 Putting Patients First

“I enjoyed the chaplain ward visit” (a patient, Survey 2014)

The declared purpose of the Chaplaincy Department is described as “seeking to meet the pastoral, spiritual and religious needs of patients, their carers and staff” (our website).

We seek to do this in a variety of ways all of which are directed at improving the care received by patients:

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| **Supporting patients** - as a consequence of a referral, or through meeting them on general ward visiting.  **Being available** to all patients and staff by being as high-profile in in-patient areas as we can.  **Leading Worship** at publicised times.  **Offering specific supportive** bedside ministries on request, e.g. sacraments and prayer.  **Supporting parents** in the loss of their baby.  **Providing funerals** for those for whom the Trust has a responsibility to do so.  **Addressing issues related to faith, culture or ethics** with particular reference to minority faiths.  **Supporting staff** informally with personal issues and professionally through offering training, advice and guidance  **Participation in the corporate life of the Trust** through serving on professional groups which affect our specialty and by affirming the work of the Trust, by e.g. contributing to Nurses and Midwives Day, Trust carol service, leading memorial services for staff who have died, and so forth.  **Meeting legal requirements** of the Equality Act 2010 and Human Rights Act 2000. The Chaplaincy supports the Trust in the promotion of equality in, and access to, cultural and religious support for all its patients. It is the lead Department in promoting the protected characteristic of religion or belief under the Equality Act and fulfils a duty of submitting evidence of such work to the Trust’s Equality and Inclusion Board.  We also undertake funerals for adults and babies as specified by contract. |

**a) What patients tell us**

As part of our review of the Department we have undertaken a Patient Satisfaction Survey. The following is a selection of responses from surveys conducted of those on wards recently visited by a chaplain. Only the seriously ill and those with cognitive impairment were excluded.

Otherwise the questioning was random and irrespective of whether a person was a committed to any faith community: “Him as a person supports anybody from any walk of life regardless of faith or culture” (patient response in Patient Satisfaction Survey for Chaplaincy).

Patients told us that the visits on the wards from chaplaincy were:

* appreciated as being ‘helpful’, ‘comforting’ and ‘helping people to feel at ease with their situation’ and giving them the chance to ‘say what they wanted to say’.
* Chaplains were perceived as first obtaining permission to undertake a visit to the patient, or leaving with good grace if not welcome.
* Chaplains communicated well.
* General ward visiting met with approval, and people welcomed the fact such ‘trawls’ could be seen to be done: “him as a person supports anybody from any walk of life regardless of faith or culture” (patient) .
* The opportunity talk to someone outside the loop of nursing or medicine was appreciated, as was the chance to talk to someone to relieve a sense of isolation or just boredom.
* As one respondent said “I like the fact that everyone is important is spite of religion”.
* As an acid test 82 % of patients said they would like further input or support from the chaplaincy should they be admitted in the future.
* 79% of those belonging to minority faith communities gave a positive response about the support they received to have their religious needs met whilst in hospital.
* Also, although we did not ask specifically about it, positive comments were made about the Sunday worship offered in both hospitals.

The additional comments in the patient survey give further insight into the value of the visits. There are two strands here:

1. Interaction with a chaplain was enjoyable, improved mood and was generally supportive. Patients were pleased and grateful to have been seen, and the character of the chaplain was important as kind, concerned and interested in their wellbeing (we take ‘nice’ as being a positive!).
2. Visits were useful in addressing concerns. Some visits were described as timely in meeting a person’s spiritual needs, others helped in sorting out issues which could not be discussed within the family circle. The chaplain gave patients an opportunity to express their fears, and or helped people with their faith.

