et al (2011) eloquently emphasises the important outcomes of documentation:

“Documentation has taken on a new meaning. It is no longer just ‘a requirement’. …Today, documentation is the essential means to both indicate and help create the integration of pastoral care into healthcare. For chaplains, documentation demonstrates and measures the impact of spiritual care on patient outcomes. Documentation is also a process of data collection for research to indicate more effective pastoral and patient care and thus determine valuable resource allocation like number of staff chaplains, number of shifts covered, and prioritization of chaplain time and energy” (Burkhart, Coglianese, et al., 2011).

Schmidt (2015, p. 2) also outlines the significance of documentation, citing a case example of one brief interaction and follow up a year later. “…It demonstrated the importance of clear and accurate documentation in the medical records by all members of the team, including chaplains and spiritual practitioners”.

Whitaker & Tuttle (2006, p. 1) also speak to why we must chart; “Pastoral care is such a “soft,” value laden, narrative driven discipline that chaplain observations and interventions are often difficult to chart. However, chaplain progress notes should document pastoral care and interpret the patient’s spiritual concerns to the line staff and treatment team. Additionally, charting helps chaplains think about the clinical implications of their role, and structure their task accordingly. The progress note can be an effective supervisory tool to track the operational and clinical performance of the chaplain staff”. They outline a project that introduced and integrated the use of progress notes by chaplaincy staff.

Henager (2008) also states that documentation is important because it articulates what chaplains do, and the professional notes are in view of the interdisciplinary team. He considers both performance and productivity, and his system incorporates Assessment, Interventions and Outcomes.

One chaplain surveyed pastoral care documentation at major hospitals and subsequently a standard of practice for all chaplains. “When access to patients' medical records was questioned at his institution, Rabbi H. Rafael Goldstein undertook a systematic survey of pastoral care access/documentation at major hospitals in the US, partnering with co-authors Deborah Marin, MD, and Mari Umpierre, PhD. The findings not only helped bring about change for the chaplains at The Mount Sinai Hospital but suggest a *de facto* standard of practice for pastoral care among top hospitals, potentially useful to all chaplains” (Ehman, 2011, p. 1).

Hilsman (2009) reminds readers of some core assumptions relating to documentation: that charting is an art, that charts are legal documents, that medical staff do read notes, that patients do access their chart, that confidentiality promotes self-disclosure, assessment is a partnership, recorded assessment consolidates spiritual care responsibility and that legibility is essential.

Conclusion

This review has outlined research pertaining to pastoral or spiritual care and chaplaincy in terms of interventions, measures, outcomes and relationships.

The spiritual care role depends upon the setting in which the practitioner is located. Spiritual Care professionals attend the care needs of patients, their families and staff members. They perform assessments to determine spiritual and religious needs, and participate in interdisciplinary care meetings. In their role, spiritual practitioners use a range of skills including listening, presence, narrative, facilitation, counselling and advocacy.

Spiritual health is measured via a range of tools. These address spirituality, well-being, spiritual/religious coping, spiritual needs, spiritual history, spiritual locus of control, spiritual distress, spiritual pain, beliefs and values, spiritual experience, and spiritual maturity.

In the literature, spiritual care 'outcomes' may refer to religious coping, enrolment in hospice, increased mental well-being, assistance in decision making, change in depression scores, patient's qualitative experience, quality of life, support for family members, patient satisfaction and more. The question arises as to how we are best to evaluate spiritual outcomes in ways that are meaningful not only to spiritual care professionals and volunteers, but also to hospital administrators and funding bodies.

In general, quantitative patient satisfaction studies have found chaplaincy has a positive effect. Spiritual care has been associated with increases in; positive religious coping, enrolments into hospice care, family satisfaction in a ICU setting, scores in mental wellbeing, quality of life, recommendations of hospital, and overall satisfaction with healthcare. These studies have also found spiritual care is associated with a reduction in depression scores and negative religious coping,

Quantitative studies have shown that spiritual care professionals provide listening presence, discernment of values and beliefs in decision making, motivation for rehabilitation, emotional support, and help in coping with illness.

Spiritual care professionals do not work in isolation. Referrals to spiritual care are largely provided by nursing staff or self-referral. Most referrals are initiated when patients are dying, where there is trauma, or there is need religious or spiritual support. Referrals can depend upon the religiosity or spirituality of the referring health care practitioner. Various health professionals see spiritual care staff as part of an interdisciplinary team, and value their contribution to health care.

Spiritual care staff report their interactions internally via medical records, and externally via published research. The profession has engaged in much discussion about the ethics of reporting, and has also acknowledged the difficulties in articulating what exactly spiritual care does. However, charting is necessary as part of an ongoing communication process with other healthcare staff, providing evidence of presence, accountability and integration with the larger team.

Spiritual Care professionals are engaging more in research, and are understanding the need to articulate outcomes and efficacy in their practice. Further research is called for to continue to build a body of evidence in support of this valued offering in the health care system.

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Appendix 1 - *Research relating to spiritual care interventions and outcomes*

Author	Research Type	Abstract
Ai and McCormick (2010)	Case Studies	Chaplains serving in the health care context provide a ministry to dying patients of inestimable worth as they comfort patients in the last chapter of the journey by being present, listening, and caring. Chaplains also play another important role, helping patients clarify ways in which their beliefs and values might influence health care decisions. This paper reviewed the current trends of spiritual diversity alongside the aging of a large Baby Boomer cohort. Chaplains may be challenged as they participate in the decision-making process, or as they support families who make decisions about the care of loved ones nearing the end of life. Many of those who seek health care and comfort as the end of life approaches will bring a startling diversity of nonbelief, beliefs, and diverse religious and spiritual practices. This pattern of diversity will profoundly affect patients' decision-making around end-of-life issues. Case studies are used to illustrate possibilities for the chaplain's role at the bedside in the face of such diversity. The dimensional information of a new scale is presented for chaplains to assess diverse afterlife beliefs. As chaplains renew their studies of the world's living religions, they will be better equipped to serve the needs of this large and spiritually diverse population.
Balboni et al. (2013)	Survey	PURPOSE: To determine factors contributing to the infrequent provision of spiritual care (SC) by nurses and physicians caring for patients at the end of life (EOL). PATIENTS AND METHODS: This is a survey-based, multisite study conducted from March 2006 through January 2009. All eligible patients with advanced cancer receiving palliative radiation therapy and oncology physician and nurses at four Boston academic centers were approached for study participation; 75 patients (response rate = 73%) and 339 nurses and physicians (response rate = 63%) participated. The survey assessed practical and operational dimensions of SC, including eight SC examples. Outcomes assessed five factors hypothesized to contribute to SC infrequency. RESULTS: Most patients with advanced cancer had never received any form of spiritual care from their oncology nurses or physicians (87% and 94%, respectively; P for difference = .043). Majorities of patients indicated that SC is an important component of cancer care from nurses and physicians (86% and 87%, respectively; P = .1). Most nurses and physicians thought that SC should at least occasionally be provided (87% and 80%, respectively; P = .16). Majorities of patients, nurses, and physicians endorsed the appropriateness of eight examples of SC (averages, 78%, 93%, and 87%, respectively; P = .01). In adjusted analyses, the strongest predictor of SC provision by nurses and physicians was reception of SC training (odds ratio [OR] = 11.20, 95% CI, 1.24 to 101; and OR = 7.22, 95% CI, 1.91 to 27.30, respectively). Most nurses and physicians had not received SC training (88% and 86%, respectively; P = .83). CONCLUSION: Patients, nurses, and physicians view SC as an important, appropriate, and beneficial component of EOL care. SC infrequency may be primarily due to lack of training, suggesting that SC training is critical to meeting national EOL care guidelines.
Bay (2008)	RCT	This randomized controlled study measured the effect of chaplain interventions on coronary artery bypass graft (CABG) patients over time. One hundred sixty-six CABG patients, received pre- and post-surgery testing at 1 month and 6 months with four instruments. Five chaplain visits were made to the intervention group, the control group received none. Comparison scores for anxiety, depression, hope, positive and negative religious coping, and religious coping styles were analyzed. Significant difference was found between groups in positive religious coping (PRC) (p = .023) and negative religious coping (NRC) (p = .046) scores over time. PRC increased in intervention group, decreased in the control group while NRC decreased in intervention group and increased in the control group. Demographics were comparable between groups. Moderate chaplain visits (average total visits time, 44 min) may be effective in helping CABG patients increase positive religious coping and decrease negative religious coping. [PUBLICATION ABSTRACT]
Cadge et al. (2008)	Review	Over the past 25 years, the Joint Commission for the Accreditation of Healthcare Organizations has changed its guidelines regarding religious/spiritual care of hospitalized patients to increase attention concerning this aspect of hospital-based care. Little empirical evidence assesses the extent to which hospitals relied on hospital chaplains as care providers during these years. This study investigates (1) the extent of

		chaplaincy service availability in US hospitals between 1980 and 2003; (2) the predictors of having chaplaincy services in 1993 and 2003; and (3) the change in the magnitude of these predictors between years. This study examines the presence or absence of chaplaincy or pastoral care services in hospitals using the American Hospital Association Annual Survey of Hospitals (ranging from 4,946-6,353 hospitals) in 1980-1985, 1992-1993, and 2002-2003. Between 54% and 64% of hospitals had chaplaincy services between 1980 and 2003, with no systematic trend over this period. In 1993 and 2003, hospital size, location, and church affiliation were central factors influencing the presence of chaplaincy services. Smaller hospitals and those in rural areas were less likely to have chaplaincy services. Church-operated hospitals were much more likely to have chaplaincy services; but between 1993 and 2003, church-operated hospitals were more likely to drop chaplaincy services than to add them. Not-for-profit hospitals were more likely than investor-owned hospitals to add chaplaincy services. Changes to Joint Commission for the Accreditation of Healthcare Organizations policies about the religious/spiritual care of hospitalized patients between 1980 and 2003 seem to have had no discernible effect on the fraction of US hospitals that had chaplaincy services. Rather, characteristics of hospitals, their surroundings, and their religious affiliations influenced whether they provided chaplaincy services to patients.
Caldeira (2012)	Reflection	AIM: This article aims to explore spiritual care in the neonatal care environment in addition to highlighting the importance of spiritual leadership of a health team in that context. BACKGROUND: Neonatal care is an ethically demanding and stressful area of practice. Babies and families require spiritual needs to be recognized in the context of holistic care. Literature around spiritual leadership is explored to nurture workplace spirituality. EVALUATION: Analysis of a range of sources provides a theoretical reflection on spiritual leadership and spiritual care in neonatal care settings. KEY ISSUES: The literature identifies that the carers should consider carefully on how care given may affect the infant and family. Themes relating to the baby's and family's spiritual needs and those of the staff in this area are identified. Spiritual leadership by the manager will provide support to the staff and help spiritual need to be met in this area of practice. CONCLUSION: Spiritual needs should be acknowledged within neonatal care whether these are of babies, families or the team itself. Implications for nursing management Managers have responsibility to ensure that spiritual care is carried out for babies and their families and to care for the team as spiritual leaders.
Calder (2011)	Mixed Methods	PURPOSE: The aim of this article is to present findings from an Australian study that explored road trauma survivors' perceptions of spirituality and of a hospital-based pastoral care service throughout their inpatient rehabilitation. All participants had experienced severe orthopaedic injury. METHOD: A mixed-method research design was used. The survey method elicited demographic, pastoral care contact and hospitalisation data. It included the Posttraumatic Growth Inventory (PTGI; Tedeschi and Calhoun 1996) and an adapted World Health Organisation Pastoral Intervention (WHO 2002) coding schema (Constitution of the World Health Organisation, basic documents, supplement. 45 ed.). An interview method was used to elicit information about participants' prior and current experiences of faith and spirituality, expectations, and experiences of the pastoral care service, and perceptions of the role of pastoral care in their rehabilitation. RESULTS: A thematic analysis of both quantitative and qualitative data identified nine core themes of supportive pastoral care. Pastoral care was seen as a valued and supportive intervention. Participants who completed the PTGI reported at least some degree of posttraumatic growth. CONCLUSIONS: Further research is recommended to examine the role and efficacy of pastoral care that is integral to road trauma recovery support.
Candy (2012)	Systematic Review	BACKGROUND: As terminal disease progresses, health deteriorates and the end of life approaches, people may ask "Why this illness? Why me? Why now?" Such questions may invoke, rekindle or intensify spiritual or religious concerns. Although the processes by which these associations occur are poorly understood, there is some research evidence for associations that are mainly positive between spiritual and religious awareness and wellness, such as emotional health. OBJECTIVES: This review aimed to describe spiritual and religious interventions for adults in the terminal phase of a disease and to evaluate their effectiveness on well-being. SEARCH METHODS: We searched 14 databases to November 2011, including the Cochrane Central Register of Controlled Trials and MEDLINE. SELECTION CRITERIA: We included randomised controlled trials (RCTS) if they involved adults in the terminal phase of a disease and if they evaluated outcomes for an intervention that had a spiritual or religious component. Primary outcomes were well-being, coping with the disease and quality of life. DATA COLLECTION AND ANALYSIS: In accordance with the inclusion criteria, two review authors independently screened citations. One review author extracted data which was then checked by another review author. We considered meta-analysis for studies with comparable characteristics. MAIN RESULTS: Five RCTs (1130 participants)

		were included. Two studies evaluated meditation, the others evaluated multi-disciplinary palliative care interventions that involved a chaplain or spiritual counsellor as a member of the intervention team. The studies evaluating meditation found no overall significant difference between those receiving meditation or usual care on quality of life or well-being. However, when meditation was combined with massage in the medium term it buffered against a reduction in quality of life. In the palliative care intervention studies there was no significant difference in quality of life or well-being between the trial arms. Coping with the disease was not evaluated in the studies. The quality of the studies was limited by under-reporting of design features. AUTHORS' CONCLUSIONS: We found inconclusive evidence that interventions with spiritual or religious components for adults in the terminal phase of a disease may or may not enhance well-being. Such interventions are under-evaluated. All five studies identified were undertaken in the same country, and in the multi-disciplinary palliative care interventions it is unclear if all participants received support from a chaplain or a spiritual counsellor. Moreover, it is unclear in all the studies whether the participants in the comparative groups received spiritual or religious support, or both, as part of routine care or from elsewhere. The paucity of quality research indicates a need for more rigorous studies.
Carlson et al. (2005)	Mixed Methods Study	BACKGROUND: Oregon's Death with Dignity Act (ODDA), which legalized physician-assisted suicide (PAS) for terminally ill individuals, was enacted in 1997. Eighty-six percent of the 171 patients who have died by PAS were enrolled in hospice. OBJECTIVE: To survey hospice chaplains regarding their views on the ODDA and experiences working with patients who request PAS. DESIGN: Single, anonymous, mailed survey. SUBJECTS: All chaplains affiliated with one of Oregon's 50 hospices. RESULTS: Fifty of 77 hospice chaplains whom we identified (65%) returned the survey. Forty-two percent of respondents opposed the ODDA and 40% supported it. Over half of respondents had, in the previous 3 years, worked with a patient who had made an explicit request for assisted suicide. Conversation with patients around PAS focused on the role of faith and spirituality in this decision, reasons for wanting hastened death, and family concerns or reactions to PAS. Chaplains did not feel that they had a strong influence on the patient's decisions about PAS (mean score of 4 on a 0-10 scale), though three chaplains reported a patient who withdrew their request for PAS because of the chaplain's involvement. Chaplains reported provision of a nonjudgmental presence helped the relationship with the patient. CONCLUSION: Oregon hospice chaplains are divided in their views on legalized PAS, but primarily see their role to deliver support to patients no matter what the patient's final decision regarding PAS.
Cheng et al. (2015)	Pilot study	Religious factors are known to contribute to treatment adherence in different patient populations, and religious coping has been found to be particularly important to adolescents dealing with chronic diseases. Adherence to prescribed treatments slows disease progression and contributes to desirable outcomes in most patients, and, therefore, adherence-promoting interventions provided by chaplains could be beneficial to various patient populations. The current article describes a pilot study to test the feasibility of a theoretically and empirically based chaplain intervention to promote treatment adherence for adolescents with CF. Cognitive interviews were conducted 24 with adolescents with CF, and content analysis was used to identify themes, which informed revision of the intervention protocol. The authors thought that presenting the methods and results of this pilot study would be helpful for chaplains who want to conduct intervention research. The results indicated that the proposed intervention was acceptable and feasible to deliver in hard copy or an electronic platform.
Clemm et al. (2015)	Mixed Methods Study	OBJECTIVE: The overall aim of this study was to discover how chaplains assess their role within ethically complex end-of-life decisions. METHODS: A questionnaire was sent to 256 chaplains working for German health care institutions. Questions about their role and satisfaction as well as demographic data were collected, which included information about the chaplains' integration within multi-professional teams. RESULTS: The response rate was 59%, 141 questionnaires were analyzed. Respondents reported being confronted with decisions concerning the limitation of life-sustaining treatment on average two to three times per month. Nearly 74% were satisfied with the decisions made within these situations. However, only 48% were satisfied with the communication process. Whenever chaplains were integrated within a multi-professional team there was a significantly higher satisfaction with both: the decisions made ($p = 0.000$) and the communication process ($p = 0.000$). SIGNIFICANCE OF THE RESULTS: Although the results of this study show a relatively high satisfaction among surveyed chaplains with regard to the outcome of decisions, one of the major problems seems to reside in the communication process. A clear integration of chaplains within multi-professional teams (such as palliative care teams) appears to increase the satisfaction with the communication in ethically critical situations.

Cooper-White (2006)	Reflection	This article summarizes the method of pastoral assessment and theological reflection detailed in Shared Wisdom: Use of the Self in Pastoral Care and Counseling, 2005, with particular attention to pastoral counselors' countertransference or intersubjective "use of the self" as a tool for empathic understanding of clients. A model of multiplicity of mind, subjectivity, and God is advanced in contrast to more traditional views. The article concludes with an appeal for messiness, complexity, and kenosis in both psychology and theology.
Cramer and Tenzek (2012)	Framework Analysis	Hospitals and hospice organizations who are hiring chaplains to provide spiritual care for terminally ill patients post online job advertisements with specific qualifications and communication skills that applicants should possess. An examination of job advertisements can uncover trends in credentials and responsibilities expected of hospice chaplains. Results of a framework analysis of 71 hospice chaplain job advertisements indicated that 44% of chaplain job advertisements did not require chaplain applicants to have completed clinical pastoral education (CPE) and 41% did not required ordination and/or endorsement from a recognized denomination. Only 37% of hiring organizations required or preferred professional certification. Furthermore, patient support (70%), ambassadorship (54%), team collaboration (52%), and interfaith proficiency (46%) were the communication skills that advertisements tended to emphasize. This article focuses on how the study findings reflect ongoing challenges for the chaplain occupational group on its path to professionalization.
Egan et al. (2014)	Qualitative study	A timely discussion of an oft neglected area of the care of dialysis patients. ABSTRACT: AIM: People with chronic kidney disease have a shortened life expectancy and carry a high symptom burden. Research suggests that attending to renal patients' spiritual needs may contribute to an improvement in their quality of life. The aim of this qualitative study was to investigate the provision of spiritual care in New Zealand renal units from the perspective of specialists. METHODS: The study followed a generic qualitative approach and included semi-structured interviews with specialists recruited from New Zealand's ten renal centres. RESULTS: Five specialist doctors and nine specialist nurses were recruited for interviews. Understandings of spirituality were broad, with most participants having an inclusive understanding. Patients' spiritual needs were generally acknowledged and respected though formal spiritual assessments were not done. Consideration of death was discussed as an often-unexamined need. The dominant position was that the specialists did not provide explicit spiritual care of patients but there was some ad hoc provision offered through pre-dialysis educators, family meetings, Māori liaison staff members and the efforts of individuals. Chaplains were well used in some services. Participants had received no pre and little in-service training or education in spiritual care. Suggestions for improvements included in-service training, better utilization of chaplaincy services and training in advance care planning. CONCLUSION: Most participants indicated they would attempt to provide some form of spiritual care, either directly or by referring the patient to appropriate services. However, participants generally demonstrated a lack of confidence in addressing a patient's spiritual needs.
Ellis et al. (2013)	Observational study	Previous studies have recognized the importance of hospitalized primary care patients' spiritual issues and needs. The sources patients consult to address these spiritual issues, including the role of their attending physician, have been largely unstudied. We sought to study patients' internal and external resources for addressing spiritual questions, while also exploring the physician's role in providing spiritual care. Our multicenter observational study evaluated 326 inpatients admitted to primary care physicians in four Midwestern hospitals. We assessed how frequently these patients identified spiritual concerns during their hospitalization, the manner in which spiritual questions were addressed, patients' desires for spiritual interaction, and patient outcome measures associated with spiritual care. Nearly 30% of respondents (referred to as "R/S respondents") reported religious struggle or spiritual issues associated specifically with their hospitalization. Eight-three percent utilized internal religious coping for dealing with spiritual issues. Chaplains, clergy, or church members visited 54% of R/S respondents; 94% found those visits helpful. Family provided spiritual support to 45% of R/S respondents. Eight percent of R/S respondents desired, but only one patient actually received, spiritual interaction with their physician, even though 64% of these patients' physicians agreed that doctors should address spiritual issues with their patients. We conclude that inpatients quite commonly utilize internal resources and quite rarely utilize physicians for addressing their spiritual issues. Spiritual caregiving is well received and is primarily accomplished by professionals, dedicated laypersons, or family members. A significantly higher percentage of R/S patients' desire spiritual interaction with their physician than those who actually receive it.

