3 Spiritual Assessment in Healthcare: An Overview of Comprehensive, Sensitive Approaches to Spiritual Assessment for Use Within the Interdisciplinary Healthcare Team

Wilfred McSherry, Linda Ross, Karnsunaphat Balthip, Natasha Ross, and Sadie Young

Abstract

The provision of healthcare involves dialogue and interaction between those receiving and those providing care. These interactions incorporate the need for building relationships based upon mutual trust and respect. The delivery of healthcare across all professions necessitates the need to conduct some form of assessment to identify an individual's healthcare needs. This assessment should be holistic in nature addressing all aspects of the person including physical, psychological, social and spiritual domains. However, because of the misconceptions and assumptions associated with the concept of spirituality, spiritual needs of the person are often overlooked and neglected in the delivery of healthcare. Therefore, this chapter provides a brief overview of some of the key features of spiritual assessment offering a new pragmatic two-question model for spiritual

W. McSherry (✉)
Department of Nursing, School of Health and Social Care, Staffordshire University, Stafford, UK

The University Hospitals of North Midlands, NHS Trust, Stoke-on-Trent, UK

VID Specialized University (Haraldsplass Campus), Stavanger, Norway
e-mail: w.mcsherry@staffs.ac.uk

L. Ross · S. Young
Faculty of Life Sciences and Education, School of Care Sciences, University of South Wales, Pontypridd, UK

K. Balthip
Public Health Nursing Department, Faculty of Nursing, Prince of Songkla University, Hatyai, Songkhla, Thailand

N. Ross
Faculty of Life Sciences and Education, School of Psychology and Therapeutic Studies, University of South Wales, City Campus, Newport, UK

F. Timmins, S. Caldeira (eds.), *Spirituality in Healthcare: Perspectives for Innovative Practice*, https://doi.org/10.1007/978-3-030-04420-6_3

assessment and goes on to explore how the model may be useful in addressing spiritual needs in a range of different settings.

3.1 Introduction

The information used in most patient care plans, whether written or electronic, is primarily derived from and based upon some form of standard assessment tool. Spiritual assessment is '…an attempt to enquire positively and unobtrusively with a patient/client or their carers into areas of life that are associated with their health and well-being. It is more than just an enquiry into physical health' ([1], p. 61). Spiritual assessment involves action and the process of enquiry combined with information gathering and interpretation [2]. Patient care plans should therefore be rooted in a variety of diverse assessments that cover the multiplicity of patient care [3, 4]. Whether or not the evaluation of a person's spiritual needs is called 'screening' or 'assessment', for healthcare professionals, this type of activity ought to be encompassed within standardised approaches to assessment. An 'appropriate spiritual assessment' allows the healthcare professional to identify the personal, religious and spiritual needs, resources and coping mechanisms of a patient.

There is recognition across healthcare practice and education that a more open qualitative approach to spiritual assessment is most appropriate, despite a growing focus and desire for more quantitative methods and scientific evidence [5]. As such, any form of spiritual assessment ought to be based upon local needs and agreements and not simply a 'tick box' exercise. The style and language should be practical, clear and simple and ideally developed with staff and patients to ensure fitness for purpose and to maximise utility [1]. It is important to note that the tool has no magic formula in itself. Its usefulness in addressing spiritual need will be entirely reliant on the discernment and sensitivity of the healthcare professional using it [5].

This chapter will briefly explore some key features of spiritual assessment and its implementation and operation across the healthcare team. The chapter offers a new pragmatic two-question model for spiritual assessment and goes on to explore how the model may be useful in addressing spiritual needs in a range of different settings.

3.2 Aims

This chapter will:

1. Explore what is meant by the term spiritual assessment, outlining the different types and approaches.
2. Describe the main features of a spiritual assessment tool giving consideration to how these will influence care.
3. Provide a pragmatic two-question model for undertaking a spiritual assessment within healthcare practice and explore its application in different settings.

3.3 Background

Healthcare is dynamic and constantly changing to meet the diverse needs of individuals and societies. Despite the vast improvements, innovations and technologies that have enhanced available treatments, the delivery of healthcare still involves the recognition and validation of the person, in a caring relationship that is dignified, respectful and compassionate. Healthcare that is devoid of these humanistic and altruistic elements can feel overly scientific and 'heartless' [6].

It is widely accepted that healthcare must attend to the holistic needs of individuals: physical, psychological, social and spiritual [7, 8]. In reality, however, although many healthcare professionals feel comfortable in assessing and supporting individuals with the first three dimensions, they feel less confident and competent with the spiritual dimension of care [9].

In recent years, healthcare provision has been driven by the scientific, medical and curative model of care. The mantra of evidence-based practice has echoed across health and care services shaping practice and the delivery of care. Spiritual aspects of care appear to be being forced or 'shoehorned' down a narrower scientific paradigm. This is evident by the development of a large number of quantitative studies [10] and bespoke indicator-based, and value clarification, spiritual assessment tools [11]. Whilst the rationale may be to gain scientific/academic credibility by producing quantifiable evidence that demonstrates impact and better outcomes, recognition must also be given to the more subjective and qualitative nature of spirituality making it difficult to measure and quantify.

