MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Transforming Spiritual Care Strategy

Updated July 2018

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Kia ngātahi te waihoe

Paddle as one

Tahuri te kei o tō waka, whawhati ngaru

Turn the front of the canoe into the waves

and push through them

Haere ki tua, papapounamu te moana

Because past the waves the ocean is flat

E topa, e rere ki uta

And we will speed off into the distance

We are committed to the principles of partnership expressed in the Treaty of Waitangi. Implicit in the Transforming Spiritual Care Strategy, is a commitment to those principles, which impose upon Chaplains the need to have regard for the spiritual and cultural needs of Tikanga Maori.

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2. BACKGROUND/CONTEXT

Spirituality means different things to different people. It may include (a search for) one's ultimate beliefs and values; a sense of meaning and a purpose in life; a sense of connectedness; identity and awareness; and for some people, religion. It may be understood at an individual or population level.

(Egan et al., 2011)

There is no universal definition of spirituality, for each of us understand, experience and express it differently. One common misunderstanding is to presume that a discussion about spirituality is a discussion about religion. Part of the reason for this is that much of the language of spirituality developed in religions. Religion may be defined as "an expression of spiritual belief through a framework of rituals, codes, and practices; the sense of otherness or a power being a deity or supreme being" (Speck, Higginson, & Addington-Hall, 2004). Many Māori observe strong traditional spiritual beliefs and practices ('wairuatanga') but may simultaneously identify with strong religious beliefs or hold eclectic spiritual beliefs. Religion is clearly spiritual in nature, but spirituality does not need to be religious. There are however some common elements that most people can probably agree on.

Spiritual care is increasingly understood as part of best practice holistic care across many healthcare settings. Evidence suggests spiritual well-being is a dimension of overall well-being for many people (WHOQOL-SRPB Group, 2006). In the last 20 years there has been a steady growth of cross-disciplinary peer reviewed publications showing the value, importance and contribution of spirituality in health (Whitford & Olver, 2012; Williams, 2006), education (Fraser, 2004), business (Lips-Wiersma & Mills, 2002) and social work (Sullivan, 2009). Spirituality is increasingly understood as having an important impact on our health and well-being (Puchalski, 2012) and this evidence has informed policy, such as the Scottish National Health Service, who note "spiritual care in the NHS must be both inclusive and accepting of human difference" (NHS Education Scotland, 2009).

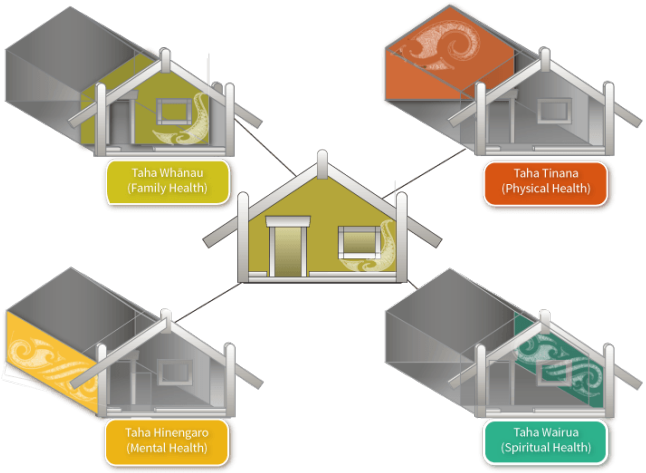
Central to care provision is the model out of which healthcare professionals practice. Traditionally healthcare works from a biomedical model. However the biomedical model alone does not address the whole person with the disease; therefore, the World Health Organisation and George Engel developed the biophysical model of healthcare. (Rumbold, 2012) This was further expanded, particularly in hospice/palliative care and Māori and Pacific approaches, to include the spiritual domain.

