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ORIGINAL PAPER

Assessing Spiritual Well-Being in Residential Aged Care: An Exploratory Review

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Abstract
With the emerging incorporation of spiritual care into the allied health stream, there is a need for a clear and validated process of spiritual review that can be understood across multidisciplinary teams. The aim and purpose of this paper was to critically review the literature regarding spiritual screening, history-taking and assessment, and explore the merits of developing a brief instrument focussed on assessing and improving the spiritual well-being of consumers within residential aged care. Following an exploratory review of the literature, the results indicate that effective processes are noted regarding the triage and identification of the needs and spiritual assessment of consumers; however, many of these tools are overly religious in content, unwieldy in size, or not specifically aimed at identifying the immediate crisis confronting the consumer. It is recommended that an assessment instrument be developed which is communicable across all allied health practitioners (including spiritual carers), which may contribute towards a taxonomy of common consumer conditions, and which will enable the development and delivery of more targeted care plans.

Keywords Residential aged care · Assessments · Spiritual well-being · Spiritual care · Chaplaincy · Religion

Introduction

Within most allied health fields internationally, there are clear processes for screening and assessment of a range of health presentations. These are defined by an evidence-based taxonomy of symptoms and conditions, which guide the development of care and therapy plans. As spiritual care is gradually gaining recognition among allied health streams (Carey and Mathisen 2018), there is a need for structured and validated multidisciplinary assessment processes, which would allow spiritual care assessments to be better implemented within residential aged care. This would also encourage a holistic collaboration between spiritual care practitioners and other allied health professionals.

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The international consensus conference (2014) which sought to identify and qualify the spiritual dimension of whole person care, defined spirituality as:

> … a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices. (Puchalski et al. 2014, p. 646).

Such a broad definition, however, is descriptive rather than prescriptive of the myriad ways in which spiritual care practitioners engage consumers across the health care system. Due to its lack of specificity, and the nebulous nature of the concepts inherent in spiritual encounters with consumers, such a definition can be problematic in seeking to establish a clear understanding of spiritual practitioner's contribution to consumer care and to the consumer's ultimate patient experience—which is emerging as an important health service outcome measure (Handzo et al. 2014).

Further, Stranahan (2007, p. 493) correctly observed that most of the literature regarding spirituality 'reveals little consensus on what it means to be spiritual, what constitutes spirituality and what contribution spirituality makes to the whole'—an issue which has confounded the integrity and validity of statistical surveys and subsequent results. For example, the most recent Australian 2016 Census allowed residents to identify as 'No religion' as an official category for the first time, resulting in 30.1% of Australians identifying as 'no religion' and 60.3% of Australians identifying as having some religious identity (ABS 2016, p. 1). However, as the definition of 'no religion' stated: 'No religion *includes secular and other spiritual belief*' (ABS 2016; emphasis by the authors), this figure offers little in understanding the proportion of Australians who identify with non-mainstream spiritual beliefs or practices.

A simple but useful differentiation between religion and spirituality has been proposed by Stranahan (2007, p.294) who argued that religion involved 'doing', whereas spirituality was more concerned with 'being'; going on to state that 'Spirituality is intrinsic to human nature, whereas religion is acquired learned behaviour', or as expressed by Peterman, 'Religion is seen… as participation in the institutionally sanctioned beliefs and activities of a particular faith group' (Peterman et al. 2002, p. 49). Over 40 years ago, Paul Pruyser asserted that religious professionals (and by extension spiritual care practitioners), were ideally suited for contributing to health care outcomes because:

> They …[pastoral theology and clinical psychiatry] …constitute broad views of human reality which do not leave out life's untidy details and do not avoid man's rocky roads to satisfaction in health or salvation. Both are attuned to the professional value of helping, in several of its aspects: healing, guiding, sustaining (Pruyser 1976, pp. 16-17).

Spiritual Care Practitioners

Religious specialists, more often now called spiritual care practitioners, have been active in the delivery of care since ancient times and across many cultures (Carey 2012; Ferngren 2012). Over the past few decades, however, the profession has undergone a shift in emphasis, away from specifically providing religious oriented care to a more holistic and spiritual approach as part of a multidisciplinary methodology covering a broad range of health care issues (Carey and Cohen 2009; Carey et al 2018; Timmins et al. 2018). Handzo

and a panel of industry experts have argued, however, that modern healthcare metrics (e.g., safety/quality, cure rates, reduced length of stay, reduced use of resources) have little relevance to traditional spiritual care, and therefore the spiritual care profession needs to evolve new paradigms and methods of engagement in order to find a valid and effective voice within the healthcare environment (Handzo et al. 2014, p. 43).

Traditionally spiritual care practitioners worked with a limited range of interventions, including prayer, sacraments (e.g., baptism, anointing, blessings, communion, last rites), combined with pastoral counselling/guidance and the reading of religious texts. Such interventions were standardised by the World Health Organization (WHO) within their 'Pastoral Intervention Codings' (WHO 2002; Carey and Cohen 2015) now called the WHO 'Spiritual Intervention Codings' (or 'WHO-SPICs'; WHO 2017) which identified four key interventions commonly engaged by chaplains/spiritual carers: (i) assessment, (ii) support, (iii) counselling/education and (iv) ritual/worship.[1] While offering structure to the classification and documentation of spiritual care interventions, nevertheless the WHO-SPICs continued the traditional range of actions, without improving the relevance of spiritual care in the modern healthcare framework, nor encouraging the evolution of new paradigms and methods of engagement.