Fisher and Brumley (2008)	Survey	OBJECTIVE: The aim of the study was to investigate nurses' and pastoral carers' spiritual wellbeing (SWB) and how it relates to their workplace. DESIGN: The study design was a survey of total populations in selected health care services. SETTING: The setting was a public and a private hospital in a regional setting, and three hospices in major cities which had a religious affiliation. SUBJECTS: Responses were obtained from 154 (11%) nurses and 8 (6%) carers in the public hospital, 40 (7%) nurses in the private hospital and 16 nurses and 7 carers (17%) in the three hospices. MAIN OUTCOME MEASURE: The Spiritual Health and Life Orientation Measure (SHALOM) was used to provide insights into staff ideals for spiritual wellbeing, as well as their lived experiences in relating with self, others, the environment and/ or God. The nurses' and carers' perceptions about how well clients are supported in these four domains of spiritual wellbeing in their workplace were also explored. RESULTS: The beliefs and worldview of health care staff influence their ideals for spiritual wellbeing (SWB) to a greater extent than age, gender, or workplace setting. These ideals markedly impact on their lived experiences which reflect their SWB. Ten percent of these staff showed spiritual dissonance in more than one of the four domains of SWB. The major finding of this study is the influence that nurses' and carers' personal experience has on the level of help they thought clients received from the services offered in their workplace. Those who are more fulfilled in relationships, with themselves, others, the environment and/or God, believe that clients receive greater help in these areas from the services provided in their workplace. CONCLUSION: SHALOM is a useful indicator of four domains of SWB of health care staff who project their own lived experience onto the way they see clients having their spiritual wellbeing nurtured. This has implications for health care staff in the workplace.
Fitchett et al. (2011)	Pilot Study	CONTEXT: Pediatric palliative care (PPC) specialists recognize spiritual care as integral to the services offered to seriously ill children and their families. Little is known about how PPC programs deliver spiritual care. OBJECTIVE: The goal of this pilot study was to begin to describe the role of professional chaplains in established PPC programs in children's hospitals in the United States. METHODS: In 2009 we surveyed 28 PPC programs to ascertain how spiritual care was provided. Of the 19 programs with staff chaplains who met additional study criteria, we randomly selected eight to study in detail. Based on interviews with the medical director and staff chaplain in these eight programs, we qualitatively delineated chaplains' roles in PPC. RESULTS: Twenty-four of the 28 surveyed programs (86%) reported having a staff chaplain on their clinical team. Among the 8 interviewed programs, there was considerable variation in how chaplains functioned as members of interdisciplinary teams. Despite these variations, physicians and chaplains agreed that chaplains address patients' and families' spiritual suffering, improve family-team communication, and provide rituals valued by patients, families, and staff. CONCLUSIONS: Our survey of these PPC programs found that spiritual care was typically provided by staff chaplains, and our interviews indicated that chaplains appeared to be well-integrated members of these teams. Further research is needed to evaluate how well the spiritual needs of patients, families, and staff are being met, and the organizational factors that support the delivery of spiritual care in children's hospitals.
Fitchett, Emanuel, Handzo, Boyken, and Wilkie (2015)	Literature Review	BACKGROUND: Dignity Therapy (DT), an intervention for people facing serious illness, focuses on dignity conservation tasks such as settling relationships, sharing words of love, and preparing a legacy document for loved ones. Research on DT began more than a decade ago and has been conducted in 7 countries, but a systematic review of DT research has not been published. METHODS: Using a PubMed search with key terms of 'dignity therapy', 'dignity psychotherapy', 'Chochinov', and 'dignity care', we found 29 articles on DT and retained 25 after full-text review. RESULTS: Of these, 17 articles representing 12 quantitative studies establish that patients who receive DT report high satisfaction and benefits for themselves and their families, including increased sense of meaning and purpose. The effects of DT on physical or emotional symptoms, however, were inconsistent. CONCLUSIONS: Conclusions point to three areas for future research on DT, to determine: (1) whether the DT intervention exerts an impact at a spiritual level and/or as a life completion task; (2) how DT should be implemented in real world settings; and (3) if DT has an effect on the illness experience within the context of not only the patient, but also the family and community. Building on this body of DT research, investigators will need to continue to be sensitive as they involve participants in DT studies and innovations to facilitate the generation and delivery of legacy documents to participants near the end of life.
Galek et al. (2007)	Survey	Given the increasing importance of understanding how healthcare workers interact with the principal person designated to meet patients' spiritual needs - the chaplain - the current study provides an inter-disciplinary perspective of the role of chaplains (and spirituality) in patients'

		emotional, physical, and spiritual health. The study surveyed a randomly selected national sample of hospital directors in four disciplines: medicine (n = 278), nursing (n = 230), social services (n = 229), and pastoral care (n = 470). Participants rated the importance of referring patients to chaplains for four different areas: pain/depression, anxiety/anger, treatment issues, and loss/death/meaning. Results revealed significant differences in referral patterns for type of hospital, professional discipline, the hospital's religious affiliation, and self-reported spirituality. Results are discussed in relation to historical views of spirituality and religion within the different disciplines.
Galek et al. (2009)	Observational	Understanding referral patterns to chaplains is essential not only to ensure proper patient treatment, but also to assist chaplains seeking to expand the range of patient situations in which they are called to intervene. Information about more than 58,000 chaplain visits was documented during the first two years (2005-2006) of the Metropolitan Chaplaincy Study. Data from 15,655 of these visits, which were made in response to referrals (26.9% of all visits), were analyzed in the present study. Seventy-eight percent of referral requests were met within the same day, and 94.9% of requests and were met within 2 days. Nurses were the most frequent source of referrals to chaplains (45.0%), followed by self-referrals from patients or requests from their family members (30.3%), with the remainder coming from a variety of hospital disciplines. The most common reason for referrals was that patients requested to see a chaplain. Other relatively common reasons for referrals were problems or issues related to illness or treatment, and end-of-life issues, concerns about death and the death of patients, with reasons for referrals differing by referral source. The most common reason for referrals among professional staff was that patients were feeling bad or in pain, followed by medical issues, and end-of-life issues. Patient and family referrals usually involved positive patient affect, whereas staff referrals usually involved negative patient affect.
George (2010)	Reflection	ABSTRACT: Human suffering speaks differently to different lived contexts. In this paper, I have taken a metaphoric representation of suffering, Ishvara, from the lived context of a Hindu immigrant woman to show that suffering is experienced and expressed within one's lived context. Further, a dominant narrative from her world is presented to show that the same lived context can be a resource for spiritual care that could reconstruct her world that has fallen apart with a suffering experience. Having argued that suffering is experienced and expressed within one's lived context, and that lived context could be a resource, in this paper I present that spiritual care is an intervention into the predicaments of human suffering and its mandate is to facilitate certain direction and a meaningful order through which experiences and expectations are re-joined. Finally, I observe that spiritual care is an engagement between the lived context where suffering is experienced and the spiritual experience and orientation of the caregiver.
Grossoehme (2015)	Editorial	Editorial – No abstract available
Guthrie (2014)	Reflection	This article offers health care chaplains a pastoral response to moral distress experienced by health care professionals. The article offers a broad definition, explores its impact on health care professionals, and looks at various interventions to ameliorate its effects. The article goes on to clarify the concept of moral distress by differentiating it from the experience of moral dilemmas, and looking closer at the aspects of initial and reactive distress. After defining moral distress, the article explores two clinical models that create a better context to understand the phenomenon. Finally, the article proposes a pastoral response to moral distress from the integration of the five functions of pastoral care: "healing," "sustaining," "guiding," "reconciling," and "nurturing" based on the work of William Clebsch, Charles Jaekle, and Howard Clinebell. The author then applies the pastoral response to moral distress by illustrating the outcome of a scenario with a critical care nurse.
Halm et al. (2000)	Reflection	Providing a healing environment for patients requires focusing on the mind, body, and spirit. When a significant number of patients reported not having an easy time finding someone to talk to about their concerns, emotional support, as a dimension of care, became a top priority in one hospital system. Since implementation of concentrated pastoral care interventions, patients' perceptions of the spiritual support provided to them during hospitalization have improved.
Handzo et al. (2008)	Review	The current study analyzes data from 30,995 chaplain visits with patients and families that were part of the New York Chaplaincy Study. The data were collected at 13 healthcare institutions in the Greater New York City area from 1994-1996. Seventeen chaplain interventions were recorded: nine that were religious or spiritual in nature, and eight that were more general or not specifically religious. Chaplains used religious/spiritual interventions, alone or in conjunction with general interventions, in the vast majority of their visits with patients and families. The types of

		interventions used varied by the patient's medical status to some degree, but the pattern of interventions used was similar across faith group and medical status. The results document the unique role of the chaplain as a member of the healthcare care team and suggest there is desire among a broad range of patients, including those who claim no religion, to receive the kind of care chaplains provide.
Handzo et al. (2015)	Discussion	Health care in industrialized countries is increasingly focused on outcomes (Department of Health, 2013). The reasons for this focus are complex and contextualized but adopting this new currency is a central driver in each of the health care systems in the countries we represent (Australia, Canada, England, Scotland, and the United States). Primary to this focus is the recognition that the cost of health care as currently provided is unsustainable. The funding of interventions and care providers is increasingly evaluated against the data for the efficacy of the intervention; that is, does it serve one or more valued outcomes? Valued outcomes are generally those that reduce costs, improve the quality of care and patient experience often measured by patient satisfaction, and=or enhance health outcomes often measured by cure rates, reduced lengths of stay, or reduced use of health care resources (Berwick, Nolan, & Wittington, 2008). There is increasing evidence that patient experience contributes along with patient safety and clinical effectiveness in influencing outcomes (Doyle, Lennox, & Bell, 2013). Whereas chaplains have generally been exempt from this economic focus, increasingly the value of chaplaincy care is being evaluated on these criteria.
Hirschmann (2011)	Discussion & Reflection	This article describes the structure and goals of chaplaincy groups in an inpatient psychiatric setting. The article also explores their therapeutic benefits for patients and offers a theological framework for thinking about the conversations that unfolded in these groups. The article focuses in particular on the value of discussion and reflection in a group setting, the significance of receiving and answering questions, and the experience of participating in a simple ritual to name hopes.
Hsiao, Chien, Wu, Chiang, and Huang (2010)	Cross-sectional design	AIM: This paper is a report of an exploration of the association of spiritual health with clinical practice stress, depressive tendency and health-promoting behaviours among nursing students. BACKGROUND: Several studies in western countries have demonstrated an association between spirituality and health. Spirituality-related research in eastern countries, however, is still in its infancy. METHODS: A cross-sectional design was adopted and structured questionnaires were used for data collection. We adopted the Probability Proportional to Size cluster sampling method to recruit nursing students in senior grades. Data were collected in 2005 using the Spiritual Health Scale, Perceived Clinical Practice Stress Scale, Beck Depression Inventory-II and Health Promotion Behaviours Scale. RESULTS: A total of 1276 nursing students with an average age of 20·1 years (SD =1·6 years) participated in the study. Spiritual health was negatively associated with clinical practice stress (r= 0·211, P < 0·001) and depressive tendency (r= -0·324, P < 0·001) and positively associated with health-promoting behaviours (r =0·611, P < 0·001). Using hierarchical regression analysis to control for demographic factors, spiritual health was found to be an important predictive factor for clinical practice stress, depressive tendency and health-promoting behaviours. CONCLUSION: These results are consistent with research findings from western countries. Educators should develop strategies to address nursing students' spiritual health. This may help nursing students to manage their stress, to reduce depressive symptoms and to enhance health-promoting behaviours.
Hughes et al. (2007)	Case Study and Discussion	Banner Good Samaritan Medical Center is a 650-bed quaternary care facility located in the south-western United States. It contains 12 intensive care units (ICUs) and experience a high patient acuity as a result of being a referral center for Arizona. The palliative care nurse practitioner and ICU clinical nurse specialist collaborated with the chaplain to entrance his visibility in the ICUs and to incorporate the philosophy of spiritual care assessments in the ICU.
Hummel et al. (2008)	Review	An electronic search was conducted on Medline for the years 1980-2005 identified 101 journal articles with the words "spiritual care" in their title, the majority of which were from nursing journals. Content analysis performed on 28 articles judged to be most relevant yielded 250 unique descriptions of interventions, which were subsequently consolidated to form 66 discrete interventions. Twenty five professional chaplains rated each item on the degree to which they considered it to be part of providing spiritual care to patients. The patterns of correlations among the interventions suggested that most of the items fell into ten major categories and a few minor categories, with only two of the major categories being explicitly religious in nature. The article discusses these categories within the context of pastoral care.
Iacono (2011)	Discussion	No abstract available
Jacobs (2008)	Discussion	No abstract available

James et al. (2011)	Qualitative study	OBJECTIVE: To provide an in-depth exploration regarding the Registered Nurse (RN) and Healthcare Chaplains' (HCC) perspective of the role of the family support person (FSP) during family witnessed resuscitation (FWR). RESEARCH METHODOLOGY/DESIGN: A phenomenological approach utilising in-depth interviews were undertaken outside of the work setting. A purposive sample of 4 RN's and 3 HCC were recruited from four sites within the United Kingdom. All interviews were tape recorded, transcribed verbatim and analysed utilising Husserl's framework. FINDINGS: Seven key themes emerged which included assessment, managing choice, navigating the setting, on-going commentary, coming to terms with death, conflicts and support. CONCLUSIONS: This study has provided an insight regarding the intense clinical engagement associated with the role of the FSP and highlighted the importance of this role for family member's optimal care and support. It is vital that adequate professional development is instigated and that support mechanisms are in place for those health care professionals (HCP) undertaking this role in order to help family members through this difficult experience.
Jankowski et al. (2011)	Review	The current article reviews the research conducted in the United States on the clinical practice of chaplains with patients and family members, referrals to chaplains, patient satisfaction with chaplaincy services, and the limited literature on the efficacy of chaplain interventions. It also discusses the methodological limitations of studies conducted on these topics and makes suggestions for improving future chaplaincy research. The authors conclude that past studies have not adequately defined chaplain interventions, nor sufficiently documented the clinical practice of chaplains, and that more and better designed studies are needed to test the efficacy of chaplaincy interventions. The authors recommend that chaplains generate research-based definitions of spirituality, spiritual care, and chaplaincy practice; and that more research be conducted to describe the unique contributions of chaplains to spiritual care, identify best chaplaincy practices to optimize patient and family health outcomes, and test the efficacy of chaplaincy care.
Jansen and van Saane (2006)	Discussion	Life stories are in the middle of interest of pastoral care workers. Life stories are told stories about our life; in these stories a process of meaning construction is taking place. In the first part of this article the authors describes the concept of life stories from different theoretical and disciplinary perspectives, like sociology, psychology and oral history. From the perspective of pastoral care the analysis of life stories is important. To analyse life stories different instruments of methods can be used. Some instruments focus on the formal structure of the story, other instruments analyse the language that is used and so on. Each instrument gives a particular analysis, which leads to specific pastoral care intervention. The second part of this article is about an empirical study on the different effects of different analyzing instruments, done by students of pastoral care and ministry. The study shows the utility of being conscious of the different effects and possibilities for pastoral care when using different analyzing instruments of life stories.
Johnson et al. (2014)	Prospective cohort study	OBJECTIVES: Spiritual distress is common in the ICU, and spiritual care providers are often called upon to provide care for patients and their families. Our goal was to evaluate the activities spiritual care providers' conduct to support patients and families and whether those activities are associated with family satisfaction with ICU care. DESIGN: Prospective cohort study. SETTING: Three hundred fifty-bed tertiary care teaching hospital with 65 ICU beds. SUBJECTS: Spiritual care providers and family members of patients who died in the ICU or within 30 hours of transfer from the ICU. INTERVENTIONS: None. MEASUREMENTS AND MAIN RESULTS: Spiritual care providers completed surveys reporting their activities. Family members completed validated measures of satisfaction with care and satisfaction with spiritual care. Clustered regression was used to assess the association between activities completed by spiritual care providers and family ratings of care. Of 494 eligible patients, 275 family members completed surveys (response rate, 56%). Fifty-seven spiritual care providers received surveys relating to 268 patients, completing 285 surveys for 244 patients (response rate, 91%). Spiritual care providers commonly reported activities related to supporting religious and spiritual needs (≥ 90%) and providing support for family feelings (90%). Discussions about the patient's wishes for end-of-life care and a greater number of spiritual care activities performed were both associated with increased overall family satisfaction with ICU care ($p < 0.05$). Discussions about a patient's end-of-life wishes, preparation for a family conference, and total number of activities performed were associated with improved family satisfaction with decision-making in the ICU ($p < 0.05$). CONCLUSIONS: Spiritual care providers engage in a variety of activities with families of ICU patients; several are associated with increased family satisfaction with ICU care in general and decision-making in the ICU specifically. These

		findings provide insight into spiritual care provider activities and provide guidance for interventions to improve spiritual care delivered to families of critically ill patients. (Crit Care Med 2014; 42:1991–2000)
K. J. Flannelly et al. (2009)		The study was designed to assess the degree to which two sets of measures about chaplains' visits with patients predicted patients' perceptions that their spiritual/religious needs and their emotional needs were met by the chaplain. The first set consisted of seven items about the chaplain's demeanor during the visit. The second set measured patient satisfaction with seven aspects of the chaplain's care, including specific interventions. Overall, the latter items were more highly correlated with, and were better predictors of patients' perceptions that the chaplain met both their spiritual/religious needs and their emotional needs than were the demeanor items. The findings indicate the usefulness of measuring the effectiveness of specific chaplain interventions. The authors discuss that effectiveness measures may be more useful that patient satisfaction measures for assessing pastoral care.
K. Piderman et al. (2010)	Survey	OBJECTIVE: To identify patient expectations regarding chaplain visitation, characteristics of patients who want to be visited by a chaplain, and what patients deem important when a chaplain visits. PARTICIPANTS AND METHODS: Three weeks after discharge, 4500 eligible medical and surgical patients from hospitals in Minnesota, Arizona, and Florida were surveyed by mail to collect demographic information and expectations regarding chaplain visitation. The survey was conducted during the following time periods: Minnesota participants, April 6 until April 25, 2006; Arizona participants, October 16, 2008, until January 13, 2009; Florida participants, October 16, 2008, until January 20, 2009. Categorical variables were summarized with frequencies or percentages. Associations between responses and site were examined using [chi] (2) tests. Multivariate logistic regression was used to assess the likelihood of wanting chaplain visitation on the basis of patient demographics and perceived importance of reasons for chaplain visitation. RESULTS: About one-third of those surveyed responded from each site. Most were male, married, aged 56 years or older, and Protestant or Catholic. Of the respondents, nearly 70% reported wanting chaplain visitation, 43% were visited, and 81% indicated that visitation was important. The strongest predictor of wanting chaplain visitation was denomination vs no indicated religious affiliation (Catholic: odds ratio [OR], 8.11; 95% confidence interval [CI], 4.49-14.64; P<.001; evangelical Protestant: OR, 4.95; 95% CI, 2.74-8.91; P<.001; mainline Protestant: OR, 4.34; 95% CI, 2.58-7.29; P<.001). Being female was a weak predictor (OR, 1.48; 95% CI, 1.05-2.09; P=.03), as was site. Among the reasons given by respondents for wanting chaplain visitation, the most important were that chaplains served as reminders of God's care and presence (OR, 4.37; 95% CI, 2.58-7.40; P<.001) and that they provided prayer or scripture reading (OR, 2.54; 95% CI, 1.53-4.20; P<.001). CONCLUSION: The results of this study suggest the importance medical and surgical patients place on being visited by a chaplain while they are hospitalized. Those who valued chaplains because they reminded them of God's care and presence and/or because they prayed or read scripture with them were more likely to desire a visit. Our results also suggest that being religiously affiliated is a very strong predictor of wanting chaplain visitation.
K. Piderman et al. (2014)	RCT	OBJECTIVE: The aim of this randomized controlled trial for patients with advanced cancer receiving radiation therapy was to determine the effect of a multidisciplinary intervention on spiritual quality of life (QOL) at the end of the intervention (week 4) and at two follow-up time points (weeks 26 and 52) METHODS: One hundred thirty-one persons were randomized to either the intervention or control (forms only) groups. The intervention included six 90-min in-person sessions based on the physical, emotion, social, and spiritual domains of QOL. Three sessions included the spiritual component. Caregivers were present for four sessions, one which included a spiritual component. Ten follow-up phone calls were made to the patients in the intervention group during the 6-month follow-up period. Patients completed the Functional Assessment of Cancer Therapy: General Scale, the Linear Analog Self-Assessment which includes an assessment of spiritual QOL, and the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp) at enrolment, and weeks 4, 27, and 52. RESULTS: Following the intervention, the intervention group demonstrated improved spiritual QOL on the FACIT-Sp, whereas the spiritual QOL of the control group decreased, resulting in significant mean changes between groups (total score: 1.7 vs. -2.9; $p<0.01$; meaning/peace subscale: 1.0 vs.-3.5; $p<0.01$; faith subscale: 3.1 vs. -1.7; $p=0.04$). CONCLUSIONS: The results indicate that a multidisciplinary intervention which includes a spiritual component can maintain the spiritual QOL of patients with advanced cancer during radiation therapy.

