Active Listening in Chaplaincy Evaluation (ALICE)

Summary Research Report

Authors

Revd Prof Michelle Briggs
Professor of Nursing
School of Health and Community Studies
Portland Building PD508A, Leeds Beckett University,
Leeds, United Kingdom
Tel: +44 (0)113 812 1924
Email: m.i.briggs@leedsbeckett.ac.uk

Dr Ana Manzano
Lecturer in Health & Social Policy
Sociology and Social Policy, University of Leeds,
Leeds, UK
Email: a.manzano@leeds.ac.uk

Dr Jill Edwards
Research Fellow
School of Healthcare University Leeds
LS2 9JT Tel. 0113 3431194
e-mail: j.edwards@leeds.ac.uk

INTRODUCTION

This report details the findings of the three phases of the Active Listening in Chaplaincy evaluation project (The ALICE Project). The ALICE project was sponsored by the Acorn Christian Healing Foundation which is a registered charity in England, Wales and Scotland. It provides a number of services including active listening courses at different levels of expertise. The project was undertaken in partnership with Leeds Teaching Hospitals Trust Chaplaincy Services; the Oncology Department in St James's University Hospital Leeds; School of Healthcare, University of Leeds and School of Health and Community Studies, Leeds Beckett University .

BACKGROUND

Although recognized as an essential skill for health professionals, there is a paucity of research which explores active listening in healthcare settings. Most research has explored active listening alongside other communications skills rather than a stand-alone skill. The exception to this can be found in primary care where Mowat et al (2011, 2012) developed an NHS listening service delivered by chaplains in GP surgeries which has provided some evidence of need and the potential to enhance patient well-being (Bunniss et al 2013)

In contrast, there is an abundance of literature focused on the role of volunteers in health and social care. In the United Kingdom (UK), volunteers have engaged in a wide range of roles (instrumental, emotional and strategic), contributing at different levels to the delivery of health and social care in the public sector, including a growing community of lay involvement in public health programme delivery (South et al 2011). It is also clear that volunteering in faith based organisations makes a large and important contribution to the public health of the nation (see http://www.faithaction.net/work/health-and-social-care/).

Available evidence suggests that volunteers are increasingly regarded as an essential part of the NHS workforce and there is a need to train and manage volunteers properly is highlighted. In the NHS, Hospital Chaplaincy departments have a long standing reputation for supporting volunteers and the numbers have started to increase in hospital settings. However, there is a

paucity of research which specifically explores the role of lay unpaid chaplaincy volunteers, particularly in relation to active listening skills. Despite the ongoing debate about the value of chaplaincy in hospitals (Carey, 1997; Orchard, 2001), listening to patients remains one of their key contributions to healthcare institutions (Handzo et al, 2008; Piderman et al, 2008; Wright, 2001). Evidence is lacking about the impact of this contribution. There is lack of data on how volunteers have contributed to the emotional needs of patients both in quantitative and qualitative terms (Naylor et al, 2013).

The importance of exploring the impact and scale of volunteering in the NHS relates to the need to re- think the role of volunteers and also to add to the evidence base for the impact of volunteers on patient outcomes (i.e. improved wellbeing, health behaviours pain relief etc. (Casiday, Kinsman, Fisher, & Bambra, 2008; Department of Health, 2011). Against this background, this project explored the feasibility of developing and implementing a hospital-based active listening intervention for patients delivered by chaplaincy volunteers in the UK NHS and to explore its potential to impact on patients' well-being.

APPROACH

The ALICE project comprised three phases each with specific aims

Phase 1: To assess the acceptability and clinical utility of the proposed intervention

A review of the literature and a focus group study explored the views of a range of stakeholders (health professionals, academics, active listening tutors, chaplaincy volunteers and patients) to the introduction of active listening sessions in acute hospital settings. Seven moderator-led focus groups were conducted among healthcare researchers and lecturers, nurses, patients, active listening tutors, active listening practitioners and chaplaincy volunteers (n=43) (see table below).

Ethical approval for the study was obtained from the School of Healthcare Research Ethics Committee at University of Leeds (Reference SHREC RP 226).