Further, while there has been some work undertaken to justify the engagement and place of spiritual care within allied health scope of practice (Carey and Mathisen 2018), it is now fundamentally important to identify the unique contribution that spiritual care and spiritual care practitioners can make to consumer experiences. This may only be achieved, however, by developing new paradigms that will require the implementation of more contemporary assessment processes which will allow dialogue and collegial engagement between spiritual care practitioners and other allied health professionals, in order to enhance consumer well-being.

Background

While spiritual care may be growing in acceptance, its developmental history continues to contribute challenges which need to be recognised and resolved. Originally, the purview of ordained ministers and chaplaincyspiritual care was generally viewed as religious in nature (Handzo et al. 2014), particularly when it entailed the delivery of pastoral healing, end-of-life or grief rituals. Ellison and Levine (1998, pp. 704–709) summarised five ways in which religious spirituality contributed to the promotion of health and the patient care environment, namely by the:

- Regulation of health behaviour and personal lifestyle
- Provision of social integration and social support
- Encouragement of self-esteem and person efficacy
- Provision of coping resources and behaviours
- Encouragement towards positive emotions and the fostering of healthy beliefs

It must be acknowledged that currently spiritual practice may have as many negative components as it has positive (Swinton 2012) and that the personal experience of spirituality is difficult to define empirically because of the existential engagement, leading Hill and Pargament (2003) to define spirituality as the personal, subjective side of religious

[1] WHO Spiritual Intervention Codings: In addition to the four key interventions noted above, an additional intervention is also included -'Allied Health Intervention' for any generic spiritual care intervention not otherwise listed.

Table 1 Lartey's dimensions of spirituality. *Source*: (Lartey 2003, pp. 140–141)

	Nature of connection	Description of connection
I.	Relationship with transcendence	Connection to that which transcends our reality
II.	Relationship with self	Connection to and coming to terms with self-hood
III.	Relationship with others	Connection to others which fosters a sense of belonging
IV.	Relationship among others	Connection to a whole that is greater than individual relationships which fosters a sense of identity
V.	Spatial relationship to both place and things	Connection with nature, with geographical and geospatial place

experience. This offers profound difficulties, however, when seeking to reify spirituality, not only between disparate faith communities, but also to incorporate the spiritual dimensions present in people who hold no formal faith expression. In truth, while a member of the Baptist, Catholic or Buddhist faith systems may describe their beliefs and engagement as coherent with others of their faith systems, they may equally find empathetic expression with someone of a differing faith system (Carey et al. 2009). The different experiences of spirituality lead Emmanuel Lartey (Lartey 2003, pp. 140–141) to posit five dimensions of spiritual connection that we might experience (refer Table 1).

The emphasis on connection in Lartey's work and the subjectivity of the spiritual experience has been increasingly reflected in accepted definitions of spirituality, leading many practitioners to creatively shift away from the traditional religious and pastoral nature of praxis towards a more flexible 'spirituality framework', opening wider avenues of scope of engagement, and potentially wider acceptance, but consequently losing some of the definition and historic narrative.

Considering the Impact of Age

Berggren-Thomas and Grigg (1995, p. 9) observed that what is needed in care is a more spiritually oriented approach which does not '…view the elderly client as spiritually challenged or needy, but instead as a person on a spiritual journey with the potential for spiritual growth'. This perspective of the spiritual journey of the older person was one explored by Erik Erikson and Joan Erikson in their seminal thesis on psychosocial development (Erikson and Erikson 1997). In their original framework, the phase of old age was stage VIII, where the person navigated the psychosocial crisis of 'Integrity versus Despair' in the hope of gaining the strength of wisdom. In the revised edition, however, a ninth final or end stage (Stage IX) was proposed in which the person renegotiated the stages (refer Table 2).

In the final renegotiation, syntonic and dystonic paradigms were reversed, so that the person commenced with despair and then if successful moved towards integrity.

> Despair, which haunts the eighth stage, is a close companion in the ninth because it is almost impossible to know what emergencies and losses of physical ability are imminent. As independence and control are challenged, self-esteem and confidence weaken. Hope and trust, which once provided firm support, are no longer the sturdy props of former days (Erikson and Erikson 1997, pp. 105–106).

Table 2 Erikson's model of psychosocial development. *Source*: (Erikson and Erikson 1997)

Stage	Relative life stage	Psychosocial crisis
I	Infancy	Basic trust versus mistrust
II	Early childhood	Autonomy versus shame, doubt
III	Play age	Initiative versus guilt
IV	School age	Industry versus inferiority
V	Adolescence	Identity versus identity confusion
VI	Young adulthood	Intimacy versus isolation
VII	Adulthood	Generativity versus stagnation
VIII	Old age	Integrity versus despair
IX	End stage	Renegotiation with syntonic and dystonic elements reversed

Bash (2004, p. 13) with a more idiopathic view of spirituality observes that 'spiritual experience is what each person says it is, and the task of nurses is to identify and respect that person's expression of their spiritual experience and to offer them appropriate support' (Bash 2004, p. 14). While this may be seen as more nebulous than the formal consensus definition quoted earlier (Puchalski et al. 2014), it does offer an openness in which we can allow the consumer to appropriate their distinct and unique spirituality, and in which care staff may offer support.

