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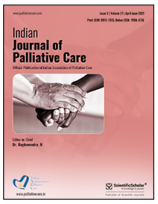

Original Article

Documentation of Assessment of Spiritual Concerns of Adult Advanced Cancer Patients: An Audit in a Hospital-based Specialist Palliative Care Service

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ABSTRACT

Objectives: Spirituality is a significant dimension of quality palliative care service provision. The purpose of our audit was to assess current practice and improve documentation of spiritual concerns of adult advanced cancer patients in a specialist palliative care (SPC) service in a tertiary care cancer centre.

Materials and Methods: In a standard-based audit, we measured the percentage of patient assessment forms with documentation of assessed spiritual concerns at a baseline and reaudit after practice change measures. We set the optimum standard that at least 60% of the case forms would have patients' spiritual concerns recorded. We implemented the following measures – (1) engaging our palliative care staff in team discussions on existing practice and identifying problems and (2) conducting a structured 2 h training module for assessment and documentation of patients' spiritual concerns.

Results: About 70.8% and 93.4% of the patient assessment forms included had documentation of assessed spiritual concerns which is higher than the standard we set at 60% and 90% at baseline and after implementing practice change, respectively. In the reaudit, we found that documentation specific to spirituality and overall psychological assessment improved. We identified that a persisting problem was the lack of recording of spiritual assessment in the patients' follow-up notes.

Conclusion: We achieved the benchmark of a standard-based audit on documentation of assessed spiritual concerns of advanced cancer patients in our SPC service. Regular audits in clinical service delivery and documentation should be integrated into quality improvement measures in palliative care.

Keywords: Audit, Documentation, Palliative care, Spirituality

INTRODUCTION

Palliative care services for advanced cancer patients include assessment and management of physical, psychological, social and spiritual domains.[1] Spirituality encompasses the concepts of meaning and purpose in life, transcendence and connection with others.[2] Spirituality plays a key role in how patients with serious, advanced disease cope with their illness.[3] Spiritual care positively impacts the quality of life, mood and coping.[4] Spiritual distress, conversely, is related to poor physical and emotional health outcomes.[5] Spirituality is a significant dimension of quality palliative care service provision.[6]

Several measures have been developed for the assessment of spiritual needs in palliative care.[7,8] Various guidelines iterate spiritual assessment.[9] The National Consensus Project for Quality Palliative Care has incorporated spirituality as one of the eight domains in palliative care provision.[9] Other guidelines also iterate the spiritual assessment and care provision for advanced cancer patients in the palliative phase.[10-12]

Clinical audit is a quality assurance process to measure conformance of clinical services with set standards and aims to bring about improvement.[13-16] An audit is an essential component of palliative care practices, irrespective of setting.

Documentation of assessment is a crucial element in clinical care. Studies have shown that patients' physical needs were documented more than nursing and psychosocial concerns, especially in end-of-life care.[17,18] A few authors have conducted audits on spiritual assessment in palliative care. Gomes-Castillo in their Quality Improvement project could increase

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clinician conducted spiritual assessment from 49% to 72% and concurrent visits with chaplain from 25% to 50% in an outpatient clinic setting.[19] A study in Singapore has reported on an audit in spiritual assessment of palliative care patients on home and hospice care in which they analysed the medical case notes.[20] Only 24% and 30% of home and hospice care patients' case notes had their spiritual assessment documented. However, this audit of case notes did not refer to any standard.

Studies in India have described research on developing and applying tools for measuring spirituality.[21] However, a clinical audit on documentation of spiritual assessment has not been hitherto published.

We aimed in this clinical audit in our specialist palliative care (SPC) service to assess whether we met the defined standard for documenting assessed spiritual concerns, identity gaps and problems in this process and improving the practice.

MATERIALS AND METHODS

Study setting

We conducted this audit in the specialist palliative medicine outpatients' clinic in a tertiary care oncology hospital.

Current practice

In our SPC team (SPCT), trained counsellors do the psychological assessment, including the spiritual needs evaluation of the patient during their first visit to the service. They document their assessment using specially designed printed forms incorporating medical, nursing and psychosocial and spiritual domains. These forms have been designed to facilitate incorporation into electronic medical records following broader hospital policy and kept simple with checkboxes for enabling medical transcriptionists to transfer from paper to electronic format.

