NHS Education for Scotland

Spiritual Care Matters

An Introductory Resource for all NHSScotland Staff

Front cover photography by Neil Wakeling

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Foreword

There have been significant developments in recent years in the understanding of spiritual care within the Health Service. We live in a multi cultural world where religious labels are too often used and seen as terms of divisiveness and tension. Within healthcare communities, as within wider society, our differences can be and are at best, seen as part of an enriching diversity of our humanity. We are also more aware of ethics and ideas which form cohesive systems of thought but which would not accept the name faith community but are more happily described as humanistic. In addition, many people have a rich array of beliefs but would not describe themselves as belonging to any one particular group or community.

Spiritual care in the NHS must be both inclusive and accepting of human difference. As we learn to listen better to the particular needs of different people, so we equip ourselves for work which is more fulfilling and effective. The provision of spiritual care by NHS staff is not yet another demand on their hard pressed time. It is the very essence of their work and it enables and promotes healing in the fullest sense to all parties, both giver and receiver, of such care.

This learning resource will, I hope, be seen as a useful contribution to the diverse area covered by the term 'spiritual care'. It is intended as a resource both for those wanting to find out a bit more about it and for those with a commitment to teach and explain its nature. The context is described in the introductory chapter along with some of the other recent related work in the NHS. The cartoons were drawn by Graham Ogilvie during several conferences on spiritual care and we are grateful for the freedom to use these illustrated messages. They are not intended to trivialise the subject but to help show the possibility of different means of communication, plus a certain lightness of touch, which can be appropriate in the realm of spiritual care. The chapters within the document were written by different people and lightly edited, and so are sometimes dissimilar in style as well as substance. There is some repetition between the chapters but again this is inevitable and it enables the chapters to stand, to some extent, on their own.

We hope that this will prove to be a useful and harmonious contribution to an important yet sometimes elusive aspect of healthcare.

Chris Levison

Programme Director for Healthcare Chaplaincy and Spiritual Care
NHS Education for Scotland
February 2009

The NHS Knowledge and Skills Framework (KSF)

The NHS Knowledge and Skills Framework (KSF) is the overarching framework which provides the basis for reviewing the development of most staff groups within the NHS. The KSF defines and describes the knowledge and skills that staff need to apply in practice to deliver quality services. At the end of each chapter within this document, a list is given of the KSF dimensions which are potentially supported by the chapter content. These links are indicative only and are neither complete nor exhaustive. They reflect the wide range and levels of competency required to support the development of a culturally competent NHS staff who are trained to respond to the spiritual and religious needs of patients, carers and staff within the healthcare system by providing or facilitating the appropriate spiritual or religious care. The range of KSF dimensions also underlines the responsibility of staff to deliver spiritual care in its broadest sense, respecting the dignity, humanity, individuality and diversity of the people whose cultures, faiths and beliefs coexist in Scottish society.

Equality and Diversity Impact Assessment

The process by which this piece of work has been Equality and Diversity impact assessed is ongoing. The selection of the steering group and the writers of chapters were invited on account of their interest and experience. The purpose and essence of spiritual care is to be person centred and to make provisions which are suitable for the expressed needs of individuals of any culture, ethnicity, age, orientation, gender, ability/disability or belief. The participants in the launch event and those who will make use of the document will be inclusive and varied. An account of this impact assessment process will be made available for those who wish it and, on completion (estimated summer 2009) will be available on the NES website.

A tribute to Chris Levison

This could not have been produced without nine years of dedicated work by Chris Levison in developing Healthcare Chaplaincy and Spiritual Care as integral to the work of the NHS. With his retirement this year it is a fitting tribute to his compassion and professionalism that this resource will enable all staff to take to heart his dedication to Spiritual Care.

Geoff Lachlan,
Religion and Belief Project,
Scottish Inter Faith Council

1. Introduction

1.1 The spectrum of spirituality

Spirituality in the early 21st century may at times appear to be dominated and caught between two extremes. We have on the one side those convinced of and hoping to celebrate a modern secularism where the old dogmas of religion will no longer oppress the rational thinkers of the day who are lifting away centuries of superstition. On the other, there are some strongly lamenting the drift from religion to raw materialism, who mourn the break up of family, society and morality, and urge their neighbours to return to God and adhere to the sacred texts of old as the only sure way forward.

Most people, however, are at neither of these extremes. Most people are somewhere on the spectrum between rational secularism and fundamentalist / literalist religion. It is said that there are few atheists in the trenches of war, in the height of a storm at sea or at the burial or bedside of a loved one. Others find it hard to see value in religion when they look at the recent history of Northern Ireland, the Middle East, the perpetrators of the 9/11 attacks and other religiously labelled terrorist attacks, or the sometimes clumsy responses of politicians and countries.

Recent research and surveys show several things happening at once. There is a decline in regular church going yet an increase in peoples' willingness to talk about spiritual things (Hay, 2001). There is a new confidence in the rights of small faith and belief communities and other minority groups to 'be themselves' and to expect to be treated as respectfully as other larger and longer established groups. There is also a growing acceptance of humanistic philosophy and values, witnessed by the increasing number of secular weddings and funerals – which again is balanced by increased interest in traditional spiritual exercises such as yoga and meditation, or spirituality of a broad and less definable type.

Many find themselves between the religious certainties of a bygone age and the cold rationality of the opposite extreme. They have values and beliefs but they do not find it easy to say exactly where they belong. Nick Thorpe, in an engaging book about the variety of lifestyles and beliefs he encounters in his travel tale 'Adrift in Caledonia: Boat Hitching for the Unenlightened' explains a not untypical position rather well:

"Spirituality is a slippery word these days, involving anything from monasticism to wind chimes, but I've never been able to resist a little tinkering under the bonnet of the soul. No longer convinced by the religious absolutes of my childhood, I nevertheless hankered after something to replace them, a workable credo with which to engage life." (Thorpe, 2006).

Spiritual care in its broad and inclusive sense can perhaps help give us a workable credo, as we acknowledge the importance of responding to spiritual need of all kinds in the healthcare environment. Spiritual care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.

A definition

"Health is not just the absence of disease, it is a state of physical, psychological, social and spiritual well being" (World Health Organisation, Precis of discussion, 1948).

1.2 Quotations

The World Health Organisation has made many statements describing the need for holistic care and the integral nature of this spiritual dimension:

"Until recently the health professions have largely followed a medical model, which seeks to treat patients by focussing on medicines and surgery, and gives less importance to beliefs and to faith. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process. The value of such 'spiritual' elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension, emphasising the seamless connections between mind and body." (World Health Organisation (WHO), 1998)

"Traditional spiritual practices such as the development of empathy and compassion are being shown to be vital active ingredients, even prerequisites, in effective healthcare – in the carer and the cared for they build wellness and happiness. Effective and efficient healthcare must now (re)take into account these core values." (Reilly, 2005)

"Spirituality is part of health, not peripheral but core and central to it. It pervades our every thought and action, each caring moment. Spirituality and health are bonded to each other, inseparable companions in the dance of joy and sadness, health and illness, birth and death." (Wright, 2005)

"Illnesses are deeply meaningful events within people's lives, events that often challenge people to think about their lives quite differently. Spirituality sits at the heart of such experiences. A person's spirituality, whether religious or non-religious, provides belief structures and ways of coping through which people begin to rebuild and make sense of their lives in times of trauma and distress. It offers ways in which people can explain and cope with their illness experiences and in so doing discover and maintain a sense of hope, inner harmony and peacefulness in the midst of the existential challenges illness inevitably brings. These experiences are not secondary to the 'real' process of clinical diagnosis and technical care. Rather they are crucial to the complex dynamics of a person's movement towards health and fullness of life even in the face of the most traumatic illness." (Swinton, 2005)

"What we feel and believe about our health can directly affect it; indeed, there is a direct impact upon our cellular structure from our emotional state. We therefore need to look more deeply at spirituality because it directly affects the wellbeing of patients. This in turn challenges us to find more rigorous assessment tools and more appropriate ways of addressing patients' spiritual needs than ticking the religion box in the case notes." (Pert, 1999)

"Furthermore, there is a growing body of evidence that stress, burnout, and the disenchantment of professional carers with their work has its roots in issues more complex than pay and conditions. Issues such as meaning, purpose, relationships, and connectedness at work (the very stuff of spirituality) are just as important as other matters, if not more so, in producing a happy and contented workforce, and an organisation that does its job well." (Wright, 2005)

"We are not human beings seeking to be spiritual rather we are spiritual beings striving to be human." (De Chardin, 2008)

1.3 National healthcare policy in Scotland

The Scottish Government Health Department (SGHD), has developed a distinctive policy background for spiritual care in NHSScotland. This follows from the World Health Organisation's (WHO) description of health requiring a spiritual and compassionate element alongside the physical, psychological and social elements in order to describe a holistic or whole person approach to health and healthcare.

The SGHD has stated explicitly in policy documents that spiritual care is integral to healthcare. It has also stated that all Health Service staff are spiritual care providers (HDL (2002) 76) and (CEL (2008) 49). In following up the earlier guidance, each Health Board has been required to draw up a spiritual care policy which applies across the board area. Implementation plans have been developed to provide a spiritual care service which is equitable and accessible for people of any faith or of no declared faith. The second guidance recognised the requirement of a degree of education for NHS staff to understand and improve the quality of the spiritual care it is theirs to provide. Specialist spiritual care staff – chaplains – already do a considerable amount of training and educating in this area and are seeking to standardise and develop the quality of such education. However it is clear that the impact of this training is at present very limited and it needs to be dealt with in a broader and more fundamental way if it is to make a difference to the capability and competence of healthcare staff in this area.

The policy framework thus outlines the need for a culturally competent specialist staff who are trained to respond to the spiritual and religious needs of patients, carers and staff within the healthcare system by providing or facilitating the appropriate spiritual or religious care. It also underlines the responsibility of *all* staff to deliver spiritual care in its broadest sense, respecting the dignity, humanity, individuality and diversity of the people whose cultures, faiths and beliefs coexist in Scottish society.

NHS Education for Scotland (NES)

NES, in its Corporate Plan of 2007 (NES, 2007), stated the need and intention to create a capability or competency framework for healthcare chaplains and healthcare staff. In the summer of 2007 a steering group was gathered together and a project group set up to write the draft document for healthcare chaplains. It was felt that dealing with the 'specialist' spiritual care providers would be the first stage and the 'generalists', ie all healthcare staff, would be the second stage. The first stage was completed

with the publication of 'Spiritual and Religious Capabilities and Competences for Healthcare Chaplains' in March 2008 (NES, 2008 b). This present document concerns and begins the broader second stage 'for all staff'.

Related initiatives already taking place

There is already a significant amount happening in the realm of spiritual care throughout the Health Service and in certain areas of learning. Sometimes it is quite explicit as in modules offered in universities or Higher Education Institutions (HEIs). Other areas such as palliative care have spiritual care more implicitly integrated within care pathways.

