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Spiritual Care Visits During Palliative Care Predicting Discharge Location

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Walden University

College of Psychology and Community Services

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Sandra Casey

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Walden University
2022

Abstract

Spiritual Care Visits During Palliative Care Predicting Discharge Location

by

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MA, Olivet Nazarene University

BA, Roosevelt University

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Spiritual care has an important role in the caring of terminally ill patients and their families. However, there is little research demonstrating the relationship between spiritual care in palliative settings and discharge location of terminally ill patients. This study addressed spiritual care as a part of the palliative care services. A total of 186 records were reviewed from the spiritual care department at a hospital in Michigan. Kirkpatrick and Shaver's attachment theory was used to evaluate the relationship between palliative care and discharge location. The research questions addressed the relationship between spiritual care visits, gender, age, religion, primary diagnosis, and race and palliative discharge location. Key findings indicated patients who received spiritual care visits were 71.5% less likely to be discharged to a nursing home compared to those who did not receive spiritual care visits (OR = .285; $p < .001$). This shows a significance difference in spiritual care visits of those patients discharged home instead of to the nursing home setting. However, gender and age were not significant in this study. The multivariate regression indicated that spiritual care, race, and caregiver availability remained significantly associated however primary diagnosis and religion did not. These findings can lead to positive social change by informing health care workers about the importance of spiritual care for palliative care patients. This may result in health care workers becoming greater advocates for spiritual care services for palliative care patients.

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Chapter 1: Introduction to the Study

Spiritual care has been important for terminally ill patients, providing supportive roles including listening, praying, and offering rituals for patients (Darren et al., 2018). But often focusing primarily on the supportive role, spiritual care has resulted in a lack of productivity in documentation and opportunities to provide practical care within the palliative care setting (Kearney et al., 2017). Regardless, older hospitalized adults should receive services tailored to their spiritual values and should be included as a treatment option when caring for terminally ill patients (National Hospice and Palliative Care Organization, 2014). Spiritual care has been beneficial for patients' well-being in palliative care when it is included in all aspects of the plan of care. Spiritual care workers are trained to provide assessments for the needs of those facing difficulties with terminal illness and crisis (Bruera & Yennurajalingam, 2012).

This study was designed to address the interest of spiritual care when it is included in the process of treatment planning and clinical decisions including discharge planning and location. Hospitals often discharge patients with insufficient planning, poor instruction, inadequate information, and a lack of coordination among the health care team members (Lin et al., 2012). By identifying the number of spiritual care assessments or visits and patients' decisions of their discharge location, I determined the potential effectiveness of spiritual care in the promotion of positive outcomes for palliative care patients. Findings from this study may result in positive social change if providers include spiritual care as a holistic component of palliative care. When spiritual care is

part of the interdisciplinary process, there is an opportunity to provide improved quality of care to patients and their families (Darren et al., 2018).

Background

An individual's spirituality may help with coping during their terminal illness. Studies show a positive correlation with spirituality and improved immune functions, positive coping, and quality of life in terminally ill patients (Kang, 2018). Additionally, many palliative care patients report that feelings of spiritual support are valuable for connecting to others and maintaining control in their lives (Rego & Nunes, 2016). Some terminally ill patients experiencing physical and financial distress may be able to address important issues to their care when spiritual pain is included in the initial assessment (Vallurupalli et al., 2012).

Though spiritual care has helped patients understand their illness and health care needs, research indicates that health care providers often miss addressing patients' spiritual needs at end-of-life care (Varllurupalli et al., 2012). Additionally, spiritual care is often excluded in the psychosocial assessment, which includes palliative care questions regarding social supports, cultural background information, screening for psychiatric illnesses, and social needs such as financial and related living distresses (Vallurupalli et al., 2012). Unmet spiritual needs tend to be associated with less quality of life, increased hospitalizations, and greater health care costs among terminally ill cancer patients. Spiritual pain has been significantly positively correlated with both physical and psychological symptoms of the illness factors (Delgado-Guay et al., 2016), suggesting

that there is a relationship among spiritual and physical and psychological distresses for patients with terminal illness.

Further, research shows that older patients seek to express their spiritual care needs or need for comfort care during times of discharge planning (Hodge et al., 2014). Spiritual care data are needed to better describe spirituality for patients in supporting the patient perspective of the role which spiritual care plays in their illness and discharge process. This study addressed this gap in research which is to address the intent of spiritual care visits when it is included in the process of treatment planning and clinical decisions at the time of discharge.

Problem Statement

Research indicates the importance of discharge location relative to palliative care outcomes (Hodge et al., 2014). For example, Flannelly et al. (2012) collected data for 1 year on 517 patients with terminal illness in a hospital setting and found that patients who received palliative and spiritual care interventions experienced lower readmissions and desire to seek further traditional medical care services in the hospital. Flannelly et al. also reviewed the total number of advanced cancer patients' deaths for 5 years in the hospital setting; when the palliative care team provided care, there was an increase from 1% to 35% in patients who declined further aggressive treatments, and those who discharged from hospital to hospice lived longer than those remaining in the hospital. Lastly, Flannelly et al. researched 339 advanced cancer patients' discharge location from the hospital, which revealed that those who did not receive adequate support from palliative

care teams were likely to receive a week or more of hospice care and die in an intensive care unit.

Additional research indicates the impact of spiritual care on palliative care patient outcomes. For example, Balboni et al. (2013) performed a study of 343 patients with advanced cancer. Patients who received support from their community spiritual clergy were less likely to discharge from the hospital setting and more likely to pursue aggressive treatments. Patients who received spiritual care from palliative care hospital clergy were more likely to utilize discharge programs and less likely to pursue aggressive treatments.

Limited research suggests that spiritual care impacts discharge location decisions for terminally ill patients. More research is needed to establish a clear relationship between spiritual care and discharge location for terminally ill patients, which this study addressed. Positive social change may result from the information from this study being used to help inform spiritual care practices in palliative care settings.

Purpose

The purpose of this study was to examine the relationship between spiritual care during palliative care and discharge location. The number of spiritual care visits was the independent variable, and the discharge location was the dependent variable. Regression analysis was used to determine whether the independent variable predicts the dependent variable. Establishing additional empirical evidence of this relationship informs spiritual care practices in palliative care settings.

Research Questions

RQ 1: To what extent is there a relationship between spiritual care visits and palliative discharge location?

H₀1: There is no relationship between spiritual care visits and palliative discharge location?

H₁1: There is a relationship between spiritual care visits and palliative discharge location?

RQ 2: To what extent is there a relationship between patients' gender and palliative discharge location?

H₀2: There is no relationship between patients' gender and palliative discharge location?

H₁2: There is a relationship between patients' gender and palliative discharge location?

RQ 3: To what extent is there a relationship between patients' age and palliative discharge location?

H₀3: There is no relationship between patients' age and palliative discharge location?

H₁3: There is a relationship between patients' age and palliative discharge location?

RQ 4: To what extent is there a relationship between patients' religion and palliative discharge location?

H₀4: There is no relationship between patients' religion and palliative discharge location?

H₁4: There is a relationship between patients' religion and palliative discharge location?

RQ 5: To what extent is there a relationship between patients' primary diagnosis and palliative discharge location?

H₀5: There is no relationship between patients' primary diagnosis and palliative discharge location?

H₁5: There is a relationship between patients' primary diagnosis and palliative discharge location?

RQ 6: To what extent is there a relationship between patients' race and palliative care predicting discharge location?

H₀6: There is no relationship between patients' race and palliative care predicting discharge location.

H₁6: There is a relationship between patients' race and palliative care predicting discharge location.

Theoretical Framework

The theoretical framework for this study was attachment theory described by Kirkpatrick and Shaver (2013), which substituted the relationship of a parent–child relationship with a relationship with God. Their research showed that those with a secure attachment to God had significantly better mental and physical health outcomes (Kirkpatrick & Shaver, 2013). Similarly, patients who feel secure in their relationship

with God may transfer their spiritual perspectives toward their spiritual care professionals to develop a relationship of trust like the relationship with God. Patients who acknowledge their beliefs and desire to utilize spiritual care in their coping process tend to seek spiritual support from their physicians and other team workers who service them in health care settings (Loetz et al., 2013). Therefore, the spiritual application of Kirkpatrick and Shaver's religion and attachment theory helped to interpret the results of the study of the relationship between spiritual care visit and discharge location. Research shows that when patients feel secure in their relationships with their palliative care workers, the workers may become significant sources to support patients' end of life choices (Millberg et al., 2012). Moreover, healthy attachments among patients and staff, including spiritual care workers, can be beneficial for patients' discharge plans and locations (Balboni et al., 2017).