Setting the standard for the audit

As this was a standard-based audit, we selected 'Recommendation 8.10 – *All patients with advanced cancer should have their physical, psychological, social and spiritual needs and their preferences for the nature and location of care, assessed on a regular basis*' from the National Institute of Clinical Excellence (NICE) Guidelines for Palliative and Supportive Care as a standard for the assessment of spiritual needs of advanced cancer patients (qualified, evidence based and specific) as the standard.[22] Although the audit team expected 100% documentation, we decided that it would not be a realistic yardstick for our first-ever audit on this topic. Therefore, we agreed to set an ***optimum standard*** that 60% of the adult advanced cancer patients referred to palliative care services should have documented assessment of their spiritual concerns noted in their case forms at their first assessment only or along with subsequent two follow-up assessments (face-to-face interview) (quantified and measurable).

Inclusion and exclusion criteria

We included assessment forms of all consecutive new patients referred to the outpatients' clinic during January and February 2016 for the initial phase and July and August 2016 for the reaudit. We excluded case forms of patients not evaluated for psychological assessment, unable to undergo psychosocial evaluation due to poor functional or performance status, in severe pain and other physical symptoms, cognitive impairment or unable or reluctant to communicate and those for whom caregivers did not agree for clear communication between the team and the SPCT.

Data collection and analysis

We used a data collection sheet [Appendix 1] that captured the patient assessment forms on psychological assessment [Appendix 2] and recorded whether spiritual concerns were assessed and documented by marking 'yes/no.' We also noted specific details (in free space next to spiritual concerns item on the case form and at the end of the psychological assessment section of the form), reasons for not assessing and not documenting the spiritual concerns. We also examined if other subsections on the form such as strengths, coping and emotions were filled. We used this data collection sheet for both the initial audit and the reaudit.

We identified the problems and gaps and discussed the results of the initial phase of the audit. Based on the problems, we developed and implemented practice change measures.

For baseline data, we analysed case forms of patients in March and April 2016. We identified problems and interventions for practice change in the next 2 months in May and June 2016 [Figure 1].

We conducted a reaudit following identification and implementation of measures for practice change by analysing the case forms in July and August 2016.

For analysis, we used frequency and percentage measures for the number of patient record forms with documentation of assessed spiritual concerns. We recorded problems identified in assessment and documentation as narratives.

The Institutional Ethics Committee approved the study (IEC/1216/1773/001). The study was registered with the Clinical Trials Registry of India (CTRI/2018/03/012540).

RESULTS

A total of 458 patient assessment forms were analysed. Three hundred and fifty assessment forms of consecutive new patients were used for baseline and 108 for the reaudit following

practice change measures. Assessment and documentation were recorded as complete if the 'spiritual concerns' item of the form was marked as 'yes/no.' The assessment was considered adequate if text relevant to spiritual concerns was entered in the free space next to spiritual concerns or at the end of the subsection on psychological assessment.

Initial audit

Meeting the standard

At baseline, 248 out of 350 patient assessment forms analysed had documented spiritual concerns. This result of 70.8% exceeded the standard of 60% set for the initial audit cycle [Figure 1a].

Problems identified

Only 27 out of 248 (10.9%) patient assessment forms with documented spiritual concerns had relevant text in the designated free space in the forms.

In 50 of these 248 forms (20.5%), the other fields in the 'Psychological assessment' section such as strengths, coping and emotional reactions were unfilled.