Focus group participants

FOCUS GROUP CATEGORY	NUMBER OF PARTICIPANTS	GENERAL AREAS OF EXPERTISE
Health Lecturers	4	Physician, communication skills lecturer, nursing lecturer, psychologist expert in measuring patient outcomes
Health Researchers	3	Social anthropologist, clinical psychologist and health psychologist expert in patient reported outcomes
Nurses	6	Oncology, intensive care, high dependency unit, liver transplant, women's health, primary care
Acorn Tutors	12	Various degrees of listening expertise and years of tutoring: bereavement, GP practices, churches, hospital visiting
Acorn Trained Listeners	8	Various contexts of listening expertise: A&E, street work, bereavement, church, hospital chaplaincy
Hospital Chaplaincy Volunteers	6	Various degrees of visiting experience and specialities: neuro-rehabilitation, oncology, haematology, mental health, transplants, care of the elderly
Patients /service user Group	4	Oncology, rheumatoid arthritis, multiple sclerosis, mental health

Focus group discussions were guided with the help of a semi-structured topic guide based around the following specific research questions:

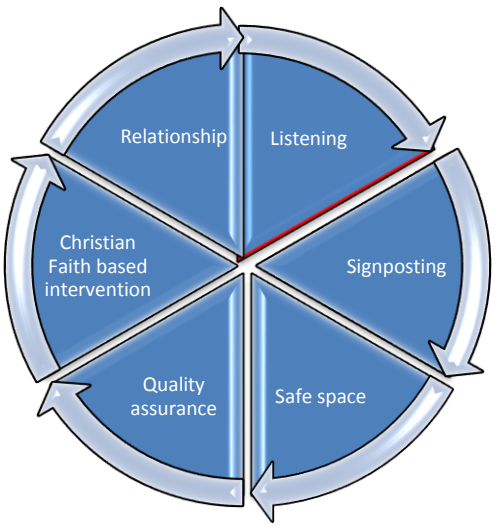
1. What do you consider to be the potential perceived benefits to using the Acorn active listening training package with volunteers?

2. What do you consider to be the potential perceived barriers to using the Acorn active listening training package with volunteers?
3. What would be the potential impact of trained volunteers providing active listening to acute settings?
4. How could this be developed into a service for use in an acute hospital ward?

Qualitative focus group data was transcribed verbatim by an independent transcriber and checked for accuracy by the two researchers. Transcripts were coded using an inductive approach and managed with the computer software programme QSR NVivo 8. A thematic approach was used to explore the range of issues identified during group discussions. Initial categories and theoretical framework were developed with a view to providing technical training recommendations that would help Acorn to develop a pilot intervention for use in the feasibility study.

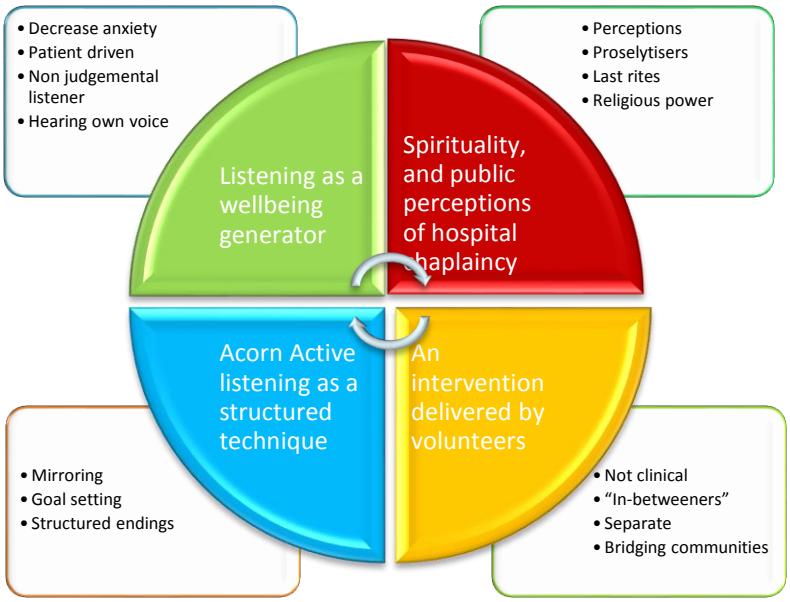
Acorn active listening is a framework (-as opposed to a model -if you do this, you get that-) because it encompasses a set of values, principles and rules that must underpin the delivery of listening activities but is not a list of prescriptive steps which the listener rigidly applies to each situation. From our data analysis, we identified six fundamental elements to propose in the Acorn conceptual framework for active listening namely: relationship, listening, signposting, safe space, quality assurance and Christian faith. Each of these elements combine to create a complex system -illustrated in the figure below.