The development of capability frameworks for a variety of disciplines has usually included the 'Ten Essential Shared Capabilities' (DoH, 2004) which were first developed by a partnership involving the National Institute for Mental Health and the Sainsbury Centre for Mental Health Joint Workforce Support Unit in conjunction with the NHS University. These capabilities are generic and are very much in harmony with spiritual care. They are:

Working in Partnership
Providing Safe and Responsive Patient Centred Care
Respecting Diversity
Promoting Best Practice
Practising Ethically
Promoting Rehabilitation Approaches
Challenging Inequality
Promoting Self Care and Empowerment
Identifying Needs
Pursuing Personal Development and Learning

Mental health training has embraced these 'Ten Essential Capabilities' which are person centred and deal with empowerment, equality and ethical issues which are similar to and might be termed spiritual care. 'Realising Recovery Learning Materials' (NES, 2008 c) is a further development of this which is essentially spiritual care as in caring for the human spirit.

The most popular Special Interest Group in the Royal College of Psychiatrists is the one called 'Spirituality and Mental Health', with over 25% of the College as members of it.

Some capability frameworks have included spiritual and religious care as specific areas for awareness and practice (Capable, Integrated and Fit for the Future: A Multi-Agency Capability Framework for Intermediate Care, NES, 2008 a).

Certain practice documents already have a rich seam of spiritual care, for example, 'The Liverpool Care Pathway for the Dying Patient' (LCP, 2003) provides an evidence based framework for the delivery of appropriate care for dying patients and their relatives in a variety of care settings. It encourages a multi-professional approach to the delivery of care that focuses on the physical, psychological and spiritual comfort of patients and their relatives that has also been shown to empower generic staff in the delivery of care.

The NICE guidelines for Palliative Care (2004) include spiritual care as a necessary and integral part of a competent service.

The Janki Foundation have produced 'Values in Healthcare - A Spiritual Approach' (2004), a personal and team development programme for healthcare practitioners. This comprehensive pack consists of seven modules on values, peace, positivity, compassion, co-operation, valuing yourself and spirituality in healthcare. The training programme uses seven 'spiritual tools' to explore the themes and apply them to life and practice. They are meditation, visualisation, reflection, listening, appreciation, creativity and play.

Some Health Boards are doing pioneering work in areas which may not be titled 'spiritual care' but are about values and being valued. NHS Lothian and University of Edinburgh are undertaking four related projects under the title 'Values Based Practice'. NHS Ayrshire and Arran are developing a system of staff support, awareness and value which it is hoped will also affect and improve patient care.

There are a number of spiritual care modules being taught in HEIs throughout Scotland. These are mostly in healthcare and nursing faculties. The *Flying Start* programme (see reference) for nurse recruitment and retention specifies spiritual and religious care elements. There is a smaller degree of spiritual care training in medical education. The training of allied health professions, support staff, administration and ancillary staff of all kinds is varied and tends not to have explicit spiritual care as part of core learning.

1.4 Purpose of the document – what we hope to achieve

We are creating a spiritual care learning resource which will help to integrate some of the various ways in which spiritual care is being talked about, taught, practised and experienced within the Health Service. We are establishing a link between much valuable and varied work which is being done by different people in many different places. The document has two aims: it will bring into relationships several different initiatives under the one theme and it will suggest the areas which are relevant for the teaching and delivery of spiritual care by and for NHS staff.

The document is not a full and final educational framework for all healthcare staff but seeks to provide a basis or preparation for such a future project.

This resource deals with core areas, skills and attitudes important for spiritual care. It references some of the frameworks and guidelines which already contribute to spiritual care awareness and practice. It highlights some examples of good practice which are already happening while indicating the areas of core knowledge, practice and awareness which would benefit all staff in their care for patients. Spiritual care brings benefit to both the giver and the receiver, indeed one of the characteristics is that these two categories can often become indistinguishable.

For whom is it written?

The document has been written to provide a reference for any healthcare staff who need or wish to find out more about spiritual care. It gives a picture of the various areas which may be understood as the ingredients of spiritual care and of various initiatives and documents which are already in existence. Its purpose is to encourage staff to continue and to develop the practice of spiritual care in their place of work. Some will recognise that they are already delivering spiritual care and it will give value to the attitudes and behaviours associated with spiritual care which are often neglected and too rarely encouraged. It is for anyone who wishes to improve or better understand the importance of this area of care in their daily work as they deal with patients, carers and colleagues. It will help staff to realise the mutuality of care and to understand some of the stresses and support possibilities within the healthcare environment.

The document will also be a resource for those who are educating staff whether pre or post registration. It will bring into view the insight and experience of colleagues who are teaching in this area. It will show how spiritual care is more about how things are done and how people share and communicate rather than adding an extra task. It will suggest how seemingly passive activities such as reflection and listening can be powerful aids in the realm of health and holistic care.

Limitations

The group undertaking this initial task was challenged to produce a document in a limited time schedule. Beside such obvious limits is the enormous breadth of the subject which does not lend itself to being easily pinned down. This particular document brings together some thoughts, particular areas and aspects, stories and examples of good spiritual care in healthcare contexts.

Spirituality is made up of so many parts and can be described in so many ways that it cannot be delineated. Human creativity, relationships, hopes, fears, guilt, happiness, religion, belief, life, death and spirituality encompass all of life. We are trying to help people better understand the nature and importance of our humanity and individuality and to help each other to behave a bit more kindly in our dealings, in the belief that people who are valued have better health and wellbeing prospects through all their health episodes, their work and their relationships.

1.5 Why spiritual care is necessary and important

The quotations in the earlier part of this document seek to remind us that we are inescapably mind/body people. It is unrealistic and no longer acceptable to treat people as less than individuals with their own resources of strength, beliefs, relationships and life context which makes a crucial difference not only to their ability to recover from, but their very understanding of health and illness.

The increasingly complicated and technical aspects of healthcare have made great strides in the understanding and treatment of a huge variety of illnesses. There is however, strong evidence that if the human elements of compassion and hope, understanding and relationship between carer and cared for are ignored, then we are forgetting and losing a crucial element of the healing process. We are narrowing and impoverishing a whole and proper understanding of health and healthcare.

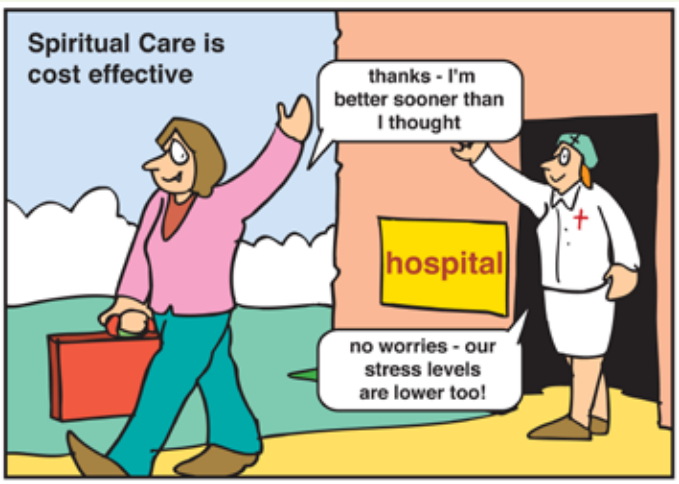
Professor Alice Brown, the Scottish Public Services Ombudsman wrote in her Autumn newsletter 2008: *"Quite often I see cases where a complaint comes through and when we look at it in detail the individual nurses and doctors may not have done anything wrong but one way or another the patient wasn't properly cared for, the system failed them. Often it can be around what might be called the softer issues which make a very important contribution to a patient's experience but which can be so easily overlooked."* (SPSO, 2008)

If we can recapture and maintain the reality of therapeutic relationships within healthcare, if we can integrate the needs of the human spirit in the care offered, there will be enormous gain in the effectiveness of our care, and in the short and long term, outcomes and satisfaction of both patients and staff.

On occasion the reasons for promoting spiritual care have been listed as:

- Ethical – because it is the right thing to do, to treat people well and appropriately whatever their faith, belief, gender, age, ability / disability, sexual orientation or life stance happens to be.
- Legal – because there is now a regulatory framework which forbids discrimination and therefore encourages the equal and fair treatment of all from any culture or background.
- Financial – because there will be greater satisfaction and better outcomes among patients and less stress and absenteeism among staff.
- Clinical – because there is a level of evidence that when people are well cared for they have a greater chance of health and, for example their immune system appears to work more efficiently.

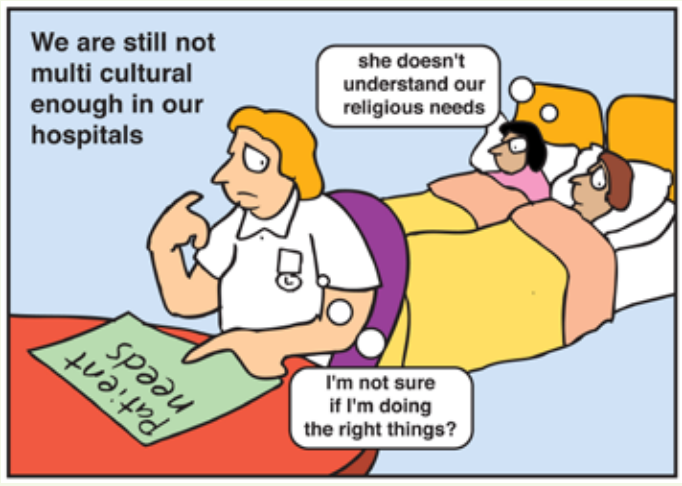
(Fair For All Religion and Belief, 2008)



Why staff often find the subject of spiritual care difficult

The very word ‘spiritual’ is difficult and uncomfortable for some. It is often helpful to turn the phrase round and say it is not about us trying to be or claiming to be especially spiritual, whatever that means to each of us. It is rather about learning to care for the human spirit in any or everyone. That human spirit is to do with their individuality, their need for meaning, peace or hope which can be expressed in many ways.

The terms spiritual care or religious care are often felt to be problematic. Spiritual care is often too closely aligned with religion and many feel they are unqualified to take part. There is a fear of getting things wrong and religion is often thought of as a divisive element in society rather than one which brings harmony. There is a nervousness around someone who is seen or felt to be ‘different’. Religious people are often seen as people of strong beliefs who are easily offended. There is little training at pre registration or post qualification level on the nature of spiritual care or spiritual need. Subjects such as active listening, bereavement or self awareness are taught in a fragmented way and often leave people feeling inadequate when faced with some of the major traumas in people’s lives. Multi faith/belief needs and spiritual care have not always been emphasised, leaving it to those with a special interest.



1.6 Spiritual care is happening already

The member of staff who asks a patient – “How are you today?” and means it, is already involved in spiritual care. In so many ways spiritual care is already happening and is not another initiative or add on, but is an encouragement to good practice which benefits both staff and patients. There are thousands of happenings or encounters within the Health Service each day which may be termed spiritual care. An expression of empathy, the sharing

of hopes and fears, family stories, gestures or humour or sadness, an accepting recognition of culture or faith or belief, all these things are indicative of the human spirit and therefore of spiritual care.

Patients and staff know the doctor who sees them as a person, the porter who relates to them as they go for a test, the physiotherapist who can stray from the exact list of questions to relate to the person with whom they are dealing. Nursing has a marvellous tradition of care, but the work of any staff member whenever it is done well, can be called spiritual as it sees the whole person and seeks to uplift and encourage.

When patients, carers and staff are seen as more than their illness, their relation or their job title we are in a win-win situation. Staff who are appreciated and looked after, whose stress as they deal with trauma of various kinds is recognised and acknowledged, are much more likely to recognise what is troubling a patient and to have resources to bring comfort. Carers feel they are respected as part of the group bringing care rather than outsiders who are likely to get in the way.