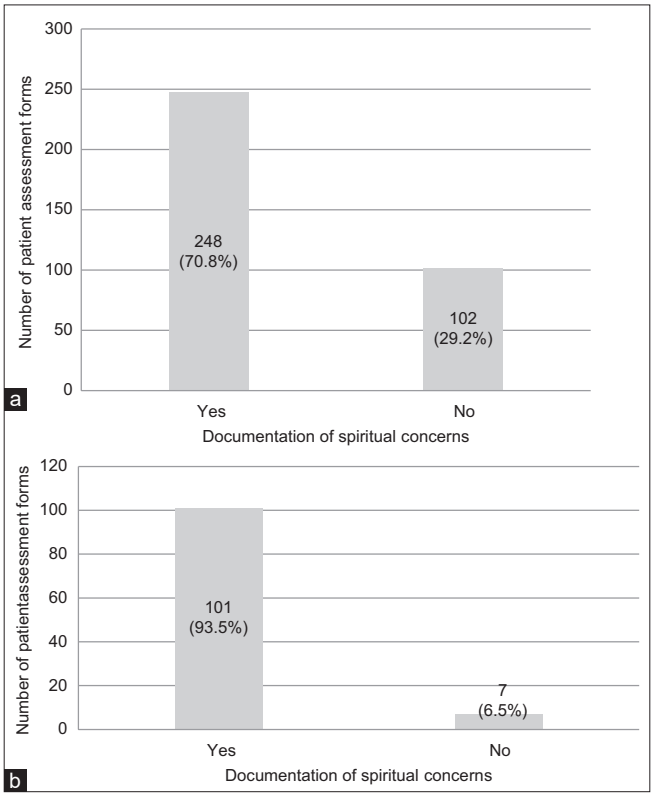

Figure 1: (a) Spiritual concerns documented – initial phase audit (number and percentage of case forms), (b) spiritual concerns documented – post-practice change (number and percentage of case forms).

In 10% of the 102 patient assessment forms without documentation of spiritual concerns, spiritual concerns were the only unfilled section of the whole form. Furthermore, despite text entered in the 'Other' section in some forms related to spiritual-existential issues, the subheading of 'Spiritual concerns' in the forms was not marked.

No documentation of spiritual assessment was evident in the follow-up patient assessment forms.

Planning and implementing measures for practice change

We presented the baseline results in a weekly SPCT meeting and distributed a two-page handout of the results.

We discussed problems identified, the need for documentation and devised a module for training of the departmental counsellors for assessment and documentation of patients' spiritual concerns.

This module was a structured 2 h training session, which included (1) statement of the importance of addressing spiritual needs/concerns, quoting NICE guidelines and standard set and (2) components of the FICA assessment tool were incorporated – 'Faith, importance of faith, integration with spiritual community and how to address spiritual issues in health care.'[22,23]

The SPCT audit team explained the correct documentation procedure to the counsellors – (a) to check the box for 'Spiritual concerns' (b) to enter some text details relevant to spirituality in the space adjacent, or at the end of the in subsection or of the psychological assessment section of the case form, where free text space was available. We displayed a leaflet covering the essential pointers in the training module on the notice boards in the departmental clinic rooms.

The audit team selected this intervention as education and training were essential to instigating practice change, which could then be analysed in the next part of the audit cycle.

For the reaudit, we revised the standard to 90% that is, 90% of the included patient assessment forms should have documentation of the assessed spiritual concerns.

Reaudit

For the reaudit, we revised the standard to 90% that is, 90% of the included patient assessment forms should have documentation of the assessed spiritual concerns. This step was taken as the standard of 60% of assessment forms having documentation of spiritual concerns was already met in the initial phase, and we wanted to see if practice change measures improved the documentation process.

Meeting the standard

Spiritual concerns were recorded in 101/108 (93.4%), which was higher than the standard of 90% agreed on [Figure 1b].

Problems identified

There was an improvement in the percentage of patient assessment forms with documentation specific to spirituality within the designated section of the forms from 10.9% at baseline to 20.8% after the practice change. Furthermore, fewer sections of the psychological assessment section (strengths, coping and emotions) were unfilled post-practice change compared to baseline (16.8% vs. 20.5%).

In only seven out of 108 patient assessment forms without spiritual concerns assessment, this was the only unfilled section, and there was no text written in the 'Other' section related to spiritual-existential issues.

However, no documentation of spiritual assessment was evident in the follow-up patient assessment forms, like the initial assessment.

The results of the reaudit were shared with the counsellors.

DISCUSSION

Our purpose for this audit was to examine if we met the standard for assessment and documentation of spiritual concerns. We met the standard we set both at baseline and after implementing practice change measures. About 70.8% and 93.4% of the patient assessment forms included had documentation of assessed spiritual concerns, which is higher than the standard we set at 60% and 90% at baseline and reaudit, respectively. This documentation was done at the first consultation in all the forms.

