



A study of the pastoral care needs of the ICU/ED staff in
a General Hospital from the Pastoral Care Department.

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Declaration

I certify that this dissertation, submitted for the degree of Masters of Arts in Leadership and Pastoral Care, All Hallows College, is entirely my own work, has not been taken from the work of others, and has not been submitted in any other university. The work of others has been cited and acknowledged within the text of my own work.

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Abstract

In a world that is in tremendous transition where the need to re-evaluate where we are socially, economically and personally is an ever present challenge, the concept of spirituality to our overall well-being and health is been focused on in a way we may never have expected. Pastoral care has a role now more than it ever had before.

However if you ask some one what is pastoral care they will pause to think. There is no definitive answer to this question. Some say it is spiritual accompaniment while other says it is just simply being present with people on a life journey.

The economic reality for this generation has impacted on the pastoral care teams as the posts in hospitals are not filled due to the fiscal policy in the respective Health Boards. This means the service is not as effective as it should be. The fact is that chaplains are needed more now than ever, especially by the staff who often work in difficult circumstances.

This study as to the needs of the ICU/ED staff from the Pastoral Care team reflects the importance of this service in the hospitals that they are present in. Staff in these two departments work in a high stress atmosphere and need support from within to help them cope with this stress. We can see that the needs are great and the greater need to be heard is vital. The Pastoral Care team play a significant role in giving this support and my research and the results of the audit of staff in these two departments validate this. The motivation behind this work is to demonstrate that pastoral care should be treated as an equal partner in a multidisciplinary approach to patient care in hospital. The conclusions reached I believe reinforces this motivation.

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Abbreviations

CNM - Clinical Nurse Manager
CPR - Cardiac Pulmonary Resuscitation
ICU - Intensive Care Unit
ED - Emergency Department
GM - General Manager
PC - Pastoral care
MALPC- Masters of Arts in Leadership and Pastoral Care.
AHC - All Hallows College
DCU - Dublin City College
HSE - Health Service Executive

Glossary

Multidisciplinary – all care providers working together to assist the recovery or otherwise of the patient.

Holistic - all elements of the patient are attended to including.
Physical/psychological/emotional/spiritual.

Resus status - the assessing of a patient as to the suitability for a full cardiac resuscitation.

This work is dedicated in the memory of

SIMON SEXTON

Paramedic based at Cavan Ambulance Station who died
in the line of his duty as he was caring for the sick on
June 3 2010

"May the smile he had for us never fade from our memories"

May he rest in peace

Preface

The proposal: a research study into how the pastoral care team are meeting the needs of the medical staff in a general hospital with particular emphasis on the needs of ICU and ED personnel.

The aim: to see how effective the pastoral care team are in helping the staff in ICU and ED departments with their day to day concerns and issues

The assumptions: the reason why this work is being done is that I believe that pastoral care is part of holistic care and that it is important for pastoral care to be part of the multidiscipline, holistic teams in the hospital, especially in the acute areas of ICU and ED.

Layout:

In this research I will attempt to get the overall impression of healthcare pastoral care as it is practiced in a hospital environment. As I develop the work I will explore the relevant literature on the subject and then focus some of the main bodies of work in regards to pastoral care. I will then design an audit under the HSE guidelines in order to gauge the pastoral care issues that staff have. I will develop a policy and procedure document within the body of work to give a guideline as to best practice in pastoral care. This is essential in all chaplaincy posts that are involved in State organisations. Finally, I will give guidelines and recommendations as to the way forward for pastoral care in this hospital and nationwide.

I have the relevant supports from the heads of departments and management in the hospital and copies of same are attached.

Chapter 1

Introduction

1.0

As I begin this research I am very aware that this is a challenge that comes at the end of a process of learning that has focused me on the value of leadership in pastoral care.

I want to look at an area of pastoral care that is close to my heart. I work full time as a chaplain in a general hospital for the last 10 years. I feel passionately about the role of the chaplain in a hospital. I believe that there is a need to see pastoral care as part of the holistic and multidisciplinary care that is available in a healthcare facility. It is in light of the basic premises of the MALPC (master's in leadership and pastoral care) that I want to research the role of pastoral care in a hospital environment with a focus on two specific departments and their staff. The staff in ICU (intensive care unit) and the ED (emergency department) work in an intense, stressful, demanding environment. I hope to demonstrate the value of integrating the pastoral care team with the staff of these two acute departments with a view to helping them in their work.

1.1

Areas that will be looked at:

In Chapter Two I will give an overview of the literature in regards to the overall concept of healthcare pastoral care/chaplaincy. In Chapter Three I will develop the theories in pastoral care taking into consideration the Christian tradition I work with in the hospital. In Chapter Four I will set out an audit to demonstrate how pastoral care can be affective in the *ICU* and *ED* departments. I will also draw up a draft policy and procedure for chaplaincy in the hospital. In the final Chapter I will make recommendations as to the way forward.

1.2

The history of pastoral care.

(At a local level.)

For me to research pastoral care in this healthcare facility it is important to see how it has developed over the last 60 years.

What is the definition of pastoral care?

According to Hulme who is cited by Kirkwood (2005, p.12) “pastoral care is a supportive ministry to people and those close to them who are experiencing the familiar trials that characterize life in this world such as illness, surgery, incapacitation, death and bereavement”. Best (1985, p. 45) in his study of pastoral care in education defines the idea as “a comprehensive concept expressing a commitment to the welfare, well being and fullest development of the individual”.

The common factor between these two initial definitions is a sense of commitment to the process. To give a spiritual angle on the notion of pastoral care Patton (1993, p.

57) states “pastoral care asks us to remember God’s action for them who God’s people are and to hear and remember those to whom they minister”. These are the seeds for developing the study that I am embarking on at this stage.

1.3

Pre Vatican 2

The concept of pastoral care was not all that wide spread in the church healthcare facilities in the fifties, where my starting point begins. Sullivan (1955, p. 37) states “all people are taught that they ought not to need help so that they are ashamed of needing it, or feel that they are foolish to seek it or expect it”. Any form of counselling even pastoral counselling was not expected by this generation. Most of the hospitals that were run at this time were governed, managed and run by a plectra of religious orders in the Irish state. These were dominated by the Sisters of Charity, the Sisters of Mercy and the Medical Missionary sisters of Mary to mention a few. They were driven by a strong religious code and practice, and ethical observance was strongly influenced by the teachings of the Catholic Church. Any pastoral care that was offered had to uphold the doctrine and ethics of the Catholic Church. So the concept of pastoral care as we now understand it was not a reality at that time. Pastoral Care was seen as spiritual care/assistance and offered to anyone of a Christian persuasion. The two main religious persuasions were Catholic and Church of Ireland. Priests/ministers were called in to assist a person who *was* having an operation (the sacrament of the sick), who was in danger of death (the last rights), to give Holy Communion to the worthy (must have had the sacrament of reconciliation) and to baptise infants in danger of death. There was very little dialogue with the patient and seldom with the staff. This was common practice at the time. The

guidelines were set by the Religious Congregation that ran the hospital and it took the teachings and changes mandated by Vatican 2 to create the concept of pastoral care as we know it today. This was also true of the Pastoral Care given in the State hospitals of the time. The sixties saw a world that was changing at breakneck speed. In culture, human rights, politics and even music it was a memorable time. The Church began to change to meet this new challenge and that was to continue to the present time.

1.4

Post Vatican Two

The development of pastoral care came as a response to the new wave of enthusiasm that was generated in the wake of Vatican 2. John Paul 2 (2002) in his address to the members of the Pontifical Council for health and pastoral care said “pastoral care for the suffering and particularly those who work in hospital always respects life and dignity in human beings”. Again John Paul 2 (2003) when speaking on the world day of the sick in February 2003 to pastoral carers said “is ready to bring help and hope especially to those affected with new diseases. You will recognize and welcome the lord who calls you to be witness to the gospel of suffering”.

We see a tremendous shift of focus from the 50s to the present. In the beginning the influence of the American experience was influential in the development of theories and ideas of pastoral care. The link between the spiritual, psychological and emotional needs of the patients was to be cared for. This in effect meant that only trained professionals could implement the new concept. The establishment of CPE (clinical pastoral education) was the model that was seen to address the issue. So the

requirement to have chaplains/ pastoral cares undergo the necessary training was essential.

In 1989 the hospital that this study is being carried out in was opened. This was seen as an opportunity by the local bishop to nominate a new chaplain and for the management in the hospital to set up a pastoral care department. The chaplain *was* to be fully trained according to the standards of Clinical Pastoral Education. This was breaking new ground. Initially the chaplain was part-time with responsibility in the local parish. The demand to take on two ministries was easy for a start but as the demand increased the chaplaincy role came under pressure. It took 10 years to have a second post established and it took another 6 years to have two permanent chaplaincy posts which is the present situation in the hospital. Pastoral care is seen as an integral part of the hospital.

One of the key ingredients to acknowledge in pastoral care is stated by Cardinal Paul Popard (1992) and is the link I want to make to the next chapter. He says “compassion urges us to move out of ourselves. It not only makes us feel for, but feel with those who suffer”. Chapter Two will develop this concept in more depth.

Chapter Two

Literature review.

2.0 Introduction.

To review the literature that is available for this research I want to pool together three areas that I am dealing with in the context of this document. The area of pastoral care, the area of the needs of staff in the Intensive Care departments, and finally, the area of the Emergency department and the needs of the staff that work there. I will look at the relevant writings, reflections, and documentations that are available concerning these three areas. The purpose of this is to demonstrate the concerns that are evident in ICU/ED departments and to see how pastoral care can address these concerns. Up to now pastoral care has been very much on the sidelines in the debate about healthcare reform. I hope to show that in the future pastoral care can work together with both the ICU and ED departments in a constructive and proactive way. I will now take the literature that is available to us in the field of pastoral care. This will be followed up with the ICU and ED departments and the relevant articles that have been researched in this area.

2.1

Pastoral care literature.

In his book entitled, “*The chaplain-physician relationship*”, the author, Larry Van DeCreek (1991) sees chaplains as having a healthy relationship with the physicians who work with them in the departments that they minister to. He is aware that there has been a strain in the relationship between these two professions in the past. However if this issue is to be addressed there has to be as a beginning a mutual respect of each others’ profession. This can only come about in a collaborative interdisciplinary approach under the umbrella of holistic care. This is further developed in, “*A practical guide to hospital ministry; healing ways*” by Harold G. Koenig (2002). He developed the area of pastoral care in a meaningful, systemic, integrated and pragmatic view. He believes that we need to have experiences of ministry that are integrated into the total structures of the hospital setting. Pastoral care has to be interwoven in the mission, philosophy and programme development of the management of the hospital.