Patient Focus Public Involvement (PFPI) has been something of a mantra in NHSScotland for a number of years. Essentially it is about valuing the individual and responding to their total individual situation. It also recognises the value of communities and their importance in enabling people to be healthy, whole people. In other words, seeing people as whole people, when organising their care and seeing them as people who have relationships, support groups and communities who help to give life its meaning and a way of coping or receiving support when going through difficult times.

The equality and diversity work which has been done in recent years and which is slowly becoming integrated into the policies and practices of the Health Service is also an ally of good spiritual care. The strands: age, disability, gender, race, religion and belief and sexual orientation, show a way of encouraging us to see the whole person as an individual. In so many ways it is our diversity which makes us so interesting as people and gives us reason to celebrate this rather than see our differences as a problem.

Several documents now describe a mutual Health Service. This is not only one where people recognise their rights and responsibilities, important though that is. Mutuality indicates an empathy where people share and understand the situation of others. Our roles in life at any one time are the result of many factors. We could be in each other's shoes and we have as much to learn from one another as we have to teach.

KSF Supporting Links

C1, C4, C5, C6
HWB 2, 3, 4, 5, 6, 7,
G1

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Further Reading

There has been a steady output of documents within NHSScotland over the last few years which has pointed to the importance being given to spiritual care for example:

NHS Education for Scotland (2006) *A Multi Faith Resource for Healthcare Staff*. www.nes.scot.nhs.uk/documents/publications/classa/multifaith/Interactive%20master.pdf

NHS Education for Scotland (2007) *Standards for NHSScotland Chaplaincy Services*.
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The Journal of the Scottish Association of Chaplains in Healthcare (SACH).

2. Spiritual Care: A Key Concept

Human beings, among all living organisms, are most aware of occupying a place within the reality of existence. We are aware of the past. We have an expectation of a future. We recognise the finite nature of our lives. It is how we cope, how this impinges on our life, our relationships, our search for meaning or purpose or value, which gives us a sense of spirituality. We stand in awe at the majesty of it all. We harbour a fear of insignificance. Something inside prompts us to ask questions and search for an answer.

This chapter is a central one in this document. The other chapters deal with aspects and elements of spirituality or spiritual care whose purpose is to ground them in healthcare experience.

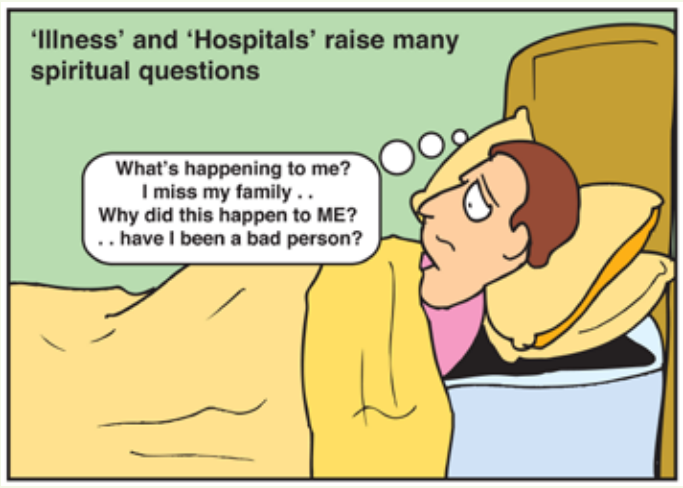
Clarifying what is meant by 'spiritual care' is essential – not only in order to formulate a workable definition but also to clarify how the concept relates to NHS staff as they learn about spiritual care and their roles in effecting it. It is difficult to be purely scientific and rational in the face of the awesome mysteries of life, such as: heroism, hope, beauty, the wonder of the universe, affection of and for a child, the compassion and altruism of people dedicated against all odds to help the needy. Such commitment to higher ideals is not only the preserve of religion, and must be inclusively described in terms of dedication to ideas like social justice, inter-connectedness, liberty, and the innate ability of humans to be what is best in being human.

Integrated wisdom

Spirituality provides the higher level intelligence and wisdom which integrates the emotional with the moral. It acts as a guide in integrating different aspects of personality and ways of being and living. It is found in the integration of several deep connections: the connection with one's true and higher self; the connection with society and especially with the poor, the deprived and underprivileged; the connection with the world of nature and other life forms; and for some, a connectedness with the transcendent.

Wholeness and relationships

A person's spirituality is not separate from the body, the mind or material reality, for it is their inner life. It is the practice of loving kindness, empathy and tolerance in daily life. It is a feeling of solidarity with our fellow humans while helping to alleviate their suffering. It brings a sense of peace, harmony and conviviality with all. It is the essence and significance behind all moral values and virtues such as benevolence, compassion, honesty, sympathy, respect, forgiveness, integrity, loving kindness towards strangers, and respect for nature. Spirituality creates and connects these virtues. This is what lies behind moral intuition. It is about knowing, and experiencing deeper meaning and connection behind apparently random events and processes such as illness and an awareness of human vulnerability.



The importance of spirituality for human health and wellbeing is becoming better understood. Spiritual wellbeing enhances and integrates all other dimensions of health, including the physical, mental, emotional and social. Spiritual wellbeing denotes a sense of connection to something larger then oneself, providing a sense of awe, wonder, meaning, purpose and personal value. The domains of spiritual wellbeing include a focus on individual human spirituality, in depth interpersonal relationships, connectedness with nature and the common agreement of ethical philosophies and faiths in the 'golden rule' that we should treat others as we would wish ourselves to be treated. Spiritual wellbeing brings a sense of 'good feeling about oneself' as a human being and as a unique individual. It happens when people are fulfilling their potential as individual human beings. They acquire a sense of direction, a sense of equality with others and they relate positively to them, as they do with the world around them.

The breadth of people's relevant experience

Those privileged and entrusted to provide care in the NHS must further develop and sustain their capacities to offer with equal seriousness, the appropriate spiritual and religious care, to discern the difference, and to respond appropriately in relationship with the person in need, who may display a huge variety of needs or demeanors such as:

Acceptance, Anxiety, Awe, Compassion, Connection, Creativity, Forgiveness, Frustration, Hope, Purpose, Peacefulness, Inspiration, Fear, Self-awareness, Understanding, Wonder, Reverence, Resentment, Trust etc.

The nurse and writer Narayanasamy (1991) listed spiritual need in the following terms: *"The need to give and receive love; the need to be understood; the need to be valued as a human being; the need for forgiveness, hope and trust; the need to explore beliefs and values; the need to express feelings honestly; the need to express faith or belief; the need to find meaning and purpose in life."*

The present policy of the Scottish Government Health Department (CEL (2008) 49) states that the following basic principles should underpin all spiritual care services provided or funded by the NHS in Scotland. They should:

- Be impartial, accessible and available to persons of all faith/belief communities and none and facilitate spiritual and religious care of all kinds, as required.

- Function on the basis of respect for the wide range of beliefs, lifestyles and cultural backgrounds found in the NHS in Scotland today.
- Value such diversity; never be imposed or used to proselytise.
- Be a significant NHS resource in an increasingly multicultural society.
- Be a unifying and encouraging presence in an NHS organisation.
- Affirm and secure the right of patients to be visited (or not) by any chaplain, belief group/ religious leader or spiritual caregiver.
- Acknowledge that spiritual care in the NHS is given by all members of staff and by carers and patients, as well as by staff specially appointed for that purpose.

Spiritual care and its relationship to religious care

Many have found the following descriptions to be helpful although they do not claim to be a full explanation.

Spiritual care is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation.

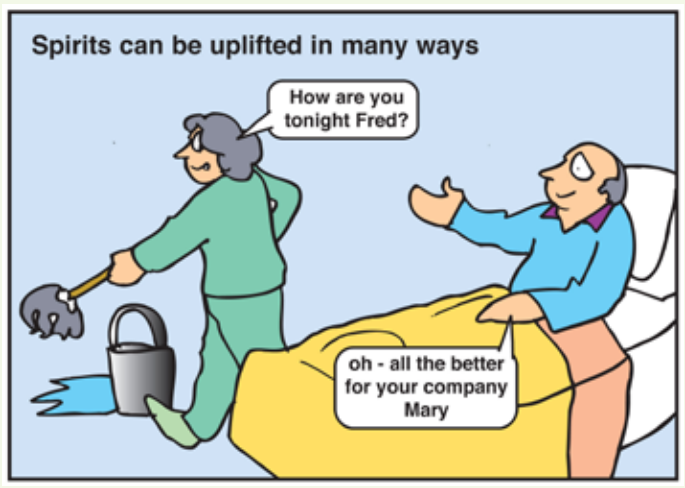
Religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community.

Spiritual care is not necessarily religious.

Religious care at its best, should always be spiritual (HDL (2002) 76).

"It was the way the nurses turned me over when I was unable to do it myself immediately after the operation. It was very intimate and just felt so very kind."

One consultant seemed to have good relationships with his patients. A woman who had recurrent cancer and had no real possibility of a cure was well looked after by him. One sunny day she seemed in particularly good spirits. In response to the question "How are you feeling today?" she replied, "Much, much brighter, Mr X has just been to see me and he brought me an ice-cream, wasn't that nice!"



An example of care which was less than spiritual

I asked the psychiatrist I was working with, "What's wrong with me?" He said, "You have a disease called chronic schizophrenia. It is a disease that is like diabetes. If you take medications for the rest of your life and avoid stress, then maybe you can cope." And as he spoke these words I could feel the weight of them crushing my already fragile hopes and dreams and aspirations for my life. Today I understand why this experience was so damaging to me. In essence the psychiatrist was telling me that my life, by virtue of being labelled with schizophrenia, was already a closed book. He did not see me. He saw an illness. We must urge our students to seek wisdom, to move beyond mere recognition of illness and to whole-heartedly encounter the human being who comes for help.

(Deegan, 1996)

Notes for Educators

1. Current healthcare policies in Scotland claim a role for all NHS staff in providing spiritual care to their patients, freely given at point of delivery, whilst indicating that staff may choose to attend to their own spiritual needs or have access to support via the chaplaincy provision/belief group (CEL (2008) 49). The implications of this form an appropriate topic in educational initiatives intended to meet this policy aim.

2. This entails mapping spiritual care in relation to its psychological, emotional, and social care and to wellbeing as the desired outcome. Spiritual care, construed as 'whole person care by whole person carers', is part of, and/or the integrating principle of holistic care, the very bedrock of health provision. 'Spiritual care' can be regarded as a consensus concept – linked with other agendas such as inclusion, but differing from 'religious care' as appropriate.

3. Defining 'spirituality' may involve differentiating the term as indicating a dimension of being human, ways in which the dimension is expressed, as a topic of study in healthcare or in educational settings (Schneiders, 1990). Is spirituality, like pain, 'whatever the person says it is?' Definitions of spirituality often point towards fundamental concerns with meaning, purpose and fulfillment: How do they differ from, for example, 'recovery' in the mental health field and what are the implications of these concerns as they become topics in the contemporary healthcare context?

4. 'Spiritual care' is all about meeting 'spiritual needs' but how does the focus on care fit with the longstanding distinction between 'care' and 'therapy'? Is a hierarchy implied by use of the terms spiritual care 'specialists' and 'generalists', with implications of professionals knowing better? If so, what are the implications for those responsible for education and learning about spiritual care in the healthcare context?

