September 2014 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Johnson, J. R., Engelberg, R. A., Nielsen, E. L., Kross, E. K., Smith, N. L., Hanada, J. C., Doll O'Mahoney, S. K. and Curtis, J. R. "**The association of spiritual care providers' activities with family members' satisfaction with care after a death in the ICU**." *Critical Care Medicine* 42, no. 9 (September 2014): 1991-2000.

SUMMARY and COMMENT: This month's feature is a "study of spiritual care providers [that is] the first to demonstrate the number and variety of activities that they report completing while providing support for families of critically ill patients" [p. 1996], and the data show associations between some of those activities and increased family satisfaction with certain aspects of ICU care. One of the authors is Chaplain Sean K. Doll O'Mahoney, ACPE Supervisor and Director of the Department of Spiritual Care at Harborview Medical Center (Seattle, WA), and he has written a special note (below) to the Network about his experience of participating in this research.

Data were gathered as part of a larger interventional study to improve palliative care in an ICU [--see Related Items of Interest (below), §V]. Questionnaires about satisfaction were analyzed from 275 family members of patients who died in a 65-bed ICU at a 350-bed level 1 trauma center between August 2003 and October 2005 (from a total consecutive sample of 587 decedents), and of these family members, 118 were identified as having been visited from a spiritual care provider. Also, a Spiritual Care Activities and Satisfaction Questionnaire [--see Related Items of Interest (below), §II] was distributed within 48 hours after deaths to 57 spiritual care providers who had direct contact with the target patient population, with 49 providers participating (86%) by returning the instrument. "Although more than half [of the spiritual care providers] were serving as interns in the Spiritual Care department and…therefore had little prior experience as spiritual care providers in the ICU…, they represented an older group of individuals (mean age, 42) with significant advanced degree training (46%)" [p. 1995]. Sampling in the study is explained to an exceptional degree, including flow diagrams for family members and providers [--see pp. 1994 and 1996].

Among the findings: "spiritual care providers reported engaging in a large number of activities with ICU patients' family members" [p. 1995]. Of 14 activities specified in the Spiritual Care Activities and Satisfaction Questionnaire,

> Actively addressing (92%) and discussing (92%) spiritual or religious needs were common. Discussions related to family members' feelings (90%) and patient values (79%) were also common as was reminiscing about the patient (80%). [pp. 1995-1996]

Other activities of note include discussing with family members the patient's wishes for end-of-life care (45%) and preparing the family for what to expect during conferences with the health care team members (27%) [--see Table 3 on p. 1997].

Regarding associations of spiritual care providers' activities with family members' feelings about ICU care:

> Discussions about the patient's wishes for end-of-life care and a greater number of spiritual care activities performed were both associated with increased *overall* family satisfaction with ICU care. Discussions about a patient's end-of-life wishes, preparation for a family conference, and total number of activities performed were associated with improved family satisfaction with *decision-making* in the ICU. [p. 1991 (abstract); emphasis added]

The authors guard against assumptions about causation in this observational study, but they do speculate about possible mechanisms behind the association between spiritual care activities and family satisfaction.

> We detected a significant association between the occurrence of discussions of patients' wishes for end-of-life care and higher overall assessments of the ICU experience. It may be the case that, for family members, the opportunity to give voice to the patient's wishes and have this acknowledged by a spiritual care provider provides some support. Similarly, the association between reminiscing about the patient and satisfaction with spiritual care supports the importance of patient-focused and family-centered approaches in which the patient is seen as an important and unique person with individual values, beliefs, and history. For family members, the opportunity for a spiritual care provider to learn about their loved one as an individual may be of particular value.
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> …[T]he significant associations between spiritual care activities and higher satisfaction with ICU decision-making may suggest that one important function of spiritual care relates to comfort with and confidence in difficult decisions. This finding also supports the hypothesis that family members' experience of decision-making depends on factors beyond the provision of information, also including spiritual and emotional support. [p. 1997]

"The ultimate goal of this study is to provide insights and guidance for future interventions designed to improve spiritual care for family of critically ill patients," write these researchers [p. 1992]. Their findings "suggest that spiritual care providers' conversations with families about the patient as an individual, with specific reference to his or her wishes for end-of-life care, may be particularly useful for families"; moreover, "interventions designed to improve the delivery of spiritual care in the ICU may be associated with improvements in family members' satisfaction with decision-making" [p. 1998]. The data here are over a decade old and come from one hospital in the Pacific Northwest, but chaplains may see here an empirical lens to view present clinical situations in their own hospitals. In addition, while the Spiritual Care Activities and Satisfaction Questionnaire at the center of this research was adapted from a form originally developed for nurses, and understandably does not delineate spiritual interventions at the level of taxonomies created by and for chaplains [see Related Items of Interest (below), §III], it indicates the breadth of chaplains' activities and implies some points of connection for multidisciplinary collaboration.