We suggest that the hierarchy of scientific evidence which values meta-analysis and systematic reviews more highly than qualitative evidence may need reconsideration and remodelling when applied to the spiritual dimension. This is important because what constitutes credible and trustworthy scientific evidence is certainly influencing and directing how healthcare professional assess, plan, implement and evaluate care, including spiritual care. Attempts to redress this balance can perhaps be seen in the Patient-Reported Outcomes Measures (PROMs) and Patient-Reported Experience Measures (PREMs) movement in its attempts to capture the patient/client experience, but again PROMs try to capture qualitative accounts using objective measures [12].

3.4 Undertaking a Holistic Patient Assessment

In the United Kingdom, the Nursing and Midwifery Council (NMC), the professional regulatory body for nurses and midwives, states:

> Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and spiritual needs. They use information obtained during assessments to identify the priorities and requirements for person-centred and evidence based nursing interventions and support. They work in partnership with people to develop person-centred care plans that take into account their circumstances, characteristics and preferences. ([13], p. 13)

This statement affirms it is the responsibility of all nurses to undertake a holistic assessment of their patient's needs in partnership with people important to them and members of the multidisciplinary team. This holistic assessment includes a spiritual assessment, an area that nurses often struggle with [9] and which this chapter seeks to address.

The following exercise (3.1) invites you to consider these different dimensions of care when undertaking a holistic assessment. The case involves admitting a patient into the emergency department. (This exercise was created by Sadie Young based on her presentation 'Incorporating spirituality into holistic patient assessment' at the 8th International Student Conference on Spiritual Care, Copenhagen, Denmark, 20–22 September 2017).

Introductory Exercise 3.1

As the admitting nurse, you have to undertake a holistic assessment of Gerry's needs. These are listed in Table 3.1. What order would you place them in? And why?

Here is some demographic and medical information about Gerry you are admitting:

Setting:	emergency department
Patient:	Gerry, 60-year-old male
Presenting complaint:	ischaemic stroke
Previous medical history:	high blood pressure
Social:	lives at home with his wife
Plan:	thrombolysis, rehabilitation

Linda Ross's group, who undertook this exercise, temporarily put them in the following order (see Table 3.2). 'Informal spiritual assessment', 'social needs' and 'mental capacity' moved around from moment to moment, which is why they are arranged around the outside.

Compare your list and prioritisation with the list presented in Table 3.2, and note the different positioning of the items. There are a number of points that this exercise highlights with regard to undertaking a holistic assessment upon admission to hospital, and these have implications for the delivery of healthcare practice:

Table 3.1 Gerry's needs

Needs/action	Order
Social needs	
Mental capacity	
Mobility	
Formal spiritual assessment, full documented assessment	
Informal spiritual assessment	
Past medical history	
Psychological assessment	
Washing, dressing, continence, eating and drinking	
Neurological assessment; Glasgow Coma Scale	
Blood pressure, pulse, respiration rate, blood glucose, ECG	

Table 3.2 Feedback on activity

Informal spiritual assessment		
Social needs	Blood pressure, pulse, respiration rate , blood glucose, ECG	**Mental capacity**
	Neurological assessment, Glasgow coma scale	
	Washing, dressing, continence, eating and drinking	
	Psychological assessment	
	Past medical history	
	Formal spiritual assessment, full documented assessment	
	Mobility	

- Assessment of patient needs is a fluid concept. The nurse can begin their assessment at handover and develop the identification of needs through observing and talking with the patient. There is no hard and fast rule of what is going to be the right procedure for every patient.
- Patient needs and assessments are subjective and individual so the nurse needs to be aware of the risks of following an overly structured and prescriptive approach.
- This task may help to illuminate the nurse's own preconceptions of their patients. Reflecting on how you undertook this exercise may highlight strengths and weaknesses within your skill set.

3.5 Approaches to Spiritual Assessment

There are many approaches to spiritual assessment well documented in the healthcare literature ranging from the informal to the more formal [2, 3, 14]. McSherry and Ross [2, 14] list six categories of approach to spiritual assessment:

Direct methods: asking direct questions about personal, religious, spiritual needs.
Indicator-based models: spiritual distress, diagnosis.
Audit tools: institutional attempts to audit practice in this area.
Value clarification: Likert-type scales to explore values/perceptions of spirituality and spiritual need.
Indirect methods: Cues to potential spiritual needs are identified through observation of the environment and/or demeanour/attitudes/behaviours of the individual.
Acronym-based models: simple models incorporated within the general assessment process, simple to administer and use.