Helen Orchard (2001) in, “*Spirituality in healthcare contexts*”, accepts that the chaplaincy team needs to engage theoretically and practically with the management of the healthcare facilities so as to see how spirituality can be manifested in the health care structures with an emphasis on the professional and ethical aspects of medical practice. There is also, she argues, a need to acknowledge the cultural dimensions of the staff that chaplains work along side, creating dialogue from the cultural diversity so as to have a deeper appreciation and respect for each others’ traditions and religious beliefs.

An author whom I have quoted earlier has moved into the need for education and the possibility of creating awareness of pastoral care concerns/issues to the staff that we

work with. Harold G. Koenig (2000) in, “*Spirituality in patient care*,” looks at the integration of spirituality into patient care. He sees that it’s not only the ministers in pastoral care that need training, but also the other healthcare professionals that care for the patient, reinforcing the need for a multidisciplinary/ holistic (see glossary) care approach to the patients/clients that we deal with. This he accepts will give the medical staff an awareness of the spiritual needs of the patient and will also give them the confidence of giving referrals to the pastoral care team.

A new author in this field is Mary Elizabeth O’Brien (2007) “*A Sacred covenant: the spiritual ministry of nursing*”. In this work she focuses especially on the spirituality of the nurses themselves and how that affects their personality. She uses the scriptures to help provide a broad spiritual grounding in her approach. This I feel is significant as I need to look at this area in trying to understand the needs of staff later on in chapter three.

Laurel A Burton (1988) in “*Making chaplaincy work; a practical approach*”, looks at chaplaincy at a practical level and not only deals with the complex issues and concerns of the patients and the management of these same patients who have long term illnesses, e.g. HIV, strokes and cancer, etc., but, also, he is aware of the need to look at developing surgical and medical reporting plans where the pastoral care issues have the same level of concern as all the other issues and that in the planning of the extended care of the patient these issues are taken into consideration. This is a collaborative approach that has not always been well received, especially in the Irish model of healthcare.

Another writer that I have come across sees education at a higher level as a benefit to the pastoral career. Van De Creek (1997) in an article entitled “*Contract pastoral care and education – the trend for the future*” taken from the journal of healthcare

chaplaincy of the same year sees the need to have all pastoral carer highly trained, practically, academically and experientially in tandem with the well trained professionals that we are colleagues with. His understanding here is that chaplains can only be respected if they have a deep knowledge of what they do. This is vital, in his opinion, in dealing with the administration that runs our healthcare facilities. The book takes in the honest experiences of the trained pastoral carer and there is evidence of the struggle they have in trying to be effective in their role. The need for support groups and supervision is part of the foundation of this work. I concur with this. However in practice it is hard to have a chaplain trained to this level of expertise in the Irish context.

One of the areas of concern in an ICU department is the anxiety that staff have in relation to pain management of the patient. Joseph H Fichter (1981) in “*Religion and pain; the spiritual dimension of healthcare*”, believes that spirituality and pain are connected. Therefore a religious understanding of pain together with the holistic approach to treating it is the key to understanding the complexity of pain. All medical staff in the ICU department is involved in pain management and in their collective wisdom have seen that pastoral care has a role to play in helping to manage it. Some may find it hard to make the link between pain and spirituality and therefore concentrate on the medical management, while those who have a deep spiritual faith can make the link and see it as a help to dealing with the pain of an individual. The next stage is the relevant information/documentation that is evident in the emergency department services.

2.2

Emergency Department literature

As I was looking at the journals for this area I was struck by a heading that flagged up a big issue for staff in the ED at this present time. The heading of the article was “*violence in the ED*”, and it was written by SP Cembrowicz, and JP Sheppard (1992), who are both based in the Bristol Royal Infirmary. In the article they indicate from a ten year survey that there were over 450 assaults on staff in the hospital varying from minor to serious injury. There was an increase of assaults toward the female staff, and the vast majority of assaults came from young adults who were intoxicated or who suffered from various levels of psychosis. As results of this report there was improvement in the area of the security and training on how to deal with aggressive people. I have been unable to find how things have been since this report was done. I would be pessimistic whether there has been any improvement in the situation if the Irish situation is anything to go by.

In an article in the, “Annals of emergency medicine”, vol. 20 (1991) entitled, “*aggression to ED staff at a university hospital*”, the authors, G.Pane, A. Winlarski, K. Saliness state in their conclusion that the incidents of aggression to staff are under reported and that if a study into the levels of incidents was carried out in the ED the benefits to the staff as well as the patients would be a safer and more secure environment.

One of the potential areas of flashpoint that can cause aggression is over crowding, again from an article in the “Annals of emergency medicine” (1990). The stress of individuals who are waiting for treatment can be manifested in aggression. The need to process and deal with the management of beds in-house and the need to create a fluency in the movement of people in an efficient and professional manner is one of

the biggest challenges. If this is approached in a collaborative manner, according to the report, the environment in the department would be healthier and the incidents of aggression and violence to the staff should decrease. In the hospital that this is been carried out in this has happened, and although the aggression is not gone the incidents and the intensity has, for the most part, declined. This does not mean that we can become complacent in the area, but it does encourage vigilance in dealing with the issue.

As ministers/chaplains in the service of caring for the sick we make assumptions about the people that we deal with. In the journal of “nursing administration” (1999) in an article entitled “*patient needs in the ED; nurses and patients perceptions*” by J.Hostutler, Susan H Taft and Clint Synder they see that there is, as in any relationship, two ways to view a situation and they feel that if the nurse and the medic that are taking care of the patient understood the full need of the individual the care could be improved. It is not just the symptoms that have to be dealt with but, also, what is deeper within the patient at an emotional, psychological and spiritual level, an area that pastoral care can be active in.

Finally we will deal with the literature that deals with ICU.

2.3

ICU literature

In the journal “Critical Care Medicine” David Johnston (1998) and his associates in the area of Clinical Investigation of the journal presents the topic “*measuring the ability to meet family needs in an intensive care unit*”. The main point they make is the need to understand that families are complex and have different needs. These needs are magnified in an ICU department due to the intensity of the environment. Failure to not notice and address these needs can create stress and this can affect the performance of the individual who is taking care of the patient. The family are in the equation of care when a patient is admitted to the ICU department.

Developing this idea in, “The journal of intensive care”, Elie Azaouly (2004) in an article “*family participation in care to the critically ill; opinions of family and staff*” states that “the family can have an active role in the care of the patient”. In a survey of the active participants involved, 88.2% of caregivers said that participation in care should be offered to families, in other words families could be involve in the care of the patient, yet only 33.4 % of family members wanted to be involved.

The debate whether or not to resuscitate a patient is an area of on-going concern. In an article entitled, “*Do not resuscitate, decisions in the medical ICU – comparing physician and nurse opinions*”, Robin S Howard (1996) and colleagues have highlighted that for the most part the physician will agrees that a patient is not in need of resuscitation more than that of the nurse-in-charge. This is a situation that creates conflict and anxiety especially for the nurse and in their professional relationship to the doctor.

This issue is developed in “the American journal of respiratory and critical care medicine”, in which Edward Ferrand (2003) in a paper entitled, “discrepancies

between perception by physicians and nursing staff of ICU end of life decisions”, argue that a collaborative approach is needed in this area. The main stumbling block for participation of the doctors with the nurses in this area is the fear of litigation. The ultimate responsibility falls with the consultant and the hierarchical model of healthcare indicates that the buck stops with the consultant.

2.4

Overview

This chapter has highlighted the need for pastoral care to re-define and re-invent itself if it is to be taken seriously in the Healthcare debate. This has to come in the form of collaborative ministry with the entire professional staff in the healthcare area. It also has to pay attention to the education and competencies of pastoral care workers, making sure they are trained to the highest standards. Information is also an issue that needs attention. As for the Emergency department the issue of aggression and self-care are vital areas of concern. In ICU the issue of families and resuscitation is both a moral and ethical issue that needs to be addressed. In the next chapter I will attempt to develop these issues further.

Chapter 3

The theoretical understanding

3.1

The well known ethicists Ashley and O'Rourke in their book "Healthcare ethics" (1997, p.130) state that, "Pastoral care has to be closely linked to the role of the nurse and the social worker; it adds depth to their firsthand concern for the patient as a person". They continue in another paragraph (1997, p.136), "the social aspects of healthcare depend upon individuals dedicated to preserving the dignity of the people they serve. This is truly the bedrock principle for formulating social policy and the organizations involved in healthcare". As I reflect on these statements I see that this is the bedrock for my development of this chapter. The motivation for any healthcare worker whether they be medic, nurse, attendant, cleaner, administrator is to take care of the primary needs of the individual patient in their care. The chaplain/pastoral carer has the same motivation but the focus is concerned with the spiritual, emotional and psychological needs of the patients.

3.2

Pastoral care: theories and concepts.

As we have seen in chapter two there are a lot of issues that come up from the point of view of the pastoral carer and the medic/nurse in the work place. To help develop this further I will deal, first of all, with the issues of pastoral care in a healthcare facility and then address the issue of pastoral care in ICU/ED departments. Then I will attempt to show how pastoral care can be of help in these departments. This is all

theoretical in nature. I hope that in chapter four when the results of the audit of the ICU/ED departments are finalised I will have a clearer idea of the areas of concern that are currently an issue at this time of insecurity and anxiety that is evident in the Healthcare sector during this present recession. This is an interesting time to carry out this work because the cry for help in the running of all healthcare facilities is getting louder and the painful truth is that no one is being heard. Can pastoral care as a concept in these facilities make a difference? Is it able to have a voice? The challenge is great, but the leaders are few to coin the phrase. According to Glen, Kofler and O'Conner (1997, p.80), "the person who cares is one who is present to another, especially in times of pain, loss and stress". I guess that the author of this publication was focused more on the patients in care, but these realities are also present in ministry to the staff in the hospitals and care homes where pastoral care has a role. Staff experience loss when someone whom they have cared for over a considerable length of time dies. They experience grief, emptiness, loss, anxiety at different levels. When they have had to deal with a difficult scenario that may not have gone well, there may be a question over their competence in work which can cause inner pain in their lives. Staff working in the ICU/ED departments, on a daily basis generally work under a great level of stress. This stress can come from having to deal with traumas, sudden deaths and difficult families. It can also come from internal struggles from within these departments. So as a pastoral carer these are areas that we can help to support people in. The only way that this can be done is if a level of trust can be developed between the chaplain and the staff members.

Psalm 111: 10, says, "The fear of the lord is the beginning of wisdom". This is a line that Dunne (1994, p.144) quotes in his work "Ethics for doctors, nurses and patients". He uses this to indicate that a chaplain can by way of his training help a person deal

with fear of their illness when the medics have been unable to alleviate the fear themselves. I think that Dunne is putting a lot of faith in the chaplain from this statement. But I guess that for him fear makes people become more realistic and knowledgeable not only about their illness, but also about their own destiny. In this way the medic/nurse can see that Pastoral care has a role not only in helping the patient but, also, in helping the person that cares for the patient.