Special Note to the Network from Article Co-Author Sean K. Doll O'Mahoney:

> I was honored to have a chance to participate in this study as a co-author. I drew two conclusions from the work involved in preparing and writing it —first, that physician/chaplain/researcher collaboration can be incredibly rewarding! Julie Hanada (former Director of Spiritual Care at Harborview) and I were able to help structure the way we interpreted the data and assess the strengths/weaknesses of the study for clinical practice, as well as share about the work we do as spiritual care providers. We also had help on the technical statistical pieces, which was wonderful. I encourage colleagues to introduce

themselves to physician-researchers in their institution who might have an interest in spiritual care, as collaborating and even writing something together is much easier than doing it alone.

My second conclusion is gratitude that the work of CPE students, primarily interns in this case, can have a real impact in the satisfaction of patients/families with their care overall, and with the decisions they made in the ICU. Recognizing that there is a correlation between spiritual care visits and family satisfaction with interns visiting makes me curious and excited to see how much stronger a correlation there could be with staff chaplains, and also reminds me of how valuable the spiritual care our students provide can be. The spiritual care providers in this article were predominately (over 50%) CPE students. In writing this article we had the opportunity to share about the educational model and extensive writing/reflection involved in CPE with a wide audience who would read *Critical Care Medicine*.

[-- *Network members may contact Chaplain Doll O'Mahoney at Seano3@uw.edu.*]

Suggestions for the Use of the Article for Discussion in CPE:

Students should be able to relate to this study not only because it addresses and affirms the role of chaplains in ICU care but because CPE interns are strongly represented in the research itself. Discussion could begin by looking over the range of spiritual care activities examined (--see Table 3, p. 1997). Does the incidence of these activities in the study roughly match students' estimates of the incidence in their own practice? Turning to the main findings reported in the article, how much attention do students give particularly to talking with family members about patient's end-of-life treatment wishes? What about preparing family members for conferences with the health care team members? Might empirical associations between these activities and family satisfaction make students want to focus more in these ways in their clinical work? Have they thought before about the effect of their activities on *satisfaction* in general? What about their potential influence around family members' decision-making? The CPE group could look especially at the researchers' discussion of family decision-making on p. 1997. Finally, for those interested in the process of research per se, the article's explanation of the sampling process offers a good and practical example for discussion of that component of research methodology.

Related Items of Interest:

I. For a commentary on our featured article, by a physician and a chaplain at the National Institutes of Health (Bethesda, MD), see:

> Danis, M. and Pollack, J. M. "**The valuable contribution of spiritual care to end-of-life care in the ICU**." *Critical Care Medicine* 42, no. 9 (September 2014): 2131-2132.

II. See the website of the End-of-Life Care Research Program at the University of Washington School of Medicine for the original Spiritual Care Activities and Satisfaction Questionnaire that was adapted for the present research. The instrument has fifteen items; the fifteenth ("Offer additional support to the family") was not included as an activity in the adapted version.

III. One taxonomy of chaplaincy interventions was recently developed Rev. Kevin Massey, et al., at Advocate Heath Care (Chicago, IL) from a $209,095 grant from the John Templeton Foundation, though HealthCare Chaplaincy, and reported at the Healthcare Chaplaincy Network's March 31-April 3, 2014 conference, *Caring for the Human Spirit: Driving the Research Agenda for Spiritual Care in Health Care* [--see our Summer 2014 *Newsletter*. The "Chaplaincy Taxonomy" is online at the Advocate Health care site, and a brief article in the hospital newsletter, *Conections* (see pp. 2-3) explains the project.

Another research-based enumeration of chaplains' activities has been developed by ACPE Supervisor Gordon Hilsman (retired) and was presented as a poster at the 2006 ACPE conference in Honolulu, HI. See his "Patient Needs, Chaplain Functions, and Outcomes for Study."