Nature of the Study

The nature of this study was quantitative with a nonexperimental, correlational research design. Quantitative research is consistent with understanding the relationship between spiritual care visits (independent variable) and patients' recorded discharge location (dependent variable), which is consistent with Kirkpatrick and Shaver's theory of spiritual application of attachment theory. Information about spiritual care visits and patients recorded discharge location were collected from patient records via a spreadsheet of the identified information provided at a hospital in Michigan. Data analysis included descriptive statistics and logistical regression analysis.

Definitions

Discharge planning: An interdisciplinary approach to continuity of care; it is a process that includes identification, assessment, goal setting, planning, implementation, coordination, and evaluation (Lin et al., 2012).

Palliative care: An approach that improves the quality of life of patients and their families facing the problem associated with life threatening illness (World Health Organization, 2017).

Spiritual care: Person-centered care that seeks to help people (re)discover hope, resilience, and inner strength in times of illness, injury, transition, and loss (Association of Professional Chaplains, 2013).

Spirituality: The aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred (Puchalski et al., 2014).

Assumptions

The topical assumption for this study was its practical importance because of the research about spiritual care and discharge location despite the demonstrated importance of both relative to palliative care patients' outcomes (Hodge et al., 2014). A methodological assumption of this study was the data needed for the study in the client's record (Patel, 2019). Kirkpatrick and Shaver's attachment theory identifies assumptions of the patients' identifying their belief in God as a positive means of coping with their terminal illness. This may ultimately lead to them finding peace and meaning from stress

because of the illness and securing healthy relationships with others (Culver & Denton, 2017).

Limitations of the Study

The research was limited by using secondary data. Secondary data as recorded in patients' records may not accurately account for the variables to be studied. An attempt to maintain contact with professional staff for verification of correct information was used to help to control in the secondary data use (Frankfort-Nachmias & Nachmias, 2008). Additionally, this study was small and may not have reflect its entire community thus results may not generalize other cultural or ethical groups. Lastly, there may have been insufficient data for the study. For example, a discussion of discharge location may have taken place during a spiritual care visit, but it was not documented. It may thus appear that spiritual care did not influence the patients' decision on discharge location (Dunn et al., 2017).

Scope and Delimitations

The scope of the study includes secondary data collected by the spiritual care department on patients 18 years and older with diagnoses of end stage cancer, dementia, and chronic heart failure diagnosis from January 2019 to December 2019 at a hospital in Michigan. The patients were inpatient in predominantly oncology and pulmonary departments of the hospital. The patients were also eligible for palliative care (chronically ill and/or have received maximum of medical therapy indicating a need for pain and symptom management). The delimitations of the study include no secondary data from patients without a terminal illness and excluded secondary data from patients without a

terminal diagnosis of cancer, chronic heart failure, and dementia who may have received treatment during, before, or after 2019. Finally, data for cancer, dementia and heart failure patients who did not meet the criteria for palliative care during or after 2019 were not included in the study.

Significance

This research study filled the gap in the literature regarding the impact of spiritual care visits on discharge location for patient care in palliative care settings (Hall et al., 2016). The results of this study may benefit the profession by resulting in decreased hospital stays and rates of unplanned readmissions for palliative care patients, which are indicators of effective discharge planning (Lin et al., 2012). Positive social change may result from the implementation of policies and standardized procedures for providing spiritual care visits to patients in palliative care settings.

Summary

Spiritual care has often been underutilized in health care settings. Research has shown that spiritual care for patients in palliative care settings is important for the proper care of patients' existential, physical, and emotional needs (Balboni et al., 2013; Flannelly et al., 2012). The results of this study may provide information regarding the contribution spiritual care can have for patients in palliative care settings. Chapter 2 will provide a review of the literature on the role of spirituality and its impact on discharge location in the palliative care setting. Chapter 3 will include the methodology, research design, and data analysis.

Chapter 2: Literature Review

The use of spiritual care assessments in the palliative care setting has increased over the years (Balboni et al., 2010). Many studies show a positive correlational between religious/spiritual issues having a significant influence on important indicators of quality of care (Delgado-Guay et al., 2015). Having some control and right to life decisions may be important to patients' quality of living toward end-of-life care. Other studies have shown that attention to spiritual needs reduces the use of aggressive care at the end of life (Balboni et al., 2010; Delgado-Guay et al., 2015). However, though patients in palliative care and oncology units have reported that spiritual care is an important factor to them, it has not been adequately addressed by the palliative care team. In a study of cancer patients with end stage heart failure, 70% expressed that their spiritual needs were minimally attended to or not supported at all by the medical system (Balboni et al., 2010).

This chapter introduces palliative care in relation to the hospice philosophy of quality care. It discusses the philosophy of palliative care and its uniqueness from hospice care. Additionally, an explanation of the palliative care movement is addressed. This chapter also reviews classical attachment theory and an attachment theory of God.

Literature Search Strategy

Articles were reviewed from 2013 to 2019, and identified studies focused on spiritual care in relation to chronic illness, pain, psychological care, palliative care, health psychology, and oncology. Other key words used were *discharge planning*, *spiritual assessment*, and *spiritual care*. Databases included Academic Search Complete (EBSCO), CINAHL (EBSCO), MEDLINE (EBSCO), PsycINFO (OVID), PubMed,

ProQuest databases, and Google Scholar. The reference list of all included studies and other relevant reviews were searched manually to identify other potentially relevant papers. The literature review explores attachment theory and spiritual care in palliative care setting.

Theoretical Framework

Classical Attachment Theory

Bowlby has been credited with constructing attachment theory, which is built on the main goal of the attachment system is to provide the infant or child with a sense of security (Reuther, 2014). He was the first attachment theorist who developed a motivational system explaining how infants seek comfort and safety, mainly from their mothers and caregivers (Reuther, 2014). Attachment theory refers to the tendency of young children to seek contact with one or more consistent caregivers when frightened, worried, or vulnerable and to find such contact comforting (Fearon & Roisman, 2017). A child's early interactions and relationships with primary caregivers influences how the individual understands the self, others, and their relationship (Davis et al., 2016). Thus, the interactions between caregivers and children influence how they relate to others throughout their lives. Children who receive attention from the parent or caregiver when in distress learn safety and security. In contrast, children who do not receive the extra affirmation from their parent or caregiver learn distrust and generally have difficulties with social interactions and interpersonal relationships. Children quickly learn what limits are set in their relationship with their primary caregiver, which is mostly likely to continue into adulthood.

In Bowlby's work with infants, he suggested that a mental picture or schema, which continues throughout life, is developed from childhood. According to Bowlby (1990), this helps to control behaviors and allows the ability to function with healthy emotional regulation. In the presence of anxiety, there are three approaches that may occur: They may move away from the attached figure (dismissive), try harder to secure their relationship with their attachment figure (preoccupied), or they may become confused and unsure of how they did to respond (Culver & Denton, 2017). Avoidant and anxious attachment demonstrate a sense of distance and less trust with caregivers (Culver & Denton, 2017). When describing the psychological significance of a secure base, Bowlby (1969) noted that individuals will be less likely to feel fear when they are confident that an attachment figure will be available when they need it. Further, children who were raised with disorganized caregivers often struggle with structure and following rules (Davis et al., 2016). Others have also since made contributions to attachment theory, such as Thompson (1999), who concluded that adult attachment behavior should be viewed in the context of a developmental process, but none have deviated from the original source of Bowlby's theory.

Religion & Attachment Theory

Kirkpatrick and Sheaver were first to expand on Bowlby's attachment theory with contributions toward attachment theory to God (Culver & Denton, 2017). In their theory regarding religion and attachment, they examined the relationship with the divine as a source of attachment that impacts the life outcomes of religious adherents (Culver & Denton, 2017). A similar theory to the infant's relationship with the mother-caregiver

was applied to an individual's relationship with God. Those believing in a God who provides a warm, responsive, and a secure base during times of threat and stress can find solace with the relationship. This relationship may be equal or even more for individuals and could compensate for an individual with an absent parent. This security ultimately may help with the understanding of someone's life purpose (Culver & Denton, 2017). Additionally, research shows that patients who use prayer as a coping mechanism are more likely to better manage negative emotions associated with various acute or chronic health related stress problems (Ellison et al., 2014).

