Standards for Spiritual Care Services in the NHS in Wales 2010

These standards are issued under section 47 of the Health and Social Care Community Health and Standards Act 2003

Supported by

UK BHC UK Board of Healthcare Chaplaincy

Association of Hospice & Palliative Care Chaplains

College of Health Care Chaplains

Scottish Association of Chaplains in Healthcare

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Introduction

These standards are issued under the powers contained in section 47 of the Health and Social Care Community Health and Standards Act 2003. They are presented to facilitate the audit of spiritual and religious care services, to ensure equality across services and to develop and integrated approach to the delivery of spiritual and religious care while at the same time being open the diversity of local services and needs, and to inform and provide an evidence base of good practice for the future development of spiritual and religious care in the NHS in Wales. The standards apply to spiritual care services funded by NHS Local Health Boards and Trusts.

Wales has a rich and diverse heritage of culture, faiths and beliefs. While spiritual care is a universal need and should therefore be available to every patient, both adult and child, as part of holistic care, the religious needs of faith communities or belief groups are specific and come within the equality and diversity agenda. It is the task of spiritual care services and standards to address both of these areas equally. The intention of these standards is to be open to and inclusive of all individuals, in order to respect a variety of beliefs, lifestyles and cultural backgrounds within the NHS in Wales today To facilitate that openness common terms have been developed and are described in the definition of terms, e.g. *faith communities* is used to describe those who see themselves adhering to a particular faith while *belief groups* is used to describe those who would recognise themselves holding individual or group beliefs such as a humanist. The working party recognise the differing understanding of terms and the communication difficulties that come with openness and inclusion however, a key element in the provision of spiritual and religious care is to work through spiritual care services to facilitate and support safe, high quality and efficient care for the services and citizens of Wales as outlined in *Doing Well, Doing Better: Standards for Health Services in Wales*.

These standards apply to all NHS services including acute general and mental health services for children, young people and adults. Where there is an issue of a patient's ability to communicate then the normal protocols would apply.

Essential to understanding the context of these Standards for NHS Spiritual Care is to recognise where they align across to *Doing Well, Doing Better: Standards for Health Services in Wales*, and how they can be delivered at a local level to ensure that services are "doing the right thing, at the right time, for the right patient in the right place and with the right staff".

These Spiritual Care standards set out the:

- criteria for what patients, carers, staff and volunteers can expect from Spiritual Care Services in Wales (These would need to be developed at a local level and form part of the strategic documents within each NHS organisation in Wales);
- criteria for how spiritual care services will be put into practice by the service primarily responsible for delivering spiritual care: Spiritual care Services (These would need to be developed at a local level and form part of the strategic documents within each organisation in Wales);
- capabilities and competencies in Spiritual Care which describe and assess the competence of individual healthcare professionals, including chaplains/ spiritual care-givers, to provide spiritual care (These would need to be developed at a local level and form part of the strategic documents within each organisation in Wales).

Acknowledgements

These standards have been adapted from the *'Standards for NHS Scotland Chaplaincy Services 2007'* (NHS Education Scotland, 2007). The Welsh Assembly Government acknowledges with thanks the support and permission of NHS Education Scotland to use and adapt these standards. The Welsh Assembly Government also acknowledges the insight and experience from the four spiritual care professional bodies: the United Kingdom Board of Healthcare Chaplaincy, the Association of Hospice and Palliative Care Chaplains (AHPCC), the College of Health Care Chaplains (CHCC), and the Scottish Association of Chaplains in Healthcare (SACH).

Audit

An audit of spiritual care services using the Standards for Spiritual Care Services in the NHS in Wales should be carried out within 1 year of their introduction to provide a benchmark for spiritual care services.

The Standards for Spiritual Care Services in the NHS in Wales should be audited once in every 3 years. (A number of standards may be audited each year as long as all are audited within a 3 year period).

To assist in the process of audit an assessment tool has been included with these standards.

Definition of terms

Belief group	Any group which has a cohesive system of values or beliefs but which does not self classify as a faith community.
Chaplain/ Spiritual Care Giver	A person who is appointed and recognised as part of the specialist spiritual care team within a health care setting. His or her job is to seek out and respond to those who are expressing spiritual and religious need by providing the appropriate care, or facilitating that care, through contacting, with the patient's permission, an appropriate faith/belief group representative.
Spiritual Care services	The services provided by the individual or team of spiritual care-givers who are employed as specialist spiritual care providers/facilitators. Often this is known as the Department of Spiritual and Religious or Pastoral care. Such services seek to answer or facilitate the appropriate spiritual or religious care to patients, carers and staff within the NHS in Wales.
Clinical supervision	Clinical supervision is essential to maintain best practice and to ensure safe practice. It addresses the well being of patients/clients and of practitioners. It usually takes the form of case studies and reflective practice and is facilitated by one with counselling and supervisory skills - very often another health professional such as a clinical psychologist. Clinical supervision for healthcare chaplains/ spiritual care givers should not be confused with management supervision or supervision through the faith community. Clinical supervision should occur during working time and at no cost to the practitioner.
Faith community	A recognisable group who share a belief system, and usually undertake religious practices such as prayer, scripture reading, meditation, and communal acts of worship.
Spiritual and religious care	Religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community, by members of the clergy of the patient's own faith. Spiritual care is usually given in a one to one relationship, is completely person centred and makes no assumptions about personal conviction of life orientation Spiritual Care is not necessarily religious. Religious care, at its best is always spiritual. (NHS HDL(2002) 76)