The Acorn Active Listening Service (AALS) Framework



In terms of benefits and barriers four key themes emerged from the data: (a) listening as a well-being generator, (b) spirituality and public perceptions of hospital chaplaincy (c) benefits of Active Listening being delivered by volunteers, (d) challenges of using a structured communication technique in hospital.

Acorn Active Listening Service Benefits, Challenges and Good Practice'



Conclusion of phase 1; Current patient care models do not allow enough time or recognition for listening encounters with patients. Despite organisational barriers embedded in acute care, healthcare professionals and patients emphasized the positive effect listening can have on patients. The effectiveness of a structured communication approach would be challenged by the acute environment but not impossible to implement and is worthy of further study. Patient interactions outside those shaped by the need to acquire targeted information are fundamental aspects of patient-centred care and chaplaincy volunteers may be able to provide this as part of their service in acute hospitals. This is characterised by this quote

> *'[Implementing Acorn Listening in hospitals] is a unique opportunity; it's a very comforting and potentially beneficial thing if it happens in a skilled way. But acute care it's an extraordinary difficult place to do just that. And it's not that it can't happen, it's whether people can create those conditions through this sort of training. And that is much more than principles, it's a lot more about practice and engagement with a range of individuals*

[…]. So I think the potential is there but the benefits are not immediately apparent to me without considering those things' (FG1, P3)

Phase 2: To develop a tailored intervention for use with NHS volunteers and deliver the training package in an acute hospital setting

In this phase a tailored active listening intervention for use with NHS hospital volunteers was developed using the findings of the first phase of the project to meet the needs of acute care settings. Chaplaincy volunteers were invited to participate and 12 volunteers attended an active listening training programme provided by the Acorn Christian Healing Foundation.

Chaplaincy volunteers attended a 10 session course that provided them with an advanced knowledge of listening skills and how to use these in acute care. The training programme was phased so as to allow for assimilation and practice of key concepts. Continuous assessment, written into the course was incorporated into the programme. This gave people an opportunity to improve and work through difficulties as they progressed through the sessions.

Course material and number of sessions is outlined in the table below. Our data analysis suggested that it was important to provide an enhanced level training, as outlined here. Not only because of the complexities of acute care but also because hospital chaplaincy volunteers have already received basic training in listening skills. Content was approved by Local NHS Ethics Committee. Each participant was given a participant information sheet which provided details of the study and the advantages and disadvantages of taking part. Each participant was also required to fill in a written consent form prior to undertaking the Acorn Active listening training.

Outline of Training Course

WEEK	SESSIONS	
ONE	SESSION 1 & 2	Catching a Vision for Listening (2.5hours) Deepening Compassion for Listening (2.25 hours)
TWO	SESSION 3	The Journey of Life (2.5 hours)
THREE	SESSION 4 & 5	Cycle of Grace (2.5hours) Mirroring (2.5 hours)
FOUR	SESSION 6	Listening to feelings (2.5 hours)
FIVE	SESSION 7	Listening to myself (2.5 hours)
SIX	SESSION 8	Listening to God (2.5 hours)
SEVEN	SESSION 9	Qualities in the Listener Becoming a Christian Listener (Total of 2.5hours)
EIGHT	SESSION 10	Listening to Loss and change including bereavement (2.5 hours) OR Bereavement (2.5 hours)
NINE	SESSION 11	Listening to the sick (2.5 hours)
TEN	SESSION 12& 13	Dilemmas with hospital case examples (2.5 hours) Signposting & chaplaincy input (2.5 hours) final assessments
	TOTAL HOURS	**33-35 HOURS**

Volunteers' results

The overall sample consisted of 12 chaplaincy volunteers. Out of these 8 were female and 6 were male. The ages of participants ranged from 40 to 80 years and over. Participants had been volunteering between 0* to over 14 years.