This list shows that spiritual assessment spans a continuum of approaches and that the terminology can be confusing. For example, in some countries (e.g. the United States and Canada), the term 'screening' (direct method) tends to refer to the initial enquiry about a person's personal, religious and spiritual beliefs and can be conducted by any healthcare professional. The outcome of the initial screening may identify the need for a more in-depth spiritual 'history' or 'assessment' which would require referral to the specialist healthcare chaplain.

Informal (indirect) methods necessitate the healthcare practitioner using a range of communication and interpersonal skills (verbal and non-verbal) to observe and assess patient need. This will require establishing rapport and a trusting meaningful relationship with the patient. First impressions are important, so an open, friendly and polite welcoming approach upon admission is vital to enabling the individual to feel comfortable and relaxed within the caring environment.

To launch directly into the admission process with a range of intrusive personal questions such as 'Do you have a religion?' or 'Do you have any personal, religious, spiritual beliefs?', for example, if the patient is in excruciating pain or experiencing severe nausea and vomiting, would certainly be inappropriate. Therefore, it is important for informal spiritual assessment to be continuous in nature and sensitive to the priorities that have resulted in admission.

Once the reasons for admission have been resolved and the patient is comfortable, it may be appropriate to ask a simple screening question to identify any urgent personal, religious and spiritual beliefs but not in any formal or structured manner. This information could be obtained during the admitting conversation or dialogue.

Formal spiritual assessment may involve the use of a structured assessment tool. Examples of acronym-based tools include *P*ermission, *L*imited information, *A*ctivating resources, *N*on-nursing assistance (PLAN) [15] and *F*aith or beliefs, *I*mportance and influence, *C*ommunity and *A*ddress (FICA) [16] and *H*, sources of hope, strength, comfort, meaning, peace, love and connection; *O*, the role of organised religion; *P*, personal spirituality and practices; *E*, effects on medical care and end-of-life decisions (HOPE) ([17], p. 81). These models are primarily used in the initial consultation, or upon first meeting the patient, to obtain information that may be indicative of underlying spiritual needs. Close attention should be given to how these tools are used and introduced within the admission process.

As highlighted above, the NMC calls for nurses to include a spiritual assessment as part of the 'holistic' care they are called to deliver. This makes sense because the nurse is in the unique position of being with the patient 24 h/day, 7 days/week. The nurse also performs advocacy and signposting roles, for example, to specialist spiritual care services. It has been argued that unless nurses identify patients' spiritual concerns, it is very likely that these concerns will go unrecognised and unmet [18].

Spiritual assessment tools have been available in the literature for almost four decades and are mostly American in origin. One of the pioneering tools was developed by Stoll [19] titled 'Guidelines for Spiritual Assessment'. This was a direct method of assessment asking a number of questions focusing upon religious beliefs, practices and sources of support. Many contemporary tools have built upon this original work.

Despite the rhetoric indicating that nurses and healthcare professionals should undertake a spiritual assessment, the evidence suggests that they find this challenging, preferring informal rather than formal approaches. Recent surveys in the United Kingdom and Australia have shown that only 2.2% ($n = 3$ out of 139, [9]) and 26% ([20], $n = 18$ out of 191) of nurses/healthcare professionals, respectively, said they used formal spiritual assessment tools. In both these studies, the most frequent means of identifying patients' spiritual needs was informally by picking up on cues from the patient, by listening and by observation.

3.6 An Integrated Approach

The overriding concern when conducting any form of spiritual assessment is that it is integrated with the entire process of care, rather than being an 'add-on' or 'optional extra'. Clarke [21] captures this when she writes:

> Nurses are in the privileged position of being able to touch and work with people's bodies in a unique way, yet have been seduced into believing that talking was the only way to provide spiritual care. This book has challenged that view and argued that there is another way to provide spiritual care by embedding it into every encounter and relationship and into the physicality of everyday nursing and midwifery care.

This quotation is important and radical in terms of its implication for spiritual assessment because it suggests a new paradigm is required around the way we conceive and undertake it in practice. It implies that spiritual assessment should be integrated within everyday nursing practice and in each patient encounter.

3.7 Introducing an Alternative Pragmatic Model for Spiritual Assessment

So far we have seen that spiritual assessment is expected of nurses as part of the wider holistic assessment they are called to undertake, but that this may not happen, certainly not in any formal way. So, how realistic is it to expect nurses to carry out a spiritual assessment in the current climate with staff shortages, where they are already overstretched and are struggling to meet immediate physical or mental health needs and to provide safe (clinical) care?

3.7.1 A Reflection upon Current Practice: A Colleague's Experience

Let us reflect on a recent example from practice. A colleague, Maggie, has just returned to work following surgery. I (LR) asked her about her experience of the nursing care. She responded by saying:

> The nurses were great but they were so rushed off their feet. They could barely fit in taking a medical history so they certainly didn't have time to ask me about my spiritual needs. But I did have spiritual needs although I might not have recognised them as such at the time.

Maggie was very frightened one night when she felt really poorly after surgery and was worried about dying. When I asked her who she would have liked to have talked to, she said a chaplain or anyone with time to listen, but not family for fear of worrying them. Her spiritual needs were never addressed and highlight Ross's [18] concerns noted above.

