SASKATOON HEALTH REGION

SPIRITUAL CARE REVIEW

FINAL REPORT

June 30, 2009

Submitted by
Leslie Gardner, Ph.D.

Leslie Gardner Consulting
Suite 20, 10630 83rd Avenue
Edmonton, Alberta, T6E 2E2
Ph: 780-438-5854; Fax: 780-439-4427
E-mail: LG5@ualberta.ca
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>I. Background and Introduction</td>
<td>10</td>
</tr>
<tr>
<td>II. Objectives and Scope of the Review</td>
<td>11</td>
</tr>
<tr>
<td>III. Methodology</td>
<td>11</td>
</tr>
<tr>
<td>IV. Findings</td>
<td>13</td>
</tr>
<tr>
<td>A. Spiritual Health</td>
<td>14</td>
</tr>
<tr>
<td>B. Services Needed to Support Spiritual Health</td>
<td>17</td>
</tr>
<tr>
<td>C. Personnel, Background and Qualifications</td>
<td>25</td>
</tr>
<tr>
<td>D. Ongoing Support for Spiritual Health Practitioners</td>
<td>32</td>
</tr>
<tr>
<td>E. Delivering Regional Spiritual Health Services</td>
<td>34</td>
</tr>
<tr>
<td>F. Summary of Findings</td>
<td>38</td>
</tr>
<tr>
<td>V. Recommended Principles for Spiritual Health Services</td>
<td>40</td>
</tr>
<tr>
<td>VI. Recommendations and Resources to Enact the Vision</td>
<td>42</td>
</tr>
<tr>
<td>VII. Alignment with Health Region Values and Strategic Directions</td>
<td>46</td>
</tr>
<tr>
<td>VIII. Transition Plan and Communications Strategy</td>
<td>50</td>
</tr>
<tr>
<td>IX. Bibliography</td>
<td>53</td>
</tr>
<tr>
<td>X. Appendices</td>
<td>55</td>
</tr>
<tr>
<td>A. Interview Questions</td>
<td>56</td>
</tr>
<tr>
<td>B. Spiritual Health Services Delivery in Six Sites and in the Saskatoon Health Region</td>
<td>58</td>
</tr>
<tr>
<td>C. The FICA Questions</td>
<td>76</td>
</tr>
<tr>
<td>D. Spiritual Care Triggers</td>
<td>77</td>
</tr>
<tr>
<td>E. Recommended Principles Link to Regional Core Values And Strategic Plan Directions</td>
<td>78</td>
</tr>
</tbody>
</table>
Acknowledgements

The reviewer would like to acknowledge and express appreciation to the many people who have supported the review process. This includes the guidance of the Advisory Committee: Shan Landry, Vice-President, Community Services for the Saskatoon Health Region; Jean Morrison, Chief Executive Officer of St. Paul’s Hospital; Brian Zimmer, Director of Mission for St. Paul’s Hospital; Brian Walton, Interim Director of Spiritual Care Department, Saskatoon Health Region and Clinical Pastoral Educator at St. Paul’s Hospital; and Joy Adams, Director of Volunteer Workforce and Strategic Initiatives Department for the Saskatoon Health Region. The time and attention of St. Paul’s board members and Saskatoon Health Region board members who shared their vision was greatly appreciated.

Special thanks are due to Brian Walton, who also organized and facilitated all of the interviews and site visits, and to Doug Cooney who prepared the literature review on best practices in spiritual care/chaplaincy that helped to shape the review.

My sincere gratitude to all those who gave so generously of their time and thoughts as interviewees for the review: in spiritual care departments across Canada, in the United States and throughout the Saskatoon Health Region. You have helped to explore a new approach to regional spiritual health services delivery.
EXECUTIVE SUMMARY

1. Background

The Saskatoon Health Region wished to complete a review of the delivery of spiritual care services in acute care facilities throughout the region with consideration of long term care as well, and to identify the components of a highly responsive and integrated spiritual care service, based on ‘best practices’. The timing for the review was influenced by three factors. First, part of the agreement in having the Catholic hospital in Humboldt become a region run facility in 2007 was to conduct a review of spiritual care services in the region. Second, the Region had concluded an agreement with St. Paul's Hospital to manage the area of spiritual care for the Region, and had established a separate Department of Spiritual Care Services with an Interim Director until the results of a review of regional spiritual care. Third there was a new Chief Executive Officer at St. Paul’s Hospital who was interested and well aware of the history of attention to spiritual care that exists at St. Paul’s as a Catholic health care organization.

2. Methodology

The review compared what exists currently within the Health Region in the organization and delivery of spiritual care services, with what is recommended in “best practice”. The review used: document review and a brief literature search to identify best practices; and structured individual and group interviews with 50 key informants, including: senior managers within the Health Region and St. Paul’s; urban and rural acute care and long term care facility administrators; practitioners delivering spiritual care and medical and nursing services in facilities; St. Paul’s Hospital Board and Regional Health Board members; directors and managers of spiritual care services; including those in acute care facilities in four sites across Canada in addition to Saskatoon Health Region and one in the United States; Saskatoon Aboriginal elders; faith community leaders from the Muslim, Buddhist, Jewish and Christian communities; denominational chaplains; and community clergy. Analysis of the information from the document review produced a list of the existing ‘best practices’ in spiritual care service delivery, and an understanding of the current options. The information from the individual and group interviews were transcribed and analyzed using accepted inductive qualitative data analysis techniques.

3. Emphasis on Spiritual Health

The review focused on ‘spiritual health’, to help people avoid any stereotypes concerning ‘spiritual care’, and to think more openly, by starting with their understanding of the desirable
end point, i.e., the spiritual health of patients, family members and staff; then considering what services would be needed to support people’s spiritual health; and then based on the services, how many of what kinds of personnel, with what backgrounds and qualifications would be needed.

4. Highlights of the Findings

- A consideration of spiritual health revealed six themes: spiritual health is a highly individual thing; that it involves a sense of wholeness, hope, purpose meaning and peace; it may include religious practices, but not necessarily; it means balance among the physical, emotional, social and spiritual aspects of our lives; feeling connected and in relationship with self, others and the transcendent; and the ability to call upon a confidence in the ultimate good of the outcome to cope in times of struggle. There was a strong correspondence between these themes and those found in the literature.

- The services that are needed include: basic compassionate care and respect from all staff; companioning people, being there in non-judgmental way that is agenda-free; helping people find meaning and comfort; helping people in complex spiritual distress to process what is happening, to re-balance and cope; access to the various faith community religious services, symbols and ceremonies as desired; supporting clinical staff; training and educating the rest of the team about spiritual health; and serving on the clinical team. Again the literature revealed similar points to which was added: participation in ethics programs, access to complementary therapies and participating in research.

- The eight categories of services identified by the review relate to the regional core values of: respect, compassion; excellence; stewardship; and collaboration. The core values of St. Paul's Hospital are similar: respect for all; compassionate caring; holistic care; stewardship; collaborative partnerships. Specifically, the spiritual health services of: compassionate care and respect; companioning people; helping people find meaning and comfort; aiding those in spiritual distress to re-balance and cope; and liaising with and facilitating diverse faith community involvement if desired; are strong indicators of the regional values of respect and compassion. Similarly, the spiritual health services of: being a support to staff; training and educating the rest of the team about spiritual health; and serving in the clinical team; all support and practice the regional values of stewardship, collaboration and excellence.

- Spiritual health service departments are becoming increasingly aware of the needs of Aboriginal and multi-faith groups. They are hiring Aboriginal and multi-faith staff as well as Aboriginal Cultural Helpers. The literature echoes the need.

- Spiritual health services are being delivered by a spectrum of both paid and unpaid workers. The paid workers include spiritual health practitioners, denominational
chaplains, and CPE residents. The unpaid workers include: community clergy, CPE interns and volunteers.

- The Saskatoon Health Region average ratio of chaplain staff per 100 inpatients (.53 for acute and .21 for long term care) falls at the low end of the range of results of the survey of jurisdictions conducted for this review (range .5 to 1.7; average 1.1 staff per 100 inpatients), and below the recent benchmarking study in the United States (range 1.2 to 1.66 chaplains per 100 inpatients for non-religiously affiliated hospitals).

- The National Association of Catholic Chaplains’ job description for a chaplain indicates that a bachelor's degree is required, along with completion of theology classes; display of skills and competencies in pastoral care. The training asks for one year of clinical experience and certification by an appropriate clinical pastoral agency.

- Acquiring and maintaining certification occurs mainly through the Canadian Association of Pastoral Practice and Education (CAPPE) in Canada. A professional chaplain requires: graduate theological education or its equivalency; demonstrated connection to a recognized religious community; clinical pastoral education equivalent to one year of postgraduate training in an accredited program recognized by the national organizations; annual continuing education; adherence to a code of professional ethics for healthcare chaplains; and professional growth in competencies demonstrated in peer review. Crucial to accountability is measuring outcomes and conducting research.

- Clinical Pastoral Education, offered through CAPPE certified instructors, plays a critical role in the formation and ongoing education of spiritual health practitioners. The principles and content can be adapted for training clinical staff and volunteers in spiritual health services.

- The identification of spiritual health needs is best accomplished through the use of standardized screening tools and protocols that guide the referral by nurses and other colleagues to a spiritual health specialist. Having spiritual health practitioners integrated into the clinical care team allows for the identification of needs through attending rounds and case conferences. Spiritual health professionals are expected to chart as a member of the team.

- Key success factors for successful integration with the clinical team included: strong support for integration from both the hospital executive and clinical leaders on the unit; staff being assigned to units and having the opportunity to become known and trusted; being visible to the team all the time; having their own space on the unit; and being invited to social events on the unit, developing relationships both formally and informally.

- Having the spiritual health practitioners involved in offering both formal and informal opportunities for ongoing education of other members of the team is very important. The literature stresses the necessity of nurse and physicians being aware of the dimensions
of their own spirituality in order to recognize and support it in others, and understanding what spiritual health practitioners can bring as a member of the team. Spiritual health practitioners can provide training to promote cultural and spiritual sensitivity.

5. Recommended Principles that Link to Regional Core Values and Strategic Directions

The review recommended twelve principles to guide a vision for Spiritual Health Services in the Saskatoon Health Region, and showed the links with the Core Values of St. Paul’s Hospital (respect for all; compassionate caring; holistic care; stewardship; collaborative partnerships) and the regional Core Values (respect; compassion; excellence; stewardship; and collaboration) and its Strategic Directions: (Transforming the care and service experience; Transforming the work experience; Partnering for improved health for Aboriginal people; Building a sustainable, integrated system; and Fostering research, learning and innovation).

- **Spiritual health practitioners are visible keepers of the regional values of: respect; compassion; collaboration; stewardship and excellence.**
  This principle emphasizes each of the above regional values, and relates particularly to the strategic directions of: Transforming the care and service experience; Transforming the work experience; and Partnering for improved health for Aboriginal people.

- **Spiritual health service delivery is highly responsive and integrated.**
  This principle is linked primarily to the values of: respect; compassion; excellence; and collaboration. It is related to the strategic directions of: Transforming the care and service experience; Transforming the work experience; Partnering for improved health for Aboriginal people; and Building a sustainable, integrated system.

- **An adequate number of paid spiritual health practitioners is necessary as part of holistic care.**
  This principle supports both the St. Paul’s Hospital commitment to the value of holistic care and the regional commitment to the value of excellence; and therefore to the values of respect and compassion; and to the strategic directions of: Transforming the care and service experience; Transforming the work experience; Partnering for improved health of Aboriginal people; and Building a sustainable, integrated system.

- **A variety of paid workforce and unpaid workforce sources can be involved in spiritual health service delivery.**
  This principle is primarily related to the regional value of stewardship; and has links to the strategic direction of: Building a sustainable, integrated system.

- **Spiritual health services put emphasis on region-wide networking and community capacity enhancing for rural communities through clinical pastoral education and direct service support;**
This principle is linked to the regional values of: excellence; stewardship and collaboration; and to the strategic directions of: Building a sustainable, integrated system; and Fostering research, learning and innovation.

- **Diversity in spiritual health practitioners is important to meet Aboriginal and multi-faith needs;**
  This principle is primarily related to the values of: respect; compassion, and excellence; and to the strategic directions of: Transforming the care and service experience; Transforming the work experience; and Partnering for improved health of Aboriginal people.

- **Spiritual health practitioners are an integral part of the clinical care team;**
  This principle is related to the values of: respect, compassion; excellence; stewardship and collaboration and to the strategic directions of: Transforming the care and service experience; and Transforming the work experience.

- **Spiritual health services include access to diverse religious practices if the patient and family want them;**
  This principle is primarily related to the values of: respect and compassion and excellence; and to the strategic directions of: Transforming the care and service experience; and Partnering for improved health for Aboriginal people.

- **Ongoing professional education/certification for all practitioners and trained volunteers involved in spiritual health services must be encouraged;**
  This principle is primarily related to the values of: excellence and stewardship; and to the strategic directions of: Transforming the work experience; and Fostering research, learning, and innovation.

- **Screening tools and protocols are used to identify need for spiritual health practitioners;**
  This principle is primarily related to the values of: excellence; stewardship; and collaboration; and to the strategic directions of: Transforming the care and service experience; transforming the work experience; and Fostering research, learning, and innovation.

- **Clinical Pastoral Education is key at both the intern and residency levels;**
  This principle is primarily related to the values of: excellence and stewardship; and to the strategic directions of: Transforming the work experience; and Fostering research, learning, and innovation.

- **Innovative interdisciplinary research is crucial for quality services.**
  This principle is primarily related to the values of: excellence; stewardship; and collaboration; and to the strategic directions of: Transforming the care and service experience; Transforming the work experience; and Fostering research, learning, and innovation.
6. Recommendations and Resources to Enact the Principles and Vision

The review presented seven recommendations for implementing a highly responsive and integrated spiritual health service, as follows:

- That the name of the department be changed from “Spiritual Care” to “Spiritual Health Services”

- That a full time Director of Spiritual Health Services be hired to develop, manage and coordinate the Spiritual Health Services department for the Saskatoon Health Region.

- That an integrated model of spiritual health services be implemented in the Saskatoon Health Region based on the above principles and on the ratio of 1.2 FTE spiritual health practitioners per 100 inpatients, that includes the allocation of additional resources (1 FTE CPE Clinical Educator/animator devoted to rural support; a .7 FTE Spiritual Health Services Volunteer Coordinator; 1 FTE Clinical Educator for a CPE residency program; 2 FTE Aboriginal Cultural Helpers; 1 FTE Multi-Cultural Spiritual Health Broker; 7.25 FTE Spiritual Health practitioners; and 3FTE administrative support; plus supplies and travel).

  The 5 to 10 year budget for the model is $1.2 million.

- That the St. Paul’s Foundation, with the Health Region and other partners, establish an Institute for Outcomes in Spiritual Health.

- That there be increased integration of spiritual health practitioners into the clinical care team through assigning spiritual care providers to clinical units, e.g., to the Palliative Care and Intensive Care areas; for the purposes of: attending rounds and case conferences, providing consultation to clinical staff and offering direct service to patients, families and staff; and recording interventions on patient charts.

- That patient access to appropriate spiritual health services be supported through the implementation across the Health Region of a suitable short, standardized screening tool (e.g., FICA); and/or accepted spiritual care triggers/protocols to be used by clinical nursing staff at the time of admission to the clinical unit, for the possible referral of the patient to a spiritual health practitioner.

- That a formal agreement be negotiated with each of the Roman Catholic, Anglican, United Church and Lutheran denominations in Saskatoon to better integrate the denominational chaplains into the Health Region spiritual health services team.
7. Recommended Transition Plan

The review recommends that the following steps be implemented within the next 12-18 months:

- Hire the Director of Spiritual Health Services
- Hire the Clinical Educator/ animator for the rural communities
- Develop an agreement with the denominational chaplains
- Hire Aboriginal Cultural Helpers
- Assign a full time chaplain to palliative care and intensive ICU
- Begin development of the Institute for Outcomes in Spiritual Health

SASKATOON HEALTH REGION
SPIRITUAL CARE REVIEW
Final Report
June 30, 2009

I. Background and Introduction

Saskatoon Health Region, established in 2002, offers a range of facility-based and community-based health services including: hospital, long-term care, home care and public health, through more than 12,000 staff and 800 physicians, with a budget of $725,000,000. The large region stretches 275 kilometers east to west, and 210 kilometers north to south, serving almost 300,000 residents in more than 100 cities, town and rural municipalities.

Within the region, spiritual care services in acute care facilities and long term care facilities are offered through: institutional full time staff equivalent (FTE) positions; different faith groups’ provision of denominationally appointed and paid chaplains; and local community clergy paid through their congregations to support their membership by visiting people in hospital. Some level of involvement of trained volunteers in spiritual care service delivery is often present in the facilities, particularly in the rural areas.

The Saskatoon Health Region wished to complete a review of the delivery of spiritual care services in acute care facilities and long term care centres throughout the region (e.g., in Saskatoon, Lanigan, Rosetern, Cudworth, Humboldt, Wadena, Wakaw, Watrous, and Wynyard) and to identify the components of a highly responsive and integrated spiritual care service. The components were to be based on ‘best practices’ in the delivery of spiritual care services, as derived from the literature, and from information on the organization and resourcing of these services in several other jurisdictions across Canada, with input from a variety of stakeholders in the Saskatoon Health Region.
A number of factors contributed to the timing for the review. In 2007, the responsibility for St. Elizabeth’s hospital at Humboldt was transferred from the Saskatchewan Catholic Health Corporation to the Saskatoon Health Region. The Humboldt community wished to retain the spiritual care services at the hospital. Part of the agreement in having the hospital become a region run hospital was to conduct a review of spiritual care services which would speak to the issue. In addition, the review was timely in that there had been several changes within the key hospital organizations. First, the partnership agreement between St. Paul’s and the Health Region was reviewed and affirmed including the continuation of Spiritual Care as a St. Paul’s Managed Care Group. Second, the Health Region divided the former Department of Volunteer Services and Spiritual Care into a Department of Volunteer Workforce and Strategic Initiatives with a Director, and a Department of Spiritual Care Services with an Interim Director, until the results of the review of spiritual care in the region. Third, there was a new Chief Executive Officer at St. Paul’s Hospital who was aware of the history of attention to spiritual care that exists at St. Paul’s as a Catholic health care organization.

II. Objectives and Scope of the Review:

The review was meant to:

- Examine the allocation of spiritual care services within three acute care clinical settings in Saskatoon: Saskatoon City Hospital; Royal University Hospital and St. Paul’s Hospital; and seven rural hospitals. Later in the review, the scope was expanded to include some consideration of long term care;
- Examine the intersection of these services with the religious community;
- Identify enhanced ways of responding to the spiritual needs of multi-faith and First Nations communities.

through the following steps:

- Complete a full inventory of the Saskatoon Health Region resources, both formal and informal, that are currently utilized to provide spiritual care services;
- Complete a survey on options for spiritual care service being used in similar health regions/organizations across the province and country;
- Be informed by a brief literature review focusing on spiritual care and ‘best practice’;
- Aid in establishing a vision for a fully integrated spiritual care service across the region with supporting principles;
- Offer recommendations about the necessary strategy and resources to enact the vision, and propose a transition plan, including a brief communications strategy to support a new structure and service system.

