Spiritual care in healthcare:

elements of best practice

A scoping review 2022

Joint Project, 2022

Spiritual Health Association (Australia)
Spiritual Care in Aotearoa New Zealand (SCANZ) Healthcare Co-design Rōpū

Authors

- ● Heather Tan
- ■ Chris Arnison
- ■ Noeleen Venter

Editorial Team

- ● Cuong La
- ▲ Assoc Prof Chrystal Jaye
- ■ Assoc Prof Richard Egan
- ● Cheryl Holmes
- ★ Assoc Prof Natasha Tassell-Matamua

● Spiritual Health Association, Australia
■ Department of Preventive and Social Medicine, School of Medicine, University of Otago, Aotearoa New Zealand
▲ Department of General Practice and Rural Health, School of Medicine, University of Otago, Aotearoa New Zealand
★ School of Psychology, Massey University, Aotearoa New Zealand

“Research affirms that spiritual care improves patient health outcomes and patient satisfaction”

TABLE OF CONTENTS

FOREWORD iv

LIST OF ACRONYMS v

EXECUTIVE SUMMARY vi

INTRODUCTION 1

METHODS 2

- Inclusion and exclusion criteria 2
- Search strategy 3
- Screening process 4
- Data extraction 4
- Method for synthesis of results 5

SEARCH RESULTS 6

- What are the current models, frameworks, guidelines, standards, and best practices for spiritual care in healthcare? 6

DISCUSSION OF RESULTS 12

- Who and where are the MFG intended for? 12
- What are the elements that make up a best practice MFG? 13
  - Indigenous spiritual care in healthcare 14
  - Philosophical or religious underpinnings and groundings 14
  - Defining concepts 15
  - Evidence-based practice 15
  - Providers of spiritual care 16
  - What do spiritual practitioners do? 17
  - Skills, competencies, credentials & staffing of spiritual practitioners and carers 18
  - Spiritual care settings and resources 20
  - Organisational structure and integration into whole person care 21
  - Assessment of spiritual needs, spiritual history, or cultural history 21
  - Spiritual care interventions, implementation, and outcomes 23
  - Documenting/charting, evaluation, accountability, and reporting 24
  - Ethical considerations 25
  - What does best practice spiritual care and interventions look like? 25

SUMMARY DISCUSSION 27

- What are the reported models of spiritual care? 27
- What are the elements that make up a best practice model in the grey literature? 28
  - Overview of spiritual care 28
  - Education and credentialling of spiritual care staff 28
  - Integration into the systems of whole person care 29
  - The spiritual care of patients and families 29
  - Overall organisational structure 30

LIMITATIONS 31

CONCLUSIONS 32

REFERENCES 34

FUNDING 39

APPENDICES 40

- Appendix A: Grey literature codes and sub-codes 40
- Appendix B: Scientific literature codebook 41
- Appendix C: More detailed grey literature coding report 43

FOREWORD

When people are overwhelmed by illness we must give them physical relief, but it is equally important to encourage the spirit through a constant show of love and compassion
– The Dalai Lama, 2006

Spirituality has always been central to the lives of people and acknowledged as one of the dimensions of wellness.[1] Scientific efforts have been made to understand the relationship between spirituality and health in recent decades. Research shows that when spiritual needs are identified and responded to as an integral part of person-centred care, an essential contribution is made to people's health and wellbeing.[2]

There is a growing body of evidence for the contribution and value of spiritual care as a recognised domain of whole person care, however, there are mixed and inconsistent models of spiritual care observed in Australia and Aotearoa New Zealand. The provision of spiritual care in many hospitals does not align with international best practice. In many cases, the delivery of spiritual care continues to be based upon historic models of funding and administration, and the quality of the service provided often remains unevaluated. This unwarranted variation is recognised as a key risk to quality and safe care.

In early 2022, Spiritual Health Association collaborated with Spiritual Care in Aotearoa New Zealand Healthcare Co-design Rōpū to conduct a scoping literature review to understand the best practice models of spiritual care within healthcare settings.

This report assembles the latest evidence of the components, elements, and characteristics that indicate a quality model of spiritual care within healthcare settings. A set of comprehensive data from peer-reviewed and grey literature between 2015 to 2022 from 18 countries have been reviewed. The aim of this literature review is the establishment of an evidence base for the co-design of a consistent model for spiritual care service and governance within Australian and Aotearoa New Zealand hospitals.

On behalf of the joint project team, we would like to express sincere thanks to the authors and other members of the editorial team for their contributions, without which this report would not have been possible.

Richard Egan

Associate Professor
Dunedin School of Medicine,
University of Otago
Aotearoa New Zealand

Cheryl Holmes

Chief Executive Officer
Spiritual Health Association
Australia

1 *8 Dimensions of Wellness*, (UMD) University of Maryland's Your Guide to Living Well. [Last accessed Oct 10, 2022]. Available from: https://umwellness.wordpress.com/8-dimensions-of-wellness/

2 Annual Report 2020-2021, Spiritual Health Association. [Last accessed 11 October 2022]. Available from: https://annualreport-spiritualhealth.org.au

LIST OF ACRONYMS

Acronym	Definition
APC	Association of Professional Chaplains (USA)
AUS	Australia
CAN	Canada
CASC	Canadian Association for Spiritual Care
HCCN	Health Care Chaplaincy Network (USA)
ICCHC	Inter-church Council for Hospital Chaplaincy (NZ)
MCDHB	Mid-central District Health Board (NZ)
MFG	Model, Framework, Guideline etc.
NHS	Nation Health Service (UK – includes NHS England and NHS Scotland)
NZ	Aotearoa New Zealand
SCA	Spiritual Care Australia
SCANZ	Spiritual Care in Aotearoa New Zealand Healthcare Co-design Rōpū
SHA	Spiritual Health Association (AUS)
SNI	Spiritual Needs Inventory
UK	United Kingdom
UKBHC	United Kingdom Board of Healthcare Chaplaincy
USA	The United States of America

EXECUTIVE SUMMARY

INTRODUCTION

This report describes a review of current models and best practice of spiritual care provision in healthcare from 2015-2022. Specifically, the two questions framing this review are:

1. What are the current models, frameworks, guidelines, standards and best practices of spiritual care in healthcare internationally?
2. What are the elements that contribute to a best practice model of spiritual care in healthcare?

METHODS

A scoping review methodology was adapted to review grey and peer-reviewed literature which addressed a spiritual care framework, guideline, standard and/or best practice in a healthcare setting. Articles published in English from 2015 onwards were considered in this review. All documents were loaded into NVivo 12 qualitative data analysis software and read in detail, with content coded according to its relevance to the review questions.

SEARCH RESULTS

The peer-reviewed literature originated from 18 countries, with Iran and the USA contributing the largest number of papers. Forty-one peer-reviewed articles and 74 grey literature documents met our criteria for inclusion in the review. The grey literature primarily included models published and promoted by professional bodies from around the world, including from the United Kingdom, United States, Australia, Canada, and Aotearoa New Zealand. The peer-reviewed literature contained a variety of structures that included 21 models, eight guidelines, four frameworks and other structures (described later in the report). For the purposes of this report, these various structures have been collectively referred to as MFG (Model, Framework, Guidelines etc.).

DISCUSSION OF RESULTS

Spiritual care MFG in the peer-reviewed and the grey literature is diverse yet there are many shared components, elements and characteristics. Figure 1 depicts thirteen common elements from the spiritual care MFGs discussed in this report. The authors have grouped these elements into the categories ‘why’, ‘what’, ‘who’, ‘where’, and ‘how’. Another element, the ‘Indigenous Spiritual Care in Healthcare’, was agreed by the project team to be of critical importance for inclusion and is shown inside the central circle.

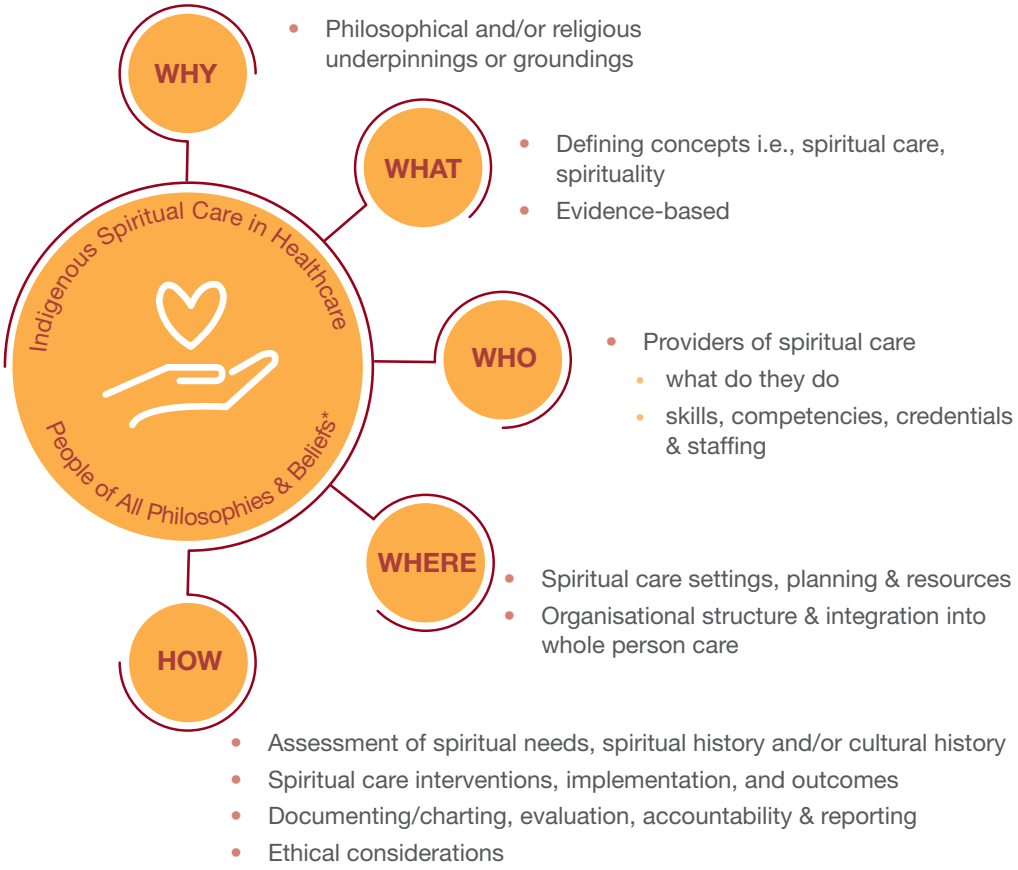

Figure 1: The common elements that make up a spiritual care in healthcare model, framework, guideline etc.
*An element added to by the Authors, not discussed in the literature review results

SUMMARY DISCUSSION RESULTS

The most comprehensive MFG for spiritual care in the healthcare systems, the most broadly inclusive and the most widely promoted models are those designed by the professional associations in the major countries from which the literature has been sourced.

None claimed to be consistently applied across their respective areas of influence and are, in most cases, recommended rather than mandated.

What are the elements that make up a best practice model?

Best practice models of spiritual care from the grey literature comprised of five main areas of importance, 1. Overview, 2. Education and Credentialling of spiritual care practitioners, 3. Integration into the systems of whole person care, 4. Spiritual care of patients/families, and 5. Overall organisational structural issues. Each of these main areas had several relevant areas associated.

3. Overview of Spiritual Care

A broad and *inclusive definition* of what spiritual care is in the healthcare system was widely provided. Attention was also given to the importance of evidence-based practice, and in a few cases, consideration given to the theory on which the MFG was based.

4. Education and Credentialling of Spiritual Care Staff

This included the areas of training, registration and credentialling, professional development, capabilities, competencies, research literacy and research participation.

Registration and credentialling were mentioned in documents from UK, USA, AUS and CAN produced by the main professional association groups. There was general agreement that registration should be encouraged although in no case was it a compulsory requirement for employment. A continuing process of *professional development* was expected and, in some cases, national standards in this regard were suggested.

Capabilities and competencies were addressed with variable degrees of detail and attention.

Research literacy and the willingness and ability to *participate in research* were discussed in the grey literature only.

5. Integration of Whole Person Care

Several areas of concern were identified. These included accountability/evaluation of practice, meeting/communication, referral process, all staff spiritual care and support, all staff education in spiritual care and crisis management.

Accountability by regular evaluation of practice, as an organisational requirement of professional staff in all sectors of healthcare as well as accountability to the organisation via annual reports from Spiritual Care/Chaplaincy departments to the organisational management, was considered important.

Communication with members of the inter-disciplinary team was considered essential by many groups for the integration of spiritual care into the whole healthcare service. This communication was also expected with relevant community groups. Serving as a mediator between patients and their families with doctors, specialists and, in some cases, the wider medical team, is an activity sometimes assigned to spiritual care practitioners.

Appropriate, clear, and written referral system was not widely addressed and is therefore a gap in the literature.

Spiritual care and support to all staff on request was widely put forward as an important part of the role of spiritual care professionals, including the provision of staff/organisational rituals as needed.

It was acknowledged that *all staff at times provide spiritual care* while also referring to the spiritual care professionals as the experts in the field. It is important that *appropriate education in spiritual care* be provided, often by senior spiritual care practitioners.

Spiritual care in times of crisis, disasters, or critical incidents was included in the role of spiritual care practitioners.

6. The Spiritual Care of Patients and Families

This addressed several aspects of care including Documenting/charting, Screening, Assessment, Interventions, Outcomes and Patient Feedback. These will now be considered in more detail.

Documenting/Charting
It was generally agreed that for safety and accountability reasons all patient visits must be recorded in a timely manner according to the local recording format.

Screening
As a separate item of care, screening was seldom mentioned, but for those who saw it as a separate part of care, components included the need for interpreters and awareness of cultural background.

Assessment
This was acknowledged as a pre-requisite for effective spiritual care and several assessment tools were mentioned. The point was made that tools need to be standardised for the environment in which they are used, taking into account that they must have the capacity to work for populations that are diverse from cultural and spiritual perspectives.

Interventions
These were discussed by the major professional bodies. It was expected that these were planned in partnership with the patient, the patient's family and the inter-disciplinary team so that they met individual and wholistic needs, including cultural needs, and were guided by ICD-10-AM/ACHI/ACS Spiritual Care Intervention Codes. Other general aspects of interventions included were active listening, developing rapport and on-going evaluation of intervention over time.

Outcomes of interventions
Patient reported outcomes were consistently affirmed, as assessed with the patient during consultation. That patients experienced the encounter with Spiritual Care practitioners as compassionate was also considered a major outcome. The outcomes as reported by the patient, must be consistent with those specifically sought by them during consultation.

Patient Feedback
Noted as different to outcomes in that the latter is often staff identified.

7. Overall Organisational Structure

This included the main themes of Workforce planning, Organisational issues, and Resources. These, no doubt, varied in different systems depending on the degree to which Spiritual Care was integrated into whole person care and therefore considered part of the overall structure and planning of the providing organisation. Of note, in relation to workforce, was that spiritual care staff employed should have diverse skills, be fully trained and credentialled and employed in numbers consistent with reasonable staff/patient ratios.

LIMITATIONS

Only documents published in English were reviewed. The included articles were not critically appraised. A reductionist approach to the review might have excluded some Māori and other Indigenous healthcare models which could have incorporated an approach to spiritual care without naming it as such. Cross-references of included literature were not reviewed.

CONCLUSION

The review aimed to identify available models for the governance and provision of spiritual care in healthcare settings and to clarify the elements of best practice that are incorporated into such models of care. If the items identified as best practice by most of the larger associations for spiritual care are in fact best practice, it may be concluded that the elements discussed in this report are the basis of spiritual care models in healthcare.

The items put forward by the two professional bodies in each of the USA and UK, covered most of the items listed as elements of best practice. In Australia, the material most consistent with the list of items discussed has been produced by Spiritual Health Association (SHA). While based in the identified features of best practice spiritual care models, and therefore the most comprehensive, the consistent application of the SHA model is still very much an aim rather than a reality.

The key findings of this literature review:

- There is no universal approach to spiritual care MFG within healthcare settings.
- Thirteen common elements of spiritual care MFGs in healthcare were identified.
- There is a lack of recognition of Indigenous spiritual care within the spiritual care MFGs.
- The theoretical underpinnings of spiritual care MFGs are not consistently stated.
- Current spiritual care MFGs reviewed in this report were developed primarily by large professional associations, whose voices/perspectives are dominant in spiritual care MFG in healthcare.