These findings were significant because we conducted an audit exercise in this area for the 1st time. Other authors have looked at the assessment of spirituality in patients on palliative care. Lee *et al.* in their retrospective case noted analysis of home and hospice care patients, found that spirituality was assessed in <1/3rd of the patients.[20] However, their study was not a standard-based audit. Some studies in India have discussed themes and support related to spirituality, but these were either reviews or qualitative studies and not audits.[21,24] Taylor *et al.*, in their paper on the second phase of the audit on the current practice of spiritual assessment and support provision in Cheshire and Merseyside, described documentation of 72% in a case notes review.[25] Our achievement of the standard of 90% in the reaudit was higher and could be due to (1) the already achieved the target of 60% earlier and (2) impact of the training module. Literature reports that almost 98% of patients are spiritual/religious and have multiple spiritual needs, so we should ideally strive to achieve a 100% target in the future.[6,26]

Studies have shown that pain and physical symptoms tended to be more frequently documented than spiritual aspects.[17,18] Our audit did not focus on documentation of pain and physical symptoms. Balboni *et al.* have looked at different aspects of spiritual care provision such as spiritual support by religious communities and the effect of spirituality assessment on end-of-life care.[27,28] Our study was an audit of documentation and, hence, did not address these issues.

In our study, we identified some problems which remained even after the reaudit. We noted improvement in recording details relevant to spirituality after the training intervention for the counsellors. However, it was unclear if the assessment was done as per the FICA tool taught in the training module. Kuin *et al.* in the Netherlands have studied how spiritual issues were discussed and addressed in palliative care consultations and found out that the physicians' expertise in exploring the spiritual needs and managing these was significant.[29] Hence, training in spirituality assessment is essential for the palliative care team, which we incorporated in our practice change measures. Although we could not record a full spiritual needs assessment due to the inherent nature of the assessment forms, we could significantly enhance the process by entering some components of the spiritual assessment using FICA in the notes.

Another challenge was that there was no documentation of spiritual concerns in the follow-up patient assessment forms. This problem remained unchanged even after interventions. According to guidelines, the spiritual needs of patients need regular evaluation as requirements might change with the illness trajectory, patient's general condition, social situation and coping skills. A possible explanation could be that perhaps the training module did not emphasise exploring and documenting spiritual needs at every assessment. Furthermore, as many patients returned to their hometown after the initial assessment, follow-up patient interviews were not possible. Other authors have reported difficulties faced by healthcare providers in palliative care in assessing spirituality.[30,31]

Limitations

Spiritual concerns might have been assessed but not recorded. Our purpose for this audit was to check for documentation. Furthermore, there were fewer patient record forms in the after practice change measures were implemented period, as compared to baseline (108 vs. 350) in a similar time frame of 2 months. An explanation is that possibly patients had difficulties in attending clinics during heavy monsoon during July and August. Although the results of the reaudit were shared with the counsellors, a formal debrief was not done. This discussion would have helped to understand their experiences for the reaudit and reiterate the emphasis on compliance to standards for future audits.

Lessons learnt

Although we met the standards in both parts of the audit cycles to document assessed spiritual concerns in our palliative care patients, gaps and problems, although reduced, persist.

Documentation of spiritual concerns is mandatory, and all palliative care professionals should take responsibility and ownership for this. However, it is not merely checking the box and should reflect the actual meaningful assessment.

A formally structured spirituality assessment tool should be mandatory, and all palliative care professionals in the department have a responsibility for using it, as also advised by other authors.[27-30]

Way forward

We need to devise processes sensitive to our palliative care patients' spirituality needs, to improve implementation and integration, as recommended.[31]

Three action plans are necessary to facilitate the above:

A) Addition of a one page form with the FICA components to the existing patient assessment record template
B) Effective teaching in structured educational programmes using the training module devised for this audit for competency improvement, as per recommendations.
C) Repeating the audit cycle with a standard of 100% compliance with the use of a formal spiritual assessment tool and identification of good process outcomes.

