

The Ars Moriendi Model for Spiritual Assessment: A Mixed-Methods Evaluation

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Researchers from all over the world have contributed to a growing understanding of spiritual care, providing a solid evidence base. Although much has yet to be learned, this evidence, combined with motivation and educational support, enables nurses to develop best practices concerning the spiritual dimension of caring (Cockell & McSherry, 2012). Spiritual well-being in patients with advanced illness is strongly associated with quality of life (Balboni et al., 2010). Healthcare providers (HCPs) (e.g., oncology nurses) view spirituality as an important aspect of palliative care, and the majority of HCPs think that patients undergoing palliative care can benefit from the regular provision of spiritual care (Phelps et al., 2012).

Some sources suggest that nurses and physicians should perform spiritual screening as part of patients' routine history-taking (Puchalski et al., 2009). HCPs should also identify any spiritual problems and develop a plan of care. Worldwide, efforts are being made to incorporate spiritual care into the education of nurses and physicians (Lovanio & Wallace, 2007; Nicol, 2012; O'Shea, Wallace, Griffin, & Fitzpatrick, 2011). However, in clinical care, the provision of spiritual care remains difficult. Although a majority of patients with advanced cancer perceive spirituality to be a relevant issue, 72% of patients with advanced cancer report that their spiritual needs are minimally or not at all supported by HCPs (Balboni et al., 2007). Barriers that stand in the way of HCPs properly addressing patients' spiritual needs include a lack of education, confidence, and the right vocabulary; a belief that spiritual care is someone else's responsibility; and various influences of secularism and diversity in society (Molzahn & Shields, 2008; Ronaldson, Hayes, Aggar, Green, & Carey, 2012; Vermandere et al., 2011).

Spiritual assessment is an increasingly important issue for nursing practice; however, the range of reliable and valid quantitative instruments for use in clinical practice is limited (Draper, 2012). More than 35 spiritual assessment tools are available in palliative care, but

Purpose/Objectives: To explore nurses' and physicians' experiences with the ars moriendi model (AMM) for spiritual assessment.

Design: Convergent, parallel, mixed-methods.

Setting: Palliative home care in Belgium.

Sample: 17 nurses and 4 family physicians (FPs) in the quantitative phase, and 19 nurses and 5 FPs in the later qualitative phase.

Methods: A survey was used to investigate first impressions after a spiritual assessment. Descriptive statistics were applied for the analysis of the survey. In a semistructured interview a few weeks later, nurses and physicians were asked to describe their experiences with using the AMM. Interviews were audio recorded, transcribed, and qualitatively analyzed. Quantitative and qualitative results were compared to see whether the findings were confirmative.

Main Research Variables: The survey assessed the feasibility of the AMM for use in palliative home care, whereas the semistructured interviews collected in-depth descriptions of healthcare providers' (HCPs') experiences with the AMM.

Findings: The AMM was perceived as valuable. Many patients shared their wishes and expectations about the end of life. Most HCPs said they felt that the patient-provider relationship had been strengthened as a result of the spiritual assessment. Almost all assessments raised new issues; however, many dyads had informally discussed spiritual issues before.

Conclusions: The current study suggests that HCPs believe that the AMM is a useful spiritual assessment tool. Guided by the model, HCPs can gather information about the context, life story, and meaningful connections of patients, which enables them to facilitate person-centered care.

Implications for Nursing: The AMM appears to be an important tool for spiritual assessment that can offer more insight into patients' spirituality and help nurses to establish person-centered end-of-life care.

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many of them have been developed for research purposes (Monod et al., 2011). Lucchetti, Bassi, and Lucchetti (2013), who reviewed the literature to compare the most