The future focus points towards the need for consistent application of evidence-based models of spiritual care across healthcare to be accepted practice, rather than simply recommended. This would require a wide acceptance of a number of concepts and approaches:

- A broad-based approach to spiritual care, inclusive of all cultures and spiritualities, with an inclusive consensus-based approach to developing spiritual care MFG in healthcare.
- The acceptance by all healthcare providers, administrators, and governments that spiritual care is an integral part of whole person care, requiring system integration and adequate resourcing.
- Testing and evaluation of MFG is critical to assess best practice of spiritual care in healthcare.
- MFG flexibility for contextualising local approaches to spiritual care.

INTRODUCTION

The provision of spiritual care in the healthcare system continues to evolve both in Australia and in Aotearoa New Zealand, alongside other major western countries such as the United Kingdom (UK), the United States (USA), and Canada. There is also interest in developing this service further in some other countries such as the Netherlands (along with other European countries) (1), Israel (much influenced by American Jewish groups) (2) and also in parts of Asia (3) and Africa. (4) In some instances, this move forward has been led by specific health interest areas such as palliative care.(5) In some countries, local professional associations for spiritual care providers have taken a strong stance in relation to both training of practitioners and the quality of care given, including for example the USA Health Care Chaplaincy Network (HCCN), the Australian Spiritual Health Association (SHA), the USA Association of Professional Chaplains (APC), and the UK National Health Service (NHS).

Globally, spirituality is recognised as adding value to health services and being essential for wellbeing (6), with research affirming that spiritual care improves patient health outcomes (7, 8) and patient satisfaction.(9, 10) National and international literature affirm the importance of spiritual care, particularly for mental health, cultural safety, end-of-life care, healthcare professional training, quality of life, pain treatment, cancer, and heart disease.(11, 12) Cost-benefit analysis is lacking in this research area although there is some evidence that suggests providing adequate spiritual care is fiscally prudent.(13)

Best practice has long been a driver for determining effective health care delivery and more efficient use of resources as well as opportunities to circulate information on health and health care more rapidly.(14) Perleth et. al. (14) define best practice in health care as

> *"the 'best way' to identify, collect, evaluate, disseminate, and implement information about as well as to monitor the outcomes of health care interventions for patients/population groups and defined indications or conditions. Information is required on the best available evidence on safety, efficacy, effectiveness, cost-effectiveness, appropriateness, social and ethical values and quality of the health care interventions."* (p237-238)

Similarly, models of health are used in the planning and delivery of health care.

This report examined international MFG of spiritual care in healthcare published in literature between 2015-2022 to address two research questions:

1. What are the current models, frameworks, guidelines, standards and best practices for spiritual care in healthcare internationally?
2. What are the elements that contribute to a best practice model of spiritual care in healthcare?

METHODS

Two research groups collaborated on this review, the Australian Spiritual Health Association (SHA) and an Aotearoa New Zealand co-design group, the Spiritual Care in Aotearoa New Zealand Healthcare Rōpū (SCANZ). The review framework for this report was adapted from the scoping methodological framework created by Arksey and O'Malley (15) and later added to by Levac et al.(16) A scoping review was selected as the most appropriate method for identifying knowledge gaps in a particular research area and investigating topics that have not been clearly identified in the literature.(17) The protocol was reviewed by SCANZ's co-design group. The methods are reported using the reporting criteria 'PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation'.(18)

Inclusion and exclusion criteria

Literature that addressed a model, framework, guideline, best practice or evidence-based practice of spiritual care in healthcare were included in this review. Grey literature, such as government, non-governmental organisations (NGO) and other health organisations' documents, and peer-reviewed literature was included in this report. The search criteria were restricted to English language articles published between 2015 and 2022 (inclusive). Literature from community, defence force or education settings were excluded. In addition, book reviews, thesis dissertations, conference abstracts, editorials, book or article reviews or replies, and articles with missing abstracts were excluded from the review (see Table 1).

Table 1: Inclusion and exclusion criteria

Criterion	Inclusion	Exclusion
Scoping review focus	Frameworks, guidelines, standards, and best practices of spiritual care in healthcare	No reference to any frameworks, guidelines, standards or best practices of spiritual care in healthcare
Type literature	Grey literature and full text, peer-reviewed publications	Book reviews, thesis dissertations, conference abstracts, editorials, book or article reviews or replies, missing abstract
Language	English	Non-English
Time period	Published from 2015 (inclusive)	Published before 2015
Geography	Any geographical place of study	No exclusions
Setting	Healthcare setting	Community, defence force and education settings.

Search strategy

The grey literature and peer-reviewed literature search and screening were conducted separately by two researchers.

Grey Literature

The following search terms were utilised in the process of seeking to answer the identified research questions in relation to grey literature (Table 2). Databases were searched in Medline, PsychInfo, EMBASE and CINHAL. Boolean operators were utilised to search the terms based on the two research questions (Table 2). In addition to searching the databases, healthcare professionals including spiritual care professionals, spiritual care academics and the Aotearoa New Zealand Spiritual Care in Healthcare co-design group were consulted for relevant documents.

Table 2: Key search terms for the scoping the grey literature

Research Question	Key Concept & Terms 1	Key Concept & Terms 2
Research question 1: **What are the reported models of spiritual care?**	Spiritual care; pastoral care; chaplain; hospital chaplaincy service; patient-centred care	Spiritual care model; practice models; models, healthcare organization; patient care team; primary healthcare; delivery of healthcare; co-production; co-design
Research question 2: **What are the elements that make up a best practice model? (Including employment structures; staffing and workforce considerations; organisational structure)**	Spiritual care; pastoral care; chaplain; hospital chaplaincy service; patient-centred care	Best practice; practice guidelines as topic; good practice; better practice; high quality; patient safety; quality; quality assurance, healthcare; quality improvement, healthcare; quality indicators, healthcare; best possible; "quality of health care"; "delivery of health care"; healthcare quality, access, and evaluation; quality measures
	Spiritual care; pastoral care; chaplain; hospital chaplaincy service; patient-centred care	Organisational structure; organisational culture; workforce; workforce planning; staffing; employment; employment process; health workforce; health professionals; healthcare professionals; health personnel; staffing ratios; personnel staffing and scheduling; multidisciplinary, interdisciplinary and interprofessional

Peer-Reviewed Literature

The search criteria and selected databases were created in consultation with a health science subject librarian, principal investigators with knowledge of the subject area and from the Aotearoa New Zealand co-design group. The search criteria were refined over several trials and discussions with the co-design group and principal investigators. The final database search was conducted in January 2022 and included AMED, ATLA, CINAHL Plus, ProQuest Central, PubMed, PsycINFO and Scopus. Boolean operators were utilised to search the terms *Spiritual care* and *healthcare* and *best practice, guidelines, frameworks, models, and evidence-based practice* (Table 3). Relevant articles were downloaded into EndNote, a reference management tool.

Table 3: Key search terms for scoping the peer-reviewed literature

Key Concept 1: Spiritual Care	**Key Concept 2:** Healthcare	**Key Concept 3:** Best Practice, Guidelines, Frameworks, Models, and Evidence-based practice.
Spiritual	healthcare	"Best practice"
spirituality	"healthcare service*"	Standard*
"spiritual care"	"health service*"	Framework*
"spiritual health"	"hospital chaplaincy service"	Model*
"spiritual wellbeing"		Guideline*
Chaplain*		
"chaplaincy service"		
"pastoral care"		
"pastoral counselling"		

Screening process

The literature selected in both streams underwent three rounds of the screening process: title, abstract and full-text screening. All articles were reviewed in EndNote to determine eligibility. Cross-references were not screened. Noeleen Ventner (NV) ensured that all full-text articles considered in the scoping review were in strict compliance with the inclusion and exclusion criteria (Table 1). The screening process deviated from the scoping methodology outlined by Arskey and O'Malley (15) and Levac et al. (16), where the screening process is conducted by two reviewers who independently screen and compare findings.

Data extraction

Documents included for the scoping review were downloaded as files into NVivo 12 qualitative data analysis software for coding. The data extraction, using coding in NVivo, was intended to identify content relevant to the review questions. All documents were read in detail and coded.

Grey literature and scientific literature were coded separately. The grey literature documents were coded with the nodes and sub-nodes. The identification of these nodes and sub-nodes was guided by the research questions. For the scientific literature, two authors independently extracted data from three randomly selected documents to develop a codebook. Codes were developed deductively and inductively.

NV and Chris Arnison (CA) then agreed on a list of codes, then the remaining number of documents were delegated between NV and CA to code according to the codebook. Coding followed an iterative process, continually re-updating the codebook and re-applying to articles included in the review. The final codes and sub-codes for the grey literature and scientific literature can be found in Appendix A and Appendix B, respectively.

Method for synthesis of results

Codes and associated quotes were downloaded from NVivo into an excel spreadsheet. A descriptive numerical summary of the document characteristics was conducted, including the distribution of studies geographically, the overall number of included studies and years of publication. The rest of the codes were analysed in accordance with the literature review questions.

SEARCH RESULTS

Forty-one peer-reviewed articles and 74 grey literature documents met the criteria for inclusion in the review (Figure 2). All documents were loaded into NVivo 12 qualitative data analysis software and read in detail, with content coded according to its relevance to the review questions. The results for each of the review questions are described below.

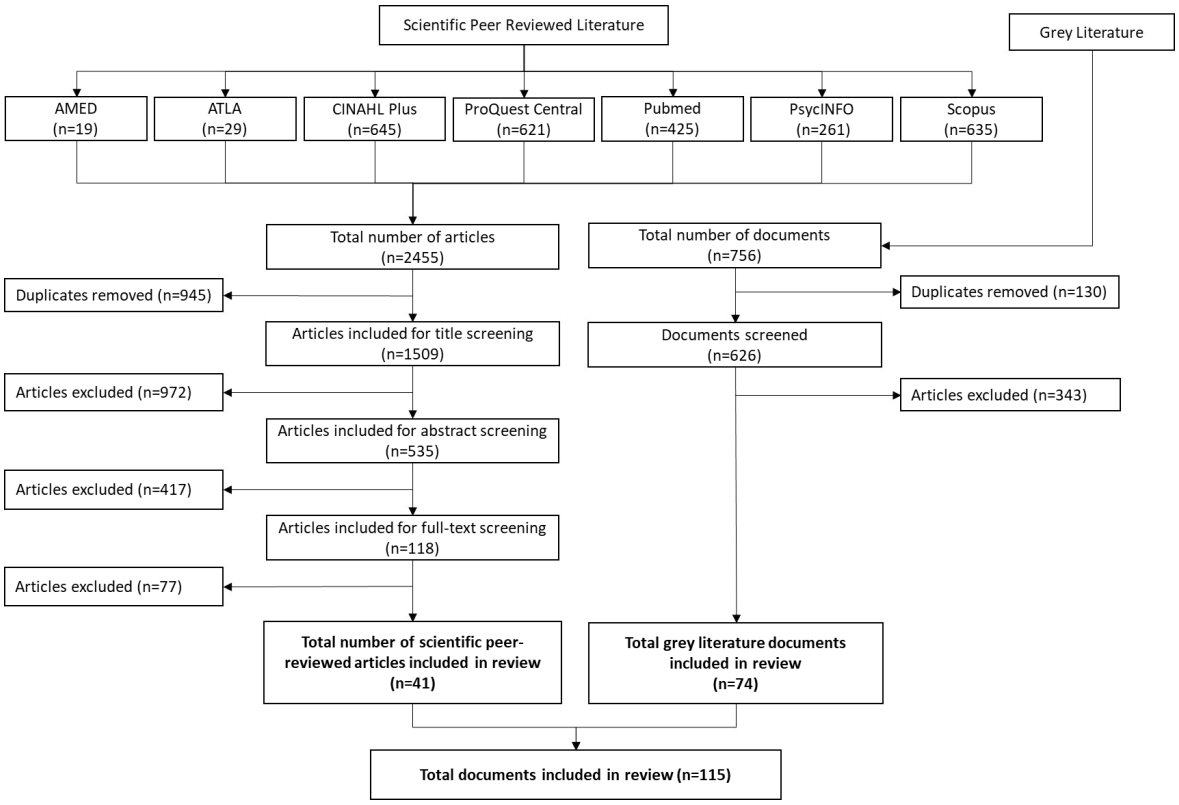

Figure 2: Flow chart of article and document screening and selection

What are the current models, frameworks, guidelines, standards, and best practices for spiritual care in healthcare?

The search strategy for peer-reviewed literature involved searching for papers referencing models, frameworks, guidelines, or best practices of spiritual care in healthcare, while the search strategy for the grey literature involved searching for documents detailing models relating to the practice of hospital chaplaincy, spiritual care, pastoral care and patient-centred care. Consequently, the grey literature reviewed consisted predominantly of models, while the peer-reviewed literature contained a variety of structures that included 21 models, 8 guidelines, 4 frameworks, a charter,(19) a policy statement,(20) a protocol-based practice,(21) a conceptual manuscript,(22) a process,(23) a certificate and standard,(24) a theory,(25) and a principle and practice.(26) As noted earlier, these are collectively referred to using the acronym MFG (Model, Framework, Guidelines etc).

The peer-reviewed literature originated from 18 countries, with Iran and the USA contributing the largest number of papers, followed by the Netherlands and Canada. Most peer-reviewed literature included in this review focussed on the development of spiritual care MFG, while a smaller number of papers described, applied, tested, evaluated and/or implemented MFG (Table 4).

Table 4: Peer-reviewed article characteristics

Article Characteristic	Number of articles
Country	
Iran	8
USA	8*
Netherlands	4
Canada	3*
Australia	2
Aotearoa New Zealand	2
Brazil	2
Denmark	2
Estonia	2
Indonesia	1
Philippines	1
Scotland	1
Kenya	1
Belgium	1
England	1
Thailand	1
Korea	1
India	1
Article intent of spiritual care MFG in healthcare	
Develop	18
Only descriptive‡	10
Apply	6
Test	3
Evaluate	3
Implement	1
Type spiritual care MFG in healthcare	
Model†	21
Guideline	8
Framework††	4
Charter	1
Policy Statements	1

Article Characteristic	Number of articles
Protocol Based Practice	1
Conceptual Manuscript	1
Process	1
Certificate and Standard	1
Theory	1
Principles and Practices	1
Healthcare area/discipline of the spiritual care MFG in healthcare	
General	20
Hospice and Palliative Care	8
Oncology	4
Cardiology	2
Mental Health	2
Hospital Setting	2
Geriatrics	1
Maternity Care	1
Medical Centre	1
Religious affiliation of the spiritual care MFG in healthcare	
None	32
Islam	4
Christian	2
Buddhist	1
Spiritism	1
Multiple ◊	1

* 1 article from USA & Canada
‡ Includes reviews
† Including 'Conceptual model' (n=2) and 'competency model' (n=1)
†† Including 'Theory/Framework' (n=1), 'Models & Framework' (n=1)
◊ Catholic, Buddhist, Christian & Jewish

The grey literature included models published and promoted by professional bodies from around the world, including the United Kingdom (NHS & UKBHC), United States (APC & HCCN), Australia (SHA & SCA), Canada (CASC) and Aotearoa New Zealand (ICCHC & MCHDB) (Table 6). The grey literature also included documents published by individuals or groups not directly affiliated with major professional associations related to areas including palliative care, equity, general practice, national disasters, aged care and mental health (Table 5).

