Spirituality is a much broader concept than religion and an integral part of people’s health and well-being. When assessing older people, their spiritual needs must not be forgotten or ignored. This article examines the spiritual care of older people. It discusses different forms of spirituality, the principles of spiritual need assessment, the impact of not addressing this care domain, and tools and approaches that can be used to assess older people’s spiritual care needs.

What is spirituality?
Before discussing how to address older people’s spiritual needs, we need to contextualise spirituality. For some, it is about engagement in religious practices within an organised group; for others, spirituality can be mediated through a relationship, a conversation, a landscape or a work of art as well as through religious practice and rituals (MacKinlay, 2017). Mowat and O’Neill (2013) noted that there are two schools of thought regarding the concept of spirituality:
- It pertains to religious belief (Franciscan spirituality);
- It pertains to people’s need for meaning, which can be found in faith in a divine entity but also in their relationships with others.

Jewell (2011) argued that we are all spiritual beings, whether we realise it or not, as we all have principles, beliefs and values, and all need to find meaning and purpose to our lives. The Royal College of Nursing, in its pocket guide on spirituality in nursing care (RCN, 2011a), explains that spirituality is not just about religious beliefs and values, but also about hope and strength, trust, meaning and purpose, forgiveness, love and relationships, morality, creativity and self-expression.

Why spiritual care is important
In health and social care provision, spiritual care aims to respond to the needs of the human spirit and provide meaning during times of trauma and sadness; this response could come through one’s faith
or through discussion with a sensitive listener (NHS Education for Scotland, 2009). In the context of illness, spiritual care may be necessary to support recovery and explore concerns about death and dying, religious and non-religious convictions, rituals and practices, relationships of significance, a sense of the sacred, and beliefs (NHS England, 2015).

There is evidence that spirituality and physical health are linked. McCullough et al (2000) suggested that people who participate in spiritual activity as individuals or in groups often live longer than those who do not. Erichsen and Büssing (2013) found a relationship between meeting the spiritual needs of older people and positive health outcomes. There is also evidence of a link between spirituality and mental wellbeing, as shown in Cornah’s (2006) review of the literature.

Churches can be places of socialisation and support, so older people who take part in the life of a religious community will often feel less isolated. They may also be encouraged to follow healthier lifestyles, as some faiths or religions condemn the use of alcohol, tobacco and/or recreational drugs (Zimmer et al, 2016).

According to the last UK census, which took place in 2011, there has been a fall in the number of people declaring they have a religion. In 2011, 25.1% of the population in England and Wales said that they had no religion, versus 14.8% in the previous census 10 years earlier (Office for National Statistics, 2012). However, Noronha (2015) has argued that, even though there may be a decline in religious involvement, it is essential that older people can continue their spiritual development through reflection and contemplation.

Meeting people’s spiritual needs

In the NHS Chaplaincy Guidelines, NHS England (2015) stated that all patients, be they religious or not, should have the opportunity to access pastoral, spiritual and religious support when they need it. As outlined above, spirituality can express itself through faith, so care providers need to recognise and address people’s needs for religious rituals and practices (Royal College of Nursing, 2011). However, there is plenty of evidence that, in many health and social care settings, the spiritual needs of older people are not met. This may be due to a range of factors, including:

- Lack of time;
- Lack of training;
- Lack of awareness, knowledge or understanding;

“Historically, care providers have been reluctant to address the spiritual domain of health because a biomedical model has been used to frame care provision”

- Reluctance or fear;
- Concerns about imposing one’s own values and beliefs on others.

After all, the Nursing and Midwifery Council’s (2018a) Code does ask nurses and nursing associates to “make sure [they] do not express [their] personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way”.

In a survey on spiritual care in nursing practice, RCN members expressed the view that nurses did not receive enough training on spiritual care provision and felt that professional boundaries, when dealing with patients’ spiritual needs, should be clarified (RCN, 2018).

Historically, care providers have been reluctant to address the spiritual domain of health because a biomedical model has been used to frame care provision. This has led to a narrow and directive approach to care that, in turn, has led to a culture that professional boundaries, when dealing with patients’ spiritual needs, should be clarified (RCN, 2018).

There are clear links between spirituality, dignity and person-centredness, and one cannot be considered without the other two. Tailoring interventions to the needs of patients can improve outcomes but, as shown in Cornah’s (2006) literature review, there are many barriers to good spiritual care provision. NHS England (2015) explains that insufficient training and experience, poor communication, insensitivity and lack of understanding of individuals’ belief systems can all have detrimental effects on the provision of good spiritual care.

Cornah’s (2006) literature review on the impact of spirituality on mental health showed that spiritual care interventions can have both detrimental and positive effects on the individual. For Cornah, then, it is particularly important to consider mental health problems and coping styles when addressing patients’ spiritual needs.

Tools, models and approaches

There are several ways to meet people’s spiritual care needs and several tools, models and approaches that can be used.

