Spiritual Health Association

Co-design of a consistent Spiritual Care Model

STRATEGIC ENGAGEMENT PLAN

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CONTEXT

In Australia, the administration and governance of spiritual care in hospitals does not align with international best practice. While there are guidance documents to accredit spiritual care practitioners, there is no consistent model of integration into health services. This means that spiritual care governance and integration into the health system is largely in the hands of individual spiritual care managers (where employed), hospital administrators or external coordinators. In many cases, the delivery of spiritual care in hospitals continues to be based upon historic models of funding and administration, and the quality of the service provided often remains unquestioned.

While there are ongoing challenges with resource allocation for health services, the return on investment for spiritual care is significant and has the potential to reduce the burden on clinical staff. A growing body of research demonstrates that when appropriate spiritual care is available to consumers the quality and safety of their care increases, as measured in both patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs).[1]

The meaning of spirituality is evolving and diversifying in Australia. In the context of health care, one in two Australians have the desire to receive spiritual care in hospitals, yet barriers exist to accessing consistent care.[2] In some countries spiritual care is integrated into the health care system and supported by recognised wellbeing models. The Te Whare Tapa Whā wellbeing model in New Zealand, for example, defines four cornerstones (or pillars) of a person's wellbeing: physical health, mental and emotional wellbeing, family and social connections, and spiritual health.[3]

This Strategic Engagement Plan is a guide for codesigning a more integrated best practice model for spiritual health care in Australia.

1. Karimi, L. and H. Tan (2020). "Validation of the Patient Reported Outcome Measure of spiritual care (PROM) in an Australian setting." Health and Social Care Chaplaincy 8(1): 71-85.
2. The Future of Spiritual Care in Australia: a national study on spirituality, wellbeing and spiritual care in hospitals - https://www.spiritualhealth.org.au/reports
3. Maori model of health and wellbeing developed by Sir Mason Durie, Ministry of Health NZ - https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

WHAT IS SPIRITUAL CARE?

Spiritual care is the provision of

assessment **counselling** **support** **ritual**

in matters of a person's beliefs, traditions, values and practices enabling the person to access their own spiritual resources.

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REMIT

The central question of our work together is:

We have a responsibility to care for the whole person when they are in hospital - this includes their spiritual needs. Research tells us that responding to spiritual needs improves health outcomes, including quality of patient experience and healthcare safety.

How do we make quality, safe spiritual care accessible in our hospitals?

WHAT DO WE MEAN BY A MODEL?

The way spiritual care is organised in hospitals currently varies considerably (different models). This project will determine what needs to be consistent in the ways spiritual care operates in hospitals to ensure quality, safe spiritual care services.

LEVEL OF INFLUENCE

The highest level of engagement being sought through this process is

COLLABORATE

(International Association for Public Participation Engagement Spectrum).

Collaborate means we will work together with you to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum possible extent.

We will promise to...

- *Listen to what people say and work to understand concerns & priorities.*
- *Commit to open and transparent conversations and make sure you are engaged along the way.*
- *Document and record all inputs.*
- *Report back on what we have heard.*
- *Base the model on the recommendations to the maximum extent possible.*
- *Add the voice of consumers at the point we are dealing with alternatives.*

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ENGAGEMENT SCOPE

To work on the model, we need to stay focused. Here is what people can influence within the scope of the project:

Negotiable

- **How spiritual care is organised:** Who provides spiritual care, where spiritual care sits within the organisational chart of public health services, who does it report to.
- **Co-dependencies:** Which relationships are important for spiritual care to work, who sits under and around spiritual care.
- **Funding:** How funding operates e.g., who pays for spiritual care in hospitals.
- **Accountability:** What reporting is required, who is spiritual care responsible to?
- **Intake:** The spiritual care referral process.
- **Implementation:** How to implement the pilot spiritual care model.
- **Language:** How spiritual care is talked about in health settings.
- **Professional regulation:** How we regulate and accredit the standards for certified spiritual care practitioners. E.g., If an agreed process towards certification of a spiritual care practitioner is recommended through the engagement process, the detail of this would not be discussed but potential next steps could be identified.