In this case Maggie had spiritual needs (to talk about fear of dying), but nurses were too busy to pick up on this. So, how realistic is it to expect nurses to carry out a formal spiritual assessment? Can we really expect them to carry out an additional

assessment on top of everything else and to deliver spiritual care as an add-on to the other nursing care? Maybe these expectations are not realistic.

However, what if you could carry out a spiritual assessment without the need for any special assessment tool and without the need for much extra time? What if all that was needed was keeping in mind two simple questions that could be used on admission and at any point during the shift thereafter, ensuring that the care being given at any point is responsive to real and current need?

These two questions are 'What is important to you right now' and 'How can we help?' (see Fig. 3.1).

Let's see how these questions might work in the above situation with Maggie. She may have responded to the first question by saying 'I'm really scared and worried about dying' and to the second question with 'I'd really like to speak to a chaplain'. Her need could have been addressed without involving much 'extra' time, as these questions could have been asked whilst the nurse was giving other care, for example, whilst helping her to turn or go to the bathroom. The only extra time needed would have been in making the phone call to the chaplaincy team. The science (helping Maggie to turn or go to the bathroom) and the art (responding to her fear about dying) of nursing would both have been evident in this example resulting in the best outcome for Maggie at that moment in time. What was important to Maggie (that which gave her meaning and purpose and which is therefore spiritual) at that moment would have been addressed. Fast forward to the morning, asking the same questions again 'what's important to you right now?' and 'how can we help' might elicit a different response such as 'I really need to get to the bathroom' and 'can you please wheel me there'. This time there is a physical need. Later, the same questions might trigger the response 'I'm really worried that my daughter hasn't arrived; she said she was coming' and 'is it possible for me to call her?' This time there is a psychosocial need.

3.7.2 Benefits of This Model

Using the same two questions for each episode of care throughout an entire shift does a number of important things:

- It ensures that *assessment is continuous*, not something that is just done on admission and then is forgotten.
- It deals with the most important (meaningful and therefore it could be argued 'spiritual') issue for the patient at any moment in time.
- The care resulting from that assessment is *dynamic*, *person-centred* and *needs led* providing the potential for the best care outcome to be achieved.
- It provides a model for holistic assessment, with the spiritual at the heart (always focusing on what is meaningful to the patient during any care episode), without the need for a special tool, much extra time or additional documentation. Needs and care can be documented as part of the normal documentation processes so there is no need for additional care plans or reporting sheets.

