

'In need of further tuning': using a US patient satisfaction with chaplaincy instrument in a UK multi-faith setting, including the bereaved

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ABSTRACT – Healthcare chaplaincy research seems further advanced in the USA. Here a US patient satisfaction with chaplaincy instrument (PSI-C-R) was used in a London NHS foundation hospital with a multi-faith chaplaincy team and population. A version of the instrument was also generated for the bereaved. PSI-C-R had not been subjected to test-retest to confirm its reliability so this was done at the pilot stage. It proved only partly reliable, but in three separate surveys a cluster of highly rated factors emerged, as in earlier studies: chaplains' prayer, competence, listening skills and spiritual sensitivity. Low-rated factors and qualitative data highlighted areas for improvement. Disappointing response rates arose from patient acuity, ethical concerns about standard follow-up protocols, and the Western Christian origins of the instrument which requires further revision for multi-faith settings, or the design of new instruments.

KEY WORDS: bereavement, chaplaincy, listening, multi-faith, prayer, quality improvements, quantitative research, spiritual sensitivity

Introduction

This research was designed to assist the Multi-Faith Chaplaincy Team at Chelsea and Westminster Hospital to make quality improvements based on patients' evaluation of chaplaincy provision. There is little UK research into patients' views of chaplaincy interventions: NHS patient surveys tend to overlook it and two recent UK studies focus mainly on what chaplaincy should offer rather than current provision.¹⁻³ It might be argued that the spiritual and religious care offered by chaplains is difficult to measure, but a literature review indicated that a quantitative survey was feasible and the instrument used was of US origin.

Quantitative patient satisfaction research is well-established in healthcare settings, for example into nursing quality. Chaplaincy patient satisfaction research, pioneered by Larry VandeCreek at Ohio State University, is based on patient satisfaction research methods, and his Patient Satisfaction

Instrument for Pastoral Care – Chaplaincy (PSI-C) has been field-tested in North America, Canada, New Zealand and Ireland.^{4,5} Its user-friendly update, PSI-C-R, has also been extensively tried in the USA, and was employed for the first time in the UK in this study which also generated a version specifically for the bereaved.⁶

Methods

Setting

Chelsea and Westminster Hospital NHS Foundation Trust, a London teaching hospital associated with Imperial College, manages a 400-bed hospital with five main directorates – medicine, surgery, women and children, HIV/genitourinary medicine, anaesthetics and imaging – and the following acute areas: adult and paediatric accident and emergency, intensive care, burns unit, neo-natal unit, stroke unit, coronary care unit and a plastic surgery ward.

The Multi-Faith Chaplaincy Team includes employees and volunteers and comprises a team leader, a Church of England Chaplain and lay visitor, a Humanist visitor, a Jewish lay visitor, a Muslim Chaplain, and a Roman Catholic Chaplain. Working across all directorates, and with the trust's Bereavement Officer, Maternity Bereavement Facilitator and Volunteer Liaison Manager, the team is represented at weekly multidisciplinary meetings of the neo-natal unit, HIV ward and palliative care/oncology team. The chaplains frequently attend dying patients and their relatives and wanted the bereaved included in this research.

The instrument(s)

There are 23 clinical items in PSI-C-R arranged under four subscales (Appendix 1). There are 25 clinical items in the version for the bereaved, which contains two additional questions about the deceased and appropriate word changes (Appendix 2). A Likert-type scale was used, ranging from 1 to 5 (strongly disagree to strongly agree). The original demographic questions were retained, except the cumbersome items about educational attainment and Christian

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denominations. The ethnicity section was expanded to conform to UK census fields. An open-ended question, ‘What did you most like or dislike about the chaplaincy service?’, was included to offset the leniency effect associated with closed questions and illuminate the quantitative data.⁷

There was an initial pilot study to confirm internal validity and three further experimental groups: discharged patients, the bereaved and inpatients. The pilot study was designed to check the instrument’s consistent reliability using the test-retest method which had not been done before. Previous researchers had evaluated the reliability of each subscale using Cronbach’s alpha test, a standard statistical test used for psychometric instruments to evaluate their internal consistency. A Cronbach’s alpha score based on an unbiased correlation of >0.60 implies reliability and the Cronbach’s alpha for the subscales had previously ranged from 0.74 to 0.96.^{7,8} Test-retest is considered a more accurate indicator of reliability.