Kevern and Hill (2015)	Retrospective study	AIM: To analyse quantitative changes in patient well-being concurrent with chaplaincy interventions in a retrospective study of a group of Primary Care centres in Sandwell and West Birmingham, United Kingdom. BACKGROUND: Anecdotal evidence suggests that support from trained Primary Care Chaplains may be particularly useful for those with subclinical mental health issues; it can reduce the tendency to 'medicalise unhappiness' and is a positive response to patients with medically unexplained symptoms. However, to date there has been no published research attempting to quantify their contribution. METHOD: Data were gathered from a group of Primary Care Centres, which make use of a shared Chaplaincy service. Demographic data and pre-post scores on the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) were collected for patients who had attended consultations with a Chaplain. These were subjected to tests of statistical significance to evaluate the possible contribution of chaplaincy to patient well-being along with possible confounding variables. FINDINGS: a substantial improvement in WEMWBS scores (mean = 9 points, BCa 95% CI [7.23, 10.79], P = 0.001) post-intervention. The improvement in scores was highest for those with initially lower levels of well-being. There is therefore evidence that chaplaincy interventions correlate with an improvement of holistic well-being as measured by a WEMWBS score. A prospective study on a larger scale would provide more detailed information on the interaction of possible variables. Further study is also required to evaluate the implications of this result for patient outcomes and GP resources. The efficacy of Primary Care Chaplaincy is under-researched and difficult to measure. This paper represents the first attempt to quantify a measurable improvement in the well-being of patients who are referred to the service.
Kevin J. Flannelly et al. (2012)	Review	BACKGROUND: Medicine has long acknowledged the role of chaplains in healthcare, but there is little research on the relationship between chaplaincy care and health outcomes. The present study examines the association between chaplaincy services and end-of-life care service choices. METHODS: HealthCare Chaplaincy purchased the AHA survey database from the American Hospital Association. The Dartmouth Atlas of Health Care database was provided to HealthCare Chaplaincy by The Dartmouth Institute for Health Policy & Clinical Practice, with the permission of Dartmouth Atlas Co-Principal Investigator Elliot S. Fisher, M.D., M.P.H. The Dartmouth Atlas of Health Care is available interactively on-line at http://www.dartmouthatlas.org/. Patient data are aggregated at the hospital level in the Dartmouth Atlas of Health Care. IRB approval was not sought for the project because the data are available to the public through one means or another, and neither database contains data about individual patients, i.e. all the variables are measures of hospital characteristics. We combined and analyzed data from the American Hospital Association's Annual Survey and outcome data from The Dartmouth Atlas of Health Care in a cross-sectional study of 3,585 hospitals. Two outcomes were examined: the percent of patients who (1) died in the hospital, and (2) were enrolled in hospice. Ordinary least squares regression was used to measure the association between the provision of chaplaincy services and each of the outcomes, controlling for six factors associated with hospital death rates. RESULTS AND DISCUSSION: The analyses found significantly lower rates of hospital deaths (beta=.04, p<.05) and higher rates of hospice enrolment (beta=.06, p<.001) for patients cared for in hospitals that provided chaplaincy services compared to hospitals that did not. CONCLUSIONS: The findings suggest that chaplaincy services may play a role in increasing hospice enrolment. This may be attributable to chaplains' assistance to patients and families in making decisions about care at the end-of-life, perhaps by aligning their values and wishes with actual treatment plans. Additional research is warranted.
Kevin J. Flannelly, Galek, and Handzo (2005)	Observational	Although a substantial number of studies have documented the spiritual needs of hospitalized patients, few have examined the prevalence of these needs and even fewer have attempted to measure the extent to which they are being met. Since chaplains are the primary providers of spiritual care, chaplains' visits to patients would appear to provide a reasonable proxy for the latter. Based on the limited data available, we estimated the proportion of hospitalized patients who are visited by chaplains. Our analyses yielded a point estimate of 20% (+/- 10%), depending on a number of factors.
Kevin J. Flannelly, Galek, Bucchino, et al. (2005)	Survey Study	A national survey of hospital directors of medicine, nursing, social services, and pastoral care was conducted to obtain opinions about the importance of various chaplain roles. On average, directors in all four disciplines rated three of the seven chaplain roles (grief and death, prayer, and emotional support) to be "very" to "extremely" important. Most of the others roles were rated between "moderately" and "very" important (religious services-rituals consultation and advocacy, community liaison-outreach). Several significant differences were found among disciplines,

		as physicians rated the importance of most chaplains' roles lower than did other disciplines. Overall, there was a tendency for directors in smaller hospitals, especially those with fewer than 100 patients, to place less importance on most of the chaplain roles investigated here.
Koenig (2012)	Discussion	No abstract available
Kopacz (2013)	In-depth interviews	The value of enhanced spiritual wellbeing has largely been overlooked as part of suicide prevention efforts in Veterans. The aim of this qualitative study is to examine the clinical pastoral care services provided by VA Chaplains to Veterans at-risk of suicide. This study was conducted using in-depth interviews with five Chaplains affiliated with a medical center located in upstate New York. This study was able to show that some at-risk individuals do actively seek out pastoral care, demonstrating a demand for such services. In conclusion, a pastoral care framework may already exist in some clinical settings, giving at-risk Veterans the opportunity to access spiritual care.
Koszycki (2010)	RCT	This pilot trial evaluated the efficacy of a multifaith spiritually based intervention (SBI) for generalized anxiety disorder (GAD). Patients meeting DSM-IV criteria for GAD of at least moderate severity were randomized to either 12 sessions of the SBI (n511) delivered by a spiritual care counselor or 12 sessions of psychologist-administered cognitive-behavioural therapy (CBT; n511). Outcome measures were completed at baseline, post-treatment, and 3-month and 6-month follow-ups. Primary efficacy measures included the Hamilton Anxiety Rating Scale, Beck Anxiety Inventory, and Penn State Worry Questionnaire. Data analysis was performed on the intent-to-treat sample using the Last Observation Carried Forward method. Eighteen patients (82%) completed the study. The SBI produced robust and clinically significant reductions from baseline in psychic and somatic symptoms of GAD and was comparable in efficacy to CBT. A reduction in depressive symptoms and improvement in social adjustment was also observed. Treatment response occurred in 63.6% of SBI-treated and 72.3% of CBT-treated patients. Gains were maintained at 3-month and 6-month follow-ups. These preliminary findings are encouraging and suggest that a multifaith SBI may be an effective treatment option for GAD. Further randomized controlled trials are needed to establish the efficacy of this intervention.
Kruizinga et al. (2013)	Interview	BACKGROUND: It is widely recognized that spiritual care plays an important role in physical and psychosocial well-being of cancer patients, but there is little evidence based research on the effects of spiritual care. We will conduct a randomized controlled trial on spiritual care using a brief structured interview scheme supported by an e-application. The aim is to examine whether an assisted reflection on life events and ultimate life goals can improve quality of life of cancer patients. METHODS/DESIGN: Based on the findings of our previous research, we have developed a brief interview model that allows spiritual counsellors to explore, explicate and discuss life events and ultimate life goals with cancer patients. To support the interview, we created an e-application for a PC or tablet. To examine whether this assisted reflection improves quality of life we will conduct a randomized trial. Patients with advanced cancer not amenable to curative treatment options will be randomized to either the intervention or the control group. The intervention group will have two consultations with a spiritual counsellor using the interview scheme supported by the e-application. The control group will receive care as usual. At baseline and one and three months after randomization all patients fill out questionnaires regarding quality of life, spiritual wellbeing, empowerment, satisfaction with life, anxiety and depression and health care consumption. DISCUSSION: Having insight into one's ultimate life goals may help integrating a life event such as cancer into one's life story. This is the first randomized controlled trial to evaluate the role of an assisted structured reflection on ultimate life goals to improve patients' quality of life and spiritual well-being. The intervention is brief and based on concepts and skills that spiritual counsellors are familiar with, it can be easily implemented in routine patient care and incorporated in guidelines on spiritual care.
L. Carey and Newell (2007)	Mixed Methods	OBJECTIVE: To explore the role of health care chaplains in providing pastoral care to patients, their families and clinical staff considering decisions to withdraw life support. METHODS: Quantitative data were obtained retrospectively from a survey of 327 Australian health care chaplains (both staff and volunteer chaplains) to initially identify chaplaincy participation in withdrawal-of-life-support issues, Qualitative data were subsequently obtained by in-depth interview of 100 of the surveyed chaplains and thematically coded using the World Health Organization Pastoral Intervention (WHO-PI) codings to explore chaplains' roles. RESULTS: Over half the staff chaplains surveyed (57%) and over a quarter of the volunteer chaplains (28%) indicated that they had been involved with patients or their families in withdrawal-of-life-support decisions, Over a third of staff chaplains (37%) and 16% of volunteer chaplains had assisted clinical staff concerning withdrawal-of-life-support issues. The qualitative data revealed that chaplains were involved with patients, their families and clinical staff at all levels of pastoral intervention, including

		"pastoral assessment", "pastoral ministry", "pastoral counselling and education" and "pastoral ritual and worship". The specific nature of chaplaincy involvement varied considerably depending on the idiosyncratic issues faced by patients, families and clinical staff. These activities indicated that pastoral care could be provided for the support and benefit of patients, their families and clinical staff facing a complex bioethical issue. CONCLUSIONS: Through a variety of pastoral interventions, some chaplains (mostly staff chaplains) were involved in assisting patients, their families and clinical staff concerning withdrawal-of-life-support issues and thus helped ensure an holistic approach within the health care context. Given this involvement and the future potential benefit for patients, families and clinical staff, there is a need to develop continuing education and research on pastoral care and chaplaincy services.
Lawrence et al. (2008)	Mixed methods study	This survey investigates the role and views of NHS spiritual advisors across the United Kingdom on the provision of pastoral care for elderly people with mental health needs. The College of Health Care Chaplains provided a database, and questionnaires were sent to 405 registered NHS chaplains/spiritual advisors. The response rate was 59%. Quantitative and qualitative analyses were carried out. Spiritual advisors describe their working patterns and understanding of their roles within the modern NHS, and their observations of the level of NHS staff awareness of the importance of spiritual issues in the mental health care of older adults. They provide insights into possible negative and positive perceptions of their roles at a service level, and contribute suggestions of topics relevant to shared education between pastoral care and clinical services. This survey further highlights ethical and operational dimensions at the point of integration of the work of spiritual advisors and multidisciplinary teams.
Lichter (2013)	Discussion	Research is an essential mark of any clinical profession, and the quality of research denotes the discipline's development. Research on chaplaincy services spans nearly a half century, and it is growing and improving. Clinical health care researchers are strengthening the chaplaincy profession by providing evidence that spiritual issues need to be addressed or health outcomes falter.
Lloyd-Williams et al. (2004)	Mixed methods study	Spiritual care is an integral part of palliative care and if asked, most members of a palliative care team would state they address spiritual issues. The majority of hospices have support from a chaplain. This study was to determine the roles of chaplains within hospices and to look at their levels of stress. A questionnaire containing both open and closed questions was sent to chaplains working within hospices in the UK. The questionnaire enquired about number of sessions, specific roles of chaplain, whether they were members of the multidisciplinary team and their sources of internal support. Stress was measured on a 10-point Likert scale and the GHQ12. One hundred and fifteen questionnaires were returned, with a 72% response rate. The majority (62%) defined their denomination as Church of England and Free Church (24%); 71% of respondents had parish commitments in addition to their hospice role. Roles were predominantly defined as spiritual care of patients and staff (95%) and bereavement support of relatives (76%) and 75% regularly attended the multidisciplinary meetings. Senior medical and nursing staff and other chaplains were perceived as providing most support. Median Likert score for stressfulness was 5, and 23% scored at or above the threshold on the GHQ12 for identifiable psychological morbidity. Clear role definition was associated with less perceived stress whereas the provision of bereavement support was associated with statistically significant increased perceived stress. The role of a chaplain within a hospice is varied and this study suggests that the provision of training and formal support is to be recommended.
Lyndes et al. (2008)	Qualitative Study	To date, the field of health care chaplaincy has little information about what constitutes "quality spiritual care." A qualitative study of four focus groups in New York, Illinois, Arizona, and California was conducted to gather preliminary information about how health care chaplains' experience and understand "quality" and "quality improvement" in spiritual care. The study revealed that many chaplains feel a tension inherent in the task of measuring spiritual care services; how does one evaluate interactions that may seem ineffable? The study also enumerated chaplains' creative efforts, often shaped by institutional contexts and cultures, to address these difficulties in measuring spiritual services. To encourage local efforts to improve the quality of spiritual care and increase chaplains' contributions to improving health care quality, this article focuses on these context-specific projects and ideas. It also makes general recommendations aimed at promoting the development of promising practices for the field.
Lyndes et al. (2012)	Qualitative Study	To date, the field of health care chaplaincy has had little information about how pediatric palliative care (PPC) programs meet the spiritual needs of patients and families. We conducted a qualitative study consisting of surveys of 28 well-established PPC programs in the United States

		followed by interviews with medical directors and professional chaplains in 8 randomly selected programs among those surveyed. In this report, we describe the PPC chaplain activities, evidence regarding chaplain integration with the PPC team, and physician and chaplain perspectives on the chaplains' contributions. Chaplains described their work in terms of processes such as presence, while physicians emphasized outcomes of chaplains' care such as improved communication. Learning to translate what they do into the language of outcomes will help chaplains improve health care colleagues' understanding of chaplains' contributions to care for PPC patients and their families. In addition, future research should describe the spiritual needs and resources of PPC patients and families and examine the contribution chaplains make to improved outcomes for families and children facing life-limiting illnesses.
Maddox (2012)	Discussion	This article is a response to a case study describing the spiritual care provided over an 18-month period by an experienced professional chaplain at a prominent cancer center to a woman undergoing stem cell transplantation following therapy for relapsed leukemia. The author, a professional chaplain at another cancer center, reviews the spiritual assessment, interventions, and outcomes presented by the attending chaplain. The author's comments are organized about the chaplain's characterization of the seven parts of the patient's spiritual profile: courage, meaning, psychological issues, courage and growth in facing spiritual/religious struggle, rituals, community, and authority. The purpose of the response is to engage those inside and outside the discipline of health care chaplaincy in a conversation about the specific aspects of providing spiritual care in health care settings.
Marin et al. (2015)	Prospective study	This prospective study investigated the relationship between chaplain visits and patient satisfaction, as measured by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Press Ganey surveys from 8,978 patients who had been discharged from a tertiary care hospital. Controlling for patients' age, gender, race, ethnicity, language, education, faith, general health status, and medical conditions, chaplain visits increased the willingness of patients to recommend the hospital, as measured by both the HCAHPS survey (regression coefficient = 0.07, $p < .05$) and the Press Ganey survey (0.11, $p < .01$). On the Press Ganey survey, patients visited by chaplains were also more likely to endorse that staff met their spiritual needs (0.27, $p < .001$) and their emotional needs (0.10, $p < .05$). In terms of overall patient satisfaction, patients visited by a chaplain were more satisfied on both the Press Ganey survey (0.11, $p < .01$) and on the HCAHPS survey (0.17, $p < .05$). Chaplains' integration into the healthcare team improves patients' satisfaction with their hospital stay.
McClung et al. (2006)	Discussion	Current accreditation and professional standards in health care reflect the importance of chaplaincy services to patients, families, the health care team, and the organization. However, inadequate spiritual assessment, the organizational structure and climate, and lack of understanding of the chaplain's role can prevent these services from being optimally utilized. Chaplains are trained extensively to provide spiritual care to patients, families, and staff as they assist in meeting the organization's mission to provide patient-centered care. Spiritual assessment is a tool for nurses to recognize patient's needs for spiritual intervention and chaplain referral. By collaborating with chaplains, nurses can help develop an organizational infrastructure capable of timely responsiveness to patients' spiritual needs.
McCormick and Hildebrand (2015)	Qualitative study	Improving the provision of spiritual care to hospitalized patients requires understanding what patients look for from a hospital chaplain, and why. This qualitative study uses grounded theory methodology to analyze data from 25 interviews with adult patients and/or adult family members who received spiritual care in a large tertiary care hospital. Analysis reveals three key themes in chaplaincy care: the attributes valued in the chaplain's *presence*, the elements necessary to form *relationship* with the chaplain, and the role of the chaplain in helping patients to discover and express *meaning* in their experiences. The authors weave these three themes together into a grounded theory and propose an assessment model that incorporates psychological theory about human motivation, faith development, and the development of autonomy. An understanding of the proposed assessment model can guide chaplain interventions and benefit all members of the clinical care team.
Morgan (2010)	Literature review and interviews	The Mental Capacity Act (2005) and the amendments to the Mental Health Act (1983) in 2007 - which came into effect in 2007 and 2009, respectively, in England and Wales - made it a statutory duty for the NHS and local authorities to refer to advocacy services. This is part of a growth in advocacy which coincides with an increase in literature on mental health and spirituality. Independent advocates and spiritual care coordinators (or chaplains) provide expressions of advocacy. For Independent Mental Capacity Advocates, social, cultural and spiritual factors are influential. Research involved a literature review on the history of advocacy and interviews with over 30 advocates, chaplains and service

		users and subsequent grounded theory analysis. The attested ''rediscovery of the spiritual dimension in health and social care'' was supported by overlaps in the practices of advocates and chaplains. This highlighted shortcomings around the professionalization of advocacy in relation to culture and spirituality.
Mundle (2014)	Case study	This case study addresses the importance of "life review" with regard to the crucial and demanding emotional work of older adults in palliative care who are experiencing the existential pain of grief and loneliness near the end of life. Drawing upon the reflexive field notes of one Spiritual Health Practitioner this case study describes the spiritual needs and care for an older deafened and emotionally-inhibited man in a long-term palliative care unit who described himself by saying "all I am is stories." By illuminating the concept of "embodied listening" in response to stories told by a patient with significant hearing loss this case study differentiates the uses of voice and of body in therapeutic relationships.
Nichols (2013)	Surveys	This project examines the effects of spiritual care on chronically ill and aging populations and those who care for them by studying the development of a comprehensive Pastoral Care Program at Episcopal Communities & Services (ECS), a non-profit that owns two Continuing Care Retirement Communities (CCRC) in Southern California (in 2010 ECS operated three communities). The study includes the vision, methodology, and specific steps taken to implement this spiritual care program and methods to measure its efficacy. Data is analyzed from satisfaction surveys conducted the year before the program's introduction and surveys taken 2 and 4 years after the institution of the Pastoral Care Program, along with anecdotal findings. Results indicated that spiritual awareness and satisfaction increased throughout the resident population after the Pastoral Care Program's establishment and that satisfaction levels continued to improve as the program developed over time. This study suggests that spiritual support (both religious and nonreligious) is a vital factor in well-being and quality of life at the end of life and that transdisciplinary palliative care is needed in long-term care settings to address spiritual and psychosocial needs.
Nieuwsma et al. (2014)	Evaluation study	BACKGROUND: Recognizing that clergy and spiritual care providers are a key part of mental health care systems, the Department of Veterans Affairs (VA) and Department of Defence (DoD) jointly examined chaplains' current and potential roles in caring for veterans and service members with mental health needs. OBJECTIVE: Our aim was to evaluate the intersection of chaplain and mental health care practices in VA and DoD in order to determine if improvement is needed, and if so, to develop actionable recommendations as indicated by evaluation findings. DESIGN: A 38-member multidisciplinary task group partnered with researchers in designing, implementing, and interpreting a mixed methods study that included: 1) a quantitative survey of VA and DoD chaplains; and 2) qualitative interviews with mental health providers and chaplains. PARTICIPANTS: Quantitative: the survey included all full-time VA chaplains and all active duty military chaplains (n = 2,163 completed of 3,464 invited; 62 % response rate). Qualitative: a total of 291 interviews were conducted with mental health providers and chaplains during site visits to 33 VA and DoD facilities. MAIN MEASURES: Quantitative: the online survey assessed intersections between chaplaincy and mental health care and took an average of 37 min to complete. Qualitative: the interviews assessed current integration of mental health and chaplain services and took an average of 1 h to complete. KEY RESULTS: When included on interdisciplinary mental health care teams, chaplains feel understood and valued (82.8-100 % of chaplains indicated this, depending on the team). However, findings from the survey and site visits suggest that integration of services is often lacking and can be improved. CONCLUSIONS: Closely coordinating with a multidisciplinary task group in conducting a mixed method evaluation of chaplain-mental health integration in VA and DoD helped to ensure that researchers' assessed relevant domains and that findings could be rapidly translated into actionable recommendations.
O'Connor et al. (2012)	Ethnographic study	This is an ethnographic study exploring the role of emotion, images, and sacred texts in the spiritual reflection of non-chaplaincy health care professionals who offer spiritual care to their patients. Purposeful sampling of 20 health care professionals was employed. These non-chaplaincy professionals were interviewed and the researchers also kept field notes on the cultures in which they worked. Both interviews and field notes were transcribed and analyzed using the constant comparative method of data analysis. Findings indicate that emotion and images are the main doors that these professionals use to reflect spiritually on their practice of spiritual care. Sacred texts are the third door. Outcomes of the use of feelings and emotions in spiritual reflection are a deeper sense of peace, grounding and letting go, that is, transformation. Recommendations for collaboration with chaplains and further research are offered.