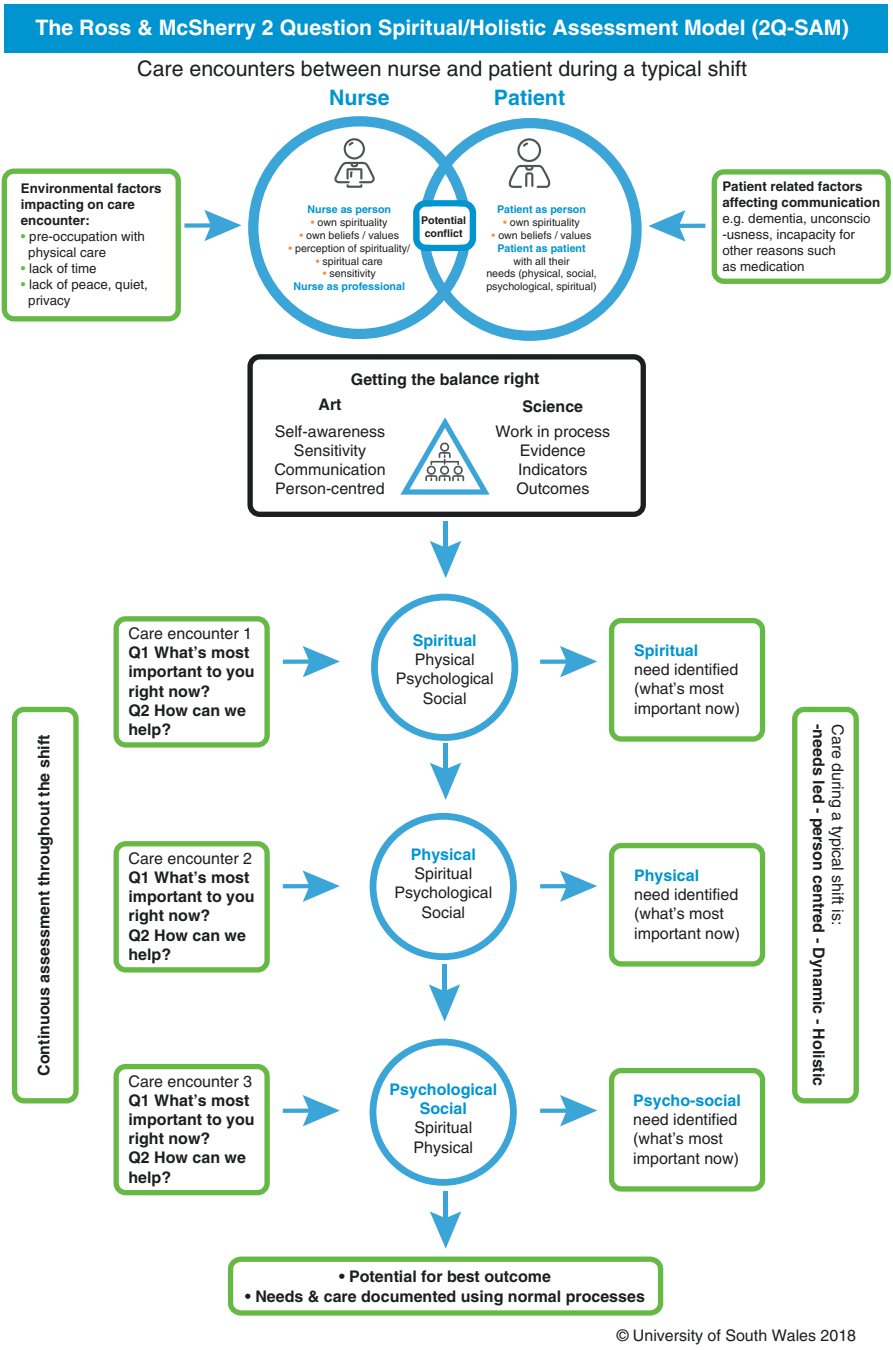

Fig. 3.1 Incorporates aspects of the following models: 'Factors which appeared to influence spiritual care' in Ross [22]. The need for balance in spiritual care in McSherry and Ross [2]. Reproduced by kind permission from M&K Update Ltd, UK from the original image drawn by Mary Blood (2010) ISBN: 9781905539277

3.7.3 Caveats in the Model

3.7.3.1 Self-Awareness

It can be seen that, in the above example, both the *art and the science* of nursing are intermingled and care emanates within the milieu of the nurse-patient relationship. This last point is crucial, because sensitive interpersonal skills, attitude, 'way of being' and personal warmth (*art*) are key to the entire care episodes' success or otherwise. It is here that the nurse's sensitivity and awareness of their own spirituality, beliefs and values is important as evidence shows that these affect the care given [22–26]. So nurses need to be aware of their beliefs/values and their own limitations, knowing when to refer on to another healthcare professional to ensure that what is important to the patient is addressed and not ignored [22].

The Caroline Petrie case (see [27]) highlights the importance of self-awareness and maintaining personal and professional boundaries.

3.7.3.2 The Unconscious Patient

Any factor interfering with the ability of the patient to communicate their need presents a challenge for holistic assessment (Fig. 3.1). So how can what is important to the unconscious patient be elicited? The question is still a valid and important one, but the patient cannot be asked. Perhaps it is down to the nurse asking the 'importance' question of friends and family combined with what information she/he can glean from the notes about what seems to have been important to the person before they became ill. Critical care diaries might be useful here as a means of identifying what is important and keeping a record of that to enable the patient to 'fill in the gaps' of that lost time after recovery [28].

3.7.3.3 The Person Who Is Conscious But has Difficulty in Articulating Their Spiritual Needs

This might apply to people with learning disabilities, dementia, or people, such as Maggie, who had difficulty in expressing how she felt about what was important to her due to the effect of strong analgesia post-surgery (PCA). In these circumstances, is the 'importance' question still useful and who is the best person to ask it? This will very much depend on the person, but someone with learning disabilities might still be able to say 'what's important' to them or to answer a variant of that, such as 'what's on your mind?' or 'what's worrying you?', which may allow them to articulate their spiritual needs. Their key worker might be the best person placed to facilitate this discussion. For the person with dementia, the care co-ordinator may be best placed to ask this question in conjunction with the family and with information obtained from the 'this is me' document and other documentation about their past life before dementia took hold. Variants of that question might include 'what gave your life meaning?', or 'what once gave you hope?'

In the case of Maggie, where powerful medication masked her ability to communicate her spiritual needs, there are perhaps two stages in this process. In response to being asked 'what's important to you right now', she may have said that she felt

very unwell and was concerned about having a temperature and infection (physical health) to which the nurse may have provided reassurance. The follow-on question here might have been 'so as well as your concerns about your temperature, is there anything else on your mind that you are concerned about right now?' This follow-on question would have given Maggie permission to raise the more difficult subject about being afraid of dying. This is important in an environment which focuses predominantly on physical aspects of care (see top left box in Fig. 3.1). This question of 'being able to speak about what's on my mind' has been identified as an important question in hospital chaplaincy [29].

3.8 Application of the Model in Different Settings

Let's see how these two questions and this proposed model might work in other situations involving other disciplines.