Participants

The pilot study was performed on 20 patients, retrospectively identified from chaplaincy records, who agreed to complete the survey again, after an interval of 10 days, for test-retest purposes. They were well known to the chaplains which facilitated follow up. The other samples were all the patients (or bereaved relatives) for whom a chaplaincy record existed and who would have had significant chaplaincy contact during a single calendar month. (Recent national guidelines towards a minimum chaplaincy data set are based on ‘significant spiritual episodes.’) Patients usually self-refer as chaplains visit the wards, or are referred by staff, their relatives, or faith community. Surveying every patient, including those who decline chaplaincy interventions, was beyond the resources of this modest study.

Responses were monitored for religious affiliation and further Muslim patients had to be surveyed consecutively to match the multi-faith character of the hospital population.

Data analysis

Data were inputted and analysed using SPSS 13.0 for Windows. Mean, median and standard deviation were calculated. In order to assess the reliability of the instrument, a test-retest design was adopted to evaluate inter-rater reliability. Results were assessed using Cohen’s κ coefficient, a non-parametric tool that is more robust than simply quoting the percentage agreement between two nominal scale evaluations rating the same object.

Results

Demographics

- 1 Response rate: tabulated response rates, demographic and statistical data followed by figures of the descending mean scores for the

discharged, inpatient and bereavement studies are shown in Table 1.

- 2 Gender: most respondents were female, significantly higher than the trust average of 55% female (Table 2).
- 3 Age: at 52 years (pilot study) to 57.8 years (discharged study) the mean age of respondents was high compared to trust figures. Actual ages ranged from 13 to 93 years.
- 4 Ethnicity: most were White British, ranging from 51.7% (inpatient study) to 66.7% (bereavement study), higher than the trust average of 45.5%.
- 5 Religion: most were Christian but some respondents had no religious convictions (Table 3). Many participants did not attend worship regularly and most – with the exception of the pilot study – did not attend services in the hospital chapel during their stay (Table 4).

Table 1. Response rates.

Study	Sample (n)	Response (n)	Percentage (%)
Pilot	20	12	60
Bereaved	27	9	33.33
Discharged	157	32	20.38
Inpatients	96	29	30.20

Table 2. Gender

Study	Sample (%)		Response (%)	
	Male	Female	Male	Female
Pilot	40	60	25	75
Bereaved	42.4	57.6	33.3	66.7
Discharged	30	70	34.4	65.6
Inpatients	45	55	31	69

Table 3. Religion.

Study	Christian (%)	Muslim (%)	Jew (%)	Other (%)	None (%)
Pilot	100	–	–	–	–
Bereaved	88.9	–	–	11.1	–
Discharged	78.1	9.4	3.1	–	6.3
Inpatients	79.3	10.3	3.4	–	6.9

Table 4. Worship attendance.

Study	Weekly (%)	Holidays (%)	Rarely (%)	Never (%)	Hospital chapel (%)
Pilot	58.3	25.0	16.7	–	66.7
Bereaved	33.3	–	55.6	11.1	11.1
Discharged	56.3	3.1	21.9	9.4	31.3
Inpatients	31.0	6.9	37.9	17.2	20.7

Quantitative data

- 1 Pilot study: Cronbach's alpha was calculated and the results, like VandeCreek's, imply reliability (Table 5). However, the main purpose of the pilot study was to obtain Cohen's κ coefficient measure outcomes from the test-retest data (Table 6).
- 2 Discharged and inpatient studies: as in earlier studies a cluster of highly rated supportive qualities emerged – the chaplain's listening skills (SQ2), competence (SQ3) and prayer (SQ1).⁴⁻⁶ Strength to go on (CQ5), made hospitalisation easier (CQ2) and help with beliefs and values (CQ3) were also appreciated. Feeling more hopeful (CQ4) and the chaplain's spiritual sensitivity (IQ) were ranked fifth and sixth in both surveys (Figs 1–4).
- 3 Bereavement study: adapting the instrument for bereaved relatives was new and prayer was ranked highest followed by other supportive factors (Figs 5–6).

