Designing and validation religious evidence-based guidelines of Sound Heart pastoral care model for hospitalized patients

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Abstract

Background and Objectives: Anxiety and fear of the future, sorrow caused by the loss of health, in patients disappointed of God's mercy, create spiritual distress that requires spiritual care for achieving Sound Heart (spiritual health). Standardization spiritual care based on religious evidence provides holistic and community-oriented care. The purpose of this study is: Designing and validation religious evidence-based guidelines of Sound Heart pastoral care model for hospitalized patients.
Materials and Methods: The study had been done with “developmental research” method with the evidence-based approach in hospitalized units of Baqiyatallah hospital in 2015. Nursing care instructions had been designed according to Settler model and with the evidence-based approach for pastoral care. For assessing content validity of the instructions with Delphi method, opinions of faculty members of Baqiyatallah, Tehran, Iran, Shahid Beheshti Universities had been considered in three stages. Applicability of the instructions had been assessed by focused group discussion method with 10 experienced experts of hospitalized Units.

Findings: By The survey of faculty members and clinical nurses, Twenty-five spiritual diagnosis of a sound heart model with more frequency were selected. Evidence-based guidelines for religious spiritual care in hospitalized patients designed and validated, that can be applied in spiritual counseling prescription model to convert the emotions derived from fear and misery to sense of security, trust, hope, optimism.

Conclusion: Faith in the God's mercy, wisdom, power, gives meaning to life events and sacred suffering from the disease. For spiritual health care, by use of prescriptive model, religious evidence-based guidelines, provides emotional compatibility with the disease.

Keywords: Instruction, pastoral care, evidence-based, patient, sound heart model

Introduction

Along with rapid changes in health care systems (Rezaei-hachesoo, Habibi, Foconkhah, 2007) “accreditation model” was used in Iran's health ministry, for providing qualitative, safe and evidence-based care. This model allows continuous survey of improving in: quality of care, patient safety, safe care environment, reducing the risks and detailed evaluation of existent methods efficiency in hospitals. Model makes sure that provided services are efficient and affordable (Marquis, Huston, 2003).

Difficulty in clinical decision makings based on patients’ interests and financial benefits of organization, have directed researches toward cares standardizing with the best evidences (Adib-hajbagheri, 2006). So that the provided information are published as strategies for clinical decision makings (instructions) (Adib-Hajbaghery , 2007). Evidence-based care, with applying results of the best studies along with knowledge, clinical experiences, specialty, and attention to patients’ values and prioritizing their interests, is the “method of clinical decision making” (French (2002)). Evidences shows solution of clinical problems like : utilizing the experts’ ideas, a recipe, a registered experience or articles of scientific researches (Nehryr, Reje, Ebadi, 2013) which make the best care possible (Yoos Malone, McMullen, Richards, Rideout, Schultz, 1997). At international level, any of evidence, including experts’ ideas, have a specific credit rating. But unfortunately Quran and infallible Imams’ sayings (confirmed by seminaries Shiite science) have not been contemplated and mediated as strong and undistorted database of reliable evidence for creating clinical guidelines of spiritual care (Eskandari, Asadzandi, Khadem, Ebadi, 2017).
The incidence of life threatening events or chronic diseases, create an important crises in one's life. Every crisis is actually a spiritual crisis (coward, 2000) that in addition to physical consequences creates considerable psychological, socio - spiritual impact and brings spiritual needs. (2007 Bingham,) Spirituality is the common characteristic of people, which is manifested in search for meaning, purpose and hope. Spiritual care identifies human needs when faced with psychological damages, grief and sorrow, fear and anxiety and considers how to respond to these problems (Holloway, 2009). Many of patients think that spiritual care of medical system are inadequate (El Nawawi, Balboni, Balboni, 2012).

Up to now, no study has succeeded in expressing the patients’ spiritual need clearly and reasons for inadequacy of cares provided. Although some studies consider inadequate training as one of the weaknesses in this area, the articles review has not shown any credible international care model, applicable to all institutions offer spiritual interventions (Abbasid, Shamsy, Movahedi, and Safari 2015).

