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ORIGINAL PAPER

Staff Perceptions of Chaplains in a Neurosciences Critical Care Unit

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Abstract

Hospital chaplains often visit critically ill patients, but neurosciences critical care unit (NCCU) staff beliefs surrounding chaplains have not been characterized. In this study, we used Qualtrics® to survey 70 NCCU healthcare workers about their attitudes toward chaplains in the NCCU. Chaplains were seen positively by staff but were less likely to be viewed as part of the care team by staff with more than five years of NCCU experience. The results of this study will allow chaplaincy programs to target staff education efforts in order to enhance the care provided to patients in critical care settings.

Keywords Chaplain · Critical care · Neurologic critical care · Staff · Nurses

Introduction

Hospital-based chaplains have a wide range of responsibilities and serve patients, families, and medical staff. Patient spirituality and religion, often the explicit domains solely of chaplains, frame patient and family medical decision making and influence a patient's ability to cope with serious illness (Koenig 2013). Chaplains are able to intervene during times of high emotional volatility to promote better patient communication (Cunningham et al. 2017). Moreover, effective cooperation between chaplains and healthcare providers is associated with improved patient health outcomes and more positive perceptions of clinical experiences (Hemming et al. 2016). For example, integration of the chaplain into the patient care team has been associated with higher patient hospital stay satisfaction scores (Johnson et al.

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2014; Pearce et al. 2011; Marin et al. 2015; Williams et al. 2011). In the current milieu of patient-centered care and an ongoing focus on patient satisfaction, hospitals have increasingly recognized the benefit chaplains provide in carrying out their healthcare missions (Ellis et al. 2012).

Despite the reported benefits of a chaplain's presence, hospital chaplains and medical professionals infrequently interact in the patient care setting (King and Crisp 2005). This may be due to inadequate understanding among the healthcare team as to a chaplain's role in the clinical setting (McCormick and Hildebrand 2015), rather than from a resistance toward incorporating complementary forms of care in the hospital (Cunningham et al. 2017). Without proper understanding of the chaplain's functions within the medical team, or without the institutional framework to support such functions, the chaplain's positive impact on patient care may be hindered (McCormick and Hildebrand 2015).

Prior studies have evaluated perceptions of chaplains on general medicine floors (Cunningham at al. 2017) and medical–surgical intensive care units (Bone et al. 2018; Choi et al. 2019). Cunningham et al. (2017) surveyed medical residents after they worked on patient care teams alongside chaplains. During focus groups, the physicians expressed their appreciation for how chaplains had expanded their view of a patient as more than just a collection of symptoms. However, there was not a clear understanding of the specific services that chaplains could provide to patients or staff. In medical or surgical intensive care units (ICUs), clinicians infrequently communicated with chaplains but found them a valuable resource when a patient was dying (Choi et al. 2019). In one study of ICU nurses, nursing staff appreciated the chaplain's physical presence on the unit and their contribution to understanding the patient as a whole person (Bone et al. 2018).

To our knowledge, no prior research has explored how chaplains are seen by staff in the neurosciences critical care unit (NCCU) setting. Like all critical care settings, the neurologic intensive care setting is emotionally charged. Notably, however, a recent survey of physician burnout reported the highest rates in critical care and neurology (48% in each) and hence the focus of this study on the NCCU (Peckham 2018). This paper seeks to characterize NCCU staff beliefs about chaplains and chaplains' roles in patient care.

Methods

Study Design

Cross-sectional study surveying NCCU staff beliefs about chaplains.

Participants and Setting

The participants were NCCU fellows, faculty, and nurses at an academic institution between August 2016 and June 2017.

Instrument Development

The survey instrument was informed by reviewing the spiritual care and service excellence literature. It was designed to solicit staff perspectives on the role of hospital chaplains in the NCCU. Input from neurologists, intensivists, nurses, and hospital chaplains with expertise in clinical excellence and spiritual care was also incorporated in developing the 33-question survey instrument. Demographic information collected included gender, age, year in training or employment, race, marital status, and faith background. The surveys contained questions assessing participant opinions on the role of chaplains in patient care. For the majority of questions, respondents recorded their opinions via four-point Likert scales ranging from "strongly disagree" to "strongly agree."

Data Collection

Participants completed the surveys online. Qualtrics® was used to deploy and manage the survey, and a link to the survey was emailed to all participants (Qualtrics Labs, Inc 2016). An informed assent statement was provided at the start of the survey, and no identifying information was recorded. This study was granted exempt status by our Institutional Review Board (IRB).

