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Staff Education to Critical Care Nurses on Spiritual Care

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Walden University

College of Nursing

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Revrey Darita Porter Amey

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and that any and all revisions required by
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Walden University

2025

Executive Summary: Staff Education Project

Staff Education to Critical Care Nurses on Spiritual Care

by

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MS, Austin Peay State University, 2015

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Executive Summary Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Summary

The Doctor of Nursing Practice (DNP) project included staff education for critical care nurses. Patients should receive spiritual care to decrease anxiety and depression that often accompany serious illnesses. Spiritual care encompasses inner peace, connection to others, transcendence, and the meaning and purpose of life.

This project aimed to teach critical care nurses the importance of providing spiritual care to their patients. The project was designed to increase nursing knowledge, skills, and attitudes of spiritual care by conducting a 30-minute didactic staff education session in the critical care unit. Nurses completed a pretest and posttest using the Spiritual Care Competency Scale (SCCS) to assess their self-perceived knowledge, skills, and attitudes of spiritual care. Next, the nurses viewed a prerecorded PowerPoint (PPT) presentation on spiritual care, followed by role-play using the Spiritual Needs Questionnaire (SpNQ) by Büssing. Fifty percent of the nursing staff ($n = 16$) who were working during the project's timeframe were able to attend. Eleven nurses scored high (99 or higher), five scored average (64–98), and no one scored low (below 64). One participant scored the maximum of 135 on both the pretest and posttest, and Participant 6 had the largest increase of 40 points.

The postintervention summative evaluation reported that 100% of participants had increased knowledge of the importance of spiritual care. Nurses reported that they plan to incorporate their increased knowledge of spiritual care to improve patient care. The recommendations are for the organization to offer spiritual care topics in the future.

Background

The gap in practice at this Doctor of Nursing Practice (DNP) project site was confirmed by the site's performance measure scorecard. The nurses were not initiating a substantial amount of spiritual care referrals to palliative services based on the data from the scorecard. Additionally, based on chart reviews, nurses were not performing optimal spiritual care for patients. The leadership speculated that the lack of training in spiritual care might be a reason for the apathy in providing spiritual care and making referrals. Therefore, the aim of this DNP Staff Education project was to improve staff knowledge related to the importance of spiritual care.

The practice-focused question for this project was, "Can a 30-minute didactic staff education on the importance of providing spiritual care to patients increase nursing knowledge, skills, and attitudes of providing spiritual care?" This DNP project was designed to raise awareness of spiritual care, inform and engage stakeholders, and promote change to the organization's approach to the subject of spiritual care. This DNP project was aligned with the organization's mission to provide compassionate care to its patients based on Jean Watson's caring theory.

The evidence that supported this project was the de-identified performance scorecard indicators provided by palliative care leadership before the start of the DNP project and subsequently during phase two of the project. The second scorecard confirmed the continued lack of nurse-driven referrals for spiritual care support. Consequently, of the 84 unit-specific spiritual care support visits for one quarter, only 16 were nurse-driven throughout the entire organization and not unit-specific referrals.

The evidence in the literature that supports this change in practice was that nurses have a desire to perform spiritual care for their patients, but feel inadequately trained to do so (Alvarenga et al., 2024; Damsma-Bakker & van Leeuwen, 2021; Elias et al., 2024; Jones et al., 2024; Momeni et al., 2022). The literature also supports that nurses want to be trained in providing spiritual care (Elias et al., 2024; Zumstein-Shaha et al., 2020). Additionally, authors agreed that patients have improved well-being and decreased stress and anxiety when they receive spiritual care (Badanta et al., 2022; Jones et al., 2024; Momeni et al., 2022; Zumstein-Shaha et al., 2020). Finally, spiritual care experts agreed that training in spiritual care should be multidisciplinary for healthcare professionals, and the literature encouraged the design of the staff education to include pretests and posttests, as well as role-play exercises (Elias et al., 2024; Jones et al., 2024; Puchalski et al., 2022).

For this project, 38 articles were reviewed and assessed, and 15 articles were used to support this DNP project. The 15 articles used offered strong support as evidence. The evidence was consistent, and only articles written in the past 5 years were used to support the project. The levels of evidence for the articles used included one Level I, seven Level III, six Level IV, and one Level V article. The evidence was found to be reliable and supportive of the DNP project.

Staff Education Project Development

The staff participants in this project included critical care staff nurses. Sixteen staff members participated in the staff education by completing a reliable and validated pretest, a 30-minute prerecorded PPT session, the same credible survey as a posttest, and the postclass evaluation; no one dropped out of the education session. The procedures

used to develop this project were the Johns Hopkins Evidence-Based Practice (JHEBP) model. The problem was identified by evaluating de-identified and aggregate quality data provided by the organization. A question was developed to address the gap found in spiritual care. The aim was to educate nurses based on the data, which indicated an opportunity for improvement. Finally, the literature was assessed to establish the best evidence for addressing the deficiency of spiritual care, which included educating nursing staff in spiritual care.