Table 5: Documents from sources other than main Professional Associations in key countries

Source Type	UK	USA	AUS	CAN	NZ
Palliative Care/EOL	2	4			2
Equity	2	1			3
General Practice	1				
National Disasters	1				
Aged Care/long term care			1	1	
Mental Health			2		
Other		2			1

Table 6: Comparison of key features of main models identified in the review of the grey literature

Quality Area Criteria	Comment	Number of documents from each organisation which met quality area criteria in each country included in review*				
		UK	USA	AUS	CAN	NZ
1. Overall						
a. Spiritual Care Defined	Either "Broadly & inclusively defined" OR "Broad & inclusive definition" OR "Broadly inclusive definition"	6 NHS 2 UKBHC	2 APC 3 HCCN	4 SHA	1 CASC	1 ICCHC
b. Evidence Based	Is the importance of this acknowledged?	2 NHS	1 ACP 1 HCCN	2 SHA	1 CASC	1 MCDHB
2. Spiritual Care Staff						
a. Training	Comprehensive, ongoing?	1 NHS	1 HCCN	1 SHA	2 CASC	None
b. Registration / Credentialling	Is it compulsory or recommended?	NHS Scot – compulsory UKBHC – recommended	Recommended by both	Details listed & recommended by both	2 CASC – recommended	2 docs listed & recommended
c. Professional development	Continuing updated PD expected	2 NHS 1 UKBHC	2 APC	2 SHA 1 SCA	2 CASC	1 doc
d. Capabilities	Capabilities to model/sector standards	1 NHS 1 UKBHCC	APC & HCCN – some capabilities listed	1 SHA – all capabilities listed	Some capabilities listed	Not listed
e. Competencies	Listed across all levels	1 NHS 1 UKBHCC	1 APC 1 HCCN	1 SHA	3 CASC	Not listed
f. Research literate and participating in research	Research literacy required & research participation encouraged	2 NHS – both 2 UKBHCC – both	APC several docs both. 1HCCN	SHA both	2 CASC	1 MCDHB
3. Integrated in System						
a. Evaluation of Practice	Organisation support for & requirement of regular Evaluation, supervision & accountability	2 NHS – including main one. 1 UKBMC	2 APC 1 HCCN	1 SHA	2 CASC	1 MCDHB
b. Communication	Interdisciplinary re patient care, quality, team resilience	All NHS documents 1 UKBHC	2 APC 2 HCCN	3 SHA	2 CASC	2 MCDHB
c. Referral Process	Established system, all staff, to community, etc	1 NHS 3 UKBHC	1 HCCN	1 SHA	1 CASC	None
d. All Staff Spiritual Care & Support	Support & Sc as requested & org. rituals	7 NHS 3 UIKBHC	2 APC 2 HCCN	1 SHA	1 CASC	1 MCDHB
e. All staff Spiritual Care Education	Recognised. All involved & educated as appropriate.	12 NHS – include some 1 UKHCB	2 HCCN	1 SHA	1 CASC	2 MCDHB
f. Crisis Management	Sc important role, debrief etc	4 NHS 1 UKBHC	None	1 SHA	None	None

Quality Area Criteria	Comment	Number of documents from each organisation which met quality area criteria in each country included in review*				
		UK	USA	AUS	CAN	NZ
4. Spiritual Care patients & families						
a. Documenting	Record all interaction with patients according to local format	4 NHS	2 APC 1 HCCN	3 SHA	1 CASC	None
b. Screening	Screening important various tools	None	1 HCCN 1 APC	1 SHA	1 CASC	None
c. Assessment	Essential, mixed with screening, multiple tools, ongoing	5 NHS 2 UKBHC	2 APC 1 HCCN	2 SHA	2 CASC	1 MCDHB
e. Intervention	Individual, wholistic, according to ICD 10, accounting for diversity	3 NHS 2 UKBHC	1 APC 4 HCCN	3 SHA	1 CASC	1 MCDHB
f. Outcomes	Exp.as sensitive, compassionate, according to need, PROM	2 NHS	1 HCCN	1 SHA	None	None
g. Patient Feedback	heard, empowered, over-all satisfaction, regularly sort PROM	3 NHS	1 APC 1 HCCN	1 SHA	1 CASC	None
5. Organisation Matters						
a. Work Force	Staff according to appropriate patient numbers, Education and Research time included, regular review of needs, succession planning	4 NHS	1 ACP 2 HCCN	2 SHA	1 CASC	1 MCDHB
b. Inclusion Issues	Integrated across all levels, IT, Organisational strategic plan, annual reporting, after hours service, Govt funded,	12 NHS 1 UKBHC	3 ACP 2 HCCN	3 SHA	None	2 MCDHB
c. Resources	Range: brochures, guidelines, space, etc	8 NHS 1 HCCN	1 HCCN	2 SHA	None	1 MCDHB

***Organisational documents included in review according to each country:** UK (NHS & UKBHC); USA (APC &HCCN); AUS (SHA & SCA); CAN (CASC); NZ (ICCHC & MCDHB).

Country acronyms: UK (United Kingdom); USA (United States of America); AUS (Australia); CAN (Canada), and NZ (Aotearoa New Zealand)

DISCUSSION OF RESULTS

Who and where are the MFG intended for?

The majority of peer-reviewed MFG were developed with the intention of improving the spiritual care of individuals treated in healthcare systems. Some were developed to educate or improve the spiritual or religious literacy of healthcare workers, while others were developed to improve spiritual care offered to the families of patients and healthcare workers. Much of the peer-reviewed MFG were in the early stages of development and many of these were designed to be applied broadly to healthcare settings.(19, 20, 23, 25, 27-34) Often, the MFG had not yet been implemented widely, and in some cases had been implemented only at a single location.(21)

> *In contrast, many of the models found in the grey literature had been implemented to varying degrees, particularly those designed and promoted by professional associations or major health providers. None of these claimed to be consistently applied across their respective areas of influence and in most cases were recommended rather than mandated.(35-37) Twelve publications related to different NHS services and foundations demonstrated localised recommendations on the model of practice.*

Some MFG were designed to be applied at an organisational level,(29, 38) while others at a local,(39) regional, (30) or national level,(20, 32) although this was not always stated in the literature. The Fellow Traveller Model was designed to be used in black and ethnic minority groups in palliative care in the UK,(40) while Moosavi et al. (41) developed a guideline of spiritual care specifically aimed at cancer patients. Raffay et al. (42) produced a revised bio-psycho-social-spiritual model of care aimed at mental health services, and Bakar and colleagues (43) developed a model to improve the psychospiritual comfort of coronary disease patients, although there appears to be nothing about this model that would necessarily prevent it from being applied to a broader context. Galbadage et al. (44) applied the biopsychosocial-spiritual model to patients with COVID-19 dying in isolation; notably, this model also addressed the spiritual wellbeing of their families, as did "Code Krishna," (21) a protocol-based practice intended to benefit the spiritual wellbeing of a patient's family members at the time of their death.

Several MFG were specifically intended to be applied in particular healthcare settings, including mental health care (45, 46) and hospice and palliative care.(1, 26, 38, 47) Some of the models intended for hospice and palliative care also addressed the spiritual needs of patients' families.(48, 49) The Clinical Practice Guidelines for Quality Palliative Care (38) defined palliative care as being available to anyone with a "serious illness," rather than only those with a terminal illness, and defined "*serious illness*" as "*a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregiver*" (p.i) as sourced from Kelley et al.(50) Additionally, these guidelines provided care for caregivers as well as those experiencing serious illness.(38) The TRUST Model for Inclusive Spiritual Care (51) also focused on providing spiritual care and support, not only to clients, but also to their caregivers.

The provision of spiritual care and support to all staff was widely put forward in the grey literature as an important part of the role of the spiritual care professional, this included the provision of staff/organisational rituals as needed.(52-60)

A smaller number of peer-reviewed MFG were intended to provide spiritual care, support, or literacy to healthcare workers. Kim et al. (61) examined the National Centre for Healthcare Leadership Competency Model and considered its applicability to spiritual care managers. The Personal-Cultural-Structure-Spiritual Reflections Model

(62) was intended to encourage religious literacy, reflection, and engagement by healthcare professionals. The Remembrance and Renewal practice implemented by Southard et al. (63) encouraged the spiritual care and wellbeing of healthcare staff via self-care practices.

Only two of the peer-reviewed papers and none of the grey literature we reviewed discussed MFG intended to provide spiritual care to Indigenous people. Wilson et al. (64) reviewed nine culturally-based Māori models of health and wellbeing, all of which acknowledged and incorporated Māori cultural beliefs and practices, while Moeke-Maxwell et al. (47) proposed an adaption to an existing Māori healthcare model intended to provide end of life care to both Māori and non-Māori.

What are the elements that make up a best practice MFG?

Despite the diversity of the spiritual care in healthcare MFGs reviewed in both the peer-reviewed and the grey literature, there are many shared components, elements, and characteristics.

Figure 3 depicts the thirteen common elements of the spiritual care in healthcare MFGs discussed in this review (shown in bullet points). These elements have been grouped into categories 'why', 'what', 'who', 'where', and 'how' by the authors. Another element added by the authors, the 'Indigenous Spiritual Care in Healthcare', is shown inside the central circle. These common elements are discussed in the following section.

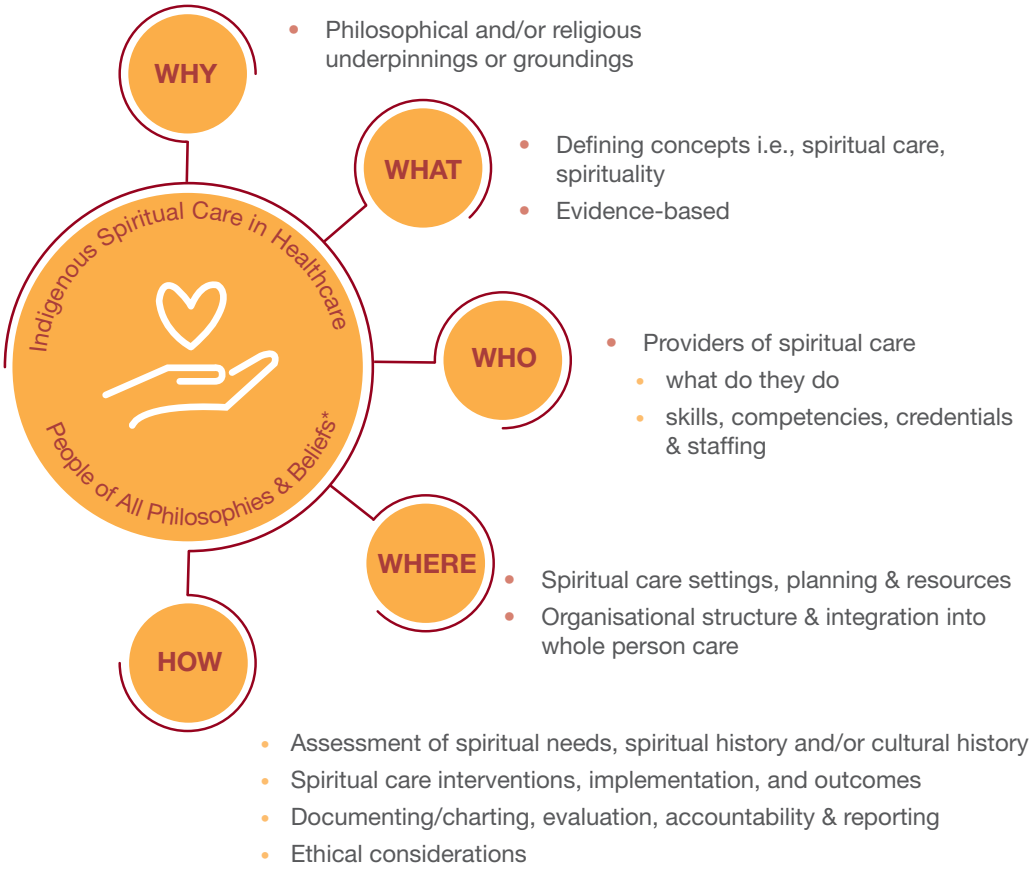

Figure 3: The common elements that make up a spiritual care in healthcare model, framework, guideline etc.
*An element added to by the Authors, not discussed in the literature review results

Indigenous spiritual care in healthcare

Of all the papers that we reviewed, only two discussed MFG that offered perspectives on spiritual care drawn from Indigenous cultures. Literature outside this review asserts spirituality is essential for many Indigenous peoples (65-70), and therefore an important element in best practice spiritual care MFG in healthcare. The lack of recognition of this in the literature we reviewed highlights a significant gap in the MFGs that have been published in the last several years. Both papers that did offer Indigenous perspectives examined models that addressed the healthcare needs of Māori in Aotearoa New Zealand. Despite the MFGs in our review originating from many countries with significant Indigenous populations, including the United States, Canada, Australia, Brazil, Indonesia, and the Philippines, only one other paper that we reviewed made passing reference to the consideration of Indigenous perspectives.(24)

Moeke-Maxwell et al. (47) interviewed bereaved Māori and non-Māori family carers in Aotearoa New Zealand and used their findings to propose a biocultural palliative care model based on the existing Te Whare Tapa Whā healthcare model, which includes wairua, a spiritual dimension. The authors found that despite this Indigenous model being grounded in Māori beliefs and values, it was applicable to both Indigenous and non-indigenous experiences of palliative care. The same study found that "*there was no difference between Māori and non-Māori with respect to the need for holistic care across the domains of Whānau (social – family/whānau health care), Hinengaro (emotional/mental health care), Wairua (spiritual health care) and Tinana (physical health care)*"[(p182)]. Together, this suggests that spiritual care MFGs based on Indigenous perspectives may be useful in providing spiritual care to all people.

Wilson et al. (64) reviewed nine models of Māori healthcare. They noted that these models were characterised by a holistic perspective of health and wellbeing where the dimensions of "*wairua (spiritual), perat (extended family network), hinengaro (the mind), and tinana (physical), are interrelated and connected*"[(p3544)]. They contrasted this perspective with that of the western biomedical model which considers physical wellbeing the primary, and in many cases, the only determiner of health, and argued that "*health and wellbeing for Māori is a holistic and relational concept*"[(p3539)]. They concluded that "*key elements for a Māori-centred model of relational care include whakawhanaungatanga (the process of building relationships) using tikanga (cultural protocols and processes) informed by cultural values of aroha (compassion and empathy), manaakitanga (kindness and hospitality), mauri (binding energy), wairua (importance of spiritual wellbeing)*"[(p3539)].

Philosophical or religious underpinnings and groundings

While not all the MFG in the papers and documents we reviewed explicitly stated the philosophical underpinnings they were grounded upon, doing so provided useful background context that allowed the reader to better understand how the MFG were developed and to assess their suitability for use in particular contexts. The importance of an evidence-based grounding and evidence-based practice was emphasised in many of the MFG, particularly in the grey literature.(35, 55, 71, 72) Similarly, the TRUST Model for Inclusive Spiritual Care (51) from the peer-reviewed literature was grounded on evidence suggesting that "*inclusive spiritual care is integral to holistic health promotion for both providing and receiving heath care*"[(p285)].(51)

Other MFG were grounded on religious beliefs and teachings. For instance, Asadzandi's Islamic Religious Spiritual Health Training Model for Patients (73) was grounded in Islamic concepts drawn from the Quran and hadith, while the Faith-Hope-Love Model of Spiritual Wellness (74) was grounded in Christian theology, and the Spiritual AIM model (34) was founded on the ethic of reciprocity "*treat others as you*

wish to be treated"[p78]. Religious and theologically underpinned MFG tended to be more commonly found in the peer-reviewed literature whereas, models found in grey literature, especially those produced by professional associations, generally took a secular, evidence-based approach that emphasised equality regardless of faith.(55, 75)

This review highlights that the theoretical underpinnings of spiritual care MFGs are not always stated, and further research and thought is required to investigate and develop appropriate theories that can underpin spiritual care MFGs in healthcare settings.

Defining concepts

Defining concepts, including clear definitions of central aspects, such as spiritual care, spirituality, and spiritual wellbeing is an important element of a best practice MFG.

Many of the models found in the grey literature provided a broad and inclusive definition of what spiritual care is, that included specific mention of equality regardless of faith or ethnicity, hope, meaning, and intrinsically human, individual focused. (35, 37, 58-60, 76-89) It should be noted in the ICCHC Annual Report,(89) that although "for all" is stated, the focus and language of the document is Christian orientated. Other frequently included aspects of defining spiritual care included, compassion, finding meaning and purpose. These characteristics of spiritual care are mentioned by all the main professional bodies who produced grey literature listed in this review, except for ICCHC.

In many of the peer-reviewed papers we examined, "spirituality" was defined, with some papers citing existing definitions,(46, 62) while others used various processes – such as group concept mapping – to arrive at original understandings.(31) The MFG that were grounded in religious ideas tended to characterise spirituality in terms of a relationship with God,(73, 74) although this was not always the case. Sheilds et al.,(34) whose model was grounded on theological themes, arrived at a definition of spirituality as "*encompassing the dimension of life that reflects the needs to seek meaning and direction, to find self-worth and to belong to a community, and to love and be loved*"[p78]. Other articles acknowledged that spirituality may involve a relationship with a divine presence for some people, but not for others, and defined spirituality in more universal terms, involving meaning, purpose, and hope.(51) Some authors suggested that while spirituality "*constitutes a fundamental core aspect of each human being*"[p8],(31) this will be unique and different for every person, and so an adequate definition of spirituality must acknowledge that each individual "*be treated as a unique being with a unique kind of spirituality and with unique values associated to that spirituality*"[p8].(31)

Defining 'spiritual wellbeing' is an important element in best practice MFG as it describes one of the outcomes that the quality of spiritual care should be aiming to achieve. It is important though that the definitions included are precise and operationalizable. In the literature we reviewed this was not always the case, with spiritual wellbeing often being described in vague terms where it would likely be difficult to assess whether they had been met. For instance, for the Faith-Love-Hope Model of Spiritual Wellness,(74) spiritual wellness involves "*having one's faith, hope, and love needs met*" [pE5], while Bangcola's Spiritual Nursing Care Framework (27) defines spiritual "wellbeing" as occurring "*when spiritual needs are satisfactorily addressed*"[p164].

