Background and Literature Review
This project was funded by the Australian Government Department of Health through an Aged Care Service Improvement and Healthy Aging Grant (2015-16).

**Project Partners**

Lead Project Partner – Meaningful Ageing Australia  
Project Partner – Spiritual Health Victoria (SHV)

**Project Management and Research**

Improvement Matters Pty Ltd – Elizabeth Pringle  
National Ageing Research Institute (NARI) – Prof Colleen Doyle, Hannah Capon, David Jackson

Acknowledgements: Elizabeth Pringle wrote the ‘Contextual and situational analysis of the aged care sector’ section of this document and parts of ‘Introduction’. David Jackson wrote the ‘Literature review’ section. Colleen Doyle and Hannah Capon wrote the ‘What is a guideline’ section. Colleen Doyle and Hannah Capon edited all sections. Catherine Voutier assisted with the literature search strategy. Cheryl Holmes, David Petty, the Project Advisory Group and Ilsa Hampton provided helpful comments on earlier versions of this review.

© Copyright Meaningful Ageing Australia (formerly known as PASCOP) and National Ageing Research Institute

**Contact Information**

For further information, contact Meaningful Ageing Australia:  
**Address:** PO Box 2127  
Royal Melbourne Hospital VIC 3050  
**Telephone:** +61 3 8387 2274  
**Email:** admin@meaningfulage.org.au  
**Website:** [www.meaningfulageing.org.au](http://www.meaningfulageing.org.au)

**Suggested citation:**

Contents

1. Main points 4
2. Introduction 5
3. Contextual and situational analysis of the aged care sector 6
4. Literature review 12
5. What is a guideline? 31
6. References 37
7. Appendix 1 51
1. Main points

The following main points were derived from this background and literature review and then contributed to the development of the Guidelines (see also Stakeholder Consultation Report):

1. Clear definitions of spiritual care and spirituality are required to inform any discussion as there is limited understanding about what spiritual care is and what it is not, and whether spirituality is ‘just about religion’.

2. The literature indicates that spiritual care is everybody’s job, so a whole of organisation approach is appropriate for these new guidelines.

3. All organisations need access to expert spiritual care for their clients (either the client’s own expert or one provided by the organisation).

4. Spiritual care needs to be multidisciplinary and interdisciplinary and include families.

5. All staff should be aware of their own spirituality and aware of their limitations.

6. Spiritual assessment and re-evaluation are important components of spiritual care.

7. A range of interventions can be considered elements of spiritual care.

8. Spiritual care has to be part of a care plan.

9. Assessment instruments that are consistent across health settings are important.

10. There is a body of evidence that indicates that access to spiritual care can enhance mental health. There is some limited evidence that spiritual care can improve outcomes for other conditions as well.

11. Cost studies about the benefit of providing spiritual care are lacking in the literature.

12. There were no existing guidelines specifically designed for application in residential aged care and home care settings in Australia.

13. Existing aged care guidelines that include domains about spiritual care are often simplistic in their guidance.

14. Existing spiritual care guidelines not targeted specifically at caring for older people are also very broad. They tend to include broad statements without linking the statements to consensus, expert opinion or evidence. Separate documents for managers and other levels of staff are not available.
2. Introduction

The background material summarised here informed the development of new spiritual care guidelines for use in Australian residential aged care and home care services. No such guidelines existed before, so in early 2015 a project to develop new guidelines was funded through an Aged Care Service Improvement and Healthy Ageing Grant to Pastoral and Spiritual Care for Older People (PASCOP, renamed Meaningful Ageing Australia in 2016). The grant was initially administered through the Australian Department of Social Services and then through the Australian Department of Health. Spiritual Health Victoria were project partners, overall project management was provided by Improvement Matters Pty Ltd and research consultation by the National Ageing Research Institute Ltd.

The project proposed to develop Guidelines that were intended primarily to meet the needs of older people living in residential aged care homes and older people receiving Commonwealth Home Support Packages, although the resulting Guidelines may have application in other settings. The Guidelines were designed to be applicable to the full spectrum of aged care providers: private, community and faith-based. It was recognised that the Guidelines must be sufficiently flexible to meet the needs of a small rural home care service, right through to a large residential aged care provider with predominantly metropolitan homes. The target audience for the new Guidelines is senior managers and key influencers who have the capacity to effect and implement change. There is no regulatory imperative associated with the Guidelines, or any additional funding available for organisations that implement the Guidelines. Therefore, adoption of the Guidelines is entirely at the discretion of the organisation.

This background document provides three main summaries. First a summary of the contextual and situational analysis of the aged care sector sets the background. Second a summary of a literature review is provided on definitions, professional backgrounds of staff who provide spiritual care, and what the expected impacts of spiritual care are for older people. Finally there is a brief summary of some formats for guidelines and a list of current related guidelines that refer to spiritual care. Some of the results of the literature review have been published previously and further summaries have been provided in industry publications. Readers are referred to the following sources for further information:

3. Contextual and situational analysis of the aged care sector

When providing spiritual care in the aged care sector, it is necessary to take into account contextual factors. The sector is subject to a range of influences such as political, economic, social and technological factors. It is important to understand this context so that the new Guidelines take into account the constraints, opportunities and profile of the sector and the older people it serves.

Profile of aged care providers

Residential care

According to the Report on the Operation of the Aged Care Act 1997 for 2014-2015 (Department of Social Services, 2015), 231,000 people accessed residential care from 2681 homes operated by 972 providers (p. xiii, 48). There were 192,370 operational places in 2013-2014 and these were operated by three types of organisations (p. 49):

- Not-for-profit (57%)
  - Comprising: religious (26%); charitable (17.9%); and community (13.7%)
- For-profit (38%)
- Governments (4.9%)
  - Comprising: State/Territory (4.1%); Local (0.8%)

The $10.6 billion funding of residential aged care comes mainly from the Australian Government (Department of Social Services, 2015). Consumers in residential aged care contributed approximately $4.1 billion in fees, mainly towards their living expenses and accommodation costs, not including accommodation bonds (Aged Care Funding Authority, 2015).

The total number of approved providers and homes are decreasing; however the number of places continues to increase. This is aligned to our ageing population growth. In 2050 there will be around 41,000 centenarians. To manage this increase in a competitive market, industry consolidation is likely to continue to reflect the growing complexity, and economic viability of operating residential aged care. There continues to be interest from the private sector from big business such as AMP (Opal Aged Care) and stock exchange floats of Estia Health, Japara Healthcare and Regis Healthcare, with a number of other providers set to follow suit (Gardner, 2015; Mills, 2015). Estia Health currently has over 4000 places in 48 facilities and has a corporate goal of achieving 10,000 places by 2020 (Estia Health, 2015). Conversely, many local and state governments are exiting the sector. There has been an increased interest from the private sector in home care packages as they seek to provide an integrated service, although private interests are still only 10 percent of the total home care packages market (Department of Social Services, 2015). Access to capital is critical for survival and many of the not-for-profit, church and charitable sector providers may struggle to fund growth in bricks and mortar.

The model of Consumer Directed Care (CDC) introduced into home care is being considered for residential aged care (Department of Social Services, 2014a). Consumer groups such as Alzheimer’s Australia support such a move (Rees, 2015) whereas provider groups have expressed reservations pending an evaluation of CDC in the home care sector (Leading Aged Services Australia, 2014b).
Home care
According to the Report on the Operation of the Aged Care Act 1997 for 2014-2015, a total of 83,800 people accessed home care packages from providers (Department of Social Services, 2015). There were 72,702 operational places in 2013-2014 operated by three types of organisations:

- Not-for-profit (82%)
  - Comprising of: religious (33%), charitable (32%) and community (17%)
- For-profit (10%)
- State/Territory governments (8%)

The funding of home care packages comes mainly from the Australian Government – $1271 million and consumers contributed approximately $87 million in fees (Aged Care Funding Authority, 2015).

A key reform has been the establishment of the Commonwealth Home Support Program (CHSP, 2014) that consolidates four programs:

- Commonwealth Home and Community Care (HACC) Program
- Planned respite from the National Respite for Carers Program (NRCP)
- Day Therapy Centres (DTC) Program
- Assistance with Care and Housing for the Aged (ACHA) Program

Other key reforms since 1 July 2015 require all Home Care Packages to be delivered on a Consumer Directed Care (CDC) basis. There are also policies of wellness, re-enablement and restorative care that aged care providers are required to meet (CHSP, 2014). These focus heavily on an active ageing model promoting physical health. The number of Home Care Packages will increase from around 72,000 places to around 100,000 places nation-wide by 2017-18 (Department of Social Services, 2016).

The home care sector is becoming highly contested and margins are tightening particularly with the change to Consumer Directed Care (CDC). Previously, funds were allocated to a program and unspent funds from one client could be reallocated to another client and/or used to fund overheads such as administration, pastoral care and education. Funding spiritual/pastoral care in the context of CDC has challenges because pastoral care is not a service that people traditionally ‘buy-in’ such as cleaning and domestic assistance. Nor is it a ‘product’ that providers have traditionally offered.

Situational analysis
It is important to understand the context and constraints impacting on aged care providers intending to implement the new Guidelines, to ensure that the Guidelines are feasible and relevant to the sector.

Political context
The residential and home care sector relies significantly on government subsidies, some of which are legislated and others regulated and therefore the political context is relevant. Changes of government and prime ministers over recent years have led to a succession of ministers responsible for aged care. The industry associations such as Aged and Community Services Australia (ACSA), Leading Aged Services Australia (LASA) and Catholic Health Australia (CHA) consistently argue that the sector is underfunded, however the private sector continues to grow.
The Government during the development of the Guidelines was constrained by a fractured senate (Fifield, 2014). In this climate, the Government may use regulatory rather than legislative instruments to effect change as these are less likely to be obstructed in the Senate. Additionally, based on the Government’s political ideology, it is anticipated that changes will continue to focus on budgetary constraint, government deregulation of quality and supply, with a shift to raising quality via market discipline through consumer choice and contestability rather than regulatory controls (CEPAR, 2014a). The Government has implemented a number of policy changes to reduce ‘red tape’ and regulatory burden on the sector and has stated that this trend will continue (Department of Social Services, 2015).

**Economic context**

Based on Commonwealth of Australia data, Australia faces a decline in revenues as the minerals sector slows (Hockey & Cormann, 2014). Furthermore, Australia faces a number of policy challenges that are contributing to a challenging fiscal outlook (KPMG, 2014). The cost of aged care is set to dramatically increase through the ageing population, therefore in a fiscally constrained environment, the Government is unlikely to increase funding of aged care on a per head basis. Therefore, it is prudent to base the new Guidelines on a model that is financially viable and more likely to result in increased efficiencies.

**Technological context**

In recent years, developments in technology and communications have been rapid and far-reaching, changing commerce, social interactions and learning. The Australian Government supports and encourages aged care providers through Aged Care eConnect (Department of Health, 2014) to utilise technology in a range of applications such as care delivery, training and education and key business processes. However, there are barriers such as capital investment, care providers’ relative inexperience with IT, poor implementation and lack of training (CEPAR, 2014b).

The Aged Care Industry Information Technology Council (ACIITC), working with Accenture, has produced a report and IT vision for aged care (ACIITC, 2013). It notes that the IT ecosystem in aged and community care is relatively underdeveloped, lacks a data dictionary, common standards and comprehensive policies making data collection, analysis and benchmarking difficult (ACIITC, 2013). This has important implications for spiritual and pastoral care as technological solutions may not be supported by an adequate IT infrastructure, nor a culture of using technology, with the average age of the direct care workforce being 55 years or over (King et al., 2012).

ACIITC has identified five information and communications technology (ICT) pillars for providers to utilise: e-health systems, telehealth and mobility services, care management systems, management information and reporting, and core technology and support. It should be noted that these priorities focus on establishing IT solutions in the care delivery and management areas such as CDC, with little mention of applications to improve workforce training and development. ICT infrastructure is increasingly being used to support older people with the capacity to digitally connect with people, events and places through access to technology such as video calls, podcasts, web-casting, tablets, messaging and emails (Bern-Klug, 2011; Larson & Larson, 2003; Schwindenhammer, 2014; Tsai, Tsai, Wang, Chang, & Chu, 2010).

**Policy, legislative and regulatory context**

Given the ageing population, governments of both persuasions are progressively implementing a three-phase reform program over 10 years, to ensure the aged care system can be sustainable and affordable and provide high quality (Department of Social Services, 2014b). These changes largely arose from the Productivity Commission inquiry ‘Caring for Older Australians’ (Productivity Commission, 2011).
These changes impacted on the financing of care, consolidation of home care, the introduction of consumer directed care (CDC), and the establishment of the Quality Agency as reflected in the legislation below:

- Aged Care (Living Longer Living Better) Act 2013;
- Aged Care (Bond Security) Amendment Act 2013;
- Aged Care (Bond Security) Levy Amendment Act 2013;
- Australian Aged Care Quality Agency Act 2013; and

A key election policy of the Liberal/National Coalition in 2013 was economic growth through deregulation and cutting red tape. Submissions by LASA and ACSA noted the need to reduce the regulatory burden of accreditation in aged care (Leading Aged Services Australia, 2014a). The Government has responded to this by establishing a pilot to trial reduced administrative burdens through the ‘The South Australian Innovation Hub Trial pilot’ (Department of Social Services, 2014c).

