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Spiritual Care: The Overlooked Need in End-of-Life Care

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Abstract

Background: A number of studies have validated the use of the FICA tool to evaluate a patient's spirituality. FICA has been helpful in many palliative care settings to screen for spiritual problems that influence the patient's overall health.

Aim: The project was a quality improvement initiative with the purpose of implementing the FICA tool as part of the admission assessment to increase chaplain referrals for inpatient palliative care services.

Methods: The staff received an in-service on using the FICA questions on admission, and a prompt to complete the screen was placed at each work station in the project setting.

Results: The project revealed a clinically significant increase in spiritual care consults between the pre and post-intervention groups. However, the p-value = 0.145 was not statistically significant.

Conclusion: A small sample size and narrow project window were a few of the limitations present in this project. Steps moving forward include increasing both the sample size and the duration of the project to capture a more accurate picture of this intervention in the palliative care setting.

Keywords: spiritual care, spiritual screen, FICA, holistic care, palliative care, chaplain consults

Spiritual Care: The Overlooked Need in End-of-Life Care

The healthcare system in the United States (US) is continually changing, and with it, the providers' roles and the desires of their patients. An overlap between healthcare disciplines is becoming normative in the United States, specifically between medicine and nursing. The overlap can easily blur the distinctives of these disciplines, respectively. The nursing profession should make an effort not to lose sight of its distinctives, including holistic care, health promotion, and disease prevention. Spiritual care is one component of holistic care. Many nursing theorists recognize the spiritual dimension of humanity and health (Petiprin, 2016). For care to be truly holistic, nurses must account for the patient's spiritual condition (Cone et al., 2016; Lau et al., 2018; Blaber et al., 2015; Donesky et al., 2020).

Patients are a driving force shifting the healthcare system toward patient-centered care. The majority of patients desire healthcare providers to provide spiritual care in tandem with their medical care, especially at the end of life (Soroka et al., 2019). To deliver competent and compassionate patient-centered care, nurses need to know how to apply the nursing process to spiritual care. When patients' needs (both physical and spiritual) are addressed, healthcare providers are moving toward reaching the Institute for Healthcare Improvement's Triple Aim goals: improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. Care will be centered around the patient, improving patient satisfaction. The comprehensive approach to the patient's well-being will increase the quality of care. Additionally, spiritually healthy patients may be less inclined to pursue aggressive and questionable medical interventions at the end of life that dramatically increase the cost of care (IHI, 2019).

Background

The National Consensus Project (2018) published guidelines for palliative care and identified spiritual care as one of eight key domains necessary for delivering quality care for palliative and hospice patients. Spiritual care is an area nurses acknowledge as both important and necessary, yet it is often neglected. Spiritual care has been shown to improve quality of life, coping, and well-being, as well as decrease anxiety due to death, loneliness, depression, and loss of meaning or purpose (Farahani et al., 2019). Conversely, failure to provide spiritual care results in less than optimal outcomes and increased morbidity (Gomez-Castillo et al., 2015). Spirituality is highly individualized and informed by culture. As a result, definitions for spirituality found in the research literature are varied. According to Robert et al. (2019), the overarching paradigm defining spirituality in current research is "making meaning of the biomedical realities from diagnosis through prognosis." The search for meaning includes understanding illness, processing distress, and making sense of suffering (Robert et al., 2019).

The National Comprehensive Cancer Network (2017) recognizes spiritual distress as an official diagnosis. Spiritual distress is pervasive in the palliative care population and connected to poor outcomes (Balboni et al., 2017; Blaber et al., 2015; Gillilan et al., 2017; Gomez-Castillo et al., 2015; Caldeira et al., 2017). The diagnosis is often overlooked, and consequently, current research identifying interventions for spiritual distress is also neglected. Moreover, there is a gap between the limited intervention research and clinical practice (Balboni et al., 2017). Research priorities identified at The State of the Science of Spirituality and Palliative Care Conference include spiritual screening/spiritual history taking/spiritual assessment, chaplaincy, interventions, and education (Balboni et al., 2017). Quality palliative and hospice care begins with spiritual screening and assessment and involves all interdisciplinary team members (Ferrell, 2017). Stakeholders include doctors, nurses, chaplains, social workers, volunteers, and palliative care

patients. The provision of spiritual care must be a high priority to deliver patient-centered care and improve the quality of life for patients at the end of life (Bernard et al., 2017).

Problem Statement

The practice setting of the project is part of a larger health system located in the Low Country of South Carolina. The medical facility cares for some of the most seriously ill patients in the area. The palliative care team is growing, and chaplains are available by patient referral. The team is comprised of doctors, nurse practitioners, social workers, chaplains, and volunteers. The spiritual care team has 11 full-time chaplains, with one solely dedicated to palliative care patients. In the last quarter of 2020, the palliative care census had a total of 672 patients.

Currently, the admission assessment does not require a spiritual screening using a validated tool. Spiritual care screening on admission to palliative care may result in more referrals to Chaplain service and spiritual care service to patients. The electronic medical record (EMR) manages the number of palliative care patients and indicates those who have requested a chaplain to be on their interdisciplinary team. At present, not all current palliative care patients have received a spiritual assessment from a chaplain at the facility.

The National Consensus Project (NCP) outlines that a spiritual screen, history, and assessment should be taken on all palliative care patients on admission (Handzo et al., 2019). A chaplain referral is needed to complete the spiritual assessment for patients at the project site. Currently, only 2% of palliative care patients admitted to the Medical Intensive Care Unit (MICU) in the fourth quarter of 2020 received a referral, as evidenced by records in the EMR. These numbers indicate the organization is falling drastically short of the recommended guidelines. The project's purpose is to increase the number of chaplain referrals as a significant step in improving patient care. With focused attention given to spiritual care through increased

chaplain referrals, palliative patients in the MICU can grow in identifying the meaning, purpose, and transcendence of personhood both in life and death.