Evidence-based practice

Evidence-based practice as an element of MFG, was a common feature in the grey literature. In the analysis of the peer-reviewed literature the presence or absence of evidence-based practice was not explicitly named.

Evidence-based practice of spiritual care MFG within healthcare settings varied in the grey literature. For example, NHS Education for Scotland (66), ACP Standards

of Practice (67), HCCN Scope of Practice (36) and SHA Guidelines (39). Indicative comments about evidence-based practice included: "*The development of spiritual care research assists in evaluating and improving the provision of spiritual care"* (39) and *"research evidence relevant to spiritual care services, and use this to promote and develop safe, effective, evidence-based practice in their local setting"* (60).

Providers of spiritual care

Specifying who provides spiritual care is an important element of best practice MFG, with most of the MFG we reviewed nominating the providers of spiritual care. In some cases, the provider was a single healthcare worker and generally these were nurses.(27, 43, 74, 90, 91) In other cases, they were a specific spiritual care role, such as a chaplain (29, 92) or a spiritual care manager.(61) In a single paper, spiritual care was undertaken by healthcare practitioners via self-care practices.(63)

Families of patients were also, in some instances, identified as being able to provide spiritual care, usually in a supplementary role. In Bangcola's Spiritual Nursing Care Theory,(27) families are considered to occupy a unique position where they can assist nurses in understanding the spiritual needs of the patient and clarify specific cultural or religious practices that may help the nurse meet these needs. In one of the Māori models of healthcare reviewed by Wilson et al.,(64) it is explained that individuals have certain obligations to others in their family and that "*this collective orientation highlights the imperative that healthcare practitioners include whānau [family] as a person's support network, especially as whānau [family] can also offer valuable social and medical history for a person*"(p3544).

Other MFG were less specific about who was responsible for providing spiritual care, suggesting it was the responsibility not of any one role but of many of the people involved in treating patients. This was often the case in the grey literature, where many models acknowledged that all staff at times provide spiritual care, while also referring to spiritual care professionals as experts in the field. In the peer-reviewed literature, several MFG also state spiritual care is provided by all healthcare professionals. For instance, in Vaishnav et al.'s Code Krishna practice,(21) spiritual care is provided by "*the entire treating team*,"(p291) while in the conceptual model developed by Hvidt and colleagues,(31) the charter of spiritual care developed by Heidari et al.,(19) and the T.R.U.S.T. Model,(51) it may be delivered by all healthcare professionals, including nurses, chaplains, psychologists, doctors, and midwives. Memaryan et al.'s guidelines (93) have a particularly broad range of potential providers of spiritual care with nurses, social workers, doctors, psychologists, and other healthcare providers, religious counsellors, and the patient's family and friends all seen as having roles to play, with nurses seen as having "*the main role in identifying the primary spiritual needs of the patients*" (p4292) and clergies being "*the main members of the team accepting referrals and performing counselling and interventions in cases of spiritual crisis*" (p4292).

In some cases, spiritual care is the delegated responsibility of all healthcare workers involved in patients' treatment due to healthcare teams lacking spiritual care specialists,(49) although it was more often the case that spiritual care was considered a shared responsibility among multidisciplinary teams, even when a spiritual care specialist was present in a workplace.(1, 20, 23, 32) For instance, the Clinical Practice Guidelines for Quality Palliative Care reviewed by Handzo et al. (38) "*presume the generalist-specialist model of spiritual care in which the professional chaplain is the spiritual care specialist, and all other members of the team are spiritual care generalists*" (p62). Memaryan et al. (93) suggest while all medical staff should be able to provide some level of spiritual care, it is important they recognise that in some situations, they will need to refer to a spiritual care specialist with more skills and experience. Braam (46) also notes that in some cases, referral may be necessary when a clinician feels either insufficiently equipped or lacks affinity to deal with religious or spiritual issues, and that one advantage of a collaborative approach is that such tasks may be allocated to those most appropriately suited to undertake them.

Holyoke and Stephenson,(26) who developed nine principles offering guidance for secular healthcare organisations wishing to improve the quality of spiritual care they provide, state as their first principle that spiritual care is "*an emergent property of the system of care, not a distinct piece or part of care*,"[(p5)] and thus see all members of the care team as being responsible for providing spiritual care, while acknowledging not all team members need be "expert" in spiritual care. Collaboration between team members is important, as evidenced by their eighth principle: "*quality spiritual care involves creating and sustaining relationships beyond those typical between co-workers*"[(p14-15)]. Memaryan et al. (93) similarly advocate for collaboration and that all members of a healthcare team who are responsible for providing spiritual care "*form a strong mutual relationship and a network through the documentation of evidence and be aware of each other's activities and provide care as a team*" [(p4292)]. Van de Geer et al.,(1) who investigated the implementation of the Dutch multidisciplinary guideline for spiritual care, noted that while the guideline considers members of multidisciplinary teams to be collectively involved in the spiritual care of patients, members will have different roles and tasks, with healthcare chaplains being responsible "*for implementation of the SC guideline and training their medical colleagues in its recommended methods*" [(p153).] Meel and Lehtsaar (33) advocate for a similar approach, with pastoral caregivers taking on the role of educating other members of the healthcare team in matters of spiritual care.

Beyond the multidisciplinary team, Braam (46) suggests in some cases it might be appropriate to work with external collaborators to provide spiritual care for mental health patients, for instance, working with clergy members, religious leaders, and pastoral workers during treatment or for outpatient counselling, while Meel and Lehtsaar (33) raise the possibility of patient support groups as a potential source of additional support.

What do spiritual practitioners do?

In the MFG where there is a specific role for a dedicated spiritual practitioner, whether that be a chaplain, spiritual counsellor, pastoral caregiver, or some other position, or where one of the functions of the role of a healthcare worker – such as a nurse – is to provide spiritual care, the activities these practitioners are responsible for should be clearly outlined, as was the case in many of the MFG we reviewed.

In some of the papers reviewed, the spiritual practitioners were expected to provide spiritual counselling for patients if required,(32, 46, 73) which might involve assisting the patient in finding coping resources, (32) or helping the patient develop optimism and courage to adapt to new circumstances.(73) In religiously grounded models, this spiritual counselling might involve religious activity, including prayer, reading religious texts, and contemplation of God.(73) In the case of Asadzandi's Islamic Religious Spiritual Health Training Model,(73) nurses were expected to provide the resources and opportunities for patients to engage in such activities. In other cases, spiritual counsellors might be available to perform religious rituals if required.(33, 46)

Identifying a person's spiritual needs in order to provide holistic care was a key function of pastoral caregivers described by Meel,(32) who writes that "*spiritual needs are often invisible and hard to notice by both the patients and by the other specialists, so it is the pastoral caregiver's job to recognise the invisible and intangible aspects of the human being and thus contribute to holistic care*"[(p6)].

Educating patients and/or healthcare workers is another activity associated with the spiritual practitioner role. This might involve helping patients come to terms with why they have been afflicted by a particular disease or condition – for instance, elucidating the role of genetic factors or lifestyle choices, rather than destiny, and therefore encouraging patients to initiate healthy behaviours (73) – or helping patients to understand medical procedures or interventions by using lay terms that are easily

understood.(92) Spiritual practitioners might also act as educators for healthcare workers, helping to enhance their understanding of the role religion or spirituality plays in treatment and recovery,(46) improve spiritual or religious literacy (33) and helping them to understand "*how faith dynamics and spiritual paradigms impact the way in which a family processes medical decisions based on their understanding of concepts such as hope, healing, miracles, and quality of life*"(p34).(92) Many of the grey literature models emphasised the importance of appropriate education in spiritual care, usually provided by senior spiritual care practitioners.(35, 52-56, 71, 94-97) One document indicated that this education in spiritual care would include volunteers if they are used.(52)

Serving as a mediator or bridge between patients and their families with doctors, specialists, and in some cases, the wider medical team, is an activity sometimes assigned to spiritual care practitioners. Meel and Lehtsaar (33) described this particular function of a spiritual practitioner's role as "*balancing the traditional authority of doctors' expertise and patients' values and preferences*"(p16). Wirspa and colleagues (92) write that "*chaplains describe their role both in terms of an approach to decision-making that differs from that of the medical team and as a location, as a "bridge" between the patient and family and medical team. They claimed skill in providing a non-anxious and unbiased presence that creates a safe container for conflictual or unacceptable feelings around complex value-charged situations and end-of-life situations. Free of medical agenda or opinion, chaplains see themselves as "holding sacred space*" (p33) for reflection on moral, ethical, religious, and cultural concerns. This activity may be particularly important in cultures where family play a central role in managing or facilitating a relative's health and wellbeing. Many of the Māori models of healthcare reviewed by Wilson and colleagues (64) emphasised the importance of family (whānau), with the authors explaining that it is "*imperative that healthcare practitioners include whānau as a person's support network, especially as whānau can also offer valuable social and medical history for a person. It is also important that healthcare practitioners assess whānau understanding of a patient's condition and provide appropriate education and support to whānau to ensure effective management of a whānau member's health*"(p3544).

Another aspect of spiritual care within an organisational context was the importance of spiritual care in times of crisis, disasters, or critical incidents. Their role in support and debrief of staff was especially mentioned in papers from three of the included countries i.e., UK, USA, AUS (40, 52, 55, 95, 98-101).

Skills, competencies, credentials & staffing of spiritual practitioners and carers

Many of the MFG we reviewed discussed the education, credentialling, skills, and competencies of spiritual care staff.

Some of the MFG outlined recommended skills and competencies for spiritual practitioners. In some cases, general religious or spiritual literacy was considered an important competency for anyone providing spiritual care,(62) while a more nuanced understanding of particular spiritual concepts, such as understanding the "*essence of the human spirit*," was considered necessary to provide spiritual care under the Faith-Hope-Love Model developed by Christman et al.(74) In at least one instance, having a personal affinity with spirituality was considered important. Braam (46) suggests that any professional who lacks such affinity might need to involve other colleagues to adequately provide spiritual care. Kim et al. (61) described management and leadership skills required by spiritual care managers. These include achievement orientation, analytical thinking, initiative, collaboration, team leadership, and network/relationship development.

In the grey literature, the issues of capabilities and competencies for spiritual care providers were addressed with varying degrees of detail and attention. Some outlined fairly detailed capabilities expected of professional providers.(35, 59, 95) The matter

of capabilities corresponding to different levels of registration was also mentioned.(59, 102) The idea of competencies being outlined across all levels of employment, including tools for evaluation of these, or ways of evidencing these, were widely mentioned.(39, 60, 97) This was not mentioned by any of the professional association documents from Aotearoa New Zealand.

The importance of research literacy and the willingness and ability to participate in research was discussed in some of the grey literature. Research at a level appropriate to understanding and incorporating relevant research into practice was considered important.(36, 37, 55, 60, 96) It was also considered important to encourage research participation at the appropriate level of competence.(57-59, 98, 103, 104)

In some peer-reviewed papers particular qualifications or training requirements were outlined. For instance, the Clinical Practice Guidelines for Quality Palliative Care discussed by Handzo et al.(38) stated that professional chaplains are master's level prepared, have taken clinical chaplaincy training, and preferably have Board Certification in chaplaincy. However, in another study that developed principles to support spiritual care at the end of life, it was suggested that not all spiritual care providers need to be "experts" in spiritual care, but "*all must be prepared, when a spiritual issue arises or could or should arise, to respond to it*" (p5).(26) The same authors went on to suggest that "*an individual who approaches hospice palliative care vocationally…likely possesses the capacities necessary to respond to spiritual needs*," although "*those with specialised training may have a different kind of knowledge, which may be needed in specific situations; for example, a priest is needed to deliver last rites, or if a patient has been struggling for several weeks with existential searching…a chaplain or a psychologist may be needed*"(p6).(26)

In the grey literature, the training of spiritual care professionals was not widely discussed. One UK document (103) mentioned the need for national standards in this regard but the others lacked any discussion of this issue. In the USA documents, HCCN Scope of Practice (35), indicated the need for inclusive training in relation to religion etc. However, the Spiritual Care Association (USA) (127), an affiliate of HCCN, offers a range of online training programs for spiritual care professionals. In Australia the SHA Capability Framework (59) emphasised the need for both national standards and very inclusive training. A Canadian document (96) spoke of the need for statutory requirements for training and the general lack of training available. Aotearoa New Zealand documents did not discuss training.

The issue of volunteer training was briefly mentioned with varying degrees of importance placed on it. One Australian document, (59) indicated that volunteers did not come within its scope, while a Canadian document devoted their whole paper to volunteer training in the long-term care sector.(105)

Registration and Credentialling of professional spiritual care practitioners were mentioned in UK, USA, AUS and CAN documents produced by main professional association groups.(72, 97, 103, 106) There was general agreement that registration should be encouraged, developed, or outline requirements at different levels etc, although in no case was it a compulsory requirement for employment. These countries also have registration bodies which set out recommendations for different levels of registration (UKBHC, APC, SCA, and CASC).

Generally, in the grey literature, it was agreed that a continuing process of professional development was expected and, in some cases, national standards in this regard were suggested.(36, 59, 106-108) SCA standards for ongoing registration also include professional development.(109)

Unique skills and competencies may be required by those providing spiritual care to members of Indigenous cultures. The Māori models of healthcare reviewed by Wilson et al. (64) stress the need for healthcare providers to possess broader cultural competency. In Māori culture, spirituality is intrinsically entwined with other cultural beliefs and practices associated with health and wellbeing, to the extent that spiritual

competency alone may not be adequate to properly address spiritual wellbeing. Furthermore, in order to provide quality spiritual care for Indigenous people, healthcare practitioners must possess a comprehensive understanding of the socio-political health context where colonisation and racism have impacted health and wellbeing, political environments may alienate communities, and stereotypes may contribute to bias in clinical decision-making.(64)

Spiritual care settings and resources

Specifying the setting(s) in which spiritual care takes place, and outlining the resources required to undertake it, are important elements in spiritual care best practice MFG. In some of the literature we reviewed, spiritual care takes place in a variety of settings – for example, curative and palliative treatment wards,(1) Islamic religious-based hospitals,(43) mental healthcare settings, (46) general practitioner medical centres, (29) health services and systems across Australia.(20, 30) While in other papers, the MFG designates a very specific setting. In the Code Krishna practice, spiritual care always takes place in "*the critical care unit at the time of the patient's death*"(p289).(21) In the Remembrance and Renewal practice,(63) spiritual self-care always takes place in an especially designed private space in medical buildings, intended solely for grieving and performing remembrance and self-care activities.

The fourth of the nine principles developed by Holyoke and Stephenson (26) for improving the quality of spiritual care for people at the end of life states that "*quality spiritual care considers place as sacred*"(p9) and elaborates on some qualities, characteristics, and features that are desirable in locations where this spiritual care takes place, including efforts to create "*a special sense of place*"(p9), that might be achieved via architectural design or furnishings, gardens that contribute to a sense of place, and hospices or palliative care wards that closely resemble the feel of a home.

In at least two of the papers we reviewed, spiritual care ideally took place not in any particular location, but everywhere. For example, Memaryan et al. (93) argue that "*spiritual care of cancer patients and their caregivers should be an inseparable part of health and medical services in all care settings"*(p4293), and should occur not only in specialised hospital departments but also in outpatient clinics, and within the community. Similarly, Moosavi et al. (41) recommend spiritual care should occur at both hospital and community levels, including as part of home-based care.

Resources required for implementing spiritual care varied between MFG. The Islamic Religious Spiritual Health Training Model suggested nurses should assist patients to pray by allowing them to change clothes, showing them Qibla direction, and providing headphones so they can listen to the Quran.(73) Galbadage et al. (44) suggested virtual funeral services and the use of remote counselling may help families who have had loved ones die of COVID-19 while in isolation, and that video-conferencing is an important tool that can be used to connect patients in isolation to their families. Holyoke and Stephenson (26) found that significant objects, including religious objects, may be valued by patients at the end of life, and could facilitate discussion about spiritual issues. The designated spaces for spiritual self-care described in the Remembrance and Renewal practice (63) are described as containing a variety of items that assist with grieving and reflection, including battery-powered candles that may be lit as part of remembrance activities, a journal where the thoughts of staff may be collected, inspirational books on bereavement, nondenominational prayer squares, and essential oils. Holmes,(20) who examined spiritual care in the Australian healthcare context, suggested hospitals provide "*a dedicated space for meditation, prayer, ritual, or reflection*"(p4), while the final dimension on the TRUST Model (51) involved asking individuals whether there may be resources they would find useful in exploring spiritual questions, that may include "*readings, educational events, retreats, or experiences that individuals identify as helpful in meeting their needs*" (p285).