In this pathology, individuals have problems maintaining relationships with others and therefore seek God to use as a surrogate attachment figure to regulate their distress (Jankowski et al., 2011). Empirical findings demonstrate that spiritual instability is like anxious God attachment and spiritual disappointment (Jankowski et al., 2011). It is also correlated with alienation, insecure attachment, and egocentrism. Further, research shows higher levels of spiritual instability associated with higher insecurity to God, increased God attachment avoidance and attachment anxiety, increased dysregulation, and increased mental health symptoms (Jankowski et al., 2011). In contrast, persons experiencing spiritual grandiosity may be identified as narcissistic or having a narcissistic personality disorder. Bowlby (1988) viewed those with a narcissistic personality type to experience attachment avoidance and have dealt with self-reliance because of the reject viewed from their caregivers. Spiritual grandiosity has been correlated with hypersensitive reactions to interpersonal offenses and anxious attachment experiences.

Both spiritual grandiosity and instability represent anxiousness toward relationships with God and others (Jankowski et al., 2011).

Literature Review Related to Key Concepts and Variables

Hospice Care

Hospice care was first developed by Dr. Cicely Saunders in the United Kingdom. The first US hospice was in Connecticut starting in 1974 (Walsh, Atkas, Hullihen, and Induru, 2011). Its basic philosophy was to provide quality and comfort care to those who are terminally ill and have a prognosis of life for six months or less. Dr. Saunders plan to utilize a team approach to patient care has been favorable for accommodating the needs of terminally ill patients. Team members generally consist of Medical Doctor, RN, social workers, chaplain, and aide. The key concepts for patients' total care incorporate the physical, psychological, spiritual, and social aspects of care. Additionally, Dr. Saunders took an approach to use settings for the patients to include the use of volunteers, bereavement services, and the formal role of a multidisciplinary team (Walsh et al., 2011). In 1981, Joint Commission Accreditation for Hospitals in the US reported more than 440 hospices in the US, and averages of 360 hospices were being planned. This number of hospice providers around the US continues to grow in large numbers.

Hospice workers provide quality care for the hospice patient. Callahan (2012) states that a hospice workers' ability to relate in a "spiritually sensitive" manner is relative to the patient's experience of life meaning and wellbeing. Patients in hospice often develop important and intense relationships with their hospice care workers. It is during this time in their lives', questions about meaning and worth may be of their

highest priority. Spiritual pain can be difficult to identify because it can be masked by physical pain (Callahan, 2012). Generally, it is the hospice caregiver who helps patients to process feelings and help to understand patient's needs.

In traditional medical care, the medical model has been the major model used in healthcare (Holyoke & Stephenson, 2017). This has distanced the medical and spiritual care professional's roles. All team members make significant contributions to the care of the patient, often spiritual issues may be overlooked or even excluded in hospice care. Hospice care was designed to support the patient and family in obtaining a life of worth and dignity (Callahan, 2012). It is often misunderstood that pain may occur in ways other than physical. This is the value of hospice care, to seek to meet the patient's needs collectively as a team. The goal of a multi-disciplinary team is not only for each member to understand and perform their role but to understand how each of the other role play a part in the patients' care. Spiritual care workers acknowledge themselves as the leaders of spiritual care but encourage other team members to provide spiritual or person-centered care. The quality of helping relationships in hospice care by all workers may help to guide the patient's spiritual and emotional well-being (Callahan, 2012).

In Callahan's study (2012), she seeks to define the relationship factors associated with spiritual care to understand "spiritually sensitive care". Her study consisted of six hospice workers who were interviewed about how they identified spiritual needs, provided spiritual care, and determined their effectiveness (Callahan, 2012). The hospice workers together made up eight years of hospice experience, and were employed as social workers, nurses, and a certified nursing assistant (Callahan, 2012). Participants were

recruited between May 2009 and August 2009 in the eastern and southern regions of the US. Participants were interviewed by telephone, which lasts for 45 minutes to an hour. Participants were asked questions such as, “How do you know when a patient has a spiritual or religious need? How do you respond? If you make a referral, is there anything else you do? Do you think your response is a source of spiritual support? Why? In total there were six questions asked, and questions 1,3, and 5 verified assessments, questions 2 and 6 verified spiritual care interventions. The results were varied as some responses were, the worker did not feel comfortable with assessing spiritual needs resulting in looking at patients’ records or assessment for guidance on their spiritual needs, or they realized on their own frame of reference and experience of what is spirituality, and how do you practice it. Several workers resulted in stating that they would refer the chaplain or spiritual care provider because it was out of their frame of reference (Callahan, 2012).

Further an additional study, discussing the effects of PTSD on hospice and palliative care patients, showed a relationship among avoidance coping, poorer health status in patients with cancer (Callahan, 2012). Feldman (2017; 1994) discusses a study which examined psychological symptoms, avoidance, and intrusive thoughts examined as predictors of cancer progression over a 1-year period. Sixty-six males and females were used in the cross-sectional analyses at the time of diagnoses. The longitudinal study showed a link to psychological stressors and increased effects of their illness. Feldman (2017) suggest that due to the chronic needs of hospice patients at end of life, establishing intense programs to address psychological stressors for this population is essential prior

to their dying and receiving less than quality of care which is the hospice philosophy of care.

Palliative Care in the United States

Walsh et al. (2011) state that palliative care refers to a philosophical concept of comprehensive medical care for patients with life threatening illness that focuses on control of pain and other symptoms, management of complications, and enhancement of quality of life. Palliative care addresses symptom management and complex medical care services for patients with advanced stages of their diagnoses.

Palliative care began in the United Kingdom in the 1960's which developed from the hospice philosophy of providing quality of life for terminally ill patients (Walsh et al., 2011). According to the Center to Advanced Palliative Care (2009) palliative care is the only program that provides holistic care using an array of treatments or interventions desired by the patients and focused on quality of life and pain management regards of a patients' prognosis. The palliative care movement in the United States has become an effort for physicians to manage advanced stages of cancer before moving to the hospice care benefit (Lutz, 2011). Most of the palliative consults and referrals for physicians originate from oncology departments with advanced stage cancer patients (Walsh et al., 2011). Palliative care services offer an opportunity to address the needs for cancer patients to look at holistic care in addition to receiving possible infusion treatments. Further people who are diagnosed with advanced cancer stages are often too fatigued and weak to receive multiple chemotherapies. Options of total care with limited aggressive

care, can be a better alternative for someone who is not quite hospice ready or eligible (Walsh et al., 2011).

Virdun, Luckett, Davidson, and Phillips (2015) state that it is estimated that at any given time almost a quarter of all hospitalized patients have palliative care needs. It has been favorable for patients who decide to live at home and receive palliative care services. Yet new projections showing the number of people who are inpatient with palliative care services is expected to increase due to the ageing population and complexities of illness and care needs exceeding community resources. Like hospice care, palliative care needs for additional psychosocial supports have been increasing at a rapid growth. Specifically, there is increased research that suggests a need to provide spiritually based assessment and supports from staff towards end-of-life care. In a study which assessed 160 palliative care patients diagnosed with terminal cancer and in a hospital setting, there was a significant correlation among patients' belief to have their spiritual wellbeing and being accurately assessed for their spiritual needs before death. Additional findings showed that those who were not considered as religious or spiritual had a higher score of depression (McClain, Rosenfield, and Breitbart, 2007).

Moreover, palliative care patients who have a diagnosis of heart failure have also been researched showing a correlation among heart failure and psychosocial –spiritual distress issues (Gillilan, Qawi, Weymillier, & Puchalski 2017) Patients with heart failure often have co-morbidities such as, anxiety, depression, dyspnea, pain, fatigue, and sleep disturbances (Gillilan et al., 2017). Recent studies show an increase in heart failure patients being referred to palliative care for quality of living treatments. Research in

several studies involving heart patients now receiving palliative care services, lack in receiving considerable services as with cancer and dementia care such as advanced care planning, discharge concerns, and quality assurance for caregivers (Gillilan et al., 2017).