Literature Search Strategy

A literature search was conducted using CINHAL, PubMed, Cochrane Library, Joanna Briggs, and Web of Science databases. The databases were searched using the following terms and phrases: spiritual needs, quality of life, spiritual care, spiritual assessment, chaplain referral, and FICA. A total of 701 citations were populated, and 54 articles were selected for review. Seven distinct searches were completed in CINHAL using a variation of the aforementioned search terms. The search yielded 505 results. Of these, 43 were selected for consideration. Three distinct searches were completed in PubMed using a variation of the aforementioned search terms. The search yielded 134 results. Of these, eight were selected for consideration. Two distinct searches were completed in Cochrane using a variation of the aforementioned search terms. The search yielded 52 results. Of these, two were selected for consideration. Two distinct searches were completed in Johanna Briggs using a variation of the aforementioned search terms. The search yielded ten results. Of these, none were selected for consideration. A final search was completed in Web of Science. The search yielded six results. Of these, one was selected for consideration. Of the 54 articles selected for review, a final total of 18 articles were chosen to guide the research intervention (see Appendix A). Citations less than five years old (i.e., 2015-2020) were included except for seminal articles or research underpinning the FICA screening tool's validation. Duplicate articles and content that was not relevant to the topic were excluded. Articles in languages other than English were omitted unless an English translation was provided. Research that validated the FICA tool's use, the importance of a spiritual assessment, and increased chaplain referral were also included. The search terms were expanded to include

quality of life and/or literature review to generate the greatest breadth of citations. The Johns Hopkins Nursing Evidence-Based Practice Level and Quality Guide was used to rate the quality of the research (Dearholt & Dang, 2018).

Literature Review

The evidence highlighted spiritual screening as an essential component for comprehensive palliative care. Many seriously ill and palliative care patients want spiritual care included with their medical care (Balboni et al., 2017; Stilos et al., 2019; Donesky et al., 2020; Blaber et al., 2015; Gillilan et al., 2017). Moreover, integrating spiritual care with medical care is proven to improve patient outcomes, alleviate symptoms, increase quality of life, and decrease healthcare utilization (Balboni et al. 2017; Donesky et al. 2020; Williams et al., 2016; Gillilan et al., 2017; Bakitas et al., 2017; Kruizinga et al., 2018; Robert et al. 2019; Ferrell, 2017; Gomez-Castillo et al., 2015).

Despite the patients' desire, spiritual care remains infrequent (Balboni et al., 2017; Stilos et al., 2019; Blaber et al., 2015; Gillilan et al., 2017; Kruizinga et al., 2018; Ferrell, 2017; Caldeira et al., 2017). Several reasons are cited for inattention to spiritual care, including time constraints, lack of training, and fear/discomfort with the topic (Gillilan et al., 2017; Blaber et al., 2015; Cone et al., 2016). Failure to provide spiritual care may result in spiritual distress, which is prevalent in palliative care and is associated with poor outcomes (Balboni et al., 2017; Blaber et al., 2015; Gillilan et al., 2017; Gomez-Castillo et al., 2015; Caldeira et al., 2017). Anxiety and depression are among the common reasons nurses request a chaplain referral in the absence of a spiritual screening tool, not spiritual distress. In fact, anxiety and depression are related to spiritual distress (Gillilan et al., 2017; Ferrell, 2017) but are two different pathologies (Caldeira et al., 2017). Everyone on the interdisciplinary team (IDT) can provide spiritual care;

however, chaplains are the spiritual care specialists (Donesky et al., 2020; Kruizinga et al., 2018). The nurse is considered a liaison between patient and chaplain (Donesky et al. 2020; Gillilan et al., 2017) and makes chaplain referrals far more than any other member of the IDT (Balboni et al. 2017; Stilos et al. 2019; Donesky et al. 2020; Poncin et al., 2020; Caldeira et al., 2017). Spiritual care referrals made in the absence of a spiritual screen are sporadic and lack a single clear motivator for the referral (Poncin et al., 2020).

There are many benefits to conducting a spiritual screen, including increased chaplain consults (Stilos et al. 2019; Lau et al. 2018; Gomez-Castillo et al., 2015), connecting patients to their preferred sources of support (Robert et al. 2019), and an increase in patient/family satisfaction with care when chaplains meet felt spiritual needs in conjunction with medical treatment (Balboni et al. 2017; Stilos et al. 2019; Robert et al. 2019). Spiritual care screening can be incorporated with a standard assessment (Gomez-Castillo et al., 2015). There are only a few spiritual screening tools available, and the development of new tools is considered a research priority (Balboni et al., 2017; Robert et al., 2019; Damen et al., 2018). The FICA tool is a suitable tool for performing a spiritual screen in palliative care patients because it has been validated by quality research (Balboni et al. 2017; Puchalski et al. 2000; Borneman et al., 2010; Blaber et al., 2015; Williams et al., 2016; Bakitas et al., 2017; Gillilan et al., 2017; Gomez-Castillo et al., 2015). FICA offers a structured way to screen spirituality (Williams et al., 2016) and is open-ended to be inclusive of all belief systems (Puchalski et al., 2000).

Theoretical Framework

The theoretical framework that underpins the research project is the Neuman Systems Model (NSM). The NSM depicts an open system where the energy exchange between person and environment is dynamic, involving characteristics and circumstances unique to the

individual. The model focuses on preventing stressors, both known and unknown, resulting in a person's disequilibrium. The model also posits a person is able to maintain a sense of well-being or equilibrium as long as the stressors do not exceed the resources available to the person (Neuman & Fawcett, 2011). The model is suitable for the project as it encompasses the key concepts outlined in the evidence-based question. The palliative care patient is the focal point of the open system in the project. The NSM holistic view of the palliative care patient considers a person's physical, psychological, sociocultural, developmental, and spiritual domains as variables of the person. According to the model, nursing's primary concern is applying the nursing process to assess, plan, intervene, and evaluate actions that preserve the patient's equilibrium as one encounters various stressors. Spirituality is an integral part of health for human beings. End-of-life is a time spirituality comes sharply into focus as a person faces the imminent closure of corporeal existence. Unfortunately, a palliative patient's heightened awareness of one's spiritual needs often goes unmet by the healthcare professionals caring for them. The spiritual care assessment will help identify key stressors that may cause the palliative care patient to lose equilibrium by failing to adapt to the system's changes. Finally, prevention as intervention is another key concept of the NSM. The referral of a spiritual care specialist is an intervention that may lead to the prevention of spiritual distress. The chaplains can provide the patient with resources to cope with the stressors associated with facing one's mortality, thus helping one maintain equilibrium.

Goals, Objectives, and Outcomes

The goal of this project is to improve patient care by incorporating tools that facilitate holistic care. The project examines the following question: Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care screen using

the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission? The population of interest is patients admitted to the inpatient palliative care service at an academic medical facility in South Carolina. The intervention will include conducting a spiritual screen using the FICA tool, along with the usual admission assessment. The FICA tool is a framework used to take a spiritual screen. The acronym stands for the components addressed in the screening tool (i.e., personal Faith or beliefs, Importance of spirituality, faith Community, interventions Addressing faith). The comparison group is comprised of patients who receive the usual admission assessment without using the FICA screen. The outcome was evaluated by the number of chaplain referrals made by palliative care patients. The time for the project is June 1, 2021, through August 31, 2021.