Qualitative data

- 1 Discharged study: some found it easy to access the service while others did not, and there was disappointment at the failure to record religion at admission. Two patients – one of whom was 'not religious' – appreciated help to 'get through a difficult situation' and another valued the reassurance offered.

Table 5. Cronbach's alpha outcomes. Subscales cover three aspects of chaplaincy ministry (see Appendix 1).

Study	Subscale 1: Coping	Subscale 2: Support	Subscale 3: Accept
PSI-C-R	0.960	0.870	0.740
Pilot 1	0.858	0.630	0.886
Pilot 2	0.900	0.773	0.892
Bereaved	0.960	0.891	0.884
Discharged	0.920	0.869	0.954
Inpatients	0.904	0.878	0.906

Table 6. Cohen's κ coefficient outcomes.

Question	Value	Approximate significance
Cq2 hospitalisation easier	0.625	0.000
Cq4 more hopeful	0.495	0.006
Cq5 strength to go on	0.664	0.000
Cq9 adjust to condition	0.538	0.002
Sq5 sacramental needs	0.650	0.000
A1 scared me	0.400	0.166
A2 talked too much	0.143	0.584
A3 made me tired	0.400	0.157

Fig 1. Discharged study. Mean scores descending A.

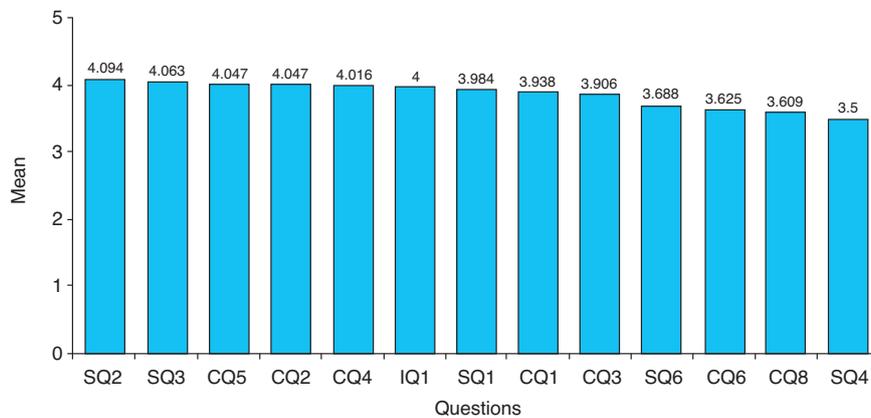


Fig 2. Discharged study. Mean scores descending B.

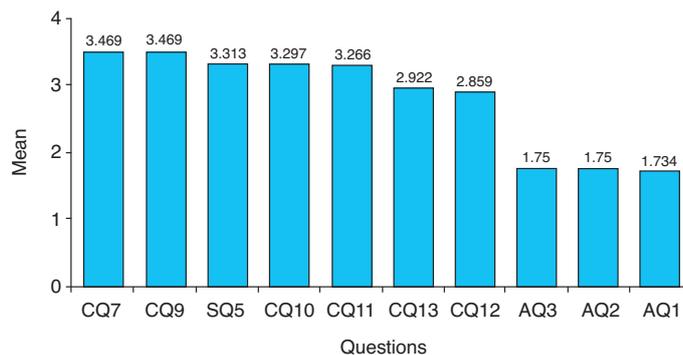


Fig 3. Inpatient study. Mean scores descending A.