For more on chaplains' activities from analyses of visits, see the following:

> Flannelly, K. J., Weaver, A. J. and Handzo, G. F. "**A three year study of chaplains' professional activities at Memorial Sloan-Kettering Cancer Center in New York City**." *Psycho-Oncology* 12, no. 8 (December 2003): 760-768. [(Abstract:) The pastoral-care interventions of chaplains at Memorial Sloan-Kettering Cancer Center were documented during two-week periods in each of three years. The study describes the pattern of referrals to and from chaplains and the kinds of interventions performed during the chaplains' contacts with patients and their families and friends. Nearly a fifth of all chaplain interventions were the result of referrals. The vast majority of staff referrals to chaplains came from nurses, with the frequency and proportion of referrals from nurses significantly increasing over time. More than a third of all chaplain contacts were with friends and family without the patient present, and over 40% of referrals to chaplains were for the friends and family of patients. Pastoral visits were significantly shorter when patients were not present. In particular, pastoral-care interventions were found to differ according to the patient's religion and the circumstances of the chaplain's visit to the patient (i.e. patient status). Visit duration also varied by patient status, with pre-operative visits being significantly shorter than post-operative or treatment visits.]
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> Handzo, G. F., Flannelly, K. J., Kudler, T., Fogg, S. L., Harding, S. R., Hasan, Y. H., Ross, A. M. and Taylor, B. E. "**What do chaplains really do? II. Interventions in the New York Chaplaincy Study**." *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 39-56. [(Abstract:) The current study analyzes data from 30,995 chaplain visits with patients and families that were part of the New York Chaplaincy Study. The data were collected at 13 healthcare institutions in the Greater New York City area from 1994-1996. Seventeen chaplain interventions were recorded: nine that were religious or spiritual in nature, and eight that were more general or not specifically religious. Chaplains used religious/spiritual interventions, alone or in conjunction with general interventions, in the vast majority of their visits with patients and families. The types of interventions used varied by the patient's medical status to some degree, but the pattern of interventions used was similar across faith group and medical status. The results document the unique role of the chaplain as a member of the healthcare care team and suggest there is desire among a broad range of patients, including those who claim no religion, to receive the kind of care chaplains provide.]
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> Handzo, G. F., Flannelly, K. J., Murphy, K. M., Bauman, J. P., Oettinger, M., Goodell, E., Hasan, Y. H., Barrie, D. P. and Jacobs, M. R. "**What do chaplains really do? I. Visitation in the New York Chaplaincy Study**." *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 20-38. [(Abstract:) The current study presents findings from the New York Chaplaincy Study about chaplain visits with patients and their families in 13 healthcare institutions in the Greater New York City area during 1994-1996. It documents the distribution of 34,279 clinical visits by religious affiliation, population

served (patients, family and friends), and type of healthcare setting (acute care and non-acute care), and analyzes the number and duration of visits with patients by their medical status. Chaplains in acute settings tended to make less frequent but longer visits with patients than chaplains in non-acute settings. On average, chaplains spent less time with patients who were alone than they did during visits with patients whose family was present during the visit or visits with only family members. Average visit duration was positively related to the percentage of visits in each of the 13 facilities that were made in response to referrals ($r = .65$, $p < .05$), and the average duration of referred visits was significantly longer ($p < .001$) than that of non-referred visits ($p < .001$). The findings are intended to provide a general picture of what these particular chaplains did in these particular institutions over this particular time-period and are not intended to represent a standard of what chaplains should be doing.]

Montonye, M. and Calderone, S. "**Pastoral interventions and the influence of self-reporting: a preliminary analysis**." *Journal of Health Care Chaplaincy* 16, nos. 1-2 (2010): 65-73. [(Abstract:) This article presents the results of 30,700 inpatient visits by chaplains in a healthcare setting over a two-year period. The authors examine the self-report data of chaplains about patients' needs, chaplains' pastoral interventions, and patient outcomes. The article questions the common practice of self-reporting by chaplains and discusses the implication that such self-reporting is more descriptive of chaplains themselves rather than describing the needs of hospitalized patients. Recommendations are made for more qualitative research, such as patient surveys, and anchoring vignettes to supplement quantitative research.]

