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The power of two simple questions

The nurses who devised a spiritual care model for acute settings explain how in works and why it can save you time as well as enhancing your person-centred practice

By Linda Ross and Wilfred McSherry

Nurses see spiritual care as fundamental to their everyday practice, but evidence shows they feel unprepared for it and want further education.

Healthcare policy, nursing guidelines and research evidence all point to the importance of the spiritual for health and well-being. Research also demonstrates that patients value spiritual care.

Lack of time and a focus on physical care in the workplace, along with the prevalence of the medical model, are frequently-cited reasons why nurses do not assess need and deliver spiritual care.

Expectations

Can nurses really be expected to assess and respond to patients' spiritual needs when they are already stretched to breaking point trying to meet essential physical and mental health needs?

How many nurses working outside palliative care, or in it for that matter, use any of the existing spiritual screening or assessment tools? Few, we suspect.

This context may partly explain why few patients at the end of life in acute hospitals in England were asked about spiritual concerns. The 2016 End of Life Care Audit by the Royal College of Physicians of more than 9,300 patient datasets, revealed just 15% of cases involved patients in discussions of their spiritual, cultural, religious, or of practical needs during the last episode of care.

A practical solution

But what if you could conduct a spiritual assessment and give spiritual care without needing more time or an extra formal tool? What if, in so doing, you could improve patient care and even save time? And what if there were added benefits – care that is co-produced, person-centred and prudent?

We believe the following simple two-question model (2Q-SAM) might help. Try it in your workplace and tell us what you think.

Looking at the first part of the model (see figure below), many factors come into play in the delivery of spiritual care, such as the values, beliefs and spirituality of the people involved (patient and nurse), the care environment and the patient's condition and ability to communicate.

Getting the balance right between the science and art of nursing is also important to ensure high quality clinical care is delivered with sensitivity, compassion and warmth.

The model is based on two key questions:

The overwhelming case for making spiritual care part of the Code rcni.com/spiritual-code

» What is most important to you now?
» How can we help?

If we take a typical shift, we can see how the model and the two questions might work in practice.

The model can be applied to the experience of the author's [Linda Ross] mother, Margaret, who was diagnosed with terminal thyroid cancer, and can enable reflection on her needs and care in the last few days of her life.

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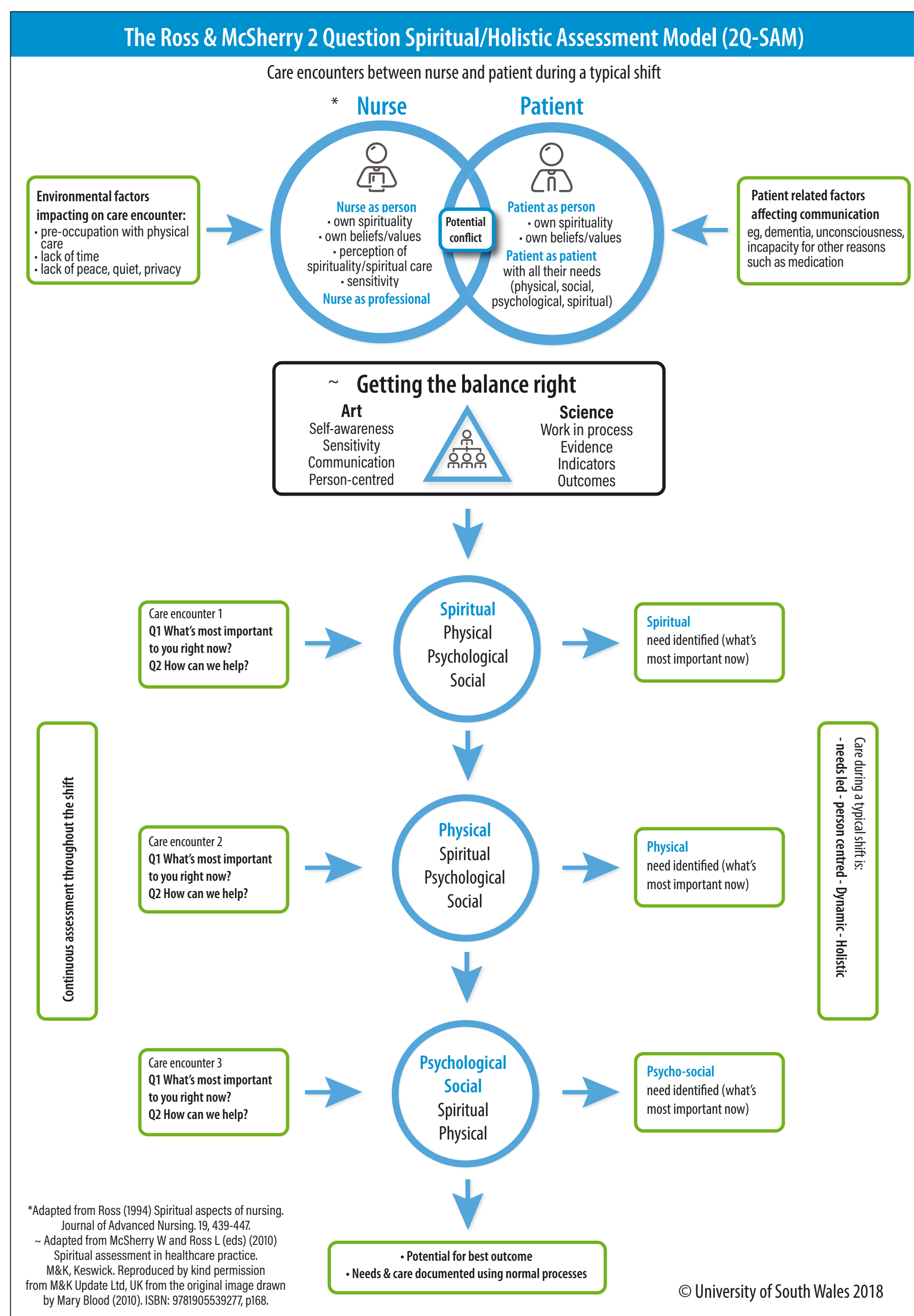


The following is an account of some aspects of her care, as witnessed by the author during regular but fleeting visits.