He Korowai Oranga, the New Zealand Māori Health Strategy 2014, acknowledges the need for continuing development of healthcare in New Zealand through the inclusion of Māori world view values and concepts. "Māori concepts of health are holistic in approach" (Hauora, 2002). Māori traditional healing is based on indigenous knowledge – it encompasses te ao Māori and a Māori view of being. Māori traditional healing practices include mirimiri (massage), rongoa (herbal remedies) and acknowledging te wairua (spiritual care). For Māori the unobservable (spiritual, mental and emotional) elements are as relevant as the observable or physical elements (Hauora, 2002).

He Korowai Oranga offers Aotearoa clear guidance. It asks that our health system, organisations, services and practice encompass three key concepts:

- Whanau Ora (health in the context of the whanau),
- Mauri Ora (the needs of the individual are considered and include emotional and spiritual care),
- Wai Ora (environmental conditions).

One health model in particular has gained wide acceptance as 'the Māori health perspective'. The "four-sided health construct, later known as Te Whare Tapa Whā (a four sided house) was often described as a traditional Māori approach to health, more correctly it was developed as a view of health, which accorded with contemporary Māori thinking" (Durie, 1994, pp.68-69).



Te Whare Tapa Whā introduced Māori worldview perspectives of health into the minds of medical practitioners and health professionals throughout New Zealand. It continues to influence health practice in Aotearoa today and continually reminds us of the centrality of spiritual care within healthcare practice. MidCentral District Health Board (MDHB) is privileged to have ongoing access to our local Rangatira Sir Mason Durie, who continues to both guide and challenge us to develop the systems and processes for advancing the integration of spiritual care within our health services.

Chaplaincy at MidCentral District Health Board

Chaplains were originally ministers of local Christian churches who visited people in hospital as part of their parish duties. By 1945 the development of full time professional chaplaincy was underway. Hospital chaplaincy has been part of the New Zealand public hospital system since about 1945 and at Palmerston North Hospital since 1948.

In the 1970s the government agreed to share in funding the service to "regularise and fund professional pastoral care" in public hospitals "for adherents of all belief systems" (ICHC, 2015). After a range of organisational changes, chaplains are now employed by the Interchurch Council for Hospital Chaplaincy

(ICHC) who contract with the Ministry of Health (MoH) and District Health Boards (DHBs) to place chaplains in 48 public hospitals.

Chaplains have honorary staff status so that they can provide appropriate spiritual care to all who need it, whatever the patient's religion, worldview or belief. Although chaplains sign the same confidentiality agreements as other staff, they are not permitted to read or write in notes and there is no clear protocol for chaplain visits. As a result, chaplains have developed a number of ways of navigating the territory.

In the initial stages of spiritual care at Palmerston North Hospital, chaplains focused on visiting patients from their own denominations with openness to all. When cuts to funding were made around 2002, the model changed. A Roman Catholic chaplain visited mainly Roman Catholic patients and all other chaplains had an ecumenical focus. By 2011 there were three models in operation where chaplains:

- Visited patients of particular denominations, eg: Roman Catholics.
- Visited bed by bed to see if anyone would like to speak to them
- Responded to requests from patients, family, whanau or staff to visit particular patients.

Chaplains also offered funerals, weddings, baptism/christenings, religious rituals, blessings and/or rituals to mark life transitions. The first church service was held in 1948 and they were a regular feature until the end of 2012 when dwindling attendances made them unsustainable.

The changing role of chaplaincy

Staff support has always been part of chaplains' contracted role; however, formal staff education was limited until chaplains started reviewing their role and introduced a *Spirituality in Healthcare* seminar in 2012. The following table highlights recent, important events that are altering the chaplaincy landscape and, as such, are foundational to the development of this strategy.

DATE	EVENT/CHANGE
Oct 2012	The first Spirituality in Healthcare seminar held to try and improve staff understanding of this area and the chaplain's role. Since then this has been run six times each year. In addition, innumerable presentations on the topic have been given at staff training days in a variety of areas including, palliative care training days, ward handovers, etc.
Nov 2012	Palmerston North Hospital Chaplaincy survey of staff undertaken to get a better understanding of the confusion around spirituality in healthcare and the chaplain's role.
Jan 2014	Co-ordinating Chaplain invited to join the leadership team of the Patient Safety and Clinical Effectiveness Group.