IV. Regarding spiritual care activities and hospitalization satisfaction scores, see our August 2011 and October 2004 Articles-of-the-Month, plus the following article by two of our featured authors, Engelberg and Curtis, et al.:

Wall, R. J., Engelberg, R. A., Gries, C. J., Glavan, B. and Curtis, J. R. "**Spiritual care of families in the intensive care unit**." *Critical Care Medicine* 35, no. 4 (April 2007): 1084-1090. [(From the abstract:) …DESIGN: Cross-sectional study, using data from a cluster randomized trial aimed at improving end-of-life care in the ICU. SETTING: ICUs in ten Seattle-area hospitals. SUBJECTS: A total of 356 family members of patients dying during an ICU stay or within 24 hrs of ICU discharge. … MEASUREMENTS AND MAIN RESULTS: Family members were surveyed about spiritual care in the ICU. Chart abstractors obtained clinical variables including end-of-life care processes and family conference data. …Multiple regression revealed family members were more satisfied with spiritual care if a pastor or spiritual advisor was involved in the last 24 hrs. of the patient's life ($p = .007$). In addition, there was a strong association between satisfaction with spiritual care and satisfaction with the total ICU experience ($p < .001$). Ratings of spiritual care were not associated with any other demographic or clinical variables. CONCLUSIONS: These findings suggest that for patients dying in the ICU, clinicians should assess each family's spiritual needs and consult a spiritual advisor if desired by the family. Further research is needed to develop a comprehensive approach to ICU care that meets not only physical and psychosocial but also spiritual needs of patients and their families.]

Also, chaplaincy and satisfaction research is addressed in summary on pp. 110-112 of the following article:

Jankowski, K. R., Handzo, G. F. and Flannelly, K. J "**Testing the efficacy of chaplaincy care**." *Journal of Health Care Chaplaincy* 17, nos. 3-4 (2011): 100-125. [The current article reviews the research conducted in the United States on the clinical

practice of chaplains with patients and family members, referrals to chaplains, patient satisfaction with chaplaincy services, and the limited literature on the efficacy of chaplain interventions. It also discusses the methodological limitations of studies conducted on these topics and makes suggestions for improving future chaplaincy research. The authors conclude that past studies have not adequately defined chaplain interventions, nor sufficiently documented the clinical practice of chaplains, and that more and better designed studies are needed to test the efficacy of chaplaincy interventions. The authors recommend that chaplains generate research-based definitions of spirituality, spiritual care, and chaplaincy practice; and that more research be conducted to describe the unique contributions of chaplains to spiritual care, identify best chaplaincy practices to optimize patient and family health outcomes, and test the efficacy of chaplaincy care.] [This article is available freely online via the journal.]

V. Data from our featured study were collected as part of a larger project, reported in the following article:

Curtis, J. R., Treece, P. D., Nielsen, E. L., Downey, L., Shannon, S. E., Braungardt, T., Owens, D., Steinberg, K. P. and Engelberg, R. A. "**Integrating palliative and critical care: evaluation of a quality-improvement intervention**." *American Journal of Respiratory and Critical Care Medicine* 178, no. 3 (August 1, 2008): 269-275. [(Abstract:) RATIONALE: Palliative care in the intensive care unit (ICU) is an important focus for quality improvement. OBJECTIVES: To evaluate the effectiveness of a multi-faceted quality improvement intervention to improve palliative care in the ICU. METHODS: We performed a single-hospital, before-after study of a quality-improvement intervention to improve palliative care in the ICU. The intervention consisted of clinician education, local champions, academic detailing, feedback to clinicians, and system support. Consecutive patients who died in the ICU were identified pre- (n = 253) and postintervention (n = 337). Families completed Family Satisfaction in the Intensive Care Unit (FS-ICU) and Quality of Dying and Death (QODD) surveys. Nurses completed the QODD. The QODD and FS-ICU were scored from 0 to 100. We used Mann-Whitney tests to assess family results and hierarchical linear modeling for nurse results. MEASUREMENTS AND MAIN RESULTS: There were 590 patients who died in the ICU or within 24 hours of transfer; 496 had an identified family member. The response rate for family members was 55% (275 of 496) and for nurses, 89% (523/590). The primary outcome, the family QODD, showed a trend toward improvement (pre, 62.3; post, 67.1), but was not statistically significant ($P = 0.09$). Family satisfaction increased but not significantly. The nurse QODD showed significant improvement (pre, 63.1; post, 67.1; $P < 0.01$) and there was a significant reduction in ICU days before death (pre, 7.2; post, 5.8; $P < 0.01$). CONCLUSIONS: We found no significant improvement in family-assessed quality of dying or in family satisfaction with care, we found but significant improvement in nurse-assessed quality of dying and reduction in ICU length of stay with an intervention to integrate palliative care in the ICU. Improving family ratings may require interventions that have more direct contact with family members.]