	Sample size	Age range	Range of volunteering in years
Male	4	40-80+	0 -14 years*
Female	8	40-79	0-12 years
Total	12		

*O years of volunteering = just started at time of training.

Training results of volunteers

Participant ID (NB; P6 missing data)	Passed, failed and did not complete training.	Gender	Age
P1	Did not complete	F	40-59
P2	Failed	F	80+
P3	Did not complete	F	40-59
P4	Passed	M	40-59
P5	Passed	F	70-79
P7	*Passed after reassessment*	M	60-69
P8	Did not complete	M	40-59
P9	passed	F	40-59
P10	passed	M	40-59
P11	passed	F	60-69
P12	Passed	F	70-79
P13	Failed	F	40-59

Conclusion of Phase 2: The course required a sustained commitment in terms of time and motivation. The NHS chaplaincy managed this well and the volunteers rose to the challenge. The completion rate was 58% and this should be born in mind in future planning.

Phase 3: To carry out a feasibility study in an acute hospital for use in both inpatient and outpatient settings

Clinical trials can be expensive and the chances of successful completion are improved if it can be shown beforehand that key elements (such as the ability to recruit patients) are feasible before the main study is embarked upon. Feasibility studies are investigations carried out before a main clinical trial to answer a question like “Can this study be done in an acute

setting?" For this feasibility study we explored whether and how the listening intervention could be delivered to inpatients and outpatients in the Oncology department of a large teaching hospital. The Acorn trained chaplaincy volunteers offered a listening service to inpatients and outpatients. This phase of the study used mixed methods and integrated quantitative and qualitative data collection and analysis. The aim of stage two of this study was to explore the feasibility of a randomised control trial (RCT) to measure the therapeutic value of active listening (AL) by Chaplaincy volunteers for patients with severe illnesses and to obtain initial indicators of efficacy. Ethical approval was granted by NHS National Research Ethics Service (NRES) in Fulham, London (12/LO/2036).

The objectives of the study were to:

- Determine whether it is feasible for chaplaincy volunteers to provide AALS to inpatients and outpatients in acute settings
- Determine whether AALS is acceptable to patients and assess the uptake
- Evaluate the profile of those accessing AALS
- Pilot outcome measures and procedure methods with a view to assessing the potential for a larger randomised controlled trial

Data collection was undertaken using 2 measurement scales or questionnaires which are described below. The European Organization for Research and Treatment of Cancer quality of life questionnaire (EORTC QLQ-C30) is a questionnaire developed to assess the quality of life of cancer patients. The QLQ-C30 version 3.0 was used in this study. It incorporates five functional scales, three symptom scales and a global health status or quality of life scale and 6 single item scales. The CARE measure is described as a person-centred measure designed to measure the amount of empathy that a patient feels they have received during a consultation with a health professional (Mercer et al, 2004). The CARE measure consists of self-completion of a 10 item measure with 6 possible responses ranging from poor to excellent including a 'does not apply' option. The CARE measure was originally developed and validated for use in primary care (Mercer et al., 2005). The measure has been used in acute settings and with other health professionals to evaluate its usefulness and validity (Mercer et al 2007). The questionnaires were administered before and after the listening intervention.

