Nurse Education Today 34 (2014) 1460–1466

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Nurses' and midwives' acquisition of competency in spiritual care: A focus on education

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ARTICLE INFO

Article history:
Accepted 8 April 2014

Keywords:
Teaching
Spiritual care
Holistic care
Nurses
Midwives
Students
Outcome
Competences

SUMMARY

Background: The debate that spirituality is 'caught' in practice rather than 'taught' implies that spiritual awareness comes about through clinical experience and exposure, requiring no formal education and integration within the curricula. This is challenged as it seems that providing students with a 'taught' component equips students with tools to identify and strengthen resources in 'catching' the concept.
Aim: This study forms part of a modified Delphi study, which aims to identify the predictive effect of pre- and post-registration 'taught' study units in spiritual care competency of qualified nurses/midwives.
Methods: A purposive sample of 111 nurses and 101 midwives were eligible to participate in the study. Quantitative data were collected by the Spiritual Care Competency Scale (SCCS) (Van Leeuwen et al., 2008) [response rate: nurses (89%; $n = 99$) and midwives (74%; $n = 75$)].
Results: Overall nurses/midwives who had undertaken the study units on spiritual care scored higher in the competency of spiritual care. Although insignificant, nurses scored higher in the overall competency in spiritual care than the midwives.
Conclusion: 'Taught' study units on spiritual care at pre- or post-registration nursing/midwifery education may contribute towards the acquisition of competency in spiritual care.

Introduction

Spiritual care is the provision of interventions that assess and address clients' spiritual needs in collaboration with the multidisciplinary team (Hospice and Palliative Nurses' Association (HPNA), 2007; Smith, 2006). 'Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires' (NHS Education for Scotland, 2009 p. 6). Examples of interventions are as follows: respecting patients' religious/faith and cultural beliefs; communicating sensitively by listening to and talking with clients; being with the patient by caring compassionately; supporting, showing empathy; facilitating participation in religious rituals; promoting a sense of well-being; and referring to chaplains and other professionals (Baldacchino, 2009; McClung et al., 2006; McSherry and Ross, 2002). Thus, spiritual care contributes towards holistic care (Puchalschi and Romer, 2000) and positive outcomes in clients (Koenig et al., 2012; Meisenhelder and Chandler, 2002; Hall, 2007).

Factors that contribute towards competence in spiritual care are learning from role models in the clinical field (Bradshaw, 1997), personal spirituality (Bailey et al., 2009), life experiences (Deal, 2010), past hospitalisation experiences (Chan, 2009), working in obstetric wards (Hall, 2007), person-centred organisation of care (McCance et al., 2009) and students' age and maturity (Wallace et al., 2008). Conversely, spiritual care is overlooked by health care professionals as it is considered as the chaplains' role (Lovanio and Wallace, 2007). This is because spirituality is defined synonymously with religiosity (Biro, 2012) and feelings of incompetence due to lack of education (Baldacchino, 2008b, 2011).

The importance of integrating spiritual care within the nursing/midwifery curricula is to enhance competence in meeting clients' needs holistically (Nursing, Midwifery Council (NMC), 2010). However, Paley (2007) argues that spiritual care should not be given by nurses at all as patients tend not to expect it from nurses (Ross, 2006). In contrast, patients perceive spiritual needs as part of the overall care given by the health care professionals and the pastoral teams (Baldacchino, 2003; Saliba and Baldacchino, 2010). Since nurses/midwives are constantly

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http://dx.doi.org/10.1016/j.nedt.2014.04.015
0260-6917/

attending to clients' needs, the need to integrate spiritual care in the respective curricula is essential (Abbas and Dein, 2011).

The spiritual dimension has been overlooked by health care professionals as the concept of spirituality is still poorly understood due to various reasons such as lack of education (Saliba and Baldacchino, 2010), ambiguity between the two complex concepts of spiritual care and psychological care (Bailey et al., 2009) and interpretation of spirituality synonymously with religiosity, rendering definition of spirituality to be 'outdated and not in keeping with modernist, multicultural or indeed secular views of the term' (McSherry, 2007 p. 25).

Research to date on the impact of teaching on spirituality in nursing is on the increase. However, only one study was traced on teaching spirituality to midwifery students (Hall, 2007). Measuring nurses'/midwives' competences in spiritual care following education is still in its infancy (Van Leeuwen et al., 2008). Hence, this study aims to assess the level of competency in spiritual care of qualified nurses/midwives, after undertaking study units delivered by the second author at the University of Malta.

Aim

To identify the predictive effect of pre- and post-registration 'taught' spiritual care study units on the competency of qualified nurses/midwives.

Conceptual framework

The study was guided by an amalgamation of three educational theories which include the theory of novice to expert (Benner, 1984), Bloom's taxonomy (1956) and the theory of reflective practitioner (Schön, 1991).

