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How Patients Experience Pastoral Care in a Tertiary Health Care Setting

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Abstract
This research aimed to establish the level of consumer experience with pastoral/spiritual care provision in a large tertiary private hospital. Two hundred and twenty-seven patients and bereaved carers of deceased patients who had received pastoral care were surveyed, with a response rate of 20% ($n = 44$). The key finding was the positive impact of pastoral care encounters, with the majority of respondents reporting provision of pastoral care to be helpful, and offered with courtesy and respect.

Keywords
Consumer experience, emotional support, health care, pastoral care, spiritual support

Introduction

The way in which pastoral care has been provided within St John of God Health Care has evolved considerably over the years, as has our understanding of the importance and benefit of this care. This evolution has prompted greater appreciation of the depth and breadth of our services, but demands greater accountability and a clear incentive to be informed by evidence-based practice. Ewan Kelly reminded us that "ours is a community where curiosity about, and attention to, what happens during moments of (pastoral) practice and the impact on those involved is not only culturally relevant but imperative" (Kelly, 2014: vi). Kelly (2014) suggested that personal reflective practice, evaluation of services and broader healthcare chaplaincy research are all part of the same continuum that are enhanced by intentional and rigorous exploration of a variety of methods and approaches to pastoral care. It is our belief that engagement in this process underpins and emphasises pastoral practice which is life-enhancing, person-centred and contributes to the emerging evidence. We entered this study with an open mind and a curiosity about the perceived efficacy of our services, but like Jankowski et al. (2011) we were cognisant that identifying specific measurable outcomes from an individual's experience of pastoral care could be challenging.

As part of our pastoral services quality review process we have routinely sought feedback (via questionnaire) from consumers who attend one of our six Remembrance Services held throughout the year. This has enabled us to improve our services and ensures our bereavement support program is responsive to the needs of those who attend. Confident of our contribution to the wellbeing of our bereaved carers, until now, we had not ventured into the somewhat less structured realm of evaluating our pastoral care interventions and interactions.

The aim of this study was to establish the level of consumer experience and satisfaction with our provision of pastoral care during a four-month period. It was anticipated these results would provide important feedback about our

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service and valuable information for formulating a more robust research process in the future.

We also hoped to receive feedback about how respondents understood their emotional and spiritual needs, and what was helpful to them during their hospital or hospice admission. We knew from our organisation-wide in-patient satisfaction surveys that emotional and spiritual needs were important to patients as they were rated highly (Press Ganey Associates, 2012, 2013). This finding concurs with Flannelly et al. (2009: 2) who stated "According to Press Ganey Associates hospitalised patients consistently say that having their spiritual and emotional needs met is one of their top priorities". We recognised the pastoral services team were not wholly responsible for meeting these needs, but were seeking some insight into how patients understood their particular needs and how our support made an impact.

The term 'pastoral care' is used throughout this paper with awareness that it is contextually inter-changeable with 'spiritual care'. For the purpose of clarity, the term 'pastoral practitioner' has been used to describe the religious or pastoral care provider, despite recognising that it may well have been a chaplain or communion volunteer who provided this care.

Context

Providing professional, evidence-based pastoral services is a priority for St John of God Murdoch, a not-for-profit Catholic Hospital that is one of 17 divisions within St John of God Health Care across Australia and New Zealand. It is a private tertiary hospital with 507 beds, including a community hospice, emergency department, comprehensive cancer care centre, and paediatric, maternity, medical, surgical, critical and coronary care units.

Our mission statement clearly articulates our intention to promote pastoral care as we "continue the healing mission of Jesus Christ through the provision of services that promote life to the full by enhancing the physical, emotional, intellectual, social and spiritual dimensions of being human" (St John of God Health Care, 2014: "Mission", para. 1). This priority is further highlighted by the current St John of God Health Care vision statement which determines that pastoral care should be offered to all regardless of religious or spiritual affiliation (St John of God Health Care, 2014).