Standard 1 Spiritual & religious care

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
Standards 2, 5, 7, 8, 9, 10, 12, 14, 17, 18, 24, 25 and 26.	Patients and their carers have their spiritual and religious needs assessed and addressed.	Spiritual and religious care has been shown to be important to patients and is acknowledged to have a significant and beneficial impact on patient outcomes. Spiritual and religious needs may be assessed and addressed by members of the healthcare team, which includes the chaplain/spiritual care giver, or with the patient's permission by contacting the patient's own faith representative. Given that spiritual and religious needs can change from moment to moment, a process of continuous assessment enables healthcare professionals to be responsive to patients and their family/carer's needs. Chaplains/ Spiritual care-givers have an expertise in spiritual and religious care and using the security of their own belief system are enabled to discern and assess the varied spiritual and religious needs of all patients, and where appropriate, their carers: e.g. the parents of patients who are children and young people and the carers of adults with incapacity. Patients should be protected from unwanted visits from spiritual and religious representatives or groups. **References** Everyone whether religious or not needs support and when confronting serious or life threatening illness or injury may have spiritual needs and welcome spiritual care as they seek to cope with suffering, loss, fear, loneliness, anxiety, uncertainty, impairment, despair, anger or guilt. Those associated with a faith community may derive help and comfort from their beliefs, from the rituals and ceremonies of their faith, and the ministry of its leaders. The NHS must offer both spiritual and religious care with equal skill and enthusiasm. **Religious Care** is given in the context of the shared beliefs, values, liturgies and lifestyle of a faith community. **Spiritual Care** is usually given in a one to one relationship and is completely person centred and makes no assumptions or judgement about the person, their personal conviction or life orientation. Spiritual Care is not necessarily religious. Religious Care, at its best, should always be spiritual. (NHS HDL (2002) 76)	**(a) Spiritual** 1.a.1 Spiritual needs are assessed and addressed and may include the following: • exploring the individual's sense of meaning and purpose in life; • exploring attitudes, beliefs, ideas, values and concerns around life and death; • affirming life and worth by encouraging reminiscing of the past; • exploring the individual's hopes and fears regarding the present and future; • exploring the individuals concerns about how their illness will affect others; • exploring the 'WHY?' questions in relation to life, death, illness and suffering. 1.a.2 Liaise with local or national resources for spiritual support and with the patient's permission contact relevant groups/individuals. **(b) Religious** 1.b.1 Religious needs are assessed and addressed and may include the following: • ceremonies; • meditation; • prayer; • rites; • sacraments; • worship. 1.b.2 With the patient's permission facilitate referrals to local faith groups and religious leaders. **(c) Protecting patients** 1.c.1 Protect patients and their carers from unwanted visits from spiritual or religious groups and representatives however chaplains/spiritual care-givers need to demonstrate sensitivity to individual circumstances.

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
		Spiritual issues have been shown to be important for patients with lung cancer or heart failure to the extent that the researchers express concern about healthcare professionals' lack of time and skills to address such issues. (Murray et al 2004)	
		Spiritual issues have been shown to be important for patients with lung cancer or heart failure to the extent that the researchers express concern about healthcare professionals' lack of time and skills to address such issues. (Murray et al 2004) Spiritual care benefits from a process of continuous assessment. The key to such assessment is the knowledge skills and actions of the multidisciplinary team. Chaplaincy/ Spiritual Care often has its roots in religion however, for the generic chaplain/ spiritual care giver their personal faith provides a base from where they can journey with people of different religious traditions and those who hold another life stance. (Chaplin and Mitchell, 2005)	

Standard 2 Access to spiritual care services

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
Standards 2, 8, 9, 10 and 24.	All patients and carers have information about and access to the spiritual care service.	Effective healthcare requires a holistic approach to patient care including physical, psychological, social, and spiritual aspects of care. While all staff and volunteers have the potential to provide or facilitate spiritual care spiritual care-givers have a particular expertise in the spiritual, religious and cultural elements of patient care. **References** All health services should make provision so that proper personal consideration is shown to the patient, for example, by ensuring that the patient's privacy, dignity and religious and cultural beliefs are respected. The task of spiritual assessment is a skilled task best undertaken by those who directly care for patients and their families. Staff who are aware of spiritual need should be proactive in offering spiritual care and accessing spiritual care services. Spiritual care should be a flexible service offering 24 hour cover. The role should not be confined to crises and emergencies. Spiritual care-givers have wide ranging experience and specialist knowledge which enables them to work with staff, patients, and carers in exploring areas of need (NAHAT, 1996).	2.1 All patients receive written information in an appropriate language and format on admission containing details of the spiritual care service available within the unit. 2.2 The written information contains an explanation of the spiritual care service, examples of situations in which the spiritual care service might be used and how contact with the spiritual care service may be obtained. 2.3 The written information is supported by verbal explanation of access to the spiritual care service during assessment. 2.4 The admission procedure ensures a check that written information is given. 2.5 There is a written protocol for referral to the spiritual care service, including out of hours. (Note: The protocol may provide for the referrals themselves to be verbal)