The objectives of this project are to:

1. Use the FICA tool to complete a spiritual screen on all new palliative patients.
2. Identify unmet spiritual needs or desires
3. Increase appropriate referral to spiritual care specialist (i.e., chaplain) for patients with unmet spiritual needs

Project Design

Project Site

The project site is located in Charleston, South Carolina. In just five years, the organization has gone from no palliative care program to receiving national recognition for its commitment to palliative care in 2019. As a Magnet designated facility, there is no nursing staff shortage, and turnover is minimal because job satisfaction is high. Magnet culture generates inherent buy-in as staff enjoy the work environment and desire to improve practice through

evidence-based approaches outlined in the Magnet Model (ANCC, n.d.). Moreover, the organization has employed one full-time chaplain dedicated to serving the palliative care population. The project was piloted only in the MICU of the main hospital.

Feasibility and Resource Requirements

Economically the project is financially viable. The intervention does not require new software or hardware for implementation. Consultation with the unit manager is ongoing to prevent potential barriers (i.e., time or cost constraints) to the project's success. An additional prompt for the FICA admission documentation was placed at the work station in each bay of the MICU. The prompt is a laminated sign attached to the computer monitor that serves as a reminder for the nurse to complete the FICA assessment when admitting a patient. All training of staff has been done in conjunction with scheduled staff meeting times or work hours. The organization is committed to building and expanding its palliative care program. The program was awarded the Circle of Life Citation of Honor from the American Hospital Association in 2019. Moreover, the organization’s academic arm recently added the country’s first Doctorate in Nursing Practice degree with a concentration in palliative care.

Population

The population of Charleston County is approximately 400,000 people. According to the Robert Wood Johnson Foundation County Health Rankings, the poverty rate is 23%, and the income inequality ratio is 5.2, almost double the national average (Robert Wood Johnson, 2020). Because palliative patients comprise all segments of society, it can be inferred these numbers represent the target population. The State's top three comorbidities are cardiovascular disease, cancer, and chronic lung disease, respectively (CDC, 2019). South Carolina has a mean rank of 37 for these comorbidities compared to the other 50 states (United Health Foundation, 2018).

The project population comprises patients admitted to a palliative care program at an academic medical facility. It is estimated that almost half of palliative care patients experience spiritual distress (Chen et al., 2018). Documentation on the prevalence of spiritual distress locally, regionally, and globally is sparse. However, depression, which is related to spiritual distress, is better documented in academic journals and national databases. Charleston County has a higher prevalence of depression among all groups than in South Carolina (BCBS, 2018). Regionally, the prevalence of depression in terminally ill patients is a staggering 43% (Kozlov et al., 2019). When combined with prevalence numbers from another state, about 1/3 of terminally ill patients suffer from depression (Shiroma et al., 2011). Globally, the numbers are approximately the same. Both Hungary and Australia report an average of 35-45% prevalence of depression in this patient population (Hadnagy, Csikos, & Nagy, 2012; O'Connor et al., 2010). In light of similar prevalence found regionally, nationally, and globally one can infer the prevalence of moderate to severe depression in the defined population is not far from the samples mentioned above.

Implementation Plan

Both nominal and ordinal data guided the project. Nominal data were used to represent categories. The demographic data classified nominally include age, race, and sex. The ordinal data, which are numbers used to indicate more or less of a particular attribute, include using the FICA tool and chaplain referral. The following data are discrete numbers that quantify the types of palliative patients screened using the FICA tool and if a chaplain referral is made.

The EMR is the repository for the data that give shape to the project. Specific data was mined from the EMR to run descriptive statistics, including population size (palliative care patients), relevant demographical information (age, sex, race), FICA screening completion, and

chaplain referral. The project's success was contingent on the implementation of the FICA screen for new palliative care admissions. Nursing staff on the unit were provided an in-service on proper use and charting of the spiritual screen. The EMR was examined at the conclusion of the project. The relevant data pertaining to FICA documentation and chaplain consults completed served as indicators for the intervention's success or failure.

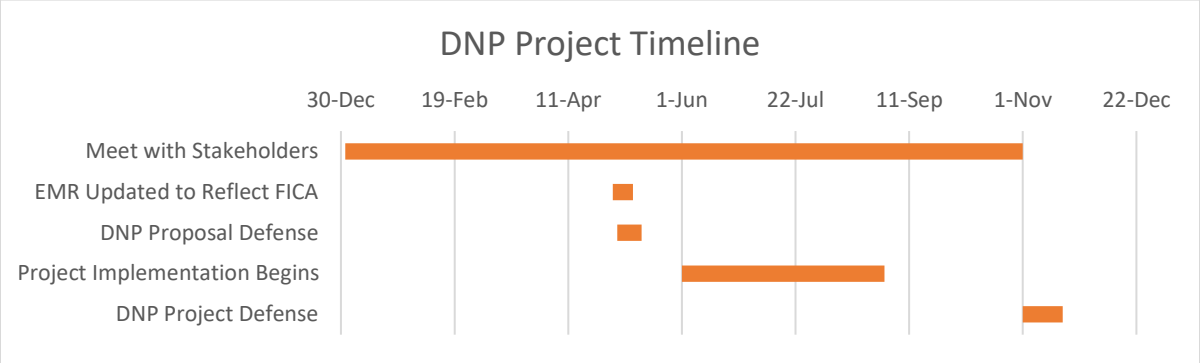
A spreadsheet software program was the backbone for storing and analyzing the project data. All the data points were coded numerically to manage the information accurately. A data dictionary or codebook was developed as a legend for all the coded data. The nominal data was coded using consecutive numbers. The ordinal data was coded with binary 0 for no and 1 for yes. The variables were arranged using a grouped frequency distribution. Bivariate analysis employing cross-tabs was used to create 2x2 tables. A spreadsheet software program with a pivot chart function made an easy-to-read table with a percentage of FICA tool use and chaplain referral for quick analysis. The program also easily calculated the mean and standard deviation for the data. Finally, the null hypothesis (There is no difference in chaplain referrals for patients screened with the FICA tool and those not screened) was tested. Additionally, a Fisher exact test determined the statistical significance between the pre and post-intervention groups.

Timeline

A visualization of the timeline for the project is presented in Figure 1.

