

Implementing spiritual care at the end of life in the Republic of Ireland

As part of our occasional series on spiritual care in Europe, **Fiona Timmins, Maryanne Murphy, Nicolas Pujol, Greg Sheaf, Sílvia Caldeira, Jacqueline Whelan, Elizabeth Weathers and Bernadette Flanagan** describe spiritual care service provision at the end of life in Ireland

Religious chaplaincy services have a long history in the Republic of Ireland (ROI). The National Association of Healthcare Chaplains (NAHC) was set up in 1981 to provide guidance and representation for professional chaplains. As early as 1985, the need to diversify beyond one single religious affiliation was evident, and Irish chaplaincy provision grew into a multifaith service. Chaplaincy roles were expanded to include pastoral care workers, and the criteria for inclusion in the service expanded to religious sisters and non-religious people.^{1,2}

Chaplaincy services

Chaplains are employed by the health service to provide pastoral, religious and spiritual care to patients in hospital. One chaplaincy services co-ordinator, 143 chaplains and seven pastoral care workers are employed (whole-time equivalents), with a total headcount of 234.³ As part of the agreement with the Health Service Executive (HSE), chaplains are expected to visit all patients and these visits are faith-related and 'appropriate to the

patient's denomination'.⁴ Co-ordination with 'representatives or minister of all faiths' is expected so that 'other people's belief systems in a developing multi-cultural society' are valued.⁴ Thus multifaith chaplaincy services, mostly managed by the dominant faith traditions, are the current system, community liaison being a key feature.⁵ This is consistent with international recommendations and NHS best practice guidelines.⁶⁻⁸

The chaplain's role in death rituals is deemed crucial by some families.⁹ Chaplains provide support in areas such as perinatal bereavement care¹⁰ and in intensive care and emergency department settings.¹¹ The HSE has recently developed domains of competence related to palliative care, including for chaplains.¹² The chaplain's role comprises assessing and addressing spiritual issues in the context of multidisciplinary working and team involvement.¹²

At the same time, the HSE has identified a 'need for change' to ensure that the provision of chaplaincy services in all hospitals in receipt of HSE funding complies with current best practice in healthcare chaplaincy. The HSE is developing national guidance and standards for healthcare chaplaincy. As part of this exercise, it established a Chaplaincy Council in 2014,¹³ which aims to support the development of spiritual and pastoral care in health- and social care settings.

Religious affiliations

Although there is a decline in religious affiliation in the ROI, 84% of people still described themselves as Roman Catholic in the last Irish census (2011),¹⁴ and local hospital statistics indicate a similar proportion of patients subscribing to the Roman Catholic

Key points

- In the Republic of Ireland, chaplaincy provision has grown into a multifaith service, and the Health Service Executive employs chaplains to provide spiritual care to patients in hospital.
- Although Roman Catholicism is still the dominant religion in the Republic of Ireland, the number of people affiliated to other religions (and to no religion) is growing.
- Nurses play an important part in the spiritual care of patients but receive little educational preparation for this role.
- It is hoped that the recent creation of a Chaplaincy Council, and of a Spirituality Interest Group at Trinity College Dublin, will lead to a more responsive, whole-team approach to spiritual care.

faith.¹⁵ The proportion of Roman Catholics has decreased with each consecutive census, but their current number (more than 3.6 million) is the largest recorded.¹⁶ At the same time, there has been a fourfold increase in the number of people citing no religion, atheism or agnosticism (n=277,237).¹⁶ Between 500 and 790 people declare themselves as humanists.^{17,18} Determining the spiritual care needs of people with no professed religion can be problematic.

The numbers of people belonging to other religious denominations are growing, linked with immigration from Eastern Europe, Africa and Asia. Since 2006, Church of Ireland affiliations have increased by 6.4%. The 2011 census notes a rise in the number of Muslims since 1991 from 0.1% to just over 1% of the total population. The number of Orthodox Christians has more than quadrupled since 2002. And a tenfold increase in numbers of Hindus has been reported since 1991.¹⁶ Table 1 shows reported religious affiliation according to the 2011 census categories.