HOPE questions

Convinced that medical care service provision should cover people’s spiritual needs, Anandarajah and Hight (2001) recommended the HOPE questions to guide the assessment of:

H – sources of hope, strength, comfort, meaning, peace, love and connection;
O – role of organised religion for the patient;
P – personal spirituality and practices;
E – effects on medical care and end-of-life care decisions.

The HOPE questions give practitioners a basis for discussing spiritual needs with patients and help them find out how to address those needs. In the first step, practitioners identify what spirituality means to the patient and what may bring them hope, strength, comfort, meaning and so on. In the second and third steps, practitioners identify the patient’s needs in relation to organised religion and to personal spirituality and practices. Finally, practitioner and patient discuss the impact of medical care and interventions on the patient’s spirituality.

It must be noted that, to be able to conduct useful and successful assessments using the HOPE questions, practitioners need to be aware of their own spiritual beliefs and values.

FICA tool

Puchalski and Romer (2000) explored another model of spiritual care provision. Health and spirituality are interlinked, so addressing a patient’s spiritual needs enables them to give meaning to their experiences of illness. Puchalski and Romer recommended using a spiritual history tool called FICA, which stands for:

- F – faith or beliefs;
- I – importance and influence;
**Clinical Practice**

**Review**

C – community;
A – address in care.

The FICA tool covers individuals’ faith and beliefs, their role in the community and what is important for them in their lives.

**Spirituality of illness or crisis**

In 2004, Van Leeuwen and Cusveller highlighted that addressing spiritual needs in ill health is not a simple matter, as there are two very different aspects involved:
- Assessing day-to-day spiritual needs, such as prayer and meditation, over which people have some control even if they are ill;
- Assessing what they referred to as the “spirituality of illness or crisis”, in which people who are faced with major changes in their lives due to ill health (or any crisis situations) experience spiritual distress that may lead them to question the meaning of life or reject their faith; their stress and anxiety increase while their ability to cope with illness decreases.

Van Leeuwen and Cusveller (2004) recommended that patients going through spiritual distress receive regular and ongoing holistic assessment and support that uses a multidisciplinary approach that is sympathetic to their spiritual needs (which may be personal to them or linked to their cultural background).

**Spiritual Distress Assessment Tool**

Monod et al (2010) developed the Spiritual Distress Assessment Tool (SDAT), designed to assess spiritual distress in hospitalised older people. The authors felt such a tool was needed because of evidence that spiritual needs were still under-assessed in many settings specialising in care of older people, and that many hospital chaplains were unaware of the different dimensions of spiritual care, but focused on religion. The SDAT identifies four domains of spirituality:
- Meaning;
- Transcendence;
- Values;
- Psychosocial identity.

To successfully ensure patients’ spiritual needs are met, it is important to consider their values so their care can be individualised and they can be referred on to others as required (Monod et al, 2010).

**Spiritual needs framework**

Nelson-Becker et al (2007) created a framework for clinicians to assess the spiritual needs of older people. It encompasses 11 domains, as follows:

- Affiliation;
- Spiritual beliefs;
- Spiritual behaviour;
- Emotions;
- Spiritual experiences;
- Values;
- Spiritual history;
- Therapeutic change;
- Social support;
- Wellbeing;
- Extrinsic/intrinsic spiritual propensity.

This framework was developed to support the spiritual assessment of older people from a social-work perspective, ensuring a holistic approach to care that goes beyond physical needs.

**Other approaches**

There are many other approaches that can be used to assess and address the spiritual needs of older people. One is reminiscence therapy, which allows them not only to discuss spiritual beliefs but also to establish a relationship, thereby allowing the discussion to evolve (Bender et al, 1998). Other approaches include:
- Using music to develop bonds;
- Effective listening;
- Ritualistic prayer or worship (Mowat and O’Neill, 2013).

**Staff competencies**

Van Leeuwen and Cusveller (2004) suggested that nurses need a number of competencies to explore and address patients’ spiritual needs – first and foremost, the competency to conduct a holistic assessment – but the environment and circumstances of care provision need to be favourable to such assessments.

The NMC (2018b) expects registered staff to “prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and spiritual needs”. The RCN (2011a) acknowledged that, to meet the spiritual needs of older people, nurses need to:
- Adopt a caring attitude;
- Recognise an older person’s need to engage in spiritual care by using observation and effective listening skills;
- Recognise the individual’s preferences about spiritual care provision and not redirect them inappropriately.

Marie Curie noted that all staff and volunteers involved in spiritual care should have some level of competence in terms of recognising people’s needs and offering adequate interventions. To help in that respect, it has developed spiritual and religious care competencies for health professionals working in specialist palliative care (bit.ly/MarieCurieSpiritual).