The review was conducted in close collaboration with an Advisory Committee comprised of: the Vice President, Community Services, of the Saskatoon Health Region; the President of St. Paul’s Hospital; the Director of Mission for St. Paul’s Hospital; the Interim Director for Spiritual Care for the Health Region, and the Director of Volunteer Workforce and Strategic Initiatives Department of Saskatoon Health Region.
III. Methodology

1. Data Collection

The review employed a descriptive approach, with a comparison of what exists currently within the Health Region in the organization and delivery of spiritual care services, with what is recommended in “best practice” in the literature and with what exists in the practice of other health regions. The review used the following data collection methods:

- **document review of**: an existing brief literature review to identify best practices; regional reports; planning documents or written descriptions of jurisdictions’ current spiritual care services organization and resourcing;
- **structured individual and group interviews** \((n=50)\) with a variety of key informants including: senior managers within the Health Region and St. Paul’s; urban and rural acute care and long-term care facility administrators; practitioners delivering spiritual care and medical and nursing services in facilities; St. Paul’s Hospital Board and Regional Health Board members; directors and managers of spiritual care services, including those in acute care facilities in: Regina; Edmonton; Winnipeg; Halifax and Louisville, Kentucky; Saskatoon Aboriginal elders; faith community leaders from the Muslim, Buddhist, Jewish and Christian communities; denominational chaplains; and community clergy. The review included an interview with the Provincial Coordinator of Spiritual Care for the province of Manitoba. The interviews were conducted either in person or over the telephone. The questions were typically sent to key informants ahead of time; (see Appendix A for a complete list of the interview questions)

2. Data Analysis

Analysis of the information from the document review produced a list of the existing ‘best practices’ in spiritual care service delivery, and an understanding of some current options. The information from the individual and group interviews were transcribed and analyzed using accepted inductive qualitative data analysis techniques (Thomas, 2006). The analysis was guided by the objectives of the review and included the following steps:

- Preparation of raw data files into a common format;
- The raw text was read in detail until the reviewer was familiar with its content and gained an understanding of the themes and events covered in the text;
- The reviewer identified and defined categories or themes, commonly created from actual phrases in specific text segments. At least three separate individuals had to make a similar comment before the comments were clustered as a theme.
- Within each category, there was a search for sub-topics, including contradictory points of view and new insights. Appropriate quotations that convey the core theme or essence of a category were often selected to illustrate the point.
3. Limitations

This was a selective review, characterized by a number of limitations.

First, the literature search was not an extensive look at the topic, but provided good coverage of recent studies that spoke to the best practice in the organization and delivery of spiritual care, also called ‘pastoral care’ and ‘chaplaincy’ in the literature. It should be mentioned that the material on best practice refers more to commonly accepted standards of professional practice, i.e., “what is done”, than to the results of what has been found to work well based on systematic inquiry. In fact, the literature includes observations from some of the profession’s key researchers that spiritual care suffers from a lack of attention to research (VandeCreek, Siegel, Gorey and Brown, 2001; Fitchett, 2002).

Second, the review began with a focus on spiritual care in hospitals, and was extended to include some consideration of long term care mid-way through. There are 10 hospitals in total in the region and 29 long term care facilities. In the rural areas, the community may have an integrated centre, comprising both acute care and long term care beds. Data collection incorporated visits to all urban hospitals and three of the seven rural hospital facilities in the Saskatoon Health Region, and included conversations with the administrators in two more rural sites. The review would have benefitted from on-site understanding of the history and the local resources in the other rural sites as well. For long term care, the interviewees included staff and administrators in: two long term care centres and one transition unit for persons waiting placement in long term care in Saskatoon, as well as one integrated rural facility and one long term care rural facility. As such, the review understands the need for spiritual care services in both settings, but has a much clearer sense of the existing spiritual care resources in hospitals than in long term care throughout the region.

Third, the scope of the review has necessarily excluded some groups. For example, this review did not include input from persons working in mental health or forensic populations, nor was it designed to hear from patients and families. The time frame for the study did not coincide with a convenient schedule for data collection for some representatives of multi-faith groups.

IV. Findings

This section presents the findings of the review. In asking key informants about spiritual care and what is needed, there was the possibility that they might frame their answers in terms of their stereotypes of what already exists. In order to free people to think more openly about this important, but little understood, service in acute and long term care, the interviews began with a bit of a twist. The first three questions used the following logic: start with an understanding of the desirable end point, i.e., the spiritual health of patients, family members and staff; then consider what services would be needed to support people’s spiritual health; and then based on the services, how many of what kinds of personnel, with what backgrounds and qualifications
would be required? Other questions then explored related topics such as ongoing training and support, issues in service delivery, and what is their vision for spiritual health services if delivered according to best practice.

Each of these sections is offered below, presenting the results of the interviews first and then the congruence of those results with the literature. A summary of the findings is provided at the end of this section.

The concluding sections of the report offer a set of recommended principles to guide a vision for spiritual health services in Saskatoon Health Region; outline recommendations and resources needed to enact the 5 to 10 year vision; indicate how the recommended principles and actions align with the Health Region Values and Strategic Directions, and then offers a brief transition plan for the first steps of the 5-10 year plan and a beginning communication strategy.

A. Spiritual Health

The respondents were asked to describe what spiritual health meant to them. They all found the question intriguing and responded thoughtfully. Their comments clustered into six main themes, each of which is explored below.

• Highly individual

The respondents were clear that spiritual health is a highly personal thing that depended very much on an individual’s own cultural perspective, beliefs, values and preferences:

“…the spiritual health of every person springs from their unique spiritual formation and background, Islam, United Church or no church. And you have to be sensitive to what they want and what their needs are…”

“…what matters in supporting spiritual health will vary from one person to the next. For this lady it might be her love of gardening that gives her that sense…”

“…It really has to be defined individually by the person, because it is an intensely personal thing with a wide variety of factors…”

• Sense of wholeness, involving hope, purpose, meaning and peace

Spiritual health was bound up with understanding the meaning of what was happening in their lives, and ultimately being at peace with it, which can offer a sense of hope, purpose and personal wholeness, with a feeling of wellbeing or integrity.

“…We are spiritually healthy if there is a sense of connectedness, wholeness, integrity within oneself and peace…”

“…Spiritual health means a number of things including: a sense of self-worth, having purpose and meaning and being able to navigate through and face life’s challenges in a hopeful way and to reflect on our experiences…”
“…How does a person have a sense of purpose and meaning…everything from ‘Why am I here, and why is my life the way it is?’ to ‘What is there to live for?’ Spiritual health involves a primary life-force that is alive and vibrant in the person. So, what are they doing to enable that hope and sense of joy and capacity for connectedness that is life-giving…”

- **May include formal religious practices, but not necessarily**

Both the interviewees who came from an explicitly religious context and those who did not agreed that spiritual health may or may not be related to a formal religious practice. They quickly made a distinction between spirituality and religion. They recognized that an increasing number of people are not connected to any particular religious or faith community, but still have an innate spiritual self.

“…I see spiritual as innate and might be part of, but could absolutely be separate from religious belief. It is important to everyone, wherever they are. There are also many who are not affiliated with a religion who just want somebody with them as they make choices, especially if there aren’t strong family supports…”

“…There are many ways to come at spiritual health, and organized religion is only one of them. There are other kinds of spiritual disciplines, such as meditation or yoga that are more public…”

“…It may have a lot or nothing to do with religion. More like, ‘What do you need in your life, and what do you have in your life? How do you work at it to make life work for you? And in that process, toward the end of life, how do you deal with your death?’ Spiritual health and religion are two separate things, but a lot of older people may have worshipped in a certain way that just becomes spiritual health and those are then mingled…”

- **Balance among the aspects of our lives includes physical, social, emotional and spiritual**

One of the first things most people said as they were considering what spiritual health meant to them was that spiritual health is part of a holistic way of approaching the whole person that includes physical, social, emotional and spiritual aspects. They indicated that spiritual health required that balance exist among the aspects. Some respondents felt that people can be spiritually healthy even though physically ill:

“…I would say mental, physical, emotional and spiritual all go together…”

“…When we are dealing with a person, we have all aspects and a person’s spirit is part of that along with the body. You can be unhealthy physically, but very healthy spiritually…”

“…It really encompasses a lot…mind, physical, spiritual, emotional. It is all connected and we are all on a search for healing of all of that…”

- **Feeling connected in relationship with self, others, nature and the transcendent**

A prominent theme in the comments had to do with a sense of being connected, and of belonging. Respondents spoke of spiritual health including healthy relationships with
oneself, family and friends and the larger community of which one is a part. People commented that spiritual health includes a positive relationship with nature, and with a sense of the Transcendent, however a person conceived of that something larger than ourselves:

“…For me, I believe that spiritual health involves a healthy relationship with yourself, others, and a Higher Power of some sort…”

“…People living in balance with themselves and relation to their environment and their community. For some that has to do with connection with nature or their own being, or their work, or something beyond, something bigger…”

“…Spiritual health brings us possibly to a place of being connected and able to relate well, not only with God, but with others and ourselves…”

• Ability to call upon one’s deep sense of identity and faith in belonging to something greater than oneself to sustain one in times of challenge and crisis

The last major theme in spiritual health had to do with an inner strength and ability to cope with life storms based on confidence or faith in the appropriateness and ultimate good of the outcome, because of a sense of care and belonging to something greater than oneself. This meant that spiritual health could involve struggle and anxiety, as seen in the following excerpts:

“…We can’t see a big picture. And it is that confidence that there is a big picture that I feel is spiritual health. So, underneath that struggle, you never lose the sense that, whatever it is that you are going through, ‘I’m in hands that are greater than mine, and for that reason, no matter what the outcome, I’ll be OK’…That’s what it means to me…”

“…It doesn’t necessarily mean happiness and joy and all of that, but just the knowledge that you are loved, no matter what your situation is, and you are supported by people and supported in a way that will help you come to a peaceful place…”

“…spiritual health goes back to that, our sense of inner self. And we are in such good hands that we don’t really have to be afraid of anything…I believe in that sense of peace and comfort in the way things are going to turn out, in spite of our fears. It will go the way it is supposed to go and to just trust that. Trust that we are in a good place in spite of what we are thinking…”

It is interesting to note the strong correspondence between the interviewee comments and the literature. The articles did not address so much the concept of “spiritual health” as “spirituality”, but the definitions given were strikingly similar. For example, the World Health Organization (1998) has proclaimed that the definition of health includes four domains of well-being: physical, mental, social and spiritual. A nursing concept clarification of the term “spirituality” recently identified five main attributes, including: **meaning** --- making sense of life situations and deriving purpose in existence; **value** --- beliefs and standards that are cherished; **transcendence** --- experience and appreciation of a dimension beyond the self; **connecting**--- relationships with
self, others, God/higher power, and the environment; and becoming— an unfolding of life that demands reflection and experience (Sanders, 2002). Spirituality is the solid centre which allows us to cope with life’s trials, in which religion may be a part, but is a separate thing (Wright 2005). Spirituality includes: dignity, meaning, purpose, gratitude, forgiveness, expression of faith, transcendence and hope (Ellipoulos, 2005). The sense of meaning can result in hope and peace of mind that enables people to cope with problems (Isaia, Parker and Murrow, 1999). Spirituality is with people at all times, although it may take on more focus in palliative care and the end of life, it should be considered part of a person’s daily activities and care (Newson, 2007).

B. Services Needed to Support Spiritual Health

1. Types of Services
Given the understanding of what spiritual health encompasses and what the desirable end point is, the next step was to ask the respondents for their perception of the services that are needed in order to nurture and support spiritual health. Their comments were categorized into eight themes, which are presented below. A general summary is provided for each theme, followed by selected quotes from the interviewees that illustrate the main points.

- Basic compassionate care and respect
  The respondents felt that basic compassionate care and respect is the job of every person involved with patients and families:
  “…We are embodied spiritual beings, and so spiritual care is the care for human beings in crisis, when we care for one another. If we provide holistic care, then everybody has a role in general attentiveness to that caring aspect and it is part of the work of nurses, doctors, social workers…and there are times of stress and loss when the need is such that the expertise of a spiritual care specialist is best suited to address the needs of this patient and family…”
  “…Carrying that message that we care is for everybody, including housekeeping…”
  “…It all really begins with the basic value of respect that is the first line of service for us, and the responsibility of everyone in the organization…”

- Companioning people
To foster spiritual health, it was felt that “being with” people and “being there for” people in their experience, (e.g., fear; loneliness; grief, suffering) rather than avoiding it, was a major theme, especially in a way that is “agenda-free”. This includes supporting patients and families in decision-making; and providing concrete help and information:
  “…We are the people who can take time to sit and listen. It’s like... ’I’m not here to poke or prod you. I’m not going to stick anything into you or suck anything out of you. I’m here for you if you want to talk to someone about something...’ We can be there for them, non-threatening and supportive.’
“…In the health care system, so much is focused on the power of making a difference, and is about doing and intervention. Whereas for the chaplain, it is about being with the person in the experience of helplessness and having the capacity to be with that person in that place rather than avoid it. Because of their own personhood, faith, training and background, the chaplain knows how to be with people in the midst of suffering and all the multi-dimensions of suffering that the person experiences…”

“…Last week I went to a ‘code’ [situation where a patient’s heart has stopped], a family with many children and grandchildren. The family didn’t have a church affiliation. I stayed there to affirm for them that their tears were OK. They asked me to say a prayer, and then I sat with the different family members and talked with them, and about the decisions they had to make and what they wanted to do.…”

• Helping people find meaning and comfort

A key theme in the type of services needed involved listening, assessing, reflecting and journeying with people in relationally based services to help them find meaning, sanctuary and hope in whatever ways matter to them; helping them to connect with internal and external resources; and creating “sacred space” for healing:

“…I think when someone is faced with any crisis, particularly in hospital, but also in long term care, things like ‘I have cancer, and it looks like I may die’ people start asking questions of meaning…”Why is this happening to me? What does this mean for me and my family and the way I live the rest of my life? How do I act in a way that reflects who I am and what is most important?” And I think my chaplain training helps me walk with those people, assess what they need, and help them look at those questions, in a deeper way based on what matters to them...

“…It is a time when people are very vulnerable and they are in crisis. There is fear of many changes, other changes. With the elderly in long term care, they have experienced so much loss…family and friends, some even children. They have had to give up their homes, their possessions, and so much that has helped them define who they are, given them meaning, and all of that. So, they really are struggling with who they are and where home is. One of my fundamental beliefs is that when people feel heard they are able to find the answers within themselves. So we need people who will be there, often to listen, someone who is present to them, to help them find meaning, to cope and to hope. That’s what a chaplain does…”

“…A woman’s family said she declared herself an agnostic. She was in very, very poor condition and for a couple of days everyone expected that she should have passed away. But her eyes stayed wide open. She looked so scared, but couldn’t verbalize anything. She had told us before that she was agnostic, and said no when they first asked her about seeing someone from spiritual care, but the family said if there is anything you can do, please do it. So, the spiritual care person went in and said something…I think about forgiveness. I don’t know what happened, but ten minutes later I went in and she was sleeping…”

“…I remember one man who was dying of cancer. Every time I was on the unit I would stop in and say hello. He told me that before I started visiting him, he hadn’t thought much about his life or a God. He said he had always been pretty self-sufficient and had enough of everything. The only thing negative in his life was that he hadn’t spoken with his daughter for 10 years. But then he told me he had phoned her. She wasn’t home, but he left a message and he was hopeful that she would get hold of him and make peace with him before he died…”
“…It is creating a sacred space for them, having that sanctuary where they feel safe enough and have enough trust in you, to tell you what is happening for them, which ultimately helps them get better. It is releasing some of that burden by affirming the person, respecting who they are, their space, angry or sad, or whatever…”

“…If a person is dying and that experience of dying is not connected to an understanding of their living, it is more threatening for people. Because then it is undoing their core, it is unrelated to how people place themselves in the world. Suddenly they are unraveling without any perspective on that unraveling. So they need help in getting that perspective and finding that connection…”

• Helping people in complex spiritual distress to process, re-balance and cope

The interviewees identified that in deep existential questions and situations of complex spiritual distress, spiritual health requires someone with clinical skills and services to assist people to process what is happening to them in healthy ways, and engage their ultimate questions so that they can re-balance who they are and cope with their stressful situation:

“…When a person experiences a crisis, or an event that is life-changing, it evokes all kinds of spiritual health issues that they may need help to process, especially if things happen very quickly…yesterday you didn’t have this bad diagnosis; today someone you love has been in a serious accident… A spiritual care specialist understands how a traumatized person tries to process and has the expertise to best facilitate that processing, and how they may need help to grow or change to do that. And that skill is very different from companioning…”

“…In those very difficult situations, my goal is to figure out what they brought with them and to position myself to help them use what they brought better. And very often it is broken…it is not working for them, and that is why we are called. Through our training and experience we have the tools that help us help them to reconfigure their way of faithing and coping…”

“…One of the important services provided by spiritual health professionals is the capacity to be what some behavioural scientists call ‘a holding environment’ that enables what is known as ‘transitional phenomena’, where you are trying to integrate your internal state with your external state. In that way we can think of prayer as a way of holding a space for someone. If there is way too much guilt or grief or anxiety, it is hard to get back on an even keel and be able to function. People need to re-balance in a serious situation, re-balance who you are and to incorporate what has happened to you. When the anxiety spikes within a person, a lot of work needs to be done to find balance again…”

• Access to faith community services, ceremonies and symbols if desired

The respondents spoke of providing access to the individual faith community prayers, sacred texts, rituals, symbols, food and ceremonies and an appropriate faith community leader if that was what the patient and family wanted. Respondents wanted to make sure that people could receive comfort through participating in their own religious traditions as they wished:

“…In this long term care setting, there are elderly and much younger people with chronic disease or brain injury. Both sets of people need the connection with their faith tradition. So there are
religious and church services, liturgy of course, but also other opportunities such as a prayer study group; or a discussion session on a book by the Dali Lama…"

"…Engaging people in their spiritual questions may spill over into religious topics, it often does, and we facilitate that. If you are Muslim and want an imam, of course we can help, because we have connections with people from that faith community…”

"…It is so important that there is a room, a sanctuary, here, and faith community services if people need that. In that sacred space people are relating to the symbols that bring them hope and comfort, a connection that allows them to transcend what they are in, and that there is something beyond which will restore them. It can provide the opportunity for those capacities within you and that you connect from deep within your soul to, to re-energize and bring life fully back in…”

• Being a support for staff

Spiritual health for the health system was seen to need “a safe place” and support for staff, e.g., doing critical incident debriefing with them; building partnerships; being “ambassadors of trust”

"…We really need them to be available to the staff on the units for whatever reason, to all the caregivers, because of the stress and the danger of burn-out. If the staff had access to some safe place for venting and consultation it would make it easier on everyone…Which industry has the highest rate of sick days? It is hospital and health care…”

"…Staff knows who I am, they will say ‘We’ve had a really tough situation’…and because we have been part of their experience and they trust us, they will say ‘Can I have a minute?’”

"…Spiritual health services should be focused on the doctors and nurses in terms of their own struggles, to help them personally in dealing with difficult situations…”

• Training and educating the rest of the team about spiritual health

The respondents felt that it was important to have training and education for the rest of the team about spiritual health services, including being able to identify patients who need more assistance with spiritual distress than they are able to provide:

"…There has to be an educational process for everybody. People who offer spiritual care are well trained professionals, but I don’t think the rest of us understand that. They have many skills, but nobody knows that…”

"…There should be education for leadership within the region. There could be a disconnect with one area looking at spiritual health and another area not necessarily understanding the effectiveness of that. So, some training in spiritual health would be helpful, and how it fits in at the Board and Senior Leadership levels, with executive leaders in management…”

"…We rely on the rest of the care team to identify, screen and triage patients that need more care, at which point they call us for support. So part of our role as spiritual care specialists is to train and educate the rest of the hospital to be able to identify patients who need more care than they can provide for someone with spiritual distress…”
• Serving on the clinical care team

In order to promote spiritual health in patients, families and staff themselves, the respondents said it was important to see spiritual health professionals serving on the clinical care team by participating in: rounds and care conferences; staff meetings; interdisciplinary education; and charting spiritual care interventions in patient charts:

“...We have chaplains assigned to units, which is a good idea, because then they are part of the team, and go to rounds and learn what is going on with the patients, families and staff. Then staff will call about the patients and also for themselves...”

“...As part of the team, the spiritual health professionals see the meaning-making story and how that is contributing or not to the patient's well-being, and highlights that and holds that up for the team to see and experience and facilitates the responses the team makes toward the patient and family to improve the kind of care they give...”