Linking this with the Erikson and Erikson's model, the task of spiritual care in aged care, lies in assessing where the individual consumer finds themselves, and to build a plan around the individual experience of their crisis' and challenges to assist them to negotiate to a state of spiritual well-being, or what Erikson names as 'gerotranscendence' (Erikson and Erikson 1997) citing work by Lars Tornstam (1997).

As Tornstam's writing drew heavily from Erikson and Erikson's theories (Tornstam 1997), along with Karl Jung (1875–1961), Abraham Maslow (1908–1970) and M. Scott Peck (1936–2005) (Jewell 2014; Tornstam 1997), there is a danger that the argument may become circular and 'co-dependent', particularly in light of criticism that gerotranscendence is a reformulation of the concept of 'disengagement' (Tornstam 1989) proposed by Elaine Cumming during the 1960s (1961). Cumming argued the case that ageing is a process of disengaging, first intrinsically within the process of ageing, then in response to physical, environmental and social states (Cumming et al. 1961); however, she too referred extensively to Erikson and Erikson (Cumming et al. 1961; Cumming and Henry 1960), compounding the risk of enmeshment due to the co-dependency upon each other's arguments.

Because Tornstam saw Cumming's thesis as intrinsically negative (to disengage and withdraw from their social and environmental constructs), he reformulated it as a positive experience (that they transcend the materialistic and rational demands of their past to find satisfaction or contentment) (Tornstam 1997, p. 153). Rather than an 'either/or' dichotomy, however, it is likely that both disengagement *and* gerotranscendence are experienced by aged care residents, and that spiritual care must include the assessment of the individual experience of the resident, to assist the resolution of those biological, psychological and social elements that might hinder their process through old age.

Spiritual Screening, History-Taking and Assessment

The timing, content and ownership of this assessment process have received growing attention over the past decades. Most of the authors (of the reviewed literature) agree to a threefold process of screening, history-taking and assessment. Discussion around 'who' undertakes each phase, and the specific questions used to understand the experience of the consumer vary considerably between the different models. Further, few of the models offer an empirical means of 'diagnosing' the needs of the consumer, nor of formulating the design and evaluation of a care plan.

The outcome summary of the consensus conference on spiritual care in palliative care (Puchalski et al. 2009) identifies that the three phases of enquiry be conducted by two distinctly different groups, with the initial screening undertaken on admission by nursing staff or social workers, the secondary phase of history, undertaken on or immediately post-admission by 'physician, nurse or other', and that the final spiritual assessment be undertaken only by specialist spiritual care practitioners (Puchalski 2011, p. 54; Puchalski et al. 2009).

The goal of the initial *spiritual screening* is to determine whether the consumer is undergoing 'serious spiritual crisis' prior to or at admission that requires immediate referral to a spiritual care practitioner (Austin 2006; Puchalski 2011; Puchalski et al. 2014).

Spiritual history-taking extends this process past triage in order to understand the needs, hopes and resources of the consumer and to understand their religious, spiritual and cultural context (Puchalski 2011; Puchalski et al. 2014). The reality in practice is often that this process is limited to identifying the faith community the person belongs to, and even here, anecdotally, many consumers are listed as '*no religious affiliation*' or '*not specified*', both of which may specify a consumer who has no spiritual or religious identification, or who simply was not questioned about their identification as this process is often skipped or missed amid the priorities of admission to acute care. This is particularly important in identifying and mediating potential issues around treatment expectations, food restrictions and religious rituals that the consumer or their community would require to be respected, particularly where failure to do so would jeopardise the patient experience, or in extreme situations, their preparedness to receive care.

The third phase, *spiritual assessment*, is perhaps the most controversial. In the acute setting, it is often not possible, due to time and resource constraints, to undertake an extensive assessment, nor to develop, let alone engage a spiritual care plan (Fitchett 2012, p. 301; O'Connor et al. 2005, p. 103.). Cadge and Bandini (2015) and Rumbold (2007, p. S62) have made the observation that it is troublesome too, that some practitioners refer to the screening and history-taking processes with the same word 'assessment' thereby muddying the definition and process of spiritual assessment. The consensus conference of 2009 (Puchalski et al. 2009), however, identified a clear pathway for the threefold discernment process (Puchalski et al. 2009, p. 891) and was explored further by Puchalski in her own exploration of formal and informal assessment protocols, to assist the identification of pre-existing issues prior to spiritual assessment. (Puchalski 2011, p. 52) (refer Fig. 1).