The professional development education specialist (EdD, MSN, FNP-RN, NPD-BC) reviewed the spiritual care education content for appropriateness and alignment with the organization's mission. A PPT presentation was developed based on the best current practices regarding assessment and delivery of spiritual care (see Appendix A). The content outline was created from suggestions from the Interprofessional Spiritual Care Education Curriculum (ISPEC) for spiritual care education. The ISPEC curriculum is congruent with national guidelines for spiritual care (Puchalski et al., 2022)

The tools used for role-play and pretest/posttest were validated tools developed by spiritual care experts. The Spiritual Needs Questionnaire (SpNQ; see Appendix B), written by Dr. Arndt Büssing, was used for a role-play exercise following the visual presentation. The Spiritual Care Competency Scale (SCCS; see Appendix C), developed by Dr. René van Leeuwen, was used for pretests and posttests to evaluate nurses' self-perceived knowledge of spiritual care competency. Permission was granted to use each tool for the DNP project by the authors (see Appendices D and E, respectively).

The implementation of this project was a prerecorded PPT presentation delivered in person on the nursing unit. The nursing staff completed the SCCS on paper; next, they

viewed the PPT presentation. A role-play exercise using the SpNQ was performed, and afterwards, the posttest using the SCCS was completed. The organization approved 0.5 education hours to participants who finished the post-class evaluation. Names were listed only on the organization's sign-in sheet to obtain education credit, and participants' personal identifiers remained anonymous on the completed pretest and posttests. The sign-in sheets were submitted to the site leader and retained by the facility. The pretests and posttests were numbered, and no identifying information was collected to maintain anonymity. Each participant received a folder at the beginning of the didactic education that contained all forms they would need to complete the education. The folders contained numbered pretests and posttests, and participants were instructed to avoid adding any personal information on the forms.

The process for collecting the pretests and posttests was for the DNP project leader to collect the tests at the end of each session. The analysis of this evidence included descriptive analysis. The pretest and posttest mean scores were compared to identify whether changes were obtained in nurses' knowledge, skills, and attitudes towards spiritual care. The change percent formula was used to evaluate the total percentage change.

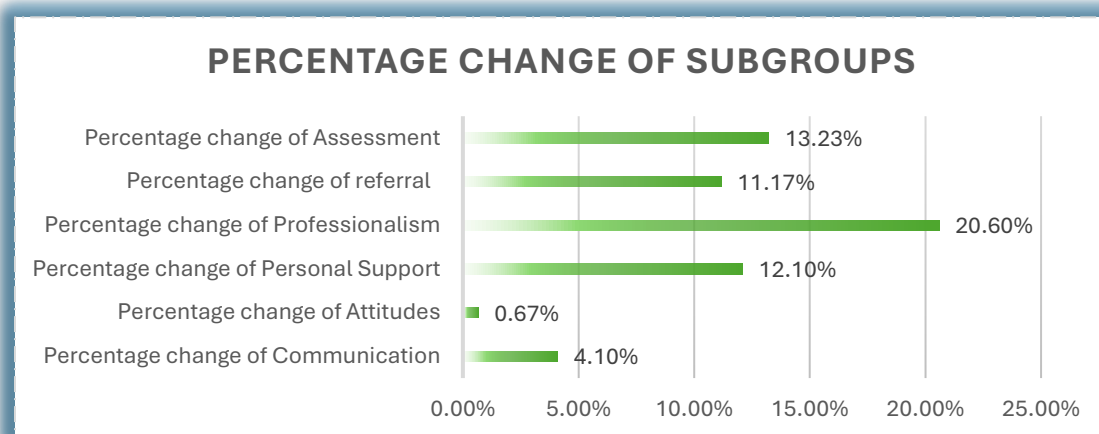
The data were evaluated using the following process: the number, the mean, and the standard deviation were calculated for the participants' pretest and posttest scores using the SPSS statistical software. Data were entered into SPSS manually to run a statistical analysis. The data were exported to Excel spreadsheets to create charts containing the data.

Results

The results of this project were an increase in nurses' knowledge, skills, and attitudes towards spiritual care following a 30-minute didactic staff education in spiritual care training. The project found an overall total percentage increase of 11.22% from pretest to posttest scores by comparative analysis. The nurses scored high in both pretest and posttest attitudes subgroups; however, there was an increase in the attitudes' subgroup of 0.67%, a 4.10% increase in communication, 13.23% in assessments, 11.17% in referrals, 12.10% in personal support, and the biggest increase was in the professionalism subgroup of 20.60% as shown in Figure 1. Overall, the staff education improved nursing knowledge in all subgroups.