DATE	EVENT/CHANGE
May 2014	Compassion seminar held for the first time in collaboration with a psychologist. This seminar recognises the issue of compassion fatigue and offers a supportive environment for staff to talk about the problem and provides strategies to cope in our challenging environment. The seminar has been run about six times a year since its inception and has been presented as a conference workshop and at a number of staff training opportunities. This year the tutors have piloted a series of four mini segments with the Emergency Department and Medical Assessment and Planning Unit.
Dec 2014	Inaugural meeting of the MidCentral District Health Board (MDHB) Spiritual Care Advisory Group was held. This multi-disciplinary group was formed as a result of the groundwork already done at Palmerston North Hospital. The intent was that it would, in partnership with ICHC, guide the improvement of the quality of spiritual care for patients, family/whanau and staff, add value to the existing chaplaincy service and develop new ways of working collaboratively to meet changing conditions.
2015	Chaplaincy is included in the Hospital Advisory Committee reporting and on the allied and specialist referral form.
Sept 2015	Co-ordinating Chaplain involved in Partners in Care, a co-design project in collaboration with the Health Quality and Safety Commission. This ensured that spiritual care was involved at initial stages of co-design development at MDHB.
Feb 2016	Announcement of partnership to transform spiritual care at MDHB over a three year period. Co-ordinating Chaplain now employed by ICHC as Spiritual Care Co-ordinator.
Mar 2016	Spiritual Care Co-ordinator part of the strategic imperative "Partnering with people, families and whanau" task force ensuring that spiritual care was associated with changing values, particularly compassion and respect.

Throughout this change and development the chaplaincy team has continued to work in supportive and cooperative ways even although the change is unsettling and the future uncertain.

MidCentral District Health Board's Strategic Framework

It is important that this strategy is closely aligned with the overall MDHB strategic direction. The strategy has been refreshed and the key, high level aspects are captured in the strategic framework below. The aspects that have been indicated are, in particular, important for this strategy. Importantly, the organisational values of compassion and respect are indelibly linked with the goals and aspirations of the Spiritual Care Advisory Group (SCAG).

The SCAG is confident that this strategy will add a valuable contribution to the MDHB strategy and help it deliver on its ultimate mission of 'Quality Living – Healthy Lives – Well Communities'.

The Ward 23 Pilot

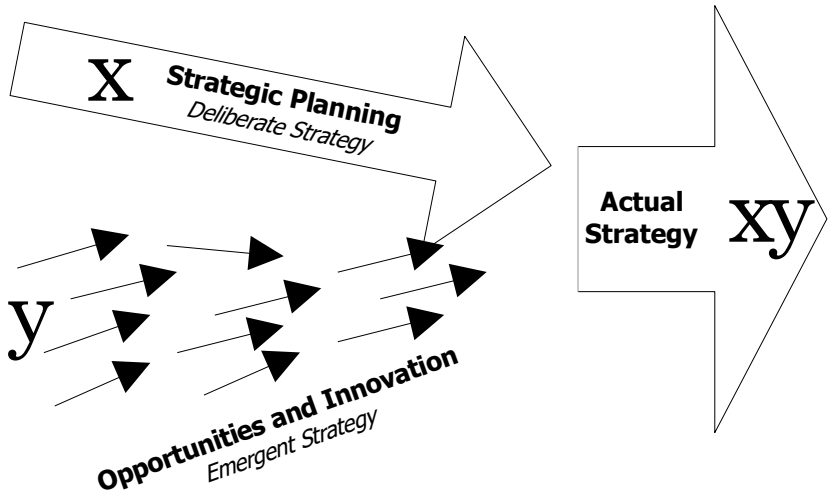
As already discussed, considerable preparation work has already been completed. The pilot project, *Addressing spiritual care in a cancer treatment ward: a quality improvement project* was an important part of this work that tried to gauge the realities of incorporating spirituality into normal screening at admission. This pilot was initiated because a previous survey had suggested spiritual care was not well understood at MDHB and the chaplaincy team was experiencing difficulties in being accepted as part of the multi-disciplinary team.