The Australian context in which our pastoral care is offered is one in which religious observance and church attendance is declining (Powell et al., 2012) but recognition of Christian spirituality is increasing (Mackay, 2016; Tacey, 2000). Although 61% of Australians identify with being 'Christian' (Australian Bureau of Statistics, 2011) only 15% of Australians attend church at least once a month (Powell et al., 2012). In addition, the proportion of people who reported 'no religion' increased from 18.7% in 2006 to 22.3% in 2011 (Australian Bureau of Statistics, 2011). Our Hospital's patient admission data confirmed this finding as 22–24% of patients admitted during this period indicated they had 'no religion'. Mackay (2016) suggested that in spite of the overall decline in religious observance, Australians still like to think of themselves as Christians who live in a country built on Christian values and beliefs. For many Australians there is a distinction between "formalised, institutional religion that is rooted in the past, and spirituality that seems more immediate, spontaneous, free-floating and potentially more personal, because it grows out of here-and-now experience" (Mackay, 2016: 114). The pastoral services team at the study hospital, grounded in the heritage and vision of the Catholic Church, has always been committed to providing a contemporary Christian pastoral care service that is respectful of patients' religious needs, and responsive to the spiritual awareness that grows out of the here-and-now experience of being hospitalised. In this context individual members of the pastoral care team provide 'pastoral' and 'religious' care.

Pastoral care is provided by professionally trained 'pastoral practitioners' from a variety of Christian denominations, including Catholic, Anglican, Baptist, Uniting, Pentecostal and Churches of Christ, with various theological and counselling qualifications and clinical pastoral education certification. These pastoral care practitioners are considered members of the multi-disciplinary team and visit patients and their families according to identified psycho-social, emotional and spiritual needs, rather than religious identification. This practice confirms Puchalski's description of the role of spiritual care in healthcare, as compassionate care that "involves serving the whole person – physical, emotional, social and spiritual" (Puchalski, 2001: 352). Our pastoral practitioners 'serve' their patients through person-centred, relational interaction and presence, and facilitate requests for a representative of a patient's own faith or cultural group to visit, thus ensuring care is inclusive of the patient's religious or cultural beliefs (Spiritual Care Australia, 2013).

Religious care is provided by three hospital chaplains: two Catholic Priests; and an Anglican Priest. This care is often characterised by the provision of ritual and sacrament, and is grounded in the stated religious beliefs, values and liturgy of the patient's faith community as defined by Spiritual Care Australia (2013). Trained and accredited pastoral volunteers also offer religious care through the provision of Holy Communion to Catholic patients as requested. These role distinctions are clear to those working within the pastoral services team; however, to patients receiving pastoral or religious care, these differences are less distinct.

Our intention as a pastoral services team is to provide person-centred pastoral care, but clear outcomes are not always obvious, causing us to question what constitutes therapeutic pastoral care, and how this contributes to the overall health and wellbeing of our patients. These and other questions related to efficiency and efficacy are increasingly being raised as we strive for excellence in our provision of best practice pastoral care.

Current feedback mechanisms in the study setting comprise: comment cards; Press Ganey Associates organisation-wide In-patient Satisfaction Surveys; and personal expressions of appreciation through cards and emails. As a general rule, comment cards do not specifically refer to pastoral services, although occasionally a pastoral practitioner's name is mentioned alongside others as being of particular assistance, or possessing attributes pleasing to the patient.

Press Ganey Associates In-patient Satisfaction Surveys (2012, 2013, 2015) have been a part of our consumer feedback process for many years, encouraging patients to rate the courtesy of the pastoral/religious caregivers. Whilst the term 'courtesy' provides some indication of the way in which caregivers approach patients, it does not provide a clear picture of the effectiveness or benefit of pastoral encounters. Nor does it enable us to define the difference between pastoral and religious care, which in our context as previously outlined is provided by a variety of people who have quite different and distinct purposes, and therefore outcomes.

Personal expressions of thanks and appreciation may be helpful in identifying individual pastoral practitioner behaviour, but they do not provide sufficient evidence for assessing the value of a team. Cards often make reference to appreciation of care and support, but what constitutes this 'care and support' or how this helped a particular patient or carer is unclear.

According to the pastoral services database for the period of this study, the majority (70%) of patient visits were initiated by pastoral practitioners rostered to allocated ward areas. In addition to these visits, pastoral practitioners were referred to specific patients by nursing/medical staff (20%) for issues such as anxiety, poor prognosis, existential concerns, transition to palliative care or a new life limiting illness diagnosis; bereavement; or a pregnancy loss. Some patients personally requested pastoral care, whilst others found a way into pastoral encounters via referrals from friends/family and concerned others (10%).