Orton (2008)	Discussion	This article provides a snap shot of the current position and recent developments in chaplaincy in health care settings particularly in England, Scotland, the United States of America and Australia in order to guide the emerging modernization agenda in the Australian context, and to assist the acceleration of the local adoption of best practice in pastoral care. Over all, the picture is one of change. As hospitals develop to meet new performance expectations services that work within the hospital system, such as chaplaincy and pastoral care, must also adapt. Rather than chaplaincy being discarded as marginal during these changes, recent research evidence supports the inclusion of pastoral care in holistic health care. Demographic changes also mean that pastoral care needs to have an emphasis on spiritual support if it is to respond to patients of other faith traditions or with secular beliefs.
Overton et al. (2014)	Case study	No abstract available
Parameshwaran (2015)	Qualitative	BACKGROUND: Of various spiritual care methods, mindfulness meditation has found consistent application in clinical intervention and research. "Listening presence," a chaplain's model of mindfulness and its trans-personal application in spiritual care is least understood and studied. AIM: The aim was to develop a conceptualized understanding of chaplain's spiritual care process based on neuro-physiological principles of mindfulness and interpersonal empathy. MATERIALS AND METHODS: Current understandings on neuro-physiological mechanisms of mindfulness-based interventions (MBI) and interpersonal empathy such as theory of mind and mirror neuron system are used to build a theoretical framework for chaplain's spiritual care process. Practical application of this theoretical model is illustrated using a carefully recorded clinical interaction, in verbatim, between chaplain and his patient. Qualitative findings from this verbatim are systematically analyzed using neuro-physiological principles. RESULTS AND DISCUSSION: Chaplain's deep listening skills to experience patient's pain and suffering, awareness of his emotions/memories triggered by patient's story and ability to set aside personal emotions, and judgmental thoughts formed intra-personal mindfulness. Chaplain's insights on and ability to remain mindfully aware of possible emotions/thoughts in the patient, and facilitating patient to return and re-return to become aware of internal emotions/thoughts helps the patient develop own intra-personal mindfulness leading to self-healing. This form of care involving chaplain's mindfulness of emotions/thoughts of another individual, that is, patient, may be conceptualized as trans-personal model of MBI. CONCLUSION: Chaplain's approach may be a legitimate form of psychological therapy that includes inter and intra-personal mindfulness. Neuro-physiological mechanisms of empathy that underlie Chaplain's spiritual care process may establish it as an evidence-based clinical method of care.
Pearce et al. (2012)	Quantitative Survey	PURPOSE: Spiritual care is an important part of healthcare, especially when facing the crisis of advanced cancer. Do oncology inpatients receive spiritual care consistent with their needs? When inconsistent, are there deleterious effects on patient outcomes? METHODS: Patients with advanced cancer (N = 150) were surveyed during their inpatient stay at a south-eastern medical center using validated instruments documenting spirituality, quality of life, mood, and satisfaction with care. Relationships between the receipt of less spiritual care than desired and patient outcomes were examined. RESULTS: Almost all patients had spiritual needs (91%) and the majority desired and received spiritual care from their healthcare providers (67%; 68%), religious community (78%; 73%), and hospital chaplain (45%; 36%). However, a significant subset received less spiritual care than desired from their healthcare providers (17%), religious community (11%), and chaplain (40%); in absolute terms, the number who received less care than desired from one or more sources was substantial (42 of 150). Attention to spiritual care would improve satisfaction with care while hospitalized for 35% of patients. Patients who received less spiritual care than desired reported more depressive symptoms [adjusted beta (SE) = 1.2 (0.47), p = 0.013] and less meaning and peace [adjusted beta (SE) = -2.37 (1.15), p = 0.042]. CONCLUSIONS: A substantial minority of patients did not receive the spiritual care they desired while hospitalized. When spiritual needs are not met, patients are at risk of depression and reduced sense of spiritual meaning and peace. Spiritual care should be matched to cancer patients' needs.
Piotrowski (2013)	Discussion	This article presents attempts to improve the quality of spiritual care offered to palliative care patients by educating nursing and other staff about spiritual screening with the goal of increasing referrals to a board certified chaplain. Attention to patients' spiritual identity and spiritual needs upon admission and throughout a hospitalization through either a formalized screening tool or provider awareness and sensitivity can

		assist patients in naming their needs, thus triggering a referral to a board certified chaplain or other spiritual counselor. Along with a spiritual care plan based upon assessment of spiritual needs and resources facilitates the healing process.
Puchalski et al. (2014)	Discussion	Two conferences, Creating More Compassionate Systems of Care (November 2012) and On Improving the Spiritual Dimension of Whole Person Care: The Transformational Role of Compassion, Love and Forgiveness in Health Care (January 2013), were convened with the goals of reaching consensus on approaches to the integration of spirituality into health care structures at all levels and development of strategies to create more compassionate systems of care. The conferences built on the work of a 2009 consensus conference, Improving the Quality of Spiritual Care as a Dimension of Palliative Care. Conference organizers in 2012 and 2013 aimed to identify consensus-derived care standards and recommendations for implementing them by building and expanding on the 2009 conference model of inter-professional spiritual care and its recommendations for palliative care. The 2013 conference built on the 2012 conference to produce a set of standards and recommended strategies for integrating spiritual care across the entire health care continuum, not just palliative care. Deliberations were based on evidence that spiritual care is a fundamental component of high-quality compassionate health care and it is most effective when it is recognized and reflected in the attitudes and actions of both patients and health care providers.
Risk (2013)	Case Study / Reflection	This article presents the case study of spiritual care for a patient suffering from Parkinson's disease who was referred to the chaplain in an out-patient depression research program. The chaplain's interventions were informed by an application of narrative theory, and the article demonstrates how this theory enabled the chaplain to help a patient develop new coping strategies for dealing with chronic disease. Using narrative theory, the chaplain assisted the patient to develop a new sense of identity as a spiritual, contingent self as the disease eroded his physical self and former life. The article includes a description of a patient's spiritual needs, chaplain interventions, and an outcomes measure of those interventions. The author argues that narrative theory provides chaplains with a language to identify and craft the unique intervention that spiritual care has in the life trajectory of this Parkinson's patient and other patients dealing with chronic illnesses.
Rosendahl et al. (2009)	Controlled trial	Effects of psychological as well as spiritual interventions on outcome in cardiac surgery have mostly been studied with a focus on pre-surgical interventions. Systematically controlled analyses of the effects of psychological and spiritual interventions depending on the patients' preference have not been performed so far, although these studies would help to assign patients to an adequate support. The By. Pass study is a bicenter, controlled trial of patients undergoing coronary bypass surgery and coronary bypass surgery combined with valve replacement surgery in 2 different German hospitals. Patients are assigned to 1 of 5 conditions, mainly according to their personal therapeutic preference: preference for psychological interventions (group 1), preference for spiritual interventions (group 2), or preference for no intervention (group 5). Patients who are open for any kind of intervention are randomly assigned either to psychological (group 3) or spiritual interventions (group 4). Six months before the start and 6 months after the end of the treatment phase, patients were assigned to the control groups. These were asked about their subjective preference (psychological, spiritual, no intervention, or no specific preference) as well but received no interventions. Patients will be enrolled from October 2006 to December 2009. The 6-month follow-up will be completed in July 2010.
Ross and Austin (2015)	Interviews	BACKGROUND: Spiritual care is an important element of holistic care but has received little attention within palliative care in end-stage heart failure. AIMS: To identify the spiritual needs and spiritual support preferences of end-stage heart failure patients/carers and to develop spiritual support guidelines locally. METHOD: Semi-structured interviews (totalling 47) at 3-monthly intervals up to 1 year with 16 end-stage heart failure patients/carers. Focus group/consultation with stakeholders. RESULTS: Participants were struggling with spiritual/existential concerns alongside the physical and emotional challenges of their illness. These related to: love/belonging; hope; coping; meaning/purpose; faith/belief; and the future. As a patient's condition deteriorated, the emphasis shifted from 'fighting' the illness to making the most of the time left. Spiritual concerns could have been addressed by: having someone to talk to; supporting carers; and staff showing sensitivity/taking care to foster hope. A spiritual support home visiting service would be valued. CONCLUSIONS: Our sample experienced significant spiritual needs and would have welcomed spiritual care within the palliative care package. Implications for nursing management Nurse managers could play a key role in developing this service and in leading further research to evaluate the provision of such a service in terms of its value to patients and other benefits including improved quality of life, spiritual wellbeing, reduced loneliness/isolation and a possible reduction in hospital admissions.

S. D. King (2012)	Case Study	This article offers a case study of a long-term chaplaincy care relationship between a woman with recurrent leukemia and an experienced oncology chaplain at a comprehensive cancer center. The case includes an extensive description of the encounters between the patient and the chaplain; a spiritual/religious assessment that includes a spiritual/religious profile and a portrait of the needs, interventions, and outcomes within the case; and a discussion of some key issues in the case, including what aspects regarding the overall care was healing. Although a number of issues were addressed, the author argues that the essence of the care and healing occurred through the faithful companioning of the chaplain. The author articulates an understanding of faithful companioning.
S. King (2011)	Case study	This article is a response by a long-term oncology chaplain to a case by another oncology chaplain. The author notes interventions key to the relationship and outcomes, highlights differences in chaplaincy styles, and summarizes significant outcomes that are common in oncology chaplaincy. The purpose of the response is to further demonstrate how chaplains think about and engage patients/families in chaplaincy care as well as to stimulate the reflective process of the readers of the case study.
Shields et al. (2015)	Discussion	OBJECTIVE: Distinguishing the unique contributions and roles of chaplains as members of healthcare teams requires the fundamental step of articulating and critically evaluating conceptual models that guide practice. However, there is a paucity of well-described spiritual assessment models. Even fewer of the extant models prescribe interventions and describe desired outcomes corresponding to spiritual assessments. METHOD: This article describes the development, theoretical underpinnings, and key components of one model, called the Spiritual Assessment and Intervention Model (Spiritual AIM). Three cases are presented that illustrate Spiritual AIM in practice. Spiritual AIM was developed over the past 20 years to address the limitations of existing models. The model evolved based in part on observing how different people respond to a health crisis and what kinds of spiritual needs appear to emerge most prominently during a health crisis. Results: Spiritual AIM provides a conceptual framework for the chaplain to diagnose an individual's primary unmet spiritual need, devise and implement a plan for addressing this need through embodiment/relationship, and articulate and evaluate the desired and actual outcome of the intervention. Spiritual AIM's multidisciplinary theory is consistent with the goals of professional chaplaincy training and practice, which emphasize the integration of theology, recognition of interpersonal dynamics, cultural humility and competence, ethics, and theories of human development. SIGNIFICANCE OF RESULTS: Further conceptual and empirical work is needed to systematically refine, evaluate, and disseminate well-articulated spiritual assessment models such as Spiritual AIM. This foundational work is vital to advancing chaplaincy as a theoretically grounded and empirically rigorous healthcare profession.
Snowden et al. (2012)	Mixed methods	Background summary
Snowden, Telfer, Kelly, Bunniss, and Mowat (2013b)	Mixed methods	Patient reported outcome measures (PROMs) are an increasingly popular and prevalent method of ascertaining the impact of an intervention in health. For example there are PROMs measuring the success of intervention in diabetes, surgery and mental health. There is currently no such measure of specialist spiritual care. This paper describes the development of the Lothian spiritual care PROM from the literature. It shows where the items within the PROM came from and how they fit with current spiritual care theory. The PROM that is constructed from this process is likely to be a valid measure of the impact of what chaplains do. A valid measure of specialist spiritual care is consistent with developing the evidence base for chaplaincy and could help service planning in a structured manner.
Snowden et al. (2013b)	Mixed methods	The Lothian PROM has shown us that chaplaincy benefitted all in this sample not just the faithful, religious or spiritual. However, this deduction arose from statistical analysis of tick box responses in the previous paper. Whilst this is a powerful finding we do not understand the deeper meaning of this in relation to how chaplains could better target their time, or better use the time they have with patients. What this paper adds: This paper adds depth and context to the findings in the previous paper. It analyses responses to the free text question: 'Please add any final comments you wish to make about how the chaplain's input affected you'. The results illuminate and explain not just the correlations established in the numerical analysis but also provide solid evidence that chaplains deliver person centred care. The importance of this observation to the NHS in particular cannot be overstated. Why this is important: The finding that the responses articulated person centred care is particularly valuable in light of:

		a) the policy imperative to deliver person centred care b) the growing recognition of the complexity of this agenda, and c) it's consistency with the findings from CCL discussed in the following papers in this special edition of SACH. How this impacts upon chaplaincy: The comments analysed here add explanatory depth to the statistical evidence of the impact of chaplaincy. They show the personal value of chaplaincy to a wide range of people. In particular they show the importance of having someone other than a clinician wholly present with people to be with them in testing times. KEY WORDS: Chaplaincy, health care, person centred care, impact of chaplaincy, chaplaincy interventions, PROM
Stranahan (2011)	Discussion	This paper explores the use of dreams in the context of pastoral care. Although many people dream and consider their dreams to hold some significant spiritual meaning, spiritual care providers have been reluctant to incorporate patients' dreams into the therapeutic conversation. Not every dream can be considered insightful, but probing the meaning of some dreams can enhance spiritual care practice. Hill's Cognitive-Experimental Dream Interpretation Model is applied in the current article as a useful framework for exploring dreams, gaining insight about spiritual problems, and developing a therapeutic plan of action. Bulkeley's criteria for dream interpretation were used to furnish safeguards against inappropriate application of dream interpretation to spiritual assessment and interventions.
Swain (2011)	Quantitative Study	Drawing on interviews with the chaplains and archival material from Disaster Chaplaincy Services-NY, this article discusses the formation of the chaplaincy at the Temporary Mortuary at Ground Zero after the terrorist attacks on September 11, 2001. It describes the initial chaplaincy response in New York by local clergy and the SAIR team of the American Red Cross. The first 6 weeks of chaplaincy at Ground Zero are explored highlighting the significant contributions of the Archdiocese of New York and Episcopal Diocese of New York out of St. Paul's Chapel. The mission and impact of the Temporary Mortuary chaplains' ministry of presence and blessing is discussed with some final reflections for the future of Disaster Chaplaincy.
Van Voorhees et al. (2014)	Survey	Cigarette smoking disproportionately affects veterans, particularly those with psychiatric diagnoses. Chaplains working within the Department of Veterans Affairs (VA) play key roles in emotional, physical, and spiritual health care of veterans, and veterans often turn to chaplains with mental health concerns. The VA/Department of Defence Integrated Mental Health Care Strategy is working to understand how collaboration between chaplains and mental health professionals may improve services to veterans, and one interest area is the role chaplains might play in facilitating the dissemination of smoking cessation programs. We report the survey results of 321 VA chaplains regarding their interest and willingness to be involved in smoking cessation efforts. Results indicated that over 80% of responding chaplains would feel "somewhat" or "very comfortable" providing information to veterans about VA smoking cessation programs, and that a smaller majority (between 55% and 85%) would feel this level of comfort engaging in smoking cessation-related activities. Findings suggest the potential for collaboration among chaplains and mental health providers in smoking cessation efforts, and also point to the need for further discussion and deeper mutual understanding between these professionals in how they view their roles in contributing to the overall health and well-being of veterans.
Vanderwerker et al. (2008)	Review	In recent years, the chaplain-to-patient ratio in U.S. hospitals has remained roughly the same while the role of the hospital chaplain has expanded. We compared data on 33,000 chaplain visits from the New York Chaplaincy Study (1994-1996) with 58,000 chaplain visits from the Metropolitan Chaplaincy Study (2005-2006), in order to explore whether changes in both the role of the healthcare chaplain and changes in the healthcare system itself have affected the amount of time that chaplains are able to spend with patients. The overall pattern of lengths of visits was stable over time, but chaplains in the Metropolitan Chaplaincy Study had proportionally fewer visits with family members and more visits with patients, more visits based on referrals, and spent more time dealing with end-of-life issues than chaplains in the earlier New York Chaplaincy Study. We discuss ways that chaplains seem to be adjusting successfully to increasing demands on their time.
Vermandere et al. (2013)	Qualitative	The purpose of this study was to identify key outcome measures of spiritual care in palliative home care. A qualitative study was conducted with experts from 3 stakeholder groups (physicians, professional spiritual caregivers, and researchers) representing 2 countries (Belgium and The Netherlands). Three key outcome measures were identified: the extent to which the patient feels that he or she is being heard and taken seriously, the extent to which the patient experiences that there is a place for that which is insoluble, and the extent to which the patient