One of the basic qualities of a pastoral carer is the ability to listen. Jerold O'Neil-Roussell (1999, p.72) highlights this when stating "attending is a necessary ingredient for listening". Developed this further on he writes (p.75), "when caregivers journey with people into the deeper levels of feelings, they become catalysts of change and transformation, bringing relief and new awareness through their listening presence - when carers are at ease with their own feelings, they provide comfort to others."

Again like a lot of authors in this field their ideas are focused on patients, but I think they, also, have value in dealing with staff. You have to experience the atmosphere in the ED, where to have someone listen to you as a staff member can be impossible at times. So if the time can be created and there is someone who has the time for you, then access to the pastoral team can be seen as a benefit. One of the concerns of staff is that they often feel they are not listened to. When they are they feel recognised, valued and even appreciated. Chaplains should never underestimate their role in this situation. The same can be said for being a listening ear to the ICU staff. The atmosphere in this department can be calmer. Staffs are one to one with the patient and as part of the intention of the department a calmer and tranquil environment is encouraged. This gives me as chaplain time to listen to the nurse/ attendant/ medic, especially when they are on night duty when it is relatively quiet and calmer. The important element in this aspect of pastoral care is that people do not want us to give

answers to the issues that come up. By and large people only want to be heard and they want to be listened to which is even more important. We should never as pastoral carers in this ministry try to sort out every one's problems. The temptation to do this could have disastrous outcomes. A nurse once said to me that the best chaplains that she ever knew were the one's that said little. She backed this up by reminding me that God designed chaplains to have one mouth and two ears so that we can listen twice as much as we speak! She herself practiced what she preached because she always had time for the patient's story when she cared for them. I feel she was spot on. Taking this to a deeper level Clarke/Seymour (1999, p.111) in, "Reflections in Palliative Care", say "the ability to relate to others, to listen and to be with those who face death were seen as perhaps more important in the context of a real world where religious convictions is only part of the richness of the human life and suffering". Those we work with may not have the same religious understanding as we do but they still have a role in the holistic care that we provide. The challenge for us is to see everyone as having a role and for us to value their role in helping us to carry out our care for others and for each other.

Brian Gough in his address to the twenty-first conference of the National Association of Hospital Chaplains (2003, p.52) stated about pastoral care departments, that "we take our place proudly alongside other healthcare professionals in providing holistic care to our patients. We have earned that place and that respect." He makes a key point here because in our role we are respected in the work that we do and we have to see that that respect puts us in a privileged position. It would be foolhardy to lose that respect in the way we carry out our ministry to patients, families and, especially, to our work colleagues.

As we conclude this section it is important to clarify the role of the chaplain/pastoral carer. Kirkwood (1995, p.xi) in his introduction sees the role as “a sincere desire to support and confront an ill patient, bringing hope, encouraging faith, stirring optimism, lifting inner tension, reliving depression and, by being there, are all part of Christ approved ministry,- “I was sick and you visited me”, in Matthew 25:36”. This notion can spread to the staff we walk alongside. Yet as a definition it is personally challenging. I want to bring hope, but I want it to be realistic. I want to challenge, but I do not want to confront. I want to take away the tension, but not at my own expense. I would have taken this idea of Kirkwood and ran with it at the start of my ministry, but as I have had a lot of experience and a lot of wisdom from that experience I would think that it is difficult to see this definition of my role as chaplain as being rolled out in the hospital I work in.

Before we take on the issues of the staff in the ICU/ED departments it is important to remember that Cobb (2005, p.38) sees that the link between the chaplain and the staff as having “good working relationships between the chaplain and the individuals in positions of responsibility. If there is harmony and mutual respect the work of the chaplain can be effortless. If not then it can be seen as arduous”.

3.3

Emergency department issues/concerns

For there to be a comprehensive overview of the main issues and concerns that are evident in the emergency department a thesis could be dedicated to this on its own. I, for my focus, will zone in on just two areas. It will be clear in chapter 4 from the comments in the audit of the departments what needs have arisen from a personal/wider perspective.

For the emergency department I want to look briefly at the issue of dealing with families at the time of resuscitation of a loved one and the issue of overcrowding in the department. These are by nature two of main stress indicators generated in an emergency department. They put all members of the team under tremendous pressure and as a result can make the working environment difficult for all that are involved in the department.

Resuscitation

According to the author P. Main in “The Journal for Critical Care” (2007, p.52) there are policies where families are present when active CPR (cardiac pulmonary resuscitation) is being carried out when the members of the family are present. There are pluses and minus’ to this practice. On the plus side it helps the family to see with their own eyes all the effort that is done to save a life, but on the minus side there can be a fear among the staff that this could lead to litigation aimed at the department if the experience created post-traumatic stress for a family member who found the trauma a difficult experience to witness. In this article continued by Patricia Main et al (2007, p.53) she writes “staff members also expressed concerns about their own emotional comfort when a patients family is present. Seeing the patient as part of a family unit could increase staff members stress and affect their ability to function efficiently during a crisis”. In “The Journal of Advanced Nursing” Kilcoyne, (2008, p.348) the studies of this practice found the same similarities. In their descriptive method on the minus side they uncovered tension between the doctor and the nurse on this issue. They concluded however that most staff members were supportive of the practice when family members are willing to be present. The reality which has been an on-going issue is that there is often a conflict of ideas around this practice between the doctors and the nurses in the department. This conflict creates its own stress and

compounds the situation even further. I would love to explore this further but that must remain a proposal for another day. The Pastoral care response to this can be seen at a practical level and at a personal level. On the practical level there is a need to have input from the pastoral care team concerning the implementation of policy and procedures on this topic and to give an ethical and moral view as to what is the correct procedure. On a personal level there is a need to create space for staff to be able to listen to each other as a team and to share their concerns on the issue. The pastoral care team could help to organise a gathering of all the main players on the team in order to deal with all the confused feelings that are present in the whole resuscitation experience.

Overcrowding

One of the most recent experiences of staff in the emergency department is overcrowding. This is due to a variety of issues; whether it is cuts in departmental budgets, amalgamation of healthcare faculties, increase in population, or the lack of availability of step down/long term beds. According to an article in the M. Kilcoyne in “Australian Journal of Advanced Nursing” (2008, p.22) the main issues are “lack of space, comfort care, and powerlessness with sub- themes being health and safety issues, lack of respect and dignity, nurse hovering, unmet basic human needs , not feeling valued, moral distress and stress and burnout”.

This was a very wide ranging research on the main reasons for overcrowding which I feel is as relevant to the Irish situation as it is to the Australian one. The conclusions reached provide “a distressing picture of nursing in the ED, as they pursue the provision of effective, holistic care of the patients in overcrowded conditions”. It is clear that there is frustration for the staff as they only want the best for the people that they care for and they feel powerless at not being able to give the care they want due

to the decisions of others who do not know the names of the staff in the department, not to mind that of the patients that come through the door. In a fit of frustration a staff member in a hospital in England put up a notice on the door of the department “abandon hope all you who enter here”; this was not only aimed at the patients and families but also at the management in that hospital. (It was taken down one hour later; you can draw your own conclusion to that). The same can be said to be true of the present situation in the health service in Ireland, especially in the large city hospitals.

The Pastoral care team can identify these issues and help others to do the same. There is a great need for self-care in all departments in the hospital, but especially in the ED department. It would be seen as a valuable contribution for the pastoral care team to collaborate with the occupational health division and the practice and development department in the hospital to help devise a self-care programme for staff who work and deal with stress on a daily basis in the hospital.

3.4

Intensive care department issues/concerns.

Intensive care by its definition is at times an intensive experience for all who work in the department. There are a variety of patients that can be cared for in this department, for example, there can be people who are recovering from extensive surgery, people injured in road traffic accidents (RTAS), people you have overdosed, people who have suffered from cardiac arrests, from a stroke (CVA) or from a brain haemorrhage (cerebral bleed). All of these patients need to have one-to-one care and management twenty four hours a day. All of which are covered by twelve hour shifts. The staffs have to not only deal with patient in their care but also they have to deal

with other external factors – medical personnel, bed managers, administration and anxious relatives, to mention but a few. All of these impact on the staff doing their work in the unit.

In my experience the issue of dealing with families is becoming more critical with every passing year. Relatives may have to watch their loved one in a ventilated state for a long period of time (a ventilated person is one who has a respiratory machine activated so that their body can rest from its normal function so as to aid recovery). The difficulty for a relative is that they are unable to communicate with the person due to the heavy sedation they are under. This causes anxiety and sometimes aggression which is aimed at the nurse who is taking care of the patient.

An article written by W. Walker in, “The Journal of Advanced Nursing” (2007, p. 623) states that there is a “fundamental conflict both between role expectations and patient care and between professional ideals and being human”. This not only highlights a disparity between nurses everyday family care practice and the underpinning theories, but, also, may contribute to occupational stress. The reality is to continue to implement best practice in the care of the patient is continually becoming a difficult experience. The solution to this is “effective planning of intervention to address family needs is fundamental as family members have been identified as essential decision makers during the patient’s illness”. The Pastoral care team can be effective here as a liaison between the family and the staff. By doing this they can defuse any hostility that is evident and generate a more harmonious communication between the two parties.

Patients are more sensitive to the environment that is around them in the hospital than they would be in their own home environment and as a consequence they are more tuned in to people's emotions than is normal. Even as an unconscious person is treated

they can subconsciously feel any stress around them, including the stress that is with the nurse that is taking care of them. According to L. Suen in the “Journal of Clinical Learning” (2008, p 2682) “nurses should have a better understanding of patients perceptions of the stressors so that the appropriate psychological support and reassurance could be given to the patient” and to a greater extent to the staff on the ward as well. The British association of critical care nursing suggests in their journal “Nursing in Critical Care”, (2007, p. 52-93), A.M. Samuelson suggests that “the life threatening illness, the acute stress reaction, the therapeutic procedures and the ICU unit environment are likely to cause discomfort to the patient and generate stress in the initial arrival of the patient”, which in turn is transferred on to the family/ relatives, which is also felt by the staff on the unit. The calming approach of the pastoral care team can help make the experience peaceful and therapeutic for all. One final comment on the question that is posed by the “Journal of Dimension of Critical Care Nursing” (2007, p.163) “what is the job satisfaction in the ICU “. As I analysed this article I was struck with the comment (p.165) that suggests “an increase in control over the pace of ones’ work should lead to a decrease in the prevalence of stress”. This can be encouraged to come about by the pastoral care team who could bring people together as a link between all the agents of care in the unit as to see how to deal with the generators of stress in the work place. The object of this would be to have some sense of job satisfaction on the ICU unit. The article highlights the following as areas of positivity for the unit, “ having a feeling of competence, being able to comfortably use ones knowledge, being aware of managements and colleagues appreciation of ones job and a greater interest and more self interest in the work were the aspects of satisfaction that significantly increased

after intervention”. Pastoral care can take a role as a model on intervention in generating job satisfaction in the ICU department.