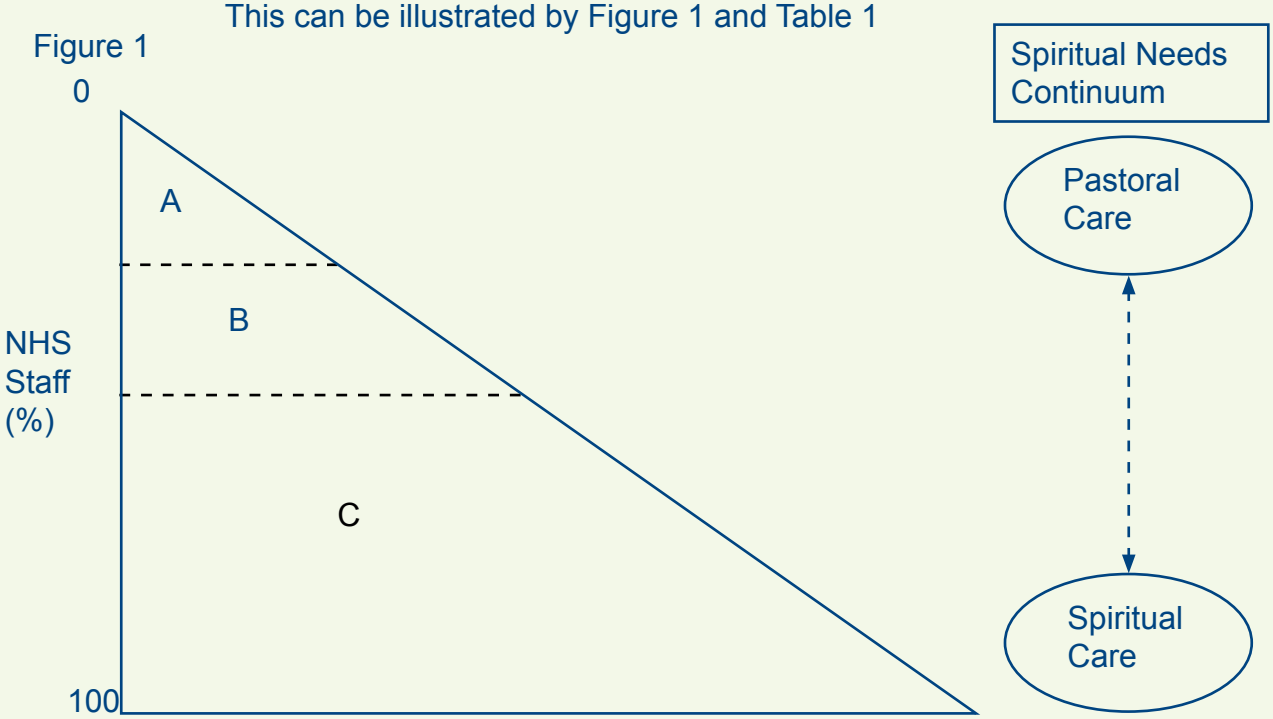
See Figure 1 and Table 1, as used by NHS Lothian, for one way of relating the generalists and the specialists.

Spiritual care delivery as envisaged by NHS Lothian: From routine to complex

Staff roles and training:
The model for delivery of spiritual care was agreed by the Spiritual Care Committee in early 2004 and is characterised by the concept of generic spiritual care and specialist spiritual/pastoral care on a continuum. Correspondingly, all NHS staff would be expected to possess or develop the generic skills required to deliver generic, routine spiritual care with a small number of staff with specialist skills providing specialist pastoral care. The latter group includes healthcare chaplains.

This can be illustrated by Figure 1 and Table 1

Figure 1



The levels or tiers of competency and intensity of training is dependent on the degree of specialisation required. As a rule of thumb, we may consider three broad categories (A-C in Fig. 1) of responsibility and training requirement (See Table 1).

Table 1 Training and support for the spiritual care roles of NHS staff

Staff Title (examples)	Role / Response	Location	Approx No.	Training & Support Type
Chaplain; bereavement /grief counsellor; patient advocate	Complex spiritual and pastoral care	Service-wide	Low	Formal qualification; CPD (in-house and external); Supervision
Spiritual care ‘championing’	More complex spiritual care & routine pastoral care	Multi-disciplinary team	Min.1 / team	In-house Continuous Professional Development (CPD) programmes; Professional supervision
All NHS staff	Routine spiritual care	All settings	100%	Induction & occasional ‘top-up’

KSF Supporting Links

C1, C2, C4, C5, C6
HWB 1, 2, 3, 4, 5, 6, 7
G1

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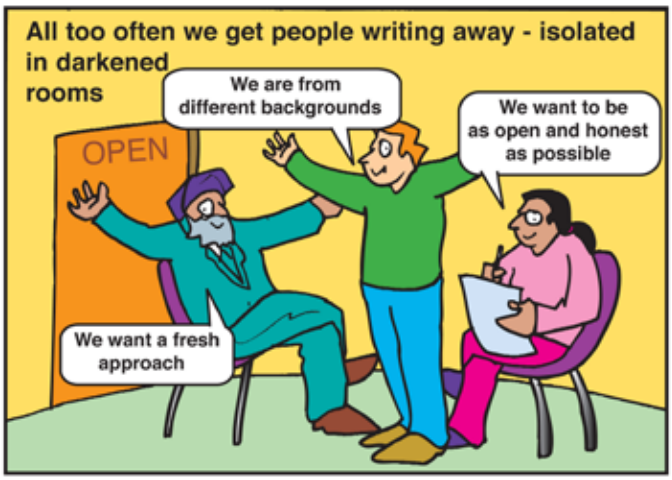
3. Religious Care

Introduction

There are many religious faith traditions practised within Scottish society. While perhaps not as prevalent as in other parts of the UK there is a rich variety of smaller faith communities alongside the generally more numerous Christian groups. Main groups include: Jewish, Muslim, Christian, Bahai', Sikh, Buddhist, Hindu and Pagan. Other belief groups such as the Humanist Society of Scotland do not regard themselves as religious but are part of the spiritual care spectrum.



People who practice their faith or religion as part of their regular life and as part of their identity have a right to continue to express this identity while undergoing healthcare. There is in fact a strong tradition within most faiths of rituals or prayers or other activities which are particularly for, or relevant to those suffering from ill health. The very purpose of most religious traditions is in part to enable people to achieve as far as possible a state of well-being in relation to God, to self, to others, in caring relationships with the poor and with the whole of creation. The ideas of respect, patient focus and equality and diversity, all suggest very positively that the NHS should be careful and well motivated to treat people appropriately whatever their cultural or religious situation. Harm and offence can be caused by carelessness in this area but great good can be done when this area is treated with sensitivity and respect. This is true of patients, carers and staff.

Ongoing religious practice

As far as is reasonably possible a person should be allowed and encouraged to continue to practice their religion, if they so wish, within a healthcare situation. The public nature of many hospitals and the numbers being dealt with can make this problematic but attempts should be made to enable people to use such religious resources they wish to express their faith. This might include rituals such as prayer and scripture reading and short acts of worship. It should normally be possible to arrange for a faith leader or representative to visit if a patient so wishes and to share such rites which are possible within the environment, taking into account the needs and feelings of others in the vicinity. Healthcare units should, as far as is possible, provide a quiet room which can be used for the purpose. The design and decoration of such a room should be undertaken with the advice of the different groups who might use it.

Religion and health

Religious practice has a long history of being linked to health matters. In days when medical services were hardly existent, people turned to their religion as a way of coping and to seek healing. Health professionals in the present day are inclined to forget how important religious practice still is for many people. Science has brought huge knowledge and skill to the practice of medicine, but there is a need to remember or perhaps rediscover how important their religion is for those who belong or relate to a faith community. For some, their understanding of their illness is related to their faith perspective. It can be that a certain religious perspective can add to the anxiety of ill health but it is far more common that the support of a religious community and the practices of religion can be of considerable help in the healing process. If religious practice can bring peacefulness and encouragement then it is reasonable to suggest that such reduction of stress and improvement in wellbeing can enable the healing process. There is evidence that the immune system is more robust when a person is less stressed. Research shows that using a holistic approach of treating mind, body and spirit can aid the recovery of a patient.

Different needs

Different faiths and belief groups have particular needs to do with their care. A proper needs analysis which includes a person's faith or belief will be more likely to result in appropriate and high quality care. Practical things like diet, washing facilities, ways of addressing people - which name to use, birth rites, death rites, modesty and communication issues are often important to religious people. Some communities wear articles of faith which should be left, if possible, or sensitively dealt with as they involve vows and there is the possibility of adding anxiety at a time when a patient needs to be stress free. The understanding of health and illness can vary and staff should be aware of and respect such differences. The 'Multi Faith Resource for NHS Staff' (NES, 2006) has much information on these areas and should be available in ward areas. When such things are dealt with well there is a proper degree of satisfaction for all.

Spiritual care service

Each Health Board in Scotland has a spiritual care service. Usually this consists of a small team of chaplains, whole-time or part-time and sometimes a team of volunteers. They are normally employed to look after and promote the spiritual needs of the whole community but will have religious expertise in some areas. Whenever a religious or faith or belief representative is needed, the spiritual care service – the chaplains – will endeavour to find the appropriate person. Most departments have a list of contacts from the various communities and some have a system of honorary chaplains for each faith community which has requested it. It should normally be possible to find the appropriate religious carer for a person with specific religious need.

Religious care

Religious care is normally provided by representatives of a particular religion. The NHS seeks to be sensitive about this whatever the religion or faith community concerned. A healthcare setting is not a place for judgement or argument about religious matters. It is about providing what is appropriate and what a person wishes. It is imperative that we respect the person even though we may disagree with their philosophy or belief. Being a supportive resource to those who differ from us should not be a problem, but should be a true and proper reason for satisfaction in a job well done.

Talking to a Sikh man in a ward after introducing myself as the chaplain, he asked me what I did. After explaining about the chaplaincy centre in the quiet room, he said "But that would really be for Christians". "No not especially at all, it's designed so that people of any faith or even of no particular faith can feel peaceful and at ease within it". "That's great," he said, "That's a super surprise".

The ward sister stopped nurses offering an elderly Sikh gentleman a basin explaining to staff how it was much more important for Sikhs to wash in running water. This gentleman gave the staff his first ever smile when it was explained to him that he would not be offered a basin but would be wheeled in the shower so that he could bathe in running water. His bed was subsequently moved (with his permission) nearer to a sink so that he could wash his hands in running water prior to eating etc.

KSF Supporting Links

C1, C4, C6
HWB 2, 3, 4, 5, 6, 7

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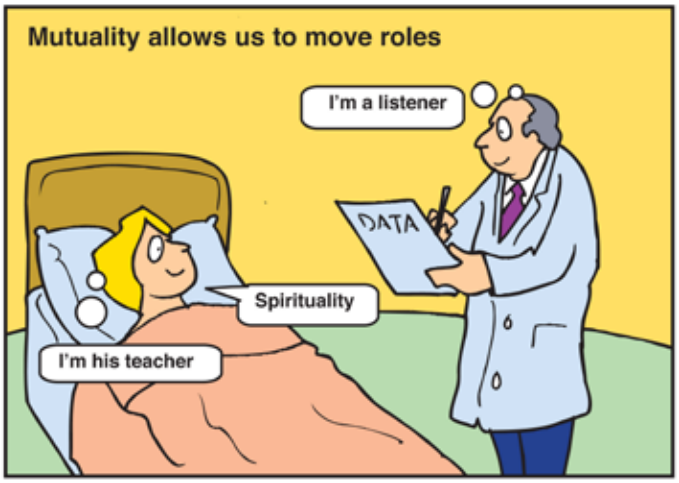
4. Communication and Relationships

"Some patients simply recover because of their satisfaction with the goodness of their doctor."
Hippocrates



Being wholly present

Communication and how we relate to a person is as simple and profound as being wholly present with them.