From 1 July 2015, the Australian Government launched the CHSP, which is central to the change agenda to support the development of an end-to-end aged care system and include a consolidation of programs. This will include a single quality framework across residential and home care including voluntary participation in a quality indicators program for aged care (Culhane, 2015; Department of Social Services, 2015). The Australian Aged Care Quality Agency (AACQA, 2015) is also examining how quality in aged care should be defined and measured. This includes discussion of quality of life measures, but excludes spirituality.

Social context

The sustainability of the aged care sector workforce also presents challenges in terms of the ageing of staff and the capacity to attract new entrants in a competitive workforce context. In the aged and community care sector at present there are around 350,000 workers with the workforce needing to quadruple by 2050 (Aged Care Funding Authority, 2015). In 2050, the sector will need up to 1.3 million workers and aged care will be competing with childcare and disability sectors for staff (CEPAR, 2014a). Projections regarding the number of pastoral and spiritual care practitioners needed are not available. Whilst the need for qualifications and skills is recognised, the reality of attracting candidates in a low-supply market means there are few entry barriers and ‘passion’ predominates as an essential criteria (CEPAR, 2014b). The labour gap is going to have to be filled from somewhere such as technology or migration. Both of these options have implications for a relational model of care.

The traditional model of working for one or two employers continues to change as workers seek flexibility, autonomy and the capacity to be selective. Websites are emerging allowing workers and clients to self-select in an open market (Better Caring, 2014). Emerging models of work continue to evolve particularly in the home care sector where the client can choose to engage their preferred care worker who may not necessarily work for the organisation providing the services. Consumer-directed care is also likely to increase the casualisation of the workforce and this has implications for relational models of care in terms of continuity and training. Brokerage and contractual arrangements for provision of care also present challenges in allowing for spiritual training, which has to be commensurate with the roles and responsibilities of brokered and contracted staff (McKeown & Cochrane, 2012).
Environmental context

Environmental considerations highlighted by the Productivity Commission (2011) report ‘Caring for Older Australians’ mainly relate to sustainability and efficiency of the sector. This is particularly the case for services located in remote areas where they encounter a range of issues such as additional costs, shortages of labour and limited choices regarding suppliers.

The industry currently consumes around 7.8 million gigajoules of energy in Australia each year and this will only increase with the growth in the ageing population and increased consumption through global warming (Office of Environment and Heritage, 2014). The rising costs of electricity for residential care facilities and consumers are likely to drive efficiencies and focus on finding savings. Extreme weather, natural disasters and hotter conditions are likely to have a cost impact that must be absorbed by providers, further diminishing available funds for non-critical operational costs.

Profile and analysis of older people who will receive spiritual care

It is important that the Guidelines are informed by the profile, demographics and trends of the current cohort of older people. The Guidelines are assumed to have currency for up to five years. Therefore, the cohort of people aged 80+ is relevant.

Demographic profile

The most critical social change relates to the demographics of the ageing population. Australians aged 85+ are projected to increase from two per cent of the population to anywhere between three and nine per cent by 2050 (CEPAR, 2014a). The Aboriginal and Torres Strait Islander population is said to increase by 59 per cent, more compared to the 20 percent increase in the non-Indigenous population (Neumann, 2014).

The Productivity Commission (2011) report ‘Caring for Older Australians’ outlined a number of social changes that are influencing the sector and will continue to impact on the care of older people. These include changes such as an increase in longevity, chronic disease and disability from lifestyle diseases such as obesity, cardio-vascular disease as well as an increase in mental health conditions. Social changes such as family breakdown, women in the workforce and a redefinition of the traditional nuclear family have also meant family carer support for older people has changed, potentially adding to social isolation.

Cultural characteristics

Around 36% of older people were not born in Australia, which is a higher proportion compared with the 24% of overseas-born people under 65 years. Older people who were born overseas came from more than 120 different countries, with twenty countries identified as birthplaces for 10,000 or more older persons (Australian Bureau of Statistics, 2011).

It is important to recognise that older Australians are not a homogenous group and this applies also to older people from CALD backgrounds. For many older people, including those from CALD backgrounds, spiritual care is especially important at the end of life, but there is a substantial proportion of people for who spiritual care and spirituality is important throughout the lifespan. There is a need for a paradigm shift, for religion and spirituality to be considered relevant at all stages of care, rather than primarily at the end of life/palliative care (Khan & Ahmad, 2014). Older people can be supported spiritually to find life’s meaning and purpose and to connect with others as they move through all the different stages associated with ageing (Baldacchino, Bonella, & Debattista, 2014; Confoy, 2002; Gall et al., 2005; Haugan, 2014).
Religious affiliation

In developing the new Guidelines, it is important to understand the spiritual profile of the cohort of older people likely to benefit from the Guidelines. According to the Australian Bureau of Statistics (2011), 69 percent of Australians and 81 percent of people over 65 identify a connection with a religion or some form of spirituality. Most (78 percent) identify with a Christian denomination. Among people over 85 years, 29 percent said they were Anglican and 22 percent said they were Catholic. A higher proportion of older people reported Orthodox Christianity (3.6 percent) compared with younger people mainly because of the Greek and Eastern European migrant presence in older cohorts. Buddhism was identified in 1.2 percent of the older population, and Muslim, Hindu and Sikh 0.5, 0.3 and 0.1 percent of people over 65. Judaism was identified in 0.6 percent of the older population.

Spiritual needs and an organisational approach

In studies that asked how spiritual and pastoral care is provided to residents, typical answers range from one-on-one pastoral visitation, worship services, reminiscence, life history and review, bible studies, choirs, friendship groups and art therapy (McDonald, 2011). Mowat and Swinton (2005) indicated that everyone has spiritual needs. This reinforces the need for the entire care team to view their roles through a spiritual lens rather than relying on pastoral and spiritual care specialists.

Spiritual care can successfully be incorporated into strategic goals for the organisation (Balding, 2015; Leggat & Balding, 2013). A number of authors have suggested that there is generally a lack of confidence among health care staff to provide spiritual care (Baldacchino, 2008; Fenwick & Brayne, 2011). For example, one study suggested that the aged care sector assumed that their staff and volunteers would be capable in providing spiritual care (Hall & Sim, 2005). This research showed that there were many different perceptions of spirituality, spiritual needs, and pastoral care among respondents in the sample of 16 aged care sites (four Brotherhood of St Laurence and 12 external for-profit and not-for-profit aged care sites). The way spiritual needs were identified and assessed was dependent on the staff who relied on their subjective knowledge and understanding of the field. In turn, individual staff knowledge and understanding also influenced the extent to which spiritual needs were included in care planning, in the development of resources, and ultimately in how spiritual care was practiced (Karakas, 2010).

Philosophy of care and theological perspectives of the model of care

The raison d’être of many faith-based organisations is explicitly to express and live-out their spiritually-based mission. To this end, many of them dedicate considerable resources to spiritual care. This could include spiritual assessment, availability of chaplains, pastoral carers (paid and voluntary) and a range of activities such as bible studies, worship services and visiting faith representatives. Nine senior managers from large faith-based, community and private organisations were interviewed for this project. All of those interviewed explained that they struggled to find suitable measures for spiritual care and they did not have performance measures at governance or operational levels (see Stakeholder Consultation Report document).

Conclusion

There are numerous contextual factors that will affect the implementation of spiritual care Guidelines. In developing the Guidelines, it has been important to consider the context in which they will be implemented in order to make the document as appropriate, effective and sustainable as possible. The profile of the industry, together with the profile of clients and residents, staff and people responsible for care should all be taken into account in developing spiritual care Guidelines.
This section summarises some results from the literature review undertaken for this project. The aims were:

- To provide an evidence base to inform the content, structure and scope of the Guidelines.
- To provide a summary of literature as the basis for industry and academic publications to be disseminated during the project and so add to knowledge in the aged care industry about spiritual care.
- To summarise any recent evidence about the effect of spiritual care on older people in residential or community aged care.

The summary presented here was in response to questions such as:

1. How is spiritual care defined in the context of meeting the spiritual needs of older people and their families/carers/representatives receiving care?
2. What particular spiritual needs exist for older people with a diverse, disadvantaged or marginalised background?
3. What constitutes best practice in relation to spiritual care and what are the enablers and drivers of best practice?
4. What tools/guidelines/resources are currently used to support spiritual care of older people in care and their families/representatives?
5. What models of standards/tools/guidelines exist in other areas to guide care provision by those involved in different aspects of care and how could these link with the Guidelines?
6. What effect does the use of Guidelines have on the quality of spiritual care provision for older people in care?
7. What is important when providing pastoral and spiritual care as perceived by aged care workers, spiritual care practitioners and volunteers?
8. What frameworks, models and formats of standards, guidelines and resources would work most effectively for these Guidelines?

**Method**

**Search strategies**

An initial search of titles followed by a search of abstracts was conducted in ‘CINAHL plus’ to identify definitions of spiritual care. Of 125 results (abstracts), 81 were retrieved that incorporated a definition of spiritual care. A second search was generated in Medline, CINAHL, PsycINFO and AMED to identify evidence to support the inclusion of spiritual care in health care for older people. The search strategy included: Published Date: 19900101-20150331; English Language; Peer Reviewed; Clinical Queries: Qualitative – Best Balance. We looked for Linked Full Text; Published Date: up to March 2015; Abstract Available; English Language; Human; Abstract Available; English Language. Key search terms were: Abstract Spirituality OR Abstract Spiritual Care OR Abstract Pastoral Care AND Abstract Residential Care OR Abstract Aged Care OR Abstract Healthcare. Results returned were from: 2719 journals, four magazines, and three other publications.

---

*This section 4 ‘Literature review’ was written by David Jackson; see also Jackson et al., (2016).*
A third search strategy was designed in parallel with the assistance and input from an Evidence Based Librarian at Melbourne Health. This search focused on combining identified keywords with the identified aims of the literature review and the expected utility of the guidelines. The initial search used a modified Cochrane strategy for ‘spirituality’ combined with a modified Cochrane strategy for ‘aged care’. The search was conducted with date limits (1995-2015) and resulted in 11,003 results.

To focus the number of results, a health facilities filter was added to the spirituality + aged search and accessed databases focusing on health executives/business. The results were reduced to 2930. After further review, the terms ‘spiritual care’ and ‘secular’ were added. The search was run in the following databases between 25/05/2015 and 29/05/2015:

- Medline via EBSCOHost (1946-)
- EMBASE.com (1974-)
- CINAHL via EBSCOHost (1937-)
- PsycINFO via EBSCOHost (1957-)
- AMED via EBSCOHost (1995-)
- Health Business Elite via EBSCOHost (1922-)
- Social Care Online via http://www.scie-socialcareonline.org.uk/ (1980-)
- Sociological Abstracts via ProQuest (1952-)
- Applied Social Science Index and Abstracts (ASSIA) via ProQuest (1987-)

(See Appendix 1 for the full search strategy)

The searches returned over 11,000 records. De-duplication was applied leaving approximately 9,000 results. Both the second and third search strategies were combined in a single EndNote database and de-duplication was again applied. From this database articles were excluded if they were: not in English language, older than 2005, out of scope, or involving an incorrect age group. From this list of 549 studies, further studies were excluded based upon a finer review of the abstract for relevance to the main aims of the project leaving 335 relevant documents for review. Throughout the literature review process, new articles were sourced from article reference lists at times and the project team provided further resources and references.

**Results**

**Definitions**

There are a number of key terms that are frequently used in the literature, and these terms have many definitions. It is important to consider different approaches and underpinning philosophies when aiming to provide Guidelines appropriate to the aged care sector. Each of these approaches or facets brings a different interpretation, emphasis and purpose. This is important to bear in mind because some approaches to spirituality arise from a medical or health paradigm that is likely to resonate with some in the residential aged care sector. Other approaches arise from a social care paradigm that is likely to resonate with the home care sector in the context of wellness, ‘re-ablement’ and restorative care.
Defining spirituality

There was evidence of great debate in the literature with regard to the best definition of spirituality (Paley, 2008). Modern spirituality emerged in the 19th Century as an alternative to religion and in keeping with the growth of secularism (Puchalski, 2012). The majority of the literature showed that spirituality is most often defined in relation to finding meaning or purpose in life and in terms of connectedness (Ferrell & Munevar, 2012). Often confused with religion, spirituality transcended this notion in the literature and filled an all-encompassing, more holistic space (McSherry, 2006a). Finding meaning and purpose through relationship and connection is central to all activities and lifestyle programs based on individual choices, preferences and needs and the literature affirmed the central role of such activities in addressing spiritual needs (Haugan, 2014; MacKinlay, 2006).

