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Teaching on spiritual care: The perceived impact on qualified nurses

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ABSTRACT

This study unit as part of the Continuing Professional Development (CPD) programme aimed at reviving the spiritual dimension in nursing care. This paper discusses the perceived impact of the study unit *Spiritual Coping in Illness and Care* on qualified nurses. The paucity of literature demonstrates some benefits perceived by the learners namely, clarification of the concepts of spirituality and spiritual care, self-awareness of personal spirituality and their current clinical practice which neglects the spiritual dimension. The ASSET model [Narayanasamy, A., 1999. ASSET: a model for actioning spirituality and spiritual care education and training in nursing. Nurse Education Today 19, 274–285] guided the teaching of this study unit. The nature of this study unit demanded an exploratory method of teaching to encourage the nurses to be active participants. Qualitative data were collected by a self-administered questionnaire from the three cohort groups of qualified nurses who undertook this study unit in 2003–2004 (A: $n = 33$), 2004–2005 (B: $n = 35$) and 2006–2007 (C: $n = 35$).

Learners found the study unit as a resource for updating their knowledge on spirituality in care and increased self-awareness of their own spirituality and nursing care. They acknowledged their role as change agents in order to implement holistic care in collaboration with the multidisciplinary team. Recommendations were proposed to integrate the spiritual dimension in education and patient care.

Introduction

Literature criticised nursing care for giving minimal attention to the spiritual dimension in patient care (McSherry et al., 2008; Baldacchino, 2008c; Mitchell and Hall, 2007). This may be due to lack of time, work overload, feelings of incompetence to deliver spiritual care and lack of education in the undergraduate and CPD curricula (Baldacchino, 2006; Keefe, 2005; McSherry, 1998). Bradshaw (1997) argues that spiritual care is caught from role-models in the clinical area rather than taught. However, since spiritual care is not being given the merited attention, learning on the spiritual dimension in care through role-modelling appears to be impracticable.

The study unit was oriented towards spiritual coping in illness and spiritual care. Experiences of spirituality may be derived from within or outside formal religion (Tse et al., 2005; Knestrick and Lohri-Posey, 2005). Thus, spiritual coping consists of religious methods such as, prayer and non-religious strategies like, talking to other patients with similar ailments (Baldacchino and Draper, 2001). Patients may turn to others for bio-psychosocial and spiritual support in order to cope and feel more in control of their situation (Koenig, 2004; Baldacchino, 2003).

Through the author's networking experience, it could be said that although some universities in the U.K., U.S.A. and Canada are known to teach on spirituality and spiritual care, few published articles were traced to date on evaluation results of the study units. Thus, this study attempts to fill in this gap by evaluating a CPD study unit.

Aim

This paper discusses the perceived impact of the study unit on *Spiritual Coping in Illness and Care* on qualified nurses.

Definitions

Spirituality is the unifying life force which integrates the bio-logical, psychological and social components which includes or excludes the religious component according to the individual belief system (Baldacchino, 2010). Thus, spirituality applies to both the believers and non-believers. While considering the individuality in the definition of spirituality, all individuals may possess the potential to experience spirituality (McSherry, 2006). The ultimate

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outcome of spirituality is to help individuals to find meaning and purpose in life (Chan et al., 2006).

Spiritual care is *being* as opposed to *doing* (Baldacchino, 2010; Halm et al., 2000; Bradshaw, 1994). Hence, spiritual care is oriented towards therapeutic communication by the caregiver's availability and actual presence to patients (DiJoseph and Cavendish, 2005; Ross, 1996). Spiritual care may help patients to explore strategies to cope with their illness to enable patients find meaning and purpose in life (Baldacchino, 2003). Thus, research recommends that spiritual care should be integrated in nursing education and nursing practice as a philosophy of care in order to enable delivery of holistic care (Sawatsy and Pesut, 2005; Baldacchino, 2010).

Conceptual framework

Following analysis of various humanistic theories of learning of Carl Rogers, Abraham Maslow, Malcolm Knowles and Paolo Freire, the **A**ctioning **S**pirituality and **S**piritual are **E**ducation and **T**raining model (ASSET) (Narayanasamy, 1999) was selected. The ASSET model encompasses a tripod of *structure content*, *process* of learning and *outcome* of education. This was considered the most appropriate as it provided a complete cycle of the teaching and learning processes of qualified staff who tended to overlook the spiritual needs of clients (Hubbell et al., 2006; Koenig, 2004).