		experiences that there is a place for that which cannot be said. Further research is needed to implement and evaluate these new outcome measures.
Wall et al. (2007)	Cross-sectional study	OBJECTIVES: There is growing recognition of the importance of spiritual care as a quality domain for critically ill patients and their families, but there is a paucity of research to guide quality improvement in this area. Our goals were to: 1) determine whether intensive care unit (ICU) family members who rate an item about their spiritual care are different from family members who skip the item or rate the item as "not applicable" and 2) identify potential determinants of higher family satisfaction with spiritual care in the ICU. DESIGN: Cross-sectional study, using data from a cluster randomized trial aimed at improving end-of-life care in the ICU. SETTING: ICUs in ten Seattle-area hospitals. SUBJECTS: A total of 356 family members of patients dying during an ICU stay or within 24 hrs of ICU discharge. INTERVENTION: None. MEASUREMENTS AND MAIN RESULTS: Family members were surveyed about spiritual care in the ICU. Chart abstractors obtained clinical variables including end-of-life care processes and family conference data. The 259 of 356 family members (73%) who rated their spiritual care were slightly younger than family members who did not rate this aspect of care ($p = .001$). Multiple regression revealed family members were more satisfied with spiritual care if a pastor or spiritual advisor was involved in the last 24 hrs of the patient's life ($p = .007$). In addition, there was a strong association between satisfaction with spiritual care and satisfaction with the total ICU experience ($p < .001$). Ratings of spiritual care were not associated with any other demographic or clinical variables. CONCLUSIONS: These findings suggest that for patients dying in the ICU, clinicians should assess each family's spiritual needs and consult a spiritual advisor if desired by the family. Further research is needed to develop a comprehensive approach to ICU care that meets not only physical and psychosocial but also spiritual needs of patients and their families.
Weaver et al. (2005)	Survey	A random sample of hospital administrators throughout the United States was surveyed about their views on the importance of eleven chaplain roles and functions. The 494 respondents fell into three categories: (1) directors of pastoral care departments (N = 132); (2) administrators of hospitals that have a pastoral care department (N = 180); and (3) administrators of hospitals that do not have a pastoral care department (N = 182). All three groups considered all eleven roles to be relatively important, although administrators of hospitals that do not have a pastoral care department gave lower ratings, overall. Meeting the emotional needs of patients and relatives were seen as chaplains' most important roles, whereas performing religious rituals and conducting religious services were seen as least important by all three groups. In all but a few instances, the level of importance that administrators assigned to the various roles were positively related to their ratings of their own religiousness and spirituality ($r's = .11$ to $.26$, $p < .05$).
Weaver, Koenig, et al. (2008)	Review	The collaborative relationship between nurses and chaplains in the health care setting is well documented. The authors review research findings including survey results demonstrating the importance of religion and spirituality in the general population and the importance of the religion and faith in people suffering illnesses. Nurses and physicians show marked differences in their attention to spiritual care as evidenced by nurses' higher rates of referrals to chaplains and the greater quantity of nursing research on spirituality in professional journals. Three factors that might account for nurses' recognition of spiritual needs are: 1) the inclusion of spiritual care in the nursing curriculum, 2) personal involvement in faith communities and, 3) the historical influences of the nursing profession. Further research of this partnership and its effect on patient care should ultimately benefit the most vulnerable individuals in the health care setting.
Weinberger-Litman et al. (2010)	Survey	Nursing has historically realized the importance of spirituality in patient care, and more than other healthcare staff, they also have recognized the integral role of chaplains in meeting the spiritual needs of patients. The present study examines specific patient and family issues for which nurses make referrals to chaplains. A previously piloted questionnaire asking how often nurses and allied staff refer patients to chaplains was distributed to 133 staff members at a New York area hospital, the majority of whom were registered nurses (RNs). ANOVA revealed significant differences with respect to the kinds of issues that nurses are likely to refer to chaplains, with referrals being most likely for family issues and least likely for treatment-related issues. A significant interaction between staff type (nurses' vs allied staff) and issues was also found. The results are discussed in relation to the nurses' desire to meet patients' spiritual needs and how this can be achieved.

Winter-Pfaendler and Flannelly (2013)	Survey	Identifying patients' expectations of and need for healthcare chaplaincy is important in terms of appropriate intervention. Therefore, a sample of 612 patients from 32 general hospitals and psychiatric clinics in the German part of Switzerland was surveyed about their expectations of chaplaincy service. A principal component factor analysis of participants' ratings found that the survey items fell into three distinct categories. These were the need for (1) emotional support, (2) help to cope with illness/disease, and (3) religious/spiritual assistance. Among the expectations, the need for emotional support was rated most important, followed by help to cope and, lastly, religious/spiritual assistance. Gender, religious denomination, general religiosity, and subjective health status significantly influenced these expectations. The results showed that fulfilling patients' expectations increases their overall satisfaction with, and the importance they accord to the chaplain's visit, as well as their confidence in the chaplain.
Winter-Pfändler and Morgenthaler (2011)	Survey	To determine in which situations head nurses refer patients to health care chaplains and to detect significant influential factors, 192 head nurses from 117 health care institutions in the German part of Switzerland were surveyed with regard to situations in which they refer to a chaplain. On average, head nurses refer "often" to a chaplain in their daily work in situations where patients are dying or need religious-spiritual service or support, but they refer only "rarely" to a chaplain in situations where patients or their families express negative feelings or where other psychosocial needs are present. Moreover, the religiosity of head nurses, working in a general acute care hospital and a positive evaluation of the chaplaincy services determine significantly whether a head nurse calls for a chaplain in a particular situation or not. For quality improvement of chaplains' work, health care chaplains have to integrate themselves into the care team. On the contrary, standardized referral processes between chaplains and nurses as well as physicians have to be elaborated to reduce subjective factors (e.g. the religiosity of the nurse) from the process of referring.
Wittenberg-Lyles et al. (2008)	Qualitative study	BACKGROUND: Hospice chaplains provide a specific expertise to patient and family care, however, individual roles and responsibilities that facilitate the interdisciplinary team environment are less well known. OBJECTIVE: The primary aim of this study was to investigate how hospice chaplains perceive their role in interdisciplinary team meetings and to what extent hospice chaplains share common experiences within the interdisciplinary team approach in hospice. METHOD: Hospice chaplains within a 10-state region participated in a 39-item phone survey about professional roles, group roles, and structural characteristics that influence their ability to participate in interdisciplinary collaboration. RESULTS: Findings revealed that professional role conflict is experienced, primarily with social workers. Informal group task and maintenance roles included team spiritual care advisor and conflict manager, and structural characteristics consisted of extracurricular communication outside of the organization. CONCLUSIONS: Although chaplains foster interdisciplinary collaboration within the hospice team, future research needs to address improvements to the chaplain's role within the interdisciplinary team process.
Ziegler (2007)	Discussion	Careful listening by health professionals to the narrative (life story) and/or imagery expressed by patients with end stage liver disease can help them deal with the numerous psychological, emotional and/or spiritual issues that can arise before and after liver transplantation. These issues seem to affect a patient's ability to make a full recovery. Patients often use narrative and imagery to raise with health professionals the total life changes that they sense in themselves, particularly following transplantation. Health professionals are well aware of the physical changes liver transplant patients' experience. However, it is important for the transplant team to be aware of the sense many patients have of whole-of-life-what we might call spiritual-transformation. Health professionals need to be sensitive to their patients' needs to explore these narratives and images. It is important to take the time to listen carefully and non-judgementally, or to refer patients to team members who are trained and skilled in this kind of listening, such as pastoral care workers or social workers. Ensuring that people have the chance to express the spiritual changes they experience will assist them to connect with values such as hope and gratitude which may aid their full recovery. It is useful reminder for all of us who work in transplantation to consider the emotional or spiritual impact of receiving a transplant. We may be more able to help people move toward 'wellness' when we keep in the forefront of our minds the enormous effect on the total person of transplantation.
Zock (2008)	Discussion	The professional identity of the chaplain in Dutch health care institutions is in need of a new theoretical underpinning. The continued employment of the "spiritual caregiver," as the professional is called in the Netherlands, may be at stake. In former days, she or he was primarily a religious office holder fulfilling ecclesiastical functions. Against the background of secularization and individualization of religions and

		worldviews, the spiritual caregiver now turns more and more into an existential counselor, focusing on the search for meaning and life-orientation of all the clients/patients/residents, irrespective of their religion or philosophy of life. This brings along the need for a conceptualization of spiritual care. What is the spiritual caregiver's particular contribution to care and treatment, compared to that of, for instance, psychotherapists and social workers? What are the specific aims, methods, and key images of the profession? This brief communication sketches the specific context in which the Dutch spiritual caregiver has to work and the identity dilemmas he or she faces.

Appendix 2 - *How is Spirituality Measured in Health Care?*

Authors	Where?	Assessment Tool	Who/What designed to assess?	Used by…	Abstract
Barber (2012)		SeRvE scale – Service User Recovery Evaluation Scale	Mental Health Recovery	Mental Health Patients To monitor interventions and as a research tool	AIMS AND METHOD: To develop a self-report questionnaire to measure mental health recovery from the service user viewpoint. Literature searches and scoping exercises indicated that psychological, social and spiritual issues should be included. The resultant provisional scale was completed by 107 service users. RESULTS: The provisional scale was shortened as a result of factor analysis. The finalised version was highly reliable (Cronbach's alpha 0.911) and valid, correlating significantly with an already established recovery scale. It contained nine recognisable subscales, the first two describing existential and religious well-being. Separate well-being and ill-being factors were also identified. CLINICAL IMPLICATIONS: An inclusive tool for service users' assessment of their own recovery, the Service User Recovery Evaluation (SeRvE) scale, has been validated. This can be used both as a research tool and clinically to monitor interventions. The importance of spiritual care for service users is highlighted.
Beardsley (2009)	USA	PSI-C-R	Patient satisfaction with Chaplaincy	Research settings	Healthcare chaplaincy research seems further advanced in the USA. Here a US patient satisfaction with chaplaincy instrument (PSI-C-R) was used in a London NHS foundation hospital with a multi-faith chaplaincy team and population. A version of the instrument was also generated for the bereaved. PSI-C-R had not been subjected to test-retest to confirm its reliability so this was done at the pilot stage. It proved only partly reliable, but in three separate surveys a cluster of highly rated factors emerged, as in earlier studies: chaplains' prayer, competence, listening skills and spiritual sensitivity. Low-rated factors and qualitative data highlighted areas for improvement. Disappointing response rates arose from patient acuity, ethical concerns about standard follow-up protocols, and the Western Christian origins of the instrument which requires further revision for multi-faith settings, or the design of new instruments.
Blanchard (2012)	USA		Spiritual distress “Any spiritual practices that may affect your care?” “Any beliefs that may affect your care?”	Nurses identifying spiritual distress	AIMS: A quality improvement initiative of nursing/chaplain collaboration on the early identification and referral of oncology patients at risk of spiritual distress. Background Research shows that spiritual distress may compromise patient health outcomes. These patients are often under-identified, and chaplaincy staffing is not sufficient to assess every patient. The current nursing admission form with a question of 'Any spiritual practices that may affect your care?' is ineffective in screening for spiritual distress. METHOD(S):

					Ten nurses on the oncology unit were recruited and trained in a two-question screening tool to be utilized upon admission. RESULTS: Six nurses made referrals; a total of 14 patients. Four (28%) were at risk of spiritual distress and were assessed by the chaplains. CONCLUSIONS: Nurses are interested in the spiritual well-being of their patients and observe spiritual distress. They appreciate terminology/procedures by which they can assess more productively the spiritual needs of their patients and make appropriate chaplain referrals. Implications for nursing management The use of a brief spiritual screening protocol can improve nursing referrals to chaplains. The better utilization of chaplains that this enables can improve patient trust and satisfaction with their overall care and potentially reduce the harmful effects of spiritual distress.
Borneman et al. (2010)	USA	FICA Faith, Importance, Influence, Community, Address Spiritual History Tool	Clinical assessment of spirituality	Clinicians	CONTEXT: The National Consensus Project for Quality Palliative Care includes spiritual care as one of the eight clinical practice domains. There are very few standardized spirituality history tools. OBJECTIVES: The purpose of this pilot study was to test the feasibility for the Faith, Importance and Influence, Community, and Address (FICA) Spiritual History Tool in clinical settings. Correlates between the FICA qualitative data and quality of life (QOL) quantitative data also were examined to provide additional insight into spiritual concerns. METHODS: The framework of the FICA tool includes Faith or belief, Importance of spirituality, individual's spiritual Community, and interventions to Address spiritual needs. Patients with solid tumors were recruited from ambulatory clinics of a comprehensive cancer center. Items assessing aspects of spirituality within the Functional Assessment of Cancer Therapy QOL tools were used, and all patients were assessed using the FICA. The sample (n=76) had a mean age of 57, and almost half were of diverse religions. RESULTS: Most patients rated faith or belief as very important in their lives (mean 8.4; 0-10 scale). FICA quantitative ratings and qualitative comments were closely correlated with items from the QOL tools assessing aspects of spirituality. CONCLUSION: Findings suggest that the FICA tool is a feasible tool for clinical assessment of spirituality. Addressing spiritual needs and concerns in clinical settings is critical in enhancing QOL. Additional use and evaluation by clinicians of the FICA Spiritual Assessment Tool in usual practice settings are needed.
Briggs (2006)		4 component measurement model	Spiritual wellness (meaning and purpose)	Depression	Overall spiritual wellness, as well as 4 individual components of spiritual wellness, has been theoretically and empirically linked with depression. Prior to this investigation, no study has examined the relationship between spiritual wellness and depression by using a 4-component measurement model of spiritual wellness. In this study of older adolescents and midlife adults, negative correlations between 4 components of spiritual wellness and

					depression were found for both groups. Results of multiple regression analyses showed that for both older adolescents and midlife adults, the only significant contributing factor of spiritual wellness to depression was meaning and purpose in life.
Burkhart, Schmidt, et al. (2011)	USA	Spiritual Care Inventory	Measuring spiritual care	Nursing staff	AIM: This article is a report of the development and psychometric testing of the Spiritual Care Inventory. BACKGROUND: Research supporting the positive association between spirituality and health has led to interest in providing spiritual care in healthcare settings. Few instruments exist that measure the provision of spiritual care. METHOD: In February/March 2007, a convenience sample of 298 adult and paediatric acute care, ambulatory, home health, hospice staff and rehab nurses at two hospitals (n = 248) and graduate students at a school of nursing (n = 50) completed a 48-item initial version of the Spiritual Care Inventory. In study 2 from July through August 2007, 78 staff nurses at one hospital (n = 30) and a different cohort of graduate students at a school of nursing (n = 48) completed the 18-item second version of the Spiritual Care Inventory. RESULTS: Exploratory factor analysis in study 1 supported a 3-factor solution (spiritual care interventions, meaning making and faith rituals) with internal consistency measures for the subscales above 0Æ80. In study 2, internal consistency remained high. CONCLUSION: Factor structures identify that spiritual care is a process of intervention, meaning making and faith rituals.
Bushfield (2010)	UK	Spiritual Life Map (HODGE)	No article available	Hospice staff	Spiritual care is an essential component of holistic hospice care at the end of life. However, hospices vary considerably in the process of spiritual assessment as a precursor to spiritual care. The Spiritual Life Map (Hodge, 2005) is one tool that has been developed to address diverse spiritual perspectives. Introduction and adoption of such a tool may require training and ongoing support to facilitate its use in a hospice setting. This qualitative study evaluated the introduction, demonstration, and use of spiritual life maps in a hospice setting. Focus groups with hospice chaplains and social workers were conducted to assess hospice professionals' definitions of spiritual care and their responses both before and after hands on training in the use of spiritual life maps as a tool in end of life care. A phenomenological approach to qualitative analysis was used. Results suggest the need for ongoing training and support in addressing spiritual needs at the end of life, and several barriers to the use of new tools. Implications for research, training, and practice are discussed.
Holt et al. (2007)	USA	Spiritual Health Locus of Control Scale	Spiritual health locus of control	African American women	The present study reports on the development and validation of an expanded scale assessing spiritual health locus of control beliefs. Additional items were developed, and the scale was pilot tested among 108 church-attending African American women. The scale was multidimensional, comprised of the

					original Active and Passive Spiritual dimensions, and additional subscales reflecting 'Spiritual Life and Faith' and 'God's Grace'. Internal consistency was acceptable, and predictive validity was evidenced by negative correlations between the Passive Spiritual dimension and knowledge about mammography, breast cancer, and breast cancer treatment, and mammography utilization. This instrument provides an in-depth assessment of beliefs regarding the role of God in one's health, and may be useful for the development of church-based health education serving African Americans.
Cook (2012)	UK	None identified		Healthcare professionals	Many service users would like their spiritual needs to be taken into account during treatment and doing so has been shown to have positive benefits. However, this rarely happens in practice. Barriers to healthcare professionals providing spiritual care include embarrassment, lack of awareness and training, fear and lack of time. This article describes the development of a spirituality care pathway as part of a wider organisational initiative to offer spiritual support in mental health services. The process highlighted the importance of developing awareness and ownership of the need for spiritual care in all service areas and among service users. A range of spiritual interventions were identified and a process of monitoring and review introduced. The approach was appreciated by service users and staff, and was developed within existing professional and management processes.
T. Daaleman et al. (2014)	USA	Quality of Spiritual Care Scale	Quality of care	Measure family experience of spiritual care at end of life. Palliative care providers	The provision of spiritual care is considered a key element of hospice and palliative care, but there is a paucity of empirically developed quality-of-care measures in this domain. OBJECTIVES: To describe the development and reliability and validity of the Quality of Spiritual Care (QSC) scale in family caregivers. METHODS: We conducted analyses of interviews conducted that included the QSC scale with family members of residents who died in long-term care settings taken after the resident had died. To determine reliability and validity of the QSC scale, we examined internal consistency, concurrent construct validity, and factor analysis with promax rotation. RESULTS: Of 165 family caregivers of decedents who were asked whether they received spiritual care, 91 (55%) responded yes, and 89 of these (98%) completed at least 80% of the QSC items. Two items (i.e., satisfaction with and value of spiritual care) were perfectly correlated so the latter item was dropped in scale development. Factor analysis identified two factors, personal spiritual enrichment (mean pattern matrix loading = 0.77) and relationship enrichment (mean pattern matrix loading = 0.72). Reliability analysis yielded a Cronbach's alpha of 0.87, and item-total correlations for all items were in excess of 0.55. Preliminary validity of the QSC was supported by significant and expected correlations in both direction and magnitude with items from validated instruments conceptually associated with the quality of spiritual care.