A two way process

Communication and relationships must be at the heart of consideration about spiritual care. As the Health Service tries to move away from a culture where those who are experts do things to patients/customers/clients who are merely recipients of what has been decided elsewhere is best for them. That may seem like a caricature but it is not totally inaccurate. Communication is always a two way process. Relationships require a degree of honesty, openness and mutuality if they are truly meaningful for both parties.

Numerous surveys have shown that the greatest difficulty patients have is often the sense that they are not listened to and not regarded or noticed as whole people with vast resources, relationships, capabilities, values and beliefs which affect their wellbeing. Stress, illness and absenteeism among staff is clearly affected by their work relationships, and by their ability to cope with people who are distressed by illness. Often the source of such stress is the inability, lack of capacity or opportunity either to listen or to talk about how they are reacting to, and feeling about all that is happening around them.

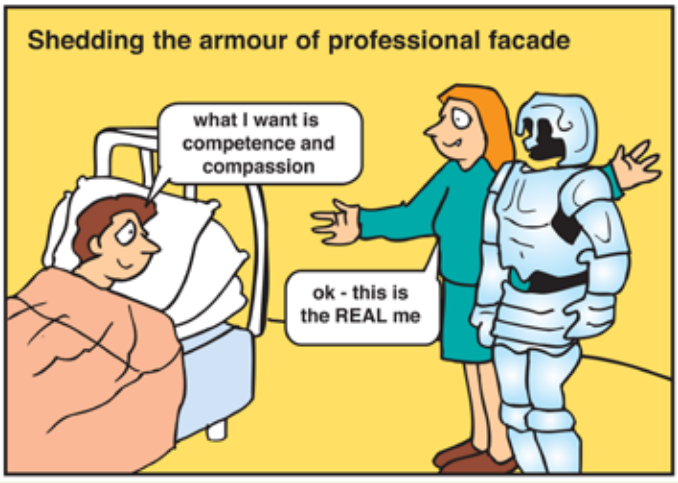
Changing the balance of care which is a clinical priority at present is more than a move from secondary to primary care or of a person taking more responsibility for their own health. It can mean that healthcare staff recognise and honour the resources a person has for healing being as important as the specific interventions of an expert.

Good communication has certain common characteristics:

- Communication involves the whole person. It is how we communicate as much as what we communicate. It is not just verbal, about words, spoken or written, it involves gestures, demeanour, tone of voice, eye contact, body language, timing etc.
- Principles such as approachability, being non judgemental, respectful, person-centred are key to good communication.
- An appreciation that all silences do not need to be filled immediately, allows people to

think before they speak and suggests that they are being given the time to marshal their thoughts and express them in the way they wish.

- Language which shows a clarity which takes into account, for example, that all people do not have perfect hearing; introductions so that people know who is speaking with them, and sensitivity which checks out that one is being understood, are all part of good communication.
- Many people experience communication difficulties and may not always understand the spoken word. It is especially important that we use clear, easy to understand language and back this up with pictures, drawings, diagrams and other means to explain important information.



Good relationships also have certain characteristics:

- There is an element of mutuality where it is recognised that each affects the other. In Health Service consultations there is acknowledgement of the expertise of the patient as well as that of the professional.
- There is an element of empathy and compassion, a willingness to see and imagine from another person's point of view (the root meaning of compassion is to share another's pain).
- Relationships have the capacity to grow (or decline) and to a certain extent they make us the people we are.
- Good relationships are characterised by honesty. It is important that a client or patient trusts the person who is explaining their medical situation. If that trust is lost, however good the motive, it is difficult to re-establish. Honesty does not have to be brutal but it needs to be reliable.

It has been said that the relationship of the care giver is often as important as the particular skill or intervention they administer. The relationship is part of the expertise and of the whole experience creating hopes or building courage or coping with reality. In the same way as a surgeon may remove or alter things, thus allowing the patient to begin the healing process, so a relationship can be the facilitating factor in a healing situation.

A therapeutic relationship builds confidence in the person undergoing treatment, and trust in the people with whom they are working. Such trust can be a help in the movement towards wellbeing and promotes resilience in those for whom things are going badly. It has to be acknowledged that a relationship has the capacity to affect us. It goes beyond the purely clinical/medical as soon as we actively listen and respond.

Relationships within the NHS are often understood within a hierarchy of status, responsibility and reward. Leadership by those who are regarded as such may be empowering or undermining depending on how it is exercised. Unless it is clear that every member of the team is valued for the work they do and the person they are, it is unlikely that good team work and optimum patient care will take place. A team where all are respected will be more than the sum of its parts. It will show the strength of diversity and complementarity.

Active listening is a discipline and an area of considerable depth. It is truly an activity and demands concentration as well as sensitivity and skill. Usually our listening is interrupted by our thoughts of how we will respond, how our experience relates to what we are being told, by the background context or noises or by our preconceptions of what we expect to hear. Active listening enables and gives a person permission to explain what they mean and how they feel. It is aided by the appropriate responses which show not only that one is hearing and listening but attempting to think along with the person. It is not about jumping to conclusions. It is not about offering solutions. It is a means of enabling a person to come to the conclusion or to the place they are comfortable with so that they can best decide what it is that they wish or have to do, or even accept what is inevitable. There needs to be an understanding of confidentiality for this to happen, although the level of confidentiality may itself have to be decided, for example, that intent to self harm or to harm others would not have this status.

Communication skills or the lack of, is often very clearly remembered. The majority of Health Service complaints can often be linked to bad communication. When a person is given bad news about their or a loved one's future, the words and the way they are delivered are often among a person's clearest memories. While, for example, grief is natural it is quite possible that it can be exacerbated by insensitive communication. Good communication, on the other hand, may reasonably be expected to be beneficial to both carer and cared for at any step in that patient journey. It is also core to beneficial enabling and empowering of people and staff management.

KSF Supporting Links

C1, C5, C6
HWB 2, 3, 4, 5, 6, 7

The value of real listening

A young mother, whose husband had been killed in an accident, leaving her with three young children, explained to the health visitor that she was getting more and more tired. During the day she was trying to support her children in their grief and also her mother in-law who was very distressed. The only time she got for herself was when she went to bed at night and then she could not sleep because of her own grief. The health visitor arranged for her to see a bereavement worker. At the end of the first meeting, she said that the hour she spent with the bereavement worker was the first time since her husband's death that she had been able to really talk to someone about her grief and her loneliness, rather than having to listen to other people talking about theirs.

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5. Spiritual History Taking and the Use of Stories

An important part of spiritual care is listening to the narratives of others and facilitating the discovery of meaning and purpose within these narratives. Narrative identity is key to a person's understanding of self and so one of the most effective ways to show respect for another is to listen to their story (Browning, 2008).

Listening to the story

For the healthcare professional, this means being ready to hear what the other has to say, being ready to take the spiritual history of the individual, alongside their medical history. For the healthcare educator, this means helping students develop the art of non-judgemental listening, so that spiritual stories can be told in an atmosphere of acceptance and safety.

Whenever this spiritual narrative is allowed to happen, both the cared for and the carer can benefit from the experience (Pesut, 2002). Such transformative experiences illustrate how understanding and empathy are in themselves effective forms, not only of therapy (Swinton, 2001) but of job satisfaction by way of promoting the carer's sense of self-worth and increasing their motivation to care.

A therapeutic activity

Listening to this personal narrative, in fact, becomes the ultimate patient-centred therapeutic activity. The patient assumes control over her or his own narrative, its structure and its interpretation. Story telling itself encourages a sense of the whole person which is vital for holistic care. A story might have a beginning, a middle and an end (if not realised, then perhaps at least in sight) which encourages a patient to make her or his own sense of the journey in healthcare. The listener, wherever they are coming from within the range of healthcare professions, in attending to the patient's own story, can help the patient to focus on the patient's own interpretation, thereby assisting the patient in the process of clarification.

The recounting of a story helps to bring both meaning and purpose to a patient. In terms of meaning, the patient is looking back over a period of her or his life, retrospectively, and recalling thoughts and feelings arising in the events of the narrative and enduing these with his or her own interpretation. In terms of purpose, the patient is helped to look forward, prospectively, and to connect the story with future goals and aspirations.

Asking appropriate questions

Through developing basic listening skills, a carer can help someone, in the telling of her or his story, to unpack layers of meaning and to make decisions about the future. For example, while it is not helpful to interpret someone's story for them, it can be very helpful to ask the following questions in an attempt to help the individual find meaning and purpose in their own narrative:

1. Out of all that you have told me, what do you consider to be the most significant?
2. What, if anything, do you want to do about that?
3. How do you feel about that decision now?

Patients can tell stories in many different ways and a skilled listener needs to discern what kind of narrative is being used. Here are some examples of patients' spiritual stories and of how these narratives were facilitated or resolved through careful listening on the part of the healthcare professional.

A woman had been admitted to hospital following a miscarriage, her third in three successive pregnancies. Her great sorrow, expressed to me as the visiting chaplain, was that she was left with nothing, i.e. there were no human remains with which she could have a funeral, or remember and mark the lives which had been there. At the same time, she indicated a vase of daffodils on the bedside cabinet. These had been given to her by her mother, but in the heat of the ward, they had all withered on their stems and not one of them had opened. She said it seemed to be a visual reminder to her of her losses, "The buds that never came to flower". I then suggested that we might do something symbolic with these buds, since we had no human remains with which to conduct a funeral. She found the idea a helpful one, and we ended up co-creating a rite involving us digging a hole in her garden, laying three of the buds at the bottom of it along with some poems she had written about her experiences and a form of words appropriate to what we were doing, and planting a rose bush on top, which comes to full flower each year.

A woman appeared distressed at an appointment concerning a possible termination. The doctor suggested, and she agreed, to visit the chaplain. The reasons for her confusion were several. Her story was not just that she had ethical qualms but rather that she did not want to be connected for a life time to the potential father of the child. At what seemed to be the end of the conversation she mentioned that her mother had died six months previously and she feared that if she went to hell for aborting her child, she would never again see her mother who she knew was in heaven.

Holding the story: empowering the patient

Spiritual stories can have many layers of meaning and interpretation. Sometimes, the patient can even make connections that are not obvious to the listening healthcare professional, or may even belong to a spiritual frame of reference inimical to the listener's own spiritual background. For example, the patient may provide a miraculous interpretation to their story when the healthcare professional does not believe in a supernatural world. The question then becomes one of whether the healthcare professional can hold the story for the patient, in the form in which it has been told, to allow the teller to come to her or his own conclusions about this. Sometimes the healthcare professional is called upon to suspend disbelief in order to help someone find meaning in their own narrative.