Differentiating Activities

George Fitchett (2012) clearly defined the nature and differences between the three activities. *Screening*, as in other disciplines, is focussed on assessing if a consumer is

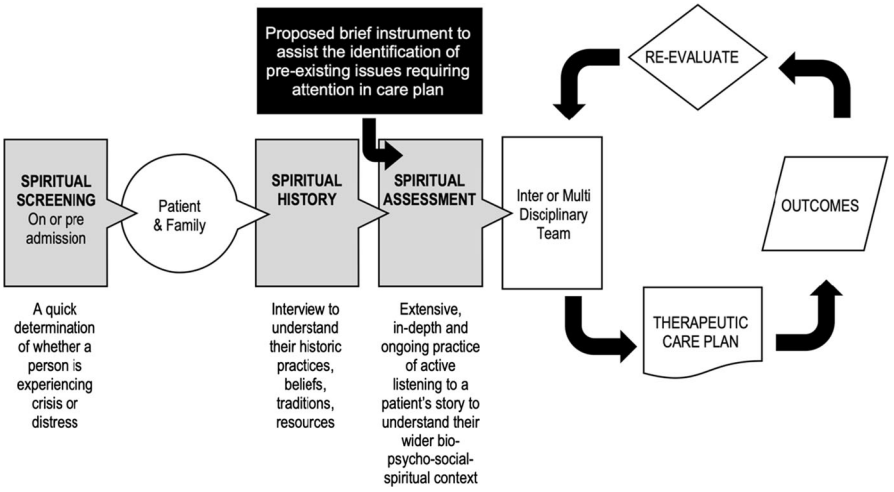

Fig. 1 Puchalski et al.'s (Puchalski et al. 2009) model of spiritual assessment modified with a newly proposed instrument. *Source*: Puchalski et al.'s (2009) spiritual assessment model modified with the [authors'] indication of a proposed brief instrument between 'spiritual history' and 'spiritual assessment'

currently experiencing spiritual distress or crisis (Fitchett 2012, p. 299; Fitchett and Risk 2009) and whether an immediate referral to a spiritual specialist is required. He advises that such screening requires a few, simple questions, that might be asked and interpreted by any health professionals. Such questions may be as simple as 'are you at peace?' or include gauging tools like the Distress Thermometer (Berger 2015). Screening then is extremely focussed, short in form and targeted to their affect in that moment.

History-taking on the other hand is a more extensive interview process seeking to explore the spiritual practices, resources and needs, and how they are able to cope in crisis (Fitchett 2012; Lucchetti et al. 2013, p. 159; Puchalski et al. 2009). Often in mnemonic form (e.g., FAITH, FICA, SPIRIT, HOPE, SHALOM; refer Table 6), the history process combines the collection of objective data (e.g., religious/spiritual affiliation, spiritual and cultural rituals and practices) as well as more subjective and 'impressional' data (e.g. meaning, sources of hope, feelings regarding illness and life; Puchalski et al. 2009, p. 893). Like screening, 'history-taking' is a tool that can be engaged by any health care practitioner (e.g. lifestyle officers, nursing, clerical, physician or spiritual practitioner; LaRocca-Pitts 2008, p. 2; Puchalski 2011), and therefore, it will contain generic phrasing over particularly liturgical or theological language. Koenig argues that an effective spiritual tool should meet five criteria (refer Table 3; Koenig 2013, pp. 41–42). It is acknowledged,

Table 3 Koenig's criteria for a history-taking tool. *Source*: (Koenig 2013, pp. 41–42)

1.	Brief (only a minute or two to administer)
2.	Easy to remember
3.	Gain information that is appropriate to the patient's particular health situation,
4.	Must be patient-centred (proactive, neutral, benevolent, non-intrusive, respectful)
5.	Acknowledged by experts in the field as valid and appropriate

however, regarding point five (refer Table 3), and as Sulmasy noted at the turn of the Century, that few of these history taking tools, have 'undergone any serious psychometric testing' (Sulmasy 2002, p. 31).

The *spiritual assessment* tools, much fewer in number, are less structured in form and content and are in effect a longitudinal conversation rather than a short question instrument. Fitchett (2012, p. 299) describes the process as the 'ongoing process of evaluating the spiritual needs and resources of persons to whom we provide care'. Rumbold (2007, p. S61) adds 'Spiritual assessment must be a process, not merely an event, as it needs to take account of emergent insights and accommodate the patient's exploration of particular issues if he or she so chooses'. The consensus conference of 2009 (Puchalski et al. 2009, p. 893) observed that:

> Formal spiritual assessment refers to a more extensive process of active listening to a patient's story conducted by a board-certified chaplain that summarizes the needs and resources that emerge in that process.

The authors included the recommendation that the chaplain's summary of the conversation should 'include a spiritual care plan with expected outcomes that is then communicated to the rest of the treatment team' (Puchalski et al. 2009, p. 893). They also confirmed the thought that assessments are not sets of questions, but rather interpretive frameworks by which the person's narrative may be heard and interpreted (Puchalski et al. 2009).

Ruth Stoll, writing from a nursing perspective some 40 years ago, proposed that because 'nurses are interested in the whole person, …nursing care should meet the person's physical, emotional, and spiritual needs' (Stoll 1979, p. 1574). She went on to propose a spiritual history-taking process which explored: The person's concept of God or Deity; the person's source of strength and hope; the significance of religious practices and rituals, and their perceptions of the relationship between their spiritual beliefs and their state of health (Stoll 1979, pp. 1576–1577). To a large degree, the current spiritual history and assessment tools have followed and refined this basic pattern. The challenge remains, however, that such measures are highly subjective, even within similar faith communities.