The following definitions were among many that were found in the literature:

“Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred” (Puchalski et al., 2009, cited in Puchalski, Vitillo, Hull, & Reller, 2014, p. 643).

“Spirituality is about meaning in life and is mediated through: relationship (with God and/or others); the arts; the environment or creation; religion (religion takes in all aspects of spirituality)” (MacKinlay, 2012b, p. 16).

“[Spirituality] gives us a sense of personhood and individuality. It is the guiding force behind our uniqueness and acts as an inner source of power and energy, which makes us ‘tick over’ as a person. Spirituality is the inner, intangible dimension that motivates us to be connected with others and our surrounding. It drives us to search for meaning and purpose, and establish positive and trusting relationships with others” (Narayanasamy et al., 2004, p. 1140).

In a previous work Narayanasamy (1999, p. 123) connected spirituality to the biological roots of human existence:

“Spirituality is rooted in an awareness which is part of the biological make-up of the human species. Spirituality is present in all individuals and it may manifest as inner peace and strength derived from perceived relationship with a transcendent God or an ultimate reality or whatever an individual values as supreme.

The spiritual dimension evokes feelings which demonstrate the existence of love, faith, hope, trust, awe and inspirations, therein providing meaning and a reason for existence. It comes into focus particularly when an individual faces emotional stress, physical illness or death.”

Spirituality was defined in many different ways depending on the discipline, way of assessing spiritual needs and target group (Timmins, Murphy, Neill, Begley, & Sheaf, 2015).

Spirituality was defined by National Health Service (NHS) Scotland (2009, p. 19) as:

“Spirituality provides the higher level intelligence and wisdom which integrates the emotional with the moral. It acts as a guide in integrating different aspects of personality and ways of being and living. It is found in the integration of several deep connections: the connection with one’s true and higher self; the connection with society and especially with the poor, the deprived and underprivileged; the connection with the world of nature and other life forms; and for some, a connectedness with the transcendent.”

Spirituality can encompass relationships and connectedness with God/divine power, life force, places, events, animals and objects that bring meaning (Haugan, 2014).
Baldacchino (2013) described seven facets of spirituality in the context of an analysis of spiritual assessment tools:

- Spirituality as a concept in its own right
- Spirituality well-being
- Spirituality needs
- Meaning and purpose in life
- Spirituality coping
- Spirituality as part of quality of life
- Spirituality care.

Swinton (2010) outlined three different approaches to spirituality:

- A generic approach. In this approach spirituality is not derived from any one tradition. This approach may not fit well for people for whom their faith is central to their spirituality.
- A biological approach. In this approach, spirituality is viewed as part of a biological or evolutionary purpose. This approach is criticised as religious beliefs are narrowly related to biological roots.
- A religion approach. This approach has three sub-categories:
  - religion and the transcendent – attending to something beyond the self
  - the sacred – a general sense of transcendence but not necessarily including God/higher being
  - religion as a projection – projection of psychological needs and desires.

**Defining spiritual care**

Rumbold (2012) outlined three models of spiritual care:

- Spirituality in the biomedical and biopsychosocial model
- Spirituality in the social model
- Spirituality in the holistic/ecological model.

Ross and McSherry (2010) emphasised the need for spiritual care to be led in a ‘person-centred’ way. They noted the need to find the right balance in spiritual care between the ‘art’ (self-awareness, sensitivity, communication and person-centred) and the ‘science’ (work in process, evidence, indicators and outcomes) (Ross & McSherry, 2010, p.168).

Spiritual care was described in the literature as being about compassion and the individual’s search for the meaning of life. Communication styles were often discussed especially in terms of the need for sensitive listening and recognising the individual’s self-worth. Spiritual care could include faith support, rites, rituals, prayer or sacrament (Cohen, 2010; NHS Scotland, 2009). Another interpretation of spiritual care was, “meeting people where they are and assisting them in connecting or reconnecting to things, practices, ideas, and principles that are at their core of their being – the breath of their life, making a connection between yourself and that person” (Lunn, 2003).
The NHS Scotland (2009, p. 6) defined spiritual care as:

“...that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.”

In Hall and Sim (2005, p. 3), the Brotherhood of St Laurence used the following definition of spiritual care in their investigation into spiritual care and spiritual poverty in aged care:

“Wholistic, life-giving, intentional care of the human spirit in the context of the individual’s life journey through transitions encompassing grief and joy, loss and gain, the search for meaning and the maintaining of fruitful relationships with self, others and the transcendent ‘other’.”

Defining pastoral care
The terms pastoral care and spiritual care can be considered to be synonymous. Pastoral care is holistic, person-centred care provided one-to-one and includes attending to an individual’s spiritual needs during times of change or crisis such as during illness or at the end of life (Morgan, 2015). Pastoral care professionals do not make any assumptions about individuals’ personal convictions and the pastoral care provided could be religious or otherwise, depending on the way the individual expressed their spirituality.

Religious care and spiritual care
The NHS Scotland (2002) defined the difference between spiritual care and religious care in the following manner: “Spiritual care is usually given in a one to one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation” while in contrast: “Religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community” (p. 6).

Considerable discussion in the literature was devoted to emphasising that spiritual care for older people with special needs clearly needs to take account of their individual backgrounds and needs (Brennan-Ing, Seidel, Larson, & Karpiak, 2013; Cobb, Puchalski, & Rumbold, 2012; Department of Social Services, 2013; Gravell, 2013; Kenny, Higgins, Soloff, & Sweid, 2012; MacKinlay, 2010; McDonald, 2010; Mitchell, Nicholson, McDonald, & Bucetti, 2011; Community Affairs References Committee, 2004).

According to the Royal College of Nursing (2011), spiritual care should not be proselytising or attempting to convert people to your own beliefs, should not be just about religion, and should not just be delegated to the chaplain or specialist only.

Spirituality, religion and ageing
The literature identified the need to provide spiritual care across the life span and also discussed the interaction between spiritual growth, religion and ageing. Elizabeth MacKinlay’s writing was prominent in this area and a number of her texts are referred to here. Her early texts referred to the expanded stages of older life with recent changes in life expectancy. Advances in science have promoted an increased lifespan, so she made a distinction between independence and dependence for older people and the implications of such distinctions for spiritual discussions (MacKinlay, 2001). According to MacKinlay (2001) the term ‘third age’ defined older people living independently and flourishing in the community in comparison to a ‘fourth age’ of similarly aged but ‘frail’ older people living with poor health, functional decline, and residing in a state of dependency. For both groups there was the potential need for spiritual care and profitable exploration of spirituality.
In MacKinlay’s (2012a) model of spiritual tasks and the process of ageing there were six identified main themes: (1) a central core of ultimate meaning, (2) a response to life based upon the person’s sense of ultimate meaning, (3) transcendence / transformation, (4) searching for final life meanings, (5) new relationships and (6) finding hope. According to MacKinlay’s model, older people have the potential to engage in these spiritual tasks and to find fulfillment and wholesomeness and healing, though for others there was the potential to encounter blocks (caused by disability, previous life experiences, and loss) upon the path to spiritual growth and fulfillment.

Another point made in MacKinlay’s writings was that greater longevity has produced more time for third agers to live in a state of ‘being’ rather than in a state of ‘doing’ (MacKinlay, 2001). This distinction may be especially relevant for older people whose functional decline restricts them from participating in a previously active lifestyle. In the state of ‘being’ older people can be presented with time to review spiritual concerns. This state of ‘being’ in modern society, in turn has been shown to impact on older people’s sense of worth and mental health. During this phase of life, independent older people can potentially seek out and explore their spirituality, moving towards spiritual growth (MacKinlay, 2012a,b).

With the onset of illness for both third and fourth age individuals, spiritual care was shown to be important for two stages: firstly, when older people are faced with disability or dementia and a change from independent living to a care environment and secondly, in the event of end-of-life and palliative care (MacKinlay, 2012a,b).

Finally, there was some intriguing but limited evidence in the literature of a relationship between having a religious background and self-reported physical and mental health (Krause, 2004). In the mental health field, searching for meaning has been found to be very relevant to older people with a religious background and related to mental well-being (Goh et al., 2014). This point is discussed further below.

**Spirituality, culture and perspective**

In light of Australia’s multicultural society, cultural perspectives were sought in the literature. Spirituality was considered an essential element of culture and as such different perspectives of spirituality should be respected as they can form an integral part of cultural identity (Rumbold, 2012).

As noted above in the section on defining spirituality, modern spirituality emerged as an alternative to religion, emerging in parallel with the secularisation of the mind and growth of science prevalent in the late 19th century (van der Veer, 2012). Therefore modern spirituality has some of its roots in the religions of the East (India and China) and from the West. Even though similar to Christianity, Muslim teachings were largely rejected in the West in the past. Modern spirituality is broadly related to an effort to seek the truth or the meaning of life. It can be experimental in nature, connected to the abstract or free from the hierarchy, boundaries and rituals of the established religions. This wider view of spirituality is not widely understood when the term spirituality is used.

In the 21st Century the cultures of many developed countries have become more secular, pluralistic, materialistic, and diverse (Tiew & Creedy, 2010). In this light, over a period of time the meaning of spirituality has changed and in some communities is less than uniformly defined, also leading to confusion about what the term signifies.

A multicultural environment requires care staff to cater for a diverse set of people and their spiritual needs (FECCA, 2015). In order to understand the various cultural beliefs and the meanings and rituals assigned to the states of wellness and illness, it is understandable that care workers require education on the practices and customs of the different racial groups in order to practice spiritual care in an informed way and to avoid stereotyping individuals or groups (Swift, 2001; Tiew & Creedy, 2010).
Existential and spiritual concerns of older people
There was considerable discussion in the literature about what existential concerns people focus on in later life. Existential concerns may become more important for older people and those at the end of their life (Bruce, Schreiber, Petrovskaya, & Boston, 2011). When nearing the end of life or encountering one’s own mortality, older people may experience existential or spiritual suffering that may include feeling hopeless, lacking in meaning, disappointment about life or regret, anxiety about death, or loss of personal identity (Bruce et al., 2011). Moreover, older people in medicalised care situations may feel unable to express such concerns, thereby creating a form of existential or spiritual distress, that could become a neglected component of their overall suffering and distress (Bruce et al., 2011).

Health care professions in the literature on spiritual care
There is a view that there is a strong connection between mind, body and spirit so, in order to provide a holistic and person-centred approach to care, in line with this view it would be considered valuable to address components of spirituality in health care. This view has not always been prominent and is not always considered worthwhile in health care settings. Throughout recent history health professions have largely adhered to a scientific reductionist or mechanistic medical model, treating the person with medicines and surgery and with less regard for the persons’ beliefs and faith in a healing or care relationship (World Health Organization, 1998). However the call for providing spiritual care is reiterated in current health literature and obviously in this literature review the bulk of the literature espoused spiritual care as an important part of health care.

A less obvious point found in the literature was that spiritual care was not the sole purview of pastoral care practitioners. In general the literature indicated that there was merit in a range of health practitioners incorporating spiritual care into their daily practice. Spiritual care was considered in the literature to be multidisciplinary and interdisciplinary and include both the older person and their support network or families – each group has a contribution in their own way but they can be united by a common definition for their practice (MacKinlay, 2006; MacKinlay & Burns, 2013; Speck, 2012). The following sections provide a summary of the main points about various professionals and their role in providing spiritual care.

Nurses providing spiritual care
There was considerable literature on spiritual nursing care (McEwen, 2005). Those who are leaders and managers can endorse the principles of spiritual care by supporting nurses who have contact with older people in developing the spiritual and emotional resources they need (McSherry, 2006a,b). One review of the nursing literature sought to understand the constructs of spirituality and the barriers and enablers for incorporating spirituality into nursing practice, analysing the factors that affected nurses’ ability to deliver spiritual care as being related to organisation, education, and individual attitudes or understanding (Tiew & Creedy, 2010).

Cockell and McSherry (2012) identified 80 nursing papers (period 2006-2010) concerning spiritual care in nursing research. Their study found that spiritual care in nursing has important implications for education and training, organisational culture, staff motivation and health, and mostly for the health of patients.

The nursing literature highlighted the impact that organisational cut-backs can have on nurses’ ability to provide spiritual care, particularly the pressure to contend with complex and high case-loads (Carr, 2010; Sanso et al., 2015). Other factors that directly impacted on nurses’ ability to participate in spiritual care included growing expectations to do excessive amounts of non-nursing tasks. Work culture and colleagues’ attitudes also prevent nurses from attending to spiritual needs.
(Carr, 2010; Tiew & Creedy, 2010). In this work environment, it is important for nurses to attend to their own spirituality and well-being (Tiew & Creedy, 2010; Chang & Johnson, 2008).