Standard 3 Working with faith communities and belief groups

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
Standards 2, 7, 8, 9, 10, 17, 24 and 26.	Spiritual care services should work in co-operation with faith communities and belief groups to ensure the appropriate provision of religious and spiritual care for patients and their carers.	It is recognised that patients and carers who are members of faith communities and belief groups may have specific requirements which can only be provided by leaders from their own communities/groups, in particular rites and ceremonies (See Standard 1 Criteria 1.4). Given that patient requests may come at short notice it is essential that there is a local referral protocol and that spiritual care services maintain and review a directory of local and national faith representatives and belief group leaders with contact details. Spiritual care-givers have a role in facilitating contact, maintaining links, and advising local faith communities and belief groups on healthcare matters relating to spiritual and religious care. Following discharge it is the faith community and belief group leaders who are most likely to provide support for their own members in the community. **References** Whole-time spiritual caregivers will normally be responsible for facilitating the ministry in hospital or other NHS facility of the religious leaders of faith communities who may seek assistance and advice (NHS HDL (2002) 76). Providing spiritual care cannot be accomplished working in isolation and spiritual care-givers must be able to work effectively with other spiritual care-givers, health and social care professionals, and representatives of faith groups or communities. (AHPCC, CHCC, SACH, 2005)	3.1 Spiritual care services are an informed resource on spiritual and religious care for NHS staff and local faith community and belief group leaders. 3.2 Spiritual care services will maintain links between the NHS and local faith community and belief group leaders e.g. through the spiritual care committee and training events. 3.3 A written protocol is in place for NHS staff to refer to local faith community leaders and belief group representatives. The protocol should include clear guidance stating that faith leaders can only be contacted with the permission of the patient or their family/carers. 3.4 A directory of contact numbers for representatives from local faith communities and belief groups is available in hospitals and units. The directory should include national contact numbers for smaller faith communities and belief groups, or numbers that are likely to change e.g. the representative lives in their own home. 3.5 The local directory should be regularly updated and the faith communities and belief groups consulted on its content and updating. 3.6 A manual outlining the principal beliefs and practices of the major faith communities and belief groups is available in all hospitals and units. Where a local manual is also in use the relevant communities and belief groups should be consulted and this local manual should include: • Religious/belief issues that have an impact on healthcare practice with suggested alternatives e.g. blood transfusions; • Religious/belief needs that have implications for the patients stay and well being e.g. diet, prayer, rites and ceremonies; • What to do in the event of an unexpected death e.g. a summary of common practices, dos and don'ts; • Information about actions or situations where it is important to be sensitive. 3.7 A written protocol for liaison and exchange of information with the identified representatives of faith communities and belief groups is in place. The protocol should respect patient confidentiality, adhere to the hospitals guidelines on the use of patient information, and protect patients from unwanted visits (See Standard 1 Criteria 1.c.1).

Standard 4 Staff support

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
Standards 2, 10, 25 and 26.	As part of the hospital or unit's provision of support for staff and volunteers the chaplain/ spiritual care giver offers personal and professional support.	It is recognised that working in a health care setting is stressful and may lead people to question their personal beliefs and philosophy including their understanding of life, death, illness, suffering and ethical issues. The complexity of issues can also cause professionals to question and reflect on their professional beliefs and to break new ground. Spiritual care can offer an informed, confidential resource to enable individuals and groups to reflect on their beliefs, philosophy and practice. **References** …spiritual caregivers will normally be responsible for supporting staff through pastoral care, the ministry of presence and, where appropriate, counselling; in consultation with local voluntary services, selecting, training, supporting and supervising volunteers to work with the chaplain/ spiritual care giver and elsewhere. (NHS HDL (2002) 76)	4.1 The spiritual care service builds working relationships with members of staff and volunteers. 4.2 The spiritual care service responds to requests from members of staff and volunteers for personal and professional support. 4.3 The spiritual care service responds to requests from members of staff and volunteers for spiritual and religious support. 4.4 With the staff member's permission the spiritual care service facilitates referrals to other sources of support with credible and assured standards equivalent to those of the NHS.

Standard 5 Education, training and research

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
Standards 21, 24, 25 and 26.	The spiritual care service is committed to supporting the continuing professional development of chaplains/ spiritual care-givers and contributes to the healthcare team's professional education, training and research programmes.	Continuing Professional Development (CPD) within the Knowledge and Skills Framework enables chaplains/ spiritual care-givers to develop their capabilities and potential to fulfil their role within the healthcare team. Through CPD the chaplain/ spiritual care giver will know what is expected of them, get feedback on their performance and will be able to identify and satisfy their development needs. Accessing individual or group clinical supervision which is focused on reflective practice is an integral part of CPD. Education and training of healthcare staff on the issues involved in the provision of spiritual and religious care, including the role of the chaplain/ spiritual care giver enhances the confidence and knowledge of care and can improve care for patients and their carers. Increasing expectations and new technologies, drugs and treatments can raise ethical questions for all healthcare professionals. Experienced chaplains/ spiritual care-givers can be an informed resource to support healthcare professionals, patients and carers in the discussion of ethical issues. The promotion of evidence based practice is enabled and supported by active participation in research. **References** The Board makes recommendations concerning professional education and training for chaplains/ spiritual care-givers at all levels and operates a scheme for awarding points in recognition of continuing professional education (CAAB, 2005). The NHS Knowledge and Skills Framework defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. (DoH 2004) Priorities in spiritual care include the training of different staff groups on the potential impact of the delivery of spiritual care to patients and their relatives, and the role staff groups may play in this (NHS QIS, 2005).	5.1 Spiritual care services are committed to continuing professional development (CPD) within the Knowledge and Skills Framework and all spiritual care-givers keep an annual record / portfolio that evidence CPD. This can include: • Attendance or presentation at conferences; • Formal education (courses attended or taught); • Teaching delivered; • Articles and books written or reviewed; • Journal club; • Reflective practice, e.g. Clinical Supervision or Clinical Pastoral Education (CPE). 5.2 The spiritual care service contributes to staff induction for new members of the healthcare team. 5.3 The spiritual care service contributes to the healthcare team's education and training programme. Topics may include: • Spiritual and Religious Care; • The Role of the Spiritual care Service and Spiritual care-givers; • Loss, Grief, and Bereavement; • Making a spiritual assessment. • Diversity issues relating to religion and belief 5.4 The spiritual care service makes recommendations for educational and training resources. e.g. recommendations for the unit's library, an appropriate course or attendance at a conference. 5.5 The spiritual care service is available to the healthcare team as an informed resource for ethical issues and discussion. e.g. serving on a local ethics committee, for consultation on individual cases, contributing to ethical debate and discussion (See also criteria 7.4). 5.6 The spiritual care service is aware of current research and best practice and considers and implements its findings.