The findings of this study should therefore be considered in the context of patients who evaluated a specific religious service, probably in response to a personal request for Holy Communion or a Priest, and those who may or may not have professed a particular faith perspective, reflecting upon interactions and conversations that resulted from pastoral care being provided during a time of need.

This study sought to answer the following questions.

- What did respondents experience as helpful or unhelpful about their pastoral encounter?
- How courteous was the pastoral practitioner who attended them?
- Did respondents feel they had been listened to appropriately, in a way that enabled them to speak honestly?
- How did the pastoral practitioners' address the respondents' spiritual/emotional needs?

Approval from the study site Human Research Ethics Committee was granted on 22 December 2014.

Method

Design

An exploratory study was undertaken using an eight-item questionnaire based on qualitative description and enumeration. Qualitative data were analysed through the identification of common and dominant themes provided in the free text. Quantitative descriptive analysis was used to collate numerical data and assess weighing of question responses.

Sample

The target population for this project comprised patients and bereaved carers of deceased patients who had received pastoral care from St John of God Murdoch Hospital pastoral services between October and December 2014.

In order to capture data that were truly representative of the diversity of our pastoral care provision, it was decided to include both discharged patients and families of deceased. We recognised the potential for differences in participant responses, but in our pastoral practice there is no clear distinction between the way in which pastoral care is offered to a patient in a medical or surgical ward or a family in the hospice. Combining both groups enabled the research to mirror our pastoral practice and our pastoral practitioners' care.

Of the 1446 potential respondents, 239 names were randomly selected from the pastoral services' visitation database. Other than patient names, no other details were identified during this process other than a 'bereavement' alert for patients who had died during or subsequent to this time frame. Bereaved families were then reviewed by the pastoral services manager to identify and exclude any people for whom the survey could potentially cause distress or confusion. Patients who were known personally by members of the pastoral services team were also excluded, as were members of the same family. This resulted in a final sample of 227 potential respondents: 204 patients; and 23 carers of deceased patients.

Survey Instrument

Recognising the inherent reluctance of Australians to discuss religion and spirituality (Tacey, 2013) it was anticipated that a short one-page survey, designed for easy completion, whilst not able to obtain comprehensive data, would potentially be acceptable to potential participants.

An eight-item questionnaire was developed following discussions with key St John of God Murdoch Hospital stakeholders (e.g. Quality Manager, Chair of Nursing, and Director of Mission) and a review of the limited empirical

literature related to consumer experience of pastoral care (Carey, 2000) and other patient reported outcome measures in the Australian pastoral care context. Given the paucity of Australian research data relating to the efficacy of pastoral care provision, we were committed to compiling our own body of evidence from Remembrance Service reviews and conversations with caregivers to understand the perceived value of our role in enhancing the wellbeing and recovery of our patients. Of particular interest and consideration in the design of the study questionnaire were the findings from the Press Ganey Associates In-patient Satisfaction Survey (2013) report which detailed patients' experience of pastoral care encounters, and a Scottish study by Snowden et al. (2012) which developed a patient reported outcome measure of the impact of specialist spiritual care. Seven items were developed to represent easily identifiable aspects of the service to which patients and carers could relate, such as the helpfulness, courtesy and listening ability of the pastoral care providers. Question 1 sought to identify whether participants remembered being visited by a pastoral practitioner.

Questions 2 and 3 were designed to identify from the participant perspective, what was or was not helpful about their pastoral encounter. Quality improvement evaluations had in the past provided generic comments relating to helpfulness of pastoral practitioners. This feedback however gave no indication of the specific way in which the patient experience was enhanced. We were curious to understand the context and attributes of our pastoral practitioners' perceived helpfulness. Or if in fact we were as helpful as we perceived ourselves to be. As pastoral encounters are inherently person-centred and conversations held with the utmost respect for the spoken and unspoken agenda of the patients, it was from these questions that we anticipated a greater understanding of how our individual interactions, engagement and behaviours impacted the emotional wellbeing of our patients. It was also anticipated that responses to these questions may have indicated whether our hospital's mission integration goal of 'developing a person-centred culture' was being met.

Question 4 was designed to elicit whether pastoral practitioners' behaviour was perceived by patients as being courteous and reflective of the values of the organisations – hospitality, compassion, respect, justice and excellence.