Psychosocial Care

Psychosocial spiritual care is defined as aspects of care concerning patient emotional state, social support and relationships, and spiritual wellbeing (Chibnall, Benett, Videen, Duckro, & Miller, 2004). Palliative care documentation includes a psychosocial care plan as part of each patient's plan of care and services. Research has shown that failure to perform an early psychosocial assessment of palliative care patients may prolong their symptoms of depression and anxiety issues (Chibnall et al., 2004). However past and present research indicates that medical institutions have done a poor job of including the psychosocial-spiritual aspects of patient care (Delgado-Guay et al., 2016). Further the Institute of Medicine (2007) issued a report titled, "Cancer for the whole patient: Meeting the needs of psychosocial health needs". The report states that "the psychosocial-spiritual dimension, including appropriate assessment and interventions, must become an integral part of the of routine cancer care for all patients". In a study using 292 advanced stage cancer patients at a palliative care clinic, patients were given the Edmonton Symptom Assessment Scale measuring psychological, social, spiritual, and financial pain. The scale was used to determine the relationship between pain, fatigue, nausea, drowsiness, dyspnea, sleep, appetite, anxiety, depression, well-being, and financial distresses. Patients who reported spiritual pain also had problems with physical and psychological distress such as depression and anxiety (Delgado- Guay

et al., 2015). Overall, it was determined that those with spiritual pain had increased levels of pain at 182% higher than those who expressed little or no spiritual pain issues (Delgado- Guay et al., 2015).

According to Inbadas (2016) Patients dealing with life limited illnesses often experience spiritual distress and existential despair along with physical suffering caused by the illness. Inbadas (2016) describes the main two concepts behind the spirituality in health care. He states that the field of spiritual care acknowledges that spiritual pain or distress experienced by patients' helps to address the complete needs of spiritual care for patients. The second concept is spirituality is the core of medical and health care services, and not an addition or one aspect of care. Both perspectives offer opportunities to re-examine how historical and cultural understandings of death contribute to the field of spirituality and healthcare (Inbadas, 2016). The changes to understanding the relationship of spirituality and medicine have led to an approach of the here and now and less reflection on life after death. This has opened the door to many disciplines taking an interest in the field of spirituality. Palliative care has been an area where patients often are aware or become aware of the relationship among the mind, body, and spirit. For this reason, palliative care has become one of the most professionally researched fields to study spirituality and medicine utilizing both qualitative and quantitative methods of study. Further research has been favorable in empirical studies showing an increased awareness and understanding of spiritual issues and positive impacts for patients. Other scholars have acknowledged that research lacks in including more on relationships,

patients' beliefs systems, and social, cultural, and religious factors to understanding additional factors of spirituality (Inbadas, 2016).

Palliative Care Patients

Palliative care is designed to avoid suffering of patients and their loved ones by incorporating a team of professionals for treatments (Walsh et al., 2011). Patients, who are at end-of-life care, need assistance to make both medical and practical decisions regarding their wellbeing (Rome et al., 2011). Palliative care may utilize life prolonging, aggressive symptom management, and psychosocial supports to help patients improve their wellbeing.

Typically, palliative care patients begin in the hospital setting mostly on oncology units (Walsh et al., 2011). The number one complaint of palliative care patients is generally physical pain. This is often associated with emotional and spiritual pain however physical pain is first addressed (Rome et al., 2011). In addition, patients often begin to experience dyspnea, restlessness, when closer to death; patients may experience the death rattle. The death rattle involves patients gaining control of their oropharyngeal secretions (Rome et al., 2011).

Rome et al (2011) report the four components of total pain for palliative care patients which deals with physical pain, dyspnea, restlessness, and the death rattle. They report that pain is often multiple and must be treated for comfort care and adequate transitioning during the end-of-life phase for patients. Anxiety, and other related emotions may be symptoms of pain and delirium. Medicines prescribed to help this process include anticholinergics, sedative-hypnotics, and opioids. Often these signs of

restlessness are associated with some form of spiritual or emotional distress towards end-of-life issues. Patients who experience terminal delirium or agitation, where their restlessness and agitation continue for an extended time, require stronger doses of opioids such as haloperidol (Rome et al., 2011). Further, research has been consistent in showing that adding psychosocial-spiritual issues are related to positive wellbeing outcomes for those who face terminal illness. Patients tend to look for more meaning and purpose in their lives as well as sources of faith and substance. It is normal for patients facing terminal illness to have increased fears, anxiety, and depression as they move closer to their deaths. Terminally ill populations show a higher risk of suicide, hopelessness, and a desire for hastened death compared to the general population (McClain, Rosenfield, & Breitbart, 2003).

Commonly, cancer patients are often of the first patients to be referred for a palliative care consult (Walsh et al., 2011). Various types of cancers, i.e., breast, and lung cancer are associated with depression and dyspnea. Some patients deal with multiple losses when being diagnosed with a terminal illness. They may struggle with accepting the loss of having cancer, their independence, and other affects. According to Rome et al (2011) anxiety, social support networks, financial and related stressors, spiritual resources, and issues with relationships with their physicians become major areas of concern for patients facing terminal illness. For this reason, treating the whole person is especially important for the patients' dignity.

Dignity therapy is defined by Montross-Thomas et al. (2015) as a brief psychotherapeutic design to address the emotional and existential needs of adults who are

receiving hospice or palliative care while enhancing a sense of legacy. Spiritual care personnel may use dignity therapy in their counseling sessions. Patients discuss their most important memories; times they felt most alive in their lives, and their accomplishments. Previous studies indicated that the therapy is effective to reduce some level of stress for advanced cancer patients to help them to find meaning in their lives Montross-Thomas et al. (2015).

New research techniques explore less of the measurement for effectiveness on how patients feel but more on if they report positive outcomes and demonstrate fewer depressive symptoms (Montross-Thomas et al., 2015). In one study using 90 participants, 45 received dignity therapy and 45 received general supportive attention for 6 sessions over a 3-week period. The study showed mixed results when discussing stress factors or reducing overall stress however provided stronger factors towards positivity among the participants who received dignity therapy (Montross-Thomas et al., 2015).

Summary

In summary, the use of psychosocial –spiritual assessments have been a significant part of the palliative care process. Many patients have identified their spiritual concerns as an important factor. However, it remains that often their spiritual needs neglected in the palliative care setting. Studies show a positive correlation between religion/spirituality issues and its influence on quality of care. Additional studies show that addressing spiritual needs reduces the use of aggressive care towards end of life. The use of empirical evidence in the relationship between spiritual care and palliative care outcomes may serve an important role in developing a more standardized application of

spiritual care assessments and delivery in palliative care settings. This is beneficial for patient's overall quality of life and reduces cost in medical care. In Chapter 3, I provide a comprehensive description of the designed study, the materials used for the study, and the details of the participants with the use of secondary data.

Chapter 3: Research Method

The purpose of this study was to examine the relationship between spiritual care during palliative care and discharge location. The research questions addressed the relationship between spiritual care visits, gender, age, religion, primary diagnosis, and race and palliative discharge location. Secondary data were used to determine the quality of care used for palliative care patients as part of the spiritual care routine assessment process. According to the Centers for Medicare and Medicaid and the Joint Commission (CMC, 2017), a spiritual care assessment for all patients admitted into hospice must be offered to receive a reimbursement. This chapter presents the research design, methodology, and data collection used for spiritual care assessments and interventions within the palliative care setting.

Research Design

This study was a quantitative study with a non-experimental correlational research design. In correlational research, data are collected to assess for the relationship with the unmanipulated variables (Frankfort-Nachmias & Nachmias, 2008). Since there was no experiment used, there were no time or resource constraints. Quantitative research is consistent with the relationship between spiritual care visits and patients' recorded discharge locations and helped to generalize the outcome of spiritual care and palliative patients' options in various locations. The independent variable was spiritual care visits, and the dependent variable was patients' decisions, after talking with a spiritual care provider, where their discharge location was a nursing home, or home setting. This study

focused on spiritual care visits co-varying with patient's decisions to choose quality of care in their living situations location.

Methodology

Population and Sample

Secondary data were available for palliative care patients between January 2019 and December 2019. These patients are typically 65 years old and older, with primary diagnosis as cancer and heart failure. They can typically spend up to 6 months or more enrolled into palliative care. Because secondary data were used, no sampling methods were used in the study. The inclusionary criteria consisted of a review of spiritual care records of palliative care patients with a terminally ill diagnosis. For this study, the medium effect size of 0.30 was used to allow for greater results. The alpha level of 0.05 and a power level of .80 allowed for reduced Type 2 error with a confidence interval of 95%, and G Power determined a sample size of 111 patients.

Setting

Terminally ill patients received a referral from their physician and were provided with a consult or referral on palliative and/or hospice services. Palliative care settings were designed for patient's comfort and well-being through medical and nursing care. The focus was on pain management and quality of life for patients and their families. Additionally, patients were given the opportunity to agree to meet with a spiritual care provider and to continue additional visits and spiritual services that were determined during the time of the initial visit. The assessment or initial visit was used to determine

spiritual care concerns, needs, including what type of service(s) should be continued, and to measure levels of spiritual and emotional distress.