Indeed, as illustrated above, the types of story that a patient tells may, or may not even be completed, and the work of the healthcare professional may be to hold the story as told, and in its incomplete form, in order that the patient can discover for her or him self how the story ends.

Empowering the patient in these ways, to tell their stories, to own them and to participate in their completion, acknowledges the patient's right of autonomy. This is very much in sympathy with a healthcare service that has moved from a paternalistic view of care to one which values patients as whole people with highly individual stories.

Notes for Educators

1. In terms of aesthetic teaching and learning, several authors (Sandelowski, 1991; Grindle and Dallat, 2001) recommend storytelling as a useful strategy to inform aesthetic knowing. Therefore, when teaching about spiritual care it may be useful to include storytelling perhaps using audio or video tape as well as literature to explore spiritual matters. Some suggested teaching materials: Lee Halls audio play 'Spoonface Steinberg'; Mike Nichols DVD 'Wit' (see references) and Jean-Dominique Bauby's book (now also available on DVD), 'The Diving Bell and the Butterfly' (1997).

2. Because of its personal nature, spiritual education has to be evocative of the personal beliefs, values and experiences of the student. Thus, teaching methods should incorporate time for discussion so that students can talk about their own stories of spirituality both in relation to themselves and patients. The emphasis on centring learning round the thinking and experiences of students suggests incorporating reflective learning as a method of learning. In a sense, reflective inquiry helps students assert a degree of control over their own theorising or metacognition (Eraut, 1994), thereby developing their cognitive and affective skills in a way that opens up new perspectives or new ways of story telling.

3. As spirituality has received little attention in healthcare education it is likely that students will require new knowledge to develop their understanding. Bearing in mind the desirability of teaching spirituality according to a broad parameter, it is important to introduce students to a wide spectrum of theoretical considerations of spirituality and this could be delivered in a lecture format. Furthermore introducing students to a variety of spiritual assessment tools might be usefully achieved by means of a lecture.

KSF Supporting Links

C1, C4, C5, C6
HWB 2, 3 , 4, 5, 6, 7

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6. Looking After One's Own Spiritual Wellbeing

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet".

Rachel Naomi Remen (2006)

The importance of spiritual self-care

One of the most important things for NHS staff to think about is how they will look after their own spiritual care needs. Since spiritual care is about looking after the spirit within each person, this is just as important for staff as it is for patients. Working in a hospital, surgery or community with those who are unwell can be emotionally and spiritually demanding. Over the course of their working life NHS staff will witness birth, death, suffering and recovery. These are significant personal experiences, which present some deep issues about what it means to be human; this can raise important questions and issues.

Each person's spiritual journey will change and evolve over time; therefore in caring for NHS patients it is helpful to have an awareness of the important issues we each face in our own lives. These will affect how fully we are able to respond to patients' spiritual needs. Unless healthcare professionals look after themselves spiritually, they will find it much more difficult to recognise and respond to the spiritual care of patients. For all of these reasons, it is important to be attentive to your own spiritual journey.

Ways to look after your own spiritual needs

For many people, looking after their own spiritual needs will include activities that help them reflect on their day to day experiences in a deeper way. Just as beliefs about spirituality and religion can be different for everyone, the activities which will help people tend to their own spirit will be personal to them. Some people will use lots of different ways to develop spiritually over their lifetime; others may have one or two particular things which they find most helpful. These might include:

- Going for a walk, appreciating the beauty of the natural world.
- Making time to talk to someone you trust about important issues that may be on your mind and in your heart.
- Attending services and taking part in the rituals relevant to your own religious faith group (e.g. attending a church or mosque).
- Finding ways to explore your thoughts and feelings using art, music, drama or writing.
- Using a meditation technique such as 'silencing'.

- Going on a retreat to get some quiet time or to explore a particular issue (e.g. grief, forgiveness, the spirituality of aging).
- Spending time in prayer alone or with others.
- Finding ways to meet others in a relaxed environment to discuss deeper questions that you want to explore.
- Reading books or attending talks that reflect on spiritual or religious issues that you are interested in.
- Finding an organisation that provides spiritual direction and meeting individually with a trained spiritual director.

Challenges to the provision of spiritual care within the NHS

Since spiritual care can be a very personal and important issue, the foundation of good spiritual care is in forming positive relationships with patients and other staff. However, often the reality of the NHS is that healthcare is provided quickly when time and resources are limited. This can lead to 'instant relationships', which may address a patient's clinical needs, but which don't necessarily have much depth to them. Given that spiritual care will often involve deeper concerns and questions a patient may have, it is helpful to recognise that providing good spiritual care within a fast-paced service environment can be difficult. One important way for healthcare staff to look after their own spirituality will be to identify friends or colleagues whom they can talk to and reflect on their experiences. At times spiritual care can raise unexpected thoughts or feelings; therefore finding someone you trust to share these ideas with can be a helpful way to cope with the stress of busy care environments.

Understanding the boundaries of spiritual care provision

For these reasons, it is important for NHS staff to understand the boundaries of the spiritual care that they can provide. Some staff will feel comfortable discussing spiritual issues when patients raise them, whereas other staff may feel uncomfortable or ill-equipped dealing with these concerns. Also, staff may well find their ability to provide spiritual care has seasons to it. Depending on what is going on in their own life, there will be times when healthcare providers feel more or less able to provide spiritual care in challenging situations. Understanding these limitations is central to good spiritual care and in these cases the priority is that staff members refer these needs to other healthcare providers who are able to deal with them, and follow up that these have been addressed. Healthcare staff are not expected to answer questions relating to spiritual or religious matters if they should feel out of their depth. Healthcare chaplains are trained providers of spiritual care and are available to give advice and support for other staff.

Other resources for support

Finally, all NHS workers are part of a much larger healthcare system which has dedicated resources to support them as they look after their own spiritual needs. Healthcare chaplains spend a large proportion of their time with staff and are available to discuss spiritual and religious issues when they arise. Services such as counselling and alternative therapies are may also be helpful for staff in caring for their own spiritual needs.

I had a difficult discussion with a group of other staff where we disagreed about the best interest of the patient over something important. The others all agreed with each other and they were quite rude and dismissive. They didn't know that at the same time my mother had just taken seriously unwell and was in intensive care. I found the discussion really stressful.

I was upset as soon as I finished working and needed a few minutes to calm down. The only place I could think of in the hospital that would be quiet and private was the chaplaincy. By the time I got there I was crying and the woman at the door could see I was upset. She told me there was tea and coffee if I wanted some and staff there if I wanted to speak to anyone. I didn't want to talk, but I sat in the quiet room for a while and thought over what had happened and got myself together.

I was meeting people later and I wouldn't have been in a good state to see them if I hadn't had some time to allow myself to feel angry and upset about what happened. It was helpful to know there was a place in the hospital where it's ok to do that.

Notes for Educators

1. It is important to encourage students to reflect on their own spiritual history and how past experience, education and upbringing can influence how they think and feel about issues of spirituality and religion. This will affect how they recognise and respond to their own spiritual needs and may also highlight attitudes that can prevent people from taking care of themselves spiritually. For example, there are often barriers to expressing emotions such as vulnerability or uncertainty in the workplace. Students can explore how these vital aspects of humanity can be integrated into their working lives in a healthy and appropriate way.
2. A useful exercise is to ask students on their own to identify times in their own lives when they have personally felt spiritually content or spiritually distressed. What happened to cause this? What did they think and feel? How was this different from other types of contentment or distress? Sharing some of these insights in small group discussions should demonstrate the diversity of spiritual experiences and how they can be interpreted.
3. It is also useful to ask students to identify an experience they felt was sacred to them or inexplicable in some way, such as a patient who unexpectedly recovers. This cultivates the awareness that there are often mysterious aspects to human spirituality, which may never be fully understood or explained.

KSF Supporting Links

C2, C5

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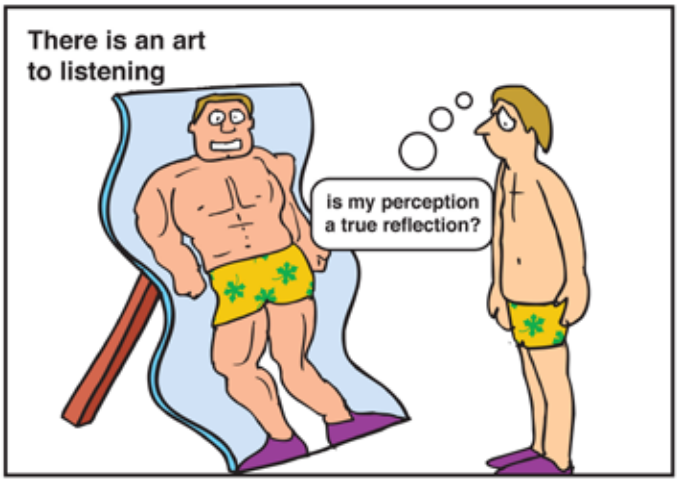
7. Reflective Practice

Reflection is the hallmark of professional practice. It is the art and skill of critically reflecting on and learning from past events and behaviour. Reflection can be done by individuals and by groups. In healthcare it is a well established method of thinking about and evaluating our actions with the aim of improving clinical practice. It is a discipline which is well worth developing for both personal and professional development.



A way of learning

Reflective practice offers us a way of learning which is experiential, cognitive and emotional, as well as verbal. It gives us a story which often has more coherence than an idea. By reflecting on an event and our participation, our feelings as well as our thoughts come into play. Things we experience more deeply and personally are more likely to be remembered and to change our practice than purely verbal or visual teaching. If reflection is done individually it will be a different experience than doing so in a group.

Individual reflection

Traditionally, religious people have used particular times of the day or the year for devotions which include reading certain literature, prayer, meditation, even silence. Some traditions use the repetition of words or mantras as a way of helping to induce the kind of peace which allows spiritual reflection to take place. Positions of the body, exercises and breathing help this kind of discipline.

Individual reflection may be done in a non religious way, for example by keeping a journal. This would record events, feelings and ideas. It could be used regularly as a time of quiet reflection. Poetry and the kind of mind/body exercise as above may be used. Some people are naturally more reflective than others. Many find it is a way of maintaining perspective and seeing things from a broader point of view.

Group reflection

When done in a group which has a degree of honesty and trust there will be difficult and even quite painful times. Groups can challenge our behaviour as well as support it. Unless there is honesty the group will not benefit from real reflection and unless there is trust there is danger of hurt which can continue outside the reflecting group and event. When a group is doing this properly there must be a supportive framework so that outcomes can be positive and constructive rather than the opposite.

Technique and approaches

Reflective practice could be thought of as an approach which aims to develop understanding and critical thinking skills. Techniques such as self and peer assessment, problem-based learning, personal development planning and group work can all be used to support a reflective approach.

Significant Event Analysis is a major area of research and new practice within the Health Service. This is a learning method which involves the multi professional and multi skilled team and it is a way of affirming the value of working together as a team. If a team does not work well together there is scope for poor practice, poor communication and increased mistakes. When a team works well the benefits are seen to be greater than the sum of the parts. This kind of exercise helps people to understand the work and the issues faced by other members of the team, it improves communication, efficiency, satisfaction and a sense of purpose and well being within the team.