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
		Chaplains/ Spiritual care-givers are support system for those engaged with the ethical dilemmas which advancing technologies and heightened expectations bring at the beginning and end of life (NHS HDL (2002) 76) Fostering a research based culture is essential to support the promotion of evidence based practice. (SYWDU 2003, 62 p18) Chaplains/ Spiritual care department or team should become involved with research e.g. collaborate with existing research teams and develop and take the lead informing research questions and projects (Speck, 2005).	

Standard 6 Resources

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
Standards 2, 10, 12, 18, 20, 24, 25 and 26.	The unit ensures the spiritual care service is provided with the resources to fulfil service standards, job description, supervision and training needs.	To enable chaplains/ spiritual care-givers to fulfil their remit as a health care professional the resources required to meet the standards for spiritual care services should be made available. All employed members of the spiritual care team/spiritual care department should receive an induction to the post and undertake introductory training. Members of the spiritual care service require access to continuing professional development, education and training to enable, maintain and enhance their skills. Professional organisations and specialist interest groups can provide advice, a source of experience and professional/ personal development opportunities for individuals and units. **References** All NHS Organisations, wherever feasible, should have either a Quiet Room, Multi-faith Sanctuary or Worship Space, or a room for meeting and teaching. Information and Signage (NHSHDL (2002) 76) There should be a system for accurate documentation and referral for those who wish to request a visit from a chaplain/ spiritual care giver or chosen faith representative. Patients and relatives will have access to a suitable room for private reflection, worship or religious observance. (NAHAT, 1996)	**(a) Spiritual care services should have:** 6.a.1 Access to quiet and private areas for confidential support of patients, carers, staff and volunteers. 6.a.2 Access to a multi-faith facility acceptable for the religious observance of all faiths. 6.a.3 Access to patient information systems for providing and facilitating appropriate spiritual or religious care and recording information and interventions. 6.a.4 Access to office accommodation and administrative support. 6.a.5 Access to communication systems to facilitate internal communication and on-call cover. For example: • Pager, mobile phone • Intranet • E-mail 6.a.6 Sufficient hours to meet the spiritual and religious needs of patients, carers, staff and volunteers, including out of hours cover. **All chaplains/ spiritual care-givers have:** 6.a.7 Received an induction to their post (new chaplains/ spiritual care-givers appointed 2010 on). 6.a.8. Undertaken introductory training (new chaplains/ spiritual care-givers appointed 2010 on). 6.a.9 Regular appraisal (at least annually) to review professional development and training needs. Identified needs to be resourced. 6.a.10 Access to external professional supervision (see criteria 5.1). **(b) It is desirable that Chaplains/ Spiritual care-givers have:** 6.b.1 Links to a professional multi-faith, interdenominational spiritual care association and/or a faith-based group if there is one. e.g. • Association of Hospice and Palliative Care Chaplains

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
			(AHPCC) • Association of Roman Catholic Chaplains in Healthcare (RCCHC) • College of Health Care Chaplains (CHCC) • Scottish Association of Chaplains in Healthcare (SACH) • United Kingdom Board of Healthcare Chaplaincy (UKBHC) .
			6.b.2 Have a recognised status within a mainstream faith community or belief group.

Standard 7 Spiritual care to the hospital or unit

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
Standards 2, 4, 5, 10, 12, 18, 24 and 25.	The spiritual care service is resource for the hospital or unit's major incident plan and other events that need a communal recognition and action.	Spiritual care services have a significant contribution to make when a major incident has been declared for example providing support to relatives and staff and offering spiritual and religious support to the injured or dying. Policies and procedures relating to major incidents should include the Spiritual care service. Events in the hospital or unit, external events such as natural disasters, world events, or personal events such as the death of a member of staff can create individual or collective needs that the chaplain/ spiritual care giver is best placed to address, either through pastoral care or by holding a suitable communal ceremony. Where appropriate consideration should be given to involving representatives of other faith communities and belief groups. Through regular staff contact the chaplain/ spiritual care giver may have insight into significant factors affecting the morale of the unit. The morale of the unit can be enhanced by raising issues and concerns with managers without breaking individual confidences. Through links with local communities, patients, carers and staff spiritual care-givers can have insight and experience that can be used as an experienced ethical resource to inform changes in healthcare services and provision. **References** Spiritual care-givers have a duty to care for the colleagues they work with. Those who are frequently exposed to high stress situations require support, comfort and counsel If this is provided in a sensitive and timely manner, it can reduce the incidence of breakdown, absenteeism and low morale. (NAHAT, 1996) In understanding the relationship of spirituality to healthcare, chaplains/ spiritual care-givers recognise that values, meaning and beliefs play an important role in the life and work of the healthcare organisation. This	7.1 The spiritual care service is included in the hospital or unit's policies and procedures for responding to major incidents. For example: • The spiritual care service is included in the call out list • Members of the spiritual care service are involved in emergency exercises • Use of the spiritual care centre • Liaison with local faith communities and belief groups **The spiritual care service responds to:** 7.2 Events in the unit which are having an impact on staff and require a communal response or event. For example: • Death or illness in a member of staff; • Unusual patient or family events. 7.3 Events external to the unit which are having an impact on staff and require a communal response or event. For example: • National disasters; • World events; • Remembrance / anniversaries. 7.4 An awareness of issues or events affecting the morale or functioning of the unit which require management awareness to resolve. For example: • Managing change; • Communication. 7.5 Requests for consultation on ethical issues relating to restructuring, changes in buildings, local priorities and working practices. For example: • Restructuring of services; • Impact on patients, carers and staff; • Equality and diversity; (Also see criteria 5.5)