Data Collection Method

For this study, the data were provided to the researcher inter-office with a confidential mailing system. Data were received on an Excel spreadsheet with no participant identifiers. Palliative care spiritual visits addressed age, gender, religion, diagnoses, and multiple comorbidities that were used in describing the demographic characteristics of the patients. Discharge locations were at home setting, and nursing home services. Data were stored at the hospital's computer with password protection. It will be kept for seven years consistent with ethical practices for data management and storage.

Data Analysis Plan

Descriptive statistics were run to determine the mean and standard deviation for patients' and number of spiritual care visits. Frequency and percentage were used to describe patients' age (1 = 65 and younger, 2 = 65 and older), gender (1 = male, 2 = female), race (1 = Asian, 2 = African American, 3 = White, and 4 = Other), religion (1 = Catholic, 2 = Protestant, 3 = non-religious, 4 = Other), and primary diagnosis (1 = cancer, 2 = heart disease, 3 = dementia, and 4 = other). The discharge location was indicated by 0 died before d/c, 1 home, and 2 nursing home placement and the discharge location. Additional variables were from social worker visits based on insurance coverage, availability of beds, and caregiver accessibilities. Logistic regression statistics was used to test for a relationship among the independent and dependent variables. Regression

allows for assessing the relationship an independent and dependent variable while controlling the effect of others (Frankfort-Nachmias & Nachmias, 2008). The test used a two-tailed test and a p value of 0.05. Raw data were input into the computer data system SPSS program.

Threats to Validity

History may be considered a threat to internal validity for this study. History is unrelated events which influences the outcome of the study (Bhandari, 2020). The study includes information from 2019, but due to COVID, the results may not be applicable. Patients are less likely to be placed in a new location or facility during the virus outbreak to maintain control over the spreading of the virus. Additionally, spiritual care visits were generally provided on a referral basis. Many of those referrals and visits were temporarily discontinued due to the virus. Lastly, spiritual care providers were less likely to receive adequate trainings on providing virtual visits for patients to influence their discharge location decisions.

Situational validity may occur as an external threat in the study. Situational threats to validity involve factors that control the discharge location causing limits in the generalized ability of the findings (Bhandari, 2020). Patients' information in this study may not indicate the variables affecting the decision of their discharge location and setting. The independent variable in the study may not include variables that affect the decision of patients' discharge location and setting. Therefore, variables such as insurance, availability of beds, and caregiver issues are included. To ensure that the study was best represented a time frame for this data studied was approximately 1 year.

Ethical Procedures

Permission was requested to use the patient data from the hospital. No patient identifiers were used, only numerical data and descriptors such as age and religion. The doctoral study proposal was also submitted to Walden University Institutional Review Board for approval of secondary analysis (approval no. NHR-21-948).

Summary

This study used secondary data for examining spiritual care visits and the prediction of discharge location. The chapter focused on the research method, design, and data collection and analysis. Chapter 4 will present the result of the data analysis, report any discrepancies in the study, and discuss limits of the study.

Chapter 4: Results

The purpose of this study was to examine the relationship between spiritual care during palliative care and discharge location. The number of spiritual care visits was the independent variable, and the discharge location was the dependent variable. Regression analysis was used to determine whether the independent variable predicts the dependent variable. Establishing additional empirical evidence of this relationship may inform spiritual care practices in palliative care settings. The results helped answer the research questions, which addressed the relationship between spiritual care visits, gender, age, religion, primary diagnosis, and race and palliative discharge location.

Data Collection

Data were received on an Excel spreadsheet with no participant identifiers from a hospital in Michigan. Secondary data were used to determine patients' criteria for the study through January 2019 to December 2019. Palliative care spiritual visits addressed age, gender, religion, diagnoses, and race was used in describing the demographic characteristics of the patients. Discharge locations were at the home setting and nursing home services.

Demographics

A total of 186 patients were included in the study. The demographic characteristics included age, race, and gender, diagnosis, spiritual care visits, and religion of participants. The demographic characteristics of participants are presented in Table 1. There were 107 participants 65 years old and younger (57.5%). In terms of race, there were 85 African American participants (27.9%) and 80 Asian participants (37.2%). There

were 108 female participants (58.06%) and 78 male participants (41.9%). For diagnosis, majority of participants have cancer (n = 106, 56.9%). Almost all participants received spiritual care visits (n= 125,67.2%) and those without spiritual care visits (n= 61; 32.8%). In terms of religion, 75 participants were Protestants (40.3%).

Table 1*Frequencies and Percentages of Demographic Characteristics (N=186)*

Demographic Characteristics		Frequency	%
Age	65 and younger	107	57.5
	Older than 65	79	42.4
	Total	186	100.0
Race	Asian	80	37.2
	African American	85	27.9
	White	7	3.5
	Other	14	26.0
	Total	186	100.0
Gender	Male	78	41.9
	Female	108	58.0
	Total	186	100.0
Diagnosis	Cancer	106	56.9
	Heart Disease	11	5.5
	Dementia	1	0.5
	Other	68	36.5
	Total	186	100.0
Spiritual Care Visits	No	61	32.8
	Yes	125	67.2
	Total	186	100.0
Religion	Catholic	38	20.4
	Protestant	75	40.3
	Non-Religious	52	27.9
	Other	21	10.4

To address the research questions, logistic regression analyses were conducted to determine the relationships between independent and dependent variables. Logistic regression analyses were deemed as appropriate because the dependent variable was categorical in nature. A significance level of .05 was used for all analyses. Prior to conducting the logistic regression analysis, assumptions of logistic regression were checked. Unlike linear regression analysis, logistic regression has fewer assumptions. First, the observations should not come from repeated measurements or matched data (Salkind, 2010). In this study, the observations are independent of each other, which are based on individual patient's data. Second, logistic regression involves the assumption of linearity of independent variables and log odds. In the case of this study, the independent variables are categorical in nature. Thus, the assumption of linearity is not violated. Finally, logistic regression requires a large sample size (Salkind, 2010). For this study, the sample size was 186 patients. All assumptions were met for this study.

Research Question 1

RQ 1: To what extent is there a relationship between spiritual care visits and palliative discharge location?

H₀1: There is no relationship between spiritual care visits and palliative discharge location.

H₁1: There is a relationship between spiritual care visits and palliative discharge location.

For the first research question, the cross-tabulation results are presented in Table 2. There were more participants discharged to home who have spiritual care. However, there were more participants discharged to nursing home who did not have spiritual care.

Table 2

Cross Tabulation Between Discharge Location and Spiritual Care

Discharge Location and Spiritual Care		Spiritual		Total
		No	Yes	
D/C Location	Home	31	98	129
	Nursing Home Placement	30	27	57
Total		61	125	186

The result of the logistic regression analysis conducted determined that spiritual care categories are significantly related to home and nursing home placement ($B = -1.256, p < .01$). The result of the analysis supported the result of the cross-tabulation analysis that there is a relationship between discharge location and spiritual care of patients ($p < .001$). Therefore, patients who received spiritual care are 71.5% less likely to be discharged to a nursing home compared to those who did not receive spiritual care visits ($OR = .285; p < .001$).

Table 3

Logistic Regression Result for Discharge Location and Spiritual Care

D/C Location		B	SE	Wald	df	Sig.	Exp(B)	95% CI for Exp(B)	
								Lower Bound	Upper Bound
Nursing Home Placement	Spiritual Care	-1.256	.336	13.989	1	<.001	.285	.147	.550
	Intercept	-.033	.256	.016	1	.898	.968		

Note: Reference Category: Home Placement

Research Question 2

RQ 2: To what extent is there a relationship between patients' gender and palliative discharge location?

H₀2: There is no relationship between patients' gender and palliative discharge location.

H₁ 2: There is a relationship between patients' gender and palliative discharge location.

For the second research question, the cross-tabulation results are presented in Table 4.

Table 4

Discharge Location and Gender

Discharge Location and Gender		Gender		Total
		Male	Female	
D/C Location	Home	57	72	129
	Nursing Home Placement	21	36	57
Total		78	108	186

The regression model (Table 4) shows that female patients are more than 1.357 times more likely to discharge home compared to male patients (OR = 1.357; $p = .350$; 95% CI: [.715, 2.575]). However, no significant association of gender with discharge home was identified (OR = 1.357; $p = .350$; 95% CI: [.715, 2.575]). The result of the analysis supported the result of the cross-tabulation analysis that there is no relationship between discharge location and gender of patients ($p = .350$).