Example from nursing/medicine: Resuscitation in the emergency department. Sam and the medical model. The following is taken from Piles ([30], pp. 36–37):

> About 12 years again, a code [resuscitation] was called in a critical care unit while I was the faculty member for students practising in this area. … The resuscitation team rushed in because Sam was in ventricular fibrillation. One member pounded his chest and started sticking needles in him to open a central line. Sam asked, "Am I going to die?" No one acknowledged his existence except to say "Breathe Sam!" Everyone was busy doing all the things they had been trained to do to restore a heartbeat. Sam asked once again, "Am I going to die?" No response except another harsh, "Breathe Sam!" More people entered the room to observe the [resuscitation] team in action but no one spoke to Sam. All Sam finally said was "I am going to die!!" Within 15 min, Sam was pronounced dead. The renunciation team left the room convinced they had done everything possible but the patient died anyway.
>
> My reaction was one of horror. There were 20 people in Sam's room but he died alone. Why didn't someone speak to that man, comfort that man, hold that man's hand, pray with that man? Had the science of nursing overshadowed the art of nursing?

So, in this scenario, had the nurse asked Sam 'What is most important to you right now?' he might have answered 'For someone to answer my question "Am I going to die?"'.

What is important to Sam (acknowledging his urgent existential question about death) seems to be in direct conflict with the healthcare team's perception of what is most important (the preservation of life).

In this situation, the nurse's role is to advocate on the patient's behalf, ensuring that what's important to the patient is acknowledged (the art) but also ensuring that the staff's concern to preserve life (science) is addressed. So there is another caveat in the model, that of conflicting priorities and how to manage that.

Example from psychology (provided by Natasha Ross, based on her presentation 'Students' perceptions of spirituality/religion and spiritual coping' at the 8th International Student Conference on Spiritual Care, Copenhagen, Denmark, 20–22 September 2017).

The two questions can equally apply in non-clinical settings, such as in psychology. As part of a university dissertation eight university students (both religious and non-religious) were interviewed about their perceptions of spirituality and the role of spiritual coping in helping them deal with student life [31]. Although the question 'what is most important to you' was not asked in that way during the interviews, students in effect answered that question by saying that a number of things were important to them as follows (from thematic analysis of the eight interviews).

Meaning and purpose:	e.g. '…being a Christian kinda gives me meaning and purpose in life…and gives me energy, gives me hope all of those kind of things'. Pt. 4
Morals and values: e.g.	'…I always relate back to those like core values and those basic ways of acting with people and I mean, everyone gets into conflict with people…and I suppose spirituality and religion have sort of helped me bite my tongue a bit more'. Pt 3
Connection with the self:	e.g. '…I think that you realise who you are and it (spirituality), helps you to become the person you wana be, not so materialistic, not so judgemental you know being the better version of you'. Pt 7
Connection with others:	e.g. '…I think because I feel spiritually connected to people um and their personalities obviously that spiritual connection gives my life meaning and purpose as well'. Pt 3
Connection with the transcendent:	e.g. '…I understand other people you know, they look at it (spirituality) as being close to God which is in my opinion, I don't see it as a difference to me seeking to be close to my soul…'. Pt 5

They also said that what helped them to cope with university life ('how can we help' question) included:

Religious and non-religious coping:	e.g. '…meditation is a big one that helps me to cope massively…if I'm just feeling stressed I'll do it because…it just helps me to calm down it just, makes my mind a lot clearer…'. Pt 8
Comfort—in an afterlife:	e.g. 'I think the greatest way it helps me to cope is…hope that there's a better world and um, yeah hope that this isn't it uh a hope that suffering is not the be all and end all…'. Pt 4

Comfort—journey in this life:	e.g. '…I suppose God does have his best interest for you you've just got to be able to, see the good in the situation…when bad things come they're not easy but it sort of helps you to get through it a lot better'. Pt 6

So these two questions could potentially be helpful to universities in planning how they may more effectively support their students throughout their studies. For example, staying connected (to self, others, transcendent) was important and was an issue raised for discussion by the participants attending the workshop at the Student Conference. Discussion centred on the loneliness and isolation felt by students even although they were very well connected by social media. So universities might foster a sense of connection by providing 'social spaces' for students to meet face to face and by including, for example, meditation/mindfulness events within well-being initatives which would facilitate time for self. The latter was suggested by interviewees as a tool which would ease stress and anxiety.

Interestingly the themes identified in this small study endorse some of the key attributes of spirituality outlined in recent definitions [32, 33].

Example from Thailand: Adolescent living with HIV/AIDS.

In Thailand it is normal practice for young people diagnosed with HIV/AIDS to visit the hospital HIV clinic (located in the outpatient department) following referral by their doctor. The HIV clinic administers antiretroviral therapy as part of the patient treatment and care package.

The primary focus of Thai nurses in the HIV clinic is on assessing the physical health status (science) of the young person to receive antiretroviral therapy, maximise adherence and minimise side effects. Due to workload demands, holistic assessments (art), which include a spiritual assessment, are not always undertaken.