Assessment and Diagnosis

The process of assessment or diagnosis in the mental health field is based in-large part on a taxonomy of symptoms and conditions such as the American Psychiatric Association 'Diagnostic and Statistical Manual of Mental Health Disorders' (DSM-5) or the World Health Organization—International Classification of Diseases and Related Health Issues (WHO-ICD-10/11), conditioned by a consideration of the consumer's personal, social and cultural context. Dziegielewski (2015, p. 28) suggests that the terms assessment and diagnosis are interchangeable, but that assessment is used more often in the allied health field because of the affiliation of 'diagnosis' with the medical model, seeing diagnosis as 'as the process of seeking underlying causes and assessment as having more to do with the analysis of relevant information' (Dziegielewski 2015, p. 30). In this light, 'assessment' is the correct nomenclature for the task under consideration; however, the question remains, 'what do we assess?'

In the fields of mental health and medical care, a clearly defined taxonomy of conditions has been established; however, within the spiritual care field, little work has been undertaken to quantify such a taxonomy. Some work has been undertaken in developing a

taxonomy of chaplain interventions (Carey and Cohen 2015; Cavendish et al. 2003; Massey et al. 2015; Sharma et al. 2016; Stang 2017) but not of the underlying issues and conditions which the interventions seek to resolve.

Of the numerous documents identified later in the exploration of this paper, only two documents included a taxonomy of behaviours and emotions which may be indicative of spiritual distress. Brunjes (2011, pp. 33–35) identified that: loss of identity, fear/dread, anger, and depression may be experienced by consumers negotiating the final phases of life and that spiritual assessment needs to pay attention to their presence. As a consequence of the American consensus conference regarding the role of spiritual care in palliative care, a more exhaustive taxonomy of issues was incorporated which added: 'existential concerns'; 'abandonment by God'; 'anger at God'; 'relationship with God'; 'conflicted belief system'; 'despair/hopelessness'; 'grief/loss'; 'guilt/shame'; 'reconciliation'; 'isolation'; 'religious/spiritual struggle' (Puchalski et al. 2009, p. 894). However, although these expressions have been identified, these are not exhaustive of the issues that consumers face, and these are not described adequately enough within the literature or other taxonomies to assist assessment.

Clearly the recreation of a spiritualised version of the DSM-5 (noted earlier) or the WHO-ICD (noted earlier) is beyond the scope of this work, nor is there any reason to propose that conditions faced by spiritual consumers are different to those faced by non or different-spiritual consumers. Rather it is more valuable to identify how a spiritual approach may contribute to multidisciplinary engagement with consumers and to assist in the development of healthcare plans which will aid practitioners to resolve crises which may arise, to manage the dystonic movement towards disengagement and to negotiate gerotranscendence.

Methodology

Search Process

To assist the identification of search terms, the PICO framework (Schardt et al. 2007) was utilised (refer Table 4). In order to understand the various professions' application of 'spiritual care assessment' and the tools currently engaged in that process, a scoping review was undertaken of key database indices used across the health sciences, namely: Scopus, EBSCO (Ageline and CINAHL), OVID (AMED, EMBASE, PsycINFO), ProQuest, and PubMed (refer Table 5).

The search terms were structured to identify both pastoral and spiritual care as each has been equally used in the literature over past decades. Searches were also undertaken to identify articles relating to 'assessment', 'residential aged care', and 'taxonomy'. These searches were then blended to refine the search strings.

Table 4 PICO search framework. *Source*: (Schardt et al. 2007)

PICO	Search target
Population	Consumers of residential aged care facilities
Intervention	Spiritual care assessments
Comparison intervention	Instruments used for patient screening and history-taking
Outcome	The development and refinement of care plans against a taxonomy of issues experienced by aged care consumers

Table 5 Literature search results

Database	Search string								
	Search 1: All fields pastoral care	Search 2: All spiritual care	Search 3: Assessment	Search 4: Residential aged care	Search 5: Taxonomy	Search 6: 1 or 2 and 3	Search 7: 1 or 2 and 4	Search 8: 6 and 5	Search 9: 7 and 5
Scopus	9293	5991	6,886,908	4477	568,674	4860	56 Acc: 5	194 Acc: 5	3 Acc: 1
EBSCO (Ageline & CINAHL)	427	4167	393,256	996	4263	1326	731 Acc: 0	211 Acc: 1	265 Acc: 3
OVID (AMED, EMBASE, PsycINFO)	84	629	375,498	264	3712	168	0 Acc: 0	1 Acc: 0	0 Acc: 0
ProQuest (Psych, Religion, Pub Hlth, Hlth/Med)	368	470	220,993	1271	2473	416	14 Acc: 0	10 Acc: 0	0 Acc: 0
PubMed	3650	1553	1,197,515	890	21,350	541	1 Acc: 0	0 Acc: 0	0 Acc: 0
Totals	13,822	12,810	9,074,170	7898	600,472	7311	802 Acc: 5	416 Acc: 6	268 Acc: 4

Search limits: (i) All fields; (ii) Date range: 2000 to present; (iii) All full text document types (iv) Language: English only; (v) ACC indicates number of articles accepted into literature review. Reason for non-acceptance into literature review included that (a) the article was specific to acute, palliative, cancer, dementia care, etcetera, (b) not general residential aged care, (c) duplicates of articles which were already identified, or (d) not relevant to terms of study; (vi) All bibliographies of the selected papers were explored to identify further documents; 185 articles were added through bibliography review

The key search term 'assessment' within the SCOPUS database produced the largest number of results (n = 6,866,908) and the largest results across all databases (n = 9,074,170). The least identified was 'residential aged care' (n = 4,477); however, the most relevant results arose from the blended search strings which, when assessed, identified only a small number of articles which addressed the PICO framework (n = 15). The bibliographies of these articles were analysed to expand the target journal articles for review (n = 185); however, many of these were not specific to the search terms, but were included because they identified and tested assessment instruments.