In the grey literature, the provision of appropriate resources, equitably distributed,

was most strongly canvased by some NHS groups, HCCN in USA and SHA in Australia. Suitable facilities for worship (multi-faith), ritual and self-reflection were specifically mentioned in many models,(35, 52, 53, 55, 59, 94, 101, 103, 110, 111) while providing spiritual care guidelines for staff were also considered an important resource.(35, 39, 55, 112) Other items for patients included multilingual brochures, websites, prayer mats, bereavement packs, and video clips.(35, 52, 53, 55, 56, 71, 105, 113)

Organisational structure and integration into whole person care

Elements pertaining to organisational structure that included workforce planning and organisational issues and resources, were found almost exclusively in the grey literature. The exact nature of these areas varies in different systems depending on the degree to which Spiritual Care is integrated into whole person care, which we therefore consider as part of the overall structure and planning of the providing organisation.

There was a widespread workforce view that staff employed should have diverse skills, be fully trained and credentialled and employed in numbers consistent with a reasonable staff/patient ratio. Employment according to faith numbers is no longer regarded as appropriate.(35, 55, 56, 58, 59, 94, 103) Regular reviews of staff numbers and action to fill the gaps was considered important.(55) While some NHS services (37, 52, 103) thought that trained volunteers played an important part, others (55) indicated that volunteers were not part of a professional workforce. Taking ethnic background in the general population into account was considered important when employing staff in mixed societies so that all groups are represented among the staff.(114)

In considering other organisational issues it is also relevant to remember that the issues discussed are prefaced upon the assumption that spiritual care is integrated and accessible throughout the whole organisation, including through IT systems. One important aspect is that spiritual care is involved in the system audit of needs and produces an annual report both of which are reflected in the organisational strategic plan and funding sources.(35, 37, 52, 55, 72, 98, 99, 103, 104)

Involvement as an integral part of the whole system requires Spiritual Care leaders to be trained in policy, politics and other matters relating to the function of the system and to be aware of the difference between management and leadership – the latter being particularly important.(35, 36, 55, 94, 101, 103)

Matters relating to staff were also raised, for example spiritual care staff are appointed by the organisation and undergo annual reviews according to organisation protocol.(37, 55, 71) Facilities such as suitable dedicated office space, perhaps near Allied Health Services, should be allocated and funding given according to need equitably across the organisation.(37, 56, 99, 112, 115) It has also been recommended that spiritual care staff be renumerated for professional development and external supervision as required for accreditation.(55, 89) Although it is acknowledged that there is a lack of consistency in the application of these matters, (101, 105, 116) it is also recommended that consistency be aimed for.(5)

Assessment of spiritual needs, spiritual history, or cultural history

Some of the MFG we reviewed appeared to see the spiritual needs of patients, or at least the patient population that is being addressed, as being reasonably universal and consistent,(74) while others recognised that spiritual needs and the meaning of spirituality varies between individuals and across communities.(27, 51) An essential part of spiritual care in the case of the latter view is assessing patients' spiritual histories – in some instances as part of obtaining a complete medical history at the beginning of treatment in order to determine their particular spiritual needs. (24, 31) This assessment is acknowledged as a pre-requisite for effective spiritual care in many of the grey literature documents.(40, 55, 57, 72, 75, 94, 101)

In the peer-reviewed literature this is addressed by policy statements in Holmes'

paper (20) on spiritual care in the Australian healthcare context, which states that: "*All patients are offered the opportunity to have a discussion of their religious/spiritual concerns; All patients have an assessment of their spiritual needs; Patient's values and beliefs are integrated into care plans; Information gathered from assessments of spiritual needs is included in the patient's overall care plan*"(p4). In the Support-Based Spiritual Care Model used by Khezri et al.,(91) the first of four steps involve "*spiritual assessment of the patients*", which includes questions such as "*How do you define spirituality or religion?*" and "*Do you have spiritual beliefs that are important to you and help you when running into problems?*"(p424). The Buddhist Spiritual Care Model for People at the End of Life (49) begins the process of spiritual care with spiritual history taking, followed by an "*assessment of the person's spiritual needs, current level of spiritual distress, engagement with spiritual/ religious beliefs, and access to spiritual resources/ supports*"(p328).

Some papers suggest specific tools that have been developed for taking an individual's spiritual history may be useful in determining ideas about possible spiritual needs. These include the Faith and Belief, Importance, Community, and Address in Care (FICA) tool,(26, 31) and the SPIRIT history tool.(26) Nissen et al. (23) present spiritual care as a process and use what they refer to as the "Meaning-Making Matrix" as a way of identifying and understanding a patient's specific spiritual needs and developing an individual spiritual care treatment plan based on these. The Meaning-Making Matrix "*helps clarify whether the identified needs are of a secular, spiritual, or religious kind, whether there are cultural variances that need to be taken into consideration, and whether the needs are of a cognitive or practical nature, or a combination of this*"(p7).(23) A number of assessment tools such as FICA, HOPE, FACT F, SPIRIT are mentioned in the grey literature,(117) HEAT relating to equality (114, 118) and multiple others.(40) The point is made that tools need to be standardised for the environment in which they are used.(56)

In the grey literature, screening as a separate item of care was not often mentioned, although it was acknowledged as often being seen as part of assessment by others. (5, 58) It was also mentioned in one SHA document.(55) Features mentioned, by those who saw it as a separate part of care, included the need for interpreters for those with languages other than the language of the service provider(40) and the availability of various screening tools.(5, 55, 58, 119)

Two of the Māori models of health that were reviewed in one paper also emphasised the importance of understanding spiritual history. Te Kapunga Putohe model recommended consideration be given to "*how a person conceptualises wairua [spirit] to determine how their beliefs influence engagement with their health providers*," (p3544) while the Meihana Model suggested "*exploring a person's wairua [spirit] by respectfully enquiring about spiritual and religious beliefs, special attachments to people, places, taonga (treasured items), and their beliefs about death and dying*" (p3544).(64)

Assessing a patient's spiritual needs is related to patient-led and person-centred care approaches that were recommended by some of the papers we reviewed. The second principle in Holyoke and Stephenson's (26) organisation-level principles and practices to support spiritual care at the end of life "*emphasises the agency of the dying person and his or her family – rather than the care providers – to guide and direct the kinds of spiritual care that is needed*"(p3). The same authors warn that "*organisations seeking to support high quality spiritual care need to be vigilant about and attentive to healthcare providers desiring routinised 'interventions' and 'best practices' approaches to spiritual care. The practices of the hospice organisations in this study adopted, promoted, and enabled a more flexible, immediate, in-the-moment approach to listening and responding to spiritual needs"*(p7).(26) Vincensi,(120) who reviewed the relationship between spiritual care and patient-centred care models, suggests that taking a patient-centred care approach – where patients are empowered "*to mutually develop their plans of care with their healthcare providers*"(p107) – leads to improved patient care, satisfaction with care, coping, and resiliency.

Spiritual care interventions, implementation, and outcomes

Spiritual care and spiritual interventions as described in the MFG we examined were operationalised in a variety of different ways and describing exactly how this is done is an important element of a best practice MFG. The Islamic Religious Spiritual Health Training Model for Patients (73) suggested spiritual interventions may begin with nurses initiating therapeutic communication with patients and their families, before engaging in spiritual counselling, which might involve "*telling stories and encouraging patients to copy the divine prophet's lifestyle*"(p177), therapeutic touch, and healing prayers. The model also recommended spiritual advisors encourage patients' relatives to visit, encourage patients to "*examine their emotional states, intentions, thoughts, feelings, and behaviours*"(p178), and advise patients on how they may practice self-control and healthy behaviour.

The Clinical Practice Guideline of Spiritual Care developed by Moosavi et al. (41) contained extensive and detailed requirements for practitioners carrying out interventions for spiritual care for cancer patients. Some of their 35 steps included establishing therapeutic communication; holding group classes where experiences may be shared; dedicating sufficient time to talk to the patient; attempting to increase the patient's hope using "giving hope" techniques; and providing means for patients to engage in religious practices if they wish to do so.(41)

A common thread in the discussion of interventions by the major groups in the grey literature was that they be planned in partnership with the patient, the family and the inter-disciplinary team and that they meet individual and wholistic needs, including cultural based issues.(35, 39, 59, 75, 95, 96, 98, 121)

Other general aspects of interventions that were included in the grey literature were: active listening, developing rapport, and on-going evaluation of intervention overtime. (35, 59, 60, 117) Two publications made it clear that interventions should always be recorded in patient notes, guided by International Classification of Diseases-10 codes. (59, 116) There was some mention of specific interventions, mostly related to specialist health areas such as mental health or palliative care. These included: Dignity Therapy Model,(2) group work and other mental health specific interventions. (119, 122)

Implementation of spiritual care described in the literature often began with a planning phase, followed by an action phase.(23) The guidelines implemented by Memaryan et al. (24) contain a "Service Provision Flowchart" offering an easily followed visual representation of steps involved in providing spiritual care, from hospital admission, to obtaining a spiritual history, to spiritual counselling, and eventually the referral to a religious/spiritual expert for care sessions if required.

The Clinical Practice Guidelines for Quality Palliative Care (38) provided details on how spiritual care may be operationalised at an organisational level, stating that: "*palliative care services include salaried professional chaplain team members and related programmatic expenses; affiliation agreements with spiritual care departments in health systems, hospitals, or hospice programs can provide timely access to professional chaplain services; additionally, partnerships with faith community leaders are encouraged and nurtured*"(p68). The Buddhist Spiritual Care Model (49) can be implemented at an organisational level by healthcare organisations integrating it "*into their organisational visions and mission and provide training to raise healthcare providers' awareness of their own spirituality by using self-reflection, spiritual self-care, and comparative practices*"(p329).

In some cases, where spiritual care is considered a fundamental element of healthcare services, what is recommended is a holistic kind of thinking where the spiritual is incorporated into every aspect of care. For example, the first principle of the Organisation-Level Principles and Practices to Support Spiritual Care at the End of Life,(26) is that "*the spiritual is not merely a part or element of care, but rather a descriptor of the kind, nature, and quality of all care*"(p3), with subsequent principles offering more tangible steps for how such an attitude may be implemented.

Much of the grey literature took this approach, where the integration of spiritual care into overall practice of healthcare was seen as best practice and steps were outlined to achieve this. Good avenues of communication with members of the inter-disciplinary team was considered essential for the integration of spiritual care into the whole healthcare service of the site of work by many groups.(35, 36, 39, 53, 55, 58, 59, 71, 72, 94, 98, 103, 104, 112, 116)

This communication capacity was also expected with relevant community groups and NHS groups in addition to those already cited above.(52, 99, 103, 123) Other sources also expressed a similar view.(5, 124) It was considered that good communication within the inter-disciplinary team builds team resilience and also contributed to occupational health and safety.(55, 117)

Another very important part of integration into overall practice of healthcare is an appropriate and clear and written referral system.(35, 52, 55) It is apparent that this issue was not addressed as often as one might hope, although a number of papers from the UK,(40, 117) and from Australia (45, 125) did refer to the importance of timely and appropriate referral to spiritual care.

In Māori models of health, spiritual care may begin to be implemented by healthcare practitioners following and respecting cultural beliefs and practices. Wilson et al. (64) suggested "*healthcare practitioners can respectfully acknowledge and support the maintenance of a person's wairua [spirituality] and their whanau [family] by joining them in karakia (Māori prayers) at meaningful times in their treatment journey,"*(p3544) *and also that "healthcare practitioners can engage with a person's whakapapa [genealogy] and whenua [land]. It is a critical component of Māori identity by asking where they are from and their whakapapa or genealogical connections instead of focussing on where they currently live. Discussions about a person and their connections to whenua [land] provide an opportunity for healthcare practitioners to engage in whakawhanaungatanga (the process of developing a relationship) by sharing knowledge and links to their whenua as part of this process"* (p3547).

In the grey literature, three of the key groups whose documents were reviewed made comments about the outcomes of interventions. The patient experience of compassion was considered a major outcome.(37) The outcomes must be consistent with those specifically sought by the patient during consultation.(55) The matter of assessing outcomes was also mentioned, recommending the use of the Patient Reported Outcome Measures or Quality of Spiritual Care Scale.(35, 126)

Related to outcomes is patient feedback, a difference being that outcomes are sometimes staff-identified rather than patient-reported. The idea that patient feedback should be regularly sought and recorded was not widely promoted but suggested by SHA (55) and NHS.(99) It was noted in both the USA and Canada that patient general satisfaction was higher among those who had received spiritual care.(58, 75, 124) Some particular aspects of spiritual care that patients have reported finding valuable are: being accepted, not judged, really listened to,(45, 117, 127) having their needs fully met, and being empowered to solve their own problems.(94)

Documenting/charting, evaluation, accountability, and reporting

It was generally agreed in the UK, USA, Australian and Canadian grey literature documents that for safety and accountability reasons all patient visits must be recorded in a timely manner according to the local recording format, with emphasis being placed, in some cases, on recording fact rather than opinion.(35-37, 52, 55, 59, 72, 96, 98, 103, 128)

Evaluation of spiritual care outcomes is discussed in only some of the MFG we examined. In the Buddhist Spiritual Care Model for People at the End of Life, (49) the final step in the model's process of spiritual care was the evaluation of the effectiveness of spiritual care activities, "*including outcomes related to the person's spiritual*

wellbeing; physical and psychological symptom experiences such as pain, depression, anxiety, sleep quality, and quality of life; and self-management related outcomes such as coping strategies, adaptation processes, and social support"[p328]. Similarly, the final phase of Nissen et al.'s Process of Spiritual Care (23) is "Evaluation" and it is recommended evaluation occur as a continuous process to ensure appropriate care is being provided, allowing the treatment plan to be modified if required. The authors suggest this evaluation be carried out using questionnaires or instruments designed to assess the effects of interventions. Moosavi et al. (41) recommended spiritual care be evaluated via both reporting, and via discussion between healthcare team members during meetings.

There was limited discussion of both reporting and accountability in the peer-reviewed MFG. Under the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care, (38) "*chaplains will be held accountable for reliably delivering on what the guidelines suggest*"[p.60], while the Spiritual Care Minimum Data Set Framework evaluated by Hennequin, (30) provides guidelines for best practice data collection that allows consistent reporting of spiritual care.

Discussion of accountability was more common in the grey literature. Accountability by regular evaluation of practice, as an organisational requirement of professional staff in all sectors of healthcare, (39, 56, 58, 95, 110) as well as accountability to the organisation via annual reports from Spiritual Care/Chaplaincy departments to the organisational management were also considered important. (36, 37, 55)

Ethical considerations

An important element that was included by some MFG we reviewed were considerations of ethical concerns or issues that should be addressed or considered when providing spiritual care. One issue raised was the potential for healthcare professionals to influence their patients' religious or spiritual beliefs, something which the authors considered should always be avoided.(46) Vincensi (120) pointed out that where holistic care has been mandated by professional or accrediting bodies, "*lack of spiritual care and thus lack of providing holistic care can lend itself to potential ethical concerns*"[p108]. The T.R.U.S.T model (51) assumed that "*inclusive spiritual care is a patient safety issue where great caution should be observed in inclusive language and nonintrusive intervention*,"[p286] and that "*it is the caregiver's ethical responsibility to ensure appropriate follow-up and referral once a need for inclusive spiritual care has been identified in the assessment or intervention of the client*"[p286]. Peeters (129) suggested that pastoral relationships are ethically complex, due not only to an imbalance of power but also a "*tension between the interpersonal and professional dynamic,*"[p43] and recommends a code of ethics for pastoral caregivers is a necessary part of quality spiritual care.

What does best practice spiritual care and interventions look like?

As many of the peer-reviewed MFG that we examined had not been widely implemented, and in many cases had not been implemented at all or were still in the process of being developed, it was difficult to determine what among them might constitute best practice. On the other hand, many of the models found in the grey literature had been applied and were being widely used. This being the case, we have chosen to refer to the grey literature to answer this final question noting that many of the MFG found in the peer-reviewed literature offer valuable additional considerations that may in future augment the best practices we outline below.

In the first instance a clearly defined referral process, which is well known by all staff, is essential in making spiritual care available to those who need and want it. A referral system will only be effective and responded to in a timely manner if the staffing levels in the spiritual care team are appropriate for the patient numbers. In addition, there needs to be a clear process of screening and assessment leading to

the identification of those who need spiritual care (apart from those who specifically ask for it). Assessment, on-going in the case of long- term patients, is also very important in the decision about what type of intervention is needed. Effective decisions about intervention also require staff to be informed about religious and cultural characteristics of their clients so that they are more able to choose interventions of best fit for that person. This of course relates to both the training of spiritual care staff and the appropriate education of other staff. The on-going provision of best practice interventions is also dependent on spiritual care staff being research literate and up to date with current best practice, as well as continuing to inform their practice through regular patient outcomes assessment and the recording of verbal patient feedback. The latter is dependent on having an appropriate documenting/charting process accessible to all clinical staff, including spiritual care practitioners.