Although the spiritual part of life is widely accepted as important by Thai scholars, the Thai academic community and the Thai government and lay Thai people including Thai adolescents do not have an expectation that their spiritual needs (which are important to them) will be addressed as part of healthcare [34–36]. Moreover, as Thailand transitions from a traditional to a modern society, a study has found that, despite Thai adolescents still continuing to pray or worship, a decreasing percentage of them believe in the law of karma as part of their Buddhist philosophy [37]. So, in the more modern Thai society, it may be more appropriate to enquire about young people's spiritual needs by asking the more generally phrased questions 'What is important to you right now' and 'How can we help?' However, the model may require to be adapted for the Thai culture by including some preliminary stages as follows.

Before asking these two questions, it would be customary to say 'Sawasdee ka or Sawasdee krub'. This greeting is about acknowledging and recognising the person. The nurse may then begin the dialogue by asking 'how are you feeling today?' whilst making eye contact and physical contact with the patient (e.g. holding the patient's hand or touching the shoulder). This shows genuine concern and

compassion and establishes trust paving the way for the young person to express any deeper fears or concerns they may have. The two questions from the model can now be asked. The following is an actual response from a young person:

> I take the ARV drugs on time because I want to be healthy. I don't want to die before my grandparents who take care of me… My grandmother has lost her daughter (my mother)… I have to live to be the representative of my mum. … I should have good behaviour. I want to continue my life [35, 36].

This young person was able to articulate his psychosocial and spiritual needs in response to those two questions. He had a strong bond with his grandparents and wanted to continue to live with them and do his best for them. Being able to do this was what was most important to him giving 'meaning and purpose' to his life, a term which may be more culturally meaningful than 'spirituality'. Follow-up questions could be phrased 'You said, you want to live with your grandparent, why is this?' and 'What is the main purpose in your life?' and 'How can we help you achieve your purpose in life?' These questions are more culturally appropriate variants of 'What is important to you right now' and 'How can we help?'.

3.9 Conclusion

This chapter provides a brief overview of the different approaches to spiritual assessment. It highlights the importance of ensuring that such assessments are conducted in a respectful, sensitive manner enabling the patient to express what is most important to them at any point in time. The new 'two-question model for holistic/spiritual assessment' suggested in this chapter provides a practical and flexible means of undertaking a holistic patient-centred assessment without the need for a special tool or extra time or paperwork. As such, it is responsive to patient need and healthcare provider need for 'prudent healthcare'. The practice examples provided show that the model is relevant and adaptable to a wide range of clinical contexts and social settings ensuring that care is truly person-centred and needs led.

3.10 Summary Points

- Careful consideration must be given to the design, development and use of spiritual assessment tools within healthcare practice.
- Spiritual assessment may be conducted along a continuum involving a range of approaches and strategies; it must always be person-centred and conducted sensitively and in a nonintrusive manner.
- Conducting a spiritual assessment must never interfere with the delivery of dignified, humanistic and compassionate care.
- Spiritual assessment tools have the potential to make a significant contribution to the delivery of holistic care.

Acknowledgement We would like to thank Professor Maggie Kirk for sharing her experience of being a patient. Maggie was Professor of Genetics Education, School of Care Sciences, Faculty of Life Sciences and Education, University of South Wales, before she retired.

References

1. McSherry W. Spiritual assessment: definition, categorisation and features. In: McSherry W, Ross L, editors. Spiritual assessment in healthcare practice. 1st ed. Keswick: M&K Publishing; 2010.
2. McSherry W, Ross L, editors. Spiritual assessment in healthcare practice. 1st ed. Keswick: M&K Publishing; 2010.
3. Draper P. An integrative review of spiritual assessment: implications for nursing management. J Nurs Manag. 2012;20:970–80.
4. Pierce B. The introduction and evaluation of a spiritual assessment tool in a palliative care unit. Scott J Healthcare Chaplaincy. 2004;7(2):39–43.
5. Gordon T, Mitchell D. A competency model for the assessment and delivery of spiritual care. Palliat Med. 2004;18:646–51.
6. The Mid Staffordshire NHS Foundation Trust Public Inquiry. Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary. 2013. Available from http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/. Accessed 28 Nov 2017.
7. NHS England. NHS Chaplaincy guidelines 2015. Promoting excellence in pastoral, spiritual & religious care. London: NHS England; 2015.
8. NICE. Care of dying adults in the last days of life. 2015. Available at https://www.nice.org.uk/guidance/ng31. Accessed 28 Nov 2017.
9. Royal College of Nursing. Spirituality survey 2010. 2010. Available at https://www.rcn.org.uk/professional-development/publications/pub-003861. Accessed 28 Nov 2017.
10. Koenig H, King D, Carson VB. Handbook of religion and health. 2nd ed. Oxford: Oxford University Press; 2012.
11. Baldacchino D. Indicator-based and value clarification tools. In: McSherry W, Ross L, editors. Spiritual assessment in healthcare practice. 1st ed. Keswick: M&K Publishing; 2010.
12. Nelson EC, Eftimovska E, Lind C, Hager A, Wasson JH, Lindblad S. Patient reported outcome measures in practice. BMJ. 2015;350:g7818. https://doi.org/10.1136/bmj.g7818.
13. Nursing and Midwifery Council. Future nurse: standards of proficiency for registered nurses. 2018. Available from https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf. Accessed 12 Nov 2018.
14. McSherry W, Ross L. Dilemmas of spiritual assessment: considerations for nursing practice. J Adv Nurs. 2002;38(5):479–88.
15. Highfield MF. PLAN: a spiritual care model for every nurse. Qual Life. 1993;2(3):80–4.
16. Puchalski C, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. J Palliat Med. 2000;3(1):129–37.
17. Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. Am Fam Physician. 2001;63(1):81–8.
18. Ross L. Nurses' perceptions of spiritual care. Aldershot: Avebury; 1997.
19. Stoll R. Guidelines for spiritual assessment. Am J Nurs. 1979;1:1572–7.
20. Austin P, MacLeod R, Siddall P, McSherry W, Egan R. Spiritual care training is needed for clinical and non-clinical staff to manage patients' spiritual needs. J Study Spirituality. 2017;7(1):50–3. https://doi.org/10.1080/20440243.2017.1290031.
21. Clarke J. Spiritual care in everyday nursing practice a new approach. London: Palgrave Macmillan; 2013.