Clinical Pastoral Education is an educational system which uses reflective practice as the basic method of learning. This is done by group work led by a trained and experienced facilitator. The basic tool is the verbatim account, as accurate as possible, of the exact conversation between the carer, chaplain, nurse, etc and the patient or client. This account is anonymised, read and explored. Questions are asked as to why it was chosen, why the conversation went in certain directions, why some messages were picked up and followed whereas others were not. It is a way of those in caring professions facing up to how they really do interact with their clients. It is illuminating and educational, while also being challenging and supportive.

Pastoral Supervision is a regular, planned and intentional space in which a practitioner skilled in supervision (the supervisor) meets with one or more other practitioners (the supervisees) to look together at the supervisees' pastoral practice. It is a relationship characterised by trust, confidentiality, support and openness that gives the supervisee(s) freedom and safety to explore the issues arising in their work. It draws on relevant psychological theory and insight to illuminate intra-personal, inter-personal and contextual dynamics.

It is in the nature of people to make the same mistakes again, to develop habits of behaviour and response which are comfortable to the giver but not necessarily the most helpful to the receiver. Honest reflective practice can help us to find out things about ourselves, sometime to 'see ourselves as others see us' but more importantly to see ourselves as our clients see us. It is a helpful way of enabling us to improve our practice. It is a learning resource which needs no outside knowledge; it is effective and always available.

KSF Supporting Links

C2

Notes for Educators

Schön and Kolb have given reflective practice a prominence in recent years, using a basic principle of reflecting on experience to improve action and professional practice. However, this is not a new or original idea; it has been developed by education such as Dewey and Lewin and can be traced back to the work of Socrates and a form of learning through questioning and feedback. It forces us to question what it is that we know and how we come to know it. More currently, Claxton has suggested that "learning to learn, or the development of learning power, is getting better at knowing when, how and what to do when you don't know what to do".

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8. Bereavement and Loss

Because life is finite, the experience of the death of someone close is universal. Each of us will have our own history of losses of people we have loved, and although we may feel we have 'dealt' with these, often the pain of the separation is not as deeply buried as we like to think.

Work in healthcare focuses on diagnosis, treatment and recovery, but our work also takes us into areas of pain and suffering, of death of the patient and the grief of the relatives or carers. And because we are human, we ourselves can feel grief when a patient dies, even although we may not have known the patient for long.

In this chapter we will consider:

- What is grief?
- What does the journey through grief look like?
- What helps people on the grief journey – and what doesn't help?
- How can we look after ourselves?

Grief is a normal response to loss

Grief is the emotional response which we feel when confronted with loss. There are many types of loss, as when we move away from our family home, or when a relationship comes to an end. People can experience grief at the loss of their health, or of their faith, or of their job. However the loss of someone close through death is a particularly painful loss.

The attachment we feel to those who are significant to us is a source of stability for us; these people, their presence and their love, are part of what Colin Murray Parkes (2007) calls our "assumptive world" – they are part of how we make sense of life. When such a person is taken away by death and we face the reality that they are not coming back, then our world is shattered. We may wonder how we will ever cope without them and that feeling of loneliness is not just physical, but emotional – we feel empty inside. Feelings of despair and of suicidal ideation are not uncommon. As a bereaved person, the one thing we want more than anything else is to have the dead person back again and our innate instinct is to cry, because childhood experience has taught us that is the way to get what we want.

The pain of grief is intense, physical as well as emotional – we ache for the person who has died.

Grief is a journey to a new normality

It is important to note that this is a journey through grief. Eighty to ninety percent of people in grief will experience an intense, but transient, emotional pain which, for a while, may affect their ability to function normally and may affect their ability to concentrate; eating and sleeping patterns can change and sometimes irrational or compulsive behaviour can be manifested.

The initial shock and numbness, in which the loss seems unreal, is often likened to a nightmare from which the bereaved person hopes he will awake to find it was all a dream. But when the reality sinks in there may be a feeling of anger, which can be expressed as anger at the Health Services, at God, at other relatives, or even at the person who has died. It is important to note that often this is an outward expression of an inner anger, and does not mean that blame is being directed at anyone.

For this majority, however, the journey through grief will proceed – with peaks and troughs of emotion – as the person works through the pain and begins to adjust – physically, mentally, emotionally and spiritually. Talking to friends, beginning to take time away from the grief, re-establishing some kind of routine and finding a new kind of normality will alternate with feelings that life has lost meaning and will never be the same again. But by around six months after the death the bereaved person will normally be beginning to emerge from their grief with no permanent detriment to their functioning. It is important to note that this is only a beginning – but while the journey itself may continue for many months or years, the outcome is positive.

However, for the other ten to twenty percent of people the journey through grief will be much harder, and may be marked by daily periods of yearning and longing for the deceased person, regular periods of deep anger or helplessness, and feelings that there is no point in life anymore. These are symptomatic of a different kind of grief – a grief which is more complicated and prolonged and which may well require some kind of skilled intervention. For these people an assessment of their grief will indicate the appropriate responses, which may vary from supportive listening to counselling or mental health interventions.

There are ways we can help bereaved people

Following the death of a patient, we may seek to be supportive by allowing bereaved relatives to speak about the person who has died, or to express their own pain; we may offer information, in writing or verbally, about the journey that lies ahead. Attention to detail such as in the performance of last offices, the giving of time for viewing and farewells, and the way property is returned, will all help the relatives start their bereavement journey.

When Jenifer's baby was still born at 38 weeks, she and her partner were devastated. All their plans and hopes and dreams were torn from them. They later spoke of the sensitivity of the midwives who gently encouraged them to spend time with their baby and who arranged for a chaplain to give a blessing to baby Scott.

Relatives and carers will appreciate the fact that staff are concerned for them, and they may be grateful for the opportunity, at the time or later, to ask questions and clarify their understanding of what has happened, which will help them begin to accept the reality of the death.

Later, for those who experience 'normal' grief, friends and colleagues can do much to help simply by being there, and by being sensitive to where the bereaved person is in their grief – listening when they want to talk, offering clear information when that is asked for, normalising the experience with accurate information which reassures the bereaved person that they are not going mad.

It is also important to allow the bereaved person time and space to begin to explore what life is going to be like without the person who has died, re-connecting with social activities and relationships. There is nothing wrong in taking time out from grief!

Following the death of his wife, after 57 years of marriage, Tom felt his life had fallen apart. When he met with a chaplain to arrange her funeral, he admitted how low he felt. The chaplain encouraged Tom to speak of his pain and Tom found himself admitting that he was thinking of ending his own life. Six months later he said "If I had not been given the chance to admit how I felt, I think I would probably have taken an overdose."

It is also, however, important to recognise danger signs when they appear and to be ready to support and encourage those who, after six months or so, appear stuck in their journey through grief. At this stage it may be helpful to encourage the bereaved to consult their doctor or to seek help from specialist organisations and therapists. The research suggests that such formal intervention should be targeted only at those who seek it and who, around six months after the death, present as at risk of developing complicated or prolonged grief.

We need to look after ourselves

Because we have our own histories of loss, and also because, too often, we seek to shut off our own emotions, we are all vulnerable when it comes to the death of those around us, whether it be friends, colleagues or patients. But at the same time we ourselves may be sad at this death; or we may find ourselves thinking of our own loved ones who have died or are dying. It is important that we acknowledge our own pains and, not there and then, but later in the day, that we give ourselves time and space to express our feelings, to ourselves or to another person.

For those working regularly with the dying or the bereaved, a regular time of reflection and / or supervision when the effect of this work on our own emotions can be explored and processed is highly recommended.

Notes for Educators

1. In discussing death and bereavement, it is important to recognise the bereavement stories of participants, and that such discussion can resurrect the feelings of loss.

2. Participants in training frequently speak of a lack of confidence in talking to bereaved people – participation in training can help build that confidence.

3. Good listening skills are the basis of good bereavement support – by speaking about the death and the deceased bereaved people actualise the loss and work through their pain.

4. The ability to normalise people's grief depends on an understanding of what is normal. Discussion of participants' own stories will help to elucidate the normal responses, as will a study of bereavement models and reading of good bereavement literature. Educators should be familiar with the models of William Worden (1991) Tasks of Mourning and Stroebe and Schut (1999) Dual Process Model.

KSF Supporting Links

C1, C6
HWB 2, 3, 4, 5, 6, 7

References

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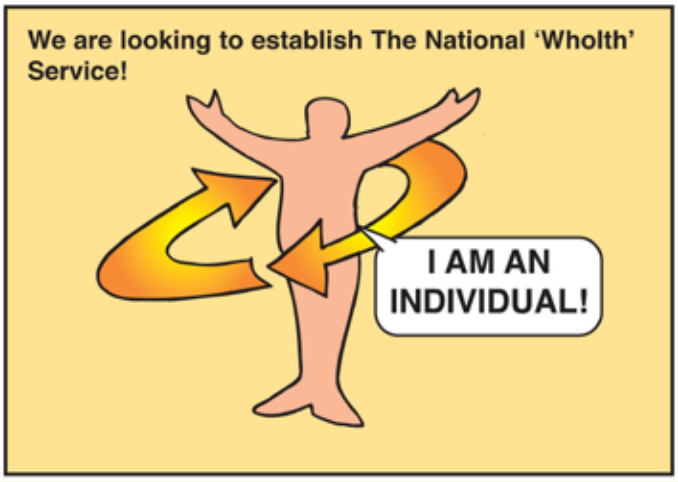
9. Spirituality, Equality and Diversity

Equality and diversity: about the whole person

Equality is about ensuring that people are treated fairly according to their needs and making this normal practice and behaviour. Diversity is about respecting differences. Spirituality includes the acceptance and valuing of the whole person.

Promoting equality and diversity is not about serving 'minority' interests. If we brought together all the groups that regularly experience discrimination, they would form a very substantial proportion of the community. One of the ways public sector agencies such as the NHS try to respond effectively to the diverse needs of the local people is by mainstreaming equality and diversity into their policies, targets, governance structures etc. Tools such as EQIA (Equality Impact Assessment) and equality monitoring help in this process.



Focus nationally and in Boards

NHS Boards across Scotland have a duty to ensure that their services are accessible by all people regardless of their age, disability, ethnicity, gender, religion/belief or sexual orientation. This section aims to develop an understanding of the link between spirituality and equality and diversity. Factors such as poverty, mental health and other societal inequality issues within a health and social care context are also considered.

There has been focus on equality and diversity within a policy and service delivery context for some considerable time. An array of directives ranging from legislative requirements including human rights directives to Scottish Government guidance are used to shape the design and delivery of services.

A holistic and up-to-date approach

A recognition that the medical model has to work in partnership with the social model allows service planners and providers to take a holistic approach in service delivery. Recognising the significance spirituality plays within a diverse and multi-belief society, the Scottish Government issued guidance (HDL (2002) 76 and CEL (2008) 49) both of which aim to develop a NHS that is reflective of modern and changing spiritual and religious care needs.

Equality and diversity is central to the ethos of the NHS in the UK and is increasingly taking centre stage in healthcare education, through a range of forums and agendas. Addressing these issues is often seen as being sensitive

and problematic for practitioners, who see themselves working within a secular setting providing medical care. These complexities often lead to a minimalist approach to providing spiritual care, without recognising that providing person-centred care involves looking at the individual as a whole.

Spirituality, as in the need for meaning and value, is an integral part of a person's 'well-being'. It has a spectrum of meanings and is a common denominator for everyone, whether or not they have a religious belief. An individual's world or societal view is usually shaped and linked to their spirituality and is often challenged and tested in times of need or distress. Understanding the importance of spirituality in an individual's life is a key in ensuring that the services we deliver are person-centred and equitable.