Data Analysis

For attitudinal questions, responses were grouped as either agreeing ("agree" or "strongly agree") or disagreeing ("disagree" or "strongly disagree"). Generalized estimating equations were used to test associations of demographic, professional and faith characteristics with beliefs about chaplains.

Results are presented as odds ratios with 95% confidence intervals. All data were analyzed using SPSS 24 (IBM, SPSS Inc., Chicago, Illinois, USA). A P value of less than 0.05 was considered to be statistically significant.

Results

A total of 112 possible participants assigned to clinical duties in the NCCU were contacted. Among those, 85 (76%) opened the link to begin the survey, with 70 consenting to and completing part or all of the survey (70/85; 82%). To ensure that respondents had spent more than two weeks in the NCCU, residents were excluded from the analysis. Sixty-five participants (65/70, 93%) were included in the final analysis. Of these 65 participants, 6% ($n=4$) were residents and fellows, 9% ($n=6$) were faculty members, 75% ($n=49$) were nurses, 3% ($n=2$) were nurse practitioners, and 6% ($n=4$) had other roles (Table 1); 75% were female and mean age was 34 (SD 10) years. Participant race was 75% white, 10% African-American, and 10% Asian. Christianity was the majority faith group, with

Table 1 Participant demographics

Parameter	Value
Participants (*n*)	65
Role (*n*, %)	
Fellows	4 (6)
Faculty	6 (9)
Nurses	49 (75)
Nurse practitioners	2 (3)
Other	4 (6)
Gender (*n*, %)	
Female	49 (75)
Male	16 (25)
Age (mean, SD)	34 (10)
Race (*n*, %)	
African-American	6 (10)
Asian	6 (10)
White	47 (75)
Other	4 (6)
Marital status (*n*, %)	
Single	35 (54)
Separated/divorced	4 (6)
Cohabitating	3 (5)
Married	23 (35)
Faith background (*n*, %)	
Catholicism	26 (42)
Protestant	15 (24)
Atheist/agnostic	10 (16)
Islam	2 (3)
Judaism	3 (5)
None	6 (10)

42% Catholic and 24% Protestant. Atheist/agnostic was the next largest belief group (16%).

A majority of participants had made a referral to a chaplain on behalf of a patient or family (88%, $n=56$) and read the chaplain's note when consulting a patient's medical record (73%, $n=47$) (Table 2). Of those who had made a referral to a chaplain, 84% ($n=47$) were nurses. Only 11% ($n=7$) of participants had consulted a chaplain to discuss their own personal concerns. A majority of staff found the chaplain's note helpful for patient care (81%, $n=38$), believed chaplains helped resolve conflicts between the medical team and patients (84%, $n=54$), and improved the quality of care given to patients (91%, $n=58$). A majority (91%, $n=58$) considered chaplains to be a part of the patient care team. Only 3% ($n=2$) of participants agreed that chaplains should only meet with patients when they are nearing death.

Table 2 Survey responses about attitudes toward chaplains among all participants

Question	Strongly agree or Agree (*n*,%)	Disagree or strongly disagree (*n*, %)
Have you ever made a referral to a chaplain on behalf of a patient or family?	56 (88)	8 (13)
Have you ever read the chaplain's note when consulting a patient's medical record?	47 (73)	17 (27)
Have you ever requested a chaplain to discuss any of your personal concerns?	7 (11)	57 (89)
I found the chaplain's note helpful in providing care to the patient	38 (81)	9 (19)
Chaplains are helpful in resolving possible conflicts between the medical care team and patients	54 (84)	10 (16)
Chaplains should only meet with patients when they are nearing death	2 (3)	62 (97)
Chaplains should be considered part of a patient's medical care team	58 (91)	6 (9)
Chaplains' interactions with patients have improved the quality of care I provide to my patients	58 (91)	6 (9)

Staff working in the NCCU more than five years had lower odds of considering the chaplain as part of the care team (OR 0.033, CI 0.002–0.680, $P=0.027$) when compared to staff working less than 12 months. Nurses had higher odds of believing a chaplain improved their quality of care (OR 6.855, CI 1.178–39.883, $P=0.032$) and supported them emotionally (OR 9.167, CI 1.443–58.239, $P=0.019$) compared to non-nurses. Gender, age, race, marital status, and faith background had no effect on these outcomes.