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| **Case Study**  Phil was someone the chaplain met on a general ward visit on ward in CRH. Phil is a severely disabled young man in his mid-30’s. He was admitted with a deteriorating pressure sore. After an initial visit it was clear that further support was both necessary and welcome. Phil received such support and Phil has acknowledged the value of impartial and consistent chaplaincy support in helping him cope with prolonged hospitalisation. One of the problems Phil has had to struggle with is going into residential care and the chaplain has been able to offer a listening ear and friendship. An enduring assumption about chaplaincy is that it is for “religious” people. With Phil religion has never been a subject of discussion. |

There are of course some points for us to ponder:

1. Visits were not frequent enough or long enough, and that the service is not adequately publicised.
2. Not everyone scored us positively, and we need to note some were uncertain or negative about the quality or purpose of our visits.
3. Even when all our visits are conducted with consent, we need to be sensitive to limiting factors such as tiredness.
4. Whilst one comment said improvement would be impossible, we know we can always do better and need to continually monitor our performance to strive for the best quality care of patients.

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| Canvassing the responses of parents who received chaplaincy support at the time of losing a baby through miscarriage or stillbirth was undertaken by the co-ordinating chaplain visiting the local SANDS (Stillbirth and Neonatal Death Society) drop-in meetings. This was hardly unbiased and the sample was very small but it was felt this was the most sensitive way to seek feedback. We also receive quite a bit of feedback in the form of cards and letters from parents thanking us for our help.  Parents were invited to comment on an anonymous proforma on the pre-funeral contact and pre-funeral visit, the funeral and follow up. A final question was asked about the group Remembering Services offered twice a year in Kirklees and Huddersfield. That parents felt they had an opportunity to discuss their deep feelings when visited before the funeral was appreciated:  “X was very really good, very helpful” and “not rushed, spent time talking about what I wanted”.  Parents had an understandable fear that the funeral may be alien to them but were reassured that they could help organise a very personalised service :  “wasn’t overpowering / too religious” “X explained everything very well and asked our opinion and what we wanted for the funeral.”  The funerals were described as “pitched just right – we chose readings, music, hymns, etc” and “simple service, X said what I wanted”.  Phone contact after the funeral was valued. Several of those canvassed had attended the Huddersfield ‘Lights of Love’ service of remembering:  “Lights of Love is very uplifting for me / the only type of bereavement service I attend”. “Lights of Love is a very positive experience. It shows you appreciate what everyone is feeling and everyone is involved” and “we really like it as it is around the time we lost x, and find it a nice peaceful time to remember him”.  One message to pass on is that one mother was really grateful of a naming and blessing for her baby whilst still on the Maternity Unit, whilst another was “disappointed the midwives did not contact the chaplaincy” to offer her such support. |

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| **Case Study**  Mum and Dad opted with sadness for a medical termination following a scan which showed the baby had anencephaly. They had no particular faith. Mum was a cello player. The chaplain suggested meeting at the crem and simply playing a quiet piece of music in the presence of the little coffin. This was done and the chaplain closed with a simple Celtic prayer. Mum sent a lovely note thanking the chaplain for the ‘opportunity to say goodbye to our beautiful daughter’ and requesting a copy of the prayer. |

* In conclusion, we are heartened by the positive response patients have given to seeing chaplains. Chaplaincy is a useful resource in supporting the morale of patients and helping them air concerns. For those with faith the chaplain was valued as someone to give support and assist with prayer and the practice of faith. More significantly, though, the role of supporting patients who have not asked for our support but with whom we connect through general ward “trawls” was appreciated. We had supposed this was the case and our survey affirms it.

**b) What staff tell us**

“A very helpful part of the team and valuable.”

We canvassed the views of ward staff with two surveys – one on the mechanics of getting hold of chaplains (conducted face-to-face with chaplains) and the other about the quality of the service (organised via ward managers).