“The International Council of Nurses Consultant Journal” (2008, p.35) in its research on this question from L.Suen who take the notion that “ a managers support has a significant effect on job satisfaction, because good relationships with managers are crucial for obtaining positive evaluations of performance and subsequently, job promotion”.

They continue this idea by suggesting that “relationships with co-workers can be an important part of job satisfaction. Friendship, co-operation and rapport with co-workers may relate to job satisfaction, while rudeness and toleration of poor job performance may lead to job dissatisfaction”. In my experience developing a good work relationship can make life better for everyone and can help make the experience for the ICU team a healthier one. The pastoral care team have their role in this as well and in turn the experience for the individual member of the team in the service they provide can be a positive one.

3.5 conclusions

It is clear from this short review that the Pastoral Care department can help the staff in both the ICU and ED departments address the on-going issues and concerns that arise for them on a regular basis. The challenge to the Pastoral Care team is can they meet this challenge or do they see it as a bridge too far.

As we have up to this point focused on the theoretical element of this study we will now gauge the opinion of the people on the ground. The audit and the comments and opinions that will flow from this will help us see what the role for pastoral care is in 2010. The second part of this chapter will give a detailed policy procedure document

for the overall pastoral care in the hospital with particular focus on the ICU/ED departments.

Chapter 4

May 2010

Chaplaincy Audit Report 2010

4.1 Background:

The Chaplaincy Audit was carried out over a 10 day period in May 2010, 50 questionnaires were circulated and there was a 68 % return rate. This according to the Practice Development Department in the HSE is a very high return rate for any audit, either clinical or administrative

I would like to offer my sincere thanks for such a high return rate as this should facilitate a quality improvement plan which is envisaged to enhance the quality of pastoral care to patients and staff.

Enclosed is a report of the facts and figures generated by the questionnaires collectively. As part of the HSE guidelines I was only allowed to contact 50 members of staff. As part of HSE recommendations no member of staff can make individual comments in an audit on any of their facilities/campuses.

This report is been circulated to the relevant departments in the hospital where the audit was carried out, this includes the General Management and Administration department of the total hospital complex.

The methodology used to collate the data was via a quantitative approach. This was so that the views of the staff on the Pastoral Care service could be captured. All participants who responded to this questionnaire were all active staff that is associated with the ICU/ED departments.

A series of 7 statements were made in the questionnaire with the participants been asked to indicate how strongly they agreed/disagreed with the statement.

This is known as a 'Likert scale' which is a recognised statistical tool used in quantitative research, to measure views and opinions of participants.

The information collected was treated in the strictest confidence and the participants will remain anonymous.

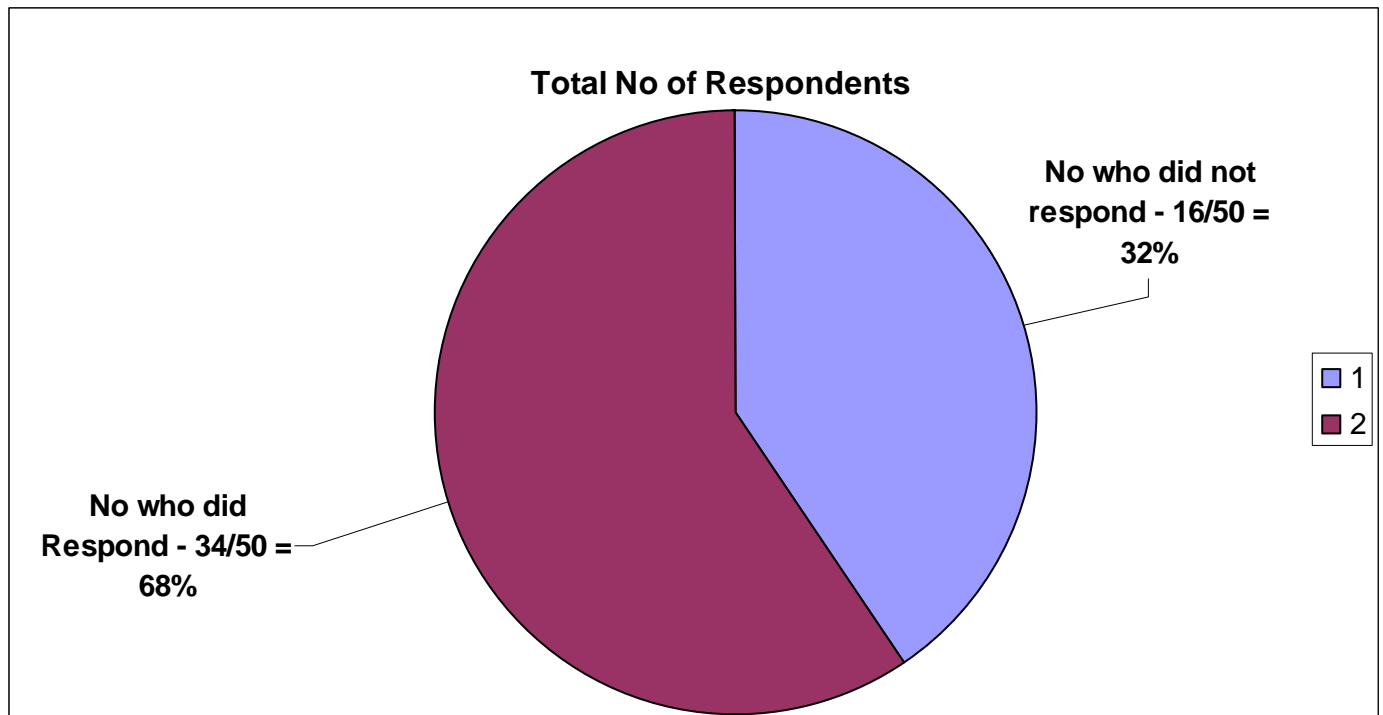
The information from this audit will be used to improve the quality of the care the Chaplaincy team provides by focussing on areas highlighted by the participants that may need change/alteration. This also fulfils the requirement of the MALPC programme (masters in leadership and pastoral care).

In this chapter I will give the information as correlated from the audit and present this in the format of diagrams and statistical breakdowns between the two departments. I will in chapter 5 take this information and see what recommendations I can deduce from it. I will, also, at the end of the chapter present a draft copy of a policy and procedure document that can be used as a help to providing pastoral care to the ED/ICU departments.

4.2 The audit

1. Pie Chart representing No of Nursing Respondents: 34/50

= 68% response rate



BREAKDOWN

Each department got 25 copies of the audit questions. The returns were the following.

ICU 19 RETURNS

ED 15 RETURNS

Analysis of the returns;

It is a given that in any audits in the HSE a return rate of 68% is considered as high and in reality this is the case. Even with only 50 audits sent out this is a good response. The breakdown on this is also good from the departments is high as well 76% from ICU and 60% from ED. For this study on each of the

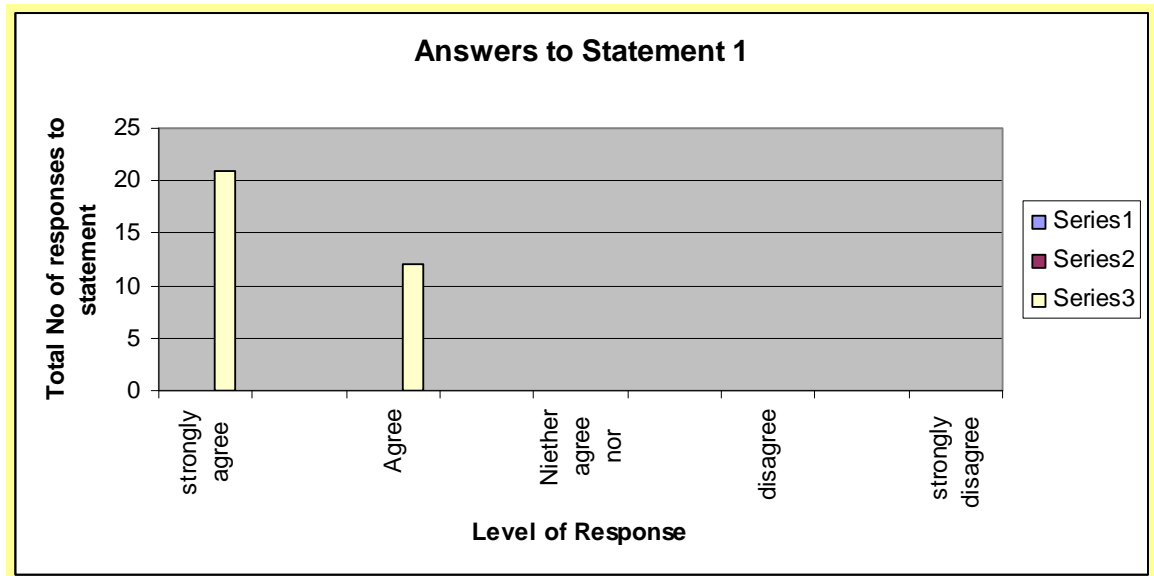
seven questions I will give a brief breakdown as to how I can see what the staff in each department felt about the impact of pastoral care on there departments.

For the purposes of Data Analysis the Likert scale is represented by the following numerical scale:

Level of Agreement/Disagreement	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
Numerical Value	1	2	3	4	5

Statement number 1

“The Chaplaincy Service is committed to providing a holistic approach of pastoral care to patients, families and staff in the ICU and ED departments.”