Key findings suggested that although 81 per cent of staff were initially confident about engaging with patients around spirituality many of them found the process challenging. Difficulties with language, role definition, time and knowledge, along with patient perceptions about chaplaincy were identified as barriers and complicated the project. Even so, 65 per cent of the patients screened considered themselves to be in some way spiritual and or religious.

The recommendations from this project inform the tasks required for integrating spiritual care into practice.

Role of this Strategy

In the majority of situations, the actual outcomes delivered are a combination of following a strategic direction (deliberate strategy) and seizing opportunities and innovative ideas (emergent strategy) that present themselves. This strategy sets out the direction to be followed but the SCAG recognises and encourages enhancement of the strategy through innovation.



3. GUIDING PRINCIPLES

Wairuatanga can be viewed as being interrelated to everything and as a fundamental aspect of health and wellbeing. Values, beliefs and practices related to wairua are considered an essential cornerstone of Māori health and well-being.

(Moeke-Maxwell, 2012).

In line with the global trend to expand the measure of health, well-being and quality of life beyond the traditional clinical and economic measures to include the spiritual dimension, the following principles (adapted Spiritual Health Australia) are seen as essential in underpinning the approach we take to the provision of care: our understanding of the factors that contribute to health wellbeing and quality of life:

- Spirituality is a universal phenomenon.
- Spirituality is one of the domains of holistic health care.
- Spirituality is respectful of and responsive to diversity.
- Spiritual care is integral to the provision of person-centred care.
- Spirituality is integral to the provision of compassionate care.
- Spiritual care is a shared responsibility.
- Spiritual care requires a whole of system and whole of organisation approach.

In addition, MDHB is committed to a patient-centric co-design model of care delivery and this includes spiritual care. In a health care context such as MDHB this approach also aligns with key organisational principles that include taking a co– design approach in all we do and ensuring an ethical framework is used to support ethical decision making in care provision.

It is intended to implement this organisational strategy as a formal strategy, which is included in the Annual Plan and also to ensure it is integral to the MDHB Strategic Plan and Organisational Development Plan.

4. SOCIETAL CHANGE

Spirituality can be considered as being essentially about primary relationships: people and their environment (land, mountains, sky, etc); people and other people in terms of justice and love (families, communities, nations, etc); people and their heritage (ancestry, culture, history, etc); and people and the numinous (that which is beyond the physical, transcendent, what some people refer to as God).

(Waldegrave, 2003).

Since the end of World War II, adherence to institutional Christianity has been slowly waning in the western world. This is reflected in our hospital admission statistics, which show more and more inpatients are choosing not to identify with a religious tradition.

Despite this our exploratory work shows that many people still consider themselves to have a spiritual and/or religious element to their lives. This is consistent with studies and experience around the world, particularly in Scotland, Australia, Canada and the United States where a broad based approach to spirituality in healthcare is well advanced. Whilst we are leading the field in New Zealand we have considerable work to do to catch up with our overseas colleagues.

There are advantages to this as much work has already been done in the development of standards and frameworks for the provision of spiritual care. In particular we note the advancement of these by Spiritual Care Australia, Spiritual Health Victoria, Meaningful Ageing Australia and The Healthcare Chaplaincy Network in the United States. There is much quality work already completed that we can learn from and adapt for our situation.

Although all this work has been done, there is still a considerable challenge to face in how we speak about this work in New Zealand when the traditional language of religion and spirituality has faded along with adherence to Christianity. New ways to speak of the essence of a person's life and how they make meaning are part of this challenge. Equally daunting is the task of helping people themselves express what matters to them in a spiritual sense, now that particular religious language has been lost.