Figure 1

Timeline of the DNP Project



Protection of Human Subjects

The project obtained approval from the organization's Institutional Review Board (IRB) to avoid unethical issues related to patient confidentiality and safety. After review, the IRB granted permission for the project as a Quality Improvement exemption (see Appendix B). Patient privacy was a top priority throughout the project. Privacy concerns were mitigated by removing protected health information from the datasets that would compromise the Health Insurance Portability and Privacy Act (HIPPA) compliance. Data security was also a priority. All data extracted from the organization's EMR was de-identified before being stored on a third-party computer, cloud storage, or portable storage device at the facility's consent. Moreover, these devices are password-protected, and EMR login passwords were not shared.

Results

Participant information is presented in Table 1. A total of 72 palliative patients were selected for the project. A total of 45 patients comprised the pre-intervention arm, and 27 patients comprised the post-intervention arm. Demographic characteristics of the 72 palliative patients who were participating in the project are also reported in Table 1. There were no substantial differences between gender and race demographics in the pre and post-intervention

groups. The main difference between the groups was age. The age of the post-intervention group was slightly younger than the pre-intervention group. The project aimed to increase the number of spiritual care consults by completing a spiritual care screen on admission. There was no statistically significant change in spiritual care consults between the pre-intervention group and post-intervention group. However, the was a positive increase in spiritual care consults between the two groups indicating clinical significance.

Table 1

Characteristic Demographics for Pre and Post-Intervention

Characteristic	Pre-Intervention n = 45	Post-Intervention n = 27
Sex		
Male	23 (51%)	15 (56%)
Female	22 (49%)	12 (44%)
Race		
White	26 (63%)	17 (65%)
Black	15 (37%)	9 (35%)
Age	65.9 ± 13.7	57.5 ± 18.4

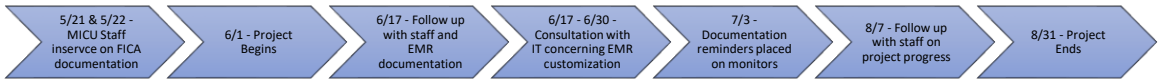
Strengths and Limitations

The strength of the project was in the design and the measure. The project design was arranged to make the data easy to analyze. Statistical and clinical inferences were quickly drawn from the analyzed results. The FICA tool was another key to the project's success. The validated tool provided a strong basis for the intervention. One limitation was the project's sample size. The sample population of n = 27 produced clinically significant results. However, due to the size,

the results are not able to be generalized. Selection bias was also a limitation as the population came directly from patients admitted to the palliative care service in the MICU. Finally, the project window was narrow. A project with a longer duration could yield different results. The steps of the intervention are seen in Figure 2.

Figure 2

Steps of Intervention



Measures and Outcomes

The small sample size was best measured using the Fisher Exact Test. The Fisher Exact Test can be used on any sample size, but is best utilized when the sample size is too small for the use of Chi-Square analysis. Similar to a t-test, the Fisher test can examine a null hypothesis using a p-value. The distribution of selected variables in this project by documentation and consultation is presented in Table 2. The difference in spiritual care documentation between the pre-intervention and post-intervention group was $p = 0.375$. There was no statistical difference in documentation between groups. There was no spiritual care documentation completed in the pre-intervention group and one instance of documentation in the post-intervention group. The difference in consultation between the two groups was $p = 0.145$. The result indicates no statistical difference between the groups. One spiritual care consult was completed in the pre-intervention group, and three consults were completed in the post-intervention group. A logistic regression to measure prediction between documentation and consultation was not indicated as no data captured this phenomenon.

Table 2

Frequency Distribution of Documentation and Consultation by Pre and Post Sample

Variables	Pre (n=45)		Post (n=27)	
	N	**%**	**N**	**%**
Documentation[a]				
No	45	100.0	26	96.3
Yes	00	00.0	01	3.7
Consultation[b]				
No	44	97.8	23	88.9
Yes	01	2.2	03	11.1

Note: a. Fisher exact test P value =.375
b. Fisher exact test P value =.145

The project's implementation in the context of the COVID-19 pandemic impacted outcomes. The spiritual screen using the FICA tool added an additional task to the admission process. The severity of the pandemic resulted in increased hospitalization. Staff shortages made completing previously required tasks difficult, let alone the completion of new ones. To cope with the swelling census, the hospital onboarded several temporary contract nurses. The nurses hired during the project's implementation phase did not benefit from the in-service provided on completing the spiritual screen. Moreover, roughly 28% of the staff that were in-serviced on using the FICA tool left the MICU during the project's implementation phase. The turnover was secondary to high paying job offers available for a nurse with intensive care backgrounds in COVID crisis designated locations.

The data indicated there was no association between spiritual care documentation and spiritual care consults. However, there was an increase in spiritual care consults between the two groups. The positive increase in spiritual care consults between the pre-intervention and post-intervention groups assumes the intervention was effective; however, it was not captured in the documentation. Often nurses will complete a task, but fail to document their work (AHC Media, 2020). The original plan was to customize the charting in the EMR. The customization was to

create a prompt for the nurse to remember to chart the completion of the spiritual screen. Unfortunately, due to constraints on human resources within the Information Technology department, the EMR customization was not actualized. Moreover, it can be difficult for staff to adopt change or create new work habits even if the organization is ready for change (Rafferty & Minbashian, 2019; Oreg & Sverdlik, 2011). The intervention required an entire unit of nurses to change the way they approached completing the admission assessment. Even though the change was minimal and training was provided, staff that were not comfortable with their own spirituality may have struggled to conduct a spiritual screen on their patients (Tiew & Creedy, 2012). Time is also an element that cannot be overlooked. The creation of an additional task, despite how quickly the task can be completed, by nature increases the workload of a nurse. In the current climate of healthcare, time is already a scarce resource. An additional task can pose a real problem for a demanding schedule.

Discussion

The project aimed to observe the effect of using the FICA tool when completing an admission history on the referral rate to spiritual care specialists for palliative care patients in the MICU. The FICA tool has been validated through qualitative research to be an effective screen for a person's spirituality. This project aimed to use the tool as a quality improvement initiative to increase the number of spiritual care consults (i.e., chaplain referrals) among inpatient palliative care patients. The scores on the primary outcome measure (spiritual care consults) did not differ significantly between the pre-intervention and post-intervention groups. Still, there was a positive increase in chaplain referrals between the groups. The future direction of a quality improvement project would be to increase the sample size and measure the associations between a spiritual screen and its impact on chaplain referrals over a longer period of time.