Discussion

While a majority of participants had referred patients or family members to a chaplain, few had ever discussed their own concerns with a member of the spiritual care team. Staff had favorable views of the chaplain's contribution to patient care. Participants who worked in the NCCU more than five years had lower odds of considering the chaplain as part of the care team. Nurses had higher odds of believing the chaplain supported them emotionally and improved their quality of patient care.

When compared to other healthcare workers, nurses had higher odds of agreeing that chaplains improved quality of care. In our study population, 84% of participants who had made a referral were nurses. This is consistent with prior observations that nurses are more likely than other healthcare staff to refer patients for a chaplain visit (Flannelly et al. 2003; Koenig et al. 1991).

Our study suggests that more experience working in the NCCU was associated with less proclivity for considering chaplains as part of the care team, even among nursing staff. One possible explanation for this finding is a recent shift in focus within healthcare on interdisciplinary teams and more comprehensive approaches to care (Bosch and Mansell 2015). Recent emphasis on interprofessional education and interdisciplinary care teams may result in newly trained providers, particularly nurses, who have been recently educated in an environment that places a higher priority on integrating chaplains into the care team. Alternatively, nurses with more experience may be more comfortable having difficult conversations with patients and families and, thus, see less reason to involve a chaplain in that patient's care. They may, in a sense, assume aspects of the chaplain's role in caring for and comforting patients and families.

Only 3% of participants agreed that chaplains should only meet with patients when they are nearing death. Prior reported perceptions of the role of chaplains in the critical care unit have included the acknowledgement of their role in comforting patients and family. For example, one critical care nurse participant in a focus group commented that "[t]he more recent referrals I've made are not about dying. They've been more about comfort for patients or family…somebody just needs someone who has 30 min of their undivided attention to do nothing but listen to them" (Bone et al. 2018). Interestingly, though, one participant in our study commented that the chaplain "could have an even bigger role if the idea of [her] only being needed close to death was altered." Even though most staff acknowledge other potential times when a chaplain's presence could be useful, this quote suggests a lingering association between chaplains and the final days of a patient's life.

Indeed, within one academic center intensive care unit, there was a median of one day from the chaplain's encounter with the patient to death or ICU discharge (Choi et al. 2019). This suggests that chaplain visits were requested for actively dying patients rather than for proactive general spiritual care (Choi et al. 2015). We wonder if using a dedicated in-house chaplain on the NCCU unit instead of relying on referrals from busy healthcare staff will better enable chaplains to address the spiritual needs of all NCCU patients and families from earlier on in a patient's stay. Over time, this could shift perceptions about the appropriate timing of chaplain interventions. Of course, limited hospital chaplain availability may make implementation difficult even with institutional support (Flannelly et al. 2004; Wintz and Handzo 2005). Alternatively, a comprehensive care delivery program—with chaplains serving alongside palliative care physicians, social workers, and other stakeholders—could be integrated into the NCCU.

Several limitations of this study should be considered. First, the study was performed at a single tertiary care center which may reduce the generalizability of our findings. Second, we did not assess whether staff had previously worked in a critical care setting outside of the NCCU. It is possible that this previous work experience may have impacted staff familiarity with chaplains in the hospital setting. Finally, although respondents were ensured confidentiality prior to taking the survey, participants may have felt uncomfortable reporting negative associations with hospital chaplains.

Conclusion

This study is the first to describe attitudes of NCCU staff toward hospital chaplains. Our results suggest that chaplains are seen positively by NCCU healthcare workers but are less likely to be viewed as part of the care team by healthcare workers with more than 5 years of experience in the NCCU. By characterizing these staff perceptions, we will be better able to identify optimal environments for chaplains to intervene to improve patient care and target staff training to allow greater integration of the chaplain into the NCCU care team.

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Compliance with Ethical Standards

Conflict of interest The authors TEP, BP, GB, DC, TYC, HT, JRC, JP, PT, and DS declare no conflicts of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. However, full ethical approval was not obtained for this study. Rather, the IRB granted an exemption for this study because no identifying information was collected about participants, and the survey administered was deemed to be of minimal risk to participants. This article does not contain any studies with animals performed by any of the authors.

General Disclosures Unrelated to the Present Work The manuscript submitted does not contain information about medical device(s)/drug(s). Partial research funding was provided through an American Academy of Neurology grant. Portions of this work have been presented at the 2018 American Academy of Neurology Annual Meeting.

Informed Consent Informed consent was not required by the IRB given the exempt nature of this study.

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