1. How to Contact Chaplaincy:

Generally speaking staff were aware -

* that the service offered is 24/7 and can be accessed via Switchboard at any time.
* There was some uncertainty about contacting those of minority faiths and some respondents suggesting contacting the chaplaincy department as the best option.
* The weakness here is that a message left on the office ansaphones may not be responded to with the urgency required: using the Switchboard is more effective.
* About half those responding were aware that guidelines for the care of patients from different faith communities is available on the Trust Intranet, and there are contact telephone numbers there too:-http://nww.cht.nhs.uk/divisions/corporate/nursing/chaplaincy/
* Whilst there was awareness that chaplains were available for all patients and would seek to give support in a range of situations, there was less appreciation that chaplains were also willing to give confidential support to staff.

1. Evaluating the quality:

Staff felt -

* We were generally perceived as valuable or very valuable in work with individual patients, and prompt or very prompt in responding to requests.
* Chaplains were seen as a model for compassionate care and part of the hospital community
* There was more doubt as to whether they could be termed ‘part of the ward team’.
* Chaplains were seen as being available to all, listening to all kind of worries and as a resource for training.
* Interestingly there was more reservation about the role of the chaplain in providing specialist input for the dying.
* It is not clear whether there was a lack of awareness of, or lack of confidence in, the provision of support chaplains could provide to staff.
* We asked staff about the value of our volunteers, and they were generally approved of.

The comments supplied give more detail.

1. There were many expressions of appreciation of the chaplaincy and its usefulness, especially with regard to patient care but also concerning personal help to staff.
2. Generally the call was for more input and a higher presence on the wards both from chaplains and volunteers.
3. Again, Sunday worship was commented on positively and the suggestion there be more support on the wards on Sundays for those too unwell to attend the chapel.

Comments critical of some aspects of the service.

1. Staff responded that the ‘Muslim chaplaincy needs to be more robust’. The difficulties of an on-call chaplain (working only 11 hours per week for the Trust) providing comprehensive cover for the whole week are discussed the section “We Work together to get Results”.
2. There was a suggestion that our Catholic chaplains ask too many questions about patients when contacted. This was perceived as a querying of the entitlement of the patient to a service. It would seem though that the questioning is about ascertaining the urgency of the request to our Catholic chaplains who are not based in the hospital and have to prioritise their work.
3. Out of hours contact could be difficult.
4. More generally there were comments that the service should be more publicised and a feeling that staff needed some more information about the role of chaplaincy, ‘in order to ‘bust the myth’ that we only “do religion”’. One response was that people who did not use the chaplaincy were perhaps unaware of its potential.

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| The Wider Perspective  Being sick has long been perceived as a holy state, nearer to eternal verities and worthy of reverence. In the Christian tradition ministering to the sick has been regarded as ministering to Christ himself: “in as much as you do this (visit the sick) to the least of your brothers and sisters you do it to me”. If you visit the medieval hospital in the Merchant Adventurer’s Hall York you see the chapel at one end of the ‘ward’ enabling patients to gain a benefit from the saving prayers offered there. In later times chaplains became keepers of the moral wellbeing of workhouse and public hospital inmates. Our Muslim brothers and sisters similarly regard care of the sick as an act of charity and encourage it upon the faithful.  Since its foundation the NHS has recognised the importance of providing for the spiritual and religious welfare of patients which in previous generations may have been regarded as one and the same thing. Yet even in this age where formal religion is practised less widely in our society the importance of an holistic approach to healthcare is upheld. Chaplaincy today stands as a profession within healthcare seeking to affirm the preciousness of each person and support them at a time of crisis in their lives. We use insights from the human sciences as well as being informed by a set of values and seek (where invited) to explore and question the meaning of suffering and death.  How this responsibility is to be met is the subject of some debate currently, with objection being made to the fact that those delivering spiritual care in a secular organisation tend to come from faith communities. Would not secular chaplains be more appropriate? If people practice a faith, are there needs not best met by the churches and faith communities they belong to? These issues will be considered at more length below.  At the time of writing there is a public consultation on revised Guidelines for the provision of chaplaincy within the NHS. These Guidelines identify key components for an effective chaplaincy service and set out good practice guidance in a variety of healthcare settings.  Anecdotal evidence has long been available concerning the practical benefits of attending to spiritual and religious need. There is now academic research to affirm that those with faith have speedier recoveries, achieve earlier discharge and generally cope better with illness - see, for example, ‘Depression in the Medically Ill – evidence for the important role of chaplains in medical settings” (Koenig and Zaben) 2013 Vol 1 Issue 2 of the Journal of Health and Social Care Chaplaincy.  In an environment where seeking conversion to faith is to be resisted, there is nonetheless the issue of how general spiritual care can be more prominent in promoting wellbeing. |