The project's scope can have a direct impact on individuals and the healthcare system as a whole. Each patient who received a chaplain consult was provided a resource that could mitigate the effects of spiritual distress. Chaplains are spiritual care specialists with unique training to help people find meaning and purpose amid complex problems. As a person finds meaning and purpose in a terminal diagnosis, they can more effectively cope with the reality of mortality. They are able to find peace despite impending death. Their ability to embrace death frees them to let go of the present and make decisions to avoid unnecessary interventions that prolong death or inflict suffering without commensurate benefit. Short-term emergency life-supporting interventions are often costly and can become long-term maintenance life-supporting interventions. People who are not at peace with the dying process are more likely to opt for expensive interventions that merely prolong death and lead to increased healthcare utilization. Spiritual care helps guide people to process and make difficult decisions regarding care at the end of their life. The spiritually healthy person can successfully navigate the pitfalls of spiritual distress and make informed rational choices about how to die in peace (Farahani et al., 2019).

Although the project was not statistically significant, it was clinically significant. A 9% increase in consults was observed between the pre and post-intervention groups. The location for FICA documentation is on the admission history flowsheet. The admission history flowsheet should be completed in the first 24 hours of inpatient admission. After the 24-hour mark, staff document care on a different flowsheet in the EMR. Even though FICA documentation did not appear in the EMR for the patients that received spiritual care consults, the increase could indicate an increased awareness among staff to conduct a spiritual screen or request a chaplain referral throughout the course of a patient's stay. As follows, the project impacted the staff's

awareness of the need for chaplain referrals to better integrate spiritual care with the medical care their patients received.

A handful of barriers were identified to explain the differences between the observed and the anticipated outcomes of the project. The overarching problem was the COVID-19 pandemic. The project started over a year into the pandemic. It was run in a unit that has borne the brunt of COVID's severest cases. Immense strain was placed on the MICU staff due to the acuity of patients, lack of resources, and the physical demands of caring for critically ill patients on airborne/droplet precautions. The spiritual screen using the FICA tool can be completed quickly. The screen does, however, increase the workload of the staff. It is difficult to calculate how many more spiritual screens would have been completed under a regular set of circumstances. Needless to say, the pandemic contributed significantly to increasing the workload experienced by the staff. The smallest work increase on an already taxed system decreases the likelihood the small task will be completed. Moreover, if the staff views the new task as a low priority, failure to complete the screen is more likely (individual staff perceptions regarding the priority of the spiritual screen was not evaluated). Another unexpected occurrence was lucrative job offers in locations hardest hit by the pandemic. The MICU staff had experienced little turnover over the years. However, during the brief three-month project window, 28% of the full-time staff nurses left for higher-paying travel assignments. These nurses were a part of the initial cohort that was in-serviced on the proper use of FICA documentation. The impact of staff turnover on patient care and documentation was not inconsequential.

Finally, the difference between observed and anticipated outcomes was related to the adjusted sample size. The usual course of an inpatient stay does not begin in the MICU. Usually, patients are admitted to a medical/surgical floor. When their condition deteriorates, patients are

transferred to MICU for a higher level of care. Upon chart review, it was noted several palliative care patients in the MICU did not have an admission history completed in the MICU. The first 24 hours of their inpatient stay began on another floor, where the admission history was completed on the initial flowsheet. Subsequently, the sample size was reduced by more than half to include only those patients whose admission assessment was completed in the MICU.

Conclusion

The project window has closed. However, using the FICA tool on admission to conduct a spiritual screen continues. The admission history of the EMR retains a place for spiritual beliefs documentation. The project is sustainable since it requires no additional financial or human resources from the institution. In light of the clinical significance, the project results can be formatted for manuscript submission. A poster or infographic can also be created and shared with the MICU to highlight the project's findings. This infographic may help change staff perceptions and elevate the priority for completing the spiritual screen in their own practice. The FICA tool is a helpful screen for identifying a person’s spirituality. It is easily adaptable for use throughout other areas within the organization.

The next steps include customizing the EMR to create a prompt for the spiritual screen section of the history to be complete on admission. A prompt will remind staff to address this vital component of a person’s background. The results of the project will also be shared with other unit managers within the organization and the clinical advancement committee. The project’s design is flexible and sustainable. These qualities create an opportunity to scale the FICA tool’s use throughout the organization. The healthcare delivery system should account for the physical needs of patients and also their spiritual needs. When healthcare providers address

patients' spiritual needs nearing the end of life, they will be addressing what truly makes us human and move toward holistic care.

References

AHC Media. (2020). Essential ED Documentation Often Missing from Chart. *ED Legal Letter, 31*(10), 1–2.

American Nurses Credentialing Center (n.d.) Magnet Model. https://www.nursingworld.org/organizational-programs/magnet/magnet-model/

Bakitas, M. A., El-Jawahri, A., Farquhar, M., Ferrell, B., Grudzen, C., Higginson, I., Temel, J.S., Zimmerman, C., & Smith, T. J. (2017). The TEAM approach to improving oncology outcomes by incorporating palliative care in practice. *Journal of Oncology Practice, 13*(9), 557–566. https://doi.org/10.1200/jop.2017.022939

Balboni, T. A., Fitchett, G., Handzo, G. F., Johnson, K. S., Koenig, H. G., Pargament, K. I., Puchalski, C.M., Sinclair S., Taylor, E.J., & Steinhauser, K. E. (2017). State of the science of spirituality and palliative care research part II: Screening, assessment, and interventions. *Journal of Pain and Symptom Management, 54*(3), 441–453. https://doi.org/10.1016/j.jpainsymman.2017.07.029

Blue Cross Blue Shield. (2018). Major depression: The impact on overall health. *Blue Cross Blue Shield, The Health of America Report*. https://www.bcbs.com/the-health-of-america/reports/major-depression-the-impact-overall-health

Blaber, M., Jones, J., & Willis, D. (2015). Spiritual care: Which is the best assessment tool for palliative settings*? International Journal of Palliative Nursing*, *21*(9), 430-438.