Results

Investigation of Current Instruments

Reviewing the selected articles, a range of instruments were identified which had been documented in a peer-reviewed environment, with quantitative and qualitative analysis. These were then analysed against the parameters already documented for screening, history-taking, and assessment instruments.

Of the twenty-three (N = 23) instruments identified only three (n = 3) were judged or asserted to be screening tools, with the 'ConnecTo' instrument judged to be inclusive of some elements of a history-taking tool; however, it appears to be predominantly a screening tool in both its original and modified forms. The instrument has been included in the review even though it does not appear to have been published in a peer-reviewed journal and does not appear to have a documented evidence base, because it has been incorporated into the operations of an important and peak aged care corporation, 'Meaningful Aging in Australia' (2017). The ConnecTo tool follows very closely the model proposed by Emmanuel Lartey (2003) emphasising the importance for relationship and connectedness for well-being. Nineteen (n = 19) of the instruments (including elements of ConnecTo) fit the criteria as history-taking instruments. The predominance of these was brief, mnemonic based structures which focussed on gathering such information as past denominations, effective practices and resources, and current needs. The remaining five (n = 5) instruments (noted in Table 6*) best met, in full or in part, the definition of a spiritual assessment instrument. These were the:

(i) 7 × 7 Model
(ii) Four Facts
(iii) RCOPE
(iv) FACIT-sp
(v) Spiritual Assessment System

Spiritual Assessment Instruments

7 × 7 Model

One of the earliest formal assessment tools, dating from the late eighties, was developed by George Fitchett and the team at Rush Presbyterian/St. Luke's Medical Centre in Chicago. Named after its form, the '7 × 7 Model' explored what Fitchett called the holistic or bio-psycho-social dimension, wherein the medical, psychological, family system,

Table 6 Literature search—instrument's identified

Instrument	Developer[(i)]	Date	Screening	History	Assessment
Guidelines for Spiritual Assessment	Stoll	1979		X	
Meaning in Life Scale	Spitzer	1980		X	
Spiritual Well-Being Scale	Paloutzian	1991		X	
7 × 7 Model	Fitchett	1993		X	X
INSPIRIT	Vande-creek	1995		X	
SPIRITual History Tool	Maugans	1996		X	
FICA	Puchalski	1996		X	
HOPE	Anandarajah	2001		X	
BELIEF	Dobbie et al.	2003		X	
Spirituality Scale	Delaney	2003/5		X	
Spiritual Needs Assessment	Galek	2005	X		
Spiritual Self-Assessment Index	Stranahan	2008	X		
FACT (revised 'Four FACTS', 2015)	LaRocca-Pitts	2008		X	(x)
SHALOM	Fisher	2010		X	
Religious Involvement Inventory	Gow	2011		X	
Daily Spiritual Experiences Scale	Underwood	2011		X	
RCOPE	Pargament	2011			X
SNAP	Sharma	2012		X	
FACIT-sp	Peterman	2014		X	X
Quality of Spiritual Care Scale	Daaleman	2014		X	
iCaring Brief Assessment	Hodge	2015		X	
Spiritual Assessment System	Bryson	2015			X
ConnecTo	Fletcher	2016	X	(x)	
Total			3	19	5

(i) Developer: Only the leading author is noted; (ii) The upper case 'X' indicates primary application, a lower case '(x)'in parentheses indicates a secondary application of the tool; (iii) Mnemonics used: INSPIRIT = (INdex of core SPIRITual experiences), FICA = (Faith, Implications, Community, Address), HOPE = (Hope source, Organised religion participation, Personal Spirituality, Effects), BELIEF = (Beliefs, Explanation, Learn or understand, Impact, Empathy, Feelings), FACT = (Faith or Belief, how Active, Coping, Treatment Plan), SHALOM = (Spiritual Health And Life-Orientation Measure), RCOPE = (Religious COPEing Scale), SNAP = (Spiritual Needs Assessment for Patients), FACIT-Sp = (Functional Assessment of Chronic Illness Therapy—Spiritual well-being)

psychosocial, cultural, social issues and spiritual dimension, the last further broken down into belief/meaning, vocation and obligations, experience and emotions, doubt (courage) and growth, ritual and practice, community, plus authority and guidance dimensions of the consumer.

This model certainly offered a comprehensive scope of engagement; however, without clear structure around the exploration of the disparate dimensions, many commentators found it a convoluted and difficult model to engage (Larocca-Pitts 2009, p. 10; O'Connor et al. 2005; Rumbold 2013, p. 8). While Fitchett's model offers a valuable scope of the assessment process, without further definition of the domains referenced, it offers little as a practical model for assessing immediate needs within day-to-day operations in residential aged care.

