Clinical Practice Guidelines for Quality Palliative Care

THIRD EDITION

National Consensus Project
FOR QUALITY PALLIATIVE CARE
DOMAIN 5: SPIRITUAL, RELIGIOUS, AND EXISTENTIAL ASPECTS OF CARE

Guideline 5.1 The interdisciplinary team assesses and addresses spiritual, religious, and existential dimensions of care.

Criteria
Spirituality is recognized as a fundamental aspect of compassionate, patient and family centered care that honors the dignity of all persons.

- Spirituality is defined as, “the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and/or to the significant or sacred.”1 It is the responsibility of all IDT members to recognize spiritual distress and attend to the patient’s and the family’s spiritual needs, within their scope of practice.2
- The interdisciplinary palliative care team, in all settings, includes spiritual care professionals; ideally a board certified professional chaplain, with skill and expertise to assess and address spiritual and existential issues frequently confronted by pediatric and adult patients with life-threatening or serious illnesses and their families.
- Communication with the patient and family is respectful of their religious and spiritual beliefs, rituals, and practices. Palliative care team members do not impose their individual spiritual, religious, existential beliefs or practices on patients, families, or colleagues.

Guideline 5.2 A spiritual assessment process, including a spiritual screening, history questions, and a full spiritual assessment as indicated, is performed. This assessment identifies religious or spiritual/existential background, preferences, and related beliefs, rituals, and practices of the patient and family; as well as symptoms, such as spiritual distress and/or pain, guilt, resentment, despair, and hopelessness.

Criteria
- The IDT regularly explores spiritual and existential concerns and documents these spiritual themes in order to communicate them to the team. This exploration includes, but is not limited to: life review, assessment of hopes, values, and fears, meaning, purpose, beliefs about afterlife, spiritual or religious practices, cultural norms, beliefs that influence understanding of illness, coping, guilt, forgiveness, and life completion tasks. Whenever possible, a standardized instrument is used.
- The IDT periodically reevaluates the impact of spiritual/existential interventions and documents patient and family preferences.
- The patient’s spiritual resources of strength are supported and documented in the patient record.
- Spiritual/existential care needs, goals, and concerns identified by patients, family members, the palliative care team, or spiritual care professionals are addressed according to established protocols and documented in the interdisciplinary care plan, and emphasized during transitions of care, and/or in discharge plans. Support is offered for issues of life closure, as well as other spiritual issues, in a manner consistent with the patient’s and the family’s cultural, spiritual, and religious values.
- Referral to an appropriate community-based professional with specialized knowledge or skills in spiritual and existential issues (e.g. to a pastoral counselor or spiritual director) is made when desired by the patient and/or family. Spiritual care professionals are recognized as specialists who provide spiritual counseling.
Guideline 5.3  The palliative care service facilitates religious, spiritual, and cultural rituals or practices as desired by patient and family, especially at and after the time of death.

Criteria

- Professional and institutional use of religious/spiritual symbols and language are sensitive to cultural and religious diversity.
- The patient and family are supported in their desires to display and use their own religious/spiritual and/or cultural symbols.
- Chaplaincy and other palliative care professionals facilitate contact with spiritual/religious communities, groups or individuals, as desired by the patient and/or family. Palliative care programs create procedures to facilitate patients’ access to clergy, religious, spiritual and culturally-based leaders, and/or healers in their own religious, spiritual, or cultural traditions.
- Palliative professionals acknowledge their own spirituality as part of their professional role. Opportunities are provided to engage staff in self-care and self-reflection of their beliefs and values as they work with seriously ill and dying patients. Core expectations of the team include respect of spirituality and beliefs of all colleagues and the creation of a healing environment in the workplace.
- Non-chaplain palliative care providers obtain training in basic spiritual screening and spiritual care skills.
- The palliative care team ensures postdeath follow up after the patient’s death (e.g. phone calls, attendance at wake or funeral, or scheduled visit) to offer support, identify any additional needs that require community referral, and help the family during bereavement (see Domain 3: Psychological and Psychiatric Aspects of Care, Guideline 3.2).

References


Clinical Implications

Spiritual, religious, and existential issues are a fundamental aspect of quality of life for patients with serious or life-threatening illness and their families. All team members are accountable for attending to spiritual care in a respectful fashion. In order to provide an optimal and inclusive healing environment, each palliative care team member needs to be aware of his or her own spirituality and how it may differ from fellow team members and those of the patients and families they serve.