“...Chaplains should definitely be charting as part of the team. And that of course means proper training, and the sensitivity around confidentiality. Chaplains should be assigned to specific units in order to be available, to participate and to develop those crucial relationships with staff. Then they hear recommendations from other staff about patients who can benefit from focused spiritual care...”

“...We've had numerous examples from staff that, after the patient spent some time with their chaplain, the person is now feeling much better, is much easier to work with, is more amenable to treatment or suggestions, and their stress level has dropped. And because the person is more on track and easier to get along with, they can even get out of hospital sooner...”

Again, it is instructive to note that the themes that arose from the analysis of respondent comments were echoed in the literature. For example, a recent article on chaplains in contemporary health care describes what those involved in spiritual health services do, including: helping families who are sitting at their loved one’s bedside to interpret signs of approaching end of life; comforting a grieving family; helping staff debrief after a hard clinical situation; and helping patients and families discuss the questions that matter most to them in the context of a serious illness or a significant loss (Jacobs, 2008). A ‘White Paper’ called “Professional Chaplaincy: its role and importance in healthcare”, including the meaning and practice of spiritual care, was published by five of the largest professional pastoral organizations in 2001. It includes an outline of ten functions and activities of professional healthcare chaplains, which are:

• When religious beliefs and practices are tightly interwoven with cultural contexts, chaplains constitute a powerful reminder of the healing, sustaining, guiding and reconciling power of religious faith;

• Professional chaplains reach across faith group boundaries and do not proselytize;

• They provide supportive spiritual care through empathic listening, demonstrating an understanding of persons in distress. Typical activities include: grief and loss care; identifying individuals whose religious or spiritual conflicts may compromise recovery or
satisfactory adjustment; facilitation of spiritual issues related to organ/tissue donation; crisis intervention and critical incident stress debriefing; spiritual assessment; communication with caregivers; facilitation of staff communication; conflict resolution among staff members, patients and family members; referral and linkage to internal and external resources; assistance with decision making and communication regarding decedent affairs; staff support related to personal crises or work stress; institutional support during organizational change or crisis;

- Professional chaplains serve as members of patient care teams by: participation in medical rounds and patient care conferences, offering perspectives on the spiritual status of patients; participation in interdisciplinary education; charting spiritual care interventions in medical charts;
- Professional chaplains design and lead religious ceremonies of worship and ritual;
- Professional chaplains lead or participate in healthcare ethics programs;
- Professional chaplains educate the healthcare team and community regarding the relationship of religious and spiritual issues to institutional services, e.g., interpreting multi-faith and multi-cultural traditions as they impact clinical services; making presentations concerning spirituality and health issues; training and supervising volunteers; conducting professional clinical education programs for lay people and clergy;
- Professional chaplains act as mediator and reconciler, functioning as a voice for those who need an advocate in the healthcare system or ‘cultural broker’ between institutions and patients, family members and staff; offering patients, family members and staff an emotionally and spiritually “safe” professional from whom they can seek confidential counsel or guidance;
- Professional chaplains may serve as contact persons to arrange assessment for the appropriateness and coordination of complementary therapies such as music or art therapy, Reiki or healing touch;
- Professional chaplains and their certifying organizations encourage and support research activities to assess the effectiveness of providing spiritual care.

(White Paper, 2001, pp 86-88)

2. Serving Aboriginal groups

In three of the six jurisdictions surveyed, the directors indicated that they had hired Aboriginal people to be part of the staff offering spiritual health services. In two settings, they were called “Aboriginal Cultural Helpers”. One of those has developed a unique Clinical Pastoral Education residency program for training Aboriginal Cultural Helpers which has been approved by the Canadian Association of Pastoral Practice and Education. In the fourth jurisdiction, hospital
patients who self-identify as Aboriginal are served through a separate regional department which offers spirituality services, social services and counseling. In all cases, respondents emphasized the need for people to have things explained in their own language if necessary.

The Saskatoon urban acute care facilities have recognized the need for specially constructed sacred space for Aboriginal people to conduct ceremonies if they wish and have provided multi-faith space. St. Paul's also has a separate space dedicated to facilitating Aboriginal healing ceremonies. Some Saskatoon long term care centres recognize the importance of Aboriginal spirituality in that they have elders whom they can call. One faith-based long term care centre has a house for Aboriginal people with disabilities that is staffed by Aboriginal people.

The respondents agreed on the importance of being responsive to the particular cultural and spiritual needs of Aboriginal groups:

“…Aboriginal people are one of the most significant stakeholders in the region, and one of the fastest growing populations. By 2020 they will be a quarter of the population. They often face medical, psychological and spiritual challenges, and they need attention…”

“…Aboriginal people have a history of a deep spirituality, with tradition and value of a spiritual perspective that needs to be reinforced wherever, in a ubiquitous way throughout the region. They need to be shown respect and have dignity. Often Aboriginal people are from out of town, maybe away from community and family, and we need to do more to help them feel more comfortable in this strange place…”

“…There are some Aboriginal people on our units where we’ve tried to bring in elders with mixed success. It’s been fairly hard to contact an elder sometimes. And if we had someone on staff we could go to that knew who was appropriate and who could make those connections for us, like an Aboriginal Cultural Helper, that would certainly help…”

“…We know that for mid-life and older members of the Aboriginal population, coming into hospital or long term care can evoke memories and reactions because of bad experiences in residential school. So, the question is, how does the health system meet the needs of Aboriginal people without re-traumatizing them? We have found our Aboriginal Cultural Helpers to be key in this regard. What is important though, is to be grounded in long-term, trustful, respectful relationships with community elders, because they will tell us what is going on and what isn’t working…”

3. Serving Multi-faith groups

The respondents were also sensitive to the need to serve multi-faith groups. Some were appreciative of the welcoming ethos they saw within the Saskatoon urban regional facilities where they have established space that can be multi-faith. The regional acute care and long term care facilities typically have established connections with a variety of faith communities and spiritual leaders from the Jewish, Buddhist, Muslim and Hindu faiths. In some cases, respondents indicated that patient families have brought in spiritual leaders from other communities to assist them. The hospitals will respond as much as possible to the special food needs of certain religious and cultural traditions. The rural communities covered in the review
indicated that the majority of their population is of Christian background. One community has some clinicians with multi-faith background, and is developing a palliative care suite designed to be non-denominational space.

Four of the six jurisdictions surveyed described steps they had taken to be more responsive to multi-faith groups. One setting emphasizes diversity and has hired ‘spiritual health specialists’, a term changed from ‘chaplain’ to be more inclusive, who are members of other faiths such as rabbis, and Buddhists, as well as Aboriginal staff. Another jurisdiction whose staff are Christian in background, works closely with the regional Diversity Coordinator who was recently hired to bring diversity awareness and improve cultural competency in all health services. In two other settings the spiritual health professionals interact and collaborate with multi-cultural resource staff that is located in the same organizational area as spiritual health services.

Respondents indicated the need to be more intentional about serving multi-faith groups in terms of formal connections with the faith communities to facilitate providing staff awareness education regarding cultural and faith beliefs and preferences:

“…Most multi-faith groups have their own approaches in the community of what to do and whom to call when someone is ill. So you can’t have a Christian attending to a Buddhist if he or she doesn’t understand what is going on. Christians can help Christians. We have to facilitate the possibility of engaging the community’s own network. They have their own circle of people who will embrace their illness and help the family…There should be no fumbling. We need to connect with them, know them and educate ourselves about the different faith groups…”

“…Spiritual health services for multi-faith groups have to start with respect for peoples’ dignity, because they have to become dependent if they are sick. Keeping in mind a respectful milieu and other peoples’ beliefs is important. Even like trying to give a person cold water to drink, not realizing that he believes that cold water is unhealthy for him, so he dehydrates himself. Spiritual health services means asking ourselves and having ways of finding out, ‘What are peoples’ ideas and beliefs about ‘health’?”

“…As much as we think we are providing spiritual care, it is based pretty much on a Christian ethic, and this does not fit all aspects of life for people, Aboriginal and those of other faiths and even no faith. At this point I think the majority of the world is non-Christian, but the services seem to be based on what is the population where you live. So it disenfranchises a certain element of the population, and that means spiritual care must be more intentional in respecting diversity…”

There was a high degree of congruence between the results from the interviews and the literature. For example, the “White Paper’ on professional chaplaincy makes explicit reference to the non-denominational and multi-faith aspects of the services in its list of functions and activities. A recent article on the pastoral practitioner in a multicultural society (Lee, 2001) makes the point that multiculturalism and globalization are the reality of our society, and that if spiritual health carries on in the same way “we will very quickly become obsolete or irrelevant if not unfaithful” (p.390). He calls for spiritual health services to make visible the invisibility of monoculturalism and “whiteness”, which he defines as the fact that:
“Euro-Americans are likely to see their world as normative. What they consider natural-unnatural and normal-abnormal are applied as if they had universal applicability. They set standards of practice and code of ethics within their organizations without considering the hidden power dynamics involved and without considering their applicability to the culturally different…” (p.391)

To do this, he says, requires embracing cultural diversity and striving to become culturally competent practitioners.

C. Personnel, Background, and Qualifications

In the logical chain of first, knowing what was meant by spiritual health, and second, what kinds of services would be needed to support it, the third key question to the interviewees was how many personnel, with what training and qualifications would be needed to best provide those services. The comments described two groups of personnel. The first were those in the paid workforce, and comprised: spiritual health practitioners, or hospital chaplains; denominational chaplains, paid by their respective denominations; and Clinical Pastoral Education residents. The second group was those in the unpaid workforce and included: community clergy; Clinical Pastoral Education interns; and trained lay volunteers. Each of these sets of personnel is discussed below, in terms of numbers, where relevant, and then qualifications and training.

1. Paid Workforce
   a) Spiritual health practitioners

Every one of the respondents indicated the need for personnel specifically dedicated to the provision of spiritual care in acute care and long term care facilities. In most jurisdictions and in a great deal of the literature, these personnel are called “chaplains”. One site prefers to call its staff ‘spiritual health specialists’ to be more inclusive of faiths other than Christian. People interviewed spoke of the personal background of a spiritual health practitioner including: grounding in one’s own faith tradition and knowledge and appreciation of other faiths; having a mature personal faith and understanding of one’s own spirituality and approach to death and dying. Other attributes included a non-judgmental attitude, open mind and heart and skills in active listening. Three of the six jurisdictions surveyed had hired Aboriginal people to be Aboriginal Cultural Helpers.

The review searched for guidelines in other jurisdictions and in the literature concerning the appropriate ratio of paid staff to inpatients. The details of the numbers and qualifications of the paid staff in each of the jurisdictions surveyed in this review are available in Appendix B.

When the number of full time equivalent positions in the surveyed jurisdictions was calculated per 100 inpatient beds (this information covered acute care services only), the average was 1.1, with a range of .5 to 1.7, the latter being observed in a faith-based organization.
In Saskatoon Health Region there are 3.0 FTE chaplain positions for roughly 600 urban inpatient beds (including neonatal, nursery and pediatric intensive care), and approximately .75 FTE (.5 Roman Catholic chaplain and .25 of the time manager of volunteer Services and Spiritual Care) for 100 rural inpatient beds in seven rural hospitals, for a total of 3.75 FTE’s for 700 hospital beds; an average of .53 FTE per 100 inpatients for hospitals. The region has 29 long term care facilities, including one directly managed by the Saskatoon Health Region for whom data were available. There is .5 FTE chaplain position for that long term care centre of about 240 beds; an average of .21 FTE per 100 long term care residents.

- The average results for the Saskatoon Health Region are at the low end of the results of the average for the survey of other jurisdictions conducted for the review.

St. Paul’s Hospital is a Catholic healthcare organization of about 200 beds plus a 27 chair hemodialysis unit within the region, that generates external funding for the spiritual care services of 3.8 FTE positions, which includes a manager who provides .5 FTE clinical care; for total clinical care of 3.3 FTE; and an average of 1.65 FTE per 100 inpatient beds.

- The average results for St. Paul’s Hospital are somewhat higher than the results of the average for the survey of other jurisdictions.

These review results can also be compared to four benchmarks available from the literature.

First, a recent survey of a random sample of 370 chaplaincy department directors in the United States showed that the mean number of chaplains employed per 100 patients ranged from 1.2 to 1.66 chaplains, except in religiously affiliated hospitals that employed an average of almost 3 (2.9) chaplains per 100 patients. The mean number of chaplains per 100 patients considering all settings, including long term care and hospices, was 1.85. The median results suggested that overall, half of the hospitals employed less than 1.33 chaplains per 100 patients and the other half employed more (VandeCreek, Siegel, Gorey, Brown and Toperzer, 2001, p.296).

Second, the ratio of 1.0 FTE per 100 inpatients derived from the early work of McSherry in the late 1980s (McSherry, 1986), that was informally cited by respondents familiar with the Canadian Association of Pastoral Practice and Education.

Third, the Guidelines on Chaplaincy and Spiritual Care in the National Health Service in Scotland (2003) provide for different amounts of staff time according to the range of inpatient beds and the areas of healthcare work. For example, their guidelines would result in a ratio of .3 - .4 FTE per 100 beds for acute inpatient (e.g., medical, surgical, oncology); 1.0 – 2.0 FTE per 100 beds for intensive care units; and .2 - .4 FTE per 100 beds for long stay units.
Of special note is that the Scotland standards for palliative care indicate that a specialist unit of 16+ beds should have 1.0 FTE spiritual care practitioner.

The fourth set of guidelines come from the Quality Commission of the Association of Professional Chaplains (2008), who use the ratio of patients to chaplain staff based on length of stay, as follows: 50:1 for those hospitalized for more than 3 days; 75:1 for patients with shorter stays; 100:1 for outpatients undergoing dialysis, or chemotherapy.

A comparison with the Scottish guidelines would require the calculation of a ratio for Saskatoon facilities based on the breakdown of number of beds per type of care that is beyond the scope of this review. It is difficult to judge whether the Saskatoon Health Region ratio would fall above or below such a comparison. Similarly, the Quality Commission ratio calculation for comparison would require information on relative patient length of stay, also not possible within this review.

- **The Saskatoon Health Region average ratio of chaplain staff per 100 inpatients (.4 for acute and .21 for long term care) falls fairly below both the results of the survey of jurisdictions conducted for this review (average 1.1 staff per 100 inpatients), and below the recent benchmarking study in the United States (1.2 to 1.66 chaplains per 100 inpatients for non-religiously affiliated hospitals).**

In terms of qualifications, the National Association of Catholic Chaplains’ job description for a chaplain ([http://www.nacc.org/resources/job_chaplain.asp](http://www.nacc.org/resources/job_chaplain.asp)) indicates that a bachelor’s degree is required, along with completion of theology classes; display of skills and competencies in pastoral care. The training asks for one year of clinical experience and certification by an appropriate clinical pastoral agency.

The 'White Paper' cited above, has stated that acquiring and maintaining certification as a professional chaplain requires: graduate theological education or its equivalency; endorsement by a faith group or a demonstrated connection to a recognized religious community; clinical pastoral education equivalent to one year of postgraduate training in an accredited program recognized by the national organizations; completing annual continuing education requirements; adherence to a code of professional ethics for healthcare chaplains; and professional growth in competencies demonstrated in peer review.

In the six jurisdictions surveyed, the spiritual service department directors indicated that their staff was typically Masters prepared. In two large tertiary care sites, because of the acuity of the cases seen, the respondents emphasized that they sought persons who had completed Canadian Association of Pastoral Practice and Education (CAPPE) certification as Specialists. This means that they have or are completing a Masters Degree; an ethics course; 4 units of Clinical Pastoral Education; 2000 hours (one year) of supervised clinical practice; and certification by CAPPE peer review.

In Saskatoon Health Region, staff chaplains and denominational chaplains for urban acute care, and the part-time chaplain at Parkridge Centre long term care, typically have a Masters
degree; or a theology degree and professional background such as nursing, have completed at least one unit of CPE; and have background in Christian denominations. The Humboldt rural hospital manager of Volunteer Services and Spiritual Care has a Christian background with training as a Licensed Practical Nurse and 2 units of CPE; the part-time chaplain is a Roman Catholic priest.

At St. Paul’s Hospital the qualifications follow the guidelines of the National Association of Catholic Chaplains cited earlier. The spiritual health practitioners are lay people of mature Christian faith and an ability to offer non-denominational compassionate presence and support in a team environment, typically from a variety of academic backgrounds (e.g., nursing), who are working in an apprenticeship model and have completed one unit of CPE. The Clinical Educator is a Masters prepared, experienced spiritual health clinician and CAPPE teaching supervisor.

**b) Denominational chaplains**

The respondents described a variety of relationships with denominational chaplains as part of the paid workforce offering spiritual health services in their jurisdictions. Denominational chaplains are typically Masters Degree prepared spiritual care practitioners who are paid by their particular denominations to serve the needs of inpatients who are members of their particular denomination. This is a service often provided when the patient is coming from out of town, where the person’s local clergy will call the denominational chaplain and ask him or her to visit a member of their congregation. Denominational chaplains also can access a list of patients from their denomination who have agreed to a visit that is compiled by the hospitals from the hospital census/admitting information, and is typically kept in the spiritual health services office.

In two of the six sites surveyed for the review, the spiritual health services department has separate contracts or “affiliation agreements” with each of the denominations for the services of the denominational chaplains. This has the impact of increasing the paid manpower available, and makes the relationship a formal one, in which the expectations of one party for the other can be clarified and signed off in writing. The scope of the expectations differed in the two sites. For one jurisdiction, which is responsible for a number of urban hospitals and has few paid chaplaincy regional staff, there are separate contracts with the Roman Catholic, Anglican, United Church, Presbyterian and Baptist denominations. They have varying number of hours of work, but it means that 15 denominational chaplains have been added to the roster as full members of the department and spiritual health services team, functioning as non-denominational chaplains, with the approval of their denominations. This jurisdiction is encouraging all of their contracted denominational chaplains to become CAPPE certified specialists.

The other jurisdiction has formal agreements as well, but they only focus on addressing the needs of people who belong to their denomination. Again, formal agreements augment the
manpower within the department, and clarify privileges such as whether or not there is access to patient records.

In the Saskatoon Health Region, four denominations have paid denominational chaplains: Anglican; Roman Catholic; United Church; Evangelical Lutheran Church in Canada, and Lutheran Church Canada. They all have a Masters in theology, and one or more units of CPE. The review determined that there has been an issue with lack of consistency between the regional hospitals’ procedures and St. Paul’s’ procedures regarding the degree to which denominational chaplains have access to patient information, and feel integrated into the spiritual care team. The denominational chaplains are very willing to contribute more as full members of the regional spiritual health services team, and are in favour of a formal agreement with the Health Region. Rural hospitals rely on community clergy and do not have denominational chaplains.

c) Clinical Pastoral Education (CPE) Residents

Clinical Pastoral Education (CPE) residents are Masters Degree graduates seeking the opportunity over the course of a year to specialize in certain areas of spiritual health services. They receive education and provide roughly 20 hours of supervised clinical service per week, for which they receive a stipend of about $2,500 per month from the region or hospital with which they work. Three of the six jurisdictions surveyed for the review offer a clinical residency program, for which they have one or more CAPPE teaching supervisors on staff. The review found that the teaching supervisor was often the director of the spiritual health services department. Running a residency program allowed the sites to support the formation of specialized expertise, including one site that has developed an Aboriginal Cultural Helper residency. It was also seen as a cost-effective strategy, since one resident returns about .5 FTE in clinical service to the setting.

In the Saskatoon Health Region, there is a clinical educator/teaching supervisor available through St. Paul’s, however the region does not at the moment have a clinical residency program.