FACT/Four Facts

Originally developed in 2008 by Mark LaRocca-Pitts (2008, 2009) as FACT, and later redesigned in 2015 as 'Four Facts' (LaRocca-Pitts 2015). Though predominantly, a history-taking tool, it moved towards becoming a Spiritual Assessment tool with the 2015 redesign which transformed the original mnemonic of:

F: the client's expressed **F**aith or belief,
A: how **A**ctive is the client's faith,
C: the client's current **C**oping mechanisms,
T: the proposed **T**reatment Plan (LaRocca-Pitts 2008, p. 2; 2009, p. 12).

The modified and updated version included four 'F's' prior to the FACT mnemonic. **F**acts about the current medical situation, how they **F**eel about their situation, **F**amily/**F**riends connections that will be resources for them, and an exploration of their personal **F**aith, beliefs, worldviews and practices. It also included a range of other F's including **F**un, **F**inances, **F**unctioning, **F**ame/**F**ortune, **F**uture expectations. Even with the modifications, however, the instrument remains predominantly a history-taking tool, although it does offer more scope for an extended conversation inherent in the spiritual assessment process. The four remaining instruments do fit the structure and definition of a spiritual assessment tool.

FACIT-sp

There are currently four versions of the FACIT-sp (Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being) instrument in circulation (refer Table 7; FACIT 2010).

All of the articles identified in the literature search engaged the FACIT-sp-12 instrument, possibly for reasons of simplicity. In the FACIT-sp scale, 27 items assess across five domains covering: physical well-being, social well-being, emotional well-being and functional well-being, before the inclusion of the 12 items of the FACIT-sp-12 which is categorised as 'additional concerns'.

The extended tool begins with the 12-item scale before incorporating questions across connectedness to God, others and nature, love, forgiveness, thankfulness and hopefulness. Such an addition may be a valuable exploration of the spiritual status of the consumer;

Table 7 FACIT-SP versions. *Source*: (FACIT 2010); FACIT-Sp = (Functional Assessment of Chronic Illness Therapy - Spiritual)

FACIT instrument	Details
FACIT-Sp:	Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being (39 items across 5 dimensions) (FACIT 2007b)
FACIT-Sp-12:	Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being; The 12-Item Spiritual Well-Being Scale (FACIT 2007a)
FACIT-Sp-Ex:	Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being, Expanded version—a 23-Item Scale. (FACIT 2007c)
FACIT-Sp-Non-Illness:	Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being, a 12-item scale modified for non-illness by altering the words of the last two questions.

Table 8 FACIT-sp instrument questions. *Source*: (FACIT, 2007a; Peterman et al. 2002, p. 52); FACIT-Sp = (Functional Assessment of Chronic Illness Therapy - Spiritual)

1.	I feel peaceful
2.	I have a reason for living
3.	My life has been productive
4.	I have trouble feeling peace of mind
5.	I feel a sense of purpose in my life
6.	I am able to reach down deep into myself for comfort
7.	I feel a sense of harmony within myself
8.	My life lacks meaning and purpose
9.	I find comfort in my faith or spiritual beliefs
10.	I find strength in my faith or spiritual beliefs
11.	My illness has strengthened my faith or spiritual beliefs
12.	I know that whatever happens with my illness, things will be okay

however, it appears to refer back to Lartey's (2003) model of connectedness without addressing more immediate expressions of spiritual crisis as: shame, grief/loss, abandonment and anger.

The 12-item instrument, with six statements relating to a sense of peace and six assessing the role of faith or meaning in illness, all rated by the consumer on a Likert scale from 0 (not at all) to 4 (very much) over the past 7 days (refer Table 8).

Though its title directs its use to the chronic illness setting, with careful facilitation it may be incorporated effectively into the residential aged care setting, however the limited range of outcomes to the instrument make it of limited value in developing a comprehensive care plan, leading Koenig to observe that the FACIT-sp tool was only effective in gauging emotional well-being (Koenig et al. 2012).

Religious Coping Scale—RCOPE

The Brief RCOPE is a 14-item instrument which developed out of Pargament's focus on religious coping mechanisms (Pargament et al. 2011, p. 51). It addresses four statements towards positive coping, on how relationship with God might inform our approach to illness or challenge, or how the illness might inform our perception of self or faith. It then addresses seven 'negative coping' subscales, whether the consumer felt they were being punished, whether the devil was attacking, or whether they had been abandoned. There are two challenges in this. Firstly, the paradox in the phrase 'negative coping' which Pargament describes as 'underlying spiritual tensions and struggles within oneself, with others, and with the divine' (Pargament et al. 2011, p. 51). Such behaviours are normally termed 'maladaptive' rather than 'negative' coping strategies, for while we may employ these as coping tools, these are more often strategies of avoidance or denial.

The second issue with Pargament's schema is that it is overtly religious, potentially creating resistance for those of a non-Christian spirituality. While therefore Pargament's assessment instrument offers some valuable perspective to the adaptive and maladaptive ways in which consumers face crisis and decline, its application is limited to religious consumers.