Last but definitely not least is the task of engaging in conversation about spirituality that can sometimes be something of an art form, with colleagues who see healthcare through a scientific lens.

5. THE STRATEGY

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.

(Puchalski, et al., 2009).

Vision

Over the next three to five years we will strive to achieve the following vision:

> *MDHB will strive to be recognised as a leader in the field of spiritual care within the New Zealand health sector through a renewed understanding of spirituality as an integral part of care.*

The table below shows in high level terms some of the **key differences** between what exists and what success will look like.

EXISTING		FUTURE
Spirituality primarily captured within a Christian definition	⇨	Spirituality will mean different things to different people, incorporate Maori spirituality and reflect multiple world views
Spiritual care as a function of chaplaincy	⇨	Spirituality is integral to compassionate care
Idiosyncratic knowledge of spirituality	⇨	Organisational understanding of spirituality
Spirituality omitted from assessment	⇨	Spiritual assessments part of clinical systems
Staff uncomfortable discussing spirituality	⇨	Compassionate and respectful staff are able to confidently discuss spirituality as part of care
Patients seen primarily as injured or ill	⇨	Patients viewed holistically
Spiritual care resources primarily supporting patients	⇨	Spiritual care resources primarily supporting staff
Hospital centric	⇨	District centric

Objectives

The key objectives for achieving the mission are:

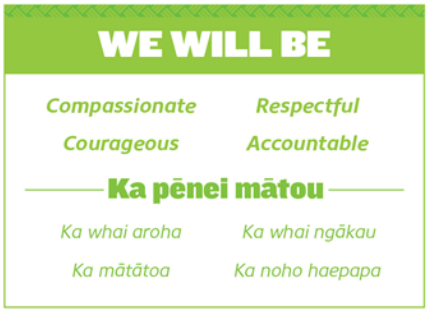
1. Create a cultural change through a renewed understanding of spirituality as an integral part of healthcare.
2. To integrate spiritual care into practice.
3. Enhance and strengthen partnerships.
4. Develop a research programme to support and promote implementation.
5. 'Get out of the block' and implement district wide.

Strategic Alignment

The spiritual care strategy has been developed to help advance the goals of the MidCentral DHB.

The following table identifies where the objectives in this strategy *primarily* contribute to the MidCentral DHB strategic imperatives.

	STRATEGIC IMPERATIVES			
OBJECTIVES	**Quality** By Design	**Connect** & Transform	**Equity** Of Outcomes	**Partner** with people and whanau
Create a cultural change through a renewed understanding of spirituality.	✓		✓	✓
To integrate spiritual care into practice.		✓	✓	
Enhance and strengthen partnerships.				✓
Develop a research programme to support and promote implementation.	✓	✓		
'Get out of the block' and implement district wide.		✓	✓	✓



6. OBJECTIVES

❶ Create a cultural change through a renewed understanding of spirituality as an integral part of healthcare

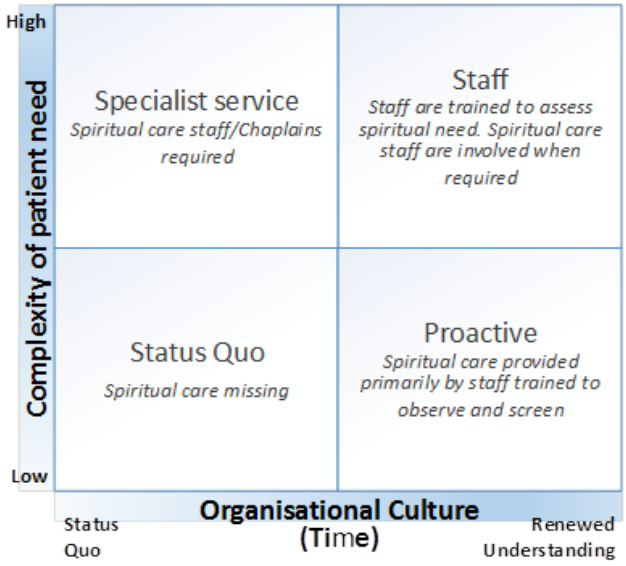
Spirituality is often confused or conflated with religion and this has contributed to it being seen as an area that is outside the work of professional health care staff. The most vital aspect of this strategy is to encourage a renewed understanding of spirituality as central to how a person sees and interprets the world. Swinton (2001) and Parkes et al. (2011) can be used to develop an appreciation of a holistic view of spirituality.