Doing well, Doing Better: Standards for Health Services	Standard Statement	Rationale	Criteria
		distinctive approach enables the chaplain/ spiritual care giver to be a resource to the institution and provide insight into a wide range of issues. (SYWDU, 2003)	

References

AHPCC (2006) *Standards for Hospice and Palliative Care Chaplaincy*. 2nd Edition. London: Association of Hospice and Palliative Care Chaplains.
AHPCC, CHCC and SACH (2005) *Health Care Chaplains Code of Conduct,* Association of Hospice and Palliative Care Chaplains, College of Health Care Chaplains, Scottish Association of Chaplains in Healthcare.
CAAB (2005) *Continuing Professional Development.* http://www.caabweb.org.uk/accreditation.asp (Accessed March 2006)
Chaplin J. and Mitchell D. (2005) *Spirituality in Palliative Care*. In McIntyre R, Lugton J, editors. Palliative Care-The Nursing Role. 2nd ed. Elsevier Churchill Livingstone, Edinburgh.
DoH (2004) The NHS Knowledge and Skills Framework (NHS KSF) and the Development review Process. Department of Health Publications, London
Murray, S. A., Kendall, M., Boyd, K., Worth, A. and Benton, F. T. (2004) 'Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers' *Palliative Medicine,* 18, 39-45.
NAHAT 1996 *Spiritual Care in the NHS: A guide for purchasers and providers.* National Association of Health Authorities and Trusts. Birmingham.
NHS HDL (2002) 76 *Spiritual Care in NHSScotland*. National Health Service Health Department Letter (2002) 76, The Scottish Executive, Edinburgh.
NHS QIS (2005) Report of the Scoping Study on the Provision of Spiritual Care in NHSScotland, NHS Quality Improvement Scotland, Edinburgh.
Patient's Charter 1991 *The Patient's Charter: A charter for Health*. The National Health Service in Scotland. The Scottish Executive, Edinburgh.
Speck, P. (2005) A standard for research in health care chaplaincy. *Journal of Health Care Chaplaincy.* 6 (1), 26-33.
SYWDC (2003) Caring for the Spirit: A strategy for the chaplaincy and spiritual healthcare workforce. South Yorkshire Workforce Development Unit, Sheffield.
UKCC (1996) *Position statement on clinical supervision for nursing and health visiting*. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting.
Welsh Assembly Government (2010) Doing Well, Doing Better: Standards for Health Services in Wales, Cardiff

Bibliography

AHPCC (2006) *Guidelines for Hospice and Palliative Care Chaplaincy* Association of Hospice and Palliative Care Chaplains, www.ahpcc.org.uk
College of Healthcare Chaplains, Free Church Hospital Chaplaincy Board, Hospital Chaplaincies' Council, Roman Catholic Hospital Chaplaincies (1993) Health Care Chaplaincy Standards, NHS Training Directorate, Bristol
DoH (2002) *National Minimum Standards and Regulations for Independent Health Care.* Department of Health, Her Majesty's Stationary Office. Norwich
MFGHC 2005 Draft Spiritual Healthcare Standards, Multifaith Group for Healthcare Chaplaincy, London.
Mitchell, D. and Hibberd, C. (2004) *A Comparative Assessment of Hospice Chaplaincy Services*. Scottish Journal of Healthcare Chaplaincy 7 (1), 6-11.
Standards for NHSScotland Chaplaincy Services 2007, supported by the NHS Education for Scotland

Self Assessment Tool

Introduction

This assessment tool has been developed to assess and audit the Standards for Spiritual care Services in the NHS in Wales.

Audit

An audit of spiritual care services using the Standards for Spiritual care Services in the NHS in Wales will need to be carried out within 1 year of their introduction to provide a benchmark for spiritual care services.

The Standards for Spiritual care Services in the NHS in Wales should be audited once in every 3 years. (A number of standards may be audit each year as long as all are audited within a 3 year period).

Using the self assessment tool

The self assessment tool has five columns, three of which require completion.

Criteria	This column is a duplicate of the spiritual care standards *Criteria* column
Self assessment question	This column poses the audit questions
Answer and evidence	This column is for answers to the questions in the Self assessment question column and the evidence to support the answer e.g. copies of documents and written protocols, results of surveys, policies and procedures etc.
Reviewer comments	This column allows a reviewer to comment on the answers and evidence
Met / not met	This column gives a choice of met or not met, however it may be that you wish to add to this by including partially met or working towards.