From a different perspective nurses practicing with limited knowledge, consistency and confidence in their concepts of spirituality, spiritual care and spiritual assessment, could cause harm, highlighting the importance of education and training (Timmins et al., 2015). The review by Timmins et al. (2015) suggested that rather than relying on nurses to access specialised textbooks, there was a greater need for general nursing textbooks to include adequate, consistent content on spirituality and spiritual care in order to equip the emerging nursing workforce to practice in a holistic manner. Spiritual care needs to recognise and respect the older person’s choice and preferences in the context of holistic care and so should be integrated with the physical, psychological (McSherry, 2006a,b), social and cultural dimensions of the whole person, and their carers and family (McNamara, 2005).

From a perspective of nursing and health care, McSherry (2006a,b) identified four internal barriers to the provision of spiritual care: (1) The inability to communicate due to sensory loss, language problems or cognitive impairments; these could be overcome by the use of picture boards and facial icons to indicate feelings. (2) Lack of knowledge in assessing spiritual needs. (3) Conflation of religion and spirituality amongst nursing home staff i.e. aligning spirituality with religiosity resulting in reduced involvement or engagement. (4) Emotional demand, particularly when staff repeatedly faced bereavement of residents that they have walked closely beside in the journey towards death as giving of oneself in this way could be emotionally demanding. Education for staff was highlighted in the literature as a solution to overcoming some of these barriers.

From this same perspective McSherry (2006a,b) identified external barriers to the provision of spiritual care: (1) attitudes of management; (2) lack of privacy; (3) workload pressures; (4) lack of education and; (5) lack of attention to needs related to relocation of residents. Physical environments were also mentioned in the literature as either facilitating or mitigating against spiritual care. A physical space for families and loved ones to meet with the older person in ways that are private and uninterrupted can enhance spiritual care (Chaudhury, Puurveen, & Lyle, 2011; Fleming & Bennett, 2014; Rigby, Payne, & Froggatt, 2010). Relationships and connection can also be supported and encouraged with visitor-friendly spaces, access to telephones and use of technology and social media (Bern-Klug, 2011; Collins & Bowland, 2012; Larsson, Nilsson, & Larsson Lund, 2013; Schwindenhammer, 2014; Sulmasy, 2012; Tsai et al., 2010). For residential care homes, a dedicated, inclusive, sacred space available for meditation, contemplation and community and faith activities can enhance spiritual care in any setting (Lie, 2001).

Daly and Fahey-McCarthy (2014) suggested four interventions to help spiritual care for nurses in particular:

1. Look to yourself to help with:
   a. Observation and reflection about the needs of individuals
   b. Creating relationships as a means to meet spiritual needs
   c. Recognising positive changes in individuals living with dementia.

2. Recognise the importance of people as inter-relational beings, being present and attentive and providing a human connection.

3. Respect the individual, upholding the person’s beliefs and values and effecting person-centred ‘dementia’ care through connection with the person, their memories, emotions, through music, art or nature and through expressions of self in terms of diet and clothing.

4. Provide support of religious/faith practices.
Chaplains providing spiritual care
Chaplains and pastoral care practitioners are the spiritual care specialists. In health care settings they generally provide spiritual care for patients or clients, but also for their families and staff. Bereavement counselling is part of their role. Their most highly rated functions, when surveyed, have been found to be prayer, emotional support and end of life support (Pesut, Reimer-Kirkham, Sawatsky, Woodland, & Peverall, 2012). Another survey found that the majority of respondents visited by a chaplain considered their care as important (Piderman et al., 2008). There was less literature available on the effect of chaplain services on health outcomes. There was some discussion in the literature about the difficulty in putting an economic value on outcomes of spiritual care. From the chaplains’ point of view, measuring ‘productivity’, collaboration with other care team members and justifying their role to the clients and families were considered problematic (Cramer, Tenzek, & Allen, 2013).

Pastoral care practitioners
According to Goh and colleagues (2014), practitioners of pastoral care contribute to looking after the personal and social wellbeing of people of any religious denominations or affiliation, by sensitive communication that includes listening, supporting, encouraging and befriending. MacKinlay (2006, p. 240) suggested four functions of pastoral care:

• “Assess individual needs
• Work within the institutional framework
• Advocate for the frail and vulnerable
• Provide holistic care for the aged person, for their family and for staff.”

Social workers providing spiritual care
Research suggested that most social workers have minimal graduate training in identifying spiritual needs (Hodge, 2006). However, when surveyed, a majority of social workers have indicated that they were interested in knowing more about how to incorporate spirituality into the profession’s assessments and therapy (Hodge, 2006).

A study by Hodge and Horvath (2011) identified the spiritual needs of people receiving services in health care settings. The needs were divided into: (1) meaning, purpose, and hope; (2) relationship with God; (3) spiritual practices; (4) religious obligations; (5) interpersonal connection; and (6) professional staff interactions (Morgan, 2015). Essential components of spiritual care identified in that study for social workers were knowledge of and competency in conducting both a brief spiritual assessment to identify if there were spiritual needs for a particular patient, and the ability to then perform a more detailed assessment in order to understand the specific needs of the patient. Conducting a spiritual assessment allowed the social worker to identify and breakdown structural barriers (e.g., access to a quiet space for prayer, prayer rugs, or a compass for orientation) to fulfill a patient’s needs. Social workers were expected to have a sound awareness of the cultural characteristics of different groups. Social workers were also expected to have sound conceptualisations of spirituality and religion. To this end, education was expected to be aimed at providing the above-mentioned components and levels of complexity in understanding of the various conceptualisations of spirituality.

The National Association of Social Workers (NASW; 2001) Standards for Cultural Competence in Social Work Practice identified that spiritual beliefs were important to a range of areas in social work practice, particularly when considering how to make sure that social work was effective and sensitive to cultural issues (see Koenig, 1998; Richards & Bergin, 2000; Van Hook, Hugen, & Aguilar, 2001).
Psychiatrists providing spiritual care

There was evidence in the literature that psychiatry has in part embraced the inclusion of the spiritual as part of a holistic and person-centered approach to healthcare (Camp, 2011; Dein, 2005). There appeared to be increasing acceptance of spirituality as a significant aspect of individuals receiving psychiatric treatment (Clark, 2012).

Dein (2005) detailed the historical perspective of medicine, and considered a shift in psychiatry’s perspective from that of Cartesian duality of body and mind and reductionist, scientific rigor in treating illness, to a more holistic view, incorporating a greater recognition that faith, meaning and connectedness were important aspects of health and healing. The Lausanne Technical Consensus statement included spiritual need in its definition of old age psychiatry: “Management is more than treatment in the medical sense. A coherent and comprehensive plan should review diagnoses and address the individual’s physical, psychological, social, spiritual and material needs as well as psychiatric diagnoses” (World Health Organization, 1997, p. 4, cited in Goh et al., 2014, p. 128).

From the perspective of psychiatrists, there was some evidence in the literature for religiosity being associated with recovery rates and higher levels of mental health (Koenig, 2001; Van Ness & Larson, 2002). Religion and spirituality were described as ways of ‘coping’ with mental illness in some clients (Lindgreen & Coursey, 1995). Swinton (2001) suggested that spirituality was very important to many people struggling with mental illness while at the same time it was not given enough prominence in care by health professionals and was sometimes perceived as unscientific and therefore not part of treatment.

However, in a study by Lawrence and colleagues (2007), old age psychiatrists recognised that awareness of the spiritual dimension might be important for older patients. Of 289 old age psychiatrists who were asked about the relevance of spiritual care and religion to the care of the elderly with a mental illness, 61% responded that it was important, 35% stated that it was fairly important and only 4% did not think it was important. The same cohort of clinicians felt that for older people, the main positive aspects of pastoral care were emotional support/enabling coping (39%), human dignity and normalisation (21%) and comfort and hope (13%). However approximately only one quarter of old age psychiatrists thought that they would refer patients to a provider of spiritual care and that it was not part of their treatment. In a study by Payman (2000), 34% of old age psychiatrists had not referred patients for pastoral care. Potential reasons for this were the conflict between the clinicians’ professional code and their personal beliefs and a lack of education and training during basic training (Lawrence et al., 2007; Payman, 2000). In synergy with the guidelines of the American Psychiatric Association (American Psychiatric Association, 2006), 78% of psychiatrists agreed that they would not let their personal beliefs stop them from offering a full range of treatment options to their patients. In Australia, 85% of a sample of 208 Australian old age psychiatrists’ surveyed, felt that there was a link between religion and mental health (Payman, 2000).

Camp (2011) indicated that psychiatry had considered the importance of individuality of expression of the spiritual and had sought to avoid over-generalisations of people’s beliefs and culture when reviewing history and assessing patients. This approach was seen in psychiatry’s adoption of a person-centred approach. Examples of efforts to effect a person-centred approach in psychiatry include the FICA mnemonic (Faith, Importance, Community, Address) provided as a framework to conduct a brief assessment of an individual’s faith, the importance of their beliefs within their life, whether they shared this with their community and whether they wished to incorporate their beliefs in their care (Borneman, Ferrell, & Puchalski, 2010).
Allied Health staff providing spiritual care

There were fewer studies found of allied health staff and spiritual care. The study by Oakley, Katz, Sauer, Dent, and Millar (2010) noted that there were no published studies looking at physiotherapists' views on spirituality and patient care. There was evidence that the professions of medicine, nursing and occupational therapy had taken spirituality into account. The results of the author's survey found that 96% of surveyed physiotherapists thought that spirituality was an important part of patient care. However only 30% felt that the physiotherapist should address spiritual concerns of their patients. The main barrier was available time (47%) and other prominent barriers were uncertainty in how to manage spiritual issues (47%) and a lack of experience in taking a spiritual history (56.3%). Studies of the role of spiritual care in psychologist practices did not emerge in this review.

Elements of spiritual care

The next step after defining spirituality and spiritual care, and exploring who provides spiritual care, was to consider practically what spiritual care might consist of, what elements are important to provide and what evidence there is that the implementation of the element can lead to improved outcomes for older people receiving aged care. The following list of elements is not exhaustive but gives a summary of some of the main elements found in the literature review.

Spiritual assessment

Spiritual assessment was arguably one of the most significant elements of spiritual care discussed in the literature. Upon commencement of care services, spiritual choices, preferences and needs should be identified to establish immediate and ongoing care with the consent of the older person (Hodge, 2006). Spiritual assessment was considered a central element of spiritual care in a number of studies (McSherry, 2013, p. 57; MacKinlay, 2006, p. 48; Baldacchino, 2013; Fitchett, 2012; Harrington, 2016). Opportunities to engage with changing or developing understanding of life meaning or purpose after critical life events can also be an important time for spiritual care (Stanley et al., 2011). There was no agreement about definition but McSherry (2013, p. 65) identified six different approaches to assessment:

- direct method
- indicator-based models
- audit tools
- value clarification
- indirect methods and
- acronym-based models.

There are numerous quantitative and qualitative assessment tools available for spiritual assessment. There was general agreement that spiritual assessment should be done using initial spiritual screening and an in-depth spiritual assessment (Fitchett, 2012, p. 299; McSherry, 2013, p. 64; MacKinlay, 2006, pp. 246-252; Baldacchino, 2013).

From a social work perspective, spiritual assessment could be considered “as the process of gathering, analysing, and synthesising spiritual and religious information into a specific framework that provides the basis for, and gave direction to, subsequent practice decisions” (Hodge, 2006, p. 318). A brief assessment, according to Hodge (2006), should include identifying: (1) denomination religious background; (2) significant spiritual beliefs and; (3) important spiritual practices.

---

2 This section summarises material published in Jackson et al. (2016).
Exploring spirituality with an individual can help staff to understand the individual’s needs (Ramezani, Ahmadi, Mohammadi, & Kazemnejad, 2014). As noted above, spiritual choices, preferences and needs can be documented, addressed and integrated, usually with clinical and lifestyle plans to facilitate holistic care (McSherry, 2006a,b; NHS Scotland, 2009; Walsh, McSherry, & Kevern, 2013).

**Trusting relationships**

According to Wilkes, Cioffi, Fleming, & LeMiere (2011), a trusting relationship can take months to develop but is an important part of spiritual care. From the health care staff perspective, the relationship includes being a companion along the older person’s journey, and being present for the individual as demonstrated by active listening and passive responses.

Maddox (2012) provided an analysis of a chaplain’s interactions with a patient at the end of their life as one example of the element of trusting relationships. The role of the chaplain may shed some light on potential elements of a trusting relationship. From the perspective of the nurse, this trusting relationship is expressed in person-centred care.

**Support groups**

Support groups can be considered an element of spiritual care. They can provide spiritual care and help to relieve depression symptoms or feeling that life has lost meaning (Miller, Chibnall, Videen, & Duckro, 2005).