Best practice intervention does not happen in isolation but is part of a whole system of care, impacted by multiple factors within the organisational structure and the training of all staff. It is part of a complex system of care. While shortcomings in one or more parts can be addressed and will result in better overall care, it is important that the whole process is collaborative for best care to be given.

In summary, a short answer to the above question is that best practice spiritual care and interventions looks like a comprehensive model of care consistently and broadly applied in a smooth and informed manner, as recommended by major groups in the UK, USA, and Australia.

SUMMARY DISCUSSION

This section summarises the outcomes of this review, focusing on the specific research questions.

- What are the reported models of spiritual care?
- What are the elements that make up a best practice model?

What are the reported models of spiritual care?

While the view of some writers, for example Trinity College Dublin,(130) is that there is currently no ideal MFG for spiritual care provision in the healthcare system, progress is being made in the integration of this care into whole person care. One systematic literature review (118) referred to a number of MFG for spiritual care provision, which were also acknowledged by other sources as having influence on the way care was provided in their location, for example, Association for Professional Chaplains.(72) Specific models were identified in the grey literature as being the foundation of the care provided in the location in which the author worked,(40) although generally no evidence was found of its wider use.

Analysis of peer-reviewed literature indicated several other MFG for spiritual care, which in many cases were focused on specialised settings.(90) Several MFG, not specifically named, were clearly designed for more general use in healthcare situations. (1, 19, 20, 23, 25, 29-34)

The overwhelming evidence arising from this review is that the most comprehensive MFG for spiritual care in the healthcare systems, the most broadly inclusive and the most widely promoted models, are those designed by the professional associations in the major countries from which the literature has been sourced or by major health providers. These are: NHS and UKBHC in United Kingdom, APC and HCCN in the United States, SCA and SHA in Australia, and CASC in Canada. In Aotearoa New Zealand, the most extensive work has been done by MCDHB, with the ICCHC making a small contribution in this regard.

None of the above MFG claim to be consistently applied across their respective areas of influence and are in most cases recommended rather than mandated. It should be noted, for instance, that although twelve grey literature publications were identified relating to different NHS services and foundations, they demonstrated their own local take on the recommended MFG of practice.(38). The Australian model promoted by Spiritual Health Association is consistent with the recommendations for credentialling and registration put forward by Spiritual Care Australia but is not at this time mandated and is not consistently applied.

The next section will discuss the features of these models and some of the challenges which are apparent in applying them consistently across all sectors of health care provision.

What are the elements that make up a best practice model in the grey literature?

Best practice models of spiritual care from the grey literature comprised of five main areas of importance: overview of spiritual care; education and credentialling of spiritual care practitioners; integration into the systems of whole person care; spiritual care of patients/families and; the overall structural organisational. Each of these main areas had several relevant areas associated. These are discussed below and a more detailed account of items coded under each area can be seen in Appendices A and B.

Overview of spiritual care

In the area of overview of spiritual care, a broad and *inclusive definition* of what this is in the healthcare system was widely provided. Attention was also given to the importance of evidence-based practice and in a few cases, consideration given to theory on which the MFG was based.

These definitions of spiritual care included specific mention of inclusive care – regardless of faith/none or ethnicity – hope, meaning, intrinsically human, individual focused. (35, 37, 58-60, 76-89) Other frequently included aspects of defining spiritual care included compassion, finding meaning, and purpose. These characteristics of spiritual care are mentioned by all the main professional bodies considered in this review, apart from the ICCHC. Some documents, both grey and peer-reviewed literature, cite existing definitions of spirituality, (46, 55, 62) while others used various processes to arrive at original understandings.

A less frequently mentioned requirement for best practice models was the issue of the importance of *evidence-based practice*. Reference to this was made by key professional bodies. (36,39,66, 67)

Related to evidence-based practice are theoretical underpinnings. It appears theory is not well developed in this literature, with little explicit theory named or explained in the documents examined for this review. Implicit theory, an ontological and epistemological positioning exists through acknowledging the spiritual domain itself (as opposed to a biopsychosocial model); and, accepting it can be assessed and addressed. This was demonstrated in some cases with the use of broad, well used, and substantiated definitions of spiritual care.(35, 37, 58-60, 76-89) The concept of spiritual wellbeing is also defined in some of the literature, although the definitions offered are less precise and may be difficult to operationalise.(28,68,69)

Education and credentialling of spiritual care staff

The main area of education and credentialling of spiritual care staff included the sub areas of training, registration and credentialling, professional development, capabilities, competencies, research literacy and research participation. The degree to which these were discussed or emphasised varied considerably among the major professional bodies.

In reviewing the area of *training of spiritual care professionals* in the grey literature, key areas touched on were the need for national standards and inclusive training (40, 65) – the latter giving particular focus to Indigenous needs in Aotearoa New Zealand– and shortage of appropriate training. Aotearoa New Zealand documents did not discuss training. The issue of volunteer training was raised from differing perspectives ranging from “not within the scope of professional practice”,(40) to volunteer training in the long term care sector.(105)

Registration and Credentialling of professional spiritual care practitioners were mentioned in grey literature documents from the UK, USA, AUS and CAN, produced by main professional association groups. (72, 97, 103, 106) There was general agreement that registration should be encouraged, developed, or outlined requirements at different levels etc, although in no case was it a compulsory requirement for employment. These countries also have registration bodies which set out recommendations for different levels of registration (UKBHC, APC, SCA, CASC).

In general, it was agreed that a continuing process of *professional development* was expected and, in some cases, national standards in this regard were suggested.(36, 59, 106-108)

The issues of *capabilities and competencies* for spiritual care providers are addressed with variable degrees of detail and attention in the grey literature. Some outline fairly detailed capabilities expected of professional providers.(35, 59, 95) The matter of capabilities corresponding to different levels of registration is also mentioned. (59, 102) The idea of competencies being outlined across all levels of employment, including tools for evaluation of these, or ways of evidencing these, was widely mentioned.(39, 58, 60, 97)

The importance of *research literacy* and the willingness and ability to *participate in research* was discussed in the grey literature. Research at a level appropriate to understanding and incorporating relevant research into practice was considered important,(36, 37, 55, 60, 96) as was encouraging research participation at the appropriate level.(57-59, 98, 103, 104)

Integration into the systems of whole person care

When there is integration of whole person care into the system, several sub-areas of concern were identified in the grey literature. These are: accountability/evaluation of practice; meeting/communication; referral process; all staff spiritual care and support; all staff education in spiritual care and crisis management.

Accountability by regular evaluation of practice, as an organisational requirement of professional staff in all sectors of healthcare,(110) and accountability to the organisation via annual reports from Spiritual Care/Chaplaincy departments to the organisational management, were also considered important.(37)

Good avenues of *communication with members of the inter-disciplinary team* was considered essential for the integration of spiritual care into the whole health care service of the site of work by many groups.(35, 36, 39, 53, 55, 56, 58, 59, 71, 72, 94, 97, 98, 103, 104, 112, 116) This communication capacity was also expected with relevant community groups.(54,94,98) Another aspect of interdisciplinary communication identified was serving as a mediator or bridge between patients and their families with doctors, specialists, and in some cases, the wider medical team. This is an activity sometimes assigned to spiritual care practitioners. (34)

Another very important part of integration into overall practice of healthcare is an *appropriate and clear and written referral system*.(35, 52, 55) It is apparent that this issue was not addressed as often as other areas in the literature.

The provision of *spiritual care and support to all staff* as requested was also widely put forward as an important part of the role of the spiritual care professional.(52-56, 58, 60, 72) Included in this part of care was the provision of staff/organisational rituals as needed. It was also well recognised that *all staff at times provide spiritual care,* while also referring to the spiritual care professionals as the experts in the field. It is important that *appropriate education in spiritual care* be provided, often by senior spiritual care practitioners.(35, 52-56, 71, 94-96)

Another aspect of spiritual care within an organisational context was the importance of *spiritual care in times of crisis, disasters, or critical incidents*. Their role in support and debrief of staff was especially mentioned in papers from three of the included countries UK, USA, and AUS.(40, 52, 55, 95, 98-101)

The spiritual care of patients and families

The spiritual care of patients and families also addressed several aspects of that care which were: documenting/charting; Screening; Assessment; Interventions, Outcomes and Patient Feedback. These will now be considered in more detail.

It was generally agreed in the UK, USA, AUS and CAN documents that for safety and accountability reasons all *patient visits must be recorded in a timely manner according to the local recording forma*t, with emphasis being placed, in some cases, on recording fact rather than opinion.(35-37, 52, 55, 59, 72, 96, 98, 103, 128) *Screening* as a separate item of care did not get a lot of mention but features mentioned by those who saw it as a separate part of care included the need for interpreters and awareness of cultural background,(40) and the availability of various screening tools.(5, 33, 55, 58, 78, 119)

Assessment is acknowledged as a pre-requisite for effective spiritual care.(40, 55, 57, 72, 75, 94, 101) A number of assessment tools such as FICA, HOPE, FACT F, SPIRIT are mentioned, (117) HEAT relating to equality (114) Spiritual Needs Inventory (118) and multiple others.(40) The point is made that tools need to be standardised for the environment in which they are used.(56) It is also important that although standardised tools can be useful they must have the capacity to work for diverse populations from cultural and spiritual perspectives.(27, 51)

A common thread in the discussion of *Interventions* by the major groups was that they be planned in partnership with the patient, the family, and the inter-disciplinary team and that they meet individual and wholistic needs, including culturally based issues,(35, 39, 59, 73, 75, 95, 96, 98, 121) and are guided by ICD 10 Codes. Other general aspects of interventions that were included are active listening, developing rapport and on-going evaluation of intervention overtime.(35, 59, 95, 117)

Three of the key groups whose documents were reviewed in this report made comments about the *Outcomes* of interventions. The patient experience of compassion is considered a major outcome.(37) The outcomes must be consistent with those specifically sought by the patient during consultation.(55) The matter of assessing outcomes was also mentioned. (23, 404, 52, 120)

Somewhat related to outcomes is the sub-section *Patient Feedback,* a difference being that outcomes are sometimes staff identified rather than patient reported. This concept was mentioned only in two publications.(39, 94) Some noted that patient general satisfaction was higher among those who had received spiritual care (58, 75, 124); of particular note being accepted, not judged, really listened to (45, 117, 127) having their needs fully met and being empowered to solve their own problems.(94)

Overall organisational structure

The section overall organisational structure presented workforce planning, organisational issues, and resources as the main sub-areas. These no doubt vary in different systems depending on the degree to which spiritual care is integrated into whole person care and is therefore a part of the overall structure and planning of the providing organisation. Of particular note in relation to workforce were that staff employed should have diverse skills, be fully trained and credentialled and employed in numbers consistent with a reasonable staff/patient ratio.(35, 55, 56, 58, 59, 94, 103) Taking ethnic background in the general population into account is important when employing staff, so that all groups are represented among the staff. (114)

In considering other *organisational issues* it is also relevant to remember that the issues discussed are prefaced upon the assumption that spiritual care is integrated and accessible throughout the whole organisation. This needs to include IT systems in a variety of settings, (1, 20, 29, 30, 43, 46) and involvement in the system audit and annual reporting processes which are reflected in the organisational strategic plan and funding sources. (35, 37, 52, 55, 72, 98, 99, 103, 104) This requires leaders trained in policy, politics and other matters relating to the function of the system who are aware of the difference between management and leadership – the latter being particularly important (35, 36, 55, 94, 101, 103, 131) and of course suitable space and other resources.(37, 55, 56, 99, 112, 115)

LIMITATIONS

It is likely that much of the academic literature on Indigenous and Māori healthcare models have been missed in this literature review. Due to the limitations of a reductionist literature review approach, any model that was not specifically a 'spiritual care in healthcare' model would not have met the eligibility criteria, and then not be analysed in this review. Furthermore, many Indigenous and Māori models of health have a holistic approach and include components of spirit and spirituality, however, these models may not explicitly be named 'spiritual care models', and therefore would not have been included in this review. Additionally, some spiritual models may not be framed in a health context and may have been missed in this review.

This review was restricted to literature published in English therefore, we were unable to review peer-reviewed and grey literature published in other languages.

No critical appraisal framework was applied to the documents included in this review however, this is not an essential element to the scoping review methodology created by Arksey and O'Malley (15) and later added to by Levac et al.(16) All literature aligned with inclusion/exclusion criteria as stated in the methods of this report.

CONCLUSIONS

Despite the diversity of the spiritual care in healthcare MFGs reviewed in this report there are many shared elements. If it can be assumed that the items identified as best practice by most of the larger associations for spiritual care are in fact best practice, it can be concluded that the elements discussed may form the basis of spiritual care models in healthcare.

In both the UK and USA, the elements of spiritual care MFG put forward by the two professional bodies in each country cover most of the items listed. In the UK, the one document produced by the main body of the NHS is the only one likely to be broadly applied across the country.(37) The other NHS documents are produced by NHS Trusts (39,52,53,71,94,98,99,112,126) associated with specific parts of the UK and there is no evidence that these have been promoted or utilised in other counties.

In the USA, it seems likely that many healthcare providers would seek guidance for their spiritual care provision from one of the two associations. In both Canada and Aotearoa New Zealand, it appears that the professional association has limited influence and several local organisations have produced documents for use in their areas.(101,56)

In Australia, the material most consistent with the overall list of qualities discussed has been produced by SHA.(59,109,128) Their work has been informed and guided to some extent by work done earlier in places like the UK and the USA. While the SHA model is the most comprehensive, its consistent application is still very much an aspiration rather than a reality.

The key findings of this literature review:

- There is no universal approach to spiritual care MFG within healthcare settings.
- Thirteen common elements of spiritual care MFGs in healthcare were identified.
- There is a lack of recognition of Indigenous spiritual care within the spiritual care MFGs.
- The theoretical underpinnings of spiritual care MFGs are not consistently stated.
- Current spiritual care MFGs reviewed in this report were developed primarily by large professional associations, whose voices/perspectives are dominant in spiritual care MFG in healthcare.

The future focus points towards the need for consistent application of evidence-based models of spiritual care across healthcare to be accepted practice, rather than simply recommended. This would require a wide acceptance of a number of concepts and approaches:

- A broad-based approach to spiritual care, inclusive of all cultures and spiritualities, with an inclusive consensus-based approach to developing spiritual care MFG in healthcare.
- The acceptance by all healthcare providers, administrators, and governments that spiritual care is an integral part of whole person care, requiring system integration and adequate resourcing.
- Testing and evaluation of MFG is critical to assess best practice of spiritual care in healthcare.
- MFG flexibility for contextualising local approaches to spiritual care.