Non negotiable

- The definition of spiritual care.
- The scope of practice of the spiritual care practitioner role.
- The current standards for certified spiritual care practitioners.
- Research findings.
- Any legislative requirements relating to spiritual care.

OBJECTIVES – THE OUTPUTS & TANGIBLE AIMS

We have identified a range of tangible objectives that we are aiming for with this project:

OBJECTIVE	INDICATOR	METHOD
A model is produced that is clear and actionable.	Feedback from the final workshop. Uptake by several hospitals for piloting the model.	Leaders events and executive interviews relating to implications of the proposed draft model. Clear process to follow documented via this Strategic Engagement plan.
The model is informed by consumers of health care, including those who have not received spiritual care particularly by drawing upon rigorous person-centred research results.	Feedback from the final workshop.	Consumer interviews relating to implications of the proposed draft model. 3 consumer positions at workshops.
Person-centred care terminology is used throughout the project and the model is inclusive of all cultures, beliefs, identities and ages.	Use of simple, clear, inclusive language.	Monitoring of language by MosaicLab and project team throughout.

OBJECTIVES – THE EXPERIENCE OF THE ENGAGEMENT PROCESS

What we want people to experience as a result of our engagement work:

OBJECTIVE	INDICATOR	METHOD
Decision makers understand what holds them back from prioritising a consistent spiritual care model Enthusiasm and motivation for action amongst leaders Key leaders understand the potential for change and there is a sense of buy-in to deliver an integrated person-centred spiritual care model.	Feedback during and after project. Strong engagement with the process.	Clear process to follow documented via this Strategic Engagement plan. Facilitation of engagement sessions and interviews.

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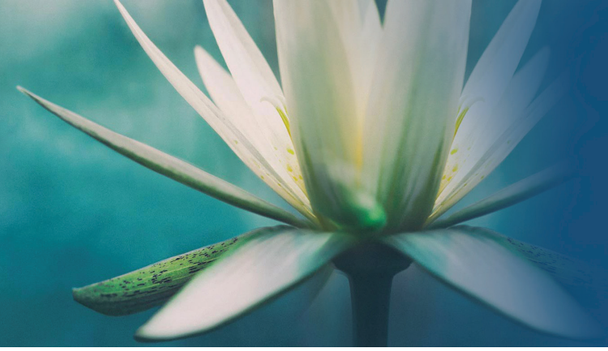

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ROADMAP

The following roadmap captures the series of engagement.

	INITIATION	LEADERS FORUM	DRAFTING THE MODEL	FEEDBACK ON THE DRAFT	LEADERS FORUM	MODEL READY TO PILOT
Timing	AUGUST/ SEPTEMBER	OCTOBER 25th ***International Spiritual Care week***	NOVEMBER	NOVEMBER	TBC	2023
Objective	Get key elements of the project agreed upon and initiate the engagement	Build the partnership with leaders and other key stakeholders to solve the remit: Understand the issue Consider possible responses Prioritise our recommendations *Optional interviews for people who cannot attend*	Draft the model	Consider gaps in the model and areas for improvement	Present the draft model Gain a sense of support for the draft model and final suggestions for improvements Gather advice from leaders to embed the model in pilot sites	Hand model over to Spiritual Health Association for piloting
Key tasks	Desktop review Interview key leaders Refine project scope	3-hour workshop Up to 6 interviews	Using feedback from interviews and the leader's forum, draft the model to the greatest extent possible	Survey Interviews	3-hour workshop	Share model and associated workshop reports
Data required as an input	Project brief	Key dilemmas Best practice model insights	Workshop report	Draft model version 1	Draft model version 2	Final pilot model
Outputs from each stage	Interview summary	Workshop report	Draft model version 1	Workshop report	Workshop report	Project debrief/learnings
Who will be involved	'Hard to reach' leaders who can influence the model of spiritual care Project team	People who can influence the model of spiritual care in health services Content experts e.g., SHA representatives Up to 3 consumers	SHA project team with MosaicLab	'Hard to reach' leaders who can influence the model of spiritual care	People who can influence the model of spiritual care in health services Content experts e.g, SHA representatives Up to 3 consumers	

PROJECT TEAM

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The project team thank you for your involvement. This project is independently facilitated by engagement specialists MosaicLab.