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# Spiritual Vulnerability, Spiritual Risk and Spiritual Safety—In Answer to a Question: 'Why Is Spirituality Important within Health and Social Care?' at the 'Second International Spirituality in Healthcare Conference 2016—Nurturing the Spirit.' Trinity College Dublin, The University of Dublin

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**Abstract:** In offering an answer to the question, 'Why is spirituality important within health and social care?' this paper articulates views on the concepts 'Spiritual Vulnerability,' 'Spiritual Risk' and 'Spiritual Safety' and argues for the centrality of spirituality within holistic, person-centred professional health and social care. It proceeds to offer a definition of Spiritual Safety and then goes on to highlight how the patient being and feeling spiritually safe and how professional carers enabling spiritual safety can reduce spiritual vulnerability and spiritual risk; and may be seen as essential aspects of professional holistic care.

**Keywords:** spiritual vulnerability; spiritual risk; spiritual safety; health and social care professionals; holism; person-centred

## 1. Introduction

In the discussion paper which follows the author articulates some thoughts on the concepts *'Spiritual Vulnerability,' 'Spiritual Risk' and 'Spiritual Safety'*, which were offered in answer to a delegate's question *'Why is spirituality important within health and social care?'* at the 'Second International Spirituality in Healthcare Conference 2016—Nurturing the Spirit.' Trinity College Dublin, The University of Dublin, 23 June 2016 [1].

### *1.1. Spirituality: Vulnerability, Risk and Safety*

In recent decades the subjects of vulnerability, risk and safety have grown in significance in all aspects of health and social care settings. UK and Irish Social policy has helped to increase the emphasis on these areas. Examples include Risk Management Policy and Process Guide [2]; Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures [3]. Additionally, professional bodies such as the Nursing and Midwifery Council in the UK (NMC) and the Nursing and Midwifery Board of Ireland (NMBI) provide accountability guidance i.e., The Code for nurses and midwives [4] and Code of professional conduct and ethics [5]. While much of social policy has focused primarily on the professional's care of the patient, it can be argued that there is a need to explicitly focus on both patient and staff care in these matters.

In caring professions, the concepts *'vulnerability'*, *'risk'* and *'safety'* are seen as central to quality care, whether to patients or colleagues. It may also be argued that these three concepts equally apply to each of the interactional dimensions of holistic care, such as, (NMBI 2015): ' . . . social, emotional, cultural, spiritual, psychological and physical experiences of patients . . . ' [6].

These concepts are not new to caring professions [7,8]. For example, one would be surprised if the nurse Florence Nightingale, or her mentor Cardinal Manning, or the nuns who provided her formative nurse training in a Paris Hospital [9] have not already spoken of such, or similar concepts. Yet the meaning of spirituality and religion are contested concepts within the health professional. Secondly, nurses question spirituality's relevance to care and many shy away from responding to such needs [7,10] and therefore omit essential interventions to holistic care, thus raising important ethical issues.

However, to what extent an individual is, and believes they are, or are assessed by competent others as, vulnerable, at risk/a risk, distressed, or unsafe with regards to any dimension of holistic care, within the physical and interactional environment they are recipients of care, raises legitimate questions for patients and care professionals alike. Concerns regarding care require investigation through rigorous assessment, followed by systematic planning and management at individual, inter-professional and inter-agency levels, as required [11].

### *1.2. Spiritual Safety*

While further research is required in this area, for example, in terms of conceptual analysis and applications to practice, the health and social care professional, may still begin an initial person-centred process by asking the patient questions to ascertain their perspective [12,13], for example:

- Is spirituality/religion important to you?
- What are your spiritual/religious needs?
- How may your spiritual/religious needs could be best met by the care team?
- Do you feel vulnerable, at risk, distressed or unsafe spiritually? If so, please outline why you feel that way and describe how the care team may support you to *be* and *feel* spiritually safe in their care.

As the approach is person centered, the questions may need to be reframed to ensure that they are conveyed in ways the person finds meaningful and relevant. Equally, it should be acknowledged that spirituality may not be of significance to some care recipients. Furthermore some patients may struggle with understanding, defining and expressing their spiritual/religious concerns/needs, and this needs to be considered.

By adopting a person centred approach, the health and social care professional may begin to address spirituality from the patient's own understanding, belief and practice and respond accordingly. *Spiritual Safety* may therefore be described and the care framed within the context of the patients own belief/faith system, if they have one, and could furthermore be defined as 'the extent to which the individual recipient of care is and feels secure to practice their faith, and also in the ways in which health and social care professionals acknowledge, understand, demonstrate respect and respond effectively to their needs/concerns, as defined by them.' [8].

In the context of person-centred approaches to care [8,12,13], it is essential that individuals *are*, and *feel* spiritually safe, as spelt out by themselves, within the physical and interactional care environment in which they receive care, and that this is managed by health and social care professionals effectively. While this may present many challenges in terms of, for example, implementation, it is incumbent on care professionals to develop appropriate evidence-based approaches were spirituality may be properly acknowledged, respected and fostered in ways which manage risk and enhance safe, quality care. The starting point for seeking such evidence on which to build care begins with the evidence provided by the individual patient themselves or, in the case of those patients who are unable to at the time, significant others such as family members.

Professionals in such settings are required to develop competencies which enhance knowledge and understanding of various belief systems, practices and pastoral supports within different religions; collaborate within inter-professional and interagency frameworks with faith professionals and develop competencies in identifying and responding to a care recipient's spiritual distress. Were professionals

are lacking in proficiency in such areas or were it is beyond their scope of professional practice they are advised to make appropriate referrals [8,14].

## 2. Conclusions

The author has suggested that the patient *being* and *feeling* spiritually safe, as expressed by the individual themselves, and the professional carer enabling spiritual safety may reduce the extent to which the individual feels and/or is vulnerable, at risk, distressed or unsafe spiritually. This should be seen as an essential aspect of professional holistic care. It is recognized that further research is required in terms of how these concepts may be fully understood and applied. However, all health and social care professionals have a role to play in acknowledging, respecting and seeking evidence-based ways of enabling and managing the spirituality of patients by beginning to actively engage with the individual on the topic.

**Conflicts of Interest:** The author declares no conflict of interest.

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