Standard 1 Spiritual and religious care

Doing well, Doing Better: Standards for Health Services	Criteria (Standard 1)		Self assessment question	Answer and evidence	Reviewer comments	Met / not met
Standards 2, 5, 7, 8, 9, 10, 12, 14, 17, 18, 24, 25 and 26.	**(a)**	**Spiritual**				
	1.a.1	Spiritual needs are assessed and addressed and may include the following: • exploring the individual's sense of meaning and purpose in life; • exploring attitudes, beliefs, ideas, values and concerns around life and death; • affirming life and worth by encouraging reminiscing of the past; • exploring the individual's hopes and fears regarding the present and future; • exploring the individuals concerns about how their illness will affect others; • exploring the 'WHY?' questions in relation to life, death, illness and suffering.	How do you ensure that patients have had the opportunity for their spiritual and religious needs to be assessed and addressed? (describe the process and how audited e.g. audit of patient information systems (notes or electronic), patient feedback etc.			
	1.a.2	Liaise with local and national resources for spiritual support and with the patient's permission contact relevant groups/individuals.	What systems are in place to liaise with local resources for spiritual support? (give details e.g. a directory of contact numbers for local/national organisations is available) (See also criteria 3.3)			
	(b)	**Religious**				
	1.b.1	Religious needs are assessed and addressed and may include the following: • ceremonies; • meditation; • prayer; • rites; • sacraments; • worship.	How do you ensure that patients and those important to them have had the opportunity for their religious needs to be assessed and addressed? (e.g. audit of patient information systems (notes or electronic), patient feedback etc.)			
	1.b.2	With the patient's permission facilitate referrals to local faith groups and religious leaders.	What systems are in place to refer to local faith groups and religious leaders? (give details, e.g. a directory of contact numbers for local/national organisations is available) (See also criteria 3.3)			

	(c)	**Protecting patients**				
	1.c.1.	Protect patients and their carers from unwanted visits from spiritual or religious groups and representatives.	How are patients protected from unwanted visits spiritual or religious groups or representatives? (e.g. is there a written protocol for the chaplain/spiritual care giver/staff member to contact/inform representatives/faith leaders of the patient's decision? See criteria 3.6)			

Standard 2 Access to spiritual care services.

Doing well, Doing Better: Standards for Health Services	Criteria (Standard 2)		Self assessment question	Answer and evidence	Reviewer comments	Met / not met
Standards 2, 8, 9, 10 and 24.	2.1	All patients receive written information on admission in an appropriate language and format containing details of the spiritual care service available within the unit.	Do patients receive written information on the spiritual care service? (attach a copy as evidence)			
	2.2	The written information contains an explanation of the spiritual care service, examples of situations in which the spiritual care service might be used and how contact with the spiritual care service may be obtained.	Does the information : a. give examples of when to contact spiritual care services? (please give page/paragraph)			
			b. examples of situations in which the spiritual care service might be used? (please give page/paragraph)			
			c. explain how to contact the chaplain/spiritual care giver? (please give page/ paragraph)			
	2.3	The written information is supported by verbal explanation of access to the spiritual care service during assessment.	Is the booklet supported by oral explanation? (give details)			
	2.4	The admission procedure ensures a check that appropriate information is given.	What procedure is in place to check information is given?			
	2.5	There is a written protocol for referral to the spiritual care service, including out of hours. (Note: The protocol may provide for the referrals themselves to be verbal)	Is there a written protocol? (Please attach a copy of the protocol as evidence)			
			Where is the written protocol held? (should be an area accessible to staff e.g. wards, patient notes, local computer network, local services manual etc.)			

Standard 3 Working with faith communities and belief groups

Doing well, Doing Better: Standards for Health Services	Criteria (Standard 3)		Self assessment question	Answer and evidence	Reviewer comments	Met / not met
Standards 2, 7, 8, 9, 10, 17, 24 and 26.	3.1	Spiritual care services are an informed resource on spiritual and religious care for NHS staff and local faith communities and belief group leaders.	In what ways do your spiritual care services act as a resource to staff? (give details)			
			In what ways do your spiritual care services act as a resource to local faith community and belief group leaders? (give details)			
	3.2	Spiritual care services will maintain links between the NHS and local faith community and belief group leaders e.g. through the spiritual care committee and training events.	In what ways do your spiritual care services maintain links with local faith communities and belief groups? (Give details)			
	3.3	A written protocol is in place for NHS staff to refer to local faith community leaders and belief group representatives. The protocol should include clear guidance stating that faith community leaders and belief group representatives can only be contacted with the permission of the patient or their family/carers.	Is there a written protocol for NHS staff to refer to local faith community leaders and belief group representatives? (Please attach a copy of the protocol as evidence)			
			Does the protocol give clear guidance on receiving the patient's permission before contacting faith community leaders and belief group representatives? (please give page/paragraph)			
	3.4	A directory of contact numbers for representatives from local faith communities and belief groups is available in hospitals and units. The directory should include national contact numbers for smaller faith communities and belief groups, or numbers that are likely to change e.g. the representative lives in their own home.	Is there a directory of contact numbers for representatives from local faith communities and belief groups? (Please attach a copy of the directory as evidence)			
			Does the directory include national contact numbers for contacts that might change? (give details)			
			Where is the directory held? (e.g. in wards, on intranet)			