The patient, as an integrated bio-psycho socio spiritual whole (Esfahani. et al. 2010) reacts to the potential and actual problems of health in four dimensions (relationship with God, self, people and nature). The holistic nursing care (George, 2007) should diagnoses and treat all these reactions (Griffith, 2005) in the life (Algoid, Mariner, Toomey, 2009), at all levels of prevention, with health promotion approach to increase bio-psycho-socio spiritual health of individual and society (Asadzandi, 2009). But unfortunately international nursing care models, which express caring in the form of operational strategy (nursing process), neglect the concept of divine spirit of the hidden realms. They have failed to recognize humans’ spiritual needs, spiritual reactions and the methods of healing the patients’ spiritual distress (Asadzandi, 2001). Clinical guidelines of pastoral care are very limited and their content is not consistent with the beliefs of patients.

Holistic Model of the Sound Heart in the paradigm of monotheistic religions, with an emphasis on the patient and family-centered care, as well as self-care and home care, utilizes patient and family participation in pastoral care with goal of achieving sound heart (pastoral health) (Asadzandi, 2015). This model defines health as Allah’s trust and knows the patients’ responsibility for maintaining and improving their health. Prescription patterns of spiritual counseling, uses the assistance of all members of health care team (doctors, nurses, clergy, social workers, psychologists, etc.) and helps patients to achieve God satisfaction (Asadzandi, 2016). Therefore, this study aimed to “designing and validation religious evidence-based guidelines of Sound Heart pastoral care model for hospitalized patients”.

Methodology

This study had been done with “developmental method” and the approach of “evidence-based function” by using “Settler model “to upgrade and develop existent knowledge. Developmental research is designing, developing a process, production or program (Richey, Klein, Nelson, 2012), Amel Ebrahim et.al. (2013) for accreditation of evidence-based instructions in patients with tuberculosis started to develop instructions of nursing care. Type of the research is called “developmental approach” and the processes of doing the work is as bellow: instructions are designed after comprehensive studies of new sources and articles and nurses’ need according to the aim group. They had been
corrected through Delphi method during some sessions in order to have a collection of experts’ opinions (Amel Ibrahim, Sahar Mohamed, Awad.2012).

The study population included; published works in the form of Persian and English scientific books and articles related to the subject and also participating of ten faculty members in study was the research environment. Nursing care instructions had been designed according to Settler model.

“Settler model “includes five stages: preparation, accreditation, comparison study, application, performance and evaluation.

Preparation stage: Includes collecting all present instructions of pastoral care existing in the units of Baqiyatallah hospital and Health Ministry, present nursing diagnosis of Sound heart model and nursing diagnosis in reference books and articles and nurses’ opinions. About the present instructions, unfortunately, there is no specific instruction in units of Baqiyatallah hospital. The qualities of non-specific guidelines were evaluated by means of Agree and glia tools. (Appendix 1)

Reviewing the evidences: In order to collect the present diagnoses in religious evidences, reference books and articles, designing clinical questions method (PICO, population or problem, intervention, compare, outcome) had been used for texts study included: reviewing all the verses related to divine trials, disasters of life ( by using valid Shiite interpretation books, Usul al-Kafi) all related articles between 2005 to 2015 with priority order based on evidence-based pyramid (from systematic reviewing studies, meta-analysis, clinical trial, tests, cohort, evidence case, case report, laboratory studies, experts and pundits’ opinion) and web sites including internal and external such as: Croquets, PubMed, Google scholar, Elsevier, SID, Magi ran with key words: care, instructions, evidence-based nursing, protocol, spiritual distress, that their full text were accessible. Considering the inclusion criteria and purposeful sampling, 170 articles chosen from 325 studied articles were sample size of this study.

Accreditation: In this stage, new instructions for spiritual care had been designed based on evidence-based method and in the form of nursing process. In order to determine content validity of the instructions specialized faculty members’ opinions of Baqiyatallah, Iran, Tehran, Shahid Beheshti universities with Delphi method, in three stages of survey and with agreement coefficient of higher than 90% had been used. Actually content validation had been done by experts.

Comparative evaluation: The stage of comparison study includes determining applicability of instructions and studying their benefits and dangers. In this stage, there were sessions of focused group discussion regarding operationalization of these instructions. It should be mentioned that initially designed instructions had been given to10 nurses who were responsible for providing direct and indirect care in units in order to study them. Then during two 4-hours sessions, all the interventions were discussed and exchange of views had been done for being implementation, regarding this by taking permission from the participants and by using MP4, voice of the attendance in the meetings had been recorded and final conclusion had been formed.
Application: In the use stage: by using nurses’ opinion, final instructions had been performed by determining operational codes. Rules: Square: This care should be recorded in the card. Circle: The care must be recorded in the treatment sheet.