Final stats/breakdowns

21 strongly agreed

13 agreed

0 for the remainder

ICU 10/ ED 11

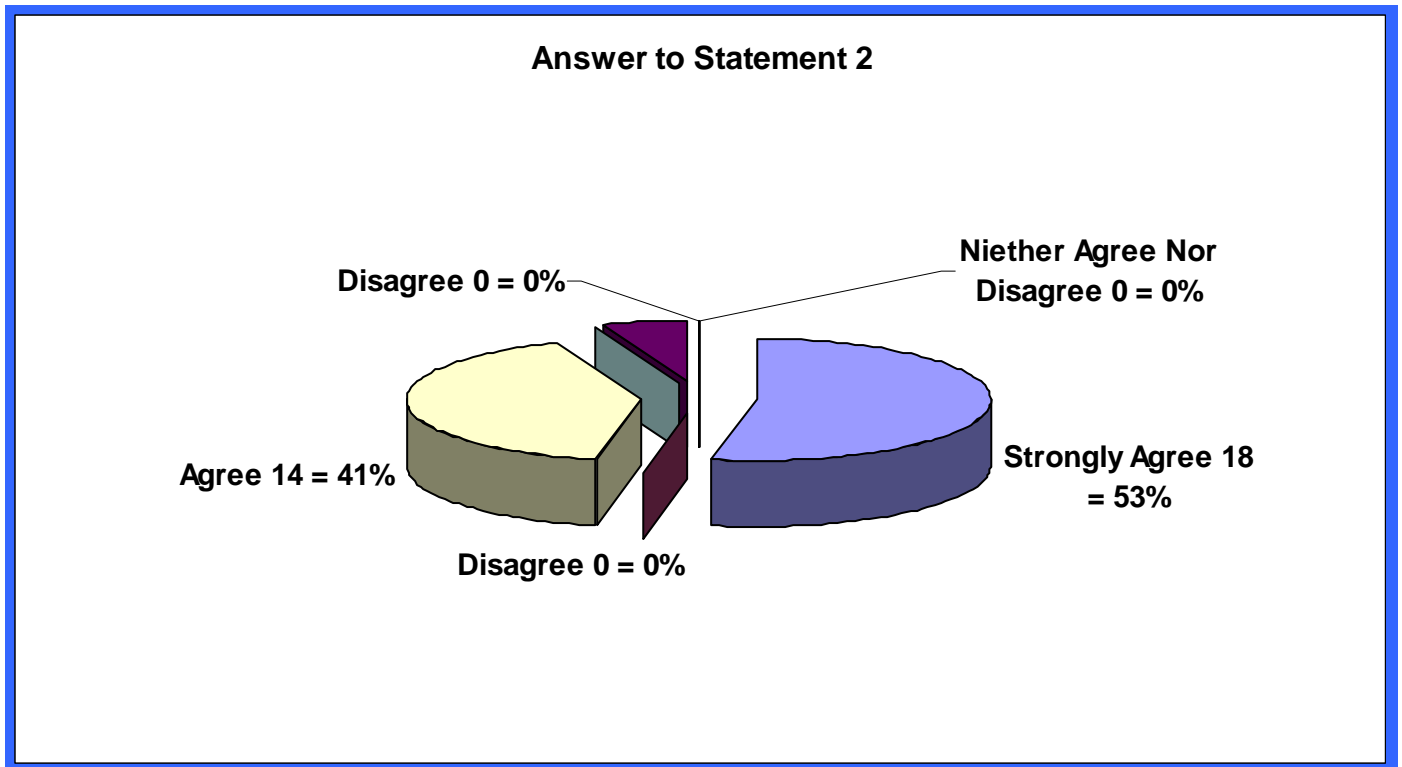
ICU 7/ ED 6

Strongly agreed 21, with ICU 10 and 11 ED; a strong acceptance that the holistic approach is evident in the pastoral care that is offered with 13 agreed, from ICU 7 and 6 from ED. This indicated that what pastoral care offers is seen as part of the general holistic care that is available to patients and all who use these departments. This is an encouraging sign at the outset.

Statement number 2

“That holistic approach that we use encompasses mind, body & spirit and is done through supporting and journeying with staff in ICU and ED departments

Responses



Final stats./ breakdowns

17 strongly agree

17 agree

ICU 9/ ED 8

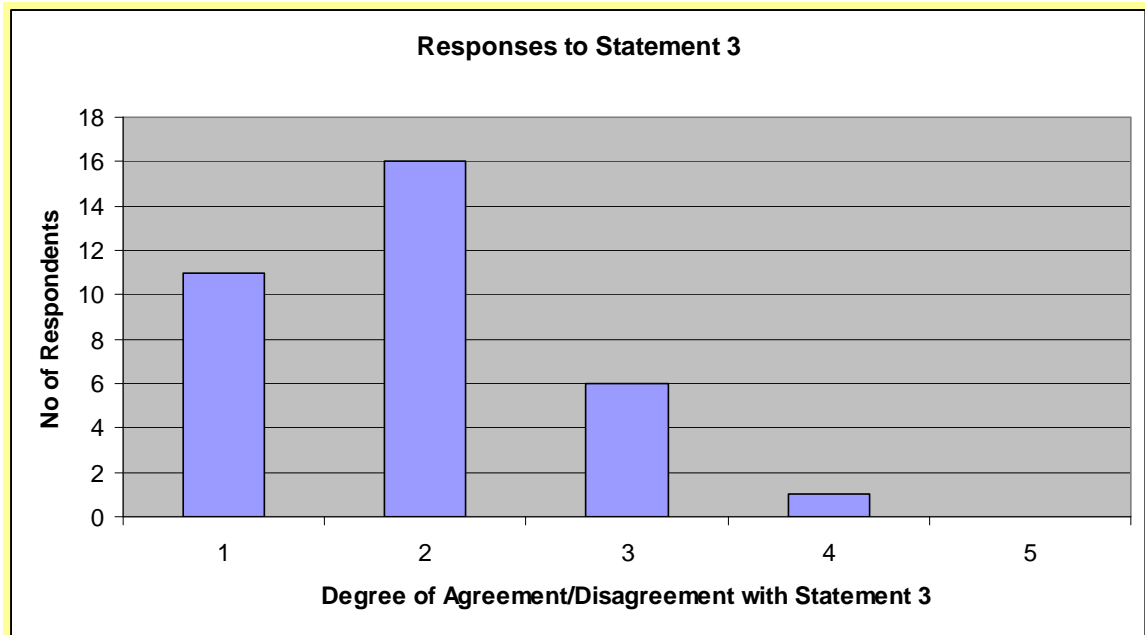
ICU 8/ ED 9

This question is a development of the original concept which is seen as very much in agreement within the department once again. This indicates that the work that is being done is acknowledged and is clearly having a positive impact on all that come in contact with the service.

Statement number 3.

“The chaplains appreciate that for staff in the ICU and ED departments in the hospital can be very challenging and stressful; in view of this the pastoral care team provide adequate support and reassurance especially in trauma situations.

Responses



FINAL STATS/ BREAKDOWNS

11 STRONGLY AGREE 13 AGREE 6 NEITHER 4 DISAGREE

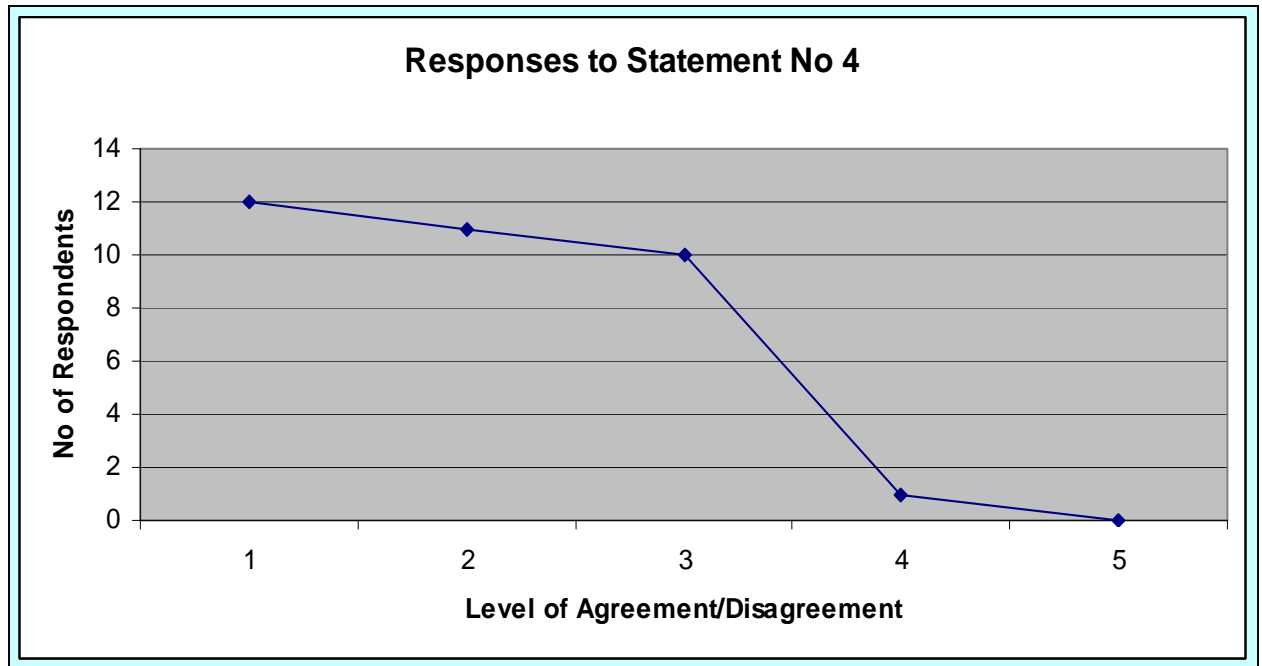
ICU 5/ ED 6 ICU 6/ 7 ICU 2/ ED 4 ICU1/ ED 3

This question has a more spread out response. 11 strongly agree and 16 agree says that this question meets the needs of the staff in certain quarters but there is a need to understand why 6 neither agree and 4 disagree. Clearly there must be areas where we can be a better support to people in the departments. If this is to be addressed it needs some intervention with the line managers and the head of the pastoral care department.

Statement number 4

“We meet; support and comfort staff in ICU/ED when they have concerns or issues in relation to pastoral care of patients and families, and we assure them of our prayers, and attend to their spiritual needs.