Question 5 was designed to assess the depth of interaction experienced by participants and to understand how they felt about the therapeutic connection. As listening is a key component of the provision of pastoral care, it was important to know whether patients felt they had been heard and understood in their pastoral encounters (Snowden et al., 2012). Feeling comfortable and safe enough to speak openly about experiences such as illness, disability, death, faith and changing relationships, indicates a level of personal security on the part of the patient that can potentially be attributed to the ability of the pastoral practitioner to establish a pastoral relationship that is respectful, meaningful and transformative. Without this foundation it is difficult to identify and address the spiritual and emotional needs of the patient or family. Hence, the question about listening preceded the question about identifying and addressing emotional/spiritual needs.

Question 6 was included to ensure we were meeting the objectives of our provision of professional pastoral care and to ascertain whether patients and families could identify what their emotional/spiritual needs were whilst in hospital. We were also curious to know whether our response to these needs met patients' expectations and were consistent with our Press Ganey In-patient Satisfaction Survey data.

Question 7 was included to ascertain whether participants had any additional feedback about pastoral services that had not previously been documented.

Question 8 requested demographic details related to gender, age and ward location in an attempt to identify any potential common themes.

Procedure

Each patient or bereaved family member was sent a letter inviting them to complete the eight-item questionnaire about our provision of pastoral care. The questionnaire included information about how to contact the pastoral services manager should he/she wish to discuss the survey personally. A reply-paid envelope was included to facilitate return of the questionnaire. Return of completed surveys was accepted as implied consent.

Results

Response Rate

Of the 227 surveys sent, two were returned as undeliverable. Forty-four completed surveys were returned, a response rate of 20%.

Demographic Details

The sample comprised 28 (64%) females and 14 males (32% – missing data = 2). The age of respondents ranged from 26 to 93 years, with the majority aged $\geqslant$ 60 years ($n = 37$, 84%).

Survey Data

(1) **Do you remember a pastoral practitioner coming to visit you?**

All respondents ($n = 44$, 100%) recalled having been visited by a pastoral practitioner. Twenty-eight (64%) respondents recalled their admission ward/area, with most areas of the hospital/hospice being represented.

(2) **What was the most helpful aspect of this visit?**

Aspects of the pastoral encounter that were most appreciated were the friendly and pleasant manner of the pastoral practitioner ($n = 16$, 36%); having someone to talk to and who would listen to them ($n = 13$, 30%), and the care and compassion demonstrated by pastoral practitioners ($n = 10$, 23%). Two respondents commented their pastoral practitioner had been helpful in addressing deeper personal needs such as being "able to talk about beliefs" and being able to "address some issues that we were not prepared to discuss prior (to the visit)" (female, 34). Two others indicated that it was helpful "someone came to speak to me and ask about me" (female, 32); and it "showed some care for the individual" (female, 78).

Three respondents (males aged 75, 45 and 60) indicated appreciation of the quality of the engagement noting, "We could talk about anything" and the conversation was "calming, helpful and enjoyable."

Several respondents identified pastoral practitioner' behaviours which were perceived as helpful. They were "good company without being pushy and intrusive" (gender not specified, 34); they were "friendly and non-intrusive" (female, 69); and "they showed appropriate concern" (male, 73). Another appreciated "the calm, peaceful and caring way they spoke and acted" (female, 66). The positive impact of the pastoral encounter was also identified by comments such as they "brightened part of the day, although I was not feeling the best" (female, 70); they were "very reassuring" (male, 66); and they "lifted my spirits at a time when I needed someone to talk to" (male, 70).

Three respondents appreciated being offered Holy Communion and two were grateful for practical help such as fixing their chair. One respondent commented that it had been good to meet the pastoral practitioner and know the service was available, even though he/she did not feel they needed anything.

(3) **What was the least helpful aspect of this visit?**

Thirty-six (82%) respondents visited by a pastoral practitioner either did not respond or noted there was "nothing unhelpful" or "nothing negative" about the encounter. The remaining eight respondents stated: the pastoral practitioner had visited during meals or rest periods; had not carried a Bible; had stayed longer than they had wished; did not return for a repeat visit; or had not listened to them in a way that was helpful.

(4) **How would you score the courtesy of the pastoral practitioner who visited you?**

Respondents were asked to rate the courtesy of the pastoral practitioner who visited them on a five-point Likert-type scale (1 = very poor and 5 = very good). Thirty-five (80%) respondents scored this item as very good with an overall mean score of 4.9. Five respondents who recalled being visited (some on several occasions) did not score this item while some respondents stated they were visited by several pastoral practitioners.

