Death is common in acute care settings: in 2018, approximately 45% of all deaths in England occurred in hospital (Bit.ly/PHEEoLCare - Profiles). The National End of Life Care Strategy (Department of Health, 2008) sets out how health professionals should care for people approaching the end of life, their families and their carers. This is further underpinned by guidance from the National Institute for Health and Care Excellence (2015), which sets out how hospitals should deliver care to the dying adult in the last days of life.

Addressing spiritual needs
End-of-life care is not just about the physical aspects of caring: it must also include a psychological and emotional assessment of patients’ needs as well as an offering of spiritual care. This is an integral part of end-of-life care and should be addressed for all patients. The Leadership Alliance for the Care of Dying People (2014) identified five priorities when caring for someone who is dying; these are outlined in Box 1.

Measuring performance against national standards for end-of-life care is essential to enable hospitals to understand what they do well and where they need to make improvements. A retrospective national audit, using a clinical casenote review of a sample of all patients dying in hospital in May 2013, reported that documentation of discussions about spiritual needs were reported for only 21% of patients (Royal College of Physicians, 2015).

In a further audit of hospital clinical care relating to all adult deaths (RCP, 2016), discussion with patients during the last episode of care regarding their spiritual, cultural, religious or practical needs was documented in 15% of casenotes; in a further 27% of cases, there had been discussion with a person important to the patient. In 89% of cases, the identified needs were reported to have been met.

Using digital systems that are already embedded in clinical care can offer a novel way to support the provision of spiritual care.

There are challenges in routinely identifying those who may benefit from spiritual care while in hospital.

Using early warning scores to widen access to end-of-life spiritual care

D

Keywords Spiritual care/End of life/ Holistic care/Early warning score

This article has been double-blind peer reviewed

Using early warning scores to widen access to end-of-life spiritual care

In this article...

- The proportion of adults dying in hospital who are not offered spiritual care
- How early warning scores can be used to identify patients at the end of life
- How one trust increased the number of patients to whom spiritual care was offered

Key points

- Spiritual care is a broad concept and an essential component of a holistic approach to delivering care.
- Current national audit data suggests that too few adults dying in hospital are given the opportunity to receive spiritual care.
- There are challenges in routinely identifying those who may benefit from spiritual care while in hospital.
- Using digital systems that are already embedded in clinical care can offer a novel way to support the provision of spiritual care.
- There is a need for wider awareness of spiritual care, as well as appropriate staff training and support.

Authors Timothy Blake is site lead chaplain and bereavement services manager; Lee Ellis is resuscitation officer and trigger response nurse; Charlotte Hoctor is end-of-life care facilitator; Mid Essex Hospital Services NHS Trust. Sally-Anne Francis is senior research fellow, Nursing Division, Basildon University Hospital, and Anglia Ruskin University. (Mid Essex Hospital Services NHS Trust and Basildon University Hospital became part of Mid and South Essex NHS Foundation Trust on 1 April 2020.)

Abstract Spiritual care is an integral part of end-of-life care. National audit data suggests that access to spiritual care for adults in hospital who are dying needs to improve. By adapting an existing digital clinical management system, the end-of-life care team at Mid Essex Hospital Services NHS Trust were better able to routinely identify patients in the final stage of life and improve access to spiritual care.

Citation Blake T et al (2020) Using early warning scores to widen access to end-of-life spiritual care. Nursing Times [online]; 116; 8: 42-44.

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Clinical Practice Innovation Spiritual care

Authors

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Abstract Spiritual care is an integral part of end-of-life care. National audit data suggests that access to spiritual care for adults in hospital who are dying needs to improve. By adapting an existing digital clinical management system, the end-of-life care team at Mid Essex Hospital Services NHS Trust were better able to routinely identify patients in the final stage of life and improve access to spiritual care.

Citation Blake T et al (2020) Using early warning scores to widen access to end-of-life spiritual care. Nursing Times [online]; 116; 8: 42-44.
Essex Hospital Services NHS Trust, employed nearly 5,000 staff and provided a comprehensive range of acute and community-based services from four sites. In the 2015 audit of adult deaths occurring at the trust, discussion with patients during the last episode of care regarding their spiritual, cultural, religious or practical needs was documented in 14% of casenotes; in a further 22% of cases, there had been discussion with a person important to the patient. Consequently, this was identified as an area for improvement.

Using the chaplaincy team to deliver training and education to clinical staff was the first consideration; however, freeing up staff to attend additional training proved challenging in a busy district hospital. It became evident that a more innovative way was needed to improve access to spiritual care. Proactively identifying patients who had a last-days-of-life care plan in place was considered as a way to improve unmet spiritual care needs.

The trust had been using the CareFlow Vitals e-observation system to record bedside clinical metrics for the previous five years. Initially the system was introduced across all 21 adult wards to identify the signs of a deteriorating patient. Nurses measure and input data to create an alert as part of an early warning system to trigger clinical interventions for the patient; these are defined by a pre-agreed trust protocol and national guidelines.