Bernard, M., Strasser, F., Gamondi, C., Braunschweig, G., Forster, M., Kaspers-Elekes, K., Veri, S.W, & Borasio, G.D. (2017). Relationship between spirituality, meaning in life, psychological distress, wish for hastened death, and their influence on quality of life in

palliative care patients. *Journal of Pain and Symptom Management*, *54*(4), 514–522. https://doi.org/10.1016/j.jpainsymman.2017.07.019

Borneman, T., Ferrell, B., & Puchalski, C. M. (2010). Evaluation of the FICA Tool for spiritual assessment. *Journal of Pain and Symptom Management, 40(*2), 163–173. https://doi.org/10.1016/j.jpainsymman.2009.12.019

Caldeira, S., Timmins, F., de Carvalho, E. C., & Vieira, M. (2017). Spiritual well-being and spiritual distress in cancer patients undergoing chemotherapy: Utilizing the SWBQ as component of holistic nursing diagnosis. *Journal of Religion and Health*, *56*(4), 1489–1502. https://doi.org/10.1007/s10943-017-0390-4

Centers for Disease Control and Prevention. (2019, May 24). Stats of the State of South Carolina. https://www.cdc.gov/nchs/pressroom/states/southcarolina/southcarolina.htm

Chen, J., Lin, Y., Yan, J., Wu, Y., & Hu, R. (2018). The effects of spiritual care on quality of life and spiritual well-being among patients with terminal illness: A systematic review. *Palliative Medicine*, *32*(7), 1167–1179. https://doi.org/10.1177/0269216318772267

Cone, P. H., & Giske, T. (2017). Nurses' comfort level with spiritual assessment: A study among nurses working in diverse healthcare settings. *Journal of Clinical Nursing, 26*(19–20), 3125–3136. https://doi.org/10.1111/jocn.13660

Damen, A., Delaney, A., & Fitchett, G. (2017). Research priorities for healthcare chaplaincy: views of U.S. chaplains. *Journal of Health Care Chaplaincy*, *24*(2), 57–66. https://doi.org/10.1080/08854726.2017.1399597

Dearholt, S. L., & Dang, D. (2018). *Johns Hopkins Nursing Evidence-Based Practice: Models and Guidelines* (3rd edition). Sigma Theta Tau International.

Donesky, D., Sprague, E., & Joseph, D. (2020). A new perspective on spiritual care. *Advances in Nursing Science,* 1. https://doi.org/10.1097/ans.0000000000000298

Farahani, A.S., Rassouli, M., Salmani, N., Mojen, L.K., Sajjadi, M., Heidarzadeh, M., Masoudifar, Z., & Khademi, F. (2019). Evaluation of healthcare providers' perception of spiritual care and the obstacles to its implementation. *Asia-Pacific Journal of Oncology Nursing, 6*(2), 122-129. https://doi.org/10.4103/apjon.apjon_69_18

Ferrell, B. R. (2017). Spiritual care in hospice and palliative care. *The Korean Journal of Hospice and Palliative Care, 20*(4), 215–220. https://doi.org/10.14475/kjhpc2017.20.4.215

Gillilan, R., Qawi, S., Weymiller, A. J., & Puchalski, C. (2017). Spiritual distress and spiritual Care in advanced heart failure. *Heart Failure Reviews, 22*(5), 581–591. https://doi.org/10.1007/s10741-017-9635-2

Gomez-Castillo, B. J., Hirsch, R., Groninger, H., Baker, K., Cheng, M. J., Phillips, J., Pollack, J., & Berger, A. M. (2015). Increasing the number of outpatients receiving spiritual assessment: A pain and palliative care service quality improvement project. *Journal of Pain and Symptom Management, 50*(5), 724–729. https://doi.org/10.1016/j.jpainsymman.2015.05.012

Hadnagy, Z., Csikós, Á., & Nagy, L. (2012). Introduction of the demoralization scale in Hungary, a study on demoralization and depression among hospice patients. *Orvosi Hetilap, 153*(19), 737–743. https://doi.org/10.1556/oh.2012.29346

Handzo, G. F., Atkinson, M.-M., & Wintz, S. K. (2019). National Consensus Project's clinical

practice guidelines for quality palliative care, fourth edition: Why is this important to chaplains? *Journal of Health Care Chaplaincy, 26*(2), 58–71. https://doi.org/10.1080/08854726.2019.1582212

Institute for Healthcare Improvement (IHI). (2019). *TA 101: Introduction to the triple aim for populations.* http://www.ihi.org/education/IHIOpenSchool/courses/Pages/default.aspx

Kozlov, E., Phongtankuel, V., Prigerson, H., Adelman, R., Shalev, A., Czaja, S., Dignam, R., Baughn, R., & Reid, M. C. (2019). Prevalence, severity, and correlates of symptoms of anxiety and depression at the very end of life. *Journal of Pain and Symptom Management, 58*(1), 80–85. https://doi.org/10.1016/j.jpainsymman.2019.04.012

Kruizinga, R., Scherer-Rath, M., Schilderman, H. J. B. A. M., Puchalski, C. M., & van Laarhoven, H. H. W. M. (2018). Toward a fully fledged integration of spiritual care and medical care. *Journal of Pain and Symptom Management, 55*(3), 1035–1040. https://doi.org/10.1016/j.jpainsymman.2017.11.015

Lau, C., Stilos, K., Nowell, A., Lau, F., Moore, J., & Wynnychuk, L. (2017). The comfort measures order set at a tertiary care academic hospital: Is there a comparable difference in end-of-life care between patients dying in acute care when CMOS is utilized? *American Journal of Hospice and Palliative Medicine, 35*(4), 652–663. https://doi.org/10.1177/1049909117734228

National Comprehensive Cancer Network Inc. (2017). *Clinical practice guidelines in oncology: Palliative care.* https://www.nccn.org/professionals/physician_gls/palliative.pdf

National Consensus Project. (2018). *Clinical practice guidelines for quality palliative care* (4th ed.). National Coalition for Hospice and Palliative Care.

Neuman, B., & Fawcett, J. (Eds.). (2011). *The Neuman systems model* (5th ed.). Pearson.

Oreg S, & Sverdlik N. (2011). Ambivalence toward imposed change: The conflict between dispositional resistance to change and the orientation toward the change agent. *Journal of Applied Psychology, 96*(2), 337–349. https://doi-org.pallas2.tcl.sc.edu/10.1037/a0021100

Petiprin, A. (2016). Nursing theorists. Nursing Theory. https://www.nursing-theory.org

Poncin, E., Niquille, B., Jobin, G., Benaim, C., & Rochat, E. (2019). What motivates healthcare professionals' referrals to chaplains, and how to help them formulate referrals that accurately reflect patients' spiritual needs? *Journal of Health Care Chaplaincy, 26*(1), 1–15. https://doi.org/10.1080/08854726.2019.1582211

Puchalski, C.M., & Romer, A.L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine, 3*(1), 129-137.