CONCLUSION

We achieved the benchmark of a standards-based audit on documentation of assessed spiritual concerns of advanced cancer patients in our SPC service. Further audits in this area are essential for refining the spiritual assessment process, overall documentation practice and periodic training. Quality improvement measures should include assessing the overall documentation process and training for the same need to be incorporated in formal departmental and institutional induction programmes for all professionals. Quality control should be an integral component of palliative care service provision.

Declaration of patient consent

Patient's consent not required as patients identity is not disclosed or compromised.

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Nil.

Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. Ferrell BR, Twaddle ML, Melnick A, Meier DE. Special Report National Consensus Project Clinical Practice Guidelines for Quality Palliative Care Guidelines. 4th ed. Available from: http://www.liebertpub.com [Last accessed on 2020 Nov 29].
2. Kellehear A. Spirituality and palliative care: A model of needs. Palliat Med 2000;14:149-55.
3. Richardson P. Spirituality, religion and palliative care. Ann Palliat Med 2014;3:150-9.
4. Sinclair S, Pereira J, Raffin S. A thematic review of the spirituality literature within palliative care. J Palliat Med 2006;9:464-79.
5. Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, *et al*. Improving the quality of spiritual care as a dimension of palliative care: The report of the consensus conference. J Palliat Med 2009;12:885-904.
6. Delgado-Guay MO. Spirituality and religiosity in supportive and palliative care. Curr Opin Support Palliat Care 2014;8:308-13.
7. Puchalski CM. Formal and informal spiritual assessment. Asian Pac J Cancer Prev 2010;11:51-8.
8. Anandarajah G, Hight E. Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. Am Fam Physician 2001;63:81-8.
9. Otis-Green S, Ferrell B, Borneman T, Puchalski C, Uman G, Garcia A. Integrating spiritual care within palliative care: An overview of nine demonstration projects. J Palliat Med 2012;15:154-62.
10. Nederland IKO. Spiritual care. National Guideline v:1.0; 2014.
11. McCusker M, Ceronsky L, Crone C, Epstein H, Greene B, Halvorson J, *et al*. Institute for Clinical Systems Improvement. Palliative Care for Adults; 2013.
12. Merseyside and Cheshire Cancer Network. Spiritual Care Guidelines and Standards. Merseyside and Cheshire Cancer Network. 2006.
13. Nice. Opioids in Palliative Care: Safe and Effective Prescribing of Strong Opioids for Pain in Palliative Care of Adults. NICE Clinical Guidelines No. 140; 2012. p. 1-62.
14. Walshe K. Principles for best practice in clinical audit. Postgrad Med J 2002;78:392.
15. Burt J, Barclay S, Marshall N, Shipman C, Stimson A, Young J. Continuity within primary palliative care: An audit of general practice out-of-hours co-operatives. J Public Health (Bangkok) 2004;26:275-6.
16. Burgess R, Moorhead J. New Principles of Best Practice in Clinical Audit. 2nd ed. Abingdon, Oxon: Radcliff Publishing; 2011.
17. Gunhardsson I, Svensson A, Berterö C. Documentation in palliative care: Nursing documentation in a palliative care unit--a pilot study. Am J Hosp Palliat Care 2008;25:45-51.
18. Hegarty M, Hammond L, Parish K, Glaetzer K, McHugh A, Grbich C. Nursing documentation: Non-physical dimensions of end-of-life care in acute wards. Int J Palliat Nurs 2005;11:632-6.
19. Gomez-Castillo BJ, Hirsch R, Groninger H, Baker K, Cheng MJ, Phillips J, *et al*. Increasing the number of outpatients receiving spiritual assessment: A pain and palliative care service quality improvement project. J Pain Symptom Manage 2015;50:724-9.
20. Lee CE, Tai IS, Yang GM, Akhileswaran R, Dignadice D, Lim A, *et al*. A retrospective audit of spirituality assessment in palliative care patients in Singapore. Prog Palliat Care 2015;23:199-207.
21. Simha S, Noble S, Chaturvedi SK. Spiritual concerns in hindu