- Meaning - The significance of life; making sense of life's situations; deriving meaning and purposeful existence.
- Value - Beliefs and standards that are cherished; having to do with the truth, beauty, worth of a thought, object or behaviour; ultimate values.
- Something beyond me [Transcendence] - Experience and appreciation of something beyond the self; expanding self-boundaries.
- Connecting - Relationships with self, others, God/higher powers, the cosmos, and the environment.
- Becoming - An unfolding life that demands reflection and experience; includes a sense if who one is and how one knows.

The Māori worldview has always embraced a holistic view and the terms 'wairuatanga' (interrelated to everything and as a fundamental aspect of health and wellbeing) or 'wairua' (the spiritual essence of each living thing) are used to speak of the spiritual dimension and things pertaining to the spirit of an individual or living being. (Moeke-Maxwell, 2012).

To guide action it is important that a model reflecting our unique perspective of spiritual care is developed. Incorporating *Te Whare Tapa Whā* the following draft conceptualisation demonstrates the core linkages that need to be incorporated.

Over time it is expected that the cultural change will change how spiritual care is seen and delivered from the left side of the diagram to the right.



Key tasks to achieve this objective:

1. Document the current organisational culture regarding spirituality.
2. In association with the General Manager People and Culture, develop a medium-term plan to renew the understanding of spirituality with the goal to have a workforce able to deliver spiritual care. It is anticipated this work could run alongside the organisational values work.

❷ To integrate spiritual care into practice

The pilot project, *Addressing spiritual care in a cancer treatment ward: a quality improvement project,* has led to a number of recommendations for improving an integrating spiritual care into healthcare practice within MidCentral Health (MCH):

- Develop organisational commitment to, and policy around, spiritual care.
- Develop procedures about how the policy will be implemented.
- Mandate spiritual care competency education as part of staff orientation and ongoing professional development. This would include clarification of roles and responsibilities of chaplains and others.
- Strengthen the process for spiritual screening/assessment and appropriate referrals.
- Develop guidelines for greater integration of the chaplaincy role into the multi-disciplinary team decision making process including the ability to document in patients' clinical notes.
- Formally partner with an appropriate academic facility to undertake further research into identifying patient needs in terms of spiritual care.
- Address the staff and public perception issues about spirituality in healthcare that get in the way of providing spiritual care in a modern health environment.

These recommendations form the foundation on which this objective will be approached. However, this strategy has taken a more holistic view and it is important that the approach is carefully considered in conjunction with the work around culture to ensure the objectives are complimentary in all aspects.

Key tasks to achieve this objective:

3. Develop a spiritual care programme and associated work plan to guide activity over the short, medium and long term. Aspects that need to be considered include; leadership, performance measures, tools and methods, the extant evidence base, standards, policies and procedures.

❸ Enhance and strengthen partnerships

ICHC has been the key stakeholder with MCH in the provision of spiritual care over many decades. The mission of the ICHC to provide spiritual support to patients, family, friends and hospital staff at times of trauma and grief means it has expert knowledge and resources that can assist in the development of self-sustaining capability within MCH. However, this strategy is taking spiritual care into a dimension that looks significantly different to how it has in the past, which will create challenges. Maintaining this important relationship is crucial to the success of this project as we creatively change.