**Rituals**

Rituals are another element often associated with religious beliefs, and often found to be an important beneficial activity for older people, including those living with cognitive impairment or with dementia (Casey, 2012; Carr, Hicks-Moore, & Montgomery, 2011; MacKinlay & Trevitt; 2010).

**Compassion**

Compassion was an element highlighted in the spiritual care literature. Compassion included respect in deciding when to discuss spiritual matters. It could include allowing an equal relationship by accessing one’s own spirituality during the connection (Pfeiffer, Gober, & Taylor, 2014).

**Prayer**

Prayer is one of the common elements of spiritual care although not necessarily relevant to spiritual care of people without a religious background. For some people prayer offers a source of strength and comfort, including those living with dementia (Carr et al., 2011; MacKinlay & Trevitt, 2010). There was some evidence in the literature that prayer was beneficial for staff and for people being cared for (Christiansen, 2008; Narayanasamy & Narayanasamy, 2008).

**Reading religious passages**

The literature discussed the role of reading religious passages in helping people to cope with stressful life events (Carr et al., 2011; Hamilton, Moore, Johnson, & Koenig (2013). There may be some benefit for people of religious backgrounds from spending time with scriptures, particularly in managing anxiety, depression, stressful situations and crisis situations (Stanley et al., 2011). Chaplains are sensitive to choosing the right time and method of praying with their clients (Maddox, 2012).
Reminiscence and story telling
Reminiscence was considered an element of spiritual care, viewed as assisting someone who is seeking to understand the journey of life and helping the individual to make sense of the meaning of their life (MacKinlay & Trevitt, 2010). Related to reminiscence, telling stories can also be considered an element of spiritual care (Southall, 2011).

Connectedness and hope
Relationships and connectedness was a major theme in the spiritual care literature. Getting to know the older person, understanding their priorities and helping them to access what they consider sacred in their lives has been highlighted a number of times (Carr et al., 2011). Connectedness is related to generating and supporting hope in the individual. The element was identified in Nolan (2011) who discussed being with an individual in order to give them strength and hope in their present existence. It is considered to assist in times of grief or illness or end of life where loss of hope may lead to despair (Bern-Klug, 2011). Stuart (2010) also suggested that attending to a person’s hope was an essential element in spiritual care.

Mindfulness and meditation
There is increasing evidence for the beneficial effects of mindfulness being practiced with the aid of a skilled practitioner and this can be extended to older people as well (Nilsson, 2014). Enabling access to mindfulness and meditation was discussed in the literature as an element of attending to spiritual needs. For example, Delaney, Barrere and Helming (2011) showed that mindfulness meditation as part of a multicomponent spiritual care intervention contributed to improved outcomes for community dwelling adults with cardiac disease. Similarly, there is a large amount of literature on the benefits of meditation; for example in Candy et al. (2012) and Delaney et al. (2011), meditation combined with massage improved quality of life outcomes.

Spiritually nurturing environments
Physical environments were discussed in terms of supporting spirituality. Ramezani et al. (2014) discussed the importance of the care environment and its role in protecting older people’s beliefs and value systems. Accessing outdoor areas can enable people to connect with the natural world, even if the outside world needs to be brought inside for those with limited mobility (Fleming & Bennett, 2014; Rigby, Payne & Froggatt, 2010).

Evidence for the effectiveness of spiritual care
The field of spiritual care covers a wide range of literature, some using a scientific framework to report on studies of the impact of interventions associated with spiritual care, other literature derived from a completely different genre. The outcomes targeted by spiritual care have covered a wide range of measurable, and some less tangible, effects. The following conditions were just a subset of those that were considered in the literature on spiritual care: anxiety, depression, grief, loneliness, dignity, control, transitions in life/relocation to long term care, cancer, pain, long term chronic illness, dementia, and stroke. There was considerable variability in the use of scientific methods to demonstrate any claimed benefits. It was acknowledged that people with chronic illness did not always automatically turn to spiritual care to assist in management of their condition (Campbell, Yoon, & Johnstone, 2010). Following is a brief summary of the main findings of studies that have considered the effects of spiritual care and the effects of addressing spirituality as part of aged care and health care.
Mental health and spirituality

A recent report from the Australian Institute of Health and Welfare (AIHW, 2013) found that at least half of the residents in aged care suffered from significant depression and anxiety. According to MacKinlay (2006), one contributing factor to depression may be failing to perceive meaning in life, which leads to feeling that life is hopeless (MacKinlay, 2006, p.99). During the past decade there has been increasing interest in how spirituality might have an impact on mental health, with a corresponding increase in evidence about the effectiveness of spiritual care (Koenig, King, & Carson, 2012; Cobb et al., 2012). For example, Baker (2000) found that ‘intentional pastoral care and nurturing the spiritual dimension’ may reduce symptoms of depression (see MacKinlay, 2012, p.48).

On the other hand, spiritual distress is associated with poorer outcomes that can include symptoms of depression, although it was not clear how spiritual distress was differentiated from depression (Larson & Larson, 2003). The spiritual care literature discussed the contribution that spiritual care could make to alleviating depression. Outside the traditional medical model, one author argued that depression could be a profoundly spiritual experience that cannot be comprehended through therapy and medications alone (Swinton, 2001, p.93). In this model depression is linked with spiritual distress, marked hopelessness, loss of meaning, a perceived break in a relationship with God/higher power and low self-esteem (Swinton, 2001, pp.93-96).

Relocation into residential aged care can be one of the most significant life events of an older person. A report from AIHW provided some recent data on the prevalence of depression symptoms among residents in residential aged care (AIHW, 2013). The report showed that over half of residents had some symptoms of depression, more so among people who had behaviours that impacted on their care needs as defined in the Aged Care Funding Instrument (AIHW, 2013).

More than 700 studies gathered in the present literature review discussed the relationship between mental health and religion, not all in the scientific framework tradition. The evidence indicated that there was a positive association between religiosity and mental health (Reeves, Beazley, & Adams, 2011). For example, depression symptoms have been shown to be moderated by spirituality in some studies. Ballew, Hannum, Gaines, Marx, and Parrish (2012) indicated that there was a weak association between depression and spirituality. Other studies found that individuals who identified as Protestant or Catholic or who considered religion or spirituality an important part of their lives were less likely to undergo depression episodes (Blazer, 2012). Some studies have found that an individualised spirituality-based intervention led to a significant improvement in quality of life, and a trend toward lower depression scores (Delaney et al., 2011). A study by Rajakumar, Jillings, Osborne and Tognazzini (2008) suggested that there was a role for spirituality in recovering from depression. Connections related to spirituality, such as connections with self, others, nature or a higher power helped people to find meaning and purpose in their lives. There was no suggestion of causality in these studies.

There have been fewer studies of older people receiving community aged care services and suffering from depression or anxiety and how they can best have their spiritual (or psychological) needs met by the service. Given the high rates of depression and anxiety in older people with multi-morbidities this is an area of research worth further investigation. It has been shown that anxiety and depression rates are high among people with cancer living in the community. For example, one study indicated that 49% of a sample experienced unhappiness and depression, and 62% of people experienced anxiety (Tsigaropoulos et al., 2009). Meeting the spiritual or psychological needs of these people is paramount.
End of life
The transition from community to residential aged care is often near the end of life and is a stage where spiritual care can be particularly helpful. Spirituality could be especially relevant when coping with this transition (Hutchinson, Hersch, Davidson, Chu, & Mastel-Smith, 2011). The importance and centrality of spiritual care was referred to in the literature on grief models of care. Moules, Simonson, Fleiszer, Prins, and Rev Bob (2007) referred to the use of a ‘map’ to assist clinicians when facilitating spiritual awareness for people experiencing grief. Specialists in grief, death and dying or trauma have shown great interest in incorporating religious or spiritual issues in their care. The meaning of spirituality has changed over time, so that religiosity can be distinguished from spirituality (Mahoney & Graci, 1999). Hilsman (1997) pointed to the valuable role that spiritual care could have in supporting both clients and staff in dealing with grief issues.

Loneliness towards the end of life could be relieved by life review and attention to spiritual needs (Mundle, 2014). A number of studies pointed to the dignity component of quality of life as being affected by spiritual care (Fenton & Mitchell, 2002; deBlois & O'Rourke, 1995; Kane, 2001; Meehan, 2012). A sense of control was the other aspect of quality of life that was important to attend to in spiritual care (King et al., 2012).

The literature on cancer treatment also addressed whether spirituality could assist in management of the condition. For example, a study of Muslim breast cancer survivors indicated that spirituality was a main psychological support among participants (Harandy et al., 2010). Spiritual care can address such outcomes as ‘meaning and peace’ and ‘preparation for end of life’ (Keall, Butow, Steinhauser, & Clayton, 2013).

The experience of pain and coping with pain was mentioned in 39 studies of spiritual care. Spiritual care or attention to spirituality was found to assist people by helping them to cope with situations of suffering and pain (Pilger, Queiroz de Macedo, Zanelatto, Gramazio Soares, & Kusumota, 2014). In one study about half of hospital chaplains had been engaged to assist with issues relating to pain (Carey, Polita, Marsden, & Krikheli, 2014). Person-centred pain management needs to take into account spiritual aspects of care as well as psychological, physical, and social aspects (Braš, Đorđević, & Janjanin, 2013).

Spiritual care was a core function of palliative care, mentioned in 98 results within the literature review. One study revealed that it was possible to improve spiritual care and confidence in providing spiritual care among health professionals in Australia (Meredith, Murray, Wilson, Mitchell, & Hutch, 2012). Spiritual care was found to be vital in supporting well-being and quality of life at the end of life. Older people can be supported to prepare for end of life through reflecting on their life and its contribution, reinforcing their worth, exploring unresolved issues, and having their preferences documented and respected (see Chaudhury et al., 2011; Confoy, 2002; Detering, Hancock, Reade, & Silvester, 2010). Importantly it was found that trans-disciplinary care is needed to address spiritual and psychosocial needs at this time (Nichols, 2013).

Dementia and spiritual care
People living with dementia are increasingly acknowledged as having the same rights as those without cognitive impairment in determining their care (Bryden, 2016). Spirituality transcends an individual's intellectual capacity, indicating that an individual's spirituality is not in any way compromised by a diagnosis of dementia or cognitive impairment. In this respect an individual living with dementia can still be involved in a search for meaning, purpose, connection, belonging, fulfillment and security (Daly & Fahey-McCarthy, 2014).
MacKinlay and Trevitt (2010) indicated that connecting with people living with dementia through spirituality rather than through ‘cognitive pathways’ can provide a better vehicle to connect. Given varying levels of engagement, expression and interest, spirituality provided a means of connecting and finding meaning in life (Daly & Fahey-McCarthy, 2014). Environments, routines and practices should be provided so that they enhance or encourage spiritual moments, reflections or insights (Zubrick, 2015) and this is especially important in caring for people living with dementia. However the implementation of this goal may be challenging for staff to achieve.

In terms of the experience of spirituality in dementia, Dalby, Sperlinger, and Boddington (2012) noted five important themes: (1) the experience of faith; (2) the search for meaning; (3) changes and losses in the experience of self; (4) staying ‘intact’ and; (5) pathways to spiritual connection and expression. Evidence about the impact of lifestyle activities such as music, singing, dancing, drawing, painting, poetry, and story-telling is sometimes couched in terms of the spiritual impact of these activities and often in the way they can enhance quality of life and give meaning and purpose (Davidson et al., 2014; Eldred, Lowis, Jewell, & Jackson, 2014; Zeilig, Killick, & Fox, 2014). Once these activities are understood as giving meaning and purpose to the individual, then their link to supporting spiritual needs becomes clearer.

Carr et al. (2011) noted that small things that caregivers may provide to people living with cognitive impairment and dementia can amount to big or important things for both the caregiver and the person being cared for. The authors acknowledged that in residential aged care facilities there was often limited time to attend to spiritual care. For people with a religious background and living with dementia, providing opportunities to keep their faith in God, pursue religious beliefs and practices, and stay connected in this way could provide positive benefits (Carr et al., 2011). For those with a religious background, being able to pray, read scriptures, attend church or to be visited by a minister or chaplain would be beneficial.

For those without a religious background, the broader idea of spirituality and spiritual care for people living with dementia was underpinned by the idea of developing caring, trusting connections and relationships and providing meaning or purpose. Such relationships were considered beneficial for both caregiver and care recipient. Being present, knowing the person, connecting with what is sacred in their lives, expressing gratitude, listening, adding touch, comforting, being peaceful, relaxed, and unhurried comprised elements of spiritual care that could be a potentially beneficial, reciprocal process for both parties in the relationship. Assisting the person living with dementia towards feeling loved, feeling respected, and feeling comforted would provide reassurance, support, and companionship; essential elements in caring for people with cognitive impairment.