The structure content and the process of teaching and learning

The study unit was developed by the author and based on the literature, research and feedback from the undergraduate students who had completed the study unit on 'The spiritual dimension in care' (Baldacchino, 2008a). It consisted of 4 European Credits Transfer System (ECTS) incorporating 28 h of teaching sessions which included the four-hour seminar (Table 1). The study unit was submitted by the CPD Curriculum Development Committee at the Institute of Health Care (IHC). Eventually, this unit was approved by the IHC Board and the Senate of the University of Malta.

This study unit had a monotheistic religious orientation since 95% of the local population are registered as Roman Catholics (Malta Archdiocese, 2007) and the displaced immigrants are registered as Christians or Moslems (Jesuits' Refugees Services, 2007). The learners had diverse clinical experiences (Table 2). This diversity enhanced their participation in the group discussions of patient case studies. This gave them the opportunity to reinforce the theory learnt by identifying individual spiritual problems/needs and spiritual coping, supported by ways of meeting patients' holistic needs.

The sessions were repeated twice weekly for twelve weeks to accommodate different duty rota. This facilitated active participation in small group discussions and sharing of experiences. The students were assessed by means of a case study presentation (Table 1). Precautions were taken to safeguard patients' health by obtaining institutional permissions and patients' consent. The Hospital Psychologist and/or the Hospital Chaplain were available for assistance in case of stress following the interview. Through the active participation in the assessment of patients, the learners became aware of the complexity of spiritual care and yielded a reflective mode of learning (Jarvis, 1995). A humanistic environment was created and an active teaching and learning process was similar to the study unit delivered to the undergraduates which is already published (Baldacchino, 2008a).

Literature review

Literature suggests the importance of evaluating study units, modules and curricula in order to identify the extent to which planned goals are achieved (McKie et al., 2008) and effectiveness of

Table 1
Study unit outline: spiritual coping in illness and care.

Study unit title: spiritual coping in illness and Care	4 ECTS
	Level 1

Learning objectives

By the end of the study unit, the learners will be able to:

a) define the term *spirituality, spiritual well-being* and *spiritual care*
b) increase awareness of personal spirituality
c) outline the spiritual distress-spiritual well-being continuum in illness
d) apply the existing Theories of stress/coping and research in care
e) assess the spiritual needs and coping of patients during illness
f) foresee their role as change agents for holistic care by implementing spirituality in care

Content

1. Concept analysis of spirituality, spiritual coping, spiritual well-being and spiritual care
2. Self-awareness exercises on personal spirituality and delivery of spiritual care
3. Spiritual distress: impact of illness on individual's life
4. Psychological theories of stress and coping
5. Research on 'Finding meaning and purpose in illness'
6. Research on self-transcendence in illness
7. Research on hope in illness
8. Assessment of spiritual needs and coping of patients during illness
9. Facilitation of coping strategies used by patients during illness
10. Holistic care: meeting individual's spiritual needs by the nursing process
11. Barriers to delivery of spiritual care.

Teaching methods

- Lessons with power-point presentations and a handout with (20–30) minutes of exploratory work: Brain-storming, questioning, patient case studies analysis, small group discussions, sharing of clinical experiences, self-reflective exercises on personal spirituality and nursing practice.
- A concluding seminar for patient case study presentations.

Assessment method: assignment:

- Case study presentation in a seminar: assessment of patient's/personal spiritual distress and spiritual coping (50%).
- Academic write-up of the presentation and spiritual care (50%)
- Evaluation by a self-administered questionnaire on the study unit (voluntary)

An extensive reference list was provided on published anecdotal and research based literature and text-books. Nurses were encouraged to do further literature search

Table 2
Demographic data of the three cohort groups of nurses.

Characteristics	Group A	Group B	Group C
	2004	2005	2007[b]
	($n=33$)	($n=35$)	($n=35$)
Male	9	8	6
Female	24	27	29
Mean years of clinical experience	17.5	14.8	16.6
Diversity in clinical experience	Community Geriatrics Medical Obstetrics Oncology Outpatient clinics Surgical Specialised care[a]	Community Geriatrics Medical Obstetrics Oncology Paediatrics Surgical Outpatient clinics Specialised care[a]	Community Geriatrics Medical Obstetrics Outpatient clinics Surgical Specialised care[a]

[a] Specialised care may include accident and emergency, intensive therapy unit, high dependency unit, cardiac intensive coronary unit, neurosurgical unit, cardiothoracic unit, coronary care unit, special care baby unit, operating theatre and renal unit.

[b] The study unit was not available in 2006 because of exigencies of the Nursing Department.