2. Unpaid Workforce

The respondents also commented on personnel who make up the unpaid workforce involved in delivering services to support spiritual health. This group included: community clergy; Clinical Pastoral Education (CPE) interns; and trained lay volunteers, as discussed below.

a) Community clergy

The respondents’ comments differentiated community clergy from paid spiritual health practitioners and denominational chaplains in that community clergy are seen as visitors in the hospital coming to serve only specific members of their own congregations. This appears to be the group that the spiritual health service directors surveyed had the hardest time monitoring. One jurisdiction was undertaking steps to connect with, register and orient a large number of ‘pastoral visitors’ including clergy, to get to know them and to stress the expectations that they
are not to proselytize nor visit any persons not on the list of their own denomination, unless expressly asked by the patient or family. One of the biggest issues from the point of view of the respondents was the protection of vulnerable patients and families from unwanted attention by persons with their own religious agenda, ordained or lay.

On the other hand, in the Saskatoon Health Region, respondents who were community clergy in this review had no trouble making similar distinctions as other respondents between spiritual health and religious observance, and appeared well aware of their limited role. They were willing to become more involved, and indicated that they would appreciate more communication with them from the regional spiritual health services department. They saw this as particularly important when they were relied upon to provide religious services in acute care and long term care facilities throughout the region on a rotational basis, and as the main source of spiritual/religious care in the rural communities.

b) Clinical Pastoral Education interns

Five out of the six jurisdictions surveyed for the review ran CPE classes and had 6-8 CPE students or interns during the summer and 4-6 during the winter providing some supervised clinical service. The interns pay the hospital for earning credit, usually toward their Masters degree, and are on site roughly 10-15 weeks for each unit of CPE they take. The other site had 8 students per year in its own program, based on the CAPPE model, called “Spiritual Diversity, Hope and Healing”. The year long program, being offered this year for the fifth year, is based on three hours of class and four hours of practicum per week, and is open to nurses, physicians, therapists, and seeks a diversity of ages and ethnic groups. This site commented that the CPE program was strong clinically, but did not feel as welcoming to as broad a range of interdisciplinary and multicultural participants as they would like.

In the Saskatoon Health Region, the teaching supervisor is the clinical educator at St. Paul’s Hospital, who offers the CPE service to students throughout the region in a similar rhythm of winter and summer sessions, and has a similar benefit from the placement of students in limited clinical practice. The respondents were very supportive of the opportunity for CPE training and wanted more.

c) Trained Lay Volunteers

Two of the six jurisdictions surveyed for the review had trained lay volunteers as part of the spectrum of service delivery. The two large tertiary care centres did not have volunteers because of the acuity and intense nature of the clinical situations they faced. The two sites with volunteers spoke of two types: religious volunteers who bring communion to patients who have made a request; and spiritual health volunteers who work with all denominations and faiths and no faith, to visit and explain the services available. The respondents indicated that careful selection of people to be volunteers and education afterwards was important to help them know when they should call in a spiritual health practitioner.
In the Saskatoon Health Region, City Hospital is growing a formal program of lay spiritual health volunteers. One of the long term care centre affiliates (Sherbrooke) is sponsored by several denominations, and has a chaplain qualified to deliver a basic spiritual care training course, enabling people, including residents of the facility, to participate in their Lay Spiritual Companionship Program. Religious volunteers will bring communion to those who have asked in the urban sites.

The five rural communities covered in this review described examples of trained lay volunteers; groups who may be natural resources for offering compassionate care and support:

- Humboldt hospital has an active group of trained spiritual health volunteers, for whom the St. Paul’s Clinical Educator has offered a 32 hour training session;

- Rosthern community has a Pastoral Care group with a local trainer, connected with long term care. There are also 2 Muslim doctors and a Philippino nurse in the hospital who may be multi-cultural training resources. Rosthern hospital is implementing a multi-faith palliative care suite;

- Watrous community representatives spoke of a local group trained as a Traumatic Events Response Team to support families of people involved in serious accidents or multiple deaths. It may be that this group is not active but may be re-energized;

- Wakaw community has local residents who have completed some CPE training and have taught pastoral care courses for a local group of volunteers. The group is coordinated by a Pastoral Care Committee comprised of the local hospital and long term care managers and two lay people;

- Cudworth community is implementing a six member lay volunteer visitor group associated with the facility. The facility provides primarily long term care but has four primary care beds and a palliative care suite. The facility manager would like ongoing training offered for such groups.

The respondents' comments indicated that there is tremendous potential in the volunteer spiritual health workforce to companion people in the rural areas. One of the issues raised by the Advisory Committee in the consideration of this potential had to do with the fact that in many rural areas, the people who volunteer for spiritual health services may be exactly the same people who volunteer for other activities that contribute to the vitality of the hospital (e.g., driving people to appointments for treatment). In the context of the expressed desire by the respondents for ongoing training and support for the spiritual health volunteers, this raised the question of the kinds of training that might be needed by the volunteers and what the relationship might be between the Health Region’s department of Spiritual Health Services and its department of Volunteer Workforce and Strategic Initiatives. The review explored the issue with the interim director and director of each department and found several facets to the question.
First is that the Health Region has not historically had formal mechanisms in either department to communicate with or coordinate resources with the surrounding rural areas. The Volunteer Workforce and Strategic Initiatives department has just begun to meet with the volunteer coordinators from some rural facilities in the last five months to try to dovetail their efforts. According to the respondents from the rural areas in this review, there is appetite and willingness to do the same with the interim director of Spiritual Care Services on spiritual health service delivery issues, but this has yet to happen.

Second, there have been inconsistent procedures in the recruitment, screening, registration and orientation of volunteers in the facilities throughout the region, and between other areas of service and the area of spiritual health, e.g., requiring volunteer references, a criminal record check, and mandatory orientation sessions to the general rules and regulations of the hospital. The director of Volunteer Workforce and Strategic Initiatives would like to open the conversation and move toward agreement on minimum standards of practice with Spiritual Care Services department and other areas in order to confirm together what is seen as due diligence in the face of possible liability concerning the volunteer workforce.

Third, with regard to the process for recruitment and training that each and any volunteer goes through, the review identified three steps. There is recruitment and screening of the volunteer, including a standard application process, and an interview to discuss suitability for the desired area of work. Then there is a general orientation to important topics in working in any hospital environment such as: basic rules and regulations, where you can go and not go; infection control, scheduling and reporting time, etc. The first two levels are generic, are meant to be common to all volunteers regardless of their desired area of placement, and are assumed to be the responsibility of the department of Volunteer Workforce and Strategic Initiatives.

Finally, there is the specific discipline and unit orientation and training in the area of placement. That level is the responsibility of the clinical staff where the volunteer will work, and with whom there is the working relationship. In the case of volunteers working in the area of spiritual health services, the responsibility for discipline specific training and supervision would fall to the current department of Spiritual Care Services.

The implication is that to have a strong, well-informed cadre of volunteers, especially in the rural areas, there needs to be resources dedicated to their recruitment, screening and general orientation as well as resources specifically available to provide training and supervision in the discipline of spiritual health services related to various clinical units.

D. Ongoing Support for Spiritual Health Practitioners

The respondents observed that the paid and unpaid workforce would need ongoing support, and mentioned two sources: the role of Clinical Pastoral Education (CPE) and a method for professional accountability and quality assurance.
1. Role of Clinical Pastoral Education (CPE)

There was strong support by the respondents for the role of CPE in spiritual health services. It was seen as key and a priority, as a very important source of training by all jurisdictions. The Canadian Association of Pastoral Practice and Education, along with the other groups who authored the “White Paper” released a document on Common Standards for Professional Chaplaincy (2004) requiring 50 documented hours of continuing education per year, which the chaplain staff can easily make up in various education opportunities.

CPE was seen as a crucial component of a spiritual health services program for students and for the formation of chaplaincy competencies. It tells an employer “I can do the job” as well as “in a sustainable way” because of the CPE training process at basic and advanced levels, with the emphasis on personal awareness, growth and development. The model of CPE that focuses on personal reflection and ‘doing your own work’, i.e., surfacing your own strengths and growing edges, was seen as foundational to the spiritual health professional whose main tool is himself or herself. One respondent put it this way:

“…I think the CPE helps me deal with myself. Say I’m walking into this room and here’s the situation. And I might feel anxious walking into a room where they are going to disconnect the ventilator and there is all this family gathered. But in CPE I’ve had the chance to look at it, to look at my own reactions to that, and to reflect on my reactions with peers, and that is a helpful thing. I’ve learned a lot from that…”

The principles and content associated with CPE is a key resource that can be adapted and used in ongoing support for volunteers as well. For example, respondents indicated that the Clinical Educator from St. Paul’s has offered a popular 32 hour course for spiritual health services volunteers at Humboldt, and the chaplain at Parkridge has developed a Lay Spiritual Companion program for volunteers.

2. Method for Professional Accountability and Quality Assurance

The respondents were clear that the method for professional accountability and quality assurance in Canada is the Canadian Association of Pastoral Practice and Education (CAPPE). CAPPE is unique in that, unlike disciplines such as nursing or medicine, it is responsible for all three areas of training, certification and discipline, whereas nurses and doctors are trained by one institution and certified and disciplined if necessary by another. The Association is one of five major associations which have together drafted a “White Paper” on professional chaplaincy, as well as Common Standards for professional Chaplaincy; Common Standards for Pastoral Educators/Supervisors; Common Code of Ethics for Chaplains, Pastoral Counselors and Students; and Principles for Processing Ethical Complaints. The respondents indicated that spiritual health practitioners should be members in good standing of CAPPE.
In Saskatoon Health Region, the spiritual health practitioners are also expected to be members of the recently formed Saskatchewan Association of Spiritual Care Practitioners in Healthcare, which is establishing itself as the group responsible for quality assurance and professional discipline if needed.

Both the respondents and the literature emphasized that part of exercising professional accountability and quality assurance is participation in defining and measuring expected outcomes of the interventions and conducting research. A recent article champions health care chaplaincy becoming a research-informed profession in the next ten years (Fitchett, 2002).

E. Delivering Regional Spiritual Health Services

1. Identification of Service Needs

One of the major themes from the respondents concerned how patients and families are identified as needing spiritual health services. The most common method across the jurisdictions was that patients were asked to identify their denomination or faith/cultural group by an admissions clerk at the time of admitting, except for those coming through emergency. This information was often considered in the hospital census administrative data. Lists are typically generated with the names of people who identified themselves as belonging to a certain denomination. The list of people in specific denominations or faith groups is then available in the spiritual health services office to the denominational chaplains and community clergy representing those specific denominations.

The respondents spoke of dissatisfaction with this approach, citing difficulties in the willingness of harried admission clerks to ask patients what may be interpreted as an embarrassing or intrusive question, the poor timing of asking about the topic when patients and families are distracted by the pressing physical health issues that brought them to hospital, and the important distinction between spiritual health and religion. Respondents also commented on the implications of new privacy of information legislation and that there had to be restrictions on access to personal patient information, unless there was a ‘need to know’ in the authorized provision of service for the patient, i.e., informed consent. The issue of whether people expressly agree to be visited by a community religious leader has been addressed in one jurisdiction surveyed by altering the wording of the question to ask patients directly and obtain their consent as follows:

“…This hospital has Spiritual Health Services available for your spiritual health while you are in hospital. The spiritual health department is staffed by spiritual health professionals. However, if you would prefer a visit from a religious leader from your own particular community, please sign below…”

Every one of the six jurisdictions surveyed for the review relied upon the clinical staff on the units to alert them to the spiritual needs of the patients. This was done either through nurses
explicitly including questions related to a patient’s beliefs or spirituality at the time that the person was admitted to the particular hospital unit, or later, after the staff had a chance to get to know the patient’s situation better and saw something that alerted them to the need for a spiritual health practitioner to help the patient. This raises a question about the point in care that is most appropriate for identifying need, and how much of that identification is initiated by the staff versus the patient. One respondent put it this way:

“...There is a disconnect there too, because on the nursing notes that they take on admission they ask, ‘Is there anything in your religious beliefs that would affect your health care? Yes/No’. and then it’s ‘Do you want us to contact Spiritual Care? Yes/No’. Well, most people typically say ‘No’ at admission, because of the religion thing. But it’s not just about religion. So then I came by one day and there was a woman sitting on the edge of the bed looking kind of down, and I just stopped in to chat and in the course of the conversation she told me all manner of things that she was really concerned about. And she said, ‘You know, when they asked me when I came in, I said ‘No’, I didn’t think I needed to see a chaplain. And then later I wondered why I said that.’ And I think that is often the case. At admission, they don’t realize all the things they are going to face...”

The literature echoes a similar concern. In a recent survey of general medical and surgical patients who were asked if they wanted to have a chaplain talk with them, pray with them and/or receive communion, only 35% requested one or more of the services and 25% asked to speak with a chaplain (Fitchett, Meyer and Burton, 2000). In addition, they found that patients with multiple stresses, who had lower religious resources, were less likely to request spiritual health services. The ones who appeared to need it most did not self-refer.

Best practices described in the literature eschew the kind of questions on the nursing admission form described by the respondent above, and favour the use of short screening tools such as the FICA (Faith, Importance, Community, Address) open-ended questions developed expressly for interdisciplinary clinicians to triage patients in need of further spiritual health services (Pulchalski and Romer, 2000; Fosarelli, 2008) (see Appendix C) including more comprehensive assessment by a spiritual health practitioner.

The literature on best practices speaks to targeting spiritual health services to specific areas, chosen for their high intensity/acuity/complexity such as: intensive care, palliative care, cardiac units, oncology, dialysis, etc. (Handzo, 2006). The literature also describes the identification of needs for spiritual health services through protocol-based referrals. The Common Standards for Professional Chaplaincy (2004) section on screening includes a table of spiritual care triggers involving high risk diagnoses and high risk spiritual indicators that can be used by both clinical unit staff and spiritual health practitioners (see Appendix D).
2. Degree of integration with the Clinical Team, including participation in charting

In every one of the jurisdictions surveyed for the review the respondents noted the importance of spiritual health practitioners being integrated well into the clinical care team. They rated their integration as high, since in four of the six sites the spiritual health practitioners had been assigned to clinical units based on needs and staff experience and preferences. The other two sites had too few staff to assign to units but they supported the concept. Integration into the clinical team included: participating in rounds, case conferences, staff meetings and documenting in the patient charts as a team member. Factors that the jurisdictions considered key success factors for successful integration with the clinical team included: strong support for integration from both the hospital executive and clinical leaders on the unit; staff being assigned to units and having the opportunity to become known and trusted; being visible to the team all the time; having their own space on the unit; and being invited to social events on the unit, developing relationships both formally and informally.

In Saskatoon Health Region, respondents indicated that region staff attend rounds on some units (e.g., palliative care) but are not formally assigned to units. The degree of integration varies a great deal (e.g., no formal presence in emergency room, or ICU, but spiritual care may be called to attend a code). It is clear to the staff that the chaplain is there to support not only the patients, but the staff themselves. Clinical staff will make referrals to the chaplains. Chaplaincy appears to be integrated into regional long term care more than acute care, although staff resources are scarce. The manager of spiritual care services at Humboldt is in close contact with the staff. There is an appreciation of spiritual care, which generally works in parallel to the clinical staff, typically offering services directly to patients, but also accepting referrals from the clinical staff.

There is a tradition and the expectation of spiritual care being part of the total care offered at St. Paul's, which is a Catholic health care organization. The spiritual health practitioners see every patient admitted for an initial visit, and are available from 8:00 am to 11:00 pm every day, so are visible to the patients and clinical staff. The degree of integration with the clinical staff varies. There is a high degree of integration in areas such as ICU, where spiritual health practitioners are routinely called; and in palliative care, and less so in other areas. Staff is not assigned to units. There has been a recent request from palliative care to have spiritual care formally assigned to the team. It is clear to the staff that the spiritual care services are there to support not only the patients, but the staff themselves. Clinical staff will make referrals to spiritual care.

With regard to charting, there is no formal policy in the region supporting that aspect of integration with the clinical team. The spiritual health volunteers in Humboldt keep their own notes regarding their visits which are added to the charts afterward, since only the manager has access to patient charts. At St. Paul's there has been a request from the ICU for spiritual health practitioners to participate in charting; and a request from the palliative care department for a spiritual health practitioner to be assigned to the team, which would presumably include charting.
The literature on best practice favours a high degree of integration of spiritual health practitioners with the clinical care team, particularly in end of life care in palliative care and intensive care units (Wall, Engelberg, Gries, Glavan, and Curtis, 2007). For example, hospices and specialist palliative care units in Scotland must have an appointed chaplain who attends multidisciplinary meetings in order to meet their National Health Service requirements. The Association of Hospice and Palliative Care Chaplains recommends that chaplains work as members of the multidisciplinary team and attend multidisciplinary team meetings (AHPCC, 2006). Further, they indicate that, as recognized members of the multidisciplinary team, chaplains should have the same access to patient notes as other team members and record their response to referrals and interventions. Similarly, the ‘White Paper’ on the meaning and practice of spiritual care includes serving as members of patient care teams and charting spiritual care interventions in medical charts (2000).

3. Ongoing education for other team members

Contributing to the ongoing education of other team members was seen as a high priority in all of the jurisdictions surveyed for the review, through the provision of both formal educational classes and informal opportunities to raise awareness of spiritual issues and interventions on a case-by-case basis. They saw an intimate connection between these opportunities and the degree to which spiritual health practitioners were integrated into the clinical team, and the ability to have clinical unit colleagues involved in spiritual screening and referral. One site offers ongoing continuing education for the whole hospital, bringing in speakers and doing skill building workshops, where 300-400 people attend, e.g., end-of-life care from different spiritual perspectives; day long workshops on Hope for physicians, nurses and allied health professionals four times a year. This site also has their spiritual health practitioners involved in teaching their adaptation of the CPE course called “Spirituality, Diversity, Hope and Healing” and in supervising students from a variety of disciplines. Another site has every one of their staff chaplains providing the other clinical staff with six in-services a year across the hospitals in their area. In all sites, chaplains are involved in presentations and orientation sessions with other staff. Those with Aboriginal Cultural Helpers and multicultural staff are particularly involved in assisting clinical staff to provide more culturally appropriate services for Aboriginal and multi-faith patients and families, usually on a more informal than formal basis.

In the Saskatoon Health Region, the spiritual health practitioners participate in education and orientation sessions for other staff as their limited time permits, e.g., the spiritual health practitioners at St. Paul’s have done a presentation for clinical staff of ICU. When the spiritual health practitioners participate in clinical rounds they have the opportunity to informally educate the other team members about what spiritual care is and can offer to the patients, families and staff themselves. The Clinical Educator offers ongoing CPE units which are available to clinical staff at St. Paul’s and throughout the region, including a special course offered to the spiritual care volunteers at Humboldt.
The literature on best practices stresses that nurse and physician clinical staff must be aware of their own spirituality before they can recognize the need in others and incorporate spiritual health services into holistic care for patients and families, and the role that spiritual health practitioners can play (McClung, 2006; Fosarelli, 2008). Further, the impact of professional spiritual health practitioners is enhanced by having them offer training and education for their clinical colleagues on topics such as: cultural awareness and sensitivity; listening skills; advanced directives and spiritual issues to help them serve patients’ and families’ emotional, spiritual and cultural needs (Handzo, 2006).

F. Summary of Findings

The summary of findings includes the following highlights:

- A consideration of spiritual health included six themes: spiritual health is a highly individual thing; it involves a sense of wholeness, hope, purpose meaning and peace; it may include religious practices, but not necessarily; it means balance among the physical, emotional, social and spiritual aspects of our lives; feeling connected and in relationship with self, others and the transcendent; and having confidence in the ultimate good of the outcome in times of struggle in order to cope;

There was a strong correspondence between these themes and those found in the literature.

- The services that are needed include: basic compassionate care and respect from all staff; companioning people, being there in non-judgmental way that is agenda-free; helping people find meaning and comfort; helping people in complex spiritual distress to process what is happening, to re-balance and cope; access to the various faith community religious services, symbols and ceremonies as desired; supporting clinical staff; training and educating the rest of the team about spiritual health; and serving on the clinical team.