Table 5*Logistic Regression Result for Discharge Location and Gender*

D/C Location and Gender		B	SE	Wald	df	Sig.	Exp(B)	95% CI for Exp(B)	
								Lower Bound	Upper Bound
Nursing	Female	.305	.327	.873	1	.350	1.357	.715	2.575
Home Placement	Constant	-1.304	.550	5.624	1	.018	.271		

Note: Reference Category: Home Placement

Reference Category: Male

Research Question 3

RQ 3: To what extent is there a relationship between patients' age and palliative discharge location?

H₀3: There is no relationship between patients' age and palliative discharge location.

H₁3: There is a relationship between patients' age and palliative discharge location.

For the third research question, the cross-tabulation results are presented in Table 6. The results show the majority of those who were discharged to home and to nursing home placement were 65 years old or younger.

Table 6*Cross Tabulation between Discharge Location and Patients' Age*

Discharge Location and Age		Age		Total
		65 and younger	older than 65	
D/C Location	Home	71	58	129
	Nursing Home Placement	36	21	57
Total		107	79	186

The regression model (Table 7) shows that age is significantly associated with patients over 65 years of age, and more likely to die before discharge compared to younger patients (OR = .042; $p = .003$; 95% CI: [.005, .340]). However, no significant association of age with discharge home was identified (OR = .714; $p = .303$; 95% CI: [.376, 1.355]).

Table 7

Logistic Regression Result for Discharge Location and Patients' Age

D/C Location and Age		B	SE	Wald	Df	Sig.	OR	95% CI for Exp(B)	
								Lower Bound	Upper Bound
Nursing Home Placement	Age>65	-.337	.327	1.063	1	.303	.714	.376	1.355
	Intercept	-.342	.482	.505	1	.477	.710		

Note. Reference Category: Home Placement
Reference Category: Age < 65

Research Question 4

RQ4: To what extent is there a relationship between patients' religion and palliative discharge location?

H₀₄: There is no relationship between patients' religion and palliative discharge location.

H₁₄: There is a relationship between patients' religion and palliative discharge location.

For the fourth research question, the cross-tabulation results are presented in Table 9.

Table 8*Cross-Tabulation Between Discharge Location and Religion*

Discharge Location and Religion		Religion				Total
		Catholic	Protestant	Non-religious	Other	
D/C Location	Home	24	48	44	13	129
	Nursing Home Placement	14	27	8	8	57
Total		38	75	52	21	186

The result of the logistic regression analysis conducted determined that religion categories are significantly related to discharge location with those discharged to a nursing home placement ($p < .001$). Patients of any religion were over three times more likely to be discharged to a nursing home- Catholics: $OR=3.208$, $p=0.22$, Protestants: $OR= 3.094$, $p=.013$, and other religions: $OR= 3.385$; $p=.039$. The result of the analysis supported the result of the cross-tabulation analysis that there is a relationship between discharge location and religion of patients ($p = .034$).

Table 9*Logistic Regression Result for Discharge Location and Patients' Religion*

D/C Location ^a		B	SE	Wald	df	Sig.	Exp(B)	95% CI for Exp(B)	
								Lower Bound	Upper Bound
Nursing Home Placement	Religion			7.436	3	.059			
	[Catholic]	1.166	.511	5.210	1	.022	3.208	1.179	8.730
	[Protestant]	1.129	.453	6.204	1	.013	3.094	1.272	7.524
	[Other]	1.219	.591	4.252	1	.039	3.385	1.062	10.785
Intercept		-1.705	.384	19.673	1	<.001	.182		

Note. Reference Category: Home Placement

Reference Category: Those with no religious affiliation

Research Question 5

RQ5: To what extent is there a relationship between patients' primary diagnosis and palliative discharge location?

H₀5: There is no relationship between patients' primary diagnosis and palliative discharge location.

H₁5: There is a relationship between patients' primary diagnosis and palliative discharge location.

Table 20

Cross-Tabulation between Discharge Location and Patients' Primary Diagnosis

Discharge Location and Diagnosis		Diagnosis				Total
		Cancer	Heart Disease	Dementia	Other	
D/C Location	Home	82	6	0	41	129
	Nursing Home Placement	24	5	1	27	57
Total		106	11	1	68	186

The result of the logistic regression analysis conducted determined that patients' diagnosis categories can be significantly related to discharge location with respect to nursing home placement. Dementia was reclassified in the "other category" due to there was only one patient with a diagnosis of dementia. To avoid skewing the home versus nursing home distribution dementia was added to the other category. The findings show that there is a significance for other diagnosis however no significance for those patients with heart disease and discharge location. Therefore, discharge location is not significantly different for other diagnosis patients compared to cancer patients. However, patients with heart disease are 2.847 (OR= 2.847, p=.107) times likely to be discharged to a nursing home than cancer patients. Overall, the result of the analysis supported the result of the cross-tabulation analysis that there is a relationship between discharge location and diagnosis of patients ($p = .012$).

Table 31

Logistic Regression Result for Discharge Location and Patients' Diagnosis

D/C Location ^a		B	SE	Wald	df	Sig.	Exp(B)	95% CI for Exp(B)	
								Lower Bound	Upper Bound
Nursing	Diagnosis			7.355	2	.025			
Home Placement	Diagnosis=1(heart disease)	1.046	.648	2.603	1	.107	2.847	.799	10.149
	Diagnosis=2(Other: Dementia, Debility, Liver disease, ALS and Stroke)	.847	.338	6.299	1	.012	2.333	1.204	4.522
	Intercept	-1.229	.232	28.028	1	<.001	.293		

Note. Reference Category: Home Placement
Reference Category: Cancer

Research Question 6

RQ6: To what extent is there a relationship between patients' race and palliative discharge location?

H₀6: There is no relationship between patients' race and palliative discharge location.

H₁6: There is a relationship between patients' race and palliative discharge location.

For the sixth research question, the cross-tabulation results are presented in Table 12.

Table 42*Cross Tabulation Between Discharge Location and Patients' Race*

Discharge Location and Race	Race				Total
	Asian	African American	White	Other	
Home	58	63	7	1	129
Nursing Home	22	22	0	13	57
Total	80	85	7	14	186

The result of the logic regression analysis conducted determined that the discharge location is not significantly different for African American patients compared to Asian patients (OR= .921, $p = .814$). However, patients of other non -White races are 34 times more likely to be discharged to a nursing home than Asian patients (OR= 34.273, $p < .001$).

Table 53*Logistic Regression Result for Discharge Location and Patients' Race*

D/C Location ^a		B	SE	Wald	df	Sig.	Exp(B)	95% CI for Exp(B)	
								Lower Bound	Upper Bound
Nursing Home Placement	Race			11.598	2	.003			
	African American	-.083	.352	.055	1	.814	.921	.462	1.836
	Other:(Native American) race	3.534	1.066	10.961	1	<.001	34.273	4.299	277.735
	Intercept	-.969	.250	14.989	1	<.001	.379		

Note. Reference Category: Home Placement

Reference Category: Asian. White race was not included in the regression due to lack of variability (all seven White patients were discharged home). Other: Native American

The overall multivariate regression included an analysis for demographics and social work factors. Results of the multivariate regression are presented in Table 14

which indicated that there is a relationship between spiritual care and discharge location (Chi Square= 110.825, $p < .001$). Once the covariates were added to the model, spiritual care, race, and caregiver availability remained significantly associated with the discharge location. However, primary diagnosis and religion no longer were significant.