Benner's theory is based on an adaptation of the five stage model of skill acquisition (Dreyfus and Dreyfus, 1980). The term skill incorporates the psychomotor skill performance and all aspects of practice including knowledge, behaviours, values and attitudes (Benner, 1984). Performance is classified into five different levels of proficiency: novice, advanced beginner, competent, proficient and expert. While students progress from one level to another, they move from analytic, rule-based thinking to intuition with an ability of addressing complexity in care. Eventually, students move from a detached observer to an actively involved caregiver (Benner and Wrubel, 1989). Thus, Benner's (1984) competency-based approach may be used to achieve competency in spiritual care at both the pre- and post-registration levels of nursing/midwifery education. However, at point of registration students are expected to reach proficiency level 3—competence which involves the nurses/midwives' ability to demonstrate efficiency; coordinate their actions with confidence; establish a plan based on considerable conscious, abstract and analytic contemplation of the problem; and complete care within a suitable time frame. Higher levels of proficiency (levels 4 and 5) may be achieved after several years of clinical experience, which render this level to be appropriate to post-registration nursing/midwifery education.

Bloom's taxonomy (1956) is consistent with Benner's theory as it provides guidance in formulating the competencies' educational objectives in spiritual care, arranged in hierarchical levels. A goal of Bloom's taxonomy is to motivate educators to focus on all three domains, creating a more holistic form of education. The cognitive and affective domains are the most relevant when achieving competency in spiritual care. Skills in the cognitive domain are oriented towards knowledge, comprehension and critical thinking. The affective domain includes the skills in dealing with people emotionally such as feelings, values, appreciation, enthusiasm, motivation and attitudes.

The reflective practitioner (Schön, 1991) proposes reflection-*in*-action and reflection-*on*-action as an intrinsic part of the professional education. This infers an interaction between thinking, action and being. The knowledge gained from the study unit (*knowing that*/*about*) is applied critically to action (*knowing-in-action*). During the process of knowledge attainment, individuals may restructure their methods of action, contributing towards an outcome of competence in assessing, planning, implementing and evaluating spiritual care. The process of achieving competence in spiritual care is closely related to the student's ability to focus on self-reflection to clarify own values, become self-aware, be able to engage in self-monitoring and self-regulation and learn from experience (Bandura, 1997). Hence, self-awareness through self-reflection is fundamental to instigate effective spiritual care (Narayanasamy, 1999; Cone and Giske, 2013).

Teaching on spiritual care

Since 2003, study units on spiritual care had been taught to undergraduate and post-graduate nursing/midwifery learners at the Faculty of Health Sciences, University of Malta (Baldacchino, 2008a,b, 2011). The aim is to define spirituality and spiritual care, increase self-awareness about personal spirituality and increase knowledge about the spiritual dimension of illness and care. This is then transferred to patient care, guided by reflection *in*-action and *on*-action in order to become competent in meeting patients' needs holistically.

Education and competency in spiritual care

The spiritual dimension of holistic care has been considered by health care organisations as fundamental to health and well-being (World Health Organisation, 1998; European Convention on Human Rights, 2000; International Council of Nursing, ICN, 2006). Similarly, nursing/midwifery education is requested to integrate the spiritual dimension of care in both the theoretical and clinical components (NMC, 2010). On qualification nurses/midwives are expected to be competent in the systematic holistic assessment of clients incorporating 'the relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors…' (NMC, 2010, p. 18). Additionally, nurses/midwives are expected to 'demonstrate an understanding of how culture, religion, spiritual beliefs … can impact upon illness and disability' (NMC, 2010, p. 108).

Education on spiritual care demonstrated positive outcomes on pre-registration nursing students (Ross, 2006; Van Leeuwen et al., 2008) and qualified nurses (Wasner et al., 2005; Baldacchino, 2011). Students were found to have increased knowledge about the definition of spirituality (Wallace et al., 2008; Baldacchino, 2008b, 2011), increased ability to deliver spiritual care (Louis and Alpert, 2000), positive attitudes and spiritual experiences (Lovanio and Wallace, 2007), increased self-awareness about personal spirituality (Sandor et al., 2006) and increased sensitivity towards patient centred care (Wasner et al., 2005).

In contrast, education programmes made learners aware of the complexity of the spiritual dimension in care whereby assessment of patients' spiritual needs was found difficult (Milligan, 2004; Baldacchino, 2011). Gender differences were found whereby females scored higher in the perceived importance of personal spirituality and patient spiritual care (Sandor et al., 2006). No significant differences were found between nurses and other health care professional groups in the attitudes towards spiritual care across time (Wasner et al., 2005). In contrast, differences were identified between nursing and medical professional groups whereby medical students scored lower in the perceived less dogmatic spirituality than the nursing students across time (Milligan, 2004).

Various methodologies were found appropriate in teaching spiritual care such as journaling, reflective exercises, sharing of experiences and self-directed learning (Greenstreet, 1999; Baldacchino, 2008a). For example, case studies approach expose learners to a model of care in the clinical practice whereby a trustful encounter with patients may help them identify their spiritual distress and needs (Hoffert et al., 2007). Clinical practice helps learners to acknowledge the complexity of reality and may help them develop assessment skills and facilitate strategies to