Nineteen (43%) respondents provided free text comments, most ($n = 16$) of which were positive such as, "they had the perfect amount of sensitivity regarding patient engagement" (male, 60); and "They were very quiet and thoughtful of my situation" (male, 70). Additionally, "Both showed great empathy with a strong drive to support the will to live" (male, 69); and "I did not have to rush but could talk like a friend" (male, 75).

(5) **Did you feel listened to, in a way that enabled you to speak openly and honestly about your situation?**

Respondents were asked to rate this question using a five-point Likert-type scale (where 1 = not at all and 5 = all of the time). Thirty-three (75%) respondents felt listened to "all of the time", whilst the remaining respondents felt listened to "most of the time" ($n = 4$) or "sometimes" ($n = 2$). The overall mean score for this item was 4.79.

Seventeen respondents provided comments, most of which were positive and highlighted the listening skills, kindness, friendliness, and open-mindedness of the pastoral practitioner. Another respondent wrote that they felt like "a close friend had paid a visit."

Three respondents felt they had been listened to but were disappointed by: not being asked more questions; being given too much information; or not being informed their pastoral visit was being documented in their medical record.

Three respondents indicated they did not need to be listened to or they chose not to speak about personal matters with the pastoral practitioner. They did however state that if they had needed to speak about their situation, they felt they would have been listened to by their pastoral practitioner. One respondent reported the pastoral relationship was so valuable they wished it would continue after discharge.

(6) **Did the pastoral practitioner address your spiritual/emotional needs?**

Respondents were asked to rate whether the pastoral practitioner addressed their spiritual/emotional needs using a five-point Likert-type scale (1 = not at all and 5 = all of the time). Six respondents made comments but did not complete the rating scale. Of these six responses, three noted that the pastoral practitioner did address their spiritual/emotional needs by providing support that assisted their recovery from surgery, and provided Holy Communion. Others indicated that they had no specific needs that required addressing.

Of the 37 respondents who rated this item, 54% ($n = 20$) agreed the pastoral practitioner addressed their spiritual/emotional needs 'most' or 'all of the time' (mean = 4.03). Fourteen respondents clarified they had no needs at the time of the visit, or did not wish to discuss their needs at this time. There were also expressions of appreciation and gratitude for the support provided. Two respondents stated they were either "agnostic" or "not spiritual", but both were appreciative of pastoral care, stating "The pastor was respectful and didn't try to push his faith on me..." and "I'm not a spiritual person, but these women created an emotional drive that was very fulfilling."

(7) **Do you have any other comments to make about your experience of Pastoral Services at St John of God Murdoch Hospital?**

Thirty-one respondents made additional comments, although some interpreted the question as relating to the hospital as a whole. Many comments were similar to those previously highlighted where respondents expressed their appreciation of the compassion, care, courtesy and helpfulness of the service.

Other comments highlighted the value of the service to the extended family such as: "I found each of the pastoral practitioners very empathetic with Dad and he was brighter after each of their visits. They also took time to ask about my welfare." Similarly: "The visits were extremely helpful in a difficult situation, not just to me but my whole family."

Several additional comments related to the perceived value of the service such as: "I believe pastoral services performs a necessary task at St John of God Murdoch Hospital", "I am so grateful to you for continuing this service", and "Keep them going - it is great to talk to people of faith who respect other people's faiths. I enjoy the quiet discussions."

Two respondents commented that follow-up visits would have been appreciated, particularly after traumatic birth experiences, whilst one respondent suggested that a short religious service be conducted on the wards.

Discussion

The most striking observation from the data was the positive impact of the pastoral encounters. An overwhelming majority of respondents indicated the pastoral visit was helpful, not just in relation to the content or the way in which the encounter had been experienced, but because of the personal attributes of the pastoral practitioners. These attributes included: being friendly; understanding; warm; positive; non-intrusive; reassuring; peaceful; compassionate; and empathetic.

Our findings indicate that despite the outcome or way in which the pastoral visit proceeded, the initial and perhaps lasting impressions of the respondents were extremely positive. Being visited by a "friendly face" which was understanding and kind was in itself a positive experience that when combined with an opportunity to talk and share concerns at a deeper level provided great comfort and benefit.