Table 64*Variation in Equation*

Variables in the equation	B	S.E.	Wald	Df	Sig.	Exp (B)	Lower	Upper
spiritual care given ***	-3.372	.700	23.215	1	<.001	0.034	.009	.135
age > 65	-1.187	.626	3.596	1	.058	.305	.090	1.041
Race ***			23.521	2	<.001			
Race (1)	-1.247	.859	2.107	1	.147	.287	.053	1.548
Race (2) ***	6.299	1.409	19.972	1	<.001	543.786	34.336	8612.157
Female	-.404	.527	.589	1	.443	.667	.238	1.874
Diagnosis			.648	2	.723			
Diagnosis (1)	-.971	1.210	.643	1	.423	.379	.035	4.062
Diagnosis (2)	-.059	.518	.013	1	.910	.943	.342	2.603
caregiver available ***	-2.660	.590	20.354	1	<.001	.070	.022	.222
Religion			6.994	3	.072			
Religion (1)	1.732	1.166	2.205	1	.138	5.651	.575	55.572
Religion (2) **	2.331	.921	6.410	1	.011	10.287	1.693	62.500
Religion (3)	1.766	1.192	2.195	1	.138	5.850	.565	60.519
Constant	3.521	1.555	5.126	1	.024	33.812		

Note. Full model= $\chi^2 = 110.825$, $p < .001$

Cox and Snell: $R^2 = .462$, Nagelkerke: $R^2 = .647$

** $p < .05$, *** $p < .001$

Summary

The purpose of this study was to fill in the gap in the literature by demonstrating the relationship of spiritual care visits during palliative care at discharge location. The research approach used a quantitative method. A review of secondary data was provided to show the patients that met the medical qualifications for palliative care services. Treatment outcomes were compared with those who received spiritual care visits and were discharged home or discharged to a nursing facility. There was a total of 186 patients, 140 of whom received spiritual care visitations. One hundred twenty-nine patients who received spiritual care visits were discharged home; 57 patients were discharged to a nursing home setting. Fifteen died before their discharge resulting in a total of 186 patient used for this study.

Six research questions were studied to determine if there was any significant difference between patients in palliative care services receiving spiritual care services and patients' decision to discharge home or nursing home setting. Logistic regression was used for the statistical outcome of this study. The results indicated a significance difference in spiritual care visits of those patients discharged home instead of to the nursing home setting. However, gender and age were not significant in this study. The multivariate regression indicated that spiritual care, race, and caregiver availability remained significantly associated however primary diagnosis and religion did not. Chapter 5 will include the summary, conclusions, and recommendations for this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Spiritual care can be important for terminally ill patients, supporting them through listening, praying, and offering rituals for patients (Darren et al., 2018). Often focusing primarily on the supportive role, spiritual care has resulted in a lack of productivity in documentation and opportunities to provide practical care within the palliative care setting (Kearney et al., 2017). However, hospitals often discharge patients with insufficient planning, poor instruction, inadequate information, and a lack of coordination among the health care team members (Lin et al., 2012). By identifying the number of spiritual care assessments or visits and patients' decisions of their discharge location, I determined the potential effectiveness of spiritual care in the promotion of positive outcomes for palliative care patients. When spiritual care is part of the interdisciplinary process, there is an opportunity to provide improved quality of care to patients and their families (Darren et al., 2018).

This study was designed to fill in the gap of spiritual care when it is included in the process of treatment planning and clinical decisions including discharge planning and location. A review of secondary data was initiated demonstrating patients receiving spiritual care visits during palliative care treatments and care. Treatment outcomes were compared with those who received spiritual care visits and were discharged home or discharged to a nursing facility. There was a total of 186 patients used in this study. There were 140 patients which received spiritual care visitations; 129 patients who received spiritual care visits were discharged home, 57 patients were discharged to a nursing home setting, and 15 died before their discharge. Logistic regression was used for the statistical

outcome of this study. The results indicated a significance difference in spiritual care visits of those patients discharged home instead of to the nursing home setting.

Interpretation of the Findings

Spiritual Care

Patients who receive palliative care services and consistent communication from their medical team, including physicians, nurses, social workers, and chaplains, have had a clearer understanding and expectations for improved care among adult critical and terminally ill patients within the transdisciplinary team care approach (Daly et al., 2013). Due the importance of patients' spirituality being supported by their team members; it resulted in patients' opportunity for making more clear and concise choices as well as improved quality of life care (Daly et al., 2013). Often patients desire to discuss with their physician and team care members the relationship of spirituality, its practicalities, and their chronic illness (Balboni et al., 2007; Hopeck, 2020). Spirituality can give meaning to patients and their families in the face of a terminal illness and provide an awareness of their own beliefs in higher powers that may or may not include the concept of God but offer hope in a life-threatening circumstance (Hennesy et al., 2020).

Patients in this study who received spiritual care visits were more likely to consider discharge locations options considering their spiritual perspective related to future health choices. A good death may be identified by some patients as having a preference of dying locations, pain management, and developing a source of peace and emotional well-being (Meier et al., 2016). Similarly, my study occurred within an acute care facility where most of the patients are seen by a spiritual care worker having an

impact on their discharge locations. Some acute care settings have incorporated spiritual care workers as part of the care plan for palliative care patients of which this location is one of those hospitals. Spiritual care referrals allow for a good collaboration, service line communication, and carry through to patients enhance the quality of spiritual care (Hennesy et al., 2020). Patients in this study were initially provided through spiritual care referrals. This presented an opportunity for good collaboration and continuum of care services to take place. Though spiritual care assessments and services are the primary responsibility of the spiritual care worker, it is essential for quality patient care to include an inclusive disciplinary approach for patients meeting the qualifications for palliative care services.

Gender

Results from a study on cancer patients in palliative care indicated the need for improvements with specific populations when they receive early palliative care treatments such as female and older patients (Nipp et al., 2016). Currently, older White females with comorbid diagnoses and receiving medical ventilation are most likely to receive palliative care services, whereas African American males are the least likely to receive care (Chalterjee et al., 2018; Engel, 2021; Vallabhajosyula et al., 2019). Further, women are most often more welcoming to the suggestion of receiving palliative care supports however younger men benefit most in early palliative care services. In my study, there were more females (58%) compared to males (42%), which reflects the possibly that more women received palliative care consultations than men. This supports the value in offering palliative care treatments as options for improved quality of life for specific

populations within an early time frame. Therefore, there is a need for specific populations to be considered when assessing for palliative care services.

Age

There is also need for person-centered tools and communication especially to clinically uncertain populations of older people 65 and older and at the stage of end of life (Ellis-Smith, 2021). This includes person-centered tools that provide opportunities to identify patients' priorities and needs, supports partnerships among patients and practitioners, and improves positive outcomes of care (Ellis-Smith, 2021). The primary age group in my study were patients who were 65 and younger (58%).

However, it is most common in palliative care studies that older patients are in need for palliative care services. One reason behind this may be due to older patients having multi-morbidities with a lacking in their understanding of their disease prognosis and progression. This population is more vulnerable to the death and dying process when the continuity of care is not included in their care planning process. Due to the difficulties in understanding the medical aspects of care, it affects the total care including the decision of a suitable discharge location for end-of-life care. This study showed that, 71.5% were less likely to be discharged to a nursing home compared to those who did not receive spiritual care services or visits. The greater number of the patients were older than 65 years but were able to approach end of life with increased quality of life care through positive outcomes of care.

Religion

Hopeck, (2020) did a study showing how caregivers view and experience talking with patients and families about spirituality in the context of end-of-life care and needs. She used semi structured interviews of 65 nurses, social workers, chaplains, and patient advocates to determine the effects of the care workers talking to patients about their spirituality at end of life. The result of this study indicated that the caregivers saw a benefit of them talking to patients with an understanding that patients/family members felt supported in their religious /spiritual beliefs and decisions.

Hopeck's study is very compatible with my study. She considers the benefits of a care team, similarly, discussed in my study, to describe care workers effectiveness when they support patients and families to seek direction from within themselves with their guidance. The focus in my study examines the data from spiritual care workers which may include all care team members in the patients' caregiving. This study uses several categories of religions, Catholics, Protestants, and Other religious groups. Compared to non-religious patients, patients of any religion are over three times more likely to be discharged to a nursing home. This supports the position that patients who receive spiritual care assessments and visits strongly consider their discharge location options based on their spiritual perspectives and discussions with spiritual care workers.

Primary Diagnosis

Engel (2021) states that many cancer patients are not referred by their physician. Patients are often in pain and limit their connections to other services, and/or they may lack the physical resources such as a vehicle or have financial challenges to access

palliative care services on their own. In a study by Oguz et al. (2021) 139 patients, majority males, who had advanced terminal cancer were admitted to the emergency department and referred to palliative care services due to inadequate symptom control, dying, lack of psychosocial supports, and symptoms of other comorbidities. This resulted in 69.8% of the patients dying in acute care services before being eligible for discharge care. Results from this study demonstrate the need for better planning and integration into hospital care. Often cancer patients receive a palliative care consultation towards the end of their diagnosis (Sheridan,2021).