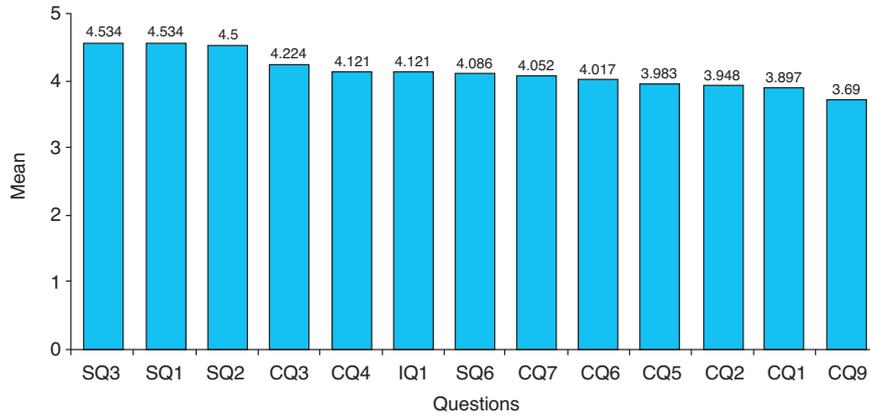


Fig 4. Inpatient study. Mean scores descending B.

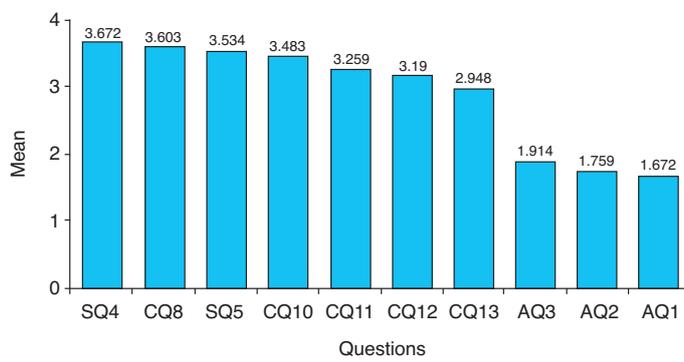


Fig 5. Bereavement study. Mean scores descending A.

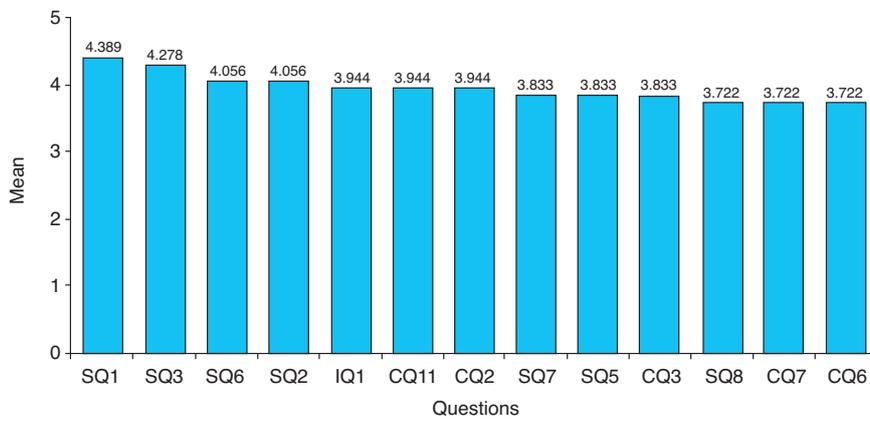
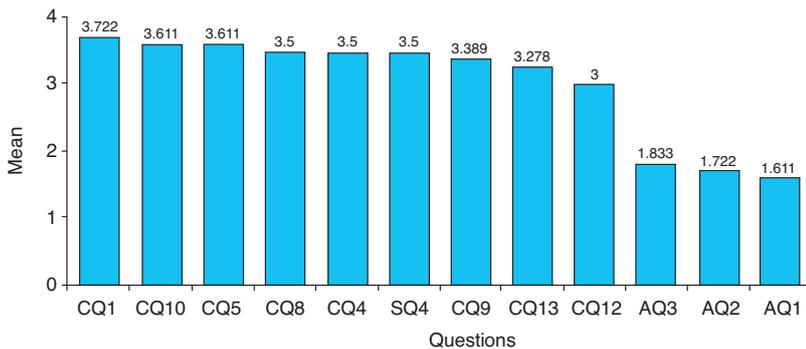


Fig 6. Bereavement study. Mean scores descending B.