This finding confirms the importance and value of pastoral presence that enables people to experience therapeutic benefit from intentional meaningful interaction with another, reminding us again of Nouwen's words that when it comes to caring, "being present to each other is what really matters" (Nouwen, 1974: 35).

It was clear from our study that pastoral practitioners presented themselves to patients in a respectful and careful manner. This way of being encouraged trust and security, which led to patients feeling confident to engage in conversation that was supportive and helpful.

Another common theme was the ease with which people felt they could talk about anything, perhaps even as friends, and the way in which the talking helped them by lifting their spirits or showing care for the individual. This supported Viti's (2009) assertion that establishing rapport, listening for feelings, reflecting and expressing empathy, all enable the identification of a patient's spiritual concerns.

The majority of respondents cited having someone to talk to and being heard as the most helpful aspect of the pastoral encounter they had experienced. This finding aligns with Snowden et al., who established that when reflecting upon chaplaincy interventions "people felt listened to, able to speak about what was on their minds, had their situation understood and their faith valued" (Snowden et al., 2012: 27).

There was consensus that respondents experienced their pastoral encounter as helpful; they felt the pastoral practitioner was courteous; and the therapeutic relationship established enabled them to talk openly and honestly about their situation. This highlighted the importance of the pastoral practitioner's interpersonal skills, their self-awareness and pastoral sensitivity. This finding concurs with Kelly (2014) who suggested the delivery of sensitive and contextually appropriate specialist spiritual care depends upon the pastoral practitioners' understanding of who they are, how they relate, what attributes and behaviours they bring to the encounter, and how they discern patient needs in the midst of this.

The majority of respondents indicated their emotional/spiritual needs were addressed, but it was not clear how the pastoral practitioners had identified or responded to this need. Several commented on the provision of Holy Communion and prayer, but most chose to rate the question without comment. This reluctance to articulate or comment on spiritual need may have been personal or contextual. Tacey suggests that Australians find it hard to talk about spiritual longings, as they fear being stigmitised or ridiculed: "We are such a radically secular culture, so materialistic, that to talk about the transcendent is almost

un-Australian" (Tacey, 2013: para. 2). Those who rated this item with a low score, clarified they had no apparent needs at the time of the visit, or they did not have any expectation or desire that the pastoral practitioner would address them. Interestingly, two respondents felt their spiritual/emotional needs were met despite identifying themselves as "agnostic" or "non-spiritual".

There is much debate about what constitutes 'spirituality' and 'spiritual care', both from an academic perspective and anecdotally within the field of pastoral care (Spiritual Care Australia, 2013). The move away from traditional religious definitions has led to a more inclusive and generic description that highlights a person's "quest for meaning, purpose, connection, belonging and hope" (Spiritual Care Australia, 2013: 7), all of which is embedded in the unique experience and story of each person. It has been suggested that spiritual care begins with:

> . . .encouraging human contact in a compassionate relationship, and moves in whatever direction need requires. It recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. (National Health Service Education for Scotland, 2009: 6)

With these descriptions in mind, it is clear from the data that respondents and their families experienced recognition of and respect for their own spirituality and an appreciation of the pastoral care that was provided, perhaps even on occasions when they may not have felt a need for this.

Whilst the aim of this study was not to identify pastoral care outcomes but to assess patient satisfaction, it is worth noting that respondents did experience common outcomes, such as those identified by Snowden et al. (2012).

The common themes identified and described by our patients as having an impact on their experience of pastoral care included: comfort; hope; being listened to; being valued; being involved; and being understood.

The level of consumer satisfaction was high, as evidenced by the additional comments that confirmed statements already clearly articulated. Pastoral practitioners' attributes of courtesy, understanding, kindness and gentleness were reiterated, as was the helpfulness, necessity and excellence of the pastoral care provided.

Further research into the specific nature of how this 'helpfulness' translates to overall health outcomes and patient satisfaction is warranted. Research by Marin et al. (2015) has suggested there is evidence that meeting spiritual need or the provision of pastoral care is associated with greater patient satisfaction, which may be an area for us to explore with greater confidence. Our most current Press Ganey Associates In-patient Satisfaction Survey (2015) data appear to support this finding, indicating that 20% of the patients surveyed who had received pastoral care during their admission, rated the question regarding their emotional and spiritual needs being met, higher than those whose care did not include pastoral services.