“National and international literature affirm the importance of spiritual care”

REFERENCES

1. van de Geer J, Veeger N, Groot M, Zock H, Leget C, Prins J, et al. Multidisciplinary Training on Spiritual Care for Patients in Palliative Care Trajectories Improves the Attitudes and Competencies of Hospital Medical Staff: Results of a Quasi-Experimental Study. *The American Journal of Hospice & Palliative Care*. 2018;35(2):218-28.
2. Kinzbrunner BM, Kinzbrunner BD. Spiritual care in Israel: the future is now. *Israel Journal of Health Policy Research*. 2014;3(1):32-.
3. Fan Chin Hong HYH, Lau Ho Yin, Leung Hui Shan, Lau Tsz Ling, Ho Ka Yee The Investigation of Spiritual Support in End of Life Services in Hong Kong (Conference Presentation). 2019.
4. Dube S. The LOVE Spiritual Care Model: A Chaplain's Tool In Clinical Practice. *Asia-Africa Journal of Mission and Ministry*. 2020;21:3-28.
5. Healthcare Chaplaincy Council Victoria/Spiritual Health Association. Consultation Paper Concerning Spiritual Care Provision in Victorian Palliative Care Services. Victoria. Australia; 2011.
6. Working Group on Spiritual Care in the NHS. Guidelines on Chaplaincy and Spiritual Care in the NHS. Scotland. Edinburgh; 2002.
7. Cobb MR, Puchalski C, Rumbold B. *The Oxford Textbook of Spirituality in Healthcare*. Oxford:Oxford University Press; 2012.
8. Koenig HG. *Spirituality in Patient Care Why, How, When, and What*. Radnor: Templeton Press; 2013.
9. Astrow AB, Wexler A, Texeira K, Kai He M, Sulmasy DP. Is Failure to Meet Spiritual Needs Associated With Cancer Patients' Perceptions of Quality of Care and Their Satisfaction With Care? *Journal of Clinical Oncology*. 2007;25(36):5753-7.
10. Marin DB, Sharma V, Sosunov E, Egorova N, Goldstein R, Handzo GF. Relationship Between Chaplain Visits and Patient Satisfaction. *Journal of Health Care Chaplaincy*. 2015;21(1):14-24.
11. Litalien M, Atari DO, Obasi I. The Influence of Religiosity and Spirituality on Health in Canada: A Systematic Literature Review. *Journal of Religion and Health*. 2021;61(1):373-414.
12. Balboni TA, VanderWeele TJ, Doan-Soares SD, Long KNG, Ferrell BR, Fitchett G, et al. Spirituality in Serious Illness and Health. *JAMA : The Journal of the American Medical Association*. 2022;328(2):184-97.
13. Hall EJ, Powell RA. Valuing the Spiritual. *Journal of Religion and Health*. 2021;60(3):1430-5.
14. Perleth M, Jakubowski E, Busse R. What is 'best practice' in health care? State of the art and perspectives in improving the effectiveness and efficiency of the European health care systems. *Health Policy* (Amsterdam). 2001;56(3):235-50.
15. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*. 2005;8(1):19-32.
16. Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. *Implementation Science*: IS. 2010;5(1):69-.
17. Peters MDJ, Godfrey CM, Khalil H, McInerney P, Parker D, Soares CB. Guidance for conducting systematic scoping reviews. *International Journal of Evidence-based Healthcare*. 2015;13(3):141-6.
18. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine*. 2018;169(7):467-73.
19. Heidari A, Kazemi A, Abbasi M, Adeli SH, Ahmari Tehran H, Eskandari N, et al. Developing a charter of spiritual care for patients. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*. 2021;33(1).
20. Holmes C. Towards national consensus: Spiritual care in the Australian healthcare context. *Religions*. 2018;9(12).
21. Vaishnav B, Nimbalkar S, Desai S, Vaishnav S. Code Krishna: an innovative practice respecting death, dying and beyond. *Indian Journal of Medical Ethics*. 2017;2(4):289-92.

22. Saad M, Lucchetti G, Peres MFP, de Medeiros R. Toward the Concept of 'Spiritist Chaplaincy'. *Journal of Religion and Health*. 2015;54(4):1460-9.

23. Nissen RD, Viftrup DT, Hvidt NC. The Process of Spiritual Care. *Frontiers in Psychology*. 2021;12:674453.

24. Memaryan N, Ghaempanah Z, Aghababaei N, Koenig HG. Integration of spiritual care in hospital care system in Iran. *Journal of Religion and Health*. 2020;59(1):82-95.

25. Ramezani M, Ahmadi F, Mohammadi E, Kazemnejad A. The grounded theory of "trust building". *Nursing Ethics*. 2019;26(3):753-66.

26. Holyoke P, Stephenson B. Organization-level principles and practices to support spiritual care at the end of life: a qualitative study. *BMC Palliative Care*. 2017;16(1):24.

27. Bangcola AA. The development of Spiritual Nursing Care Theory using deductive axiomatic approach. *Belitung Nursing Journal*. 2021;7(3):163-70.

28. Geer Jvd, Visser A, Zock H, Leget C, Prins J, Vissers K. Improving Spiritual Care in Hospitals in the Netherlands: What Do Health Care Chaplains Involved in an Action-Research Study Report? *Journal of Health Care Chaplaincy*. 2018;24(4):151-73.

29. Giffen S, Mitchell D. The evolution of spiritual care and healthcare chaplaincy in Scotland. *Health and Social Care Chaplaincy*. 2018;6(1):36-45.

30. Hennequin C. Evaluating the Effectiveness of Frameworks Benchmarking for Quality Spiritual Care in Victoria, Australia. *Health and Social Care Chaplaincy*. 2021;9(2):278-97.

31. Hvidt NC, Nielsen KT, Kørup AK, Prinds C, Hansen DG, Viftrup DT, et al. What is spiritual care? Professional perspectives on the concept of spiritual care identified through group concept mapping. *BMJ Open*. 2020;10(12).

32. Meel L. Interdisciplinary Team-Based Pastoral Care Model for Estonian Healthcare Institutions: The Professionals' Insight and the Model Adjustments. *Occasional Papers on Religion in Eastern Europe*. 2018;38(2):1-39.

33. Meel L, Lehtsaar Tn. Interdisciplinary Team Based Pastoral Care: A Potentially Adaptable Model for Estonian Healthcare. *Occasional Papers on Religion in Eastern Europe*. 2017;37(3):1-33.

34. Shields M, Kestenbaum A, Dunn LB. Spiritual AIM and the work of the chaplain: a model for assessing spiritual needs and outcomes in relationship. *Palliative & Supportive Care*. 2015;13(1):75-89.

35. Health Care Chaplaincy Network. Scope of Practice. 2016.

36. Association of Professional Chaplains. Standards of Practice for Professional Chaplains. 2015.

37. National Equality and Health Inequality Team NHSE. NHS Guidelines 2015: Promoting Excellence in Pastoral, Spiritual and Religious Care. Equality Analysis. 2015.

38. Handzo GF, Atkinson MM, Wintz SK. National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care, Fourth Edition: Why is This Important to Chaplains? *Journal of Health Care Chaplaincy*. 2020;26(2):58-71.

39. National Health Service Foundation Trust: Bradford Teaching Hospitals. The Bradford Model for Integrated and Inclusive Spiritual, Pastoral and Religious Care (SPaRC). 2021.

40. Selman L, Harding R, Speck P, Robinson V, Aguma A, Rhys A, et al. Spiritual Care Recommendations for People from Black and Minority Ethnic Groups (BME) Receiving Palliative Care in the UK (with special reference to the sub-Saharan African Population. 2010.

41. Moosavi S, Borhani F, Akbari ME, Sanee N, Rohani C. Recommendations for spiritual care in cancer patients: a clinical practice guideline for oncology nurses in Iran. *Supportive Care in Cancer*. 2020;28(11):5381-95.

42. Raffay J, Wood E, Todd A. Service user views of spiritual and pastoral care (chaplaincy) in NHS mental health services: A co-produced constructivist grounded theory investigation. *BMC Psychiatry*. 2016;16.

43. Bakar A, Nursalam, Adriani M, Kusnanto, Qomariah SN, Efendi F. The development of islamic caring model to improve psycho-spiritual comfort of coronary disease patients. *Indian Journal of Public Health Research and Development*. 2018;9(10):312-7.

44. Galbadage T, Peterson BM, Wang DC, Wang JS, Gunasekera RS. Biopsychosocial and Spiritual Implications of Patients With COVID-19 Dying in Isolation. *Frontiers in Psychology*. 2020;11:588-623.

45. Chaplaincy Services SA inc. A Research Report Compiled for Submission to the Mental Health Unit, SA Health. 2012.

46. Braam AW. Towards a multidisciplinary guideline religiousness, spirituality, and psychiatry: what do we need? *Mental Health, Religion & Culture*. 2017;20(6):579-88.

47. Moeke-Maxwell T, Collier A, Wiles J, Williams L, Black S, Gott M. Bereaved Families' Perspectives of End-of-Life Care. Towards a Bicultural Whare Tapa Wh Older Person's Palliative Care Model. *Journal of Cross-Cultural Gerontology*. 2020;35(2):177-93.

48. Kyung-Ah K. Models for Spiritual Care in Hospice and Palliative Care. *Korean Journal of Hospice & Palliative Care*. 2018;21(2):41-50.

49. Raweewan P, Warunee F, Hunsa S, Pikul P, Voss JG. Development of a Buddhist Spiritual Care Model for People at the End of Life. *Journal of Hospice & Palliative Nursing*. 2016;18(4):324-31.

50. Kelley AS, Bollens-Lund E. Identifying the Population with Serious Illness: The "Denominator" Challenge. *Journal of Palliative Medicine*. 2018;21(S2):S-7-S-16.

51. McHaro SK. T.R.U.S.T. Model for Inclusive Spiritual Care: Critique of Middle-Range Theory. *Journal of Holistic Nursing*. 2018;36(3):282-90.

52. National Health Services Trust: University Hospitals of Leister. Spiritual Care UHL Policy (Chaplaincy). 2016.

53. National Health Service Wales. Standards for Spiritual Care Services in the NHS in Wales. 2020.

54. Health Care Chaplaincy Network. Spiritual Care: What it Means. Why it Matters in Health Care. 2016.

55. Spiritual Health Association. Guidelines for Quality Spiritual Care in Health. 2020.

56. Mid-Central District Health Board. MDHB Spiritual Care Standards. 2021.

57. UK Board of Healthcare Chaplaincy. Audit Tool for Spiritual Care Services Standards. 2020.

58. Joint Publication: ACPE A, CASC, NACC, Neshama. The Impact of Professional Spiritual Care. 2018.

59. Spiritual Health Association. Capability Framework for Spiritual Care Practitioners in Health. 2020.

60. UK Board of Healthcare Chaplaincy. Spiritual Care Competencies of Healthcare Chaplains. 2020.

61. Kim DH, Fitchett G, Anderson JL, Garman AN. Management and leadership competencies among spiritual care managers. *Journal of Health Care Chaplaincy*. 2022;28(1):128-37.

62. Chan WYA, Sitek J. Religious Literacy in Healthcare. *Religion and Education*. 2021;48(1):102-20.

63. Rettig AE, Southard ME, Lambrecht-Stock E, Bohley K, Disher C, Flewellen M, et al. Remembrance and Renewal: Health Care Staff Spiritual Self-Care. *Journal of Holistic Nursing*. 2020;38(1):139-46.

64. Wilson D, Moloney E, Parr JM, Aspinall C, Slark J. Creating an Indigenous M ori centred model of relational health: A literature review of M ori models of health. *Journal of Clinical Nursing*. 2021;30(23-24):3539-55.

65. Fleming J, Ledogar RJ. Resilience and Indigenous Spirituality: A Literature Review. *Pimatisiwin*. 2008;6(2):47-64.

66. Lindsay N, Haami D, Tassell-Matamua N, Pomare P, Valentine H, Pahina J, et al. The spiritual experiences of contemporary M ori in Aotearoa New Zealand: A qualitative analysis. *Journal of Spirituality in Mental Health*. 2022;24(1):74-94.

67. Poroch N, Arabena K, Tongs J, Larkin S, Fisher J, Henderson G. Spirituality and Aboriginal People's Social and Emotional Wellbeing: A Review. Australia: Cooperative Research Centre for Aboriginal Health, Darwin. 2009.

68. Tomaselli A, Xanthaki A. The Struggle of Indigenous Peoples to Maintain Their Spirituality in Latin America: Freedom of and from Religion(s), and Other Threats. *Religions* (Basel, Switzerland). 2021;12(10):869.

69. Valentine H, Tassell-Mataamua N, Flett R. Whakairia ki runga: The many dimensions of wairua. *New Zealand Journal of Psychology* (Online). 2017;46(3):64-71.

70. Tassell-Matamua N, Lindsay N, Moriarty TR, Haami D. Indigenous M ori notions of spirit and spirituality as enablers of resilience and flourishing in Aotearoa New Zealand. In: Weaver H, editor. *The Routledge International Handbook of Indigenous Resilience*. Routledge; 2022.

71. National Health Service: Education for Scotland – Spiritual Care. Spiritual and Religious Care Capabilities and Competencies for Healthcare Chaplains. 2008.

72. Association of Professional Chaplains. Standards of Practice for Professional Chaplains in Acute Settings. 2009.

73. Asadzandi M. An Islamic Religious Spiritual Health Training Model for Patients. *Journal of Religion and Health*. 2020;59(1):173-87.

74. Christman SK, Mueller JR. Understanding Spiritual Care: The Faith-Hope-Love Model of Spiritual Wellness*. Journal of Christian Nursing*. 2017;34(1):E1-e7.

75. Health Care Chaplaincy Network. Outcomes – What is Quality spiritual Care and How Do You Measure it? 2021.

76. Association of Professional Chaplains. Code of Ethics. 2000.

77. Waitemata District Health Board. Media Release: Generous Support Enables New Spiritual Care Centre to Open to Patients. New Zealand; 2015.

78. Balboni T, Johnson, K. Pargament, K., Keonig, H. Fitchett, G., Handzo, G, Sinclair, S., Taylor, E., Puchalski, C., Steinhauser, K. State of the Science: Spirituality and Palliative Care Research: Health Care Chaplaincy – Caring for the Human Spirit. Conference Presentation. 2015.

79. Spiritual Health Victoria/Spiritual Health Association. Enhancing Quality and Safety: Spiritual Care in Health. National Consensus Conference Report. 2017.

80. Independent Maori Statutory Board. The Wairuatanga Report for Tamaki Makaurau. 2019.

81. van de Geer J, Leget C. How spirituality is integrated system-wide in the Netherlands Palliative Care National Programme. *Progress in Palliative Care*. 2012;20(2):98-105.

82. Vlasblom JP, Walton MN, van der Steen JT, Doolaard JJ, Jochemsen H. Developments in Healthcare Chaplaincy in the Netherlands and Scotland: A Content Analysis of Professional Journals. *Critical Horizons : Journal of Social & Critical Theory*. 2014;2(2):235-54.

83. Centre for Research on Aging. Spiritual Care in Israel – An Evaluation of the Programs Funded by UJA Federation New York. 2009.

84. Hong FC, Hang HY, Yin LH, Shan LH, Ling LT, Yee HK. The Investigation of Spiritual Support in End of Life Services in Hong Kong (Conference Presentation). 2019.

85. De la Porte A. Spirituality and Healthcare: Towards Holistic People Centred Healthcare in South Africa. 2016.

86. Poncin E, Brandt P, Rouiller F, Drouin M, Robert Z. Mapping the Healthcare Chaplaincy Literature: An Analytical Review of Publications Authored by Chaplains and Theologians Between 2000 and 2018. *Journal of Health Care Chaplaincy*. 2020;26(1):16-44.

87. Eham J. Patient=Led Pastoral Care: A Model of Practice of Interfaith Chaplaincy in Hospitals. (Unpublished). 2019.

88. Willemse S, Smeets W, van Leeuwen E, Nielen-Rosier T, Janssen L, Foudraine N. Spiritual care in the intensive care unit: An integrative literature research. *Journal of Critical Care*. 2020;57:55-78.

89. Inter-church Council for Hospital Chaplaincy. Annual Report 2020/21. 2021.

90. Babamohamadi H, Kadkhodaei-Elyaderani H, Ebrahimian A, Ghorbani R. The Effect of Spiritual Care Based on the Sound Heart Model on the Spiritual Health of Patients with Acute Myocardial Infarction. *Journal of Religion and Health*. 2020;59(5):2638-53.

91. Khezri E, Bagheri-Saveh Mohammad I, Kalhor MM, Rahnama M, Daem R, Salehi K. Nursing care based on the Support-Based Spiritual Care Model increases hope among women with breast cancer in Iran. *Supportive Care in Cancer*. 2022;30(1):423-9.

92. Jeanne Wirpsa M, Emily Johnson R, Bieler J, Boyken L, Pugliese K, Rosencrans E, et al. Interprofessional Models for Shared Decision Making: The Role of the Health Care Chaplain. *Journal of Health Care Chaplaincy*. 2019;25(1):20-44.

93. Memaryan N, Jolfaei AG, Ghaempanah Z, Shirvani A, Vand HD, Ghahari S, et al. Spiritual Care for Cancer Patients in Iran. *Asian Pacific Journal of Cancer Prevention*. 2016;17(9):4289-94.

94. National Health Service Foundation Trust: South West Yorkshire Partnership. Pastoral and Spiritual Car Framework. 2012.

95. UK Board of Healthcare Chaplaincy. Spiritual and Religious Competencies for Healthcare Chaplains Bands 5,6,7, & 8. 2015 revised.

96. Canadian Association for Spiritual Care. Competencies of Certified Practitioners (Section II). 2019.

97. Spiritual Care Providers (Community Appointed): Credentialling Framework. [report]. 2021.

98. National Health Service Tayside. Nursing and Midwifery Spiritual Care Policy. 2021.

99. National Health Service Trust: Nottingham University Hospitals. Provision of Spiritual and Pastoral Care Policy. 2010.

100. Papadopoulos I, Koulouglioti C, Lazzarino R, Ali S. Towards a National Strategy for the Provision of Spiritual Care and Support inn Major Health Disasters. EXECUTIVE SUMMARY. Middlesex University London – Research Centre for Transcultural Studies in Health. 2021.