					CONCLUSION: Preliminary testing of the QSC scale suggests that it is a valid and reliable outcome measure of the quality of spiritual care at the end of life.
Dedeli et al. (2015)	Turkey	Patient's Spiritual Needs Assessment Scale	Spiritual needs and activities	Oncology Nursing	The purpose of this study was to assess the oncology patients' spiritual needs and activities. Besides, the study was to provide clinical evaluation of the feasibility and usefulness of the Patients Spiritual Needs Assessment Scale. This descriptive and cross-sectional study was performed by using a demographic and spiritual practices questionnaire, the Turkish version of the Patients Spiritual Needs Assessment Scale. The results of our study demonstrated that the most common spiritual needs of patients with cancer were "to address issues before death and dying" (100%), "feel a sense of peace and contentment" (94.8%), and "for companionship" (93.5%). Spiritually assessing a patient with cancer requires knowledge of how spiritual needs may manifest and how to talk with a client about his or her spiritual needs. These findings can help nurses to begin this process of providing spiritual care for patients with cancer.
Delgado-Guay et al. (2011)	USA	Systems of Belief Inventory Functional Assessment of Chronic Illness Therapy – Spiritual Wellbeing Expanded (FACIT-SP-Ex)	Measuring spiritual pain, spirituality and religiosity.	Palliative Care setting	CONTEXT: Spirituality, religiosity, and spiritual pain may affect advanced cancer patients' symptom expression, coping strategies, and quality of life. OBJECTIVES: To examine the prevalence and intensity of spirituality, religiosity, and spiritual pain, and how spiritual pain was associated with symptom expression, coping, and spiritual quality of life. METHODS: We interviewed 100 advanced cancer patients at the M.D. Anderson palliative care outpatient clinic in Houston, TX. Self-rated spirituality, religiosity, and spiritual pain were assessed using numeric rating scales (0 = lowest, 10 = highest). Patients also completed validated questionnaires assessing symptoms (Edmonton Symptom Assessment Scale [ESAS] and Hospital Anxiety and Depression Scale), coping (Brief COPE and Brief R-COPE), the value attributed by the patient to spirituality/religiosity in coping with cancer (Systems of Belief Inventory-15R), and spiritual quality of life (Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being-Expanded [FACIT-Sp-Ex]). RESULTS: The median age was 53 years (range 21–85) and 88% were Christians. Almost all patients considered themselves spiritual (98%) and religious (98%), with a median intensity of 9 (interquartile range 7–10) of 10 and 9 (range 5–10) of 10, respectively. Spiritual pain was reported in 40 (44%) of 91 patients, with a median score of 3 (1–6) among those with spiritual pain. Spiritual pain was significantly associated with lower self-perceived religiosity (7 vs. 10, P = 0.002) and spiritual quality of life (FACIT-Sp-Ex 68 vs. 81, P = 0.001). Patients with spiritual pain reported that it contributed adversely to their physical/emotional symptoms (P < 0.001). There was a trend toward increased depression, anxiety, anorexia, and drowsiness, as measured by the ESAS, among patients with spiritual pain (P < 0.05), although this was not

					significant after Bonferroni correction. CONCLUSION: A vast majority of advanced cancer patients receiving palliative care considered themselves spiritual and religious. Spiritual pain was common and was associated with lower self-perceived religiosity and spiritual quality of life.
Dhar et al. (2011)	India	Spiritual Health Scale (114 items)	Spiritual Health	No article available*	In the midst of physical comforts provided by the unprecedented developments in all spheres of life, the humanity is at cross roads and looking at something beyond these means. Spirituality has now been identified globally as an important aspect for providing answers to many questions related to health and happiness. The World Health Organization is also keen at looking beyond physical, mental and social dimensions of the health, and the member countries are actively exploring the 4th Dimension of the health i.e. the spiritual health and its impact on the overall health and happiness of an individual. National Institute of Health and Family Welfare (NIHFW), realized this need and initiated a research study in this direction. In this study, an effort was made to define this 4th Dimension of health from a common worldly person's perspective and measure it. 3 Domains, 6 Constructs and 27 Determinants of spiritual health were identified through a scientific process. A statistically reliable and valid Spiritual Health Scale (SHS 2011) containing 114 items has been developed. Construct validity and test- retest reliability has been established for urban educated adult population. The scale is first of its kind in the world to measure the spiritual health of a common worldly person, which is devoid of religious and cultural bias. Its items have universal applicability.
Draper (2012)	UK	Review of spiritual assessment tools	Various aspects of spirituality Includes tables outlining existing spiritual assessment tools	Nursing practice implications	To describe the current 'state of the art' in relation to spiritual assessment, focusing on quantitative, qualitative and generic approaches; to explore the professional implications of spiritual assessment; and to make practical recommendations to managers seeking to promote spiritual assessment in their places of work. METHOD: The paper integrates aspects of a recent systematic review of quantitative approaches to measuring spirituality and a recent meta-synthesis of qualitative research into client perspectives of spiritual needs in health and the principles of generic assessment, before drawing on the wider literature to discuss a number of professional implications and making recommendations to nurse managers. IMPLICATIONS FOR NURSING MANAGEMENT: The issues to emerge from this paper are (1) that spiritual assessment is an increasingly important issue for nursing practice, (2) that the range of reliable and valid quantitative instruments for use in clinical practice is limited, (3) that there is overlap in the domains and categories of spirituality identified by quantitative and qualitative researchers, and (4) that nurse managers seeking to introduce spiritual assessment will do

					so in the context of a professional debate about the relevance of spirituality to contemporary practice.
Fitchett (2012)	USA	Book Chapter – discussion			The past 25 years have seen remarkable developments in the relationship between religion, spirituality, and health. There is a growing body of research investigating the relationship between religion and health and there is growing acceptance of the role of religion and spirituality in health, especially in palliative care. During this period numerous models for spiritual assessment have also been developed. In light of this, I believe we no longer need to develop new models for spiritual assessment. Rather, we need to focus attention on a critical review of the existing models and the dissemination of best practices in spiritual assessment. The chapter has three sections: it begins with a review of some existing models for spiritual assessment, then describes the research about spiritual assessment and concludes with a description of issues that will need to be considered in a critical review of models for spiritual assessment. Readers should be aware that the perspective I bring to this chapter is that of a liberal Quaker chaplain and chaplain-educator who has worked in a large, urban, academic medical centre in the USA for over 30 years.
Kevin J. Flannelly, Galek, and Handzo (2005)	USA	Proportion of patients who are visited by chaplains		Measure of proportion of patients visited by chaplains	Although a substantial number of studies have documented the spiritual needs of hospitalized patients, few have examined the prevalence of these needs and even fewer have attempted to measure the extent to which they are being met. Since chaplains are the primary providers of spiritual care, chaplains' visits to patients would appear to provide a reasonable proxy for the latter. Based on the limited data available, we estimated the proportion of hospitalized patients who are visited by chaplains. Our analyses yielded a point estimate of 20% (+/- 10%), depending on a number of factors.
Galchutt (2013)	USA	Palliative Care Specific Spiritual Assessment	Story, suffering, spirit, sense-making	Palliative care team use	This article reflects a project to create, refine, and use a palliative care specific spiritual assessment, with the intent to implement its use for both an inpatient Palliative Consult Service (PCS) and a Spiritual Health Service (SHS) team. Extensive meetings with these services to confirm a shared understanding of the use of this spiritual assessment to facilitate communication with PCS through consistent language about the patient's story, suffering, spirit, and sense-making. Following a pilot phase of using this palliative care spiritual assessment, five presentations were shared with the SHS team to explore using this assessment. Although the SHS team decided not to use its content, these presentations spurred dialogue toward what was to become a SHS standardized documentation process, eventually called data, intervention, outcome, plan (DIOP).
Gijsberts et al. (2011)	Netherlands	Conceptualising Spiritual Wellbeing	Spiritual Wellbeing – Nursing and research	Palliative Care context	Although spiritual caregiving is a key domain of palliative care, it lacks a clear definition, which impedes both caregiving and research in this domain. The

					aim of this study was to conceptualize spirituality by identifying dimensions, based on instruments measuring spirituality in end-of-life populations. A systematic literature review was conducted. Literature published between 1980 and 2009, focussing on instruments measuring spirituality at the end of life was collected from the PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PsychINFO databases. Inclusion criteria were: (1) the studies provide empirical data collected with an instrument measuring spirituality or aspects of spirituality at the end of life; (2) the data report on a (subgroup) of an end-of-life population, and (3) the instrument is available in the public domain. Content validity was assessed according to a consensus-based method. From the items of the instruments, three investigators independently derived dimensions of spirituality at the end of life. In 36 articles that met the inclusion criteria we identified 24 instruments. Nine instruments with adequate content validity were used to identify dimensions of spirituality. To adequately represent the items of the instruments and to describe the relationships between the dimensions, a model defining spirituality was constructed. The model distinguishes the dimensions of Spiritual Well-being (e.g., peace), Spiritual Cognitive Behavioral Context (Spiritual Beliefs, Spiritual Activities, and Spiritual Relationships), and Spiritual Coping, and also indicates relationships between the dimensions. This model may help researchers to plan studies and to choose appropriate outcomes, and assist caregivers in planning spiritual care.
Gray (2011)	USA	Spiritual Health Inventory	No article available	Measuring abstinence or length of abstinence post-substance abuse treatment	A study of US military veterans, post-substance abuse treatment, to determine whether spirituality scores calculated from the Spiritual Health Inventory (SHI) correlated with abstinence or length of abstinence. 32 veterans responded and completed the SHI and a Brief Form Questionnaire that consisted of a total of 31 Likert scale questions designed to measure spirituality scores and self-report of recovery duration, importance of AA/NA participation, and actual participation rates. Parametric test measures (independent sample t-test and Pearson's r correlation) were employed with results indicating that spirituality was significantly correlated with abstinence and length of abstinence. Respondent ages or AA/NA participation did not significantly correlate with abstinence. Future research should include a larger sample size to adequately address power analysis requirements.
Haugan (2015)	Norway	Functional Assessment of Chronic Illness Therapy Spiritual Wellbeing (FACIT-SP)	Spiritual Wellbeing	Nursing Home	BACKGROUND: Spiritual well-being has been found to be a strong individual predictor of overall nursing home satisfaction and a fundamental dimension of global as well as health-related quality-in-life among nursing home patients. Therefore, access to a valid and reliable measure of spiritual well-being among nursing home patients is highly warranted. OBJECTIVES: The aim of this study was to investigate the dimensionality, reliability and construct

					validity of the Functional Assessment of Chronic Illness Therapy Spiritual Wellbeing scale in a cognitively intact nursing home population. DESIGN AND METHOD: A cross-sectional design was applied, selecting two counties in central Norway from which 20 municipalities representing 44 different nursing homes took part in this study. Long-term care was defined as 24-hour care with duration of 6 months or longer. Participants were 202 cognitively intact long-term nursing home patients fulfilling the inclusion criteria. Approval by all regulatory institutions dealing with research issues in Norway and the Management Unit at the 44 nursing homes was obtained. Explorative and confirmative factor analyses as well as correlation with selected construct were used. RESULTS: Though three items loaded very low (k = 0.22, 0.26, 0.32) indicating low reliability, the three-factor model for the FACIT-Sp spiritual well-being scale provided an acceptable fit (v2 = 101.15 (df = 50), p-value <0.001, RMSEA = 0.075 p = 0.030, NFI = 0.90, GFI = 0.91, AGFI = 0.85) for older nursing home patients, demonstrating acceptable measurement reliability. Construct validity was supported by significant correlations in the hypothesised direction with the selected constructs. CONCLUSION: The three-factor model is an improvement over the original two-factor construct, based on these nursing home data. The measure yielded significantly factor loadings, good composite reliability and construct validity. KEYWORDS: FACIT-Sp, confirmatory factor analysis, construct validity, dimensionality, nursing home, reliability, spiritual well-being.
Hodge (2006)	USA	JCAHO Spiritual Assessment Questions		Social Work	Growing consensus exists regarding the importance of spiritual assessment. For instance, the largest health care accrediting body in the United States, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), now requires the administration of a spiritual assessment. Although most practitioners endorse the concept of spiritual assessment, studies suggest that social workers have received little training in spiritual assessment. To address this gap, the current article reviews the JCAHO requirements for conducting a spiritual assessment and provides practitioners with guidelines for its proper implementation. In addition to helping equip practitioners in JCAHO-accredited settings who may be required to perform such an assessment, the spiritual assessment template profiled in this article may also be of use to practitioners in other settings.
Hoffert et al. (2007)	USA	Client Spiritual Assessment Tool	Measuring two dimensions of spirituality: Human relationship and Higher power.	Intervention to assist nursing staff to perform spiritual assessment	According to the literature, a majority of nurses and nursing students report a lack of comfort and ability to perform a spiritual assessment. The researchers designed and implemented an intervention program to address the 4 barriers most frequently identified as obstacles to performing a spiritual assessment. They discuss this study and suggest teaching interventions to assist nursing

					students to assess and implement spiritual care. Researcher-developed tools are presented and can be made available for use.
Hsiao et al. (2013)	Taiwan	Spiritual Health Scale Short Form	Spirituality	Tested on nursing students	To further examine the psychometric properties of the spiritual health scale short form, including its reliability and validity. BACKGROUND: Spirituality is one of the main factors associated with good health outcomes. A reliable and valid instrument to measure spirituality is essential to identify the spiritual needs of an individual and to evaluate the effect of spiritual care. DESIGN: A cross-sectional study design was used. METHODS: The study was conducted in six nursing schools in northern, central and southern Taiwan. The inclusion criterion for participants was nursing students with clinical practice experience. Initially, 1141 participants were recruited for the study, but 67 were absent and 48 did not complete the questionnaires. A total of 1026 participants were finally recruited, indicating a response rate of 89·9%. The psychometric testing of the spiritual health scale short form included construct validity with confirmatory factor analysis, known-group validity and internal consistency reliability. RESULTS: The results of the confirmatory factor analysis supported the five-factor model as an acceptable model fit. In the known-group validity, the results indicated that people who are in the category of primary religious affiliation have better spiritual health than people in the category of secondary religious affiliation and atheism. The result also indicated that the 24-item spiritual health scale short form achieved an acceptable internal consistency coefficient. CONCLUSIONS: The findings suggest that the spiritual health scale short form is a valid and reliable instrument for the appraisal of individual spiritual health. Relevance to clinical practice The spiritual health scale short form could provide useful information to guide clinical practice in assessing and managing people's spiritual health in Taiwan.
Jones (2006)	USA	A basic spiritual assessment model	No article available *	Chaplaincy	In 2001, the major certifying bodies for professional chaplaincy published Professional Chaplaincy: Its Role and Importance in Healthcare. This publication came about as 2 opposing forces came to a head: the financial world of health care where costs were being cut, which resulted in fewer chaplains, and the world of health care accreditation where spiritual assessments and the care for patient's spiritual needs were being pushed. In 1998, the Joint Commission on the Accreditation of Healthcare Organizations stated that "patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values." The "White Paper," as it came to be known, was a response to the cuts being made to spiritual care programs in light of increased awareness to spiritual needs of patients. As a strong advocate for professional chaplaincy, I recognize that quality spiritual care cannot occur through only 1

					member of the multidisciplinary care team. Chaplains may be the spiritual care experts, but each member of the care team can assist in making basic assessments and caring for the spiritual needs of patients and their families.
Kevern et al. (2013)		Care Plans – spirituality components within			Misrepresentation of patient spirituality in care plans (Kevern et al., 2013)
L. Carey et al. (2009)	Australia	WHO Pastoral Intervention Codings	Pastoral interventions	Pastoral care staff reporting on patient interactions	As part of an Australian national project, quantitative data via a survey were retrospectively obtained from 327 Australian health care chaplains (staff and volunteer chaplains) to initially identify chaplaincy participation in various bioethical issues— including organ procurement. Over a third of surveyed staff chaplains (38%) and almost a fifth of volunteer chaplains (19.2%) indicted that they had, in some way, been involved in organ procurement issues with patients and/or their families. Nearly one-fifth of staff chaplains (19%) and 12% of volunteer chaplains had also assisted clinical staff concerning various organ procurement issues. One hundred of the surveyed chaplains volunteered to an interview. Qualitative data were subsequently coded from 42 of the chaplains who had been involved in organ procurement requests. These data were thematically coded using the World Health Organization 'Pastoral Intervention Codings' (WHO-PICs). The qualitative data revealed that through a variety of pastoral interventions a number of chaplains (the majority being staff chaplains) were engaged in the critical and sensitive issues of organ procurement. It is argued that while such involvement can help to ensure a holistic and ethically appropriate practice, it is suggested that chaplains could be better utilized not only in the organ procurement process but also for the training of other chaplains and clinicians.
Ledbetter (2008)	USA	Clinical + Coping Score.	Measures coping.	Chaplains	Hospital chaplains struggle to know which patients most likely need pastoral care and why. The author presents a computerized model to screen and document indicated patients. A new screening tool is introduced, the Clinical+Coping Score, which can check with greater precision for patients who show evidence of insufficient coping. This screening model informs the subsequent assessment and intervention opportunities, though they are not discussed. The model's format enables chaplains to efficiently and effectively document pastoral screening using the hospital's electronic charting program. Two levels of visitation priority are suggested. In so doing, the chaplains are able to identify the indicators for pastoral care contacts and interventions, as well as the number of patients whose recognized needs have yet to be addressed.
M. King et al. (2013)	UK	Beliefs and Values Scale (BVS)	Strength of spiritual beliefs.	Palliative Care setting	OBJECTIVES: Despite growing research interest in spirituality and health, and recommendations on the importance of spiritual care in advanced cancer and palliative care, relationships between spiritual belief and psychological health near death remain unclear. We investigated (i) relationships between strength

					of spiritual beliefs and anxiety and depression, intake of psychotropic/analgesic medications and survival in patients with advanced disease; and (ii) whether the strength of spiritual belief changes as death approaches. METHODS: We conducted a prospective cohort study of 170 patients receiving palliative care at home, 97% of whom had a diagnosis of advanced cancer. Data on strength of spiritual beliefs (Beliefs and Values Scale [BVS]), anxiety and depression (Hospital Anxiety and Depression Scale [HADS]), psychotropic/analgesic medications, daily functioning, global health and social support were collected at recruitment then 3 and 10 weeks later. Mortality data were collected up to 34 months after the first patient was recruited. RESULTS: Regression analysis showed a slight increase in strength of spiritual belief over time approaching statistical significance (+0.16 BVS points per week, 95% CI [-0.01, 0.33], p = 0.073). Belief was unrelated to anxiety and depression (-0.15 points decrease in HADS for 10 points increased in BVS (95% CI [-0.57, 0.27], p = 0.49) or consumption of psychotropic medication). There was a non-significant trend for decreasing analgesic prescription with increasing belief. Mortality was higher over 6 months in participants with lower belief at recruitment. CONCLUSION: Results suggest that although religious and spiritual beliefs might increase marginally as death approaches, they do not affect levels of anxiety or depression in patients with advanced cancer.
McGee and Torosian (2006)	USA	Spiritual Health Profile "Multidimensional Measurement of Religiousness/Spirituality for use in Health Research" assessment developed by the Fetzer Institute to obtain a "Spiritual Profile" on our patients.	Assess and address domains of spirituality	Psychiatric setting	This paper describes a successful effort to quantitatively assess and address different domains of spirituality as part of a "biopsychosocialspiritual" treatment model on an inpatient psychiatry unit. A "spiritual health profile" can be easily obtained and integrated into the treatment planning, actual treatment, and discharge planning processes. Spiritual functioning varies in meaningful ways that correlate with psychiatric impairment. Addressing spiritual health status holds promise as a way of enhancing psychiatric outcomes.
Monod et al. (2011)	Switzerland & USA	Systematic review of instruments FACIT-Sp Spiritual Wellbeing Scale		Instruments used in research	INTRODUCTION: Numerous instruments have been developed to assess spirituality and measure its association with health outcomes. This study's aims were to identify instruments used in clinical research that measure spirituality; to propose a classification of these instruments; and to identify those instruments that could provide information on the need for spiritual intervention. METHODS: A systematic literature search in MEDLINE, CINHAL, PsychINFO, ATLA, and EMBASE databases, using the terms "spirituality" and "adult$," and limited to journal articles was performed to identify clinical studies that used a spiritual assessment instrument. For each instrument

					identified, measured constructs, intended goals, and data on psychometric properties were retrieved. A conceptual and a functional classification of instruments were developed. RESULTS: Thirty-five instruments were retrieved and classified into measures of general spirituality (N = 22), spiritual well-being (N = 5), spiritual coping (N = 4), and spiritual needs (N = 4) according to the conceptual classification. Instruments most frequently used in clinical research were the FACIT-Sp and the Spiritual Well-Being Scale. Data on psychometric properties were mostly limited to content validity and inter-item reliability. According to the functional classification, 16 instruments were identified that included at least one item measuring a current spiritual state, but only three of those appeared suitable to address the need for spiritual intervention. CONCLUSIONS: Instruments identified in this systematic review assess multiple dimensions of spirituality, and the proposed classifications should help clinical researchers interested in investigating the complex relationship between spirituality and health. Findings underscore the scarcity of instruments specifically designed to measure a patient's current spiritual state. Moreover, the relatively limited data available on psychometric properties of these instruments highlight the need for additional research to determine whether they are suitable in identifying the need for spiritual interventions.
Nakau et al. (2013)	Japan	FACIT-Sp. QOL – Short form-36 Health Survey Questionnaire Cancer Fatigue Scale	Spiritual care in cancer	Oncology	BACKGROUND: Psycho-oncological care, including spiritual care, is essential for cancer patients. Integrated medicine, a therapy combining modern western medicine with various kinds of complementary and alternative medicine, can be appropriate for the spiritual care of cancer because of the multidimensional characteristics of the spirituality. In particular, therapies that enable patients to establish a deeper contact with nature, inspire feelings of life and growth of plants, and involve meditation may be useful for spiritual care as well as related aspects such as emotion. The purpose of the present study was to examine the effect of spiritual care of cancer patients by integrated medicine in a green environment. METHODS: The present study involved 22 cancer patients. Integrated medicine consisted of forest therapy, horticultural therapy, yoga meditation, and support group therapy, and sessions were conducted once a week for 12 weeks. The spirituality (the Functional Assessment of Chronic Illness Therapy-Spiritual well-being), quality of life (Short Form-36 Health Survey Questionnaire), fatigue (Cancer Fatigue Scale), psychological state (Profile of Mood States, short form, and State-Trait Anxiety Inventory) and natural killer cell activity were assessed before and after intervention. Results In Functional Assessment of Chronic Illness Therapy-Spiritual well-being, there were significant differences in functional well-being and spiritual well-being pre- and post-intervention. This program