Again the literature revealed similar points to which was added: participation in ethics programs, access to complementary therapies and participating in research.

- Spiritual health service departments are becoming increasingly aware of the needs of Aboriginal and multi-faith groups. They are hiring Aboriginal and multi-faith staff as well as Aboriginal Cultural Helpers.

- Spiritual health services are being delivered by a spectrum of both paid and unpaid workers. The paid workers include spiritual health practitioners, denominational chaplains, and CPE residents. The unpaid workers include: community clergy, CPE interns and volunteers.
• The Saskatoon Health Region average ratio of chaplain staff per 100 inpatients (.4 for acute and .21 for long term care) falls fairly below both the results of the survey of jurisdictions conducted for this review (average 1.1 staff per 100 inpatients), and below the recent benchmarking study in the United States (1.2 to 1.66 chaplains per 100 inpatients for non-religiously affiliated hospitals).

• The National Association of Catholic Chaplains’ job description for a chaplain indicates that a bachelor’s degree is required, along with completion of theology classes; display of skills and competencies in pastoral care. The training asks for one year of clinical experience and certification by an appropriate clinical pastoral agency.

• Acquiring and maintaining certification occurs mainly through the Canadian Association of Pastoral Practice and Education (CAPPE) in Canada. A professional chaplain requires: graduate theological education or its equivalency; demonstrated connection to a recognized religious community; clinical pastoral education equivalent to one year of postgraduate training in an accredited program recognized by the national organizations; annual continuing education; adherence to a code of professional ethics for healthcare chaplains; and professional growth in competencies demonstrated in peer review.

• Crucial to accountability is measuring outcomes and conducting research.

• Clinical Pastoral Education, offered through CAPPE certified instructors, plays a critical role in the formation and ongoing education of spiritual health practitioners. The principles and content can be adapted for training clinical staff and volunteers in spiritual health services.

• The identification of spiritual health needs is best accomplished through the use of standardized screening tools and protocols that guide the referral to a spiritual health specialist. Having spiritual health practitioners integrated into the clinical care team allows for the identification of needs through attending rounds and case conferences. Spiritual health professionals are expected to chart as a member of the team.

• Key success factors for successful integration with the clinical team included: strong support for integration from both the hospital executive and clinical leaders on the unit; staff being assigned to units and having the opportunity to become known and trusted; being visible to the team all the time; having their own space on the unit; and being invited to social events on the unit, developing relationships both formally and informally.

• Having the spiritual health practitioners involved in offering both formal and informal opportunities for ongoing education of other members of the team is very important. The literature stresses the necessity of nurse and physicians being aware of the dimensions of their own spirituality in order to recognize and support it in others, and understanding
what spiritual health practitioners can bring as a member of the team. Spiritual health practitioners can provide training to promote cultural and spiritual sensitivity.

V. Recommended Principles to Guide a Vision for Spiritual Health Services in the Saskatoon Health Region

The recommended principles to guide a vision for spiritual health services in the Saskatoon Health Region are based on a survey of other jurisdictions, a review of the literature on best practices and comments from a variety of stakeholders in the Saskatoon Health Region. Appendix E provides a summary table of the links between these principles, the five core values and five strategic directions. Additional details of the linkages are explored later in the section on Values and Strategic Directions.

- **Spiritual health practitioners are visible keepers of the regional values of: respect; compassion; collaboration; stewardship and excellence.**
  This principle emphasizes each of the regional values, supporting overall excellence and relates particularly to the strategic directions of: Transforming the care and service experience; Transforming the work experience; and Partnering for improved health for Aboriginal people.

- **Spiritual health service delivery is highly responsive and integrated.**
  This principle is linked primarily to the values of: respect; compassion; excellence; and collaboration. It is related to the strategic directions of: Transforming the care and service experience; Transforming the work experience; Partnering for improved health for Aboriginal people; and Building a sustainable, integrated system.

- **An adequate number of paid spiritual health practitioners is necessary as part of holistic care.**
  This principle supports the regional commitment to the value of excellence; and therefore to the values of respect and compassion; and to the strategic directions of: Transforming the care and service experience; Transforming the work experience; Partnering for improved health of Aboriginal people; and Building a sustainable, integrated system.

- **A variety of paid workforce and unpaid workforce sources can be involved in spiritual health service delivery.**
  This principle is primarily related to the regional value of stewardship; and has links to the strategic direction of: Building a sustainable, integrated system.

- **Spiritual health services put emphasis on region-wide networking and community capacity enhancing for rural communities through clinical pastoral education and direct service support;**
Diversity in spiritual health practitioners is important to meet Aboriginal and multi-faith needs;
This principle is primarily related to the values of: respect; compassion, and excellence; and to the strategic directions of: Transforming the care and service experience; Transforming the work experience; and Partnering for improved health of Aboriginal people.

Spiritual health practitioners are an integral part of the clinical care team;
This principle is related to the values of: respect, compassion; excellence; stewardship and collaboration and to the strategic directions of: Transforming the care and service experience; and Transforming the work experience.

Spiritual health services include access to diverse religious practices if the patient and family want them;
This principle is primarily related to the values of: respect and compassion and excellence; and to the strategic directions of: Transforming the care and service experience; and Partnering for improved health for Aboriginal people.

Ongoing professional education/certification for all practitioners and trained volunteers involved in spiritual health services must be encouraged;
This principle is primarily related to the values of: excellence and stewardship; and to the strategic directions of: Transforming the work experience; and Fostering research, learning, and innovation.

Screening tools and protocols are used to identify need for spiritual health practitioners;
This principle is primarily related to the values of: excellence; stewardship; and collaboration; and to the strategic directions of: Transforming the care and service experience; transforming the work experience; and Fostering research, learning, and innovation.

Clinical Pastoral Education is key at both the intern and residency levels;
This principle is primarily related to the values of: excellence and stewardship; and to the strategic directions of: Transforming the work experience; and Fostering research, learning, and innovation.

Innovative interdisciplinary research is crucial for quality services.
This principle is primarily related to the values of: excellence; stewardship; and collaboration; and to the strategic directions of: Transforming the care and service experience; Transforming the work experience; and Fostering research, learning, and innovation.
experience; Transforming the work experience; and Fostering research, learning, and innovation.

VI. Recommendations and Resources to Enact the Vision

This section presents seven recommendations for implementing a highly responsive and integrated spiritual health service. Responsive means not only the ability to respond to referrals from other members of the clinical team in a timely manner, but also to do so in a culturally appropriate way for Aboriginal people or multi-faith groups. Integrated means a fully regional spiritual health service, where there is a common understanding, approach, and sense of a regional team with urban and rural facilities supporting one another. Integrated also means a situation where spiritual health practitioners are visible, accepted and contributing members of the clinical care team.

- **That the name of the department be changed from “Spiritual Care” to “Spiritual Health Services”**

  This recommendation will emphasize that spirituality is part of being human and that one expression of our healthy spirituality is found in our common need for hope, awe, joy, love and belonging, which can be expressed in various ways, including our various religious traditions and ceremonies. Spiritual health services for the region allows for regional activities addressing not only the needs of individual patients, families and staff, but also the strategic growth of activity to support the spiritual health of the regional health care organizations and that contribute to the spiritual health of the communities of the region.

- **That a full time Director of Spiritual Health Services be hired to develop, manage and coordinate the Spiritual Health Services department for the Saskatoon Health Region**

  It is recommended that the Director be a CAPPE teaching supervisor, and have a joint reporting relationship to the Vice President of Community Services for the Health Region and the Chief Executive Officer of St. Paul’s Hospital, which is responsible for Spiritual Health Services as a managed care area for the Health Region. It is expected that the relationship between the Spiritual Health Services department at Saskatoon Health Region and Spiritual Care services at St. Paul’s Hospital will continue to be one of mutual respect and collaboration, honouring the unique relationship that St. Paul’s has with the Health Region. The Director is not expected to have any authority over staff resources that are funded separately through the St. Paul’s Foundation to serve St. Paul’s.

- **That an integrated model of spiritual health services be implemented in the Saskatoon Health Region based on the above principles and on the ratio of 1.2**
FTE spiritual health practitioners per 100 inpatients, that includes the allocation of additional resources as outlined in Table 1.

This best practice model focuses on: providing personnel drawn from the Aboriginal and multi-faith community to offer more culturally responsive spiritual health services; increasing the number of spiritual health practitioners to meet accepted current benchmarks; and recognizing the key role that clinical education and training play in the formation of spiritual health practitioners, and in the ongoing professional development for a variety of staff and volunteers involved in spiritual health services, especially in the rural areas.

**Increased resources:** The recommended additional resources include: 2 Aboriginal Cultural Helpers and one multi-cultural health broker; 7.25 FTE practitioners to augment the current regional staff; (2.5 FTE for rural hospitals, seen as .5 FTE in 5 different rural areas of the Health Region; 2.25 FTE for the urban hospitals; and 2.5 for long term care); 2 FTE CPE Clinical Educators; and 3 FTE administrative support.

**Rural service and educational support:** One of the Clinical Educators is to be devoted to rural support for creative spiritual health services educational programming. This person is envisioned to be both educator and ‘animator’ within the rural communities, working with the facilities, and with the five other .5 spiritual health practitioner colleagues placed throughout the region. The idea is to identify and enhance the capacity of the existing rural resources to offer spiritual health services, including clinical staff, community clergy and volunteer groups, through CPE-based and other experiential education, development and support activities.

Part of the resources for building the capacity of rural and urban facilities to support spiritual health is to have a .7 FTE Spiritual Health Services Volunteer Coordinator dedicated to the recruitment, screening and general orientation/support of rural and urban spiritual health services volunteers. This person would be placed in the department of Volunteer Workforce and Strategic Initiatives, with the volunteer coordinators for other health areas.

**Clinical Residency program:** The second Clinical Educator will develop a CPE residency program in the Health Region for up to 6 residents to foster specialization and advanced clinical education opportunities. Each resident will be paid a stipend of $25,000 for their year. The advanced clinical education includes their clinical service, through which they each provide about .5 FTE.

- That the St. Paul’s Foundation, with the Health Region and other partners, establish an Institute for Outcomes in Spiritual Health
  A crucial component in holding the values and advancing the vision of Spiritual Health Services in the Saskatoon Health Region, lead by St. Paul’s, is to have the St. Paul’s Foundation, with the region and other strategic partners, sponsor an “Institute for
Outcomes in Spiritual Health”. One of the biggest gaps in best practice in spiritual health is attention to research and performance measurement in spiritual health care. This is the opportunity for the partners to promote a leadership position to conduct professional research, and to define effectiveness of spiritual health services, with the participation and support of its boards, senior management and medical and nursing clinical leaders. There is opportunity to enhance the advanced education of CPE residents and other students and to conduct groundbreaking research on the implementation of the unique proposed model of building capacity in the region’s rural areas.

- That there be increased integration of spiritual health practitioners into the clinical care team through assigning spiritual care providers to clinical units, e.g., to the Palliative Care and Intensive Care areas: attending rounds and case conferences, providing consultation to clinical staff and offering direct service to patients, families and staff; and recording interventions on patient charts.

This recommendation speaks to implementing best practice that makes spiritual health services an integral part of care, especially to those in critical and end-of-life situations.

- That patient access to appropriate spiritual health services be supported through the implementation across the Health Region of a suitable short, standardized screening tool (e.g., FICA); and/or accepted spiritual care triggers/protocols to be used by clinical nursing staff at the time of admission to the clinical unit, for the possible referral of the patient to a spiritual health practitioner.

This recommendation supports the best practice of using protocols for screening for spiritual concerns or distress in patients and families. The success of course, depends upon the willingness of the other clinical staff, likely nurses, to reliably carry out the screening. This recommendation speaks to the quality of the working relationship and the integration of spiritual health practitioners into the clinical team, as mentioned above, and also supports the need for spiritual health services resources for increased education and training for nursing staff regarding spirituality, spiritual care triggers and spiritual health services.

- That a formal agreement be negotiated with each of the Roman Catholic, Anglican, United Church and Lutheran denominations in Saskatoon to better integrate the denominational chaplains into the Health Region spiritual health services team.

This recommendation recognizes the important role that the denominational chaplains have played in the provision of spiritual health services to patients and families in the past. It goes further by recognizing that there could be great benefit in making better use of the talent there, and negotiating to what extent each denomination would be willing to sponsor their staff in serving not only members of their own denomination, but also other patients referred through the spiritual health services department. Having formal agreements gives the denominational chaplains a higher profile within the region and gives all partners the opportunity to clarify expectations, e.g., open communication
with team members, access to patient information, confidentiality, the standard regarding no proselytizing, etc. It also is a mechanism for increasing the amount of well trained resources available to support spiritual health services.

### Table 1: Five to Ten Year Budget Proposal

Note: this proposal does not include the existing resources at St. Paul’s hospital. The calculation of the number of total FTE spiritual health practitioners is based on the benchmark of 1.2 FTE chaplains per 100 inpatients (VandeCreek et al. 2001)

<table>
<thead>
<tr>
<th>Role / Position</th>
<th>Description / Rationale</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of SHR Spiritual Health Services: 1 FTE</td>
<td>This person is typically a CAPPE teaching supervisor.</td>
<td>$90,000</td>
</tr>
<tr>
<td>CPE Clinical Educator: 1 FTE</td>
<td>devoted to rural support for creative spiritual health services educational programming</td>
<td>$75,000</td>
</tr>
<tr>
<td>Spiritual Health Services Volunteer Coordinator: .7FTE</td>
<td>to be located within the department of Volunteer Workforce and Strategic Initiatives to support the recruitment, screening, and general orientation of spiritual health services volunteers in rural and urban facilities</td>
<td>$40,000</td>
</tr>
<tr>
<td>Clinical Educator for CPE residency program: 1 FTE</td>
<td>(up to 6 residents; goal of 2 residents in specialty area of rural spiritual health)</td>
<td>$75,000 for educator $25,000 x 6 for residents (give back 3FTE of service) $75,000 $150,000</td>
</tr>
<tr>
<td>Aboriginal Cultural Helpers: 2 FTE</td>
<td></td>
<td>$55,000 x 2 = $110,000</td>
</tr>
<tr>
<td>Multi-cultural Health Broker: 1 FTE</td>
<td></td>
<td>$55,000</td>
</tr>
<tr>
<td>Spiritual Health Practitioners: 7.25 FTE</td>
<td></td>
<td>$55,000 x 7.25 = $398,750</td>
</tr>
<tr>
<td>Rationale:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 940 total region inpatient beds, including Parkridge, (but excluding St. Paul’s) @ 1.2 FTE per 100 beds is a total of 11.3 FTE;</td>
<td></td>
<td>$398,750</td>
</tr>
<tr>
<td>- minus existing 3.3 FTE current regional urban staff;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- minus .75 FTE in Humboldt; = a total of 7.25 new FTE,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 7.25 new FTE to be divided up as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 2.5 FTE for rural hospitals;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 2.25 FTE for urban acute care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 2.5 FTE for long term care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 FTE administrative support</td>
<td>(1 for rural activities; 1 for the Director and the CPE educators; 1 for urban practitioners)</td>
<td>$35,000 x 3 = $105,000</td>
</tr>
<tr>
<td>Materials / supplies</td>
<td></td>
<td>$10,000</td>
</tr>
<tr>
<td>Travel for rural meetings</td>
<td></td>
<td>$25,000</td>
</tr>
</tbody>
</table>
VII. Alignment with Saskatoon Health Region Values and Strategic Directions

This section outlines how following the recommended principles (p.37 above) and implementing the elements in the recommended five to ten year proposal absolutely aligns with and furthers the Saskatoon Health Region’s five values and five Strategic Directions, as outlined in the Strategic Plan, 2007-2010. (see Appendix E for a summary table showing the link between the principles and the values and strategic directions.) Each of the areas is discussed in turn.

A. Values:

A recent publication on measures of chaplain performance and productivity by Catholic Health Initiatives (2002) talks about the presence of spiritual health services as a visible indication that the organization “walks the talk”, and acts as a symbol, reminder and catalyst of the organization’s identity, mission and values, promoting patient, staff and community relations. Further thoughts of how enhanced spiritual health services would express the Health Region’s values include:

Respect:

Enacting the principles and recommendations would mean Spiritual Health Services’ increased focus on the beliefs, preferences and cultural traditions of patients and families, including Aboriginal Cultural Helpers, and a multicultural health broker, which would visibly foster the regional value of respect, i.e., recognizing that all people and their needs are important.

Compassion:

One of the main services offered by the region through those involved in Spiritual Health Services would be more of a listening presence, caring genuinely for others, to be there with and for patients and families, where compassion emerges from listening and understanding (Bub, 2006). It follows that implementing the recommendations outlined here would greatly enhance the region’s capacity to offer compassionate care.

Excellence:
Implementing the recommendations and resources to enact the vision for integrated and responsive Spiritual Health Services promotes excellence and quality by facilitating responses to the Accreditation Survey Report for the Saskatoon Health Region (2007). For example, having the recommended additional spiritual health practitioners would allow the assignment of spiritual health resources to units such as Intensive Care and Palliative Care. Better integration of spiritual health workers into the ICU clinical care team addresses the suggestion in the Accreditation Report for additional spiritual support in its end-of-life care as assessed by patient satisfaction (p.266).

Further, having spiritual health practitioners assigned to the palliative care team would address the Accreditation Report suggestion that the team be more prepared to pay close attention to emotional symptoms and provide psychosocial and spiritual support to both the patients and their family members (p.323).

Regarding rural support, the Accreditation Report also recommended that there be a comprehensive, standardized program of palliative care throughout the Health Region, and indicated that clients in rural areas may not receive the same level of care as urban (p.316). The palliative care strategic plan lists five priorities including the expansion of rural resources and education for health professionals. The Accreditation Report suggested that palliative care continue to provide education in-services, region-wide, on palliative issues that include ethics, general counseling, advance directives, support and grief counseling, sharing resources from a variety of health professionals. Palliative care team access to an assigned spiritual health practitioner, as recommended here, plus the five part-time spiritual health practitioners in rural areas, plus the Clinical Educator dedicated to community resource development and education, could go a long way to forming a collaborative group that would strongly support the implementation of a comprehensive standardized palliative care program across the Health Region.

**Stewardship**

A recent discussion of best practices in pastoral care makes the point that, Spiritual Health Services can contribute to the responsible use of human resources in that having spiritual health practitioners available to Health Region staff in times of professional and personal stress may reduce days absent and turn over (Handzo, 2006). Further, when the source of pain and suffering is spiritual rather than physical, the availability of spiritual health practitioners to facilitate patients finding more peace and comfort can save the system the inappropriate use of medication. The implementation of the recommended clinical pastoral education residency program shows the responsible use of human resources because it is a cost-effective way of providing quality spiritual health services.

**Collaboration:**
The implementation of the recommendations regarding Spiritual Health Services is entirely consistent with the value of cultivating and honouring relationships, since spiritual health services are by definition relationally based, both with patients and families, other professionals involved in care, and the faith communities with which they work. Further, the recommendations listed here are all meant to support collaboration with the Health Region’s rural communities and its academic partners.

The eight categories of services identified by the review relate to the regional core values and the St. Paul’s Hospital core values. Spiritual health service in its entirety is an essential component of holistic care. In addition the spiritual health services of: compassionate care and respect; companioning people; helping people find meaning and comfort; aiding those in spiritual distress to re-balance and cope; and liaising with and facilitating diverse faith community involvement if desired; are strong indicators of the regional values of respect and compassion. Similarly, the spiritual health services of: being a support to staff; training and educating the rest of the team about spiritual health; and serving in the clinical team; all definitely support and practice the regional values of stewardship, collaboration and excellence.