Performance and evaluation: In this study, clinical implementation was not possible. At the end, quality of new designed guidelines was compared to previous ones which got a good score.

Findings

Considering that no specific pastoral care instructions was observed, in this study, among the pastoral diagnoses of sound heart model (Asadzandi, 2013) with surveys of professors and clinical nurses, twenty-five diagnoses which had more frequency were selected such as: Fear, Anxiety, Sorrow, Spiritual Distress (Hopelessness, Risk for Suicide, Anger, People Pessimism, Pessimism in God, Insecurity, Hatred, Sense of revenge, Jealously, Atrocity, Backbite, Pride, Ingratitude), Sleep Pattern Disturbance, spiritual Self-Care Deficit, disorder in praying, Lack of Preparation For death, Fear of Death, Dying, Risk for Quicken Hard, Risk for Grave Horror. The guidelines of pastoral care were designed and validated with religious evidence-based approach in the hospitalized patients.

803. Spiritual Distress (NANDA)

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<th>Nursing diagnosis:</th>
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<td>Spiritual distress related to disorder in praying</td>
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<th>Evaluation criteria</th>
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<td>Performing acts of worship</td>
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<th>Nursing measures</th>
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<tr>
<td>1 Evaluation of patient anxiety</td>
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<td>2 Daily check of health services and patients’ clothes</td>
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<td>3 Determining the direction of Quibble</td>
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<td>4 Keeping prayer, getting familiar with prayer secrets, praying on time, correctly performance, observing its rules and etiquettes</td>
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<td>5 Planning health services so that it does not interfere with the patient's Prayer</td>
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<td>6 Recalling that prayer is a relief</td>
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<td>7 Making sure that there is no physical harm in prayer</td>
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<td>8 Recommend to night prayer</td>
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<td>9 Recommend to the invocation of the Lord's prayer</td>
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<td>10 Teaching positive effects of prayer</td>
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<td>11 preparing facilities for the morning, afternoon, evening prayer</td>
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<td>12 Preparing the facilities for tayammum (Ablution with clean soil)</td>
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<td>13 Recommendations to worship in the chapel section</td>
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Results and discussion

Facing with disease creates spiritual distress and emotional reactions for patients that Elizabeth Cobbler Ross described them in grief process (five stages of: shock and denial, anger deriving from fear and loneliness, bargaining and transaction, depression, severe sadness and even suicidal thoughts, and in some cases adaptation) (Sadvk, Sadvk, Pedro Ruiz. 2015). But the patients’ reaction to diseases is depend on their attitude to the world and meaning they give to life events (such as diseases) (Asadzandi, 2016).

The human experience in all cultures has shown that in critical situations when diseases threat the life, man has always asked a sacred and divine source for help (Potter, Perry, 2005) and need for spirituality becomes very important (Harvey, Silverman, 2007). Spirituality as essence of human existence, is an inherent quality in all human beings, representative of harmonious relation with self, others, nature, and God. It helps to find goal and meaning of life (Lee, Connor, Davidson, 2008). Studies have shown that spiritual beliefs, has been associated with all aspects of health and disease, direct daily life habits, it is the source of support, strength and recovery. It increases ability to adaptation with distress of disease and speed up recovery. It makes man feel better and stronger to cope with disease (Potter, Perry, 2003). Worship has a positive impact on increasing coping mechanisms, and brings relaxation and comfort (Vance, 2001). All these findings are consistent with current research. The purpose of spiritual approaches is strengthening and reforming the individual’s quadratic relations (with God, people, self, creatures). In psychological approaches, goal of treatment is a positive and hopeful attitude (Fallahi-Khoshknab, Mazaheri, 2007) which is considered by the Sound Heart model too.

Nurses’ ignorance of patient’s spiritual aspect and its relation to health will definitely have irreparable damages for patients and nursing profession (Mauk, Shmidt, 2004). Nurses should increase their knowledge about the ways that spiritual beliefs affect: the life style, coping mechanisms, selection of care and treatment methods. They should aggregate spirituality in nursing care. For getting positive feedback from the patients, nurses should improve their relation with patients and their families (Mazaheri, Fallahi-hoshknab, Madah, Rahgozar, 2006). These findings are consistent with the prescriptive model of Sound Heart which describes the role of the care givers as “Mentors”.