In my study, cancer is the primary diagnosis. It is very common of palliative care patients to have a diagnosis of cancer with a potential for uncontrolled pain management and lack resources to access care for themselves. This study shows most of the patients are recommended for palliative care services due to the diagnosis of cancer. The lack of resources available for this population can often affect decision making for patients' desired discharge location and other related issues. However, in this study, patients with heart disease were 3 times more likely to be discharged from an acute care facility to a nursing home. Research shows that a study with cancer patients, predominantly males of color, who received palliative care services in early stages had fewer emergency visits, hospitalizations, and hospital deaths (Engel,2021)

Race

Boyce et al., 2021 did a population based cross sectional survey of 1480 cancer patients with the Texas Cancer Registry and approaching end of life with final options for care being primarily choosing aggressive care and /or enrollment in hospice care. After

utilizing an adjusted analysis for black and Hispanic patients, the study determined higher patients of color opposed to palliative care treatments and usage of medication for comfort care. There were 13.3% that indicated that they would prefer to receive medication to prolong their life even if it meant that they would feel physically worst from the medication. Generally, those indicating this preference lived with a family or significant person who they trusted and wanted to continue living.

Patients who were living alone, in rural communities, and age 41-65, compared to those 65 and older, in rural areas stated that they would prefer pharmacological interventions at end-of-life care. Another group of patients opposed any life shortening treatments or palliative drugs. However, a smaller percentage of persons of color aged 65-79 years with the most college education in the study were most likely to accept palliative care interventions. The study indicates that the largest percentage of those in the study choosing aggressive treatments were persons of color (Boyce et al., 2021). Research has shown that those less likely to receive palliative care services are those individuals of color with no insurance or non-managed care insurance and generally located in the rural southern regions of the US (Engel, 2021).

To my knowledge, my study is unique to many studies on spiritual care and end of life issues because it uses a larger number of non-White patients with insurance (98.9%). While this community has its share of poverty -related concerns, these patients had access to good insurance which likely helped them to receive options of care including palliative care treatments. Overall, there was no significance in the differences of discharge location among African American and Asian American patients. However

other non-White patients were 34 times more likely to be discharged to a nursing home than Asian patients. Additionally, this could support their means to access their preferred discharge locations.

Limitations of the Study

This study presents the following limitations for consideration. The study was conducted by obtaining secondary data in patients' charts collected from the hospital. Information was gathered from the patients' charts. The assumption was the secondary data and informational contacts with the spiritual care department, allow for consistency and accuracy for greater validity of the variables being studied. However, there was opportunity for the information to be miscommunicated or miscopied on the Excel spreadsheets. Additionally, there was an overrepresentation of non-Whites in this study however the largest population of palliative care patients are White females thus the findings may not be accurate based on the generalization of the population served. The statistical significance was reached in four of the six research questions, with the relationship among patient's gender, and age and palliative discharge locations showing no significance.

Generally, patients are referred to have a spiritual care assessment often based on the other disciplines on the care team. This can present a problem when there is an assumption that the patient needs to have an assessment only based on a religious need instead of a complete assessment for spiritual distress or needs. Studies indicate that healthcare workers often interpret religious and spiritual synonymously. Thus, often

referrals may not be needed, or specific needs may not be assessed when this understanding is dominated in healthcare workers (Kang, Chun, Kim & Kim, 2021)

Recommendations

Recommendations for Future Research

Secondary quantitative research was used for this study. The primary recommendation for this study would be to use a larger data collection with experimental data. A second recommendation would be to use a larger sample population reflecting a variety of patient demographics, and a wider selection of diagnosis for palliative care criteria, would increase the chances of representing more individuals with similar characteristics found in the population (Ponto, 2015). This may be validated by the countywide health priorities being similar in the health assessment. A large majority of the full community included chronic heart failure, and cancer which were significant in this study. Lastly, a recommendation for use of an approach using mixed methods may be beneficial. Some sources of spiritual care research recommend considerations of mixed methods studies for a more comprehensive understanding to those in healthcare settings lacking in clarity on exactly what spiritual care is and how to provide spiritual care services adequately for patients' wellbeing (Kang, et al., 2021). This is particularly true in palliative and hospice care settings where nursing staff tend to be the, along with chaplains, a primary caretaker for patients' spiritual care needs. Using two types of research approaches may capture any misperceptions, and offers a balance of guidelines, usage of its data collection and analysis (Kang, et al., 2021).

Recommendations for Practice

Spiritual care is important for patients especially when they are moving towards end of life. This care is a vital component in acute care settings as part of the patients plan of care also known as the continuum of care. The original philosophy of palliative care includes the benefits of spiritual care in the interdisciplinary care plan and process for patients diagnosed with serious and chronic diagnoses. This has been proven and documented to be the most effective care for the patient, family, community, and healthcare system (Roy, 2021). Identifying this plan of care for all those in need improves positive outcomes and addresses unmet healthcare needs.

The National Palliative Care Registry (2018) reports that only about half of the palliative care teams in the US includes a professional spiritual care worker with only 41% fully staffed with an interdisciplinary team consisting of a physician, nurse, social worker, and a chaplain. While the numbers are growing, away from rotating spiritual care workers to a primary lead spiritual care worker, it is recommended that acute care systems offer fully staffed palliative care teams for meeting the patients emotional and spiritual needs in all palliative care settings

It is typical that patients, and their loved ones as able, prefer to go home with a home-based palliative care program (Roy, 2021). This has increased in the last number of years as community palliative and hospice options are more available to patients (Roy, 2021). It is recommended that acute care facilities provide greater opportunities for home based palliative care in earlier intervention in acute care for palliative care services. Home based palliative care has been found to reduce the risk of dying in hospitals, and to

decrease symptom burden and lessen caregiver distress (Davis et al., 2015; Roy, 2021). Further, research shows that patients and caregivers who choose to discharge home are more likely to have a higher level of involvement in the discharge planning process (Roy, 2021).

Finally, it is recommended that the perspectives of health care professionals regarding death and dying issues be considered for acute care patients being admitted to palliative care services. Palliative and hospice care services are generally associated with death and dying processes. Acute care workers are typically looking to this process as a last option because they seek to cure illnesses. Often this thinking prevents teams to avoid early treatment of palliative care, resulting in continued aggressive care which may be unhelpful for patients' wellbeing. Research on qualitative studies shows that nurses often report feeling they are not prepared or supported from management to address emotional and communicative conflicts among patients and caregivers about their treatments or the realities of end-of-life situations (Maffoni et al., 2020). Fitch et al. (2016) report that health care workers are more likely to make good decisions towards patients at end of life when all team members are communicating the same plan of care, skill based educational resources are accessible, and there is opportunity to debrief emotions and thoughts related to death and dying either one on one or in group sessions as workers need. Often services such as these are led by a professional spiritual care worker.

Recommendations for Policy

In a national representative study by Sheridan et al. (2021) they showed that advanced stage cancer patients who received a palliative care consultation within the first several days of their diagnosis, had a 25% decrease per patient cost as compared to those patients experiencing usual care services. However palliative care services are still not initially offered to all patients with a terminal illness. Some concerns with delivering high quality and lower costs in healthcare especially among the elderly, are being re-evaluated based on each states decisions on how they want to include palliative care services. The National Academy of State Health Policy (2018) has reviewed the needed policies for states to consider in their determination. These policies are believed to enhance the quality of care for individuals with serious illness: adopting regulations that define, standardize, and support palliative care delivery, implementing palliative care reimbursement policies and quality measures within Medicaid and state employee health programs to promote high- value care, incorporating palliative care into public health and public education strategies, and convening stakeholders to inform policy and programmatic changes.

Research is favorable to palliative care services as it decreases the necessities for additional hospitalizations, reduces cost, and the use of emergency department services who generally do not offer training in treatments for terminally ill patients who qualify for palliative care services. Initially the state is responsible for the allocation of resources to acute hospitals to provide palliative care services. Each state designs their plan of care. Generally, it may be incorporated into hospice care, or other state programs. Based on

National Academy for State Health Policy (2018) research, Maryland is the only state that mandates that hospitals with more than 50 beds have a palliative care program.

Lobbyist and other activist groups will need to advocate for the benefits and supported research for states to set better mandates to include palliative care services for all who qualify.

Conclusions

While there is still more research needed to demonstrate the practice benefits of palliative care for patients, families, and communities, it is obvious that palliative approaches do support improved outcomes of care. I am happy to present this paper highlighting a larger population of non- White patients utilizing palliative care services. However stronger research for non- White communities needs more representation in addition to the current studies with the majority White population. Palliative care services provide improved patient satisfaction scores, improved quality of life care, reduce anxiousness for patients and caregivers, and offer opportunities for patients make choices for extended periods of their life. When we include the health care workers role and assess the cost benefits, it allows for a more well -rounded attempt to adequately provide an increase in equality in health care services.

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