B. Strategic Directions

The recommendations and underlying principles can also be seen to further each of the five Strategic Directions:

**Transforming the Care and Service Experience**

Implementing the recommendations related to expanding Spiritual Health Services shows a commitment to this Strategic Direction since the provision of Spiritual Health Services would address factors related to respect and compassion: being more patient-centered by showing respect for patient values, preferences and needs; ensuring patient and family comfort and providing emotional support, and providing more coordinated and integrated care, all of which are part of this Direction.

The literature indicates a connection between spiritual care and perceived quality of care. A recent discussion of medicine, spirituality and patient care stressed that spirituality is an important part of medical care because spirituality is part of what it means to be human (Fosarelli, 2009). A study of end-of-life care in long term care showed that those who had received spiritual care were perceived by family members to have had better care (Daaleman, Williams, Hamilton and Zimmerman, 2008); while an examination of the spiritual care of families in the intensive care unit revealed a strong association between satisfaction with spiritual care and satisfaction with the total ICU experience (Wall, Engleberg, Gries, Glavan, and Curtis, 2007). Enhanced Spiritual Health Services would support the region in its pursuit of exceptional service.

**Transforming the Work Experience**
Transforming the work experience speaks to the desire for a more healthy work environment, including a more culturally sensitive and caring community of colleagues who work closely together. Implementing the recommendations for Spiritual Health Services proposed here will further this Strategic Direction by facilitating the inclusion of a supportive spiritual health perspective on collaborative healthcare teams. The work experience would also be transformed through contributing to Aboriginal people fully participating in the spiritual health services workforce.

**Partnering for Improved Health for Aboriginal People**

Implementing the recommendations for Spiritual Health Services as proposed, especially hiring Aboriginal Cultural Helpers, demonstrates a commitment to more responsive services for Aboriginal groups, thereby fulfilling the Strategic Direction to improve the patient satisfaction and health of First Nations and Metis people and respect cultural diversity in service delivery, consistent with the provincial direction for northern and Aboriginal health.

**Building a Sustainable, Integrated System**

This Strategic Direction speaks to the values of stewardship and excellence, and describes efforts needed to streamline and integrate acute care, implement a population health approach and new health information systems. It indicates that the population patterns and urban-rural mix within the region is shifting and discusses some of the rural community concerns over access to health care. Implementation of the recommendations for Spiritual Health Services for five part-time spiritual health practitioners in different rural areas and a full time Clinical Educator devoted to education and support of the rural resources would be an expression of the Health Region being more aware of and addressing unique rural needs that is called for in this Direction, and provide the opportunity for Spiritual Health Services to be integrated into the goal for a communities’ rural health strategy.

**Fostering Research, Learning and Innovation**

This Strategic Direction speaks to the core values of excellence and collaboration and is consistent with provincial goals to focus on education and training and to strengthen health research capacity in Saskatchewan. Implementation of the Institute for Outcomes in Spiritual Health is certainly action toward more visible research and a research culture in the organization to support quality and evidence-based practice that this Strategic Direction advocates.

Further, the implementation of the recommendations regarding the two Clinical Educators, one for ongoing continuing education for rural staff and volunteers, and one to develop and run a clinical residency program for advanced CPE students, fits with the call for continuing education and training to bolster the Health Region’s learning environment that is part of this Strategic Direction.
VIII. Transition Plan and Communication Strategy

A. Transition Plan

This section of the review considers which of the elements of the recommendations in the review should be implemented first, within the first 12-18 months.

- **Director of Spiritual Health Services**

Having the Director on board as soon as possible is important, since this person will be the one to champion and put in place the elements of the vision for an integrated and responsive spiritual health service for the region. The Director will need to establish a wide variety of working relationships, and see that the inventory of resources in facilities throughout the region that was begun by this review is expanded, and that a similar inventory of spiritual care resources be conducted in the remaining 26 long term care centres. The Director will work with the Aboriginal community to discuss the concept of Aboriginal Cultural Helper and establish a process for putting the two staff in place.

- **Clinical Educator for the rural communities**

This is another critical personnel choice for the Director. This is the person who can continue the visits and conversations with rural administrators and community resources begun in this review, to establish relationships and build networks so that the needs and strengths are better understood, and consult with the communities concerning the half-time spiritual health practitioners that are meant to be located throughout the region in order to best meet the local needs. The Clinical Educator can also start immediately to assess the training needs of the clinical staff and volunteers.

- **Agreement with the denominational chaplains**

The Director can begin right away to examine the components of a formal agreement with the denominations for the services of their denominational chaplains to bring them closer into the Spiritual Health Services team, preferably as full members acting also as non-denominational chaplains.

- **Hire Aboriginal Cultural Helpers**
It is important that proper process be involved for involving the elders and members of the community in the hiring of the Aboriginal Helpers. The process may take some time but should be begun immediately as an indication of the Health Region’s commitment.

- **Assign a full time chaplain to palliative care and intensive ICU**

To support meeting the 2007 Accreditation Report suggestions and recommendations, the Director should assign spiritual health practitioners to the units that are already welcoming, such as palliative care and intensive care, and others that the existing chaplains might name.

- **Begin development of Institute for Outcomes in Spiritual Health**

As a major symbol of the Health Region and St. Paul’s commitment to the area of spiritual health, work should begin at the board and senior management level on the development of the Institute for Outcomes in Spiritual Health. It is recommended that an implementation committee be struck, including the Director of Spiritual Health Services. This committee would benefit from establishing contact with and preferably going to visit other centres such as the George Washington Institute for Spirituality and Health (www.gwish.org).

### B. Communication Plan

This section provides a brief look at the desired outcomes, target audiences, key messages and tools involved in communication about the implementation of the new Spiritual Health Services vision and resources. It assumes that the Boards of St. Paul’s and the Saskatoon Health Region have been involved in the decision to implement but might still benefit from additional forms of communication.

- **Desired outcomes**

The communication plan is expected to:
- inform people of the principles and vision behind the new department, and how the decision to implement the new vision furthers the values and strategic directions in the Strategic Plan 2007-2010;
- to provide them with information on the actual resources that are being added, and how that relates to what and who had gone before (history);
- to introduce them to the people who have been hired, their backgrounds and qualifications, what they will be doing and how to reach them for further information.

- **Target Audiences**
The target audiences include:
- the general public;
- the Boards of St. Paul’s and the Health Region;
- the Minister and provincial health officials;
- senior management and staff within the Health Region and St. Paul’s
- church denomination and multi-faith group head organizations
- the Universities and theology schools
- the acute care and long term care facility management and staff

• Key Messages

- that the Saskatoon Health Region and St. Paul’s Hospital value spiritual health services as part of an integrated approach to care
- the implementation of the Spiritual Health Services vision furthers the Health Region’s values and Strategic Directions
- the Saskatoon Health Region and St. Paul’s Hospital are jointly committed to increasing patient, family and staff access to quality spiritual health services by:
  ➢ increasing the number of spiritual health service practitioners available, in both the rural and urban areas,
  ➢ assigning resources to palliative care and intensive care;
  ➢ hiring Aboriginal Cultural Helpers
  ➢ developing an Institute for Outcomes in Spiritual Health

• Tools

A variety of tools will be used that will be tailored to the target audiences, including: city and rural newspapers, and television; newsletters produced by churches and faith groups; internal newsletters and bulletins produced by the provincial government departments for the public and its staff; briefing notes and backgrounder information for government communication departments; PowerPoint presentations at existing meetings, e.g., Board meetings; regional staff meetings; the rural administrators’ monthly meeting; the rural ministerial group meetings, etc.

IX. Bibliography

Association of Professional Chaplains; American Association of Pastoral Counselors; Association for Clinical Pastoral Education; National Association of Catholic Chaplains; National Association of Jewish Chaplains; Canadian Association for Pastoral Practice and Education. (2004). *Common Standards for Professional Chaplaincy*. [http://www.professionalchaplains.org](http://www.professionalchaplains.org).


x. Appendices
APPENDIX A: interview Questions
(not all questions were asked of all interviewees. Senior Managers and Board members were asked for their vision of spiritual care)

1. What do you understand spiritual health to be? (What dimensions of our existence as human beings does it include?)

2. What kinds of services need to be in place to support people in hospital/long term care in their quest for spiritual health?

3. How many of what kinds (i.e., background and qualifications) of personnel do you have in this region to provide or resource the various services you just described? Is there anything you would change?

4. What proportion of your population in acute care (patients/families/staff) identify themselves as aligned with a particular religion or denomination?

5. How do you meet the spiritual care needs of those patients/families/staff who do not identify themselves with any particular religion or denomination, who have a more pluralistic perspective, or who are secular or atheistic?

6. What role, if any, do denominational chaplains play in providing spiritual care services within acute care facilities in your region?

7. What is the nature of the arrangement between the hospital and the denomination(s) for their chaplains’ services? (e.g., how formal/informal; method of remuneration, etc.) What works well with this arrangement and what would you change?

8. How do you address the spiritual care needs of acute care/long term care patients/families and staff from multi-faith backgrounds (e.g., Jewish; Muslim; Hindu; Buddhist)? What have been the main issues in implementing this? What needs to be in place for success?

9. How do you address the spiritual care needs of First Nations or Indigenous patients/families/staff? What have been the main issues in implementing this? What needs to be in place for success?

10. In terms of an organizational chart, where is Spiritual Care services situated in your regional organization? To whom does it report?

11. What process is involved in recruiting/hiring these personnel? (e.g., interdisciplinary committee)
12. What process is involved in providing them with professional support and supervision? (e.g., role of, connection with organizations such as CAPPE)

13. Are there standards or guidelines available for deciding how many staff is needed?

14. On a scale from 1 to 10, with 10 being high, how well integrated into the overall team providing patient care do you see your spiritual care personnel?

Can you tell me a story or give an example that illustrates why you rated as you did? (e.g., At what point in care, or under what circumstances, are spiritual care services typically involved?)

What are the key factors behind successful integration?

15. If spiritual care services were to be organized and delivered according to ‘best practices’, what would that look like for you?

16. Is there anything else you would like me to know?

APPENDIX B: Spiritual Health Services Delivery in Six Sites and in Saskatoon Health Region
<table>
<thead>
<tr>
<th>Dimensions of Delivery</th>
<th>Site 1</th>
<th>Site 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of Department</td>
<td>Spiritual Health Services (SHS) in one facility; one of founding principles is inclusivity and pluralism; Motto of hospital: “May hope flourish here” which is seen as a multi-faith, multi-cultural unifying theme</td>
<td>Spiritual and Religious Care (SRC) for a health region</td>
</tr>
<tr>
<td>2. # IP beds covered</td>
<td>720 pts any one day in one large hospital</td>
<td>10 urban hospitals plus rural facilities</td>
</tr>
<tr>
<td>3. Reporting Relationship in Org</td>
<td>Director of Spiritual Health Services reports to a Vice President</td>
<td>Manager of Spiritual and Religious Care reports to the Director of Rehabilitation Services (includes Social Work; Occupational Therapy; Physical Therapy; Psychology) who reports to a Vice President</td>
</tr>
<tr>
<td>4. Process for recruitment</td>
<td>Director and a couple of SHS staff will review applications, often with people from the unit to be served, e.g., psychiatric health; important for buy-in</td>
<td>Leader reviews applications for regional staff; denominations select own denominational chaplains; Catholic church has the majority of chaplains</td>
</tr>
<tr>
<td>5. Paid Staffing</td>
<td>Staff called “spiritual health specialists”; changed from “chaplain” to be more inclusive; &amp; from “spiritual care” because ‘care’ seemed too one-way; Director plus paid staff: 7.0 FTE; actually translates into 17 people; includes 4 part-time on-call; 3 at 4 days a week. 2 of the staff are Aboriginal. Coverage is 8:30-10:00pm during the week; with on-call after hours and weekends</td>
<td>Staff called “chaplain” Manager plus 2 kinds of regional paid staff; and denominational chaplains paid by their denominations: 1.5 SRC paid FTE to cover 10 urban hospitals; 3 full-time; 2 at .75FTE 3.0 chaplains assigned to Mental Health, paid and hired by the Mental Health program, a separate part of the regional system; not part of SRC 15 denominational chaplains who are full members of the SRC, paid for by the Roman Catholic, Anglican, United Church, Presbyterian and Baptist.</td>
</tr>
<tr>
<td>6. Relationship to denominational chaplains</td>
<td>Have had some difficulties in the past; need people who are prepared to follow professional guidelines of the hospital and SHS; no formal agreement with denominations</td>
<td>SRC has separate contracts with the different denominations; they have varying number of hours of work, but all are functioning as SRC non-denominational chaplains with approval of their denomination.</td>
</tr>
<tr>
<td>7. Role of community clergy</td>
<td>Community clergy are differentiated from SHS staff in that: -they are visitors in the hospital coming to serve specific members of their own congregation only; -have access to a list kept secure in the SHS department of persons from their own faith group who have signed at admission requesting a visit; -can look at their own list in the SHS department, can’t take it away or copy, to comply with health information legislation.</td>
<td>Now undertaking steps to connect with and orient a large number of “pastoral visitors”; to stress what expectations are, and get to know them; -they are visitors in the hospital with name tags coming to serve specific members of their own congregation only; -they can look at the list of persons identifying their own denomination</td>
</tr>
<tr>
<td>8. Background &amp; qualifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Paid staff:</strong> Emphasize diversity; have rabbis, Buddhists, Aboriginal staff and elders; Christian; offer complementary therapies such as Reiki and Therapeutic Touch; Changed job description to reflect Masters Degree in spirituality; counseling; therapy; philosophy; not just theology; must be able to teach *** (see appendix) - Director and 2 staff studied at Hope Foundation in Edmonton</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Paid staff:</strong> Christian background representing a variety of denominations, but all are functioning as non-denominational chaplains available to anyone; - job description reflects requirement for M.Div.; and Canadian Association of Pastoral Practice and Education (CAPPE) member in good standing - staff chaplains are (CAPPE) specialists (i.e., Masters Degree; 4 units of CPE; ethics course; 2000 hours of supervised clinical practice, and certification by CAPPE peer review); - encouraging all denominational chaplains to become CAPPE certified specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trained Lay Volunteers:</strong> two types of volunteers: a) religious volunteers who bring communion to those who have asked; b) spiritual health volunteers who work with anyone, visit and explain the services available; - education important to help volunteers know when they are out of their depth and need to call a paid staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trained Lay Volunteers:</strong> two types of volunteers: - religious volunteers who bring communion to those who have asked; - 4-5 trained spiritual care volunteers who work with anyone, visit and explain the services available; - would like to expand the number of trained volunteers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Students:</strong> have 8 students per year in own education program called “Spiritual Diversity, Hope and Healing” modeled on CAPPE; - open to nurses; physicians, therapists, open to diversity of ages and ethnic groups; - year long program based on 3 hours of class and 4 hours of practicum per week; adds service to SHS - Each student has a mentor from SHS staff; course being offering this year for the fifth year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Students:</strong> have 8 – 9 CPE students during the summer and 4 over the winter; so region has benefit of added SRC service by being a CPE practicum setting; - region has 3 CPE teaching supervisors since each student is supervised; - usually M.Div. students, but also have had M.Ed., M.A. gerontology and Masters in Counseling Therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Identification of needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>- On daily basis, 33 out of 720 (4.6%) identify as part of a religious denomination or faith group on a question asked at admission; - 50-60% of patients are from the Aboriginal community - The admission question asked has changed at initiation of SHS. - SHS receives referrals from the nurses and doctors on the units; and from patients and families - SHS will make “cold calls” visiting people on the units to which they are assigned</td>
</tr>
<tr>
<td>-20-30 year-olds typically do not identify a denomination on admission; 40-50% of patients are Roman Catholic - have discovered through review of patient satisfaction survey that patients needs are not being met for spiritual care, or for culture and language or interpretation because the question not routinely being asked whether their cultural, spiritual, or religious needs are an important part of their care while they are in hospital</td>
</tr>
<tr>
<td>- SRC receives referrals from the nurses and doctors on the units; are working to have requests come earlier than just end of life; - want nursing staff to ask question about spiritual care when they are doing an initial intake assessment on the unit to be there right from the beginning; - SRC will make “cold calls” visiting people on the units to which they are assigned, but feel this is not the way to go of the future.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dimensions of Site 1</th>
<th>Site 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>To help people understand what SH is:</td>
<td>-SHS staff are drawn from multi-faith groups, including Aboriginal, although they serve all faiths and no faith;</td>
</tr>
<tr>
<td>-brochures are widely distributed throughout the hospital units, with an insert explaining complementary therapies;</td>
<td>-Offer the “Spirituality, Diversity, Hope and Healing” education program, which is also a university-recognized course;</td>
</tr>
<tr>
<td>-there is a page for SHS in the hospital patient services booklet;</td>
<td>-Have a large sanctuary and a smaller room; neither space has any permanent symbols of any particular faith group, which allows various groups to project whatever they want onto the space; the sanctuary has ventilation for smudging ceremony;</td>
</tr>
<tr>
<td>-posters in the waiting rooms</td>
<td>-Each faith group has space in a cupboard in the sanctuary for the sacred symbols and objects or materials they need (e.g., prayer mats for Buddhist and Muslim people; sage, sweetgrass for Aboriginal people, bibles for Christians, etc.)</td>
</tr>
<tr>
<td>-SHS publishes six booklets on various themes to help patients and families cope: e.g., “While You are Waiting”; “Children, and Grief and Loss”</td>
<td>-the SHS staff keep a list of community multi-faith group leaders; if a patient requests a specific faith group leader not available on staff, the SHS staff will facilitate that; including Aboriginal elders.</td>
</tr>
<tr>
<td>To help people understand what SRC offers:</td>
<td>-work closely with regional “Diversity Coordinator” (a Muslim imam) hired last year to bring diversity awareness and cultural competency to all health services; SRC represented on Diversity Committee;</td>
</tr>
<tr>
<td>-now putting together a brochure for staff about the SRC services for staff and for patients and families;</td>
<td>-will be refashioning CPE unit to be offered in the spring of 2009 to start from the beginning with a diversity lens</td>
</tr>
<tr>
<td>-believe SRC is under-utilized because staff do not have a solid sense of what they can offer to patients/families and for staff</td>
<td>-use community connections to multi-faith leaders, including Buddhist, Muslim, Hindu, also connections as needed with Aboriginal elders when patients ask</td>
</tr>
<tr>
<td>12. Support for staff; ongoing education; supervision; Role of Clinical Pastoral Education (CPE) training</td>
<td></td>
</tr>
<tr>
<td>Education/on-going support seen as key and a priority:</td>
<td></td>
</tr>
<tr>
<td>-2.5 hrs per month devoted to in-service and team-building for SHS staff, e.g. role play difficult clinical situations;</td>
<td>-E.g., since CAPPE has required an ethics course for specialist certification, the hospital has partnered with a local theology professor to offer her CAPPE approved ethics course designed for professional chaplains; to 11 SRC chaplains; doing the course for credit at university, and able to access some of $600 tuition cost from SRC professional development fund; course is open to anyone, and is situated at the hospital; -SRC agreed to once week 2 hour session on ethics, finished in April 09</td>
</tr>
<tr>
<td>-2 one day long retreats per year;</td>
<td>-CPE seen as very important source of training, and is being revised to reflect diversity lens;</td>
</tr>
<tr>
<td>-CPE seen as one important source of training, although not enough suited to the SHS commitment to diversity in faith groups and disciplines</td>
<td>-SRC is encouraging all denominational chaplains to achieve CAPPE specialist certification</td>
</tr>
</tbody>
</table>