Responses



FINAL STATS/ BREAKDOWNS

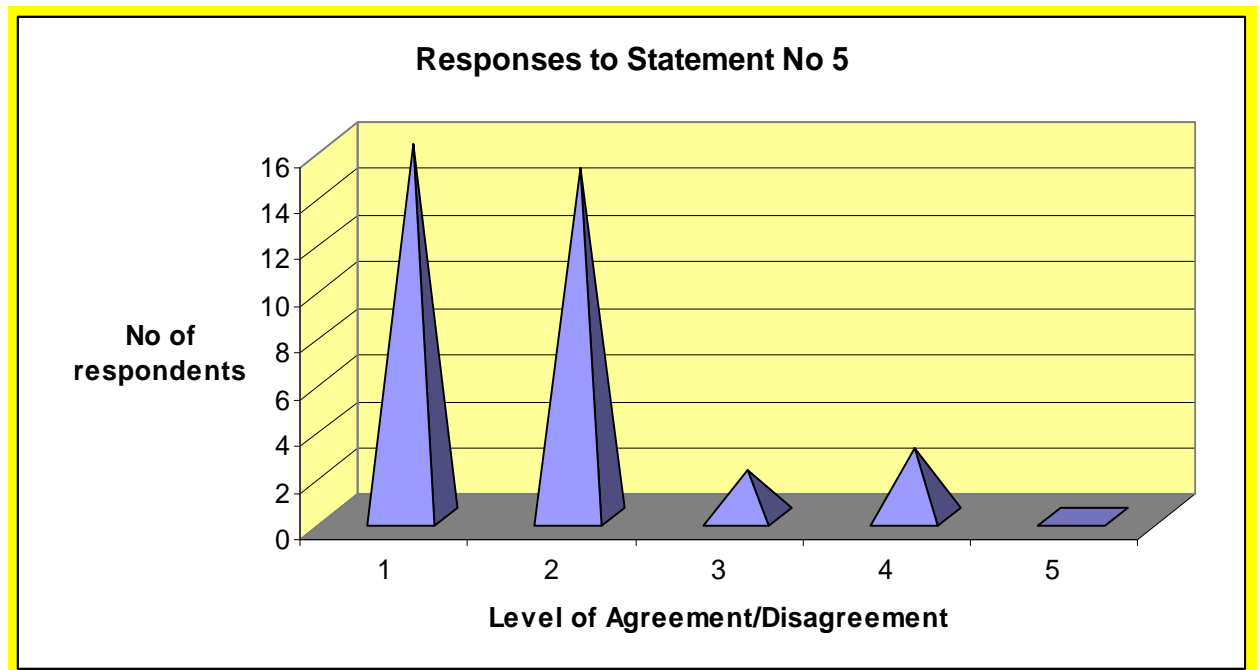
12 STRONGLY AGREE	11 AGREE	10 NEITHER	1 DISAGREE
ICU/5 ED 7	ICU 6 / ED 5	ICU4/ED 6	ED1

Again a pattern develops here in this question. The broad understand of the spiritual support is accepted; however the fact that 11 people were unsure and one disagreed is a cause of some concern. Do those 11 believe that pastoral care does not sustain their spirituality? If this is the case, taking this as just a cross section of respondents, the need to look at how we attend to spiritual needs of the staff may need to be reviewed.

Statement number 5.

“Our presence in the ICU/ED departments helps to show the hospitals commitment to multidisciplinary care and we feel we play our part, especially in dealing with families of patients who are ill”.

Responses



FINAL STATS/BREAKDOWNS

15 STRONGLY AGREE. 14 AGREE. 1 NEITHER. 2 DISAGREE. 2 NO
REPLY

ICU 7/ ED 8

ICU8/ED6

ED 1

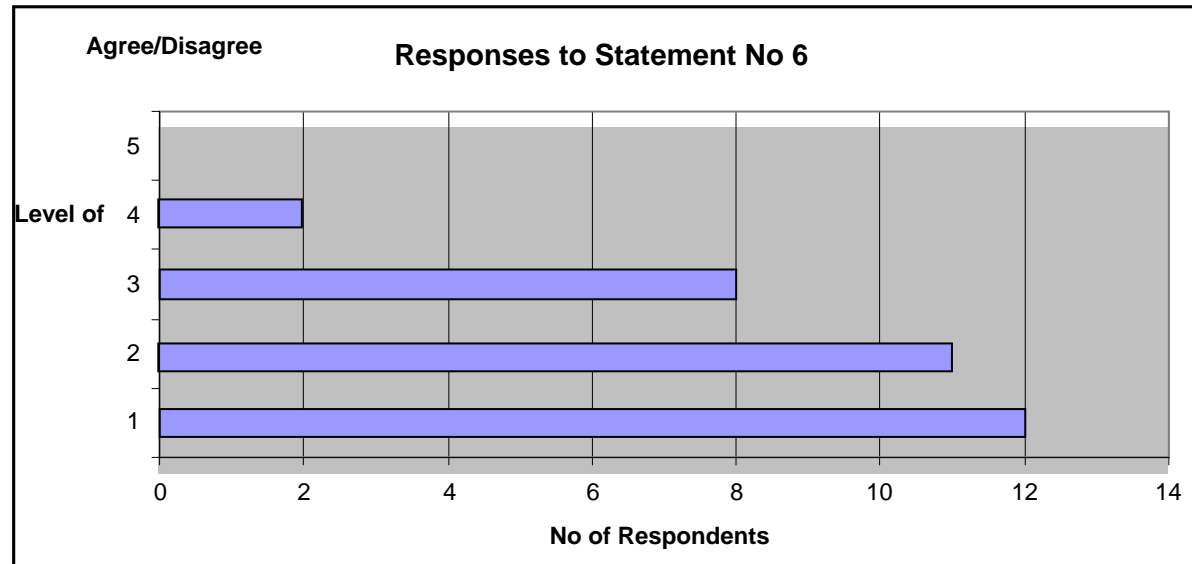
ED 2

The area of multidisciplinary approach is seen as a high agreement which is encouraging. This indicates that pastoral care as a concept is integrated in the running of the ICU and ED departments. This has only come about as a result of a good on-going working relationship with the chaplains' in the department that have been surveyed.

Statement number 6.

“We promote Pastoral Care through the support and education of staff and volunteers.”

Responses



FINAL STATS /BREAKDOWN

STRONGLY AGREE 12 AGREE 11 NEITHER 8 DISAGREE 2. 1 NO
REPLY

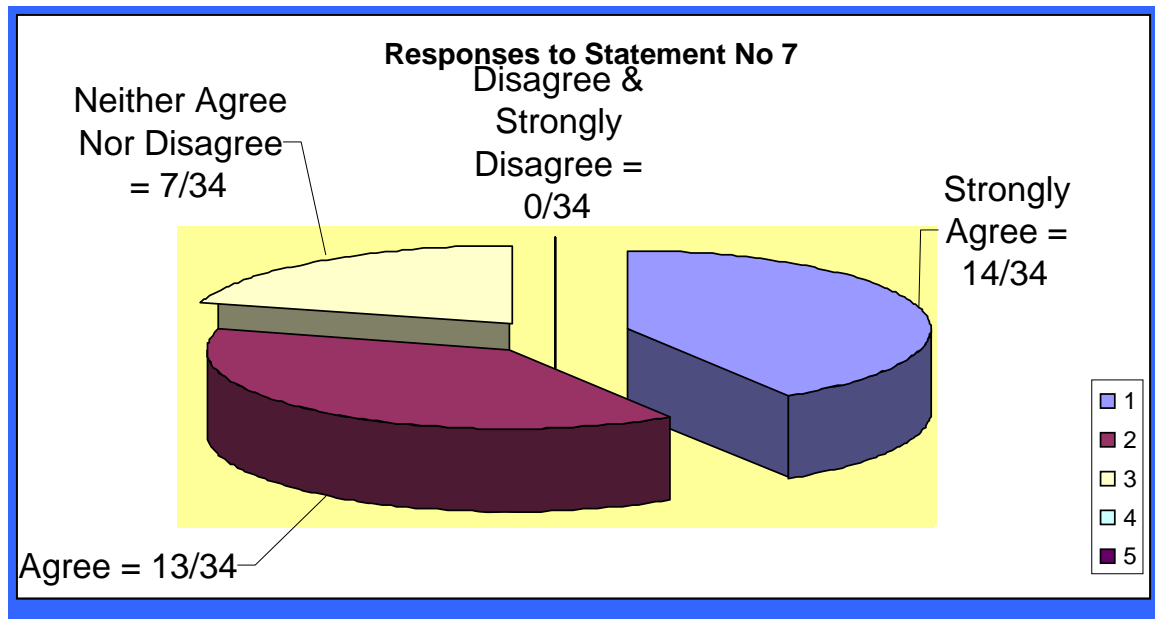
ICU 7/ED 5 ICU4 ED7 ICU4/ED4 ED 2

This is a question that has a very even response across the board. It is clear that a lot of work has been done in informing staff through education, but there is a clear invitation from the staff to look at this more in detail. If more staff knew more about the pastoral service that is provided then multidisciplinary care would be enhanced a great deal.

Statement number 7.

“We provide a comprehensive pastoral care service to all staff working within the hospital especially in time of personal need and concern”

Responses



FINAL STATS/BREAKDOWN

14 STRONGLY AGREE 13 AGREE 7 NEITHER 0 THE REST

ICU 7 ED 7 ICU 4/ ED 9 ICU2 ED 5

As with the previous question this has also given an equal response to the idea that we help all staff. There is a belief that we do help all levels of staff but there needs to be a review as to see how everyone is cherished by the chaplaincy team. The respondents have given a mandate to the pastoral care department to integrate themselves in ED/ICU and to develop there service for the betterment of these acute departments in the hospital

14.3

Policy and procedure document for ICU/ED departments

The following are recommended guidelines for dealing with ED/ICU departments that can be part of a policy and procedure document for pastoral care in a hospital. As part of this body of work I want to insert a section on the value of having in place policies and procedures as a guideline to developing a pastoral care department.

According to the guidelines from the HSE a policy is a high level plan of action which outlines a principle that governs activity and which individuals are expected to follow. An effective policy – making process needs to encompass three key themes: - vision, effectiveness and continuous improvement.

To be effective it has to be the following

1. Forward-looking; it must have a vision that can be followed up over a sustained period of time
2. Outward looking; take into account global considerations and experiences.
3. Innovative and creative; looks at the area that it deals with and encourage fresh and creative thinking.
4. Evidence based; uses all the information that it can source
5. Inclusive; involves all the stakeholders in the process
6. Joined up; takes a holistic approach, going beyond the boundaries that exist while respecting existing guidelines and structures.

7. Review; keep in the vision existing policies and see them as part of the development
8. Evaluation; the policy must be designed in a way that it will be effective immediately.
9. Learns lessons; learns from experiences what works and what does not through systemic evaluation and review.

4.4

The following are guidelines for pastoral care policy and procedure in ICU

Patients and families in the ICU require ongoing and consistent pastoral care as they experience life treating crisis and events

Objectives

- A. To provide immediate pastoral care, chaplains are available 24/7.
- B. To ensure that patients and families receive the highest standard of pastoral care in this acute department.
- C. To enable patients and families deal with the existential questions raised by critical illness.

Procedure

1. Chaplains visit patients in the ICU on a daily basis
2. The chaplain can be contacted when a patient is in distress or anxious, worried, or given a poor prognosis, or when family or staff need support.
3. The chaplain assesses the spiritual and religious needs of the patient, family of staff and responds appropriately with support, prayers and the rituals of the church.
4. Visits are noted on the care plan of the patient
5. Chaplains arrange follow up visits.

4.5

The following is policy and procedure for pastoral care in the ED

The service delivered in the ED is by nature demanding and stressful. The pastoral care teams are available to minister to patients, family members and staff.

Objective

To ensure that families and friends are offered quality pastoral care during their stay in the ED.