cancer patients undergoing palliative care: A qualitative study. Indian J Palliat Care 2013;19:99-105.
22. National Institute for Health and Care Excellence. Improving Supportive and Palliative Care for Adults with Cancer. 2004; Available from: https://www.nice.org.uk/guidance/csgsp. [Last accessed on 2021 Feb 12].
23. Puchalski CM. The FICA spiritual history tool #274. J Palliat Med 2014;17:105-6.
24. Narayanasamy A. Palliative care and spirituality. Indian J Palliat Care. 2007;13(2):32.
25. Taylor E, Gaunt K, Groves K, Whitfield A, Baldry C GD. Spiritual assessment and provision: An audit of current practice. BMJ Support Palliat Care 2012;2:A1-A107.
26. El Nawawi NM, Balboni MJ, Balboni TA. Palliative care and spiritual care: The crucial role of spiritual care in the care of patients with advanced illness. Curr Opin Support Palliat Care 2012;6:269-74.
27. Balboni TA, Balboni M, Enzinger AC, Gallivan K, Paulk ME, Wright A, *et al*. Provision of spiritual support to patients with advanced cancer by religious communities and associations with medical care at the end of life. JAMA Intern Med 2013;173:1109-17.
28. Balboni T, Balboni M, Paulk ME, Phelps A, Wright A, Peteet J, *et al*. Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. Cancer 2011;117:5383-91.
29. Kuin A, Deliens L, van Zuylen L, Courtens AM, Vernooij-Dassen MJ, van der Linden B, *et al*. Spiritual issues in palliative care consultations in the Netherlands. Palliat Med 2006;20:585-92.
30. Pronk K. Role of the doctor in relieving spiritual distress at the end of life. Am J Hosp Palliat Care 2008;22:419-25.
31. Abbas SQ, Dein S. The difficulties assessing spiritual distress in palliative care patients: A qualitative study. Ment Health Relig Cult 2011;14:341-52.

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APPENDIX 1

DATA COLLECTION FORM

I. GENERAL

1. Patient identification number
2. Caseform – Included/Excluded
3. If excluded - Reasons for exclusion:
   - A. Patients not evaluated for psychological assessment – as per the records in their casenotes
   - B. Patients with very poor functional/performance status and hence, unable to undergo detailed psychological assessment - as per the records in their casenotes (recorded performance status)
   - C. Patients in severe pain or with severe physical symptom/s and hence, unable to undergo detailed psychological evaluation - as per the records in their casenotes (recorded symptom assessment)
   - D. Patients unable or reluctant to verbally communicate with palliative care staff during their initial assessment or follow up consultations - as per the records in their casenotes
   - E. Caregivers reluctant for patients to communicate with palliative care staff during their initial assessment and follow up consultations - as per the records in their casenotes

II. FOR CASEFORMS INCLUDED:

1. Date of first assessment of patient -
2. Number of follow up assessments -
3. Dates of follow up assessments – 1)
   2)
4. Documentation of Spiritual concerns –

a) Yes/No Box– Checked/Not checked

b) If not checked – Any reasons stated – Yes/No
   If yes – specify :

c) Any text next to the box 'Yes/No' – Text/No Text
   If text – specify:

d) Any text relevant to spiritual concerns in section 'Other' - Text/No Text

If text – specify:

5. Problems in documentation of spiritual concerns, if recorded –

   Yes/No/Unclear

   If yes – specify:

6. Any other comments/remarks-

APPENDIX 2

What more patient wants to know	1. Physical a. Disease related curability, contagiousness b. Symptom related current, future, terminal 2. Treatment related 3. Social/Family related .,. 4. Psychological/Emotional 5. Spiritual 6. Study/Employment related 7. Financial 8. Legal 9. Life expectancy 10. QOL 11. Other:			
Decision making ability		Poor □	Fair	Good D
Diagnosis and prognosis explained	Yes □	No □		
Emotional Reaction after disclosure	Normal sad depressed angry anxious worried restlessness guilt denial □ crying □ confused □ optimistic □ acceptance □ other: □			
Spiritual concern	Yes □	No □		
Comfort Zone	a. with people b. alone/rest c. hobbies/interest d. prayer/worship, other			
Strength and coping strategies	seeking support □ controlling □ Distancing denial avoidance confronting accepting D problem solving			
Other				

3. Support System:

Medical Facility available	**Close by**	**Far**	**Not available**
Family support available	Yes D	No □	
Details of hospice given	Yes D	No □	
Refer to social worker	Yes O	No □	
Recounselling required	Yes O	No □	