Dimensions of Site 1

Dimensions of Site 2
<table>
<thead>
<tr>
<th>Dimensions of Site</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.Method for professional accountability, quality assurance</td>
<td>SHS has developed a code of ethics for the department; Director does yearly performance appraisal and meets with staff once per month; have 2 committees in the region: a spiritual care coordinating committee where those who are practitioners in the hospitals get together about operational, day-to-day issues; and a regional spiritual care advisory committee.</td>
<td>SRC is guided by professional ethics as approved by CAPPE; SRC chaplains are required to be a CAPPE member in good standing; SRC is part of the internal group attending to the results of the patient satisfaction survey and working with quality assurance personnel in the region.</td>
</tr>
<tr>
<td>14.Degree of integration with clinical team</td>
<td>On scale from 1-10 with 10 high, rated at 9 or 10, very integrated; strong support from both hospital executive and clinical leaders; staff are assigned to units and become one of the team; visible to clinical team all the time; have own space on the unit; invited to social events on unit; invited to participate in the current internal review of Emergency Services.</td>
<td>On scale from 1-10 with 10 high: staff chaplains rated at 8, very integrated; but rating variable for denominational chaplains, with an average of 5 depending on culture on the unit; -staff are assigned to units collaboratively with the chaplains, depending on their gifts and interests (e.g., ICU cardiac; oncology, palliative) -visible to clinical team</td>
</tr>
<tr>
<td>15.Participation in charting</td>
<td>staff participate in rounds, staff meetings, discharge planning and document as a team member</td>
<td>staff participate to varying degrees in rounds, staff meetings, discharge planning and documenting as a team member, depending on the unit</td>
</tr>
<tr>
<td>16.Role of staff in education for other members of team</td>
<td>SHS does twice as much education as other jurisdictions; SHS department offers ongoing continuing education for whole hospital, bring in speakers, do skill building workshops, where 300-400 people attend, e.g., end of life care from different spiritual perspectives; offer day long Hope Workshops for physicians, nurses and allied health professionals four times a year, with 70-80 each time; staff are involved in teaching the “Spirituality, Diversity, Hope and Healing” program and in supervising students.</td>
<td>SRC trying to become more integrated in whole health team by: participating in the interdisciplinary orientation for all new staff; and in educational events such as the 3 day palliative care workshop; SRC staff are often called upon to make presentations to various hospital groups concerning the services offered the SRC leader is a CPE teaching supervisor involved in teaching and supervising students</td>
</tr>
<tr>
<td>17.Relationship to surrounding rural areas</td>
<td>gap at regional level since no permanent position for a SHS regional Director for consistency, coordination and best practice education at all sites no relationship between this hospital and the rural areas</td>
<td>gap at regional level; rural communities rely on community clergy, who will form a committee around hospitals and long term care centres to make sure religious needs are met; rural areas do not have access to same resources as urban facilities</td>
</tr>
<tr>
<td>Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>1. Name of Department</strong></td>
<td>Spiritual Care Services (SC) for a health region</td>
<td>Spiritual Care in Supportive Care Services department in a large tertiary care centre</td>
</tr>
<tr>
<td><strong>2. # IP beds covered</strong></td>
<td>600-650 pts in 2 acute care teaching hospitals; plus 1 long term care and rehabilitation hospital; plus rural facilities</td>
<td>678 beds</td>
</tr>
<tr>
<td><strong>3. Reporting Relationship in Organization</strong></td>
<td>Director reports to an Executive Director, who oversees a number of areas, and who reports to a Vice President</td>
<td>Coordinator of Spiritual Care reports to Manager of Supportive Care Services (Supportive Care includes Clinical Ethical services; Spiritual Care Services and Aboriginal Cultural Helpers; Multi-cultural and language support services; Volunteer Services; Psychology and Pastoral Counselling), who reports to a VP</td>
</tr>
<tr>
<td><strong>4. Process for recruitment</strong></td>
<td>- Leader reviews applications for regional staff; denominations select own denominational chaplains; would like to see the region more involved in choosing them.</td>
<td>Coordinator and Manager will review resident and fellow applications, often with people from the units</td>
</tr>
<tr>
<td><strong>5. Paid Staffing</strong></td>
<td>Staff called “chaplain” Manager .5 FTE paid by the region Artist-in-residence 1 FTE paid by region, 50% time for patient art therapy 1.3 FTE Palliative care chaplains, contributed to by federal Department of Veterans Affairs (do not report to SC manager, but to Dir of palliative care) .6 FTE for other areas of chaplaincy contributed to by federal Department of Veterans Affairs 5.0 FTE denominational chaplains paid for by the Roman Catholic, Lutheran and United Church denominations</td>
<td>- no regional paid FTE non-denominational staff chaplains - have put emphasis on Aboriginal Cultural Helpers: 4FTE; with one FTE devoted to education through the Aboriginal Helper Training Program, that CAPPE has accredited - have 4 residents and 2 fellows (post residency) who are paid roughly $2500 per month and who contribute 3FTE of chaplaincy work - coverage is 24/7</td>
</tr>
<tr>
<td><strong>6. Relationship to denominational chaplains</strong></td>
<td>The SC department has separate “Affiliation Agreements” with each of the denominations for the services of the denominational chaplains. The chaplains do not function as non-denominational staff of the SC department. They focus on addressing the needs of people in acute care who belong to the denomination and are from out of town, and sometimes long term care. - They do have access to the patient records</td>
<td>Have one Roman Catholic chaplain 4 days a week paid for by the denomination, who works with Catholic patients, self-identified at admission, or referred by the clinical team. This arrangement has been in place for a long time, but has not been formalized through an Agreement or contract.</td>
</tr>
<tr>
<td><strong>7. Role of community clergy</strong></td>
<td>Community clergy are called upon to address the needs of people from their individual congregations do not have access to patient records, just the list of people who have identified themselves as belonging to a particular faith community.</td>
<td>- community clergy are visitors in the hospital coming to serve specific members of their own congregation only; - have access to a list of persons from their own faith group who have self-identified at admission - the hospital gives them identification tags and parking</td>
</tr>
</tbody>
</table>

### Dimensions of Site 3

### Site 4
### 8. Background & Qualifications

**Paid staff:** Christian background representing a variety of denominations. 
- Job description for paid regional staff (Director, her Manager and palliative care chaplains) reflects requirement for Masters level preparation and CAPPE specialists; 
- Denominational chaplains need some theological education, faith formation, and a minimum of 2 units of CPE.

**Paid staff:** SC coordinator has a minimum of CAPPE specialist and Manager of Supportive Care Services is a CAPPE teaching supervisor. This site believes strongly that spiritual care service providers should be CAPPE specialists, with lots of diversity within that, i.e., Buddhist and other faiths can do CAPPE training, although its roots are Judeo-Christian. Expect chaplains to be grounded in their own faith tradition, but able to transcend that within their care of the other.

**Aboriginal Cultural Helpers:** are people well respected in their communities for their wisdom and experience; are supported and approved by their elders; have been with the Spiritual Care department for a long time.

**Volunteers:**
- 1 volunteer M.Div. chaplain .2FTE

**Trained Volunteers:** This setting does not have trained lay volunteers in spiritual care because of the highly acute and complex nature of the problems presented by the patients and families, and the ability needed to support staff in the crises they face.

**Students:** the Director runs a CPE program, and has the benefit of the added service of students to meet referrals. 
- Would like to see CPE expand to include a level of education for First Nations people

**Students:** have 2 psychology interns; 4 CAPPE residents and 2 CAPPE fellows per year, as well as the opportunity for an Aboriginal Cultural Helper resident to study with an Aboriginal mentor for a year in the site’s own training program for Aboriginal Cultural Helpers, which has been accredited by CAPPE.

### 9. Identification of Needs

People are asked to identify their denomination at admission, and when they are on the hospital unit, a nurse taking their history will also ask questions about their religion.
- SC receives referrals from the nurses on the units;
- People who enter the hospital through emergency are not asked
- People who can attend a pre-admission clinic will be asked as part of a number of assessment questions, although the depth of identification depends on nurses’ comfort level with own spirituality and spiritual care issues.

- Currently gathering information from the hospital census database to describe the population characteristics more clearly.
- A good proportion of patients are from the Aboriginal community, particularly because the site has a formal Aboriginal Health Program.
- Use of the formal list at admission is one way for patients to indicate what they need at admission. People are asked whether they would like to identify what faith group they are part of, and the computerized form for the admitting clerk has a drop-down list that includes “unspecified” and “unknown”.
- The chaplains rely on the clinical staff on the units to identify spiritual health needs and refer to SC department.
<table>
<thead>
<tr>
<th>Delivery (cont’d)</th>
<th>10. Communication of services available</th>
<th>To help people understand what SC is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly through word-of-mouth</td>
<td>- brochures are distributed throughout the hospital units</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Method for serving multi-faith and Aboriginal</th>
<th>- multi-faith community small, less than 5% of the population</th>
</tr>
</thead>
<tbody>
<tr>
<td>- a reform Judaism rabbi comes from out-of-town every month, with other lay people identified as resources;</td>
<td></td>
</tr>
<tr>
<td>- similarly, would rely on lay people from Muslim community to come and support people in hospital</td>
<td></td>
</tr>
<tr>
<td>- fairly large Aboriginal population in urban centre. If people have an Aboriginal background, even though not explicitly connected to Aboriginal spirituality, they are followed as hospital patients through a separate department of Native Health Services, which offers spirituality services, social services and counseling, paid for by the region.</td>
<td></td>
</tr>
<tr>
<td>- will often work with Native Health Services when patient and family also have Christian roots and ask</td>
<td></td>
</tr>
<tr>
<td>- the acute care centres have ‘Native Healing Centres’ space as part of the hospital, constructed to facilitate healing ceremonies</td>
<td></td>
</tr>
<tr>
<td>- The site is home to the regional Aboriginal Health Program. The SC department have put emphasis on Aboriginal Cultural Helpers: 4FTE; with one FTE devoted to education through the Aboriginal Cultural Helper Training Program, that CAPPE has accredited where an Aboriginal Cultural Helper resident works with and learns from a mentor for a year.</td>
<td></td>
</tr>
<tr>
<td>- the site facilitates Aboriginal people in engaging in their own healing ways and traditions while in the hospital.</td>
<td></td>
</tr>
<tr>
<td>- the SC service providers work closely with their colleagues in Multi-cultural services to meet the needs of multi-faith community, and have made connections with faith community leaders in the urban area that they can call and draw upon.</td>
<td></td>
</tr>
<tr>
<td>- the sanctuary is set up to be a multi-faith sacred space</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. Support for staff; ongoing education; supervision; Role of Clinical Pastoral Education (CPE) training</th>
<th>Specialist designation seen as important for regional staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPE training offered to students</td>
<td>CPE training is seen as the crucial source of ongoing support and service.</td>
</tr>
<tr>
<td>- this site has built strong Supportive Care Services with the aid of its residency program, including a Spiritual Care department residency for an Aboriginal Cultural Helper and another residency in the neighbouring Clinical Ethics department.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dimensions of Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimensions of</td>
<td>Site 5</td>
</tr>
<tr>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Delivery (cont’d)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>13. Method for professional accountability, quality assurance</strong></td>
<td>- SC is guided by professional ethics as approved by CAPPE; - SC regional chaplains are required to be a CAPPE member in good standing; - SC is looking to the provincial association of chaplains to focus on professional standards and accountability; concerned that chaplains have proper training</td>
</tr>
<tr>
<td><strong>14. Degree of integration with clinical team</strong></td>
<td>On scale from 1-10 with 10 high: rated at 5, - not integrated because the staff are too few to be assigned to specific units; - the staff do get referrals; especially those who have a connection with patients from palliative care and women’s health programs. Chaplains assigned to palliative care patients go with the patients wherever they are, in community or facility.</td>
</tr>
<tr>
<td><strong>15. Participation in charting</strong></td>
<td>- staff chaplains have access to charts; as do denominational chaplains; - because chaplains are too few to be assigned to units, they do not have the opportunity to participate to any great degree.</td>
</tr>
<tr>
<td><strong>16. Role of staff in education for other members of team</strong></td>
<td>- SC will respond to staff development requests, but are spread very thin and do not have many resources to do so.</td>
</tr>
<tr>
<td><strong>17. Relationship to surrounding rural areas</strong></td>
<td>- gap at regional level; rural communities rely on community clergy; - rural areas do not have access to same resources as urban facilities</td>
</tr>
<tr>
<td>Delivery</td>
<td>Site 5</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. Name of Department</td>
<td>Spiritual Care and Cultural Services for a large tertiary care centre</td>
</tr>
<tr>
<td>2. # IP beds covered</td>
<td>700+ beds</td>
</tr>
<tr>
<td>3. Reporting Relationship in Organization</td>
<td>Director of Spiritual Care and Cultural Services reports to a Senior Operating Officer who reports to the Chief Operating Officer at the site.</td>
</tr>
<tr>
<td>4. Process for recruitment</td>
<td>- Director and chaplain staff review applications; along with the patient care manager of the unit in question; helpful in embedding the new person into the care area</td>
</tr>
<tr>
<td>5. Paid Staffing</td>
<td>Staff called “chaplain”</td>
</tr>
<tr>
<td></td>
<td>- have 8FTE staff chaplains; would use 2 more FTE easily</td>
</tr>
<tr>
<td></td>
<td>- have another .4FTE for after hours/weekend coverage; regular hours Monday-Friday 8:00am -4:00pm, but available 24/7</td>
</tr>
<tr>
<td></td>
<td>- have up to 6 CPE students; including 4 stipended residents, 3 paid by the hospital; one by the Catholic diocese;</td>
</tr>
<tr>
<td></td>
<td>- there are 2 FTE Aboriginal Cultural Helpers who report to the Director responsible for Aboriginal Health at the site complex.</td>
</tr>
<tr>
<td>6. Relationship to denominational chaplains</td>
<td>(No information collected)</td>
</tr>
<tr>
<td>7. Role of community clergy</td>
<td>community clergy are visitors in the hospital coming to serve specific members of their own congregation only; have access to a list of persons from their own faith group who have self-identified at admission</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimensions of</td>
<td>Site 5</td>
</tr>
</tbody>
</table>
| 8. Background & qualifications | Paid staff: largely, but not exclusively, Christian background, but all are functioning as non-denominational chaplains available to anyone.  
- Aboriginal Cultural Helpers can be selected with help of the Aboriginal Cultural Helper training program; must be accepted by Aboriginal community; looking for process of formation with both deep cultural awareness and knowledge of Western culture.  
- Staff chaplains are (CAPPE) specialists (i.e., Masters Degree; 4 units of CPE; ethics course; 2000 hours of supervised clinical practice, and certification by CAPPE peer review); sees importance of specialist certification for credibility, accountability and externally validated, consistent level of competence needed to address the depth and seriousness of the issues encountered by this site's patients.  
Paid staff: Christian background representing two major denominations.  
-Job description for paid chaplain staff reflects requirement for Masters level preparation; two years experience; including 4 units of CPE; Board certification in the Association of Professional Chaplains or related organization;  
-Staff chaplains have to have skills as educators as well as clinicians. |  
  
Trained Volunteers: This setting does not have trained lay volunteers in spiritual care because of the highly acute and complex nature of the problems presented by the patients and families, and the ability needed to support staff in the crises they face.  
  
Trained Volunteers: This setting does not have trained lay volunteers in pastoral care.  
  
Students: have 2 CPE students and 4 stipended residents per year, which offers additional (2FTE) clinical chaplaincy services for the department, i.e., 12 days per month of on-call, and May-July is 18-20 days.  
Students: the Director runs a CPE program, and has the benefit of the added service of students to meet referrals.  
- There are a total of 7 residents, paid a yearly stipend;  
- There are also CPE interns who pay the hospital for earning clinical credit, usually in their Masters education, and are on site 10-15 weeks.  
  
9. Identification of needs | Between 30-40% of patients will self-identify a faith tradition at admission, usually Christian, with 50%+ being Roman Catholic  
- Between 6-8% have Aboriginal background, with 5% self-identifying;  
- 5-10% each will identify as Muslim or Jewish, with fewer Sikh, Hindu, Buddhists  
- Options for identifying needs are: at pre-admission; at admission; and at intake on the clinical units. People in Emergency are not asked any questions and often can not speak for themselves.  
- Referrals from nurses, doctors social workers and others on the hospital units,  
- Staff will make “cold calls” visiting people on the units.  
- All patients are screened for spiritual/emotional/life-risk issues at the time of admission by nursing staff during the admission assessment process. Patients with needs are referred to Pastoral Care for further assessment.  
- Nurses are trained by staff chaplains in spiritual assessment to identify spiritual needs  
- The population that the site serves is not a greatly diverse population; the constituency is basically Christian, with approximately 60% Baptist and Roman Catholic |  
  
Dimensions of Site 5 | Site 6 |
### Delivery (cont’d)

<table>
<thead>
<tr>
<th>10. Communication of services available</th>
<th>To help people understand what Spiritual Care and Cultural Services offers:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Spiritual Care and Cultural Services makes available and distributes to all units and to patients they meet with a printed card that describes what spiritual care is and some of the services available, sanctuary location, etc.</td>
</tr>
<tr>
<td></td>
<td>The nurses indicate the services available through the Pastoral Care Department during the admission assessment.</td>
</tr>
<tr>
<td>11. Method for serving multi-faith and Aboriginal</td>
<td>- use community connections to multi-faith leaders, including Buddhist; Muslim; Hindu; also connections as needed with Aboriginal elders when patients ask</td>
</tr>
<tr>
<td></td>
<td>- there are 2 FTE Aboriginal Cultural Helpers who report to the Director responsible for Aboriginal Health at the site complex</td>
</tr>
<tr>
<td></td>
<td>- there is not a large multi-faith or Aboriginal population</td>
</tr>
<tr>
<td></td>
<td>- if there is a need for a Jewish cantor or a Muslim imam, the staff have a list of community resources they can call.</td>
</tr>
<tr>
<td>12. Support for staff; ongoing education; supervision; Role of Clinical Pastoral Education (CPE) training</td>
<td>Education/on-going support seen as key and a priority:</td>
</tr>
<tr>
<td></td>
<td>- the department provides 2 weeks of conference leave for each chaplain;</td>
</tr>
<tr>
<td></td>
<td>- the site provides on-line registration at no charge to the Oates Institute (a life-long distributed learning community integrating spirituality, ethics and healing)</td>
</tr>
<tr>
<td></td>
<td>- staff chaplains can pursue further education at the local university and have the opportunity to serve at the site in the ethics area.</td>
</tr>
<tr>
<td></td>
<td>- each chaplain is required to have 4 units of CPE or working to soon obtain it;</td>
</tr>
<tr>
<td></td>
<td>- each chaplain has to become certified in a professional pastoral association that requires a certain number of hours of continuing education annually.</td>
</tr>
<tr>
<td>Dimensions of Delivery (cont’d)</td>
<td>Site 5</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>13. Method for professional accountability, quality assurance</strong></td>
<td>- Staff and students are guided by professional ethics as approved by CAPPE; the quality of a chaplain has a collective agreement behind it when the person has gone through the CAPPE specialist certification process; - chaplains are required to be a CAPPE member in good standing; and go through a peer review process every five years to maintain their credential. - Chaplains at the site are active in the CAPPE initiative to establish Standards of Practice and competencies for professional practice; - Aboriginal Cultural Helpers receive feedback from peers and their elders in the community.</td>
</tr>
<tr>
<td><strong>14. Degree of integration with clinical team</strong></td>
<td>On scale from 1-10 with 10 high: staff chaplains rated at 9, very integrated; -- every one of seven ICU units has a staff chaplain assigned because they are the toughest emergent situations. - next is coverage for the ER; and whatever is left is reserved for students with back up by a staff chaplain to assist as needed. - visible to clinical team.</td>
</tr>
<tr>
<td><strong>15. Participation in charting</strong></td>
<td>- staff and students attend clinical rounds for patients; hear recommendations from other members of the clinical team about patients who can benefit from focused spiritual care; document as a team member.</td>
</tr>
<tr>
<td><strong>16. Role of staff in education for other members of team</strong></td>
<td>- the staff on the units take every opportunity to alert the clinical team to what the chaplain staff can do and that the call to bring in a chaplain is theirs to make. - chaplain staff are involved in presentations and orientation to other staff.</td>
</tr>
<tr>
<td><strong>17. Relationship to surrounding rural areas</strong></td>
<td>- rural communities rely on community clergy; - rural areas do not have access to same resources as urban facilities; - since many patients are coming from rural and sometimes remote areas, staff will become involved as cultural helpers to maintain ties with community and family.</td>
</tr>
<tr>
<td><strong>Delivery</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>1. Name of Department</strong></td>
<td>Spiritual Care Services for a health region</td>
</tr>
<tr>
<td><strong>2. # IP beds covered</strong></td>
<td>675+ in total in Saskatoon City Hospital; Royal University Hospital; and St. Paul’s (Catholic) Hospital; - 7 rural hospitals with a total of about 100 acute care beds - 29 long term care facilities in the city and 7 rural communities with a total of about 2,100 beds.</td>
</tr>
<tr>
<td><strong>3. Reporting Relationship in Organization</strong></td>
<td>Interim Regional Director of Spiritual Care Services reports to a Vice President</td>
</tr>
<tr>
<td><strong>4. Process for recruitment</strong></td>
<td>Managers at the region and at St. Paul’s respectively, review applications</td>
</tr>
<tr>
<td><strong>5. Paid Staffing</strong></td>
<td>Staff called “chaplains” or “spiritual care workers” in region urban facilities; and “spiritual care associates” at St. Paul’s; Staff called “chaplains” in long term care</td>
</tr>
<tr>
<td><strong>Region Urban:</strong> Part-time Interim Director; 3.0 FTE chaplains for urban acute care; .5 chaplain at Parkridge long term care centre; Hours are 8:00 am-4:00 pm, with after-hours call-back</td>
<td></td>
</tr>
<tr>
<td><strong>St. Paul’s</strong> (funded through the St. Paul’s Foundation): Director of Mission spends .25 on spiritual care; 1.0 FTE Manager spends .5 as spiritual care practitioner; 3.3 FTE which translates into about 7 spiritual care associates; since staff are on-site 8:00 am-11:00 pm every day of the year; and 1.0 FTE Clinical Educator.</td>
<td></td>
</tr>
<tr>
<td><strong>Region Rural:</strong> Humboldt Hospital: 1.0 FTE Spiritual Care Manager; .5 FTE chaplain; .4 FTE assistant</td>
<td></td>
</tr>
<tr>
<td><strong>6. Relationship to denominational chaplains</strong></td>
<td>4 denominations have paid denominational chaplains: Anglican; Roman Catholic; United Church; Evangelical Lutheran Church in Canada, and Lutheran Church Canada; all have Masters in theology; - there is an issue with lack of consistency between regional and St. Paul’s procedure regarding the degree to which denominational chaplains have access to patient information, and are integrated into the spiritual care team - rural hospitals rely on community clergy and do not have denominational chaplains</td>
</tr>
<tr>
<td><strong>7. Role of community clergy</strong></td>
<td>They are visitors in the hospital coming to serve specific members of their own congregation only; - have access to a list of persons from their own faith group who have signed at admission requesting a visit; - are relied upon to provide religious services in acute and long term care facilities throughout the region on a rotational basis - are relied upon as the main source of spiritual/religious care in the rural areas other than Humboldt.</td>
</tr>
</tbody>
</table>