Procedure:

1. Nursing staff contact the chaplain:
 - When someone is dealing with a life treating illness
 - When a patient or family member requests the support of the chaplain
 - When some one dies
2. The chaplain makes themselves known to the staff member and obtains the relevant information
3. The chaplain offers support to the patient, or family member
4. The chaplain assesses the pastoral need of the patient and plans an appropriate response.
5. The need may be to just offer support through being present with compassion and sensitivity.
6. If the sacraments are required, then the visiting chaplain facilitates the administration of the appropriate sacraments
7. Support of family members is perceived as crucial as they cope with the shock and distress experienced by sudden illness, accident or death.

8. If a family member wants to spend time with the dying person, the chaplain facilitates this in negotiation with the staff in the ED
9. The chaplain remains available to the family and staff during any crisis.
10. When the patient dies, the chaplain gathers the family around the body and offers prayers for the dead, if requested to by the family or staff
11. After the death the chaplain remains available to offer support to all involved.
12. The chaplain provides information regarding the chapel of rest and practical guidelines for organising the funeral.
13. The staff members in the ED need the support of the pastoral care team.
14. If the staffs need debriefing then the chaplain in conjunction with the critical nurse manager on duty, facilitates this.

In reality the above guidelines can merge into one overall policy as they would be of help to the two departments.

The last chapter will deal with recommendations and conclusions in the area.

Chapter 5

Recommendations and conclusions

5.1

Introduction

As I come to the final chapter I have to say I am aware of the needs of the ED/ICU staff now more than ever. I believe that the role of pastoral care is a great untapped resource that needs to be resourced and developed to meet the needs not only of the staff in these departments, but, also, the needs of the wider hospital community. It is evident that pastoral care is just one of many solutions that are needed in the care of the staff in acute areas in the hospital. I hope as I bring this work to a conclusion I will be able to point out ways of improving the service and, hopefully, make it more relevant to the people who use it. The climate that this work is been done in is varied. One the one hand, you have staff working in a stressful and demanding environment, while on the other hand, you have people with vision and determination trying to developing the services that they provide. I wish to acknowledge all of these elements as I conclude my work.

5.2

Main conclusions.

The levels of stress in each of the departments is evident not only in the literature and theoretical review but it also comes out in the audit that what pastoral care offers is vital in helping staff to cope with the day to day stresses of the working day. In the ICU department the intensity of 24 hour care of patients (usually split in 12 hour shifts) can affect the staff in their care, especially the nurse in charge of the patient. What makes it more difficult is the interaction of the family members with the staff that causes anxiety not only for themselves and the patient but also to the staff. On

many occasions' the patient is on the ward for a long period of time and this can cause the family to become impatient and tired and can make them act irrationally. This can, at times, make the staff members feel intimidated which is not helpful. Pastoral care could be an intermediary in these situations and help create harmony for all involved. The issue of end-of-life decisions can often cause a crisis in conscience and give rise to ethical concerns. The nurse has to deal with areas of resuscitation and can at times be in conflict with the consultant in charge of the patient. This is an area where pastoral care can be a support.

For the ED department the main issues are traumatic death and the on-going issue of overcrowding in the department. The overcrowding which is a regular occurrence builds up stress in the ED. Patients become impatient while waiting to be seen. This has a knock on impact on the relatives who feel the anxiety of their loved ones and they transfer this anxiety onto the staff sometimes in a violent, aggressive and inappropriate way. Pastoral care could support staff here and calm any anxiety arising in the waiting areas under the guidance of the staff.

Traumas and death by themselves can have the biggest impact on staff. The affects are way beyond the clocking of time. A need to create a space for staff working in these areas could be looked at.

5.3

Implications of the findings

I am only able for the purpose of this study to deal with just some of the concerns expressed. The overall need is to develop the pastoral care service so as to meet the concerns of the staff attached to the ICU/ED. This will mean additional resources and personnel. If these issues are not dealt with the pressures on staff will continue which in turn will cause stress induced illness and hence time off which, in turn, will put

more pressure on the wider resource of the general hospital. The findings highlight that as the society we live in grows older the demands on the services will be greater. Pastoral care has a role to play in addressing the issues named and it is important that it develop a role of support and fraternity with the members of staff who are at their most vulnerable.

5.4

Expected and unexpected findings

I was not all that surprised with the issues that came up in this research. I was always aware of the ED concerns around overcrowding on the department and the issue of trauma of varying kinds arising from deaths that are unexpected or dramatic. I was however surprised to learn about the resuscitation issues mentioned by the Advanced Journal of Nursing (2003) in chapter 3. The article talks about the level of unease that can arise between the doctor/consultant and the nursing staff in coming to an agreement as to what is the best way forward in the event of a decision having to be made about the resuscitation status of a patient. I deal with this reality on a regular basis and I was never aware of there being an issue around this. I am now more tuned in to this. I have seen situations where there was a difference of opinion between the various parties involved in the care of the patient as to their future medical treatment. In regards the ICU I was aware of the external factors that impact on the care of the patients. However I have become more understanding of the particular issue of dealing with the relatives of the patient. This can cause high levels of stress to individual nurses and they can be very vulnerable when having to deal with disappointed/ angry relatives who question the care of their loved one and who may not be able to hear that the person that is in the care of the ICU department might not survive the surgery or accident that they have been in. If the pastoral care department

becomes more aware of this issue then it can help take the pressure off the staff and help them focus on the individual needs of the critically ill patient.

As a result of the audit itself as an overview exercise I was happy with the responses and the participation. 68% is very high in the HSE for an audit and that is a validation of support for the department from the units that took part. I was surprised at the fact that on education awareness we do not make an impact as well I would have liked to have seen. There is a need to create awareness of the needs and effectiveness of pastoral care to the staff. Better vision and resources in the pastoral care department may help address this concern. If I had time to broaden this I would think that some people may feel left out by the chaplaincy department and that should not be the case. This shows a weakness in the effectiveness of the service. The consoling fact is that it can be resolved with some creative thinking and a clear vision as to how pastoral care can be more effective to ALL staff in the relevant departments. The challenge is are all the agents for change willing to step up and make this happen. That is the big question.

5.5

What are the findings regarding the literature.

The literature discusses and reinforces the 'myths' that are associated with the departments in question.

Helen Orchard (2001) believes that if pastoral care engages with the management of the hospital in a positive and forthright way then it may be seen as important as the medical/surgical department in the hospital. This is an issue that all pastoral care teams must address. If they do not then their role will diminish within the hospital and eventually they will be marginalised or worse phased out. History will not be kind to the chaplaincy departments if they do not step up and make change possible.

In the ED department the evidence that the department can be a dangerous area to work in is accepted by Lynn (2009) who points out that the stress of waiting is a catalyst for aggression and can spill out onto the staff in that department. This is backed up by the anecdotal accounts from ED department's world wide. The solution is to put in place systems that take the stress out of waiting, for example, bigger and brighter waiting areas for people to gather in with calm music in the background. Pastoral carers are trained to see the value of a calm environment and this training could be a help in creating a good ambiance in the waiting area.

Finally in the ICU Johnson (1998) discusses the issue of family dynamics and how complicated they have become for modern families. Consequently pastoral carers need to deal with family dynamics as part of their ministry to the families they meet in ICU. The pastoral care team could develop in-services training in helping staff with breaking bad news or in understanding the complexities of family dynamics. These are only a few of the issues that are dealt with by the literature on this topic.

5.6

Strengths and weakness of this study

I began this study over six months ago and I have found it to be stimulating and challenging. It has given me a personal conviction that the work we do in hospital chaplaincy is necessary and the evidence from the research and audit reinforces this view.

As strength the study shows that when staff is in need of help the role of the chaplain is important and that that role must be seen always as part of the multidiscipline and holistic care of the particular hospital. The issues of concern around stress in overcrowded EDs and dealing with the impact of traumas on the staff of these departments is considered an important issue for the pastoral care teams to deal with.

Likewise the ethical issues of resuscitation and working with families in the ICU department is an area that the chaplain can have a role in addressing, for example, in giving an opinion on ethical concerns or helping staff address family issues and concerns. This study shows the role of pastoral care is on the agenda of the staff not only on the ED/ICU departments but also right through the hospital.

The weaknesses are in the result of the audit. The audit is taken from a small section of the personnel in each department. As part of the HSE I had to follow guidelines that are set out and have to be followed very strictly. I was unable to get a comment from the participants as the guidelines state that I cannot ask any personnel to comment on their department as it may have a negative affect on the moral of the department. This meant that all I got was a quantified response which is fine but it does restrict the richness of the findings. The other area that I could not fully address was that of the spirituality of the ministry that pastoral care does. Even though this is the foundation of the work of pastoral care I could not raise it with staff as one of my major concerns in the audit. I went along with the HSE guidelines on this. I feel that pastoral care as a concept is expected by the management to deals with the emotional issues of staff in isolation rather than seeing the spiritual dimension as part of the overall package that we offer.

5.7

Further ideas on research.

There are three ideas/issues that came up within these two departments that are also linked to pastoral care. The first one is the way we break bad news to patients and/or their families in the ED/ICU departments. It is vital that this is done in the most appropriate way. As a colleague of mine once commented, "If you tell bad news well you will always be remembered, but if you tell bad news badly you will never be

forgotten”. If there was ever a true word spoken then that was it. Research into what constitutes good communications in giving bad news would be invaluable.

Secondly, a study into the integration of spirituality and ethical concerns would be a great asset to staff in these two departments. It would give them a better understanding of the major ethical and religious concerns that people have when they come into the care of these departments.

And finally there needs to be work done in the area of the self-care of the staff both in these departments and also in the pastoral care team. There are two groups of people who as patients are difficult to deal with, namely, healthcare workers and religious. I know this not from research but as a personal fact. When they are patients they want to be discharged ASAP, their own needs come second to others. This is a noble act but we are no good for others if we do not take care of ourselves. Developing programs of self-care for all personnel is a must as the pressure builds on the health services but this is especially true for people working in the ED and ICU departments of the hospital.

5.8

Has this added to my present awareness?

This work has been a major learning curve for me. I have up to now kept to my own discipline as chaplain and I never really integrated my work into the middle of the ICU/ED departments. I now see that my work is appreciated by many and it is also clearer that it was for me what people have to deal with on a daily basis. I guess that as I only dropped in and out of these departments when required to I never really felt part of the intensity of the work in these areas. I have through my reading and the audit and my own personal reflection been able to see what it is really like for staff and how for a greater part of my work with them I have taken them all for granted.

I, also, have been able to reinforce my own view that this is a job for a number of people in a team, not just for one man on his own personal quest in seeking recognition for pastoral care in the hospital campus. The work as a whole is a major learning curve for me and I hope it will also have the same impact all who read this work. Pastoral care at the moment is not given the recognition it deserves and I hope that after reading this work there maybe a better awareness of its role in the health care services.