- 2 Inpatient study: Comments were brief, presumably due to the demands of the inpatient experience. Chaplains' visibility was noted and a Muslim parent appreciated their 'understanding of multi-cultural/diverse faiths'. Kindness, thoughtfulness, caring and generous amounts of time spent listening were all mentioned.
- 3 Bereavement study: Two comments revealed that chaplains are sometimes known to patients but not to their relatives. There was appreciation for the monthly memorial service, led by the chaplains, though one family did not wish to attend. The harrowing nature of perinatal grief was expressed, with thanks for the chaplain's role in the funeral.

Discussion

Recruitment and bias

The high pilot study scores (not shown) suggest bias. Many of these participants were regular worshippers and attended the hospital chapel, but they were also the most responsive, which was vital to the test-retest procedure. Frequency of visits may have been another factor as 41.7% of these participants received three to six visits, while many received only one or two visits, ranging from 44.4% (bereavement study) to 59.4% (discharged study). The lack of Muslim respondents was clear at the pilot stage. Although most participants described themselves as Christian many never attend church, or only do so rarely, so the surveys embraced people who are not church members. Postal survey returns were disappointing, especially concerning discharged patients.

Instrument reliability

There were only eight κ outcomes in total, five of which indicated a significant measure of agreement, though the factors concerned were not rated highly, and the three connected with acceptance of chaplains showed slightly weaker agreement, perhaps because they were hard to distinguish. Over time, therefore, the instrument was only partly reliable.

Ethical issues

The low response rate from discharged patients was probably due to the ethics committee's decision that people were not to be approached more than once because the questionnaire explored sensitive topics. However, it would have helped to employ follow-up protocols to ensure a better possible response. The ethics committee subsequently approved a substantial amendment to the research protocol so that the inpatient survey could take place, which revealed that many patients were too ill to respond, even with help.

The multi-faith dimension

The Muslim Chaplain had personally approved the Muslim sample for the pilot study but none responded, and no Muslims

replied to the bereavement survey. The chaplaincy team were probably overly optimistic in assuming that Muslim patients would relate to a questionnaire of Western Christian origin. Eventually, three Muslim patients and one Jewish patient replied to the discharged survey and the inpatient study. This exceeds the 2.6% Muslim and 0.336% Jewish patients listed in the trust's annual statistics, but trust figures record just 19.5% of patients as Christian, and 74.9% of religious data as blank or 'unknown', which suggests reluctance either to enquire about, or to disclose, religious affiliation.

Satisfaction with chaplains

- 1 Generally: English healthcare chaplaincy is encouraged to be more research focused and this project attempts to add to its evidence base.⁹ Patients rated chaplains' supportive interventions more highly than their contribution to recovery or the discharge process. Chaplains' spiritual sensitivity and their effect on patients' hopefulness were strikingly affirmed by their equal ranking in the discharged and inpatient surveys. Communication with peoples' faith communities and medical teams might require improvement, or perhaps patients appreciate the apparent independence of chaplains, who were mainly well-received and perceived as unthreatening.
- 2 Bereavement study: the chaplain's prayer scored highest, since many relatives encounter a chaplain first when they request final prayers for a loved one. The ranking tells a story: at an emotional time, as the family prepare for the patient's death, prayer from a capable chaplain is essential if relatives' needs are to be met during the final prayers. Chaplains' ability to listen to grieving people, together with their spiritual sensitivity, can help relatives adjust to bereavement, making that experience easier. Hope is sometimes emphasised at this stage but chaplains' contribution to it was not significant, presumably because their involvement occurs when the hope of physical recovery is slight.¹⁰

Conclusion

The project attempted to measure patient satisfaction with chaplaincy to facilitate service quality improvements and PSI-C-R was specially adapted for the bereaved. Test-retest revealed that the instrument was only partly reliable, though a consistent set of patient priorities emerged from quantitative analysis of the three main surveys. Further radical revision is needed to improve its efficacy in a multi-faith setting and the development of new instruments is recommended.