			How do staff access the directory, including out of hours?			
	3.5	The local directory should be regularly updated and the faith communities and belief groups consulted on its content and updating.	When was the directory last updated?			
			How did you consult with local faith communities and belief groups (give details).			
	3.6	A manual outlining the principal beliefs and practices of the major faith communities and belief groups is available in all hospitals and units. Where a local manual is also in use the local manual should include: • Religious/belief issues that have an impact on healthcare practice with suggested alternatives e.g. blood transfusions; • Religious/belief needs that have implications for the patients stay and well being e.g. diet, prayer, rites and ceremonies; • What to do in the event of an unexpected death e.g. a summary of common practices, dos and don'ts; • Information about actions or situations where it is important to be sensitive.	Are copies of the manual in use? (give details)			
			Is there a local manual outlining the principal beliefs and practices of the major faith communities and belief groups available? (Please attach a copy of the manual as evidence.			
			Does the local manual outline religious/belief issues that can impact on healthcare practices for each religion/belief? (please give page/paragraph number)			
			Does the local manual outline religious/belief needs that have implications for the patient's wellbeing for each religion/belief? (please give page/paragraph number)			
			Does the local manual have a section on what to do in the event of an unexpected death for each religion/belief? (please give page/paragraph number)			
			Does the local manual contain information about actions or situations where sensitivity is important for each religion/belief? (please give page/paragraph number)			
			Were local faith communities and belief groups consulted when preparing the manual (give details)			
			When was the local manual last updated and were local faith communities and belief groups consulted (give details)			

			Where is the manual(s) held? (e.g. on the wards)			
			How do staff access the manual(s), including out of hours?			
			When was the manual(s) last reviewed/updated?			
	3.7	A written protocol for liaison and exchange of information with the identified representatives of faith communities and belief groups is in place. The protocol should respect patient confidentiality, adhere to the hospitals guidelines on the use of patient information, and protect patients from unwanted visits (See Standard 1 Criteria 1.c.1).	Is there a written protocol for liaison and exchange of information with identified faith community leaders/belief group representatives? (Please attach a copy of the manual as evidence)			
			In what ways does the protocol adhere to the hospital guidelines on the use of patient information? e.g. data protection, Caldicott guardians etc.			
			In what ways does the protocol protect patients from unwanted visits? (See also criteria 1.c.1)			

Standard 4 Staff support

Doing well, Doing Better: Standards for Health Services	Criteria (Standard 4)		Self assessment question	Answer and evidence	Reviewer comments	Met / not met
Standards 2, 10, 25 and 26.	4.1	The spiritual care service builds working relationships with members of staff and volunteers.	In what ways does the spiritual care service seek to build relations with staff and volunteers? (give details e.g. include initiatives or practice to encourage relations with particular staff/volunteer groups)			
			Is there evidence of good working relationships? (give details, e.g. staff/volunteer survey?)			
	4.2	The spiritual care service responds to requests from members of staff and volunteers for personal and professional support. .	In what ways does the spiritual care service provide personal and professional staff support? (give details)			
			Are incidences (not content) of support recorded? (e.g. a diary/log noting the time spent and whether professional or personal. No name or content need be recorded, preserving confidentiality)			
	4.3	The spiritual care service responds to requests from members of staff and volunteers for spiritual and religious support	In what ways does the spiritual care service provide spiritual and religious staff support?			
			Are incidences (not content) of support recorded? (e.g. a diary/log noting the time spent and whether spiritual or religious. No name or content need be recorded, preserving confidentiality)			
	4.4	With the staff member's permission the spiritual care service facilitates referrals to other sources of support.	How does the spiritual care service facilitate referrals to other sources of support (give details e.g list resources referred to or resources available and referral procedure)			

Standard 5 Education, training and research

Doing well, Doing Better: Standards for Health Services	Criteria (Standard 5)		Self assessment question	Answer and evidence	Reviewer comments	Met / not met
Standards 21, 24, 25 and 26.	5.1	The spiritual care service is committed to continuing professional development (CPD) within the Knowledge and Skills Framework and all chaplains/ spiritual care-givers keep an annual record / portfolio that evidences CPD. This can include: • Attendance or presentation at conferences; • Formal education (courses attended or taught); • Teaching delivered; • Articles and books written or reviewed; • Journal club; • Reflective practice, e.g. Clinical Supervision or Clinical Pastoral Education (CPE).	Do all chaplains/ spiritual care-givers have an up to date record / portfolio of CPD activity? (give details, e.g. a summary of areas of activity and objectives from Knowledge and Skills framework)			
			When required for registration Have all chaplains/ spiritual care-givers achieved the required level of CPD to maintain registration as a healthcare chaplain/ spiritual care giver? (give details e.g. the number of points required and achieved)			
			How does the spiritual care service:			
	5.2	The spiritual care service contributes to staff induction for new members of the healthcare team.	• contribute to staff induction? (give details)			
	5.3	The spiritual care service contributes to the healthcare team's education and training programme. Topics may include: • Spiritual and Religious Care; • The Role of the Spiritual care Service and Chaplains/ Spiritual care-givers; • Loss, Grief, and Bereavement; • Making a spiritual assessment. • Diversity issues relating to religion and belief	• contribute to the healthcare team's education programme? (give details)			
			• contribute to the healthcare team's training programme? (give details)			
	5.4	The spiritual care service makes recommendations for educational and training resources. e.g. recommendations for the unit's library, an appropriate course	• Make recommendations for educational and training resources? (give details)			

Doing well, Doing Better: Standards for Health Services	Criteria (Standard 5)		Self assessment question	Answer and evidence	Reviewer comments	Met / not met
		or attendance at a conference.				
	5.5	The spiritual care service is available to the healthcare team as an informed resource for ethical issues and discussion. E.g. serving on a local ethics committee, for consultation on individual cases, contributing to ethical debate and discussion (See also criteria 7.4).	• Serve as an informed resource for ethical issues and discussion? (give details)			
	5.6	The spiritual care service initiates, supports and contributes to research within the healthcare setting, within the areas of spiritual care, and spiritual and religious care, e.g. local research projects, multi-site research projects and national research projects.	• initiate, support and contribute to research within the unit? (give details)			
			• initiate, support and contribute to research within spiritual care, spiritual and religious care? (give details)			
	5.7	The spiritual care service is aware of current research and best practice and considers and implements its findings.	In what ways does the spiritual care service ensure it is aware of current research and best practice? (give details)			
			How does the spiritual care consider and implement current research and best practice findings? (give details)			