5.9

Implications

For far too long while the role of the chaplain has been seen as important it has by in large been invisible to most. The fact is that as people who care for people who are vulnerable we need to be seen as a professional group of people. Work in a professional manner, act in a professional manner and be treated in a professional manner. This is a challenge that may be hard to meet but must be done. It means working in an environment that is compliant with good work practices. It means setting up structures that comply with health and safety guidelines. It means that self-care policy and procedures are acted upon. And most of all that the dignity of all the people who seek pastoral care services are respected.

I feel that as I come to the end of this work a great sense of achievement. As a journey in life this has been a challenge for me but also an exciting encounter. I hope that this study will be a help to others who may read it and that, above all, it will be a help to the personnel in the ED/ICU departments to whom the study was aimed at.

In the word of my late father when Cavan won the Ulster championship

“That is they say is that”

Appendices

Copy of the questioner

The proposal;

A research study into how the pastoral care team are meeting the needs of the medical staff in a general hospital required from the pastoral care team the emphasis on ICU/ED personnel.

The aim;

Is to see how effective the pastoral care team are in helping the staff in ICU/ED departments in the day to day concerns and issues.

The assumptions;

The reason why this work is being done is that I believe that pastoral care is part of holistic care and that it is important for pastoral care to be part of the fabric of the hospital I a multidiscipline, holistic teams especially in acute areas of ED/ICU.

Layout;

In this research I will attempt to get the overall impression of healthcare pastoral care as it is practiced in a hospital environment. As I develop the work I will explore the relevant literature on the subject and then focus on few main bodies of work in regards to pastoral care. I will then design an audit under the HSE guidelines in order to gauge the pastoral care issues that staff have. I will develop a draft policy and procedure document with in the body of work to give guidelines as to best practice in pastoral care. This is essential in all chaplaincy posts that are involved in state organ actions. Finally I will give guidelines and recommendations as to the way forward for pastoral care in the hospital the work is being carried out in. I have the support of the relevant heads of departments and management in the hospital and copies of same are attached.

The design of this audit is laid out in a way that you are not expected to identify your self. The information will be a part of the overall thesis and as such does not require individual participant's identification.

AUDIT 2010

For thesis requirement for MALPC (masters in leadership in pastoral care.

Chaplaincy Service

Thanks for taking the time to complete this survey. The purpose of this exercise is to **examine** the effectiveness of the chaplaincy service in Cavan general, with the view of developing **and improving** this service. This audit will have a two fold affect. It is part of the requirement for completion of my MALPC (masters in leadership in pastoral care) under the umbrella of DCU and ALL HALLOWS COLLAGE. Also it will be a help in future development of the pastoral care department in the hospital.

All comment is in confidence and no participant needs to be identified.

Mission Statement

The Chaplaincy Service is committed to providing a holistic approach of pastoral care to patients, families and staff at Cavan General Hospital

Our policy statements: each statement is the questions that will be asked. They will respond to them on the scale recommended. Seven questions in all. At the end of each question they will be asked to make further comments.

Attached below is the Audit tool that will gauge our present service, with a view to improving and developing it.

Ground Rules of this Audit:

- The Audit is completely anonymous and confidential. This is to allow participants to be honest and frank in answering the questions asked.
- The Audit will use an evidence based tool to measure your opinions stated. This is to valid the findings. The tool is called a 'Likert scale'.
- Norman – here's some background stuff about likert scales:

The Likert scale

Principle

The Likert technique presents a set of attitude statements. Subjects are asked to express agreement or disagreement of a five-point scale. Each degree of agreement is given a numerical value from one to five. Thus a total numerical value can be calculated from all the responses.

Presentation

The questionnaire can be produced very rapidly on a spreadsheet package:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
For each of the statements below, please indicate the extent of your agreement or disagreement by placing a tick in the appropriate column					
1. Criminals convicted of murder should be hanged					
2. Trial by jury should be abolished					

This allows you to transfer the data from completed questionnaires straight to the spreadsheet, which allows rapid calculation of results. You could also invite respondents to enter their answers directly at the computer.

Alternatively, a word processor allows rather more flexible presentation:

Piloting

It's generally a good idea to run a pilot survey so as to eliminate any ambiguous statements, negative statements or statements which might seem unduly 'leading', such as the use of the word 'criminals' in the first example above.

Validity test

In principle, it's a good idea to run the test on a group whose attitudes are known. For example, you would expect British National Party members to score negatively on attitudes to ethnic minorities. If they don't, there's something wrong with your survey. If they do, then your test is valid. In practice, though, it's not always easily possible to find such a group.

Content validity

You should, if necessary, ensure that an expert in the field you are dealing with checks out the content validity of your questionnaire.

The second format is in the following style.

Audit questions:

Overall concept of pastoral care:

The pastoral care team is providing a service in Cavan General Hospital for the past 21 years. At this stage we are interested in finding out, how you find the service and can we improve it. We value your opinion and the opinion of your staff. Perhaps at the next ward meeting you would read these statements and offer your opinion.

The mission statement and policy we are setting the seed for the development and enhancement of chaplaincy. We have come a long way from a priest on call in the parish 6 days a week to the present stage of having 2 priests on call dedicated to the needs of the hospital solely.

However we recognize that there is a process that must be acknowledged, so the service must keep up with these new demands. In cooperating with this audit you as staff will have a say as to how we can move forward.

I hope that when we have this audit completed we will be in a strong position to implement the national association of hospital chaplains , “ Guidelines for Best Practice in Healthcare Facilities”, which will, in turn, help to set in place a policy and procedure for chaplains specifically for Cavan general hospital and its related care facilities. I also appreciate the help with this in regards the thesis that I am working on for my MA

I consent to participate in this audit ☐

Statement number 1 “The Chaplaincy Service is committed to providing a holistic approach of pastoral care to patients, families and staff in the ICU and ED departments.”

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree

Statement number 2 “The holistic approach that the chaplain use encompasses mind, body & spirit and is done through supporting and journeying with staff in the ICU and ED departments

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree

Statement number 3. “The chaplains appreciate that for staff in the ICU/ED departments in the hospital can be very challenging and stressful; in view of this the pastoral care team provide adequate support and reassurance especially in trauma situations”

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree

Statement number 4. “We meet, support and comfort staff in ICU/ED when they have concerns or issues in relation to the pastoral care of patients and families, and assure them of our prayers, and attend to their spiritual needs.”

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree

Statement number 5. “Our presence in the ICU/ED departments help to show the hospital’s commitment to multidisciplinary care and we feel we play our part, epically in dealing with families of patients who are ill”.

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree

Statement number 6. “We promote Pastoral Care through the support and education of staff and volunteers.”

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree

Statement number 7.

“We provide a comprehensive pastoral care service to all staff working within the hospital especially in time of personal need and concerns”

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree

Is there any areas that has not been covered and you would like to comment please use this space to do so

On behalf of the pastoral care team in the hospital we are grateful to you for taking time out to assist us with this audit. I hope that this can be done over the next two weeks. The complete results will be part of my thesis for the MALPC that I am completing this summer. . Many thanks for your help.

Fr Martin Gilcreest
Chaplaincy audit 2010



CONSENT FORM FOR PARTICIPANTS IN A RESEARCH PROJECT

You are being invited to participate in a research study entitled

PASTORAL CARE FOR ICU/ ED staff,

That is being conducted by FR MARTIN GILCREEST

Who is a student/ graduate student at All Hallows College required to conduct

research for a degree masters in leadership in pastoral care

Under the supervision of ... Norman Jennings

Contact number of College: 01 837 3745

The student will provide you with fuller information about the research study, including its purpose, procedures, and participation, as well as the arrangements for confidentiality, anonymity, and the preservation of privacy. Participation by organisations or individuals is entirely voluntary, and a participant is free to withdraw at any time. If you have any questions, please feel free to ask the researcher, or contact the supervisor. This project has been reviewed and approved by the Programme Board for the degree and the Research Ethics Committee of All Hallows College.

I freely consent to my participation in this research project.

Signature

Name in Block LettersDate.....



**CONSENT FORM FOR A PARTICIPANT ORGANISATION IN A
RESEARCH PROJECT**

Your organization Cavan general hospital is being invited to participate in a research study entitled:

Pastoral care for ED/ICU staff

That is being conducted by Fr Martin Gilcreest

Who is a student/ graduate student at All Hallows College required to conduct research for a degree in MA in leadership in pastoral care

Under the supervision of NORMAN JENNINGS

Contact number of College: 01 837 3745.

The student will provide you with fuller information about the research study, including its purpose, procedures, and participation, as well as the arrangements for confidentiality, anonymity, and the preservation of privacy. Participation by organisations or individuals is entirely voluntary, and a participant is free to withdraw at any time. If you have any questions, please feel free to ask the researcher, or contact the supervisor. This project has been reviewed and approved by the Programme Board for the degree and the Research Ethics Committee of All Hallows College.

I consent to the participation ofin this research project.

SignatureOfficial Position

Name in Block LettersDate.....

Information leaflet;

Dear participant,

I would like if you could participate in the following audit on your ward. I am at present completing an MA in leadership in pastoral care. As part of this I am attempting to carry out a thesis entitled “pastoral care for ED/ICU staff. The idea behind this is to see how affective pastoral care is in working along side the members of staff in your department. The results of which I hope will help all involved to see how pastoral care is part of the holistic/multidisciplinary approach. And it is hoped that it will also serve to enhance the service in the departments that it is carried out in.

If you wish to ask myself more about this I am contactable on bleep 168 for any clarification. I appreciate the cooperation of your line manager/ CNM in this project and most importantly yourself as part of your team. When you have completed this audit please leave in the marked box in the staff room as soon as possible

Once again

Many thanks

Fr Martin Gilcreest

Director of pastoral care

Cavan general hospital

Fr Martin Gilcreest
Director of Pastoral Care
Chaplains Department
Cavan General Hospital

2nd

November 2009

Re: MALPC.

Dear Fr Martin

I am happy to support you in your endeavours to provide pastoral care to staff at our hospital and I agree with the approach you have outlined.

If I can be of any further assistance to you please let me know.

Yours sincerely



Eddie Byrne
Director of Nursing

Dear Fr Gilcreest

I am in receipt of the changes from you as recommended by the **Healthcare Research Advisory Committee** (HRAC) and wish to advise that Dr Declan Bedford has had an opportunity to review same.

I note that ethical approval has been granted for your above study by the Ethics Committee, All Hallows College.

I can confirm that you have met all the conditions of the Committee and you may commence your study.

This will be formally noted at the next HRAC meeting.

A formal letter will be issued to you in the near future.

Kind regards

Eimear Dowling
Research Ethics Administration
Tel: 046 9280556

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