**What we have learnt**

* **Patients and staff want more of us!**
* **We need to carry on what we are doing in offering a broad, generic service. Chaplaincy visits are appreciated by the overwhelming majority of patients, not just those who have a faith**
* **The visits are enjoyed by patients and seen as a way of airing worries and problems**
* **Staff feel we contribute to the compassionate care offered on their ward**
* **Staff feel we can be supportive to the majority of their patients**
* **We need to promote ourselves and what we do through publicity and explaining our role**
* **We need to be pro-active in offering support to staff**

**c) The Multi-Faith Dimension of Putting the Patient First**

“The staff development has had a very positive impact and serves as a sound base for support from the trust for this development” (page 21, Evaluation of the [CHFT] Muslim Chaplaincy Service, 2014).

We are pleased to be a multi-faith chaplaincy and to have chaplains and volunteers representing local faith communities, including Muslim, Sikh and Buddhist. We also have links with the local Interfaith Councils in both Calderdale and Kirklees. As long ago as in 2002 the Department recruited a Muslim chaplain, who in 2013 generously shared his hours with two female Muslim chaplains, to better cater for the needs of Muslim women in hospital.

Earlier this year, they produced a very comprehensive report on their activities and vision for the future: see Evaluation of the Muslim Chaplaincy Service 2014. The Evaluation makes the point that as well as using any purely mathematical framework for allocating resources regard needs to be had to “local trends, Trust needs, staff feedback and expressions of support and measures that ensure that compassion is at the core of any dimension of care offered” (page 14).

Here is a summary of recent work undertaken by our Muslim chaplains – figure 4.1

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| **Staff Facing**  *Assist Midwives with their bereavement telephone support line for all bereaved mothers. Some female Muslim patients were followed up via this route.*  *'South Asian perspective on grief and loss’*  *'Coping with Raw feelings' for midwives*  *'baby loss' for student midwives*  *Participating in Chaplaincy team meetings*  *Proactive in the recruitment of and mentoring Muslim volunteer chaplains. Working as a team with the wider Chaplaincy in planning and delivery of training for the Muslim volunteers.*  *Mentoring staff*  *Attending compulsory courses and arranging attendance to CPD courses for personal development.*  *Religious & Cultural Awareness training for Health Care Staff*  *Attending Multi Disciplinary Meetings - organ donation, end of life care etc*  *Halal Food Training to Staff*  **Publications**  *Ramadhan support-Managing the fasting patient info etc circulation*  *Chaplaincy Leaflet input*  *Release of bodies leaflet input*  *Pregnancy loss leaflet input*  *‘What to do following a Muslim Death’*  *‘Out of Hours Release of Deceased patients’*  *Examiner article*  **Patient Facing**  *Administering birth rituals*  *Administering last rites*  *Spiritual and Pastoral Care visits Advising on matters of Jurisprudence – diet, medicine, ethics, prayers, inheritance, death etc..*  *Offering Funeral Prayers*  *Provision of support/ service and burial for those experiencing miscarriage*  *Provision of 24/7 on call between two Chaplains*  *Dealing with Safeguarding Matters*  *administering birth rituals*  *Administering last rites*  *Provision and supervision of prayer and ablution facilities*  *Monitoring Halal food*  *provision of culturally sensitive memorial service*  *Visiting the neonatal unit and Child Development Centre (CDC)*  *Building good relationships with staff from maternity and Children’s ward - increasing referrals*  *networking with maternity staff have - increases in referrals of mothers*  **Networking and Outreach**  *Representation of the NHS trust within the Muslim community*  *Seeking local community involvement through fundraising for ablution facilities.*  *Mentoring and support for university students wanting input from Muslim chaplaincy as part of their degree when requested*  *Additional Training as part of CPD*  *Raising awareness of chaplaincy services within the local community*  *Working as a team with the wider Chaplaincy in planning and delivery of training for the Muslim volunteers*  *Proactive in the recruitment of and mentoring Muslim volunteer chaplains*  *Attending compulsory courses and arranging attendance to CPD courses for personal development*  *Input into Local Trust Polices such as Dress Code, infection control policy etc*  *Attending external events and meetings in relation to the Trust’s interests e.g. Consanguinity, Euthanasia, abortion, Coroner matters*  *Engaging with and collaborating work between community representatives and trust departments – bereavement, out of hours release of bodies, Creating community Links*  *Outreach engagement re chaplaincy interfaith within the wider communities and faith institutes*  *Currently a member on the ‘national board of the chaplaincy assessors panel’* \*  *Previously sat on the board of the trust foundation membership as a councillor and supported the ethos of our local trust foundation membership*  *Attending MHCCN (Muslim Health care Chaplaincy Network) meetings* |