101. British Columbia Ministry of Health. Spiritual Health: A Framework for British Columbia Spiritual Health Professionals. 2012.

102. Inter-church Council for Hospital Chaplaincy. Code of Conduct. 2020.

103. National Health Service: Education for Scotland – Spiritual Care. Spiritual Care and Chaplaincy. 2009.

104. Mid-Central District Health Board. Transforming Spiritual Care Strategy. 2016.

105. Quality Palliative Care in Long Term Care Alliance. Train and Sustain: A Model for Volunteer Spiritual Support in Long Term. 2013.

106. Canadian Association for Spiritual Care. Scope of Practice (Section III). 2019.

107. UK Board of Healthcare Chaplaincy. Fitness to Practice Guidance. 2017.

108. Inter-church Council for Hospital Chaplaincy. Statement of Intent. 2018.

109. Spiritual Care Australia. Credentialling Standards for Registration of Professional Spiritual Care Providers.

110. Canadian Association for Spiritual Care. Standards for Practice (Section I). 2019.

111. Network for Pastoral and Spiritual Care in Health. Equity and Diversity in Healthcare Chaplaincy: Introduction. 2015.

112. National Health Service Foundation Trust: Essex Partnership University. Spiritual Care Policy for all Faiths and None. 2018.

113. Queensland Government. Framework for the Integration of Spiritual Care in Queensland health Facilities. 2020.

114. Central Cancer Network. He Anga Whakaahuru: Supportive Cancer Framework. New Zealand. 2018.

115. Ministry of Health. Achieving Equity in Health Outcomes: Highlights of important national and international papers. Wellington, New Zealand: Ministry of Health. 2018.

116. Health Care Chaplaincy Network BI. The Critical Role of Spirituality in Patient Experience. 2016.

117. Association of Chaplaincy in General Practice. GP Chaplaincy Handbook: A Practical Guide to Service Provision. 2019 revised 2021.

118. University of Hull- Spiritual Care Department. Spiritual Care at End of Life: A Systematic Literature Review. 2010.

119. Balboni TA, Fitchett G, Handzo GF, Johnson KS, Koenig HG, Pargament KI, et al. State of the Science of Spirituality and Palliative Care Research Part II: Screening, Assessment, and Interventions. *Journal of Pain and Symptom Management*. 2017;54(3):441-53.

120. Vincensi BB. Interconnections: Spirituality, Spiritual Care, and Patient-Centered Care. *Asia-Pacific Journal of Oncology Nursing*. 2019;6(2):104-10.

121. National Health Service: Education for Scotland – Spiritual Care. A Multifaith Resources for Healthcare Staff. 2021.

122. New Zealand Government Health and Safety Lead. Facilitation Guide – Module 4: Wairua – Mental and Spiritual Health Resilience. 2020.

123. Supportive Education and Quality Palliative Care SEQUAL. Spiritual Care in Palliative Care: An Information Sheet. 2017.

124. Providence Health and Services. Standards of Excellence of Spiritual Care. 2007.

125. New South Wales Health and Civil Chaplaincy Advisory Committee. NSW Memorandum of Understanding. 2011.

126. National Health Service Lothian. Healthcare Chaplaincy: the Lothian Chaplaincy Patient Reported Outcome Measure (PROM): The Construction of a Measure of the Impact of Specialist Spiritual Care. 2012.

127. Australian Catholic University. What are the Benefits of Pastoral Care to Hospital Patients and Aged Care Residents? A Project Report. 2018.

128. Spiritual Health Association. Spiritual Care in Medical Records: A Guide to Reporting and Documenting Spiritual Care in Health Care Services. 2019.

129. Peeters EJH. Quality Pastoral Relationships in Healthcare Settings: Guidelines for Codes of Ethic. The Journal of Pastoral Care & Counseling. 2020;74(1):42-52.

130. Trinity College Dublin. An Exploration of Current in-Hospital Spiritual Care Resources in the Republic of Ireland an Review of International Chaplaincy Standards. 2016.

131. Care NHSEfSS. Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff. 2009.

FUNDING

The Aotearoa New Zealand Spiritual Care in Healthcare Co-design group received funding from the Aotearoa New Zealand Health Research Council, from the 2021 Activation Grant.

APPENDICES

Appendix A: Grey literature codes and sub-codes

Table 7: Coding Nodes/Sub-nodes for the Grey Literature

Node/Code	Sub-Node/Sub-Code
Overall Features	Defining Spiritual Care
	Evidence Based Practice
	Specific Models mentioned
Spiritual Care Staff	Training
	Registration/Accreditation
	Professional Development
	Capabilities
	Competencies
	Research Literacy
	Research Participation
Integration into overall care system	Evaluation of Practice
	Interdisciplinary communication
	Referral Process
	All staff spiritual care and Support
	All staff Spiritual care Education.
	Crisis Management
Spiritual Care of Patients and Families	Documenting/Charting
	Screening
	Assessment
	Interventions
	Outcomes
	Client Feedback
Organisational Matters	Workforce Planning
	Inclusion of SC in the planning, funding, reporting, etc.
	Resources provided

Appendix B: Scientific literature codebook

Table 8: Codes and sub-codes for the scientific peer-reviewed literature analysis

Code	Sub-Code
1. Article and study description codes	1.1 Year 1.2 Title 1.3 Journal 1.4 Country 1.5 Intervention or study type 1.6 Study or Article Aim 1.7 Study population or participants 1.8 Study methods or methodology 1.8.1 Data collection tools and instruments employed 1.9 Study outcome measures 1.10 Important study results 1.11 Study Limitations 1.12 Study recommendations
2. Model/Framework/ Guideline (MFG) codes	2.1 Article intent of the MFG 2.2 Model, framework, guideline (MFG) or other 2.3 Summary of MFG 2.4 MFG purpose or aim 2.5 MFG or article Health discipline/area 2.6 MFG Application Level 2.7 Religious affiliation of MFG 2.7.1 Applicability to multiple traditions or non-religious 2.8 How was the MFG developed 2.9 Recommendations for developing MFG 2.10 Integration or alignment with other models 2.11 Outcomes of MFG

Code	Sub-Code
3. Components of the MFG Codes	3.1 Summary of MFG components 3.2 Philosophical underpinning 3.3 Definitions 3.3.1 Define spirituality 3.3.2 Definition of spiritual wellness 3.3.3 Definitions of spirit 3.3.4 Relationship between spirit and body 3.4 Spiritual Care setting 3.5 Resources 3.6 Who receives spiritual care 3.7 Spiritual Care Providers & Referral to other providers 3.8 Spiritual/Cultural History 3.9 Measurements of spiritual health 3.10 Define and operationalise spiritual care 3.11 Accountability 3.12 Reporting spiritual care activities 3.13 Implementation 3.14 Evaluation 3.15 Spiritual Distress 3.16 Spiritual Needs
4. Indigenous Spiritual Care in Healthcare Codes	4.1 Indigenous Spiritual Care in healthcare

Code	Sub-Code
5. Spiritual Care Activities Codes	5.1 What do spiritual care practitioners do 5.1.1 Bridge gap between patient-families and HCWs 5.1.2 Education 5.1.3 Family support 5.1.1 Mediate 5.1.4 Palliative Care 5.1.5 Provide Spiritual Care & Counselling 5.1.6 Religious guidance & Services 5.1.7 Whole person care 5.1.8 Support patients adapt to new circumstances 5.1.9 Support patient and family decision-making 5.1.10 Support, advise, work with other HCWs 5.2 What skills and competencies do SCPs need 5.3 Barriers and challenges for spiritual practitioners 5.4 What do patients-families want from spiritual practitioners and spiritual care 5.5 Outcomes of spiritual care
6. Other Codes	6.1 Multidisciplinary Teams 6.2 Patient led care 6.3 Patient-centred care 6.4 Ethical concerns 6.7 Opportunities for future research

Appendix C: More detailed grey literature coding report

Node	Sub-Node	Coded material
Overview Spiritual Care		
	What is Spiritual Care	» For all people regardless of culture, religion, or none » Inequality must be addressed » Hope strength, meaning, purpose, relationship » Concept of inner space » To give healing on all levels » Includes ritual as appropriate » A new talking therapy » Offered throughout the cancer journey » Particular attention to Māori needs & perceptions » A unique service – intrinsic aspect of humanity » May involve religion
	Evidence Based Practice	» Continued evaluation to ensure evidence based » Measuring patient outcomes validates practice » Important to strengthen evidence base » Current evidence limited more research needed » International commitment to evidence based » Research to validate tools for local setting » Important to implement EB in local settings
Educ. & Cred SC staff		
	Training	» Integral and ongoing » Training needs to be broad including cultural diversity » National standards needed » Include integration of values, faith etc » Include specialties such as MH » Knowledge of scope & boundaries » Statutory requirements regarding training » Masters level + required sup practice » Lack of training available e.g., CPE » CPE available but needs to be adapted to local culture » Training to prevent proselytizing » Training when volunteers used » No statutory requirements at this time

Registration/ credentialling	» To be professional need registration process » Groups working on required components of self-regulation » Registration encouraged through UKBHC » Research, Dev and produce docs. Out-lining registration » Consider mandatory registration » Develop a national body to oversee registration » Qualities that should be present in chaplains » Common standards of certification exist & are listed » Framework support consistent approach to credentialling » Outlines registration requirements for different levels » Registration body sets standards » Consistent minimum requirements deg + 2 CPE » 3 levels recognised & defined » Board certification recommended USA » Open broadly to SC practitioners
Professional Development	» Equity & diversity training module for all staff » Continuing updated training expected » Reflective practice part of ongoing PD » National Scheme of continuous development » PD re unfamiliar cultures and religions » SC practice assumes responsibility/is committed to PD
Capabilities	» Professional boundaries e.g in accompanying the dying » Quality markers/capabilities listed » Able to articulate goals and plans of care » Able to integrate spiritual, emotional, existential etc concepts into practice » Capabilities corresponding to registration requirements » Capabilities associated with diversity » Cross referenced to Model of Service Standards

	Competencies	» Competencies across all levels » Tools for developing competencies » Ways of evidencing competencies » Recognised as needed & some listed » Cultural competencies » Competencies essential unless supervised » Ethical behaviour always
	Research Literacy & Participation	» All familiar with research at the appropriate level and able to integrate into practice » Regularly update knowledge of relevant research and its translation to practice » Good health literacy practice » Encourage participation in research as appropriate » Ongoing involvement towards development of standards & regulation
Integration into Whole System		
	Evaluation of Practice	» Regular evaluation & supervision, self- reflection & feed – back from different levels » At least annual reviews » Accountability
	Inter-disciplinary Communication	» Communication re best patient care » Partnerships with external community groups » Senior SC practitioners demonstrate leadership within inter-disciplinary teams » Building team resilience » Communicate re quality & safety » Guidelines for inter-disciplinary team working » Medical & social models working together – staff feel more valued and find meaning in work
	Referral Process	» Patients who request chaplain support must be referred » Any staff member can make a referral » Referral by primary health team » Chaplain can refer to other allied staff as relevant » With patient permission refer to local faith communities as appropriate » Well established preferably written referral process » Follow up referrals in a timely manner » Chaplains provided with religious affiliation of patients for approaching

	All staff SC & Support	» Provided to all staff as requested » Build working relationships and respond to requests for support » Rituals at organisational events
	All staff SC Educ.	» Other staff e.g., nurses involved in SC » SC educ as appropriate for other staff » Conferences & workshops with all staff » Training in referral process » Volunteer training programs if they are used » All staff are made aware of SC services » Annual feedback from staff re use of assessment tools » Training in Medical schools
	Crisis Management	» Sc particularly important » Staff provided with debrief opportunities after difficult circumstances » SC staff a part of major incident team
Sc Patients & Families		
	Documenting & Charting	» For safety & accountability records must be maintained according to local format » Document all visits in patient medical notes » Effort to accurately record patient religious beliefs » Document resources accessed by patients/ families » Differentiate fact from opinion » Record timely spiritual screening
	Screening	» Interpreters trained in use of language for SC » FICA intervention tool » Screening important » Various tools

Assessment	» Sometimes interchangeable with screening » Prerequisite for effective SC » Tool FICA, HOPE, FACT F, SPIRIT » 4 domains of assessment: personal, communal, environmental & transcendental » Various tools – none adopted by all » Building a relationship is essential to assessment » Assessment results should be documented » Assessment leads to plan development » Identifying individuals' unique needs » Multiple other tools listed » Tool SNI » Repeated at times especially for long term illness » Take care not to "medicalise" too much with tools » Trend towards development of local tools » Not consistently applied » Use agreed tool – preferably standardised » HEAT equity tools used inn NZ » 3 levels of assessment: » LOVE model narrative approach

Interventions	» By consultation with interdisciplinary team » Restricted use of Spiritually Focused Therapy » Interventions that meet individual and wholistic needs » Can become mingled with assessment during an active listening process » Dignity given to the deceased » Including special needs in a MH setting » Intervention plan in partnership with patient, family and interdisciplinary team » Scoping interventions and improvement interventions » Interventions include: multi-dimensional communication spiritual rapport, access according to need, exploring existential issues » 4 interventions listed relating particularly ti MH » Interventions focused on formal therapeutic model » Important to [pan only on patients' needs, beliefs, culture etc and not own » Culturally based evidence-based practice I utilised in planning interventions » Types mentioned: psychotherapeutic, life review, mind-body interventions » Must be included in overall patient care plan » Reviewed in line with assessment throughout treatment » Recorded consistently in line with ICD 10 codes » Chaplain provides support throughout intervention » May include group work » Use Dignity Therapy model
Outcomes	» Not insensitive or proselytising » The experience of compassion is a key outcome » Must be available according to need for disadvantaged groups » Assessing outcome measures: Quality Spiritual Care Scale, PROM » Specifically sort as per patient consultation » RPOM a recommended tool for assessing outcomes

Patient Feedback	» Valued being accepted, not judged, really listened to » Being empowered to solve their own problems » Provision of ability to have needs fully met in assessment and interventions highly valued » A guide to engaging with consumers » Regular conducting of patient satisfaction surveys » General patient satisfaction higher among those who received SC » Qualities of Scare identified: caring, understanding, empathetic, specific needs met, feeling listened to, valued and peaceful » SC teams should seek feedback from patients » Patient feedback heard and recorded » Evidence that patients believe medical outcomes are improved with SC
Organisational Structure	
Workforce Planning	» Fully trained and certified staff » Employ staff according to an appropriate staff/ patient ratio: faith numbers in beds are no longer useful » Trained volunteers can play a significant part » Staff workload to take into account the whole process of care including of staff » Staff education must be included in workload (20%) » Time for research must be included » MH sites may need higher staff ration » Working with non-faith groups must be included » Staff specifically from Māori background must be employed » Regular review identifies gaps to be filled » Volunteers not a part of professional workforce » Succession planning is very important » Both regulated and non-regulated SC providers utilised » Employment of Sc staff consistent with national guideline

Organisational Issues	» SC integrated and available across all levels including IT system for records » SC provide rituals at organisational events as required » National strategy for funding and other resources in crisis events » SC produces audit of needs to be included in organisational strategic plan » SC annual report produced and made available widely across the organisations » SC leaders are trained in policy, politics key issues etc in order to work within the organisational structure » Spiritual values and culture at the heart of organisational planning » SC aware of difference between management and leadership – latter very important » Provides person centred care to all » Funding according to need across the board » Policy and practice including community services » Location of SC near other allied health services » SC reports concerns directly to appropriate governing body in organisation » SC staff appointed by the organisation » audit of UKBHC standards within one year of implementation » Use of Reflective Practice Model is documented policy » Establish SC department and provide suitable space and equipment » Lack of consistency » Renumeration for PD and external supervision » All organisational annual review of staff » Quality care reporting » Line of reporting through allied health » Aim all services report consistent across state » Clear job and person description for staff in MH » All health services have inconsistent plans and structure » Aim for consistency according to agreement » After hours service

Resources	» Equitable supply of resources across all levels » Patient information brochures multi-lingual » SC guidelines for staff » Websites, placemats, leaflets re SC » Resources for worship ritual, reflection » Document of staff re range of faith group contacts etc. » Bereavement pack for families » Information regarding withholding of treatment in relation to different faith groups » As possible outdoor garden/reflection spot » Full resources available for linguistically diverse groups (Māori, Indigenous Australians) » Ensuring quality information for patients EQUIP tool

> Globally, spirituality is recognised as adding value to health services and being essential for wellbeing

Spiritual
Health
Association

UNIVERSITY
of
OTAGO
Te Whare Wānanga o Otāgo
NEW ZEALAND