Recent palliative care research confirms this, suggesting that chaplains help patients "align their care plans with their values and promote a culture of respect and dignity, both of which are associated with increased patient satisfaction and reduced use of aggressive care at the end of life" (Wolf et al., 2015: 5), thus improving a patient's experience. Whilst beyond the scope of this study, these factors are worth considering in the light of our findings and our desire to develop a more robust research agenda for the future.

Whilst the low response rate of 20% may be viewed as a limitation, it is consistent with expected response rates for mailed questionnaires (Grove et al., 2013). One of the advantages of surveying across our entire health campus that included medical, surgical and obstetrics wards, emergency and intensive care departments, and a free-standing tertiary hospice, was the diversity of patient experience captured. This demonstrated the breadth of our provision of pastoral care, but it posed a challenge when trying to collate results and relate them back to specialty areas. We acknowledge that respondents did likely self-select, so the findings may only be transferable to this group of respondents as we were unable to determine any potential differences between responders and non-responders.

Another limitation was the inability to separate the responses from the inpatients (or indeed their carers) and the bereaved families, or identify the ward areas from which the respondents had been admitted. Therefore, we were not able to draw any significant conclusions about the way in which they experienced the provision of pastoral care or whether their ward allocation or personal situation impacted their experience.

The questions themselves had limitations as we could only assess general responses and reactions, rather than deeper therapeutic benefits. In order to do this, future studies could identify those patients visited consistently within a specific ward or frequently admitted patients to assess the added value of pastoral care provision in relation to their identified spiritual need. Alternatively we could focus on those patients who request pastoral care during their admission and seek qualitative data regarding their expectations and experience of this care.

Surveying across the specialty areas of the campus also highlighted the diversity of the pastoral care providers, all of whom appear to have been seen as 'pastoral practitioners' by patients, despite fulfilling separate, distinct roles. Of importance to many respondents was the timely provision of Holy Communion and the Anointing of the Sick, which given our Catholic mission and values was anticipated, but not necessarily guaranteed. These results provide additional evidence that the specific

religious needs of our patients are being appropriately supported.

This diversity of pastoral care provision creates challenges in analysing the data, but these results confirm the reality that our provision of pastoral care at St John of God Murdoch Hospital is grounded in a contemporary evidence-based definition of spiritual care. Spiritual care that is underpinned by the St John of God Healthcare vision that, through our interaction with others, "we invite people to discover the richness and fullness of their lives, give them a reason to hope, and a greater sense of their own dignity" (St John of God Health Care, 2014: "Vision", para. 1).

Conclusions

We can confidently conclude from our study that most respondents found the provision of pastoral care to be helpful, and offered with courtesy and respect. Patients and their families felt listened to in a way that enabled them to speak openly and honestly about their situation and to voice any spiritual or emotional needs they wished to discuss. Although the overall level of consumer satisfaction was not specifically rated, we can establish from the data that the majority of respondents were satisfied with the pastoral care they received. Respondents commented positively about having the opportunity to speak to someone who was friendly and compassionate, seeing this as recognition of the hospital's holistic model of care. They expressed appreciation for the non-intrusive and empathetic interactions which enabled them to feel supported.

The volume of positive feedback has enabled us to gain greater clarity about how pastoral practitioners are perceived and experienced by those they visit, but without comparison to non-responders or critique from those consumers who were not satisfied with our provision of pastoral care it is difficult to identify specific areas for improving our practice. This study is viewed as a stepping stone as we seek to pursue a more robust and specific pastoral care research agenda.

Recommendations

Having confirmed the importance of consumer feedback the following recommendations have been identified.

i. A process of continuous consumer engagement should be implemented to ensure the quality and efficacy of our pastoral services. This will take into consideration the diversity of the service and the need to further identify and clarify which aspects of our service are most beneficial. Continuous service review will potentially contribute to the wider body of evidence related to patient experience and consumer satisfaction, paving the way for a more vigorous and structured future research agenda to be established. It will also enable us to identify new or existing aspects of our care that require our attention and review.

ii. Greater consideration should be given to pastoral support for those who experience traumatic births, which will lead to more intentional maternity referrals and facilitate individualised care.

iii. Caregiver education should be provided in relation to pastoral visit timing and duration; identifying spiritual/emotional need; and informing patients that their pastoral visits are documented in medical records.

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