Nurse Education Today 36 (2016) 445–451

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

# Factors contributing to student nurses'/midwives' perceived competency in spiritual care

Linda Ross [a,*], Tove Giske [b,1], René van Leeuwen [c,2], Donia Baldacchino [d,3], Wilfred McSherry [e,4,5], Aru Narayanasamy [f,6], Paul Jarvis [a,7], Annemiek Schep-Akkerman [g,8]

[a] School of Care Sciences, Faculty of Life Sciences and Education, University of South Wales, Pontypridd, Wales, CF37 4BD, UK
[b] Haraldsplass Deaconess University College, Ulriksdal 10, 5009 Bergen, Norway
[c] Reformed University for Applied Sciences, Grasdorpstraat 2, 8012EN Zwolle, Netherlands
[d] Faculty of Health Sciences, University of Malta, Msida, Malta
[e] School of Nursing and Midwifery, Faculty of Health Sciences, Staffordshire University/The Shrewsbury and Telford Hospital NHS Trust, Stafford, United Kingdom
[f] Faculty of Medicine & Health Science, School of Health Sciences, Queens Medical Centre, University of Nottingham, Nottingham NG7 2HA, United Kingdom
[g] Reformed University of Applied Sciences, Grasdorpstraat 2, 8012 EN Zwolle, the Netherlands

ARTICLE INFO

*Article history:*
Accepted 9 October 2015

*Keywords:*
Spirituality
Spiritual care
Nurse education
Spiritual care competence

SUMMARY

*Background:* The spiritual part of life is important to health, well-being and quality of life. Spiritual care is expected of nurses/midwives, but it is not clear how students can achieve competency in spiritual care at point of registration as required by regulatory bodies.
*Aim:* To explore factors contributing to undergraduate nurses'/midwives' perceived competency in giving spiritual care.
*Design:* A pilot cross-sectional, multinational, correlational survey design.
*Method:* Questionnaires were completed by 86% (n = 531) of a convenience sample of 618 undergraduate nurses/midwives from six universities in four countries in 2010. Bivariate and multivariate analyses were performed.
*Results:* Differences between groups were small. Two factors were significantly related to perceived spiritual care competency: perception of spirituality/spiritual care and student's personal spirituality. Students reporting higher perceived competency viewed spirituality/spiritual care broadly, not just in religious terms. This association between perceived competency and perception of spirituality is a new finding not previously reported. Further results reinforce findings in the literature that own spirituality was a strong predictor of perceived ability to provide spiritual care, as students reporting higher perceived competency engaged in spiritual activities, were from secular universities and had previous healthcare experience. They were also religious, practised their faith/belief and scored highly on spiritual well-being and spiritual attitude/involvement.
*Conclusions:* The challenge for nurse/midwifery educators is how they might enhance spiritual care competency in students who are not religious and how they might encourage students who hold a narrow view of spirituality/spiritual care to broaden their perspective to include the full range of spiritual concerns that patients/clients may encounter. Statistical models created predicted factors contributing to spiritual care competency to some extent but the picture is complex requiring further investigation involving a bigger and more diverse longitudinal sample.


## Background

The spiritual part of life is recognised internationally as having an important part to play in health, well-being and quality of life (e.g. World Health Organisation [WHO], 2002; Koenig et al., 2012) and spiritual care features within healthcare policy and guidance internationally (e.g. NICE, 2004; www.palliatief.nl/Themas/Ethiekenspirituelezorg/tabid/4098/Default.aspx). There is much debate surrounding the definition of spirituality (e.g. Pike, 2011). A recent concept analysis identifies three common elements; transcendence, connectedness of self/others/nature/higher power and meaning in life (Weathers and Coffey, 2015). These elements also feature in the eight domains of spirituality

* Corresponding author. Tel.: +44 1443 483109; fax: +44 1443 483118.
*E-mail addresses:* linda.ross@southwales.ac.uk (L. Ross), Tove.giske@hdh.haraldsplass.no (T. Giske), r.vanleeuwen@viaa.nl (R. van Leeuwen), donia.baldacchino@um.edu.mt (D. Baldacchino), w.mcsherry@staffs.ac.uk (W. McSherry), arunaray@outlook.com (A. Narayanasamy), paul.jarvis@southwales.ac.uk (P. Jarvis), a.schep@via.nl (A. Schep-Akkerman).
[1] Tel.: +47 55979630.
[2] Tel.: +31 634781680.
[3] Tel.: +356 2340 1847.
[4] Tel.: +44 1785 353630.
[5] Part-time Professor at Haraldsplass Deaconess University College, Bergen, Norway.
[6] Tel.: +44 7551927701.
[7] Tel.: +44 1443 483614; fax: +44 1443 483019.
[8] Tel.: +31 38 4255573; fax: +31 38 4230785.

http://dx.doi.org/10.1016/j.nedt.2015.10.005
0260-6917/

identified by the WHO in its international measure of spiritual well-being (WHO, 2002) which includes: connectedness to a spiritual being or force, meaning of life, awe, wholeness and integration, spiritual strength, inner peace/serenity/harmony, hope and optimism, and faith. This definition is health focused and, therefore, of particular relevance to nursing. The Royal College of Nursing (RCN, 2011b) adopts a similar definition and cites the NHS Education for Scotland's (2009, p. 6) definition of spiritual care as:

> that care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.