					improved quality of life and reduced cancer-associated fatigue. Furthermore, some aspects of psychological state were improved and natural killer cell activity was increased. CONCLUSIONS: It is indicated that integrated medicine performed in a green environment is potentially useful for the emotional and spiritual well-being of cancer patients.
Power (2006)	UK	Discussion of spiritual assessment		Nurses to assess patients	Patients' 'spirituality' is widely considered to be a factor that nurses need to consider in their assessments. But Jeanette Power suggests ways in which assessments can be undertaken, and questions whether one assessment tool can prove adequate in measuring the significance of spirituality in the lives of individuals, all of whom may interpret its meaning differently.
Robinson (2013)	USA	Doctorate Lists a number of spiritual assessment tools in chapter four Some notes on writing up pastoral interventions	Spiritual Distress	Chaplaincy	Hospitalized patients are at an elevated risk of suffering from spiritual distress. Patients value and expect having spiritual and emotional needs met when hospitalized. A direct correlation exists between spiritual and physical health, making spiritual assessment and care a pastoral priority. Research indicates a lack of proper training for pastors making hospital visits. The purpose of this project is to provide pastors with resources and understanding of spiritual assessment of hospitalized patients. This project also provides pastors with a template for a new model of spiritual assessment to aid with establishing a spiritual assessment tool to meet their ministry needs, and fit their ministry personality, administer self-care, and evaluate their assessment and intervention.
Schultz et al. (2014)		Screening tool for interest in spiritual care. Who wants it and what do they want?			BACKGROUND: As professional spiritual care (chaplaincy) is introduced to new cultures worldwide, it bears examining which elements of screening and care are universal and, for those elements showing cultural difference, to study them in each culture. No quantitative spiritual care patient study had previously been done in Israel. Our objectives were twofold: 1) to examine who wants spiritual care in Israel, including demographic and clinical variables, and to compare against other results worldwide to further develop universal screening protocols 2) to see what patients want from spiritual care specifically in the Israeli setting. METHODS: Self-administered patient questionnaire examining spirituality/religiosity, interest in spiritual care (subdivided by type of care), and key demographic, social, and clinical data. The study setting was an Israeli oncology center at which spiritual care had been recently introduced. RESULTS: Data from 364 oncology patient questionnaires found 41% interest in spiritual care, as compared to 35%-54% in American studies. Having previously been visited by a spiritual caregiver predicted patient interest in further spiritual care (AOR 2.4, 95% CI 1.2-4.6), suggesting that the new service is being well-received. Multivariate stepwise logistic regression analysis identified additional predictors of openness to receiving spiritual care: self-describing as somewhat/very spiritual vs. not

					spiritual (adjusted odds ratio [AOR] 3.9 and 6.3, 95% CI 1.8-8.6 and 2.6-15.1) or traditional/religious vs. secular (AOR 2.2 and 2.1, 95% CI 1.3-3.6 and 1.1-4.0); and receiving one visit a week or less from family and friends (AOR 5.6, 95% CI 2.1-15.1). These findings are in line with previous American studies, suggesting universality across cultures that could be utilized in screening. Differences in demographic data and medical condition were not significant predictors of patient interest, suggesting a cultural difference, where age and education were predictors in the American context. Levels of interest in explicitly religious or spiritual support such as prayer or addressing religious/spiritual questions were much lower than in other cultures. CONCLUSIONS: Results illustrate the demand for and satisfaction with the new Israeli service. The cross-cultural comparison found both culture-dependent and possibly universal predictors of patient interest, and found lower interest in Israel for explicitly religious/spiritual types of support.
Selman et al. (2012)	International	Spirit – 8	Spiritual Wellbeing	Palliative care	CONTEXT: Despite the need to assess spiritual outcomes in palliative care, little is known about the properties of the tools currently used to do so. In addition, measures of spirituality have been criticized in the literature for cultural bias, and it is unclear which tools have been validated cross-culturally. OBJECTIVES: This systematic review aimed to identify and categorize spiritual outcome measures validated in advanced cancer, human immunodeficiency virus (HIV), or palliative care populations; to assess the tools' cross-cultural applicability; and for those measures validated cross-culturally, to determine and categorize the concepts used to measure spirituality. METHODS: Eight databases were searched to identify relevant validation and research studies. An extensive search strategy included search terms in three categories: palliative care, spirituality, and outcome measurement. Tools were evaluated according to two criteria: 1) validation in advanced cancer, HIV, or palliative care and 2) validation in an ethnically diverse context. Tools that met Criterion 1 were categorized by type; tools that also met Criterion 2 were subjected to content analysis to identify and categorize the spiritual concepts they use. RESULTS: One hundred ninety-one articles were identified, yielding 85 tools. Fifty different tools had been reported in research studies; however, 30 of these had not been validated in palliative care populations. Thirty-eight tools met Criterion 1: general multidimensional measures (n=21), functional measures (n=11), and substantive measures (n=6). Nine measures met Criterion 2; these used spiritual concepts relating to six themes: Beliefs, practices, and experiences; Relationships; Spiritual resources; Outlook on life/self; Outlook on death/dying; and Indicators of spiritual well-being. A conceptual model of spirituality is presented on the basis of the content analysis. Recommendations include consideration of both the clinical and

					cultural population in which spiritual instruments have been validated when selecting an appropriate measure for research purposes. Areas in need of further research are identified. CONCLUSION: The nine tools identified in this review are those that have currently been validated in cross-cultural palliative care populations and, subject to appraisal of their psychometric properties, may be suitable for cross-cultural research.
Selman et al. (2013)	International	Spirit – 8 Palliative Outcome Scale	Spiritual Wellbeing	Palliative Care	BACKGROUND: Patients with incurable, progressive disease receiving palliative care in sub-Saharan Africa experience high levels of spiritual distress with a detrimental impact on their quality of life. Locally validated measurement tools are needed to identify patients' spiritual needs and evaluate and improve spiritual care, but up to now such tools have been lacking in Africa. The African Palliative Care Association (APCA) African Palliative Outcome Scale (POS) contains two items relating to peace and life worthwhile. We aimed to determine the content and construct validity of these items as measures of spiritual wellbeing in African palliative care populations. METHODS: The study was conducted at five palliative care services, four in South Africa and one in Uganda. The mixed-methods study design involved: (1) cognitive interviews with 72 patients, analysed thematically to explore the items' content validity, and (2) quantitative data collection (n = 285 patients) using the POS and the Spirit 8 to assess construct validity. RESULTS: (1) Peace was interpreted according to the themes 'perception of self and world', 'relationship to others', 'spiritual beliefs' and 'health and healthcare'. Life worthwhile was interpreted in relation to 'perception of self and world', 'relationship to others' and 'identity'. (2) Conceptual convergence and divergence were also evident in the quantitative data: there was moderate correlation between peace and Spirit 8 spiritual well-being ($r = 0.46$), but little correlation between life worthwhile and Spirit 8 spiritual well-being ($r = 0.18$) (both $p < 0.001$). Correlations with Spirit 8 items were weak to moderate. CONCLUSIONS: Findings demonstrate the utility of POS items peace and life worthwhile as distinct but related measures of spiritual well-being in African palliative care. Peace and life worthwhile are brief and simple enough to be integrated into routine practice and can be used to measure this important but neglected outcome in this population.
Teal (2007)	USA	Spiritual Experience Interview. Coding system.	Spiritual Maturity No article available	Chaplaincy with Christian clients	There is growing interest in the topic of spiritual maturity. Pastors, lay counsellors and Christian professional mental health workers who work with Christian clients are increasingly interested in how to promote spiritual development and subsequently assess any progress. Up to this point, instruments used for the purpose of assessing spiritual maturity have shown some promise, yet have wrestled with the issue of respondents' biasing the results, particularly due to unconscious defensive mechanisms. This paper

					outlines how the fields of psychoanalysis, neurobiology, and attachment theory are all converging upon similar conclusions related to the importance of evaluating implicit/nonverbal communication when considering a person's state of mental health. Based upon an assumption of psychological and theological integration, we assert that these conclusions pertain to the realm of spiritual health and development as well. This paper outlines our effort to develop and conduct initial validation procedures on a coding system for the Spiritual Experience Interview (SEIn). This coding system for the SEIn constitutes an effort to tap into implicit or unconscious aspects of respondents' communication and thereby bypass defenses. Unlike self-report measures, the interview format brings these subjective implicit processes to light in a subject's narrative style so that they may be coded, analyzed, and interpreted. In the current study, extensive reviewing of SEIn responses led to theoretical descriptions as to how the different attachment categories would manifest in the spiritual realm, and the development of individual continuous scales. A rating team was formed and trained to code SEIn transcripts for the individual continuous scales developed. Then, using an independent data set, clinicians with extensive experience in the areas of attachment and relational spirituality gave transcripts spiritual attachment dimensional categorical ratings. On that same data set, the rating team coded transcripts for the individual continuous scales and correlation analyses were conducted. Additionally, in an effort to demonstrate some external validity, the individual continuous scales were correlated with the results of responses to the Early Memory Test (EMT; Mayman, 1968). The results of these analyses are discussed in detail and suggestions for future research are outlined.
Timmins and Kelly (2008)	Ireland	Some discussion of a range of tools in ICU setting		Spiritual assessment in ICU setting	AIM: The aim of this paper is to explore various approaches to spiritual assessments in contemporary intensive and cardiac care (ICU/CCU) environments. BACKGROUND: Despite the increasing recognition that spiritual care is essential for quality patient care, an agreed spiritual assessment approach and tool for use in ICU/CCU settings remains elusive. METHOD: An overview of spiritual assessment and spiritual assessment tools. CONCLUSION: It is suggested that the staff in ICU/CCU nursing settings choose or develop a formal assessment tool that most closely matches their considered collective definition of spirituality, which has been considered in light of their mission statement and philosophy of care. RELEVANCE TO CLINICAL PRACTICE: Spiritual assessment is essential to formulate a care plan as spiritual care provides a powerful inner resource to critically ill patients in acute clinical environments.

Vivat et al. (2013)	International	EORTC – European Organisation for Research and Treatment of Cancer	Spiritual Wellbeing (cross-cultural context)	Palliative Care	BACKGROUND: No existing stand-alone measures of spiritual wellbeing have been developed in cross-cultural and multiple linguistic contexts. AIM: Cross-cultural development of a stand-alone European Organisation for Research and Treatment of Cancer (EORTC) measure of spiritual wellbeing for palliative care patients with cancer. DESIGN: Broadly following EORTC Quality of Life Group (QLG) guidelines for developing questionnaires, the study comprised three phases. Phase I identified relevant issues and obtained the views of palliative care patients and professionals about those issues. Phase II operationalised issues into items. Phase III pilot-tested those items with palliative care patients. Amendments to the guidelines included an intermediate Phase IIIa, and debriefing questions specific to the measure. SETTING/PARTICIPANTS: Phase III pilot-testing recruited 113 people with incurable cancer from hospitals and hospices in six European countries and Japan. RESULTS: A provisional 36-item measure ready for Phase IV field-testing, the EORTC QLQ-SWB36, has been developed. Careful attention to translation and simultaneous development in multiple languages means items are acceptable and consistent between different countries and languages. Phase III data from 113 patients in seven countries show that the items are comprehensible across languages and cultures. Phase III patient participants in several countries used the measure as a starting point for discussing the issues it addresses. CONCLUSION: The EORTC QLG's rigorous cross-cultural development process ensures that the EORTC QLQ-SWB36 identifies key issues for spiritual wellbeing in multiple cultural contexts, and that items are comprehensible and consistent across languages. Some cross-cultural differences were observed, but data were insufficient to enable generalisation. Phase IV field-testing will investigate these differences further.
Warner (2005)	USA				While listed as a tool for spiritual assessment and intervention, this is a basic list of major religious practices and beliefs. There is no discussion included.
Whitford and Olver (2012)	Australia	Facit-Sp	Spiritual Wellbeing	Cancer care – spiritual wellbeing	OBJECTIVE: This study explored associations between the recently proposed three-factor structure of the 12-item Functional Assessment of Chronic Illness Therapy—Spiritual Wellbeing (FACIT-Sp) subscale (Peace, Meaning, and Faith), quality of life (QoL), and coping in an oncology population. METHODS: A total of 999 newly diagnosed, study eligible, consecutive cancer patients completed the FACIT-Sp and the Mental Adjustment to Cancer (MAC) scale. RESULTS: Hierarchical multiple regressions revealed that Peace alone added 3% to the prediction of QoL and accounted for 15.8% of the overlap in Total Functional Assessment of Cancer Therapy—General (FACT-G) scores (both po0.001). Meaning alone added 1.3% to QoL prediction and accounted for 5.8% in overlap (both po0.001). Faith did not significantly contribute to the unique prediction or overlap of QoL. Correlational analyses revealed that Peace was

					most prominently associated with the QoL subscales of Functional (r50.64) and Emotional Wellbeing (r50.61) and the coping styles of Helpless/Hopeless (r5_0.53), Fighting Spirit (r50.47), and Anxious Preoccupation (r5_0.34). Meaning was also highly associated with Functional Wellbeing (r50.56), Helpless/Hopeless (r5_0.53), and Fighting Spirit (r50.54), but in addition, Social Wellbeing (r50.49). CONCLUSIONS: The three-factor model of spiritual wellbeing appears psychometrically superior to previous models as it further discriminates between which components are most highly associated with improved QoL facets and coping styles. This study provides normative data on newly diagnosed patients with cancer and further highlights the clinical contribution of such detailed assessment. Copyright r2011 John
Whitford et al. (2008)	Australia	Facit-Sp		Spiritual Wellbeing Nursing staff	OBJECTIVES: This study investigated including spiritual wellbeing as a core domain in the assessment of quality of life (QOL) in an Australian oncology population. METHODS: Four hundred and ninety consecutive cancer patients with mixed diagnoses completed the Functional Assessment of Chronic Illness Therapy} Spiritual Well-Being (FACIT-Sp) and the Mental Adjustment to Cancer (MAC) scale. RESULTS: Overall, 449 patients completed assessments. Spiritual wellbeing demonstrated a significant, positive association with QOL (r¼0.59), fighting spirit (r¼0.49) and a significant, negative relationship with helplessness/hopelessness (r¼_0.47) and anxious preoccupation (r¼_0.26). A hierarchical multiple regression showed spiritual wellbeing to be a significant, unique contributor to QOL beyond the core domains of physical, social/family, and emotional wellbeing (R2 change¼0.08, p¼0.000). However, high levels of meaning/peace or faith did not appear to significantly impact patients' ability to enjoy life despite chronic symptoms of pain or fatigue, making the current results inconsistent with other findings. CONCLUSION: Results lend further support to the biopsychosocialspiritual model. By failing to assess spiritual wellbeing, the 'true' burden of cancer is likely to be miscalculated. However, at this stage, the exact clinical utility of spirituality assessment is unclear.

Appendix 3 - *Spiritual Care – A Team Approach*

Authors	Research Design	Abstract
Anandarajah (2008)	Descriptive	PURPOSE: The explosion of evidence in the last decade supporting the role of spirituality in whole-person patient care has prompted proposals for a move to a biopsychosocial-spiritual model for health. Making this paradigm shift in today's multicultural societies poses many challenges, however. This article presents 2 theoretical models that provide common ground for further exploration of the role of spirituality in medicine. METHODS: The 3 H model (head, heart, hands) and the BMSEST models (body, mind, spirit, environment, social, transcendent) evolved from the author's 12-year experience with curricula development regarding spirituality and medicine, 16-year experience as an attending family physician and educator, lived experience with both Hinduism and Christianity since childhood, and a lifetime study of the world's great spiritual traditions. The models were developed, tested with learners, and refined. RESULTS: The 3 H model offers a multidimensional definition of spirituality, applicable across cultures and belief systems that provides opportunities for a common vocabulary for spirituality. Therapeutic options, from general spiritual care (compassion, presence, and the healing relationship), to specialized spiritual care (e.g. by clinical chaplains), to spiritual self-care are discussed. The BMSEST model provides a conceptual framework for the role of spirituality in the larger health care context, useful for patient care, education, and research. Interactions among the 6 BMSEST components, with references to ongoing research, are proposed. CONCLUSIONS: Including spirituality in whole-person care is a way of furthering our understanding of the complexities of human health and well-being. The 3 H and BMSEST models suggest a multidimensional and multidisciplinary approach based on universal concepts and a foundation in both the art and science of medicine.
Bastani (2014)	Cross-sectional	BACKGROUND: Having a child with leukaemia requires a high level of care-giving responsibility. Results of existing studies support the theory that hope and spirituality are important to mothers of children with cancer to help them to deal with their child's diagnosis and illness. Therefore, the purpose of this study was to investigate spiritual health and hope among mothers of children with leukaemia. METHODS: In this cross-sectional study, the participants were mothers of children with leukaemia. The sample size was estimated to be 150 mothers recruited from a teaching children's hospital in Tehran, Iran2, with the consecutive sampling method. The instrument for data collection was a questionnaire that gathered personal information, with scales related to spiritual wellbeing and hope as the main variables. The validity and reliability of the Persian version of the scales have been confirmed previously. For data analysis, descriptive and inferential statistics (central tendency, independent t test, X^2 ANOVA, Pearson correlation coefficient) were used, and were performed by SPSS Software (version 16). Findings: 52% of the participants showed a low level of spiritual wellbeing, which was significantly related to the educational status ($p \leqslant 0.001$) and economic condition ($p \leqslant 0.001$) of the mothers. 54% of the participants had a low level of hope, which was significantly related to age ($p=0.007$), marital status ($p=0.025$), educational level ($p \leqslant 0.001$), employment status ($p=0.008$), and economic condition ($p \leqslant 0.001$). In addition, there was a statistically significant positive and direct relationship between the variables of spiritual wellbeing ($p \leqslant 0.001$) and hope ($p \leqslant 0.001$). Interpretation: According to our findings, understanding these factors and their relationship may provide better strategies for designing effective interventions that can reduce the burden on mothers of children with leukaemia.
Battey (2012)	Discussion	AIM: The purpose of this article is to explore the current status, perspectives and attitudes of nurse managers, nurses and others toward spiritual care. BACKGROUND: The nursing profession has not defined what is expected of the nurses and some question the need for teaching it in nursing education. The leadership roles of chief executive officers, nursing leaders, chaplains and others are considered. Gallup polls indicate people consider religion very important in their lives, but studies show patients report receiving none or limited care.