Promoting equality and diversity requires promoting the spirituality agenda, this is evidenced by the fact that inequality and discrimination can impact on an individual's spiritual needs or fulfilment. Recognising specific needs of people from different religions/beliefs as well as from the same religion/belief helps in developing a person-centred service.

There is increasing evidence that when a person is treated, valued and regarded as a whole person in such ways, they are better equipped to cope with illness and the working of a person's natural defences, such as the immune system, is more effective.

Positive, practical, ethical

Organisations benefit from harnessing equality and diversity in a number of ways. For example, staff who are able to understand and address the needs of their clients can provide better customer satisfaction. Organisations which promote and respect the diversity of the workforce benefit from a wider talent pool.

In addition to the business case there is also a strong moral case for equality and diversity. It is not acceptable to discriminate against people on account of their ethnic origin, gender, age, sexual orientation, disability, faith or belief etc. In order to eliminate discrimination and promote equality of opportunity, UK government have legislated a number of anti-discrimination laws. Public sector agencies such as NHS have a statutory duty to comply with a number of anti-discrimination duties. All NHS staff need to understand these duties to ensure that their organisations are fully compliant with their responsibilities.

Within the context of the NHS, equality and diversity is a broad and inclusive concept. It is about understanding people, their differences, similarities and their specific needs, and delivering a responsive service. It is about how people access services, treatment, employment, and how services can have adverse impacts on people – and thus on our communities – because of a lack of appreciation of different cultures, traditions and practices.

Examples of good practice:

- When making appointments with someone who is a devout Muslim, it is better to avoid a Friday afternoon which is a time of prayer. There is a similar sensitivity for many Jewish people, especially in winter, for whom the Sabbath begins on Friday at sundown.

- Care must be taken to make sure that access to outpatient areas is accessible to those who use wheel chairs.
- Information should be available in the language(s) used by the local population. Written information should be as clear as possible as many have sight or reading difficulties.
- A person's marital status, orientation or age should have no bearing on their employability if they are able to do the job.
- Quiet rooms should be accessible and welcoming to those of any or no particular faith or belief.

Please contact the equality lead for your NHS Board for further information on the work around equality and diversity in your Board.

KSF Supporting Links
C6

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Further Reading

Equality in Health e-library
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10. Organisational Spirituality

"Honouring our spiritual nature in the workplace is not only good for our souls (and psyche), but also good for the workplace too."
The Foundation For Workplace Spirituality

If staff are to be encouraged to express their spirituality through the holistic model of health in caring for patients, then the organisation itself must reflect those same core spiritual attitudes and values towards its staff. Thus senior management must demonstrate their commitment to a spirituality of the organisation for, as both the HDL and the CEL, HDL (2002) 76 and CEL (2008) 49, on Spiritual Care in the NHS state, such care is not only for patients, but staff as well.

However, the business case for workplace spirituality must never be seen as the primary reason for developing it. Rather it should be seen as the morally right approach to take, particularly in the organisation known as the 'caring profession'.

Organisational spirituality can be defined as:

"Enabling each employee to be able to realise their highest human potential, by embodying spiritual values and attitudes within the workplace such as meaning, love, compassion, acceptance, forgiveness, value, and integrity."
Alfred, 2002.

There are a number of discernible benefits of a more positive workplace spirituality, where staff are valued and find meaning in their daily work:

- Release of human potential, such that staff bring their 'whole person' to work, using their innate strengths of creativity and empathy in their working relationships.
- Enhancement of a culture of 'service' to other staff and the organisation, rather than competition or undermining. This can only happen if staff personal values resonate with the organisation's.
- Staff find 'meaning' in the workplace situation, which leads to improved personal job satisfaction, lower rates of workplace stress and absenteeism.
- Improved performance of the organisation follows from the above, with lower staff turnover and better recruitment.

Signs of a flourishing organisational spirituality would include:

- Policies and procedures of the organisation promoting a culture of personal growth, self-knowledge, and the maintenance of integrity.
- Staff enabled to create, achieve, and influence in their daily work.
- The organisation having shared values which generate not only supportive relationships between staff but also a sense of belonging and meaning.
- Leaders who, by demonstrating courage, creativity, sensitivity, and empathy, have the ability to inspire other staff to reach their potential.
- The presence of an active and effective staff support system.

It is now widely accepted that those organisations which have a 'spiritually-friendly' culture, show universally lower than average rates of absenteeism, workplace stress and staff turnover. 'Spiritual cultures' also provide opportunities for transcendence and interconnectedness through the work process which, within a moral framework, results in increased and better output. Thus, workplace spirituality is not only just good for the 'soul', but is also good for the workplace itself.

A man is walking along a road and sees a stonemason working. He stops to admire the smooth blocks of stone, and the stonemason stops working to have a break and pass the time of day. The man asks, "What are you doing?" The stonemason answers, "I come here every morning and work until nightfall, cutting stones for my master. It pays the bills, so I cannot complain." The man bids him farewell and continues his journey.

Further along the road he meets another stonemason. This one is working flat out, and had a much larger pile of stones beside him. The man asks: "What are you doing?" The stonemason answers, "Sorry, I can't stop to talk. I am paid according to the number of stones I cut each day, so I must get on." So the man bids him farewell and continues his journey.

Further along the road he meets a third stonemason, who has an even larger and very well cut pile of stones beside him. The man asks, "What are you doing?" The stonemason answers, "If you look behind you can see the foundations of the Cathedral we're building. I'm responsible for the stones in the arch above the west door. I want my grandchildren's grandchildren to be able to look up and see what I have made, so I have to make sure that every stone is worthy of posterity."

(Poole, 2006)

As Poole herself says, after telling the above story, *"we are all building cathedrals, we just need to find them in the daily work that we do. Organisational spirituality offers one way of starting this journey".*

KSF Supporting Links

C1, C2, C6

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Further Reading

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11. Use of Chaplaincy and Spiritual Care Services (Referral)

All change – you are now the focus – we are relying on you.

What comes into your mind as you think of chaplaincy?

- The local minister or priest visiting patients who could be in hospital for a few weeks?
- Chaplains providing religious support?
- Whole time chaplains dedicating their time to visit almost every patient in the larger hospitals?

Did you know that today the chaplains are there for people of all faiths and none but they need your help? They're asking you to help them identify:

- Where they need to be working?
- Who needs to see them?
- Who is asking for help because they are frightened or lonely or asking difficult questions?

You are the key to the delivery of good spiritual care in the NHS!

No matter what job you do, you are often the person best placed - in the wards, the corridors or at reception - hearing what people say and how they feel.

You may be the person who hears a silent cry, so you need to recognise and develop the skills you may already have, but equally know when the chaplains may be able to provide that higher level of support in difficult situations.

Why do we need chaplains and spiritual care?

Everyone, whether religious or not, needs support, especially in times of crisis. Many patients, carers and staff have spiritual needs and welcome spiritual care when they are:

- Facing difficult questions about life and death.
- Searching for the meaning in their illness.
- Looking for help to cope with their illness and with suffering, loss, loneliness, anxiety, uncertainty, impairment, despair, anger and guilt.

But what do chaplains actually do?

They are available to patients and staff in a number of different ways, to:

- Support people at difficult times.
- Listen to their stories.
- Work in one to one situations and understand relationships.
- Provide training to help you develop skills in spiritual care.
- Provide information about different faith and belief groups and about bereavement.

How do I find a chaplain?

- Every Health Board has a spiritual care policy which will tell you the type of spiritual care service you can expect in your hospital.
- Every Health Board will have a department of spiritual care and the details of this should be easily available on the intranet, notices, leaflets, through the switchboard.
- Every hospital should have a chaplain. They may work whole or part-time but it is important you get to know them because you need to know who you are referring people to or whose advice you are asking.

At present chaplains working in the community are usually linked to mental healthcare hospitals.

Are chaplains available 24/7?

Whole-time chaplains will mainly work office hours. Part-time chaplains will work in a pattern which suits the hospital. However, chaplains are usually available on an on-call rota providing twenty four hour cover. The areas they cover will vary from place to place but this is usually for acute hospitals. Information should be clearly displayed if this service is available where you work.

Andy was nearing the end of his life and it was hard for the family to go away home. He loved football and there was a big match on the TV that evening so the nurses took his bed through to the sitting room. Bill should have finished after he'd cleared up after tea but he sat down and watched the match too. Andy had died before the family could get back in but when they heard what Bill had done they had very special thoughts of Dad's last hours when he wasn't alone.

Are chaplains only a phone call away?

Yes, each hospital will have its own referral system and this is undergoing review in many areas but the simplest way is always the best

- Telephone the chaplains' office.
- Set off the bleep or pager which whole-time chaplains carry.

KSF Supporting Links

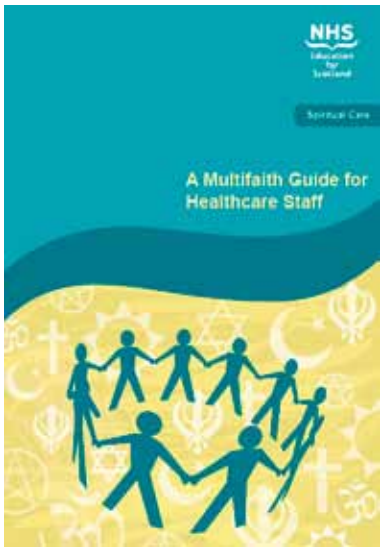
C1, C4, C5, C6
HWB1, 2, 3, 4, 5, 6, 7

Further Reading

There are local and national resources available to help you.

A Multi-Faith Resource for Healthcare Staff, will tell you specific needs of people of different faiths and beliefs. This should be on every ward.

www.nes.scot.nhs.uk/documents/publications/classa/multifaith/Interactive%20master.pdf



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Appendix 1.
KSF Dimensions and Titles

Dimension	Title
C1	Communication
C2	Personal and People Development
C3	Health, Safety and Security
C4	Service Improvement
C5	Quality
C6	Equality and Diversity
HWB1	Promotion of health and wellbeing and prevention of adverse effects on health and wellbeing
HWB2	Assessment and care planning to meet health and wellbeing needs
HWB3	Protection of health and wellbeing
HWB4	Enablement to address health and wellbeing needs
HWB5	Provision of care to meet health and wellbeing needs
HWB6	Assessment and treatment planning
HWB7	Interventions and treatments
HWB8	Biomedical investigations and intervention
HWB9	Equipment and devices to meet health and wellbeing needs
HWB10	Products to meet health and wellbeing needs
EF1	Systems, vehicles and equipment
EF2	Environments and buildings
EF3	Transport and logistics
IK1	Information processing
IK2	Information collection and analysis
IK3	Knowledge and information resources
G1	Learning and Development
G2	Development and innovation
G3	Procurement and commissioning
G4	Financial management
G5	Services and project management
G6	People Management
G7	Capacity and capability
G8	Public relations and marketing

Appendix 2.
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Back cover image is of the quiet room at Dumfries and Galloway Royal Infirmary.

The back cover quote comes from words of welcome at the Sanctuary, the quiet room at Edinburgh Royal Infirmary.

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Sanctuary
… a place of refuge, of shelter, of protection, where nature and the world of spirit meet. A place safe to use, to come and go, to bring and leave, to wait or be…