Role of nurses

Notwithstanding chaplains' specialist skills, awareness is growing that the spiritual care of patients is the concern of all members of the healthcare team.¹⁹ Koenig has widely supported the involvement of physicians in the delivery of spiritual care.²⁰

While the UK has made recommendations for the role of nurses in this area,^{21,22} there is little specific guidance for nurses in the ROI. Nursing board requirements in the domain of 'holistic approaches to care and the integration of knowledge' specify that the nurse 'implements planned nursing care/interventions to achieve the identified outcomes' and 'creates and maintains a physical, psychosocial, and spiritual environment that promotes safety, security and optimal health'.²³ Nurses are also required to understand 'the nature of the individual' and the biological, psychological, socioeconomic, cultural, spiritual and political factors 'influencing the development of the individual and his/her experience of health and illness across the life span'.²³

Nurses in the ROI, like many of their peers in other countries,²⁴ hold very positive views about spiritual care and consider that they have a role to play in addressing patients' spiritual needs (including referral to

Table 1. Religious affiliation of people living in the Republic of Ireland (all nationalities) according to the 2011 census¹⁴

Religion	Number	%
Roman Catholic	3,831,187	84.66
Church of Ireland or England, Anglican, Episcopalian	124,445	2.75
Muslim	48,130	1.06
Orthodox (Greek, Coptic, Russian)	44,003	0.97
Other Christian religion	39,652	0.88
Presbyterian	22,835	0.50
Apostolic or Pentecostal	13,876	0.31
Other stated religions	75,655	1.68
No religion	256,830	5.68
Not stated	68,668	1.52
Total population	4,525,281	100

chaplains). Many are actively providing spiritual care.²⁵ However, there is very little educational preparation for this role and it occurs mostly at undergraduate level²⁵ – again a feature of nursing worldwide.²⁴

Spirituality Interest Group

The creation of a multidisciplinary Spirituality Interest Group at Trinity College Dublin in 2013 provides a platform to develop a deeper understanding of the concept of spiritual care and a space to promote, debate and discuss the role of spirituality in healthcare. It is hoped that these ongoing developments, along with the work of the Chaplaincy Council,¹³ will strengthen current approaches to the provision of spiritual care to healthcare service users in the ROI, and lead to a more responsive, whole-team approach that reflects best practice and is sensitive to increasingly diverse patient needs.

This article is part of a series on spiritual care service provision at the end of life. In previous issues we covered the Netherlands (Vol 19 No 4), Italy (Vol 19 No 6), the UK (Vol 20 No 1), Germany (Vol 21 No 2), Finland (Vol 21 No 6) and Estonia (Vol 22 No 1).

Declaration of interest

The authors declare that there are no conflicts of interest.

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■ The European Palliative Care Research Centre in Norway has developed a web-based tool, Eir, through which patients can communicate information about symptoms, functioning, quality of life, needs and preferences to healthcare providers. **Kari Sand, Cinzia Brunelli, Sunil X Raj and Stein Kaasa** explain how this could greatly improve symptom management in cancer care.

■ For an elderly person who is 'living with frailty', an accident resulting in a significant injury may be the event that tips the balance over to 'dying with frailty'. **Julian Cavalier** describes the difficult decision-making process in the case of a frail elderly woman with a fractured humerus, and suggests a tool that could help clinicians make decisions in complex cases such as hers.

■ **Maja de Brito, Bruno Fonseca and Barbara Gomes** report on the creation of the Clinical Academic Palliative Care Forum in the north of Portugal. This helped disseminate and integrate locally conducted research by bringing clinicians and researchers together – and the scheme could be emulated elsewhere.

■ **Enric Benito, Clara Gomis and Javier Barbero** describe spiritual care at the end of life in Spain.

■ It is crucial that hospices play their part in palliative care research. But how should they go about it? **Elizabeth Reed and Jennifer Todd** describe the research strategy developed through organisational consensus at Princess Alice Hospice in Surrey.

■ In Great Britain the National Council for Palliative Care organises workshops designed to improve the knowledge, skills and confidence of health- and social care workers looking after people



with dementia at the end of life.

Suyu Liu, Rick Fisher and Anthea Innes have evaluated the outcomes of one such workshop that took place in Dorset.

■ Are genograms useful in specialist palliative care assessment?

Louise Charnock has reviewed the literature and found that the little research there is on the subject does not allow to give a definite answer to that question.

■ Recent years have seen the development of virtual communities of practice in palliative care. One such community, Palliverse, was launched in September 2014 by clinicians and researchers from Australia and New Zealand. **James Jap** and colleagues tell us more about what Palliverse does and the benefits it provides.

■ **Michael Tapley, David Jolley and Ann Regan** from Willow Wood Hospice in the UK express strong views against the Deprivation of Liberty Standards (DoLS), which they say create more issues than they solve, and ask their European colleagues to contribute to the debate by explaining what impact DoLS might have in their countries.

■ **Santiago Rodríguez Corrêa, Carla Mazuko, Mayara Floss, Geoffrey Mitchell and Scott A Murray** describe the rationale behind, and opportunities for, developing palliative care at primary care level in Brazil.

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