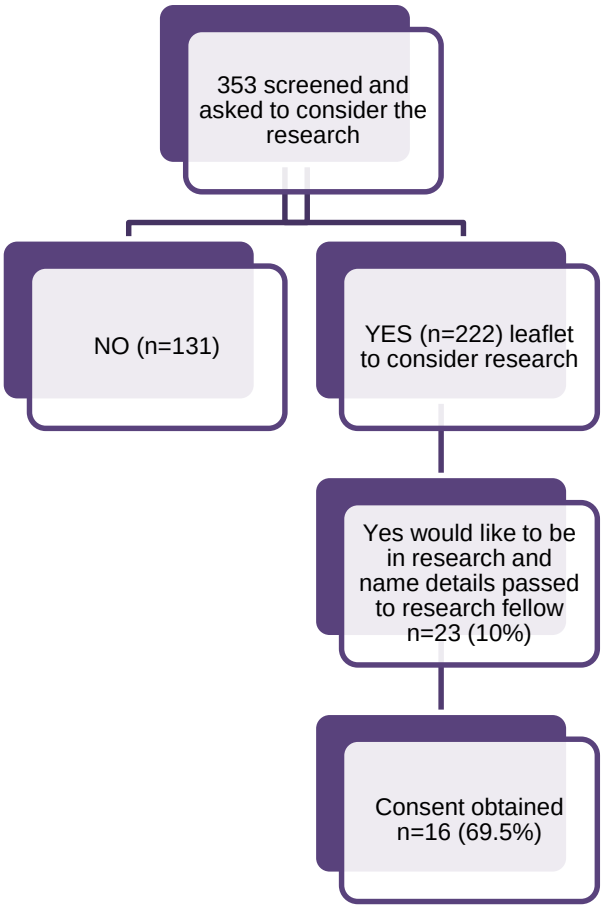
The procedure followed for inpatient recruitment involved inpatients being screened in the first instance by a member of the LTHT Chaplaincy Department who handed out a study leaflet and explained a little about the study to patients on the wards. This approach to recruitment was a condition of ethical approval being given for the study. It was felt that patients should be screened by Chaplaincy staff employed by the LTHT. After screening, the names of patients who expressed an interest in taking part in the project were passed on to the research fellow who was then able to approach the patients and discuss the study further. The process of recruitment of outpatients did not differ substantially from inpatients with the exception of the presence of chaplaincy volunteers. These volunteers worked in the outpatient's clinic where they connected with patients socially and offered support (e.g. offering a drink to waiting patients) and/or a listening ear to any patient. Leaflets about the study were offered to all patients attending outpatients on entry to the outpatients' clinic. Patients who expressed an interest were referred to the research fellow (JE). Patients who consented to take part in the study were offer up to 3 listening sessions and every attempt was made to ensure they received the maximum number of sessions they desired. The initial session was arranged by the researcher who liaised with the patient and the chaplaincy volunteer.

When a patient indicated they would like further listening sessions, these were arranged between the volunteer and the patient directly. This helped to minimise any disruption to the patient's daily routine and during visiting times which were avoided by the researcher.

Outpatients were also offered up to 3 listening sessions and the sessions were organised to coincide with their next outpatient attendance or at a time/date convenient to them. All patients recruited at outpatients chose to have a session when they returned as a day case for treatment.

All active listening sessions were delivered by the unpaid chaplaincy volunteers who had undertaken and passed the Acorn Active Listening training. A total of 7 volunteers were available when patient recruitment began but due to various reasons only 5 were available for the duration of this phase of the study. One volunteer moved out of the area shortly after recruitment began and another was unavailable due to gaining full time work until close to the end of the recruitment period. The gender break down of volunteer was 4 females and 3

males. The chaplaincy team kept a screening log for 6 months to assess the uptake of the invitation to participate; the results are shown in the figure below.



Recruitment continued and a final sample of 29 patients was achieved in the final analysis. This sample broke down into 23 females (79.3 %) and 6 males (20.7 %). The age range of participants (n=28) was from 41 to 86 years giving a mean age of 49 years. One patient's age was not recorded. Out of the 29 patients recruited, 22 were happy to reveal their religion and 7 preferred not to say. Out of the 22 who revealed a religion 12 (41.4 %) described themselves as Christian, 9 (31%) as non-religious and one as Muslim. Out of the 29 patients data on ethnicity was available on 28 (96.6%) and these broke down into white -British 82.8 % (n=24), 3.4 % Black (n=1) and 3.4% Asian (n=1).

Out of the 29 patients recruited and for whom data was available (n=28), the majority were recruited as inpatients n=23 (79.3 %). Inpatients were recruited across 4 wards for a period of 12 months. Out of the 29 patients, 26 (89.6%) had listening sessions. The majority of

them (n=22) were inpatients and 4 outpatients at the time of recruitment. This is outlined in the table below