MacKinlay (2012a) described the use of spiritual reminiscence in providing spiritual care to older people along the continuum of ageing. Spiritual reminiscence was effective in guiding/assisting older people towards uncovering meaning in their lives. Reminiscence required the spiritual care provider to be present with the older person, or the person living with dementia and required the caregiver to engage in communication that would acknowledge the older person as a spiritual being and take into account the spiritual tasks of ageing. Finding meaning in conversations with people living with dementia required an ‘imaginative openness’ in order to help the listener to interpret the person’s response without dismissing it (MacKinlay, 2012). Communication techniques are especially important to consider when interacting with individuals with dementia. As with physical care, in providing spiritual care to people living with dementia it is important to be aware of and use non-verbal cues effectively, i.e., touch, proximity, positioning or the direction one’s body faces, and leaning in if hearing impaired.
Gataric, Kinsel, Currie and Lawhorne (2010) discussed bereavement and dementia, and indicated that there are interventions that can assist when addressing bereavement and the processes that alter grieving in people with dementia. Spiritual or affective engagement was highlighted as important to address for people with cognitive impairment. Caregivers may also find spirituality useful in coping with their dementia caregiving experiences (Márquez-González, López, Romero-Moreno, & Losada, 2012).

Organisational impact of spiritual care

Literature on spirituality within organisations emerged from three main sources, each having a unique perspective: (1) spiritual care provided within aged, health and social care contexts; (2) spiritual care in the context of institutional chaplaincy such as military, sport, education and prisons; (3) organisational spirituality related to the leadership and management domains.

According to Rumbold (2012), the dominant models within health care are the biomedical model and the social model. The biomedical model, in its extreme form, focuses on disease, illness, and treatment, and sees health as an absence of disease. The focus is narrow and concerned primarily with the causative pathology and methods of treatment. In this model, patients (who are no longer autonomous) present and are cared for by members of a health care agency. In doing so they are relinquishing their control, autonomy, and their connectedness to outside sources of support when in submission to the expert knowledge and care of the care agency and its staff. The biomedical model sits within the framework of the other dominant model; the social model. The social model is concerned with equality and support, and in allowing people to participate in society as fully as their situation allows. Key strategies are supporting, normalising, educating and providing resources.

According to Rumbold (2012), the spiritual model can be incorporated into the social model in two ways: functionally, in providing support and participation that improves health, and substantively, by including people's spirituality as part of their cultural identity in health care.

The biomedical model would require the spiritual model to demonstrate quantifiable impacts to health outcomes in the form of compliance with therapy and cost effectiveness. The social model impacts include greater social connectedness, resilience and improved social support. The challenge inherent in integrating the spiritual model with the social and biomedical models is to maintain the spiritual model's connectedness with the greater concepts of modern spirituality outside of the health care system, as by nature the health care system's focus is narrow. Essentially the outside discourse on spirituality (outside the walls of health care), e.g., human destiny, human possibility and culture, must be allowed to permeate the models of spirituality in health care, to inform practitioners about diversity of spiritual experiences.

McSherry and Ross (2010, 2013) proposed that a disconnect can begin at the governance level, where strategic intent relating to spiritual care is often expressed in ‘motherhood statements’, rather than measurable key performance indicators. Governance is critical to effective and efficient development and monitoring of spiritual care (McSherry, 2013). The expectations set at governance level drive management’s behaviour. Parmenter (2012) highlighted that people would do what management inspected (or measured) rather than what management expected. Parmenter (2012) also reinforced that key performance indicators linked everyday work to strategic objectives. Therefore, in order to drive an integrated model of spiritual care, the governance body must set key performance indicators that flow down to performance expectations of functional areas, teams and individuals.
To place this in the context of an older person living in either residential aged care or receiving home care, MacKinlay (2001) suggested that it was important to note that relationships with God and/or others were not mutually exclusive, or in parallel. From a theological perspective, a relationship with God could tend to mirror human relationships. For some people, experiencing a deep relationship with God enhanced intimacy in human relationships; and conversely effective human relationships could improve a person’s relationship with God (MacKinlay, 2001). A theological explanation for this view was that relationships were essentially Christological in nature; a gift from God that occurred in and was sustained by Christ (Hauerwas & Yordy, 2003).

Where a person could not engage in meaningful relationships, the faithful presence and sustaining faith of others could provide meaning and hope (Swinton, 2001). Given the importance of relationships in meeting spiritual needs, a foundation to quality spiritual care would best be built on the organisation’s human resource management (HRM) strategy because spiritual care should be everyone’s business (MacKinlay, 2006). It was imperative that HRM systems and processes such as recruitment, selection, induction, job descriptions, rostering, performance management, and reward and recognition systems were geared towards attracting, retaining and developing people who were able to form meaningful relationships (Eaton, 2000; Rumbold, 2012).

If skills, competency, qualifications and experience were the prized currency, this reinforced a task-based model of care (Sheard, 2015). It was argued that focusing on capability and skills sets should be secondary to the need to recruit staff based on emotional intelligence, identity and beliefs (Sheard, 2013). Therefore, it was suggested that human resource systems should be about recruiting and selecting staff who have high emotional intelligence with the capacity to form close relationships with older people. Skills and competencies could generally be taught and acquired, whereas emotional intelligence and the capacity to deeply connect with people is almost impossible to be acquired where it does not exist.

However, it is not enough to recruit the most appropriate staff, other HRM processes need to be in place to support spiritual care (Compton, 2014). Consistent assignment of staff as caregivers to the same older person enables mutual relationships of trust and openness to develop and be experienced (Castle, 2011; Roberts, Nolet, & Bowers, 2015). For example, if rostering was structured to fill shifts most economically, there is no consistency for residents. Relationships could not be formed and trust not built, therefore those fleeting spiritually significant moments would go unrecognised or never emerge. An organisational commitment to ‘consistent assignment’ has demonstrated significant positive outcomes where small teams of staff consistently care for a group of residents, getting to know them, forming deep and meaningful relationships and ‘doing life together’ (Castle, 2011). However, if the leadership at every level does not practice and model relational care on its staff, the culture of trust, openness and sharing will not be fostered in the organisation.

**Conclusion**

As has been reiterated in the above literature review, all those who have contact with older people can have some responsibility and accountability for spiritual well-being (Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014). It is more about the qualities rather than the roles (Daaleman, Usher, Williams, Rawlings, & Hanson, 2008). In terms of a whole of organisation approach, Hudson and Richmond (2000) indicated that everyone had a role in the spiritual care of residents. They noted that in most cases, spiritual care was not mentioned in job descriptions, nor assessed as part of performance or recognition. If the entire care team had a role and arguably a responsibility for spiritual care, then it would need to be explicitly recognised in every job description. This would need to be supported by an effective performance management system that had a structured and intentional process for monitoring and assessing emotional and relational attributes of staff.
Performance appraisal and quality improvement processes should include seeking the views of older people regarding their satisfaction with care and services in a way that maintains confidentiality (Corazzini et al., 2015; Meissner & Radford, 2015). A culture of connectedness, compassion, being with and being present to older people should be reflected in recruitment and selection, training, rosters, position descriptions, work values and performance appraisal systems (Lustbader & Catlett Williams, 2006; Radford, Shacklock, & Bradley, 2015).

Those who have direct contact with older people should be trained and equipped with spiritual awareness to understand their own spirituality, have a basic conversation with an older person, know when and how to refer to someone else when spiritual needs arise, incorporate spirituality into their own role and provide compassionate partnering (Kadonoff, 2014; MacKinlay & Trevitt, 2012; McSherry, 2006). There needs to be a referral system in place to enable access to specialised spiritual carers at short notice and on an on-going basis where or when spiritual distress and needs are identified, with the consent of the older person (Kadonoff, 2014; Larson & Larson, 2003; Swinton & Pattison, 2010). Spiritual care needs should be sensitively shared to ensure that all those who have direct contact with older people have access to information appropriate to their role and relationship (McDonald, 2011; McSherry, 2006; Walsh et al., 2013).
5. What is a guideline?4

This final section provides information about what guidelines generally consist of, and lists some existing guidelines that include spiritual care as a component. At the beginning of this project there were no Australian spiritual care guidelines that had been written specifically for use in residential aged care and home aged care settings, so the following discussion of guidelines is provided as background to illustrate the content of guidelines in related areas, and was used to inform the structure, size and format of the new Guidelines.

Types of guidelines

Guidelines exist in a number of different formats. Clinical practice guidelines can be very short; for example evidence-based information sheets for health professionals on best practice are short two to three page sheets with recommendations. Each recommendation is graded from A to C depending on the level of support or evidence that is found for the recommendation. Grades are generally determined by the scientific methodology used to assess the strength of association between two variables. Grade A is the strongest support category for recommendations that should be put into practice. Grade B is moderate support indicating that the application of the recommendation should be considered. Grade C is not enough evidence to warrant support. References are provided to support each recommendation (Joanna Briggs Institute, 2010).

A longer clinical practice guideline provides detailed information on all aspects of the condition. For example, the Chronic Heart Failure Guidelines provide 86 pages on definition, aetiology, diagnosis, supporting patients, management, interventions, treatments, support in various stages of the disease (including palliation) and NHMRC levels of evidence for clinical interventions and grades of recommendation (Chronic Heart Failure Guidelines Expert Writing Panel, 2011). Longer guidelines generally include a section on how to use the guideline in order to achieve the desired outcome.

A structured protocol is another type of guideline. Definitions and structure for following a specific procedure are provided. Guidance is given on how to undertake specific processes and a structured checklist is used to guide practitioners in assessing whether they have followed the protocol correctly.

A flowchart is used in some evidence based clinical guidelines to provide guidance on paths to follow depending on the individual’s condition. A summary of evidence is referenced, including level of quality of the evidence.

Unlike clinical practice guidelines, a position statement is not linked to levels of evidence but is still referenced. For example, Position Statement 13 of the Australian and New Zealand Society for Geriatric Medicine (ANZSGM, 2012) on Delirium in Older People is a 15 page statement that provides practitioners with information on diagnosis, nosology and treatment, epidemiology, aetiology, pathology and prevention. In a similar way, a policy directive provides guidelines for processes that can be undertaken to maintain a certain level of health care. For example, the Healthy Skin Program of the Northern Territory Government (Centre for Disease Control, 2010) provides a 27 page guideline for community control of scabies, skin sores and crusted scabies in the Northern Territory. Background information is provided, followed by definitions and a clinical presentation. Information is presented on how to set up a program including planning, community involvement and education, baseline screening, treatment, maintenance and evaluation. A bibliography of education resource ideas, fact sheet, equipment list and example monitoring sheets are provided.

---

4 This section ‘What is a guideline?’ was written by Colleen Doyle and Hannah Capon.
An information paper for health professionals provides a summary of the latest information about a treatment. For example, the Asthma and Complementary Therapies information paper is a 16 page summary of the use of complementary therapy in managing asthma (National Asthma Council Australia, 2012). Key messages are provided as a summary of the document. Resources are also provided for further information. An assessment of the quality of published evidence (from poor to very good) and overall rating of the benefit of each type of treatment (from -3 to +3) is provided. Therapies where no controlled studies are available are also listed.

A different approach is that taken in the Guidelines for a Palliative Approach for Aged Care in the Community Setting, which are best practice guidelines funded by the Australian Department of Health and Ageing (2011). The guidelines are a 391 page document. The document includes the guideline development process, definition of a palliative approach to care; delivering a palliative approach in a number of different models of care; advance care planning; physical symptom assessment and planning; psychosocial care; spiritual support; and chapters on specific groups such as Aboriginal and Torres Strait Islander people; people from cultural and linguistically diverse groups and other special needs perspectives. Levels of evidence are provided for each recommendation. Two accompanying booklets are shorter summaries of 33 pages, one aimed at older people living in the community and one for care workers. Advice is provided in the form of practice tips, additional advice and case studies to illustrate how the advice might be put into practice.

Another example of guideline formats is the Guidelines for Preventing Falls of the Australian Commission on Safety and Quality in Health Care (ACSQHA, 2009). The guidelines were developed by a multidisciplinary expert panel. An additional external quality reviewer reviewed the guidelines. The final document also drew on previous versions, a search of the most recent literature, a Cochrane review, feedback from health professionals and policy staff, clinical advice from an expert advisory group, guidance from external expert reviewer including international reviewers and guidance from relevant specialist groups. Papers that were retrieved from the literature review were classified using the NHMRC six-point rating system. Recommendations were divided into evidence based recommendations, good practice points, points of interest and case studies.

### Grading systems

An overall grading can be provided for each recommendation in a guideline. The levels of evidence and grades of recommendation adopted by the NHMRC (1999) use four levels of evidence and a grading system (see Boxes 1 & 2 below). The Joanna Briggs Institute (JBI; Jordan, Lockwood, Aromataris, & Munn, 2016) developed three grades of effectiveness to assign to recommendations in guidelines (see Box 3 below).