**Dimensions of Saskatoon Health Region**
<table>
<thead>
<tr>
<th>Dimensions of</th>
<th>Saskatoon Health Region</th>
</tr>
</thead>
</table>

### 8. Background & qualifications

**Paid Staff:**

**Region Urban:** Staff chaplains and denominational chaplains for urban acute care and the part-time chaplain at Parkridge Centre have a Masters degree; have completed at least one unit of CPE; and have background in Christian denominations.

**St. Paul’s** (funded through the St. Paul’s Foundation): The spiritual care associates are selected as lay people of mature Christian faith and an ability to offer non-denominational compassionate presence and support in a team environment, coming from a variety of backgrounds (e.g., nursing), who are working in an apprenticeship model and have completed one unit of CPE; the Clinical Educator is a Masters prepared spiritual care clinician and CAPPE teaching supervisor.

**Region Rural:** The Humboldt hospital Spiritual Care Director has a Christian background with training as a Licensed Practical Nurse and 2 units of CPE; the part-time chaplain is a Roman Catholic priest.

**Trained Lay Volunteers:**

**Region Urban:** The acute care facilities do not have a formal program of trained lay volunteers. One of the long term care affiliates (Sherbrooke) is sponsored by several denominations, and has a chaplain qualified by CAPPE to deliver the basic spiritual care training course, enabling people, including residents of the facility, to participate in their Lay Spiritual Companionship Program.

**St. Paul’s:** Religious volunteers will bring communion to those who have asked.

**Region Rural:** The 5 rural communities covered in the review described examples of trained lay volunteers; groups who may be natural resources for offering compassionate care and support:

- a) Humboldt hospital has an active group of trained community volunteers, for whom St. Paul’s Clinical Educator has offered a 32 hour training session;
- b) Rosthern community has a Pastoral Care group with a local trainer, connected with long term care; there are also 2 Muslim doctors and a Philippino nurse in the hospital who may be multicultural resources; Rosthern hospital is implementing a multi-faith palliative care suite;
- c) Watrous community had a local group trained as a Traumatic Events Response Team to support families of people involved in serious accidents or multiple deaths; this group may not be currently active, but could possibly be re-energized;
- d) Wakaw community has local residents who have completed some CPE training and have taught pastoral care courses for a local group of volunteers; the group is coordinated by a Pastoral Care Committee comprised of the local hospital and long term care managers and 2 lay people;
- e) Cudworth community is implementing a 6 member lay volunteer visitor group associated with the facility; the facility provides primarily long term care but has 4 primary care beds and a palliative care suite. The facility manager would like ongoing training offered for such groups.
<table>
<thead>
<tr>
<th>9. Identification of needs</th>
</tr>
</thead>
</table>
| **Region Urban**: Patients who come through acute care pre-admission clinic or regular admitting departments (not ER) are asked to identify their denomination or faith community during the admission process. The information is used to generate separate lists of people who self-identify per faith community. This information is freely available to the staff chaplains, and less so to denominational chaplains and to community clergy. The latter two groups may have restricted access and are expected to look only at the list of people from their own denominations. Denominational chaplains sign in and sign out, and must have signed a document pledging confidentiality. The list is not routinely kept in a secure place.  

- Staff chaplains at Saskatoon City Hospital (SCH) and Royal University Hospital who are present in some units in the hospital will attend rounds and accept referrals from other members of the clinical team; and will make “cold calls” on the wards as time permits. The role of the chaplain at SCH is changing with the consolidation of acute care beds and the implementation of the Transitional Units.

Patients admitted to long term care facilities in the region are asked about their denomination or faith tradition. The chaplains who offer spiritual care services in long term care have some opportunity to get to know the individual residents and their spiritual needs, and will take referrals from staff. They are often involved with the staff in designing and coordinating group spiritual and religious programming to meet common needs (e.g., battling loneliness, boredom and helplessness), as well.

**St. Paul’s** (funded through the St. Paul’s Foundation): - Patients who come through acute care pre-admission clinic or regular admitting department (not ER) are asked to identify their denomination or faith community at admission. It is estimated that about 50% self-identify, with a growing number of Aboriginal patients and families. The information is used to generate separate lists of people who self-identify per faith community. In addition, every patient who is admitted is visited initially by a member of the Spiritual Care staff to assess their needs, and so staff can correct/update the list established at admission. This information is freely available to the spiritual care staff, denominational chaplains, and community clergy. Non-staff clergy must register to have access to the lists, which are kept in a secure place in the Spiritual Care department. Spiritual Care staff are known by members on various hospital units, especially ICU and Palliative Care, and will accept referrals from other members of the clinical team and directly from patients and families.

**Region Rural**: Patients who come through regular admitting (not ER) are asked to identify their denomination or faith community during the admission process. The information is used to generate separate lists of people who self-identify per faith community. This information is freely available to the community clergy. The community clergy are expected to look only at the list of people from their own denominations. Some communities which have active Pastoral Care groups will respond to requests from the hospital or long term care staff or patients/families themselves to visit certain patients.

<p>| Dimensions of | Saskatoon Health Region |</p>
<table>
<thead>
<tr>
<th><strong>Delivery (cont’d)</strong></th>
<th><strong>Region Urban</strong></th>
<th><strong>Region Rural</strong></th>
</tr>
</thead>
</table>
| 10. Communication of services available | The regional facilities have a variety of brochures available, depending on the hospital or long term care centre; chaplains in acute care may participate in staff orientation and presentations as time allows.  

*St. Paul’s* (funded through the St. Paul’s Foundation): - has a brochure and fact sheets describing the services that are made available to patients through the initial visits to everyone admitted by the Spiritual Care staff, through distribution on the units, waiting rooms, etc., and through the personal contact that Spiritual Care staff have with the clinical staff and the patients and families (e.g., Spiritual Care Staff are called in ICU when there is a code to be with families)  

*Region Rural*: the rural communities covered in the review indicated that the services available are typically thought of as “religious care” offered through the community clergy, rather than the broader aspects of “spiritual care”, although in emergent and end-of-life situations, they will call upon their lay volunteer “pastoral care groups” for compassionate presence and support. |
| 11. Method for serving multi-faith and Aboriginal | The regional acute care and long term care facilities have connections with a variety of faith communities and spiritual leaders from the Jewish, Buddhist, Muslim, and Hindu faiths; as well as community Aboriginal elders whom they can call as needed. In some cases, patient families have brought spiritual leaders in from other communities to assist them. The hospital will respond as much as possible to the special food needs of certain religious/cultural traditions. The urban acute care facilities have taken steps to have sacred space that can be multi-faith; including Aboriginal traditions. The long term care centres also recognize the importance of Aboriginal spirituality in that they have Aboriginal elders whom they can call. Sherbrooke long term care centre has a house for Aboriginal people with disabilities called Wichitowin Place that is staffed by Aboriginal people.  

*St. Paul’s* (funded through the St. Paul’s Foundation): - the Spiritual Care Services staff have connections with a variety of faith communities and spiritual leaders from the Jewish, Buddhist, Muslim, and Hindu faiths; as well as community Aboriginal elders whom they can call as needed. The hospital will respond as much as possible to the special food needs of certain religious/cultural traditions. St. Paul’s hospital reflects its commitment to non-denominational, multi-faith service in its having a sacred space that can be multi-faith; as well as separate space designed to accommodate Aboriginal ceremonies of healing.  

*Region Rural*: the rural communities covered in the review indicated that the majority of their population is of Christian background, and do not typically serve many Aboriginal people. The hospital at Rosetnhem has some multi-faith clinicians; and the hospital recently developed a palliative care suite designed to be a non-denominational service available to any faith group. |
| 12. Support for staff; ongoing education; supervision; Role of Clinical Pastoral Education (CPE) training | The regional staff have monthly staff meetings; there is some support for ongoing education; consult with one another informally; CPE seen as important source of ongoing education and credibility.  

*St. Paul’s* (funded through the St. Paul’s Foundation): Manager is in close contact with the staff; meetings called on an as-needed basis; consult with one another informally. There is some support for ongoing education. CPE is valued as a source of ongoing education offered through the Clinical Educator at St. Paul’s.  

*Region Rural*: The Manager of spiritual care services at Humboldt is in close contact with her staff. In the past, she has called upon resources as needed from the manager at St. Paul’s and then the regional manager; and also the Clinical Educator. |
<table>
<thead>
<tr>
<th>Dimensions of Delivery (cont’d)</th>
<th><strong>Saskatoon Health Region</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>13. Method for professional accountability, quality assurance</strong></td>
<td><strong>Region Urban</strong>: The regional staff are members of CAPPE, which is the main training and credentialing association for professional chaplains in Canada. As such, they are guided by the professional code of ethics and standards of practice being developed by CAPPE. The association is developing guidelines for the required number of annual hours of continuing education in order to maintain professional standing (e.g., 50 hours), and standards indicating levels of competency. CAPPE also requires a peer review every 5 years. There is no systematic peer supervision process in the regional facilities. Staff are also members of the newly formed Saskatchewan Association of Spiritual Care Workers in Health Care, which is meant to be the provincial association responsible for quality assurance and professional discipline. <strong>St. Paul’s</strong> (funded through the St. Paul’s Foundation): As above. In addition, St. Paul’s has an ethicist who is available to the Spiritual Care services staff at St. Paul’s and the regional facilities for consultation in difficult situations. <strong>Region Rural</strong>: The regional staff attend rounds on some units (e.g., palliative care) but are not formally assigned to units. The degree of integration varies a great deal (e.g., no formal presence in emergency room, or ICU, but spiritual care may be called to attend a code). It is clear to the staff that the chaplain is there to support not only the patients, but the staff themselves. Clinical staff will make referrals to the chaplains. Chaplaincy is better integrated into long term care than acute care, although staff resources are scarce.</td>
</tr>
<tr>
<td><strong>14. Degree of integration with clinical team</strong></td>
<td><strong>Region Urban</strong>: The regional staff attend rounds on some units (e.g., palliative care) but are not formally assigned to units. The degree of integration varies a great deal (e.g., no formal presence in emergency room, or ICU, but spiritual care may be called to attend a code). It is clear to the staff that the chaplain is there to support not only the patients, but the staff themselves. Clinical staff will make referrals to the chaplains. Chaplaincy is better integrated into long term care than acute care, although staff resources are scarce. <strong>St. Paul’s</strong> (funded through the St. Paul’s Foundation): There is a tradition of the expectation of spiritual care being part of the total care offered at St. Paul’s, which is a Catholic health care organization. The spiritual care associates see every patient admitted for an initial visit, and are available from 8:00am to 11:00 pm every day, so are visible to the patients and clinical staff. The degree of integration with the clinical staff varies. There is a high degree of integration in areas such as ICU, where spiritual care staff are routinely called; and palliative care, and less so in other areas. Staff are not assigned to units. There has been a recent request from palliative care to have spiritual care formally assigned to the team. It is clear to the staff that the spiritual care services are there to support not only the patients, but the staff themselves. Clinical staff will make referrals to spiritual care. <strong>Region Rural</strong>: The Director of spiritual care services at Humboldt is in close contact with the staff. There is an appreciation of spiritual care, which generally works in parallel to the clinical staff, typically offering services directly to patients, but also accepting referrals from the clinical staff.</td>
</tr>
<tr>
<td><strong>15. Participation in charting</strong></td>
<td><strong>Region Urban</strong>: There is no formal policy supporting spiritual care services to participate in charting. <strong>St. Paul’s</strong> (funded through the St. Paul’s Foundation): There has been a request from the ICU for spiritual care staff to participate in charting; and a request from the palliative care department for a chaplain to be assigned to the team, which would include charting. There is no formal policy supporting spiritual care services to participate in charting. <strong>Region Rural</strong>: The spiritual care staff and trained volunteers at Humboldt keep their own notes regarding their visits. These notes are added to the charts afterward. Only the Director has access to patient charts.</td>
</tr>
<tr>
<td>Dimensions of Delivery (cont’d)</td>
<td>Saskatoon Health Region</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------</td>
</tr>
</tbody>
</table>
| **16. Role of staff in education for other members of team** | Region Urban: The staff participate in education and orientation sessions for other staff as their limited time permits. When they participate in clinical rounds they have the opportunity to informally educate the other team members about what spiritual care is and can offer to the patients, families and staff themselves.  
St. Paul’s (funded through the St. Paul’s Foundation): - The staff participate in education and orientation sessions for other staff as their time permits, e.g., the staff have done a presentation for clinical staff of ICU. The Clinical Educator offers ongoing CPE units which are available to clinical staff at St. Paul’s and throughout the region, including a special course offered to the spiritual care volunteers at Humboldt.  
Region Rural: The manager of spiritual care services at Humboldt sends a newsletter to staff on a regular basis and circulates “thoughts for the day” for support and inspiration which is modeling spiritual care. |
| **17. Relationship to surrounding rural areas** | Region Urban: The staff within the acute and long term care facilities of the region have not had any formal connection with spiritual care resources in the rural areas, nor been involved in resourcing them. The manager of the regional staff has been a support to the manager of spiritual care services in Humboldt since the hospital became a regional facility in 2007.  
St. Paul’s (funded through the St. Paul’s Foundation): - The manager of spiritual care services offered support as needed to the manager of spiritual care services in Humboldt when the hospital was a Catholic health care organization, and the Clinical Educator has offered training to volunteer groups in several rural areas including Humboldt.  
Region Rural: The administrators of the Rosthern hospital and the Cudworth facility have been involved in conversations with the regional palliative care team in the implementation of their respective palliative care suites. |
Appendix C: the FICA Questions

Faith:

What is your faith or belief? (Do you consider yourself spiritual or religious? What things do you believe in that give meaning to your life?)

Importance:

Is it important in your life? (What influence does it have on how you take care of yourself? How have your beliefs influenced your behavior during this illness? What role do your beliefs play in regaining your health?)

Community:

Are you part of a spiritual or religious community? (Is this of support to you? How? Is there a person or group of people you really love or who are important to you?)

Address:

How would you like me to address these issues in your health care?
Appendix D: the Spiritual Care Triggers

<table>
<thead>
<tr>
<th>High Risk Diagnosis:</th>
<th>High Risk Spiritual Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Terminal diagnosis</td>
<td>• End of life issues: DNR/removal of support, active dying</td>
</tr>
<tr>
<td>• Acute critical diagnosis</td>
<td>• Intensive care unit admission</td>
</tr>
<tr>
<td>• Death</td>
<td>• Cultural challenges or spiritual practices</td>
</tr>
<tr>
<td>• Trauma</td>
<td>• Need for advance directives education</td>
</tr>
<tr>
<td>• Code</td>
<td>• Tissue/organ donation</td>
</tr>
<tr>
<td>• Extreme prematurity</td>
<td>• History of significant previous loss</td>
</tr>
<tr>
<td>• Fetal death</td>
<td>• Family conflict interfering with care</td>
</tr>
<tr>
<td>• New spinal cord injury</td>
<td>• Communication issues with healthcare team</td>
</tr>
<tr>
<td>• Terminal wean</td>
<td>• Lack of support systems</td>
</tr>
<tr>
<td>• New cancer diagnosis</td>
<td>• Grief or loss</td>
</tr>
<tr>
<td>• Palliative care status</td>
<td>• Loss of coping skills</td>
</tr>
<tr>
<td>• Potential organ donation</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix E: Recommended Principles Links to Health Region Strategic Plan Values and Directions

(Areas of relationship are marked with an “X” on the chart)

<table>
<thead>
<tr>
<th>Recommended Principles to Guide a Vision for Spiritual Health Services</th>
<th>Health Region Core Values &amp; (St. Paul's Hospital Core Values)</th>
<th>Strategic Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respect</td>
<td>Compassion</td>
</tr>
<tr>
<td>Spiritual health practitioners are visible keepers of the regional values of: respect; compassion; excellence; stewardship and collaboration</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Spiritual health service delivery is highly responsive and integrated</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>An adequate number of paid spiritual health practitioners is necessary as part of holistic care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>A variety of paid workforce and unpaid workforce sources can be involved in spiritual health service delivery</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Spiritual health services put emphasis on region-wide networking and community capacity enhancing for rural communities through clinical pastoral education and direct service support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommended Principles to Guide a Vision for Spiritual Health Services</td>
<td>Health Region Core Values &amp; (St. Paul’s Hospital Core Values)</td>
<td>Strategic Directions</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Respect</td>
<td>Compassion</td>
<td>Excellence/ (Holistic Care)</td>
</tr>
<tr>
<td>Diversity in spiritual health practitioners is important to meet Aboriginal and multi-faith needs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Spiritual health practitioners are an integral part of the clinical care team</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Spiritual health services include access to diverse religious practices if the patient and family want them</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ongoing professional education/certification for all practitioners and trained volunteers involved in spiritual health must be encouraged</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Screening tools and protocols are used to identify need for spiritual health practitioners</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Pastoral Education is key at both the intern and residency levels</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Innovative research is crucial for quality services</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>