The 2Q-SAM is retrospectively and hypothetically applied to the care episodes described below (the model was not used by the staff).

Although the two questions may seem rather mechanistic and repetitive in the way they are used below, this is for illustration purposes only.

In reality they would be asked in different ways as part of the normal conversation with a patient and would be embedded into the nurse's practice throughout a shift.

7am: The start of an early shift. Margaret hasn't slept well. Her mind has been working overtime throughout the night trying to take stock of her situation since being diagnosed with metastatic cancer.

Nurse: 'What's most important to you right now?' (Q1)

Margaret: 'I really didn't sleep well. I'm so tired now.' (physical need)

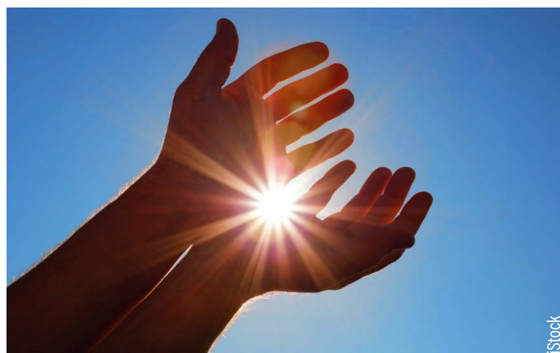
The nurse may not need to ask the 'How can I help?' question (Q2) verbally, but knowing that a patient has just been discharged from one of the single rooms the nurse is able to offer Margaret the use of that room until the next admission comes in so that she can get some sleep.

Led by need

Asking the 'importance' question here means the nurse doesn't need to waste time bringing breakfast or asking Margaret if she wants a wash, which would seem most relevant at that time of the morning; her most important need (for sleep) is being taken care of, saving time.

The nurse may choose to ask a follow-on question – 'Why were you unable to sleep?' – which would allow Margaret to express her deeper concerns about how her 89-year-old husband will manage without her when she dies (spiritual, social needs).

10am: Margaret is awake. The nurse asks: 'What's most important to you now?' (Q1), to which Margaret responds: 'I could do with a wash, but I've got no energy.' (Physical need). The 'How can I help' (Q2) question is obvious: she needs help with that task.



Empathetic questioning can unlock essential information about a patient's spiritual needs

1pm: After lunch the nurse asks again: 'What's most important to you right now?' (Q1) Margaret replies: 'I don't suppose there's a wheelchair I could use for when my husband comes, please?' (physical need).

Again, the 'How can I help?' question (Q2) does not need to be asked because it is obvious what is needed.

Unspoken wishes

Unbeknown to the nurse, Margaret actually wants her husband to wheel her to a quiet place to tell him her wishes for her funeral.

By providing a wheelchair, the nurse is meeting a spiritual as well as a physical need. Gentle enquiry on Margaret's return to the ward might provide an opportunity for Margaret to say what is on her mind, if she wishes.

5pm: After visiting time is over, the nurse asks again: 'What's most important to you right now?' (Q1) Margaret tells the nurse about her concerns. They have a cry together (emotional, psychological need), and the nurse asks: 'How can I help?' (Q2). Margaret asks if there is a chaplain in the hospital. The nurse makes the referral and the chaplain calls the next day, and regularly thereafter until her death.

Conversation then turns to her most pressing need, which is to be transferred to the palliative care unit, her preferred place of death (physical, psychological and spiritual needs).

I discovered later that the chaplaincy team worked hard with the ward to fulfil that wish. Margaret made it to the palliative care unit 12 hours before she died.

Continuous assessment

In the above example, the 2Q-SAM ensured that what was most important to Margaret at any point was addressed through a process of continuous assessment. The care she received was person-centred, needs-led, dynamic and holistic. It was also prudent: it only did what was necessary at any point.

The 2Q-SAM could be a realistic solution to delivering spiritual care – or care that is spiritual – in a resource-challenged health service.

We would like to know if it makes any difference to the care you give. Does it, for example, make care more needs-led, patient-centred and prudent?

We invite you to try it out with one patient during one shift, asking the two questions, or variants of them, at key points in that shift then consider the following:

» Did doing so make any difference to the care you were able to give, and if so how?
» Did it take more or less time?
» What did your patient think (if you feel able to ask)?
» Did you modify the model in any way? For example, rewording the questions?

Feedback

We welcome feedback on the 2Q-SAM model. Comment on this article online at rcni.com/spiritual-questions. Or email linda.ross@southwales.ac.uk or W.McSherry@staffs.ac.uk

The 2Q-SAM model will be covered in more detail in a chapter in the book Spirituality in Healthcare: Quality and Performance, edited by Fiona Timmins and Silvia Caldeira, to be published by Springer next year.

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