#### Box 1: Definitions from NHMRC (1999) of levels of evidence and descriptions

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evidence obtained from a systematic review of all relevant randomised controlled trials</td>
</tr>
<tr>
<td>II</td>
<td>Evidence obtained from at least one properly designed randomised controlled trial</td>
</tr>
<tr>
<td>III-1</td>
<td>Evidence obtained from well-designed pseudo-randomised controlled trials (alternative allocation or some other method)</td>
</tr>
<tr>
<td>Level</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>III -2</td>
<td>Evidence obtained from comparative studies with concurrent controls and allocation no randomised (cohort studies), case-control studies, or interrupted time series with a control group</td>
</tr>
<tr>
<td>III -3</td>
<td>Evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group</td>
</tr>
<tr>
<td>IV</td>
<td>Evidence obtained from case series, either post-test, or pretest and post-test</td>
</tr>
</tbody>
</table>

**Box 2: Definitions of the grading system of NHMRC (1999) levels of evidence and grades of recommendation**

A – body of evidence can be trusted to guide practice  
B – body of evidence can be trusted to guide practice in most situations  
C – body of evidence provides some support for recommendation(s) but care should be taken in its application  
D – body of evidence is weak and recommendation must be applied with caution  
Good practice point – recommended best practice based on clinical experience and expert opinion

**Box 3: Definitions from JBI on grades of recommendation**

A – Strong support that merits application  
B – Moderate support that warrants consideration of application  
C – Not supported

**Types of recommendations**

- Evidence based recommendations  
- Consensus based recommendations  
- Practice point (expert opinion)

**Levels of evidence**

The GRADE working group (2004, p. 1490) offered the following categories of levels of evidence:

- “High: Further research unlikely to change confidence in the estimate of effect”  
- Moderate: Further research is likely to have an impact on confidence in the estimate of effect and may change the estimate  
- Low: Further research is very likely to have an important impact on confidence in the estimate of the effect as it is likely to change the estimate  
- Very low: Any estimate of effect is very uncertain”.


Conclusion

While the above grades of evidence work well for clinical practice guidelines, much of the spiritual care literature does not lend itself to scientific grading systems, crossing boundaries between art and science, biomedical and social models and a range of philosophies of care. Instead the new Guidelines are informed by available literature and consensus from stakeholders and experts.

Examples of international and Australian guidelines incorporating elements of spiritual care

The following examples are international and Australian guidelines relevant to aged care but not written specifically for aged care. Each guideline mentions spiritual care or includes sections relative to spiritual care. For each guideline, see below the country of origin, year of publication, author as well as a brief description of the relevance to spiritual care and for whom the guideline was intended.

United Kingdom 2004 – National Institute for Clinical Excellence

*Guidance on Cancer Services. Improving Supportive and Palliative care for adults with cancer – The manual*

This guideline specifically focuses on needs of people with cancer and was written for various levels of health care, including individual health, social care, cancer networks, provider, and professional organisational levels.

United States 2006 – Joint Commission on Accreditation of Healthcare Organisations (Hodge, 2006)

*A Template for Spiritual Assessment: A Review of the JCAHO Requirements and Guidelines for Implementation*

This guideline is written for social workers and provides advice on spiritual assessment as an important part of a holistic assessment.

Australia 2007 – Sydney and Flinders University (Clayton, Hancock, Butow, Tattersall, & Currow, 2007)

*Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers*

This guideline provides a set of phrases that may be used to validate a person’s responses and to encourage the person to continue to explore issues, and encourages referral for specialist palliative care services for complex spiritual needs. The guidelines are written for Australian health practitioners. No detailed reference is made to chaplains, spiritual care or religion.

Scotland 2008 – NHS Scotland

*Spiritual and Religious Capabilities and Competences for Healthcare Chaplains*

Written for health care chaplains, this guideline includes information on knowledge and skills needing for practice, communication skills, spiritual assessment and intervention, and the role of the chaplain in the hospital or unit. There is also information on reflective practice and personal and spiritual development.

Australia 2009 – Centre for Palliative Care Education & Research (Hudson, Quinn, O’Hanlon, & Aranda, 2009)

*Family meetings in palliative care: Multidisciplinary practice guidelines*

Based upon a psychological perspective and written for health professionals, this guideline offers criticism of a biomedical approach to care whereby the clinician offers information without taking into the equation the needs of the family or person. It makes the point that meetings should be structured to address the needs of the person and family rather than by only addressing the needs of health professionals.
Scotland 2009 – NHS Scotland
*Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff*
Written for all health care staff, this guideline is comprehensive in covering spirituality and providing spiritual care. It is not specific to aged care or to providing spiritual care to older people.

United Kingdom 2009 – Equality and Human Rights Group, Department of Health
*Religion or belief. A practical guide for the NHS*
This guideline avoids preconceptions regarding peoples beliefs based upon a statement of religious or non-religious belief as peoples beliefs change over time. It was written for all NHS staff, including employers, employees, service planners, commissioners and providers.

United States 2009 – National Consensus Project for Quality Palliative Care
*Clinical Practice Guidelines for Quality Palliative Care Second Edition*
This guideline was written for multidisciplinary health progressions as it notes that the interdisciplinary team will be involved in assessment and response to issues of existential and spiritual nature and comments that these professionals will require appropriate education. It is also tailored for an organisational audience.

Australia 2010 – Palliative Care Australia (Aleksandric & Hanson, 2010)
*Health System Reform and Care at the End of Life: A Guidance Document*
This guidance document is relevant for all consumers, carers, students, health professionals, managers, researchers and policy makers who have an interest in palliative care and health reform. The guideline mentions cultural and spiritual competence and safety related to end of life care being incorporated into multidisciplinary education programs. This is in the context of Australia’s indigenous, immigrant, asylum seeker and refugee community’s needs.

Australia 2010 – Centre for Palliative Care (Hudson et al., 2016)
*Clinical Practice Guidelines for the Psychosocial and Bereavement Support of Family Caregivers of Palliative Care Patients*
This guideline is aimed at multidisciplinary health care professionals and clinical services. It provides advice about communicating with patients, but there is no specific mention of spiritual care.

Wales 2010a – NHS Wales
*Standards for Spiritual care Services in the NHS in Wales*
This guideline was written for NHS Local Health Boards and NHS Trusts, as well as NHS services, including acute general and mental health services, for children, young people and adults. The guideline offers details on spiritual assessment, providing staff support, education and training and resources. It is for care of the full range of age spans.

Wales 2010b – NHS Wales
*Guidance on Capabilities and Competences for Healthcare Chaplains/ Spiritual Care Givers in Wales*
This guideline offers advice on spiritual care in all health care settings and is directed at Local Health Boards and National Health Services Trusts as well as faith communities, the general public and NHS staff engaged in whole-patient care.

UK 2011 – Royal College of Nursing
*Spirituality in nursing care: a pocket guide*
This guideline is comprehensive in covering spirituality in nursing, but again is not specific to aged care or needs of older people.
UK (Current) – Royal College of Nursing

*Spirituality in nursing care: online resource*

This is an online resource related to the above pocket guide.

International 2012 – International Council of Nurses

*The International Council of Nurses Code of Ethics for Nurses*

The first element of the code ‘Nurses and people’ specifies that nurses in providing care should promote an environment where human rights, values, customs and spiritual beliefs of patients, families and the community are respected. Secondly the code sets out the importance of mental, physical, social and spiritual wellbeing of nurses.

Netherlands 2014 – Agora Spiritual Care Guideline Working Group

(European Association for Palliative Care)

*Spiritual care nation-wide guideline, Version: 1.0*

This comprehensive guideline gives detailed information about how to provide spiritual care to individuals in a number of care settings. It is written primarily for doctors and nurses, but does not exclude care providers from other disciplines.

Australia 2016 – Guideline Adaptation Committee (NHMRC)

*Clinical Practice Guidelines for Dementia in Australia*

These Clinical Practice Guidelines are aimed at health care staff including medical, nursing, carers and allied health, having a particular focus on aged care. The guidelines highlight that spiritual assessment is important for palliative care and for assessment and management of BPSD.
6. References

ACIITC (Aged Care Industry Information Technology Council) (2013). *Digital Care Services: Harnessing ICT to create sustainable aged care services*. Canberra: ACIITC.


Hilsman, G. J. (1997). The place of spirituality in managed care. Attending to spiritual needs can help managed care systems achieve their goals. Health Progress (Saint Louis, Mo.), 78(1), 43-46.


McNamara, S. (2005). The gift we give each other is the light of our presence. AORN Journal, 82(6), 957-960. doi:10.1016/S0001-2092(06)60247-0


Rigby, J., Payne, S., & Froggatt, K. (2010). What evidence is there about the specific environmental needs of older people who are near the end of life and are cared for in hospices or similar institutions? A literature review. *Palliative Medicine, 24*(3), 268-285. doi:10.1177/0269216309350253


7. Appendix 1

Search strategy details

Medline via EBSCOHost (1946- )

Searched: 20.05.15

S1  (MH “Spiritual Therapies+”)
S2  (MH “Religion+”)
S3  AB (religio* OR spirit OR soul OR souls) OR TI (religio* OR spirit OR soul OR souls)
S4  AB ((belief* OR believe*) N3 (relig* OR spiritual*)) OR TI ((belief* OR believe*) N3 (relig* OR spiritual*))
S5  AB (deity OR divinity OR divine) OR TI (deity OR divinity OR divine)
S6  AB (faith* OR pray*) OR TI (faith* OR pray*)
S7  AB (pastoral OR spiritual) N3 care OR TI (pastoral OR spiritual) N3 care
S8  AB (annoint* OR spiritual) OR TI (annoint* OR bless*)
S9  AB (“laying on of hands” OR therapeutic touch) OR TI (“laying on of hands” OR therapeutic touch)
S10 AB (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR “no religion” OR humanis*) OR TI (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR “no religion” OR humanis*)
S11 AB (psychic OR faith OR mental OR traditional) W3 healing) OR TI ((psychic OR faith OR mental OR traditional) W3 healing)
S12 AB (peace OR serenity) OR TI (peace OR serenity)
S13 AB (mystic* OR transcend* OR esoteric* OR meditat*) OR TI (mystic* OR transcend* OR esoteric* OR meditat*)
S14 AB (existential* or salutogenesis) OR TI (existential* or salutogenesis)
S15 AB (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR “latter day” OR hindu* OR islam* OR muslim* OR moslem* OR judaism OR jew* OR tao* OR sikh* OR rastafari*) OR TI (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR “latter day” OR hindu* OR islam* OR muslim* OR moslem* OR judaism OR jew* OR tao* OR sikh* OR rastafari*)
S16 AB (confucianism OR eastern philosoph*) OR TI (confucianism OR eastern philosoph*)
S17 AB (god OR allah OR supreme being OR angel OR angels) OR TI (god OR allah OR supreme being OR angel OR angels)
S18 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17
S19 (MH “Homes for the Aged”)
S20 AB aged care OR TI aged care
S21 AB (residential N3 (aged or elderly or geriatric)) OR TI (residential N3 (aged or elderly or geriatric))
S22  S19 OR S20 OR S21
S23  (MH “Nursing Homes+”)
S24  (MH “Long-Term Care”)
S25  (MH “Hospices”)
S26  (MH “Rehabilitation Centers+”)
S27  (MH “Hospitals+”)
S28  AB ((long term OR extended) W1 care) OR TI ((long term OR extended) W1 care)
S29  AB (nursing OR care) W1 home* OR TI (nursing OR care) W1 home*
S30  AB (hospice* OR rehabilitati* OR hospital*) OR TI (hospice* OR rehabilitati* OR hospital*)
S31  S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30
S32  (MH “Aged+”)
S33  AB elder* OR older W1 (adult* OR people OR person OR m?n OR wom?n) OR (late* OR “end of”) W1 life OR oldest old OR TI elder* OR older W1 (adult* OR people OR person OR m?n OR wom?n) OR (late* OR “end of”) W1 life OR oldest old
S34  S32 OR S33
S35  S31 AND S34
S36  S22 OR S35
S37  S18 AND S36

EMBASE.com (1974- )
Searched: 25.05.15
#1  ‘spiritual healing’/exp
#2  ‘religion’/exp
#3  (religio* OR spirit OR soul OR souls):ab,ti
#4  ((belief* OR believe*) NEAR/3 (relig* OR spiritual*)):ab,ti
#5  (deity OR divinity OR divine):ab,ti
#6  (faith* OR pray*):ab,ti
#7  ((pastoral OR spiritual) NEAR/3 care):ab,ti
#8  (annoint* OR bless*):ab,ti
#9  (“laying on of hands” OR “therapeutic touch”):ab,ti
#10  (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR “no religion” OR humanis*):ab,ti
#11  (psychic OR faith OR mental OR traditional) NEXT/3 healing):AB,ti
#12  (peace OR serenity):ab,ti
#13  (mystic* OR transcend* OR esoteric* OR meditat*):ab,ti
#14  (existential* OR salutogenesis):ab,ti
#15  (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR “latter day” OR hindu* OR islam* OR muslim* OR moslem* OR judaism OR jew* OR tao* OR sikh* OR rastafari*):ab,ti
#16  (confucianism OR eastern NEXT/1 philosoph*):ab,ti
Background and Literature Review