Questionnaire and supplementary documents

The full questionnaires and letter sent to the bereaved are available from the author upon request.

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Appendix 1. PSI-C-R.

1 Ministry that promotes coping

- Cq1 The chaplain helped me to realise God cares for me
- Cq2 The chaplain's visits made my hospitalisation easier
- Cq3 The chaplain helped me use my faith/beliefs/values to cope
- Cq4 The chaplain helped me feel more hopeful
- Cq5 The chaplain's visits gave me the strength to go on
- Cq6 The chaplain's visits aided my spiritual growth during illness
- Cq7 The chaplain helped me face difficult issues
- Cq8 The chaplain helped me overcome my fears
- Cq9 The chaplain helped me adjust to my medical condition
- Cq10 The chaplain's visits contributed to my readiness to return home
- Cq11 The chaplain's visits contributed to a faster recovery
- Cq12 The chaplain helped the clergy of my congregation understand my situation
- Cq13 The chaplain helped me cooperate with the doctors and nurses

2 The supportive ministry of chaplains

- Sq1 The chaplain's prayer was a comfort to me
- Sq2 The chaplain gave the impression s/he was really listening to me
- Sq3 The chaplain seemed to know what s/he was doing during the visit
- Sq4 The religious worship service met my needs
- Sq5 My need for the sacraments was fulfilled
- Sq6 After talking with the chaplain I felt better about my problems

3 Acceptance of the chaplain's ministry

- Aq1 The chaplain's visits scared me
- Aq2 The chaplain talked too much
- Aq3 The chaplain's visits made me too tired

4 Independent item

- Iq1 The chaplain seemed to be a person of spiritual sensitivity

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Appendix 2. Instrument for the bereaved.

1 Ministry that promotes coping

- Cbq1 The chaplain helped me to realise God cares for me/my loved one
- Cbq2 The chaplain's input made the experience of death and bereavement easier
- Cbq3 The chaplain helped me/my loved one use our faith/beliefs/values to cope
- Cbq4 The chaplain helped me/my loved one feel more hopeful
- Cbq5 The chaplain's input gave me/my loved one the strength to go on
- Cbq6 The chaplain's input aided our spiritual growth during loss and bereavement
- Cbq7 The chaplain helped me/my loved one face difficult issues
- Cbq8 The chaplain helped me/my loved one overcome my fears
- Cbq9 The chaplain helped my loved one adjust to the process of dying
- Cbq10 The chaplain helped me adjust to the process of my loved one dying
- Cbq11 The chaplain's input helped me adjust to the process of bereavement
- Cbq12 The chaplain helped the clergy of my congregation understand my situation
- Cbq13 The chaplain helped me/my loved one cooperate with the doctors and nurses

2 The supportive ministry of chaplains

- Sbq1 The chaplain's prayer was a comfort to me/my loved one
- Sbq2 The chaplain gave the impression s/he was really listening to me/my loved one
- Sbq3 The chaplain seemed to know what s/he was doing during the visit
- Sbq4 My loved one's need for the sacraments was fulfilled
- Sbq5 The 'last rites'/final prayers met the needs of my loved one
- Sbq6 The 'last rites'/final prayers met my needs
- Sbq7 The funeral service [if conducted by a chaplain] met my needs and those of my family
- Sbq8 After talking with the chaplain I felt better about my problems

3 Acceptance of the chaplain's ministry

- Abq1 The chaplain's involvement scared me/my loved one
- Abq2 The chaplain talked too much
- Abq3 The chaplain's visits made me/my loved one tired

4 Independent item

- Ibq1 The chaplain seemed to be a person of spiritual sensitivity