Anyone involved in spiritual care provision needs to acknowledge that this is not just about meeting religious needs; those involved in assessing patients need to be able to:

---

**Box 1. Reflection exercise: spiritual domain assessment in a care home**

Joyce Simpson is 93 years old. From childhood onwards and throughout her entire life, she has attended her local Methodist church and been an active member of that community. Five years ago, Ms Simpson had a sudden stroke, which left her with limited mobility and dementia. On discharge, she moved into a nursing home, which was some distance away from the community she knew and loved. The care home arranged for a priest to come once a month to deliver a sermon to its residents.

You are a member of the nursing care team at the home and reflect on the following questions:
- Are Ms Simpson’s spiritual needs being met at the care home?
- How would you assess Ms Simpson’s spiritual needs?
- Who could you involve in Ms Simpson’s care to meet her spiritual needs?
- What needs to feature in your action plan to address Ms Simpson’s spiritual needs?

The person’s name has been changed.

---

**Box 2. Reflection exercise: evaluate practice**

Take a moment to reflect on practice – your own and/or that of other members of staff – to identify whether the spiritual needs of older people are met in your workplace. Consider the following questions:
- How well is spiritual care assessed in your workplace?
- What barriers prevent you or your colleagues from assessing the spiritual needs of the older people under your care?
- What could be done to improve the assessment process in terms of spiritual care provision?
Clinical Practice Review

- Recognise their own limitations;
- Liaise effectively with the multidisciplinary team.

Spiritual care in dementia

An area in which spiritual care provision is deemed particularly important is in the management of people with dementia. Ødbehr et al (2017) described spiritual care for this group as:
- Performing religious rituals that provide a sense of comfort;
- Coming to know individuals with dementia, which provides an opportunity to understand what gives meaning and purpose to their lives;
- Attending to their basic spiritual needs, which provides an opportunity to appreciate their vulnerability and humanness.

Discussions between the health professional and the individual allow the health professional to create a trusting environment in which the relationship can flourish and the individual can feel listened to and supported. Such discussions allow the health professional to get to know the individual and instigate interventions to address their needs.

For Wells (2017), addressing a person’s spiritual needs – especially if that person has dementia – creates connectivity: Wells adds that some care environments can be perceived as “inhumane”, so interventions allowing people to express their individuality, values and beliefs should be encouraged.

MacKinlay and Trevitt (2010) discussed the use of reminiscence therapy and life story telling to help people who have dementia with their spiritual needs. These activities foster an understanding of the person’s life, thereby providing meaning, and promote interaction with others, thereby enhancing socialisation.

Conclusion

In many settings, health professionals are reluctant to tackle the spiritual domain of care. Some may lack the required understanding, awareness and knowledge; although there are several tools and models supporting the delivery of spiritual care available, their implementation is patchy. Care providers may consider that discussing religious faith is sufficient to meet older people’s spiritual needs, but spirituality is not only about religion but more broadly about individuals’ principles, beliefs and values.

The spiritual domain should be an integral part of the holistic assessment of older people. It allows a deeper understanding of the person, thereby providing meaning, building up a person’s ability to cope and reducing the negative impact of disease and ill health. Boxes 1, 2 and 3 offer reflection exercises and questions that can be used to assess the spiritual domain of health in older people. The fact that spiritual care can enhance people’s experience of illness and contribute to the healing process needs to be more widely recognised.

References

Marie Curie (2014) Spiritual and Religious Care Competencies for Specialist Palliative Care. Bit.ly/MarieCurieSpiritual

Royal College of Nursing (2011a) Spirituality in Nursing Care: A Pocket Guide. Bit.ly/RCNSpiritualityGuide
Royal College of Nursing (2011b) RCN Spirituality Survey 2010: A Report by the Royal College of Nursing on Member’s Views on Spirituality and Spiritual Care in Nursing Practice. Bit.ly/RCSpiritualitySurvey

Box 3. Questions to assess the spiritual domain of health in older people

- Do you consider yourself spiritual or religious?
- What kind of activities or viewpoints are important to you? Which activities or viewpoints give value to your life?
- Would you like to receive spiritual support in any way?
- Do you attend a place of worship?
- Is there any religious or spiritual ritual that you would like to continue during your stay in this facility?
- Is there any religious or spiritual ritual that you need support with?
- Would you like to discuss your spiritual needs with a professional?
- Would you like to stay in touch with your faith community in any possible way?

CLINICAL SERIES

Assessment of older people series

Part 1: Definition, principles and tools
Bit.ly/NTOldAssess1

Part 2: Physical domain
Bit.ly/NTOldAssess2

Part 3: Functional domain
Bit.ly/NTOldAssess3

Part 4: Psychological domain
Bit.ly/NTOldAssess4

Part 5: Social domain
Bit.ly/NTOldAssess5

Part 6: Spiritual domain
Bit.ly/NTOldAssess6

Part 1: Definition, principles and tools
May

Part 2: Physical domain
Jun

Part 3: Functional domain
Jul

Part 4: Psychological domain
Aug

Part 5: Social domain
Sep

Part 6: Spiritual domain
Oct