#17 (god OR allah OR “supreme being” OR angel OR angels):ab,ti
#18 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12
OR #13 OR #14 OR #15 OR #16 OR #17
#19 ‘home for the aged’/exp
#20 “aged care”:ab,ti
#21 (residential NEAR/3 (aged or elderly or geriatric)):ab,ti
#22 #19 OR #20 OR #21
#23 ‘nursing home’/exp
#24 ‘long term care’/exp
#25 ‘hospice’/exp
#26 ‘rehabilitation center’/exp
#27 ‘hospital’/exp
#28 (“long term” OR extended) NEXT/1 care):ab,ti
#29 ((nursing OR care) NEXT/1 home*):ab,ti
#30 (hospice* OR rehabilitati* OR hospital*):ab,ti
#31 #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30
#32 ‘aged hospital patient’/exp OR ‘frail elderly’/exp OR ‘very elderly’/exp
#33 ((elder* OR older) NEXT/1 (adult* OR people OR person OR man OR men OR
woman OR women)):ab,ti
#34 ((late* OR “end of”) NEXT/1 (life OR “oldest old”)):ab,ti
#35 #32 OR #33 OR #34
#36 #31 AND #35
#37 #22 OR #36
#38 #18 AND #37

CINAHL via EBSCOHost (1937-)
Searched: 22.05.15
S1 (MH “Religion and Psychology+”)
S2 (MH “Religion and Religions+”)
S3 (MH “Spiritual Healing+”)
S4 (MH “Psychological Well-Being”)
S5 AB (religio* OR spirit OR soul OR souls) OR TI (religio* OR spirit OR soul OR souls)
S6 AB ((belief* OR believe*) N3 (relig* OR spiritual*)) OR TI ((belief* OR believe*)
N3 (relig* OR spiritual*))
S7 AB (deity OR divinity OR divine) OR TI (deity OR divinity OR divine)
S8 AB (faith* OR pray*) OR TI (faith* OR pray*)
S9 AB (pastoral OR spiritual) N3 care OR TI (pastoral OR spiritual) N3 care
S10 AB (annoint* OR bless*) OR TI (annoint* OR bless*)
S11 AB (“laying on of hands” OR therapeutic touch) OR TI (“laying on of hands” OR
therapeutic touch)
S12 AB (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR "no religion" OR humanis*) OR TI (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR "no religion" OR humanis*)

S13 AB ((psychic OR faith OR mental OR traditional) W3 healing) OR TI ((psychic OR faith OR mental OR traditional) W3 healing)

S14 AB (peace OR serenity) OR TI (peace OR serenity)

S15 AB (mystic* OR transcend* OR esoteric* OR meditat*) OR TI (mystic* OR transcend* OR esoteric* OR meditat*)

S16 AB (existential* or salutogenesis) OR TI (existential* or salutogenesis)

S17 AB (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR "latter day" OR hindu* OR islam* OR muslim* OR islam* OR muslim* OR moslem* OR judaism OR jew* OR tao* OR sikh* OR rastafari*) OR TI (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR "latter day" OR hindu* OR islam* OR muslim* OR moslem* OR judaism OR jew* OR tao* OR sikh* OR rastafari*)

S18 AB (confucianism OR eastern philosoph*) OR TI (confucianism OR eastern philosoph*)

S19 AB (god OR allah OR supreme being OR angel OR angels) OR TI (god OR allah OR supreme being OR angel OR angels)

S20 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19

S21 AB aged care OR TI aged care

S22 AB (residential N3 (aged or elderly or geriatric)) OR TI (residential N3 (aged or elderly or geriatric))

S23 S21 OR S22

S24 (MH “Nursing Homes+”)

S25 (MH “Long Term Care”)

S26 (MH “Hospices”)

S27 (MH “Rehabilitation Centers+”)

S28 (MH “Hospitals+”)

S29 AB ((long term OR extended) W1 care) OR TI ((long term OR extended) W1 care)

S30 AB (nursing OR care) W1 home* OR TI (nursing OR care) W1 home*

S31 AB (hospice* OR rehabilitati* OR hospital*) OR TI (hospice* OR rehabilitati* OR hospital*)

S32 S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31

S33 (MH “Aged+”)

S34 AB elder* OR older W1 (adult* OR people OR person OR m?n OR wom?n) OR (late* OR "end of") W1 life OR oldest old OR TI elder* OR older W1 (adult* OR people OR person OR m?n OR wom?n) OR (late* OR "end of") W1 life OR oldest old

S35 S33 OR S34

S36 S32 AND S35

S37 S23 OR S36

S38 S20 AND S37
PsycINFO via EBSCOHost (1597-)

Searched: 22.05.15

S1 DE “Spirituality”

S2 DE “Religion”


S4 (DE “Philosophies”) OR (DE “Confucianism”) OR DE “Existentialism” OR DE “Humanism” OR DE “Mysticism” OR DE “Nihilism” OR DE “Realism (Philosophy)”

S5 (DE “Atheism”) OR (DE “Agnosticism”)

S6 DE “Soul”

S7 AB (religio* OR spirit OR soul OR souls) OR TI (religio* OR spirit OR soul OR souls)

S8 AB ((belief* OR believe*) N3 (relig* OR spiritual*)) OR TI ((belief* OR believe*) N3 (relig* OR spiritual*))

S9 AB (deity OR divinity OR divine) OR TI (deity OR divinity OR divine)

S10 AB (faith* OR pray*) OR TI (faith* OR pray*)

S11 AB (pastoral OR spiritual) N3 care OR TI (pastoral OR spiritual) N3 care

S12 AB (annoint* OR bless*) OR TI (annoint* OR bless*)

S13 AB (“laying on of hands” OR therapeutic touch) OR TI (“laying on of hands” OR therapeutic touch)

S14 AB (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR “no religion” OR humanis*) OR TI (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR “no religion” OR humanis*)

S15 AB (psychic OR faith OR mental OR traditional) W3 healing) OR TI ((psychic OR faith OR mental OR traditional) W3 healing)

S16 AB (peace OR serenity) OR TI (peace OR serenity)

S17 AB (mystic* OR transcend* OR esoteric* OR meditat*) OR TI (mystic* OR transcend* OR esoteric* OR meditat*)

S18 AB (existential* or salutogenesis) OR TI (existential* or salutogenesis)

S19 AB (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR “latter day” OR hindu* OR islam* OR muslim* OR mosleim* OR judaism OR jew* OR tao* OR sikh* OR rastafari*) OR TI (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR “latter day” OR hindu* OR islam* OR muslim* OR mosleim* OR judaism OR jew* OR tao* OR sikh* OR rastafari*)

S20 AB (confucianism OR eastern philosoph*) OR TI (confucianism OR eastern philosoph*)

S21 AB (god OR allah OR supreme being OR angel OR angels) OR TI (god OR allah OR supreme being OR angel OR angels)

S22 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21

S23 AB aged care OR TI aged care

S24 AB (residential N3 (aged or elderly or geriatric)) OR TI (residential N3 (aged or elderly or geriatric))
S25  S23 OR S24
S26  DE “Long Term Care”
S27  DE “Nursing Homes”
S28  DE “Hospice”
S29  DE “Rehabilitation Centers”
S30  DE “Hospitals” OR DE “Psychiatric Hospitals” OR DE “Sanatoriums”
S31  AB (long term OR extended) W1 care OR TI ((long term OR extended) W1 care)
S32  AB (nursing OR care) W1 home* OR TI (nursing OR care) W1 home*
S33  AB (hospice* OR rehabilitati* OR hospital*) OR TI (hospice* OR rehabilitati* OR hospital*)
S34  S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33
S35  DE “Aging” OR DE “Geriatrics” OR DE “Gerontology”
S36  DE “Elder Care”
S37  AB elder* OR older W1 (adult* OR people OR person OR m?n OR wom?n) OR (late* OR “end of”) W1 life OR oldest old OR TI elder* OR older W1 (adult* OR people OR person OR m?n OR wom?n) OR (late* OR “end of”) W1 life OR oldest old
S38  S35 OR S36 OR S37
S39  S34 AND S38
S40  S25 OR S39
S41  S22 AND S40

AMED via EBSCOHost (1995- )
Searched: 22.05.15
S1  (DE “SPIRITUALITY”)
S2  (DE “RELIGION”)
S3  AB (religio* OR spirit OR soul OR souls) OR TI (religio* OR spirit OR soul OR souls)
S4  AB ((belief* OR believe*) N3 (relig* OR spiritual*)) OR TI ((belief* OR believe*) N3 (relig* OR spiritual*))
S5  AB (deity OR divinity OR divine) OR TI (deity OR divinity OR divine)
S6  AB (faith* OR pray*) OR TI (faith* OR pray*)
S7  AB (pastoral OR spiritual) N3 care OR TI (pastoral OR spiritual) N3 care
S8  AB (annoint* OR bless*) OR TI (annoint* OR bless*)
S9  AB (“laying on of hands” OR therapeutic touch) OR TI (“laying on of hands” OR therapeutic touch)
S10  AB (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR “no religion” OR humanis*) OR TI (irrelig* OR disbelie* OR unbelie* OR non-faith OR atheist* OR agnostic* OR secular OR “no religion” OR humanis*)
S11  AB (psychic OR faith OR mental OR traditional) W3 healing) OR TI ((psychic OR faith OR mental OR traditional) W3 healing)
S12 AB (peace OR serenity) OR TI (peace OR serenity)
S13 AB (mystic* OR transcend* OR esoteric* OR meditat*) OR TI (mystic* OR transcend* OR esoteric* OR meditat*)
S14 AB (existential* or salutogenesis) OR TI (existential* or salutogenesis)
S15 AB (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR “latter day” OR hindu* OR islam* OR muslim* OR moslem* OR judaism OR jew* OR tao* OR sikh* OR rastafari*) OR TI (buddhism OR buddhist* OR church* OR christian* OR catholic* OR protestant* OR anglican* OR orthodox* OR jehovah* witness* OR mormon* OR “latter day” OR hindu* OR islam* OR muslim* OR moslem* OR judaism OR jew* OR tao* OR sikh* OR rastafari*)
S16 AB (confucianism OR eastern philosoph*) OR TI (confucianism OR eastern philosoph*)
S17 AB (god OR allah OR supreme being OR angel OR angels) OR TI (god OR allah OR supreme being OR angel OR angels)
S18 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17
S19 (DE “HOMES FOR THE AGED”)
S20 AB aged care OR TI aged care
S21 AB (residential N3 (aged or elderly or geriatric)) OR TI (residential N3 (aged or elderly or geriatric))
S22 S19 OR S20 OR S21
S23 (DE “LONG TERM CARE”)
S24 (DE “NURSING HOMES”)
S25 (DE “HOSPICES”)
S26 (DE “REHABILITATION CENTERS”)
S27 (DE “HOSPITALS”)
S28 AB ((long term or extended) W1 care) OR TI ((long term or extended) W1 care)
S29 AB (nursing OR care) W1 home* OR TI (nursing OR care) W1 home*
S30 AB (hospice* OR rehabilitati* OR hospital*) OR TI (hospice* OR rehabilitati* OR hospital*)
S31 S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30
S32 (DE “AGED”)
S33 (DE “AGING”)
S34 AB elder* OR older W1 (adult* OR people OR person OR m?n OR wom?n) OR (late* OR “end of”) W1 life OR oldest old OR TI elder* OR older W1 (adult* OR people OR person OR m?n OR wom?n) OR (late* OR “end of”) W1 life OR oldest old
S35 S32 OR S33 OR S34
S36 S31 AND S35
S37 S22 OR S36
S38 S18 AND S37
Health Business Elite via EBSCOHost (1922- )
Searched 29.05.15
S1 DE “SPIRITUAL care (Medical care)”
S2 DE “SPIRITUALITY”
S3 TX spiritual care
S4 S1 OR S2 OR S3
S5 TX aged care
S6 DE “OLDER people -- Care”
S7 DE “NURSING care facilities”
S8 DE “LONG-term care facilities”
S9 DE “HOSPICES (Terminal care facilities)”
S10 DE “REHABILITATION centers”
S11 DE “HOSPITALS”
S12 S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11
S13 S4 AND S12

Social Care Online via http://www.scie-socialcareonline.org.uk/ (1980- )
Searched: 26.05.15
“spiritual care” in all text fields

Sociological Abstracts via ProQuest (1952- )
Searched: 29.05.15
“spiritual care” in all text fields

Applied Social Science Index and Abstracts (ASSIA) via ProQuest (1987- )
Searched: 29.05.15
“spiritual care” in all text fields