Standard 6 Resources

Doing well, Doing Better: Standards for Health Services	Criteria (Standard 6)		Self assessment question	Answer and evidence	Reviewer comments	Met / not met
Standards 2, 10, 12, 18, 20, 24, 25 and 26.	**(a)**	**Spiritual care services should have:**	**Do the spiritual care services:**			
	6.a.1	Access to quiet and private areas for confidential support of patients, carers, staff and volunteers.	• have access to quiet and private areas for confidential support?			
	6.a.2	Access to a chapel or prayer room acceptable for the religious observance of all faiths.	• have access to chapel or prayer room (please describe).			
			• how do you ensure the chapel or prayer room is acceptable to all faiths (give details)			
	6.a.3	Access to patient information systems for providing and facilitating appropriate spiritual or religious care and recording information and interventions.	• have access to the patient information systems?			
			• record interventions in the patient information systems?			
	6.a.4	Access to office accommodation and administrative support.	• have access to office accommodation (give details)			
			• have administrative support (give details)			
	6.a.5	Access to communication systems to facilitate internal communication and on-call cover. For example: • Pager, mobile phone • Intranet • E-mail	• Have access to communication systems to facilitate internal communication (give details)			
			• Have access to communication systems to facilitate on-call cover (give details)			
	6.a.6	Sufficient hours to meet the spiritual and religious needs of patients, carers, staff and volunteers including out of hours cover.	Are the hours sufficient to meet the needs of patient's carers, staff and volunteers? (give details/evidence e.g. needs unable to be met)			
			What is your spiritual care service out of hours cover commitment? (give details)			
			How does your spiritual care service			

			meet the out of hours cover commitment? (give details/evidence)			
		Chaplains/ Spiritual care-givers have:				
	6.a.7	Received an induction to their post (new chaplains/ spiritual care-givers appointed 2010 on).	Have all new chaplains/spiritual care giver received an induction?			
	6.a.8.	Undertaken introductory training (new chaplains/spiritual care giver appointed 2010 on).	Have all new chaplains/ spiritual care-givers undertaken introductory training?			
	6.a.9	Regular appraisal (at least annually) to review professional development and training needs. Identified needs to be resourced.	Have all chaplains/ spiritual care-givers received an annual appraisal within the last year?			
			Have all chaplains/ spiritual care-givers had their training needs identified?(give details)			
			Have resource implications identified and agreed? (give details)			
	6.a.10	Access to external professional supervision (see criteria 5.1).	Does the chaplain/ spiritual care giver have external supervision? (give details e.g. clinical supervision every 4-6 weeks or CPE)			
	(b)	**Chaplains/ Spiritual care-givers should:**				
	6.b.1	Desirably have links to a professional, multi-faith, interdenominational spiritual care association, and/or a faith-based group if there is one. e.g. Association of Hospice and Palliative Care Chaplains (AHPCC) Association of Roman Catholic Chaplains in Healthcare (RCCHC) College of Health Care Chaplains (CHCC) Scottish Association of Chaplains in Healthcare (SACH)	Are all chaplains/ spiritual care-givers a member of a professional spiritual care association and specialist interest group? (Give details e.g. AHPCC, CHCC, SACH)			
			Is the membership confirmed? (e.g. a current letter/card confirming membership)			
	6.b.2	Have a recognised status within a mainstream faith community or belief group.	Do all chaplains/ spiritual care-givers have a recognised status with a mainstream faith community or belief group? (give details)			

Standard 7 Spiritual care to the hospital or unit

Doing well, Doing Better: Standards for Health Services	Criteria (Standard 7)		Self assessment question	Answer and evidence	Reviewer comments	Met / not met
Standards 2, 4, 5, 10, 12, 18, 24 and 25.	7.1	The spiritual care service is included in the hospital or unit's policies and procedures for responding to major incidents. For example The spiritual care service is included in the call out list Members of the spiritual care service are involved in emergency exercises Use of the spiritual care centre Liaison with local faith communities and belief groups	How is the spiritual care service included in the hospital or unit's major incident procedure? (give details e.g. outline the role of the spiritual care service, e.g. its inclusion in the call out list, and include a copy relevant section of the policy/procedure manual)			
		The spiritual care service responds to:	**How does the spiritual care service respond to:**			
	7.2	Events in the unit which are having an impact on staff and require a communal response or event. For example: • Death or illness in a member of staff; • Unusual patient or family events.	• events in the unit? (give details: No name or personal content need be evidenced to preserve confidentiality)			
	7.3	Events external to the unit which are having an impact on staff and require a communal response or event. For example: • National disasters; • World events; • Remembrance / anniversaries.	• External events? (give details)			
	7.4	An awareness of issues or events affecting the morale or functioning of the unit which require management awareness to resolve. For example: • Managing change; • Communication.	• matters or events affecting morale or functioning of the unit? (e.g. an advocacy role representing staff or management concerns without breaking confidence)			
	7.5	Requests for consultation on ethical issues relating to restructuring, changes in	• requests for consultation? (give details)			

		buildings, local priorities and working practices. For example: • Restructuring of services; • Impact on patients, carers and staff; • Equality and diversity; (Also see criteria 5.5)				