Identifying those at the end of life

The system was introduced to promote effective communication across the multidisciplinary team and provide efficient use of resources. Its aim was to identify the right person for the right patient at the right time. Part of the success of this system was the fact that it differentiated between those patients who needed active escalation and those who could, potentially, be at the end of their life; it ensured patients were on the care pathway that would meet their individual needs.

Proactively identifying patients who had the last-days-of-life care plan in place was considered as a way to improve unmet spiritual care needs across all 21 adult wards to identify the signs of a deteriorating patient. Nurses measure and input data to create an alert as part of an early warning system to trigger clinical interventions for the patient; these are defined by a pre-agreed trust protocol and national guidelines.

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identified as ‘not for monitoring’ (Fig 1). Clinicians could then see which patients were not for vital-signs monitoring and the trigger-response team could use the icon to identify whether patients required review. In addition, the end-of-life care facilitator identified a further benefit: the icon served as an opportunity to improve care for patients at the end of life. By using the list of patients whose digital record featured the icon, it was possible to identify those who might wish to receive care from the pastoral and end-of-life team.

A programme of spiritual care interventions was established by the chaplaincy team and offered to those identified through use of the icon. Until this opportunity arose, the chaplaincy team depended on receiving referrals from patients, families, staff and others in the community.

Impact of the new system
In the year from April 2017 until March 2018, before we used the CareFlow Vitals icon, the records kept by the team showed 201 referrals to the chaplaincy team for patients at the end of life (or for their families). In April 2018, the team began to pilot the scheme using the CareFlow Vitals system to extend the reach of the pastoral care team and chaplaincy services.

From April 2018 until March 2019, the chaplaincy team provided spiritual care to 364 patients, an increase of 81% compared with the previous year. This increase was related to our use of the CareFlow Vitals icon (Table 1). Spiritual care was provided to 86 patients for whom the referral was attributed to use of the CareFlow Vitals icon. These cases comprised 24% of our end-of-life care caseload that year and 52% of the total increase.

The numbers cited relate to those patients identified using the CareFlow Vitals system who accepted spiritual care; as it does not include all those who were approached and asked if they wished to be referred to the chaplaincy team \(n = 322\), the impact of the new system is underreported in terms of patients being given the opportunity to receive spiritual care.

In 2018-2019, we identified 322 patients who were flagged as at the end of life using the CareFlow Vitals system; of these, 130 patients declined support and 86 accepted it; there was no response from the remainder of those approached (this is often because families do not respond to requests or staff do not report back).

There are a few notes of caution to our work. It is impossible to know whether patients at the end of life might have been referred to us by another means, even if not logged as CareFlow referrals. Some of the increase in caseload in 2018-2019 may have been the result of staffing changes to the chaplaincy team. There were some false positives in that some ‘not for monitoring’ patients were not in the last days of life but were for fast-track end-of-life discharge home.

Conclusion
Spiritual support is a recognised aspect of holistic care for people who are dying. We have described a locally developed innovative solution to improve the accessibility of end-of-life care at our trust. Implementation of this scheme has been hugely beneficial to identifying individuals dying in hospital; it has given more patients the chance to receive spiritual care and provided a consistent service across different clinical areas. NT

Box 1. Caring for a person who is dying: five priorities
When caring for a patient who may die within the next few days or hours, it is important that:

● This possibility is recognised and communicated clearly, decisions made and actions taken are in accordance with the person’s needs and wishes, and these are regularly reviewed and decisions revised accordingly
● Sensitive communication takes place between staff and the dying person, and those identified as important to them
● The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
● The needs of families and others identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
● An individual plan of care – which includes food and drink, symptom control, and psychological, social and spiritual support – is agreed, coordinated and delivered with compassion

Table 1. Referrals to the chaplaincy team pre and post intervention

<table>
<thead>
<tr>
<th>Source of referral</th>
<th>Pre-intervention, n</th>
<th>Post-intervention, n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>128</td>
<td>146</td>
</tr>
<tr>
<td>CareFlow Vitals</td>
<td>n/a</td>
<td>86</td>
</tr>
<tr>
<td>Family</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Trust chaplain</td>
<td>13</td>
<td>33</td>
</tr>
<tr>
<td>Palliative care team</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Volunteer</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Faith leader</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Therapist</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>201</td>
<td>364</td>
</tr>
</tbody>
</table>

*Intervention was the introduction of the CareFlow Vitals icon

**Fig 1. ‘Not for monitoring’ icon**

[Department of Health (2008) End of Life Care Strategy: Promoting High Quality Care for all Adults at the End of their Life. London: DH.]
[Leadership Alliance for the Care of Dying People (2014) One Chance to Get it Right: Improving People’s Experience of Care in the Last Few Days and Hours of Life. London: DH.]