Pastoral care includes: instilling hope, pastoral support and facilitating spiritual growth (Vance, 2001). It requires some skills like: harmony with attention; nonverbal communications, sensitivity, sincerity, trust development; interpersonal communication skills, self-awareness, collaboration, understanding patients’ limitations and religious needs (Shelly, fish, 1988).Spiritual care includes practices and activities such as: respect and maintaining dignity of patient, listening carefully to patient, helping patient to understand meaning of disease (Lavassani, Keyvanzahdeh, Arjmand, 2006). Listening to concerns, helping the patient to pray, reading holy religious books, expressing hope, and explaining the importance of spiritual concerns in the final stage of life, referring to clerics or others are providing pastoral intervention (MC Ewen, 2000). Spiritual care decreases the patient’s distress during hospitalization and it is focused on patient’s spiritual and mental needs (Wachholtz, Kenneth, 2005).The Sound Heart model emphasizes on the effect of bio-psycho-
socio spiritual environment, patient’s reaction to disease, spiritual skills training, necessitates understanding patient’s spiritual beliefs, recognizing their spiritual needs for pastoral care giving.

Although "spiritual distress" was adopted as nursing diagnosis, in the North American Nursing Diagnosis Association (NANDA) classification in 1988 (Carpenter, 1999) and nowadays, in different communities of the United States, spirituality is taken as a key dimension for health and recovery. The church nursing is being carried out, with respecting and considering dignity of patient (Chin, Kramer, 2004) but unfortunately, the nurses who provide spiritual care, are in minority and all those who offer it, do not record it and some nurses have no spiritual awareness (Cavendish, Konecny, Mitzeliotis, Russo, 2003).

The results of various studies show that more than 50 % of nurses do not give spiritual care in practice, and they feel that, they do not have enough skill and ability in this area (Mazaheri, FallahiKhoshknab, Madah, Rahgozar, 2006). Mostly in the nursing literature, the spiritual dimension of human existence is not emphasized since, there are not enough scientific texts in this area or the care givers do not believe in God (Potter, Perry, 2003). The reasons of inadequate attention to the issue of spirituality are: 1) nurses' lack of spiritual consciousness; 2) fear of the impact of personal opinions on the patients; 3) time limitations; and 4) lack of training in the field of spiritual intervention in nurses (Pullen, Tuck, Mix, 1996). Yardley in his study gives three reasons for the lack of proper pastoral care: 1) Determining the spiritual needs of patients is not easy; 2) Who can do them? 3) How confidently can we have proper pastoral care? (Wachholtz, Kenneth, 2005) Although holistic nursing at the global level emphasizes identifying patient’s needs, most nursing books emphasize the physical and psychological needs of patients more than spiritual needs (Andrew, Boyle, 2003). Despite this fact that in all nursing schools, it is taught nursing care is a bio-psychological, socio spiritual care, but the content of pastoral care, is rarely presented. Mostly, spiritual care is talked about as a part of psychosocial care with expressions, such as: attention to the spiritual beliefs of the patients (Matthew, 2000).

Many studies have shown poor quality of clinical nursing in Iran (FallahiKhoshknab, Mazaheri, 2007) and despite the strategy of “Ministry of Health” for evidence-based nursing, but evidence-based pastoral care guidelines for patients suffer from pastoral distress are not designed scientifically and systematically yet. While the major factor in improving the quality of care, is capability of quality measuring and the most valuable quality measurement is assessing the nurses’ performance in providing care (Lee, Connor, Davidson, 2008). Nurses as a large group of medical team, have considerable effects on improving the patients' satisfaction (Ghamari, Anousheh, Hajizadeh, 2008). Clinical guidelines are one of the major tools for improving quality of care (Yoyos, Malone, McMullen, Richards, Rideout, and Schultz, 1998). This research could be useful in resolving the existent vacuum for providing holistic and community oriented care to patients believing in the Abrahamic religions. Creating unity, improving quality and assessing pastoral care, require using of religious evidence-based guidelines for pastoral care. Also, the use of the nursing process in Sound Heart model as a dynamic way is recommended. Thereby, it is recommended to use recipes of spiritual guidelines for emotionally compatibility with illness and its consequences, as well as the implementation of planned spiritual counseling.
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