The partnership with the Pae Ora Māori Directorate is seen as foundational within this strategy to ensure Maori cultural approaches to spiritual care are supported and integrated. Also crucial are the development of relationships with other key stakeholders including a diverse range of religious and cultural groups. This has begun through the Partners in Care Project with the Bhutanese and Afghan refugee communities.

Key tasks to achieve this objective:

4. Identify all key stakeholders and develop an engagement and communication plan as a means of both disseminating the strategy and deepening relationships.
5. Review the resources available to support the spiritual care programme.

❹ Develop a research programme to support and promote implementation

All of the work in developing a changed approach to spiritual care has been grounded in the emerging research that is appearing in the academic journals. This has been important to show the relevance of spiritual care. Now the challenge is to implement change based on research but also grounded in practical day to day service delivery.

Addressing spiritual care in a cancer treatment ward has delivered our first understandings of what the complications are. As previously mentioned, the recommendations from that report will form a key part in integrating spiritual care into MCH practice.

The next objective is to form a group of academic researchers interested in following this project through and helping us form pilots that can be properly set up, assessed and learnt from. Interest has been shown and discussions are underway to ensure a range of researchers can assist us.

Key tasks to achieve this objective:

6. Develop a partnership with an appropriate academic facility to undertake further research into identifying patient spiritual care need(s).

❺ 'Get out of the block' and implement district wide

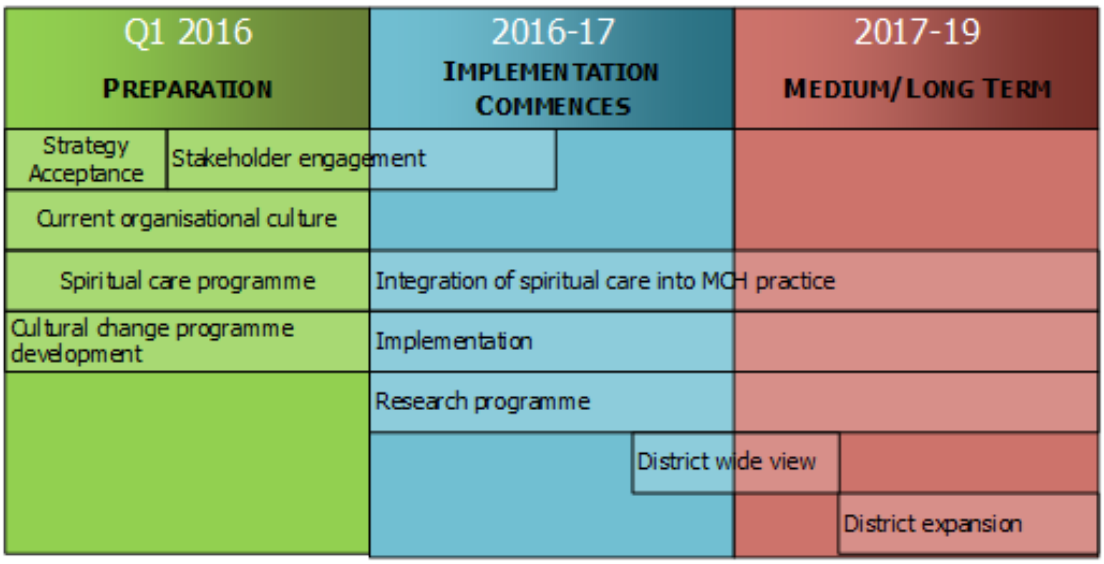
The vast majority of health care interactions are conducted in primary care settings. In order to achieve the vision of this strategy a coordinated effort, working with a wide range of primary care people and organisations, will be essential. It is, however, recognised that first a track record of success needs to be developed within MCH in order to provide both experience and credibility. This objective therefore is reliant on the successful delivery of this strategy within the MCH environment which is in itself, a challenging mission.

Key tasks to achieve this objective:

7. Incorporate the lessons learned from the work within MCH and develop or extend the spiritual care programme to encompass a district wide view.

Time Frames

The following diagram provides a high-level overview of the anticipated time frames.



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