		EVALUATION: While the spiritual dimension of holistic care is considered essential to healing, its practice has yet to be achieved. KEY ISSUES: Requirements and criteria are in place through accreditation agencies and professional codes identifying spiritual care as part of the role of nursing, but guidelines for implementing spiritual care are vague and broadly stated. CONCLUSIONS: If nurse managers implement agency-wide programmes of spiritual care then clear direction can be provided for the nursing staff. IMPLICATIONS FOR NURSING MANAGEMENT: An agency-wide programme of spiritual care practice for nurses needs to be developed not only to provide evidence for accreditation but also to provide guidelines for nursing staff.
Bloomer (2013)	Qualitative descriptive	This qualitative descriptive study was undertaken in two metropolitan ICUs utilising focus groups to describe the ways in which ICU nurses care for the families of dying patients during and after the death. Participants shared their perspectives on how they care for families, their concerns about care, and detailed the strategies they use to provide timely and person-centred family care. Participants identified that their ICU training was inadequate in equipping them to address the complex care needs of families leading up to and following patient deaths, and they relied on peer mentoring and role-modelling to improve their care. Organisational constraints, practices and pressures impacting on the nurse made 'ideal' family care difficult. They also identified that a lack of access to pastoral care and social work after hours contributed to their concerns about family care. Participants reported that they valued the time nurses spent with families, and the importance of ensuring families spent time with the patient, before and after death.
Burkhart and Androwich (2009)	Discussion	Nursing is at a critical juncture in creating data repositories that support nursing research and theory development, as health systems adopt and design electronic health records. This article discusses how informatics theory can be used to guide designing nursing documentation screens and analyzing the resulting data sets, while highlighting methods to maximize reliability and validity and to address measurement issues. Examples will be applied to spiritual care, a required dimension of care. These examples present methods to capture and study “soft” areas of nursing that have not traditionally been documented or measured. Key words: documentation, electronic health records, informatics, nursing research, nursing theory, spirituality, standardized terminology.
Byrne (2007)	Discussion	This article is a sequel to 'Spirituality in palliative care: what language do we need?' (Byrne, 2002). It looks at the language of pastoral care, its place in palliative settings and how it is regarded by patients and carers. Spirituality and spiritual need is multifaceted, and the various beliefs regarding the concept of spirituality and the spiritual needs of terminally ill patients are appraised, and the methods of spiritual assessment reviewed. The role of the chaplain in spiritual care is also assessed, and an ability to move beyond the boundaries of their own denominational position addressed. Several components of the language of pastoral care are identified.
Cadge et al. (2011)	Qualitative Study	This article analyzes interviews with pediatric physicians (N = 30) and chaplains (N = 22) who work at the same large academic medical centers (N = 13). We ask how pediatric physicians understand and work with chaplains and how chaplains describe their own work. We find that physicians see chaplains as part of interdisciplinary medical teams where they perform rituals and support patients and families, especially around death. Chaplains agree but frame their contributions in terms of the perspectives related to wholeness, presence, and healing they bring. Chaplains have a broader sense of what they contribute to patient care than do physicians.
Dolan et al. (2011)	Discussion	Pain is a common symptom experienced by individuals who are in treatment for cancer and becomes more prevalent for those with more advanced stages of malignancy. Critical care nurses are essential in the management of cancer-related pain, which is a challenging problem when individuals who have a cancer diagnosis are admitted to the intensive care unit for emergent conditions. Regular, thorough, and patient-appropriate assessments by experienced critical care nurses guide selection of treatment modalities, including pharmacologic and non-pharmacologic techniques. In addition, existential pain necessitates spiritual care intervention, and involvement of other appropriate interdisciplinary team members can result in improved management of all types of pain experienced by critically ill individuals with cancer. KEYWORDS: cancer, critical care, pain.
Evans and Ume (2012)	Discussion	Although health disparities are well documented, the extent to which they affect end-of-life care is unknown. Limited research funding leads to sparse and often contradictory palliative care literature, with few studies on causal mechanisms. This article explores the psychosocial, cultural, and spiritual health disparities existing in palliative and end-of-life care with the goal of identifying future

		research needs. This article reports efforts to determine knowledge gaps related to health disparities in psychosocial, cultural, and spiritual aspects of end-of-life care in which the authors draw upon recent literature from multiple databases. Although few data are available, studies show that minorities make little use of hospice, often because of lack of knowledge about hospice or palliative care, family-centered cultures, and preferences for more aggressive end-of-life care than hospice allows. The authors conclude that future research should include a search for theoretical and causal mechanisms; prospective longitudinal investigations; diverse patients, conditions, contexts, and settings; methodological diversity and rigor; and interdisciplinary, culturally sensitive interventions.
Frazier et al. (2015)	Qualitative Study	OBJECTIVE: This study assesses the perceived impact of a required half-day with a hospital chaplain for first-year medical students, using a qualitative analysis of their written reflections. METHODS: Students shadowed chaplains at the UCLA hospital with the stated goal of increasing their awareness and understanding of the spiritual aspects of health care and the role of the chaplain in patient care. Participation in the rounds and a short written reflection on their experience with the chaplain were required as part of the first-year Doctoring course. RESULTS: The qualitative analysis of reflections from 166 students using grounded theory yielded four themes: (1) the importance of spiritual care, (2) the chaplain's role in the clinical setting, (3) personal introspection, and (4) doctors and compassion. CONCLUSIONS: Going on hospital rounds with a chaplain helps medical students understand the importance of spirituality in medicine and positively influences student perceptions of chaplains and their work.
Goodall (2009)	Discussion	Spiritual care has become an integral part of the care package offered to older people who move to residential care. However, spirituality is a word that can mean everything or nothing and as such becomes difficult to define. Assessment of 'spiritual care' becomes a real challenge, because it raises important questions. These are as follows: the nature of spiritual care; how it is offered; and who takes responsibility for it. This is especially true in dementia care homes where residents cannot normally take part in evaluation. This paper offers a model of evaluation of spiritual care by using reflection, relationship and restoration, and through observing the virtues described in the Biblical concept of 'fruit of the spirit'.
Hodge and Horvath (2011)	Qualitative meta-synthesis	Spiritual needs often emerge in the context of receiving health or behavioural health services. Yet, despite the prevalence and salience of spiritual needs in service provision, clients often report their spiritual needs are inadequately addressed. In light of research suggesting that most social workers have received minimal training in identifying spiritual needs, this study uses a qualitative meta-synthesis (N = 11 studies) to identify and describe clients' perceptions of their spiritual needs in health care settings. The results revealed six interrelated themes: (1) meaning, purpose, and hope; (2) relationship with God; (3) spiritual practices; (4) religious obligations; (5) interpersonal connection; and (6) professional staff interactions. The implications of the findings are discussed as they intersect social work practice and education.
Keall et al. (2014)	Qualitative - interview	AIMS AND OBJECTIVES: To investigate the facilitators, barriers and strategies that Australian palliative care nurses identify in providing existential and spiritual care for patients with life-limiting illnesses. BACKGROUND: Palliative care aims to be holistic, incorporating all domains of personhood, but spiritual/existential domain issues are often undertreated. Lack of time and skills and concerns for what you may uncover hamper care provision. DESIGN: A qualitative study through semi-structured interviews. METHODS: We interviewed 20 palliative care nurses from a cross section of area of work, place of work, years of experience, spiritual beliefs and importance of those beliefs within their lives. Questions focused on their current practices of existential and spiritual care, identification of facilitators of, barriers to and strategies for provision of that care. Their responses were transcribed and subjected to thematic analysis. RESULTS: The nurses' interviews yielded several themes including development of the nurse-patient relationship (14/20 nurses), good communication skills and examples of questions they use to 'create openings' to facilitate care. Barriers were identified as follows: lack of time (11/20 nurses), skills, privacy and fear of what you may uncover, unresolved symptoms and differences in culture or belief. Novel to our study, the nurses offered strategies that included the following: undertaking further education in this area, being self-aware and ensuring the setting is conducive to in-depth conversations and interactions and documentation and/or interdisciplinary sharing for continuity of care. CONCLUSION: Palliative care nurses are well placed to provide existential and spiritual

		care to patients with the primary facilitator being the nurse-patient relationship, the primary barrier being lack of time and the primary strategy being undertaking further education in this area. RELEVANCE TO CLINICAL PRACTICE: These findings could be used for nurse-support programmes, undergraduate or graduate studies or communication workshop for nurses.
Lawrence et al. (2008)	Survey	This survey investigates the role and views of NHS spiritual advisors across the United Kingdom on the provision of pastoral care for elderly people with mental health needs. The College of Health Care Chaplains provided a database, and questionnaires were sent to 405 registered NHS chaplains/spiritual advisors. The response rate was 59%. Quantitative and qualitative analyses were carried out. Spiritual advisors describe their working patterns and understanding of their roles within the modern NHS, and their observations of the level of NHS staff awareness of the importance of spiritual issues in the mental health care of older adults. They provide insights into possible negative and positive perceptions of their roles at a service level, and contribute suggestions of topics relevant to shared education between pastoral care and clinical services. This survey further highlights ethical and operational dimensions at the point of integration of the work of spiritual advisors and multidisciplinary teams.
Moran (2005)	Survey	Clergy (N = 179) in the catchment areas of four hospitals in New York and Connecticut were surveyed about their pastoral care activities. Factor analysis revealed two separate sets of problems presented in pastoral counselling, with respect to clergy's ratings of their competence to address them. The first factor included grief, death and dying, anxiety, and marital problems, in descending order of frequency. The second factor consisted of depression, alcohol/drugs, domestic violence, severe mental illness, HIV/AIDS, and suicide. Clergy were significantly less confident of their ability to deal with Factor 2 problems, yet clergy rarely consulted with mental-health professionals about either type of problem. Less than half of the clergy had training in Clinical Pastoral Education, but those who did tended to feel they were more competent to deal with both types of problems. On average, clergy devoted 3.7 hours per week to visiting patients and nearly 55% said they were "definitely more likely" to refer a patient to a hospital with a pastoral care department.
Perechocky et al. (2014)	Pilot Program	INTRODUCTION: Medical students have typically received relatively modest training in approaches for engaging the concerns of patients and families facing life-threatening situations and terminal illnesses. We propose that medical students would perceive benefits to their communication skills, understanding of the role of the chaplain, and knowledge of emotional and spiritual needs of grieving patients and families after shadowing hospital-based trauma chaplains whose work focuses on emergency department traumas and intensive care units. METHODS: The authors developed a pilot program in which medical students shadowed a trauma chaplain during an on-call shift in an urban level 1 trauma center. Students subsequently completed an evaluative survey of their experience. RESULTS: Of 21 participants, 14 (67%) completed the questionnaire. Students observed an average of 1.50 traumas and 3.57 interactions with patients or families. One-third of the students witnessed a death. More than 90% of respondents agreed or strongly agreed that (1) the program provided them with a greater understanding of how to engage patients and families in difficult conversations; (2) they learned about the chaplain's role in the hospital; and (3) the experience was useful for their medical education, careers, and personal development. About two-thirds (9/14) perceived that they learned how to discuss spirituality with patients and families. All recommended the experience be part of the medical school curriculum. DISCUSSION: Observational experiences with hospital-based trauma chaplains might be an effective nondidactic approach for teaching medical students effective communication with patients and families, collaboration with chaplains, and spirituality in patient care.
Puchalski et al. (2014)	Discussion/Descriptive	Two conferences, *Creating More Compassionate Systems of Care* (November 2012) and *On Improving the Spiritual Dimension of Whole Person Care: The Transformational Role of Compassion, Love and Forgiveness in Health Care* (January 2013), were convened with the goals of reaching consensus on approaches to the integration of spirituality into health care structures at all levels and development of strategies to create more compassionate systems of care. The conferences built on the work of a 2009 consensus conference, Improving the Quality of Spiritual Care as a Dimension of Palliative Care. Conference organizers in 2012 and 2013 aimed to identify consensus-derived care standards and recommendations for implementing them by building and expanding on the 2009

		conference model of interprofessional spiritual care and its recommendations for palliative care. The 2013 conference built on the 2012 conference to produce a set of standards and recommended strategies for integrating spiritual care across the entire health care continuum, not just palliative care. Deliberations were based on evidence that spiritual care is a fundamental component of high-quality compassionate health care and it is most effective when it is recognized and reflected in the attitudes and actions of both patients and health care providers.
Pugh et al. (2010)	Discussion	Despite its importance in end of life care, spiritual care is poorly addressed. This article presents the results of an innovative service in which nurses notify hospital chaplains of all patients placed on the Liverpool Care Pathway and the chaplains then visit to offer spiritual support to both patients and their carers. Nurses reported that the service was valuable not only for patients and their families but also for themselves and the whole clinical team. All nurses said they wanted the service to continue.
Rabow and Knish (2015)	Retrospective study	Spiritual well-being is threatened by cancer, but its correlation with other illness symptoms and the efficacy of palliative care (PC) to ameliorate spiritual suffering are not well understood. We conducted a retrospective study using a convenience sample of oncology patients at a comprehensive cancer center who received concurrent oncologic and palliative care between 2008 and 2011 and completed ESAS, QUAL-E, and Steinhauser Spiritual well-being survey questions was conducted. Descriptive, correlation, and t test statistics. Eight hundred eighty-three patients surveyed had an average age of 65.6 years, with 54.1 % female, 69.3 % white, and 49.3 % married. Half (452, 51.2 %) had metastatic disease. Religious affiliation was reported as Christian by 20.3 %, Catholic by 18.7 %, and "none" by 39.0 %. Baseline spiritual well-being was not significantly correlated with age, gender, race, cancer stage, marital status, insurance provider, or having a religious affiliation. Greater spiritual well-being was correlated with greater quality of life (<p=0.001) and well-being (<p=0.001), and with less depression (<p=0.001), anxiety (<p=0.001), fatigue (p=0.005), and pain (p=0.01). In multiple regression analysis, the associations persisted between spiritual well-being and anxiety, depression, fatigue, and quality of life (R ^sup 2^=0.677). Spiritual well-being improved comparing mean scores immediately prior to initial PC consultation with those at first follow-up (2.89 vs. 3.23 on a 1-5 scale, p=0.005). Among patients with cancer receiving concurrent oncologic and palliative care, spiritual well-being was not associated with patient age, gender, or race, or disease stage. It was correlated with physical and emotional symptoms. Spiritual well-being scores improved from just prior to the initial PC consultation to just prior to the first PC follow-up visit.
Raffay (2014)	Literature review	AIM: To explore how our understanding of care practice is shaped by the extent of our engagement with staff and patient experience. BACKGROUND: In spite of the fact that service users desire good spiritual care and that government guidelines recognize its importance, frontline staff in psychiatric settings often find current spiritual assessment tools hard to use and the concept of spirituality difficult to comprehend. METHOD: A database search was conducted, the grey literature analysed, spirituality assessment tools were explored, and an approach based on user experience was considered. KEY ISSUES: Each of these four perspectives resulted in different perceptions of care. CONCLUSIONS: By engaging patient and staff experience, we begin to see spiritual care very differently. There may be rich opportunities for research into the lived experience of the support systems that service users create for each other on wards when they experience staff as inaccessible. IMPLICATIONS FOR NURSING MANAGEMENT: Deeper engagement with patients and staff and their concerns is likely to result in breakthroughs in both the understanding and the practice of spiritual care as well as potentially other areas of nursing care.
Seyedrasooly et al. (2014)	Descriptive correlational	INTRODUCTION: Disclosure of cancer prognosis is one of the most difficult challenges in caring of cancer patients. An exact effect of prognosis disclosure on spiritual wellbeing of cancer patient was not completely investigated. Therefore, the present study aimed to investigate the relationship between perception of prognosis and spiritual well-being among cancer patients. METHODS: In this descriptive-correlational study, which conducted in 2013, two hundred cancer patients referred to Shahid Ghazi Hospital and private offices of two oncologists in Tabriz participated with convenience sampling method. Perception of prognosis was investigated by Perception of Prognosis Inventory and spiritual wellbeing of cancer patients was investigated by Paloutzian and Ellison Inventory. Data were analyzed using descriptive statistics and Pearson correlation test. RESULTS: Participants reported positive perception about the

		prognosis of their disease (score 11 from 15) and rated their spiritual well-being as high (score 99 from 120). There was a positive correlation between the perception of prognosis and spiritual health among cancer patients. CONCLUSION: Disclosure of cancer prognosis has negative effects on cancer patients. This result highlights the importance of considering cultural factors in disclosure of cancer prognosis. According to limitations of the present study approving these results need more studies.
Wong and Yau (2010)	Descriptive phenomenological	Nurses emphasize spiritual care in maintaining patients' holistic health; however, the provision for spiritual care is found to be inadequate. The limited study in exploring the nurses' perception on applying spiritual care in Hong Kong has been noted. This descriptive phenomenological study investigated the experiences of spirituality and spiritual care in Hong Kong from the nurses' perspective. Ten nurses were purposively invited for an unstructured interview. Thematic analysis was used for data analysis, and three themes emerged: the meaning of spirituality, benefits of applying spiritual care, and difficulties in applying spiritual care. This study provided preliminary insights into the development of spiritual care in Hong Kong.

Appendix 4 - *Range of Documentation Styles for Pastoral Care*

Author	Documentation Format	Identifiers	Examples
Burkhart, Coglianese, et al. (2011)	Electronic Systematic Nomenclature of Medicine Clinical Terms, or SNOMED CT	Includes terms such as spiritual assessment, fear, coping, hope, grieving that also can be measured on a 5-point Likert scale, where 1 is the worst state and 5 is the best state	No examples
	Progress Notes	PIE Problem, Intervention, Evaluation SOAP Subjective, Objective, Assessment, Plan.	No examples
Donovan (ND.)	Progress Notes		Avoid Statements that are Not Observable. - Patient understood the clinical situation. - Patient stated, "I understand what the doctor is saying." Avoid Statements that are Outside your Scope of Practice. - The patient is close to death. - The nurse indicated "death is imminent." - Reinforce your Professionalism. - Visited with nurse before seeing patient. - Consulted with RN to review recent events / social hx. (Note: families visit; professionals see patients or consult.) Do Not Imply that Showing Up Is Enough - Plan: Follow-up Daily - Your suggestions? Use Legal Language Carefully and Correctly - AMD Consult: Patient did not seem competent. - Patient was alert and oriented to year, but not to place, president, or situation. I was not comfortable proceeding at this time
Handzo (2007)	Electronic Records	Spiritual Screening, Spiritual History, Spiritual Assessment, Profile/Diagnosis/Spiritual Treatment Plan, Interventions, and Measurement/Current Assessment/Outcomes	No examples
Henager (2008) PowerPoint presentation	Progress Notes	Assessment, Interventions and Outcomes	No examples

Hilsman (2009) Franciscan Health System	Progress Notes		1. What – Title - Pastoral Care (Spiritual Care) 2. When – Date / Time (24 hour clock) 3. Who – The Patient 4. Why you met this person 5. (Why she is hospitalized) 6. How she related to you in the encounter 7. What – Issues – Assessment descriptions/concepts 8. What – Chaplain functions - performed for this person 9. What – Plan – What you will do for this person 10. Who – You - Signature & professional identity
Hull (2011) Saint Louis University Hospital in Saint Louis, MO	Electronic charting – Meditech Progress Notes	"At our hospital we follow a specific format for a Progress Note: "Need," "Intervention," and "Response."	Need – what was the referral or the need of the patient; Intervention – what did the chaplain do, what went on with the chaplain and patient, and or family; what next; Response – what response did the patient or family have No specific examples offered
Nelson and Stang (ND) Ottawa Hospital		Activity, Intervention, Outcome Reason / Source for Referral: Personal / Spiritual History: Spiritual-Religious-Cultural Practices / Rituals: Spiritual / Emotional Status: Spiritual Support / Interventions: Outcomes: Spiritual Care Plan:	No examples
Peery (2008)	Electronic Records	Reason Interventions Outcomes Assessment Plan	No examples
Ruff (1996), Hennepin County Medical Center in Minneapolis, MN	SOAP	S = Subjective Information, O = Objective Information, A = Assessment, and P = Plan (of care)	S: "It sure is a good feeling to be getting out of here today." 0: Pt sitting up in bed. Was friendly and quite willing to talk. Spoke of how this hospitalization caused him to "take stock" of his life. He stated he "made his peace" with God 5 years ago and that gives him a "comfortable" feeling. Said tomorrow is his 68th birthday and he is looking forward to starting a new decade of his life in a couple of years. A: Pt appears comfortable with his condition although more acutely aware of his mortality. Hence his talk of taking stock of his life. Appears to be using his faith in God as an anchor for his reflection upon life.

			P: Do not plan to visit pt again unless discharge plans change.
Standards of Practice developed through the Association for Professional Chaplains (2009) http://www.professionalchaplains.org/files/professional_standards/standards_of_practice/standards_practice_professional_chaplains_acute_care.pdf	Medical record	Documentation should include but is not limited to the following: Spiritual/religious preference and desire for or refusal of on-going chaplaincy care. Reason for encounter. Critical elements of spiritual/religious assessment. Patient's desired outcome with regard to care plan. Chaplain's plan of care relevant to patient/family goals. Indication of referrals made by chaplain on behalf of patient/family. Relevant outcomes resulting from chaplain's intervention	Documentation in medical record of: - Spiritual/religious screening and assessment. - Patient's on-going spiritual/religious and ritual needs and the plan for meeting such needs, e.g., anointing, communion, Sabbath candles, clergy visits. - Spiritual/religious struggle issues that affect the plan of care. - The patient's wish to receive or terminate on-going chaplaincy care. - Chaplain's participation on interdisciplinary teams affecting patient's plan of care.
Standards of Practice for Professional Chaplains in Long-term Care http://www.professionalchaplains.org/files/professional_standards/standards_of_practice/sop_longtermcare.pdf	In facilities not using a medical model, documentation should include:	• Spiritual/ religious preference. • Relevant information obtained from spiritual screen. • Resident's involvement in spiritual care activities. • Referrals to chaplain for spiritual assessment and intervention.	Information gathered by a spiritual screen may be summarized by the chaplain or his/her designee in the **resident** service record. This documentation would include the resident's preferences for particular religious, cultural or spiritual activities. Because **resident** service records do not have the same confidentiality protection standards as medical records, the chaplain must ensure that the resident's confidentiality is maintained with respect to personal information.
University of Toledo Medical Record Documentation Policy	Progress Notes	SOAP format	No examples
Wintz (2008)	Electronic	Reason, Assessment, Contributing Outcomes, Plan for ongoing care, Recommendations	No examples

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