Spiritual care is expected of nurses (e.g. International Council of Nurses, 2012) who should be competent in its delivery at point of registration (e.g. NMC, 2010). Spiritual care competency has been defined as the knowledge, skills and attitudes needed for delivery of spiritual care (Attard, 2015; van Leeuwen et al., 2009). Whilst spiritual care competency frameworks exist for palliative care (Marie Curie Cancer Care, 2003) and chaplaincy (NHS Education for Scotland, 2008), work has only recently begun on developing frameworks for nursing (e.g. Attard, 2015; van Leeuwen et al., 2009). Whilst the expectation is that nurses will be competent in spiritual care at point of registration, little is known about the factors that contribute to the acquisition of spiritual caring skills and spiritual care competency by student nurses/midwives. The literature highlights that spiritual care teaching and personal attributes of the nurse/midwife may be two factors.

### *Spiritual Care Teaching*

Nurses overwhelmingly and consistently report the need for further education on spiritual care (Lewinson et al., 2015; RCN, 2011a). There is some evidence that educating nurses in spirituality and spiritual care results in: greater understanding of the complex nature of spirituality and spiritual care; improved interpersonal/communication skills; a more person centred approach to care; personal benefits, such as greater job satisfaction (e.g. van Leeuwen et al., 2008; Cockell and McSherry, 2012; Cone and Giske, 2012; Giske and Cone, 2012; Cooper et al., 2013). Clinical experience may provide additional opportunities for gaining competence in spiritual care (Giske, 2012). However differences in study design, sampling and rigour in many of these studies prevented firm conclusions from being drawn.

### *Personal Attributes of the Nurse/Midwife*

There is evidence that the personal spirituality of the nurse/midwife may dictate whether or not and how spiritual care is addressed, with those claiming and practising religious/spiritual beliefs being most at ease with spiritual care (Taylor et al., 2008; van Leeuwen et al., 2008; Giske, 2012), but again many of these studies were small in scale with varying methodologies and rigour. There is further evidence from other healthcare professional groups that personal beliefs and values impact upon clinical decisions about patient care. For example non-religious doctors were more likely than religious doctors to prescribe continuous sedation thus speeding up death at end of life (Seale, 2010).

Clearly further work is needed including larger samples from different countries and a sound methodology, to identify the factors contributing to student nurses/midwives attainment of spiritual care competency. In a previous paper we described how a sample of students from four countries perceived spirituality/spiritual care and their competency in giving spiritual care (Ross et al., 2014). In the current paper we further interrogate the same data to identify factors contributing to spiritual care competency.

## Method

### *Aim*

To explore factors contributing to undergraduate nurses'/midwives' perceived competence in giving spiritual care.

### *Design*

Cross-sectional, multinational, correlational survey design.

### *Sample*

Questionnaires were distributed to a target convenience sample of 618 undergraduate nursing/midwifery students at six universities (three religious, three secular) in four countries (Wales, Malta, Netherlands [three universities], Norway) in September 2010. A response rate of 86% was achieved (n = 531, range 78% [Wales]–100% [Netherlands]). Thus the findings can be considered to be representative of the target sample, but not necessarily of all student nurses undertaking nurse training in the countries included. Ethical approval was obtained from ethics committees within each university and external organisations as required by each country. Participation of universities and students was voluntary and anonymity and confidentiality were assured.

The sample was given verbal and written information about the study 1–2 weeks in advance of the questionnaires being administered by the authors during class time. Those not wishing to participate returned blank forms.

The sample, described in Table 1 below, included mainly female (85%) nursing students (95%) in year one of their course, aged up to 20 years (57%) and studying at secular universities (62%). Most were religious (87%, mainly Christian 80%), practised their faith/belief in a range of ways (51–60% daily/weekly), had experienced significant life events (55%) and had no previous health care experience (60%).

### *Data Collection*

Students completed five questionnaires relating to the study aims as follows.

- Purpose designed demographic questionnaire which asked questions about gender, age, educational background, religious affiliation/life view, etc.
- JAREL Spiritual Well-being Scale (Hungelmann et al., 1996). JAREL measures spiritual well-being and contains 21 items (all items loaded at 0.5 or above) and three subscales: faith/belief; life/self responsibility; life satisfaction/self actualization. Treated as a categorical variable, JAREL measures three levels of spiritual well-being: low (0–50); medium (51–84) and high (85–126). JAREL was developed for nursing and includes religious and existential domains of spirituality.
- Spiritual Attitude and Involvement List (SAIL, Meezenbroek et al., 2008). SAIL consists of 26 items arranged in three dimensions with seven subscales: Connectedness to oneself (meaningfulness, trust, acceptance); to the environment/others (caring for others, connectedness with nature); to the transcendent (transcendent experiences, spiritual activities). Factorial, convergent and discriminant validity were demonstrated. Subscales showed adequate internal consistency and test–retest reliability. SAIL can be employed as a continuous measure ranging from 1 to 6 with higher scores indicating higher levels of spiritual attitude/involvement or it can be employed as a binary variable whereby high spiritual attitude/involvement is indicated by a SAIL score of >4.