* The importance of the support offered to staff and the fact that cultural and religious issues often feature alongside specific pastoral situations need noting.
* In our Patient Satisfaction Survey 78% of those from an ethnic minority group said they felt well supported or supported in respect of faith and culture. We gained no specific comments on this issue.
* One of the salient features of the work of the Muslim chaplaincy is the support given in working through the impact of a minority religious and cultural viewpoint on the hospital as institution. Examples of this are ensuring the provision of halal food, supporting midwifery services over miscarriage or stillbirth within the South Asian community, or working on the policy for releasing deceased patients out of hours. Such issues prompt the development of policy and practice beyond the involvement with individual patients.
* The Muslim chaplaincy also interfaces closely with the community. It is not unusual for the chaplains to be involved in accompanying local community leaders into hospital to support them in acclimatising to a pressing pastoral situation in what is for them an unfamiliar and perhaps intimidating environment .

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| **Case Study**  A question was raised by a Muslim doctor on the neonatal unit regarding the permissibility of giving donor breast milk. The doctor had been asked this question by a number of Muslim parents and wanted to clarify what the Islamic perspective was, in order to convey the correct information. From a medical perspective the doctor had felt giving donor breast milk to neonatal babies was the best option.  The question was picked up by a female Muslim chaplain on a ward round who forwarded it to the lead Muslim Chaplain / Imaam who conveyed the appropriate answer. |

**Our Muslim chaplains have identified several areas for development. These are:-**

* **Further input in the midwifery services, including networking with clinical staff, provision of follow-up home visiting following a bereavement, and appropriate written information.**
* **Involvement in the Child Development Unit.**
* **Development of services to support those with dementia.**
* **Development of educative programme for staff to enable them to understand the Muslim perspective and so enhance the person-centred care offered.**

The Muslim Evaluation also comments that whilst the local Muslim community has grown in recent years, chaplaincy provision has not, and calls for more resources. Whilst such growth in the population generally is undeniable, it begs the question of how an adequate response can be made at this time of financial stringency. For a consideration of the wider demographics in relation to current in-patients statistics, please the section on ‘Interfaith Relations’.

**What we have learnt**

* **Providing person-centred care to members of minority ethnic groups is generally valued**
* **The delivery of appropriate and effective care often has implications for hospital staff and our minority faith chaplains need to invest in networking and education throughout CHFT**
* **Reaching in to the local faith communities is important in establishing confidence in the chaplaincy, especially with minority faith groups.**
* **Calculating the resources required to meet the needs of patients from minority faith communities cannot be easily done by reference to the national formula** (of one chaplaincy session to 35 in-patient beds).