22. Ross LA. Spiritual aspects of nursing. J Adv Nurs. 1994;19:439–47.
23. van Leeuwen R, Tiesinga LJ, Middel B, Post D, Jochemsen H. The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care. J Clin Nurs. 2008;17(20):2768–81.
24. Cone P, Giske T. Nurses' comfort level with spiritual care concerns. A mixed method study among working nurses. J Clin Nurs. 2017;26:3125–36. https://doi.org/10.1111/jocn.13660.
25. Ross L, van Leeuwen R, Baldacchino D, Giske T, McSherry W, Narayanasamy A, Downes C, Jarvis P, Schep-Akkerman A. Student nurses perceptions of spirituality and competence in delivering spiritual care: A European pilot study. Nurse Educ Today. 2014;34:697–702.
26. Ross L, van Leeuwen R, Baldacchino D, Giske T, McSherry W, Narayanasamy A, Downes C, Jarvis P, Schep-Akkerman A. Factors contributing to student nurses'/midwives' perceived competency in spiritual care. Nurse Educ Today. 2016;36:445–51.
27. Alderson A. Nurse suspended for offering to pray for elderly patient's recovery. 2009. Available from http://www.telegraph.co.uk/news/health/news/4409168/Nurse-suspended-for-offering-to-pray-for-patients-recovery.html. Accessed 27 Nov 2017.
28. Egerod I, Christensen D, Schwartz-Nielsen KH, Ågård AS. Constructing the illness narrative: a grounded theory exploring patients' and relatives' use of intensive care diaries. Crit Care Med. 2013;39(9):1–7.
29. Snowden A, Telfer IJM, Kelly EK, Bunniss S, Mowat H. I was able to talk about what was on my mind'. The operationalisation of person centred care. Scott J Healthcare Chaplaincy. 2013;16:14–24.
30. Piles C. Providing spiritual care. Nurse Educ. 1990;15(1):36–41.
31. Ross N. Exploring students' perceptions of their spirituality and the role of this in coping. Unpublished BSc Psychology and Counselling dissertation: The University of Northampton; 2017.
32. Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: reaching national and international consensus. J Palliat Med. 2014;17(6):642–56.
33. Weathers E, McCarthy G, Coffey A. Concept analysis of spirituality: an evolutionary approach. Nurs Forum. 2016;51(2):79–96.
34. Balthip Q. Achieving harmony of mind: a grounded theory study of people living with HIV/AIDS in the Thai context. Unpublished doctoral dissertation, Massey University, Palmerston North, New Zealand; 2010.
35. Balthip K, McSherry W, Nilmanat K. Spirituality and dignity of thai adolescents living with HIV. Religion. 2017;8:257.
36. Balthip K, McSherry K, Petchruschatachart U, Piriyakoontorn S, Liamputtong P. Enhancing life purpose amongst Thai adolescents. J Moral Educ. 2017;46(3):295–307. https://doi.org/10.1080/03057240.2017.1347089.
37. Ramajitti Institute. Child watch during 2011–2012. 2012. http://www.teenpath.net/data/r-research/00011/tpfile/00001.pdf. Accessed 2 June 2017.

Suggested Reading

McSherry W, Ross L, editors. Spiritual assessment in healthcare practice. 1st ed. Keswick: M&K Publishing; 2010.
Puchalski C, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. J Palliat Med. 2000;3(1):129–37.
Stoll R. Guidelines for spiritual assessment. Am J Nurs. 1979;1:1572–7.