Brief Methodological Report

Development and Preliminary Testing of the Quality of Spiritual Care Scale

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Abstract

Context. The provision of spiritual care is considered a key element of hospice and palliative care, but there is a paucity of empirically developed quality-of-care measures in this domain.

Objectives. To describe the development and reliability and validity of the Quality of Spiritual Care (QSC) scale in family caregivers.

Methods. We conducted analyses of interviews conducted that included the QSC scale with family members of residents who died in long-term care settings taken after the resident had died. To determine reliability and validity of the QSC scale, we examined internal consistency, concurrent construct validity, and factor analysis with promax rotation.

Results. Of 165 family caregivers of decedents who were asked whether they received spiritual care, 91 (55%) responded yes, and 89 of these (98%) completed at least 80% of the QSC items. Two items (i.e., satisfaction with and value of spiritual care) were perfectly correlated so the latter item was dropped in scale development. Factor analysis identified two factors, *personal spiritual enrichment* (mean pattern matrix loading = 0.77) and *relationship enrichment* (mean pattern matrix loading = 0.72). Reliability analysis yielded a Cronbach's alpha of 0.87, and item-total correlations for all items were in excess of 0.55. Preliminary validity of the QSC was supported by significant and expected correlations in both direction and magnitude with items from validated instruments conceptually associated with the quality of spiritual care.

Conclusion. Preliminary testing of the QSC scale suggests that it is a valid and reliable outcome measure of the quality of spiritual care at the end of life. J Pain Symptom Manage 2014;47:793–800. © *2014 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words

Quality of care, spiritual care, measurement, end of life

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Accepted for publication: June 15, 2013.

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0885-3924/$ - see front matter
http://dx.doi.org/10.1016/j.jpainsymman.2013.06.004

Introduction

Attention to the spiritual needs of patients and caregivers at the end of life, and the provision of high-quality spiritual care, have been advocated by the Institute of Medicine, the National Hospice and Palliative Care Organization, and the Joint Commission on Accreditation of Healthcare Organizations.[1–3] Although seriously ill patients and families want their religious and spiritual values, beliefs, and practices included in their care decisions and processes, this goal is infrequently achieved.[4] Even when spiritual care is included in overall care planning, there is limited evidence demonstrating the impact of spiritual care on health care outcomes, such as satisfaction with care. For example, family members of decedents who received spiritual care in long-term care settings rated their overall care in the last month of life more highly compared with decedents who did not receive spiritual care.[5] Unfortunately, this is one of only a handful of studies that document the contribution of spiritual care to the overall quality of health care.[6,7] Without an evidence base that can demonstrate value, spiritual care runs the risk of being marginalized in health care settings.[6]

The acknowledged limitations around spiritual care and quality are significant, especially in light of emerging consensus practice guidelines such as those of the National Quality Forum, which include the provision of spiritual care services as a preferred practice of quality palliative care.[8] In addition to the National Quality Forum, the National Consensus Project for Quality Palliative Care released clinical practice guidelines that include an assessment and response to spiritual, religious, and existential care needs that is based upon the best available evidence.[9]

Although there are multiple instruments that can be used to assess spiritual needs,[10] these differ from a quality measure intended to assess care for a population of patients.[11] In a recent review of a proposed set of quality measures for hospice and palliative care, investigators concluded that the spiritual care domain was among the least developed.[11] In consequence, this study describes the development and initial testing of a measure designed to assess the quality of spiritual care provided to family caregivers of dying patients at the end of life.

Methods

Item and Instrument Development

The Quality of Spiritual Care (QSC) measure was developed to assess the spiritual care received by dying patients and their family caregivers. Our understanding of spiritual care and stimulus material for the measure were developed through a study described elsewhere.[12,13] In brief, we previously conducted semistructured interviews with seriously ill patients and family caregivers, using Donabedian's quality of care framework,[14] to describe the structure and process of spiritual care and its association with specific outcomes. Recipients of spiritual care reported that the outcome of satisfaction with care was greater when spiritual care included helping with understanding of their illness state and helping to cope with their illness.[13]

On the basis of these results, 11 items were developed that encompassed three process domains (i.e., help with coping, facilitate relationships, promote understanding) and the outcome domains of the perceived value of and satisfaction with spiritual care received. The scale is prefaced by: "Looking back over the last month of [DECEDENT'S] life, please tell me if you strongly disagree, disagree, agree, or strongly agree with each statement about spiritual care." Each item is a statement about an aspect of spiritual care accompanied by a 4-point Likert response with a scoring range from 11 to 44.

Identification and Recruitment of Study Subjects

Family caregivers were identified and recruited as part of a study to assess measures that gauge the quality of care and dying at the end of life in long-term care.[15,16] Briefly, a stratified sample of 169 long-term care settings—66 nursing homes and 103 residential care/assisted living sites—participating in the Collaborative Studies of Long-Term Care were recruited from four states.[17] Participating sites identified up to three eligible decedents,

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