	Total	Comments/reasons	Action for future trial
Number of patients included	29 - consented 26 – had listening session	90% received listening	
Total Number of listening sessions	20 having 1 session 2 having 2 sessions 4 having 3 sessions	Most patients were only able to have one session due to speed of discharge. One inpatient had session as outpatient due to this.	Recruit as inpatient but deliver across both
Patients with complete data (pre and post session).	22 4 post intervention questionnaires not returned	Patients discharged before questionnaires could be collected Patient too ill/tired after session to fill in questionnaires	SAE left with patients for them to post back questionnaires if unable to fill in after session or discharged before JE could collect.
Patients who did not have session after recruitment	3	Due to quick discharge Too ill for session Hospital transport issues	
Gender	23 Females 6 Males		
outpatients	6		
inpatients	23		

The analysis of the EORTC and CARE questionnaires were undertaken separately using the IBM computer software programme Statistical Package for Social Sciences (SPSS). The aim of the analysis was to identify an appropriate outcome measure or measures which could be used in a future clinical trial to assess the effects of active listening sessions on patients. Examining the frequency of responses at baseline and after the intervention give us a better

indication of which measures would be most appropriate for a future clinical trial. We noted that the area where most change had occurred was in emotional function (EF). Although the numbers are small, patients appeared to improve in this area. After the intervention there was a slight downward trend at questions 21, 22, 23, 24 to the responses 'very much' and 'quite a bit'. This may suggest that patients' were less tense, worried, irritable and depressed. Given that there was a slight upward trend to the responses 'not at all' and 'a little', this may be indicative of those patients who were feeling more tense, irritable, worried and depressed to others may benefit the most from the intervention.

The small sample in our study makes it difficult for us to claim that the intervention has had any significant impact on the patients in this study. However, King (1996:565) suggests that small improvements may be valued in very sick populations and should be examined in context of the type of conditions and other factors, particularly the sample size. Similarly, Bedard et al (2014) also discuss the importance of 'minimal important differences in the EORTC'. They point out that,

> '*with a sufficient sample size, statistically significant values for the change can be obtained; however, the significance or meaningfulness of this change is less frequently assessed'* (Bedard et al, 2014: 110).

One aim of our study was to identify measures to measure the impact of the active listening intervention on patients for a future clinical trial. The ability of the EORTC to differentiate between physical and emotional wellbeing has been of importance to our study. It has enabled us to identify one measure to take forward into a clinical trial, although holistic impact of the intervention should not be disregarded.

The majority of volunteers were given scores of 4 (very good) and 5 (excellent) across all ten items on the CARE measure by patients with an exception of a few patients who scored volunteers with 2 (fair) or 3 (good). The patients' comments indicated that the listening sessions were generally well received and appreciated by patients. There is no suggestion in the qualitative comments that patients who scored volunteers lower than others were less enthusiastic about the idea of providing active listening in a hospital setting. It should be noted that not all patients provided qualitative comments and the research team, due to

ethics, were unable to question patients about their diagnosis, current treatment and situation, which may have impacted on their scores.

Conclusion of phase 3: The evidence gathered in this study demonstrates that the provision of active listening in a hospital setting is able to address an unmet need and is feasible to deliver in acute care setting.

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Conference presentations

1. Briggs M, Edwards JE, Manzano A Swift C *Active Listening in Chaplaincy Evaluation (ALICE): results of a UK feasibility study in hospital* British Association for the Study of Spirituality Manchester, UK May 2016
2. Briggs M *Active Listening in Chaplaincy Evaluation (ALICE)* Faith in Health and Healing 2014 "Care on the edge" 3rd April 2014 Medical School at Birmingham University
3. Briggs M Edwards J Swift C Manzano A *Active Listening in Chaplaincy Evaluation (ALICE); Phase 1; mapping the intervention* Faith in Health and Healing 2014 "Care on the edge" 3rd April 2014 Medical School at Birmingham University
4. Briggs, M., Manzano, A. *Active Listening in Hospital: Staff and Patient Perspectives* British Sociological Association: Medical Sociology Conference 2013 Sept University of York

Publications

1. Briggs M (2014) Compassion; fundamental to nursing care or are nurses too fatigued to care *Pain News* 12(4) 214-216
2. Manzano A, Swift C, Closs SJ, Briggs M, (2015) 'Active Listening by Hospital Chaplaincy Volunteers: Benefits, Challenges and Good Practice', *Health and Social Care Chaplaincy,* 3.2 (2015), 201-221 DOI: 10.1558/hscc.v3i2.26065[2], Repository URL: http://eprints.whiterose.ac.uk/86308/

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