Rafferty, A. E., & Minbashian, A. (2019). Cognitive beliefs and positive emotions about change: Relationships with employee change readiness and change-supportive behaviors. *Human Relations, 72*(10), 1623–1650. https://doiorg.pallas2.tcl.sc.edu/10.1177/0018726718809154

Robert, R., Stavinoha, P., Jones, B. L., Robinson, J., Larson, K., Hicklen, R., Smith, B., Perko, K., Koch, K., Findley, S., & Weaver, M. S. (2019). Spiritual assessment and spiritual care offerings as a standard of care in pediatric oncology: A recommendation informed by a systematic review of the literature. *Pediatric Blood & Cancer*, *66*(9). https://doi.org/10.1002/pbc.27764

Robert Wood Johnson Foundation. (2020). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/app/south-carolina/2020/rankings/charleston/county/outcomes/overall/snapshot

Shiroma, P. R., Geda, Y. E., Mohan, A., & Richardson, J. (2010). Antidepressant prescription

pattern in a hospice program. *American Journal of Hospice and Palliative Medicine*, *28*(3), 193–197. https://doi.org/10.1177/1049909110385539

Soroka, J.T., Collins, L.A., Creech, G., Kutcher, G.R., Menne, K.R., & Petzel, B.L. (2019). Spiritual care at the end of life: Does educational intervention focused on a broad definition of spirituality increase utilization of chaplain spiritual support in hospice? *Journal of Palliative Medicine, 22*(8), 939-944. https://doi.org/10.1089/jpm.2018.0579

Stilos, K., Ford, B., Lilien, T., & Moore, J. (2019). The role of spiritual care with the introduction of an end of life order set. *Journal of Pastoral Care & Counseling*, *73*(1), 41–48. https://doi.org/10.1177/1542305018822283

Tiew, L. H., & Creedy, D. K. (2012). Development and preliminary validation of a composite Spiritual Care-Giving Scale. *International Journal of Nursing Studies*, *49*(6), 682–690. https://doi.org/10.1016/j.ijnurstu.2011.11.014

United Health Foundation. (2018). America's Health Rankings. https://www.americashealthrankings.org/explore/annual/measure/Overall/state/SC

Williams, M. G., Voss, A., Vahle, B., & Capp, S. (2016). Clinical nursing education: Using the FICA spiritual history tool to assess patients' spirituality. *Nurse Educator*, *41*(4), E6–E9. https://doi.org/10.1097/nne.0000000000000269

Appendix A

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Michael VrMeer/Evidence Tables

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP Question	Observable Measures	Limitations	Evidence Level, Quality
1	Balboni, T.A., Fitchett, G., Handzo, G.F., Johnson, K.S., Koenig, H.G., Pargament, K.I., Puchalski, C.M., Sinclair, S., Taylor, E.J., & Steinhauser, K.E. (2017)	State of the Science Report	N/A	-Spiritual Screen tools are research priority. -FICA tool has been tested and validated quantifiably	N/A	N/A	I, A
2	Gomez-Castillo, B.J., Hirsch, R., Groninger, H., Baker, K., Cheng, M.J., Phillips, J., Pollack, J., & Berger, A.M. (2015)	QI Project (Quasi-Exp.)	Sample = pts with serious ca endocrine, immune, neuro, or genetic diseases Size = 79 Setting = Outpt Pain Palliative Care Clinic	-FICA helps develop a more comprehensive treatment plan -Spiritual assessment chaplain consults both increased -Early spiritual support decrease healthcare utilization and healthcare cost	-FICA tool used -Engaging clinical and spiritual stakeholders -Spiritual assessment included with standard assessment -Correlation between screening and chaplain referral	-Only focused on completing sp. Assessment not impact of outcomes -FICA used for adults this study had peds -Indi. Effects of both intervention not easily observed	II, B

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP ?	Observable Measures	Limitations	Evidence Level, Quality
3	Williams, M.G., Voss, A., Vahle, B., & Capp, S. (2016)	Quasi-Experimental	Sample = Nursing Students Size = 31 Setting = Rural Medical Center in the Midwest	-FICA recommended by the Hartford Institute of Geriatric Nursing -FICA Evidence based tool	-Students used FICA tool to take spiritual history	-Possible sample bias -small sample size	II, A
4	Bakitas, M.A., El-Jawahri, A., Farquhar, M., Ferrell, B., Grudzen, C., Higginson, I., Temel, J.S., Zimmermann, C., & Smith, T.J. (2017)	Literature Review	Sample = RCTS Size = 13	-FICA recommended for spiritual assessment	N/A	N/A	II, A

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP ?	Observable Measures	Limitations	Evidence Level, Quality
5	Borneman, T., Ferrell, B., Puchalski, C.M. (2010)	Mixed Methods	Sample = Cancer Pts >18yo Sample Size = 76 Setting = ambulatory clinic of comprehensive ca center	-FICA is a valuable tool for clinical assessment -FICA provides info on beliefs affecting healthcare decision making.	- FICA id aspects of life that provided greatest spiritual support -correlated results with another validated tool	-small sample size -same illness (CA) -Outdated but research supporting validation	II, A
6	Blaber, M., Jones, J., & Willis D. (2015)	Literature Review	N/A	-Spiritual history taking tools have an important role in identifying the spiritual needs of patients -FICA is the only validated tool among the four reviewed	-Four tools evaluated based on literature review: HOPE, FICA, FAITH, SPIRITual	-FICA is susceptible to cultural bias -Literature mostly represented by secularized Christian perspective of spirituality	III, B

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP ?	Observable Measures	Limitations	Evidence Level, Quality
7	Robert, R., Stavinoha, P., Jones, B.L., Robinson, J., Larson, K., Hicklen, R., Smith, B., Perko, K., Koch, K., Findley, S., & Weaver, M.S. (2019)	Systematic Review	Sample = Quantitative and qualitative research on spiritual assessment Size = 39 articles	-Emphasizes the importance of spiritual needs assessment -Provide strong recom For spiritual needs assessment based on quality of observational evidence and risk for existential crisis -Conclude spiritual support is perceived as helpful and sp as resource for coping strong	-The findings did not universally endorse a preference for spiritual support, thus highlighting the need for spiritual assessment as essential for linking preferred support and available spiritual care resources	-Lack of intervention studies and outcome reporting -Lack of standard definition of spirituality -Lack theoretical model coherence -Lack of longitudinal designs -Lack of ethnic and religious diversity -Lacked atheists and agnostics	III, A
8	Ferrell, B.R. (2017)	Literature Review	N/A	-Anxiety and depression may be related to spiritual distress -Spiritual screening done early in care to identify needs.	-Spiritual assessment directs the spiritual interventions	N/A	III, C