Spiritual Assessment System (SAS)

The spiritual assessment system proposed by Ken Bryson (2015) explores the meaning-making dimensions across the whole person, how disease contributes to the person's loss of meaning, and how that meaning might be restored. The instrument lists 69 questions across three dimensions of the person: the carbon, social and neo-cortical self, mirroring the bio-psycho-social construct of self. The responses to these questions are then plotted on a multi-axial 'person-making template' (Bryson 2015, p. 93). Though Fitchett's (2012, p. 299) description of any spiritual assessment tool is that it is conversational rather than a set of questions, the SAS does offer a holistic framework in which to explore a person's experience and perceptions, it does make reference to faith systems other than Christian, and does indicate that the author has explored this framework in nursing homes. However, it appears from the quoted article that these are not residential aged care settings (Bryson 2003) and the size of this instrument is intimidating in framing the early phase of developing a care plan.

Discussion

The aim and purpose of this paper was essentially twofold: to critically review the literature regarding spiritual screening, history-taking and assessment, plus explore the merits of developing a brief instrument focussed on assessing and improving the spiritual well-being of consumers within residential aged care.

Following a review of the literature, it can be affirmed that, overall, much work has already been devoted to exploring spiritual care in the context of palliation, cancer, pain, acute care in emergency departments (ED), intensive care units (ICU) and hospital wards, both inpatient and outpatient (Azarsa et al. 2015; Bekelman et al. 2010; Benito et al. 2014; Daaleman et al. 2014; O'Connor et al. 2005; Williams and Sternthal 2007).

Very little, however, has been undertaken in the extended care environment that is residential aged care. What has been undertaken indicates that effective processes are noted within the literature regarding the triage and identification of the needs and spiritual assessment of consumers; however, many of these tools are overly religious in content, unwieldy in size, or not specifically aimed at identifying the immediate crisis confronting the consumer.

Also a number of documents (Burke et al. 2018; MacKinlay 2006; Ødbehr et al. 2015) while they do explore spiritual care in the context of dementia and residential aged care; nevertheless, once dementia becomes the major diagnostic criteria, interventions subsequently shift from cognitive assessments and interventions to affect regulation and containment.

It is noted too, that in the current Australian context, further challenges are created because age is not necessarily a definer of tenancy. Owing to the limited options for care of younger people with chronic health conditions, some facilities care for consumers aged in their 20s through to centenarians. Catering for the bio-psycho-social-spiritual needs of such a diverse population group requires specific tools to assist the identification of the issues facing each individual consumer and the tailoring of well-being support strategies.

Throughout their aged care residency, consumers frequently wrestle with feelings of grief, abandonment, loss of independence, depression and anxiety, and spiritual care practitioners seek to ameliorate these conditions; however, new tools would be

advantageous to ensure that specific spiritual needs are identified effectively and resolved holistically.

Conclusions and Recommendations

If spiritual practitioners are to further develop their place among the allied health professions, it will be due to the way their paradigms and instruments share a common language and are accepted across multidisciplinary health care teams. This is particularly true in residential aged care, where the strategic participation of spiritual health practitioners in the preparation and delivery of care plans, have the potential to make an essential contribution to the well-being of residents.

Admittedly valuable contributions to the literature encouraging a multidisciplinary approach have recently been made through texts such as *Spiritual Care for Allied Health Practice: A person-centred approach* (Carey and Mathisen 2018) and *Evidence-based Healthcare Chaplaincy: A research reader* (Fitchett et al. 2018). Yet work still needs to be undertaken in the identification of consumer issues commonly experienced by residents and the integration of spiritual assessment results into care plans, which can be progressively monitored and evaluated throughout the tenure of the consumer in residential aged care.

To facilitate this, it is recommended that a research strategy is required to identify core elements for a taxonomy that will identify bio-psycho-socio-spiritual issues which are commonly faced by consumers of residential aged care facilities. With the identification of six-to-eight key issues (for example), a brief psychometric instrument could be developed and validated to assist practitioners to refine and direct the spiritual assessment process in conjunction with the development and delivery of care plans.

It is also recommended that such a new and brief tool will form a bridging instrument between the 'spiritual history-taking' process and the formal 'spiritual assessment' process (see Fig. 1), so as to 'assist the identification of pre-existing issues requiring attention in a care plan'. The new instrument should focus on emotional and attachment states, including guilt, shame, anxiety, alienation/abandonment and grief/loss, which the care plan will then address in accordance with the spiritual, cultural and experiential needs and expectations of the consumer. A new instrument should not, however, be framed in specifically religious or spiritual terminology, but rather in generic language in order to allow adoption of the instrument regardless of the faith or lack-thereof, expressed by the consumer. Spiritual interactions will continue to be founded and grounded in the trilogy of screening, history-taking and assessment, but through the proposed instrument such assessment tasks will be more refined and targeted.

The spiritual care profession walks the same ground as other allied health professionals, often engaging the same challenges and conditions to address the well-being of residents. Only through clarifying the language of that engagement, refining the assessment process to match those of like professions, and encouraging the development of consumer care plans which effectively communicate goals and therapeutic strategies across the care teams, will there be a truly holistic collaboration of spiritual care practitioners with other allied health professions.

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Compliance with Ethical Standards

Ethics Approval Ethics approval was not required, as this study did not involve any animal experimentation or human participants.

Conflict of interest The authors declare no conflict of interest.

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