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP ?	Observable Measures	Limitations	Evidence Level, Quality
9	Caldeira, S., Timmins, F., Campos de Carvalho, E., & Vieira (2017)	Cross-sectional qualitative study	Sample = Ca pts receiving chemo >18 yo Size = 169 Setting = A hospital in Portugal	-Nurses primary mechanism for chaplain referral -Nurses lack of awareness (no screen) prevents chaplain referral	-Use the nursing process to implement spiritual assessment and care.	-Sample bias (convenience) -Sample from single site and country. Not generalizable -Study design precludes statements of causality	III, B
10	Damen, A., Delaney, A., & Fitchett, G. (2018)	Qualitative	Sample = Chaplains Size = 193 Setting = Four Chaplaincy Conferences in 2016	-Spiritual screening and referrals are research priorities for spiritual care specialists -The priorities of the participants is in line with the literature	-Ranking of what was considered a research priority among chaplains	-Sample selection bias -The sample size is small	III, B

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP ?	Observable Measures	Limitations	Evidence Level, Quality
11	Stilos, K., Ford, B., Lilien, T., & Moore, J. (2019)	Retrospective Chart Review	Sample = Patients referred to a palliative care team for end-of-life care Sample size = 70 Setting = A medical center in Canada	-CARES tool integrated in CMOS to prompt spiritual screen and assessment -The Comfort Measures Order Set (with booklet) Increased the number of referrals to the spiritual care team.	-Comfort Measures Order Set included CARES tool for spiritual screen and assessment -Survey was sent to family member 6 week after patients' death to measure impact of spiritual care.	-Short time frame may understate long-term impact -Sample size was small and results not generalizable	III, B
12	Poncin, E., Niquille, B., Jobin, C., Benaim, C., & Rochat, E. (2020)	Qualitative Study	Sample = Nurses, Doctors, PCT, and OT Sample Size = 12 Setting = Lausanne University Hospital, Switzerland	-Referrals are not made by a single clear motivator -Only two used specific religious terms (Broad Definition) -	-Who made referral -Why the referral was made	- small sample size difficult to generalize -Possible Interviewer bias -Interviews not recorded and accuracy of transcription not guaranteed	III, B

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP ?	Observable Measures	Limitations	Evidence Level, Quality
13	Lau, C., Stilos, K., Nowell, A., Lau, F., Moore, J., & Wynnychuk, L. (2018)	Retrospective Chart Review	Sample = Oncology & Internal Medicine pt admitted to inpatient palliative care Sample Size = 83 Setting = A moderate sized medical center in Canada	-Significant improvement in spiritual care among those that had the CMOS, which initialed a spiritual screen compared to those who did not -Significant increase in SC involvement with CMOS 66% with and 19% without p = 0.00005	-67% of the patients received the CMOS and 33% did not -66% with CMOS received spiritual care 34% did not. Only 19% without CMOS received SC and 81% did not.	-Trigger for clinician to initiate CMOS not elucidate -Sample size was small and not able to be generalized	III, B
14	Cone, P.H., & Giske, T. (2016)	Cross-sectional study	Sample = Norwegian Nurses Size = 172 Setting = various care settings	-Many nurses are poorly prepared for taking spiritual assessment -Comfort with taking spiritual assessment can increase via education, culture of spiritual screening, and self reflection and personal preparation for assessing spirituality	-Nurse comfort level with spiritual assessment In relationship to sense of preparedness, age, background, and education	Homogenous sample not able to generalize -Interview and selection bias -Internal consistency and reliability of the tool	III, B

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP ?	Observable Measures	Limitations	Evidence Level, Quality
15	Puchalski, C.M., & Romer, A.L. (2000)	Expert Opinion	N/A	Spiritual assessment should be done across the lifespan. -Spiritual care belongs to no one discipline -FICA is open-ended to include a wide range of beliefs -FICA used in med school curricula	N/A	-Outdated, but seminal article	V, C
16	Gillilan, R., Qawi, S., Weymiller, A.J., & Puchalski, C.M. (2017)	Expert Opinion	N/A	-FICA has been validated in various clinical settings and feasible to for spiritual assessment	N/A	N/A	V, B

Among patients admitted to a palliative care program at an academic medical facility, how does a spiritual care assessment using the FICA tool upon admission, compared to usual admission assessment, affect referrals to spiritual-care specialists during the course of inpatient admission?

Article Number	Author & Date	Evidence Type	Sample, Size, Setting	Findings that help answer the EBP ?	Observable Measures	Limitations	Evidence Level, Quality
17	Kruizinga, R., Scherer-Rath, M., Schilderman, H.J.B.A.M., Pulchalski, C.M., van Laarhoven, H.H.W.M. (2018)	Expert Opinion	N/A	Attention to pts spiritual needs is the responsibility of all healthcare providers. -Generalist-Specialist Model healthcare practitioner (i.e. nurse) does screening; specialist addresses the sp. need	N/A	N/A	V, C
18	Donesky, D., Sprague, E., & Joseph, D. (2020)	Expert Opinion	N/A	-Nurses regularly at the bedside and have best opportunity to recognize spiritual need. -Nurses taught holistic care and spiritual care is incorporated in nursing curriculum.	N/A	-Not much literature on the intersection of nursing care and chaplaincy.	V, C

Appendix B

MUSC
Medical University of South Carolina

Quality Improvement/Program Evaluation

Self-Certification Tool

Sponsored by the MUSC Institutional Review Board

Date: 09/24/2020

Project Title: Spiritual Care in End-of-Life Care

To: Michael VrMeer

Based on your responses to the IRB QI/Program Evaluation Self-Certification Tool, in which:

1. The project will not involve testing an experimental drug or device.
2. The project has not received federal funding to be conducted as human subjects research.
3. The project is not a multi-site project.
4. The primary intent of the project is not to conduct a systematic investigation designed to contribute to generalizable knowledge.
5. The results of the project will be published, presented or disseminated outside MUSC.
6. The project is intended to improve or evaluate the practice or process within a clinic or program at MUSC.

This project is determined to be quality improvement and is therefore not subject to IRB review or approval. If the project changes in any way, please repeat the use of this tool to determine if the project continues to be quality improvement.

If you indicated intent to publish your quality improvement endeavor, it is strongly suggested to use the SQUIRE guidelines when writing up this project for publication.

Please retain a copy of this Self-Certification for your records. The determinations from this tool are subject to audit by the University Compliance Office.

If you have any questions, please contact: The MUSC IRB 843.792.4148.