Figure 1

Percentage Increases Between Pretest and Posttest Scores for SCCS

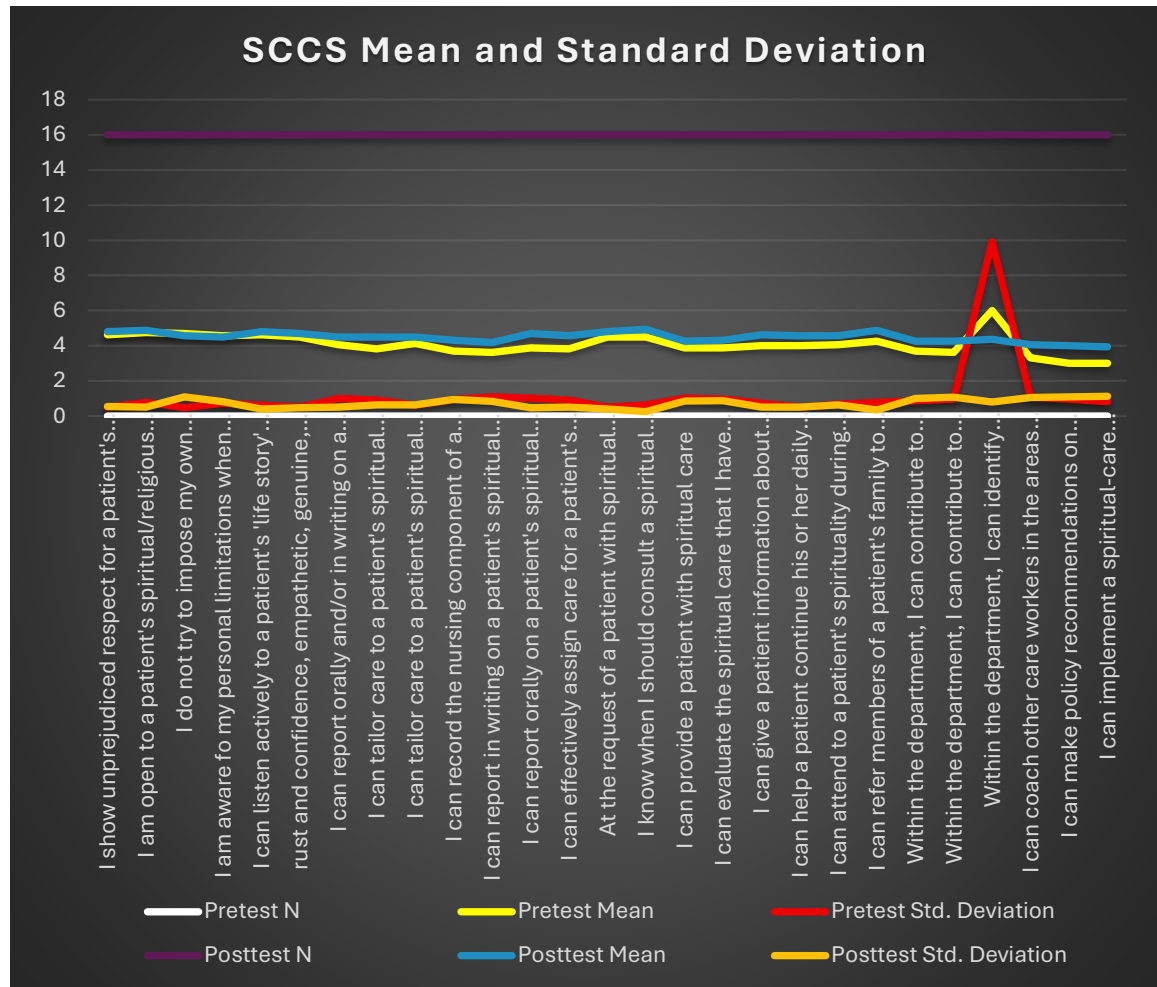


Note. A percentage change for pretest, posttest scores for each category for attitudes was 0.67% increase; referrals, 11.17% increase; communication, 4.10% increase; assessment, 12.50% increase; personal support, 12.10% increase; and 20.60% increase for professionalism. The increase between the total pretest and posttest scores was 11.22%.

The pretest and posttest consisted of 27 questions with six subgroups: *attitudes, communication, referrals, assessment and implementation, personal support and patient counseling, and professionalism* (see Figure 2) for mean scores and standard deviations for each category. All sixteen participants completed both tests, and the mean scores were slightly higher on the posttest scores. The six subgroups were divided with four questions representing attitudes, two questions for communication, three questions for referrals, six questions for assessment and implementation, six questions for personal support and patient counseling, and six questions for professionalization and improving the quality of spiritual care. Posttest scores were higher for each category.

Figure 2

Mean and Standard Deviation for the 27-Question SCCS



Note. Sixteen critical care nurses participated in the pretest and posttest Spiritual Care Competency Scale (SCCS) survey. Posttest mean scores were higher than pretest scores. The 27-question test addressed nurses' self-perceived competency in spiritual care and is divided into six categories: Attitudes, Communication, Referral, Assessment and Implementation, Personal Support and Patient Counseling, and Professionalism.

The impact of this project to the organization was increased knowledge of spiritual care for nurses. A summative evaluation of the spiritual care education reported that learning outcomes were met. Nurses reportedly increased their competence in completing a spiritual care assessment for patients.

Limitations

The DNP project was limited by the small number of participants. The nursing unit experienced a heavy workload during the timeframe the class was offered. Additionally, half of the nurses who participated had previous experience, plus more than half had 10 or more years of experience, which might have influenced the higher pretest scores of self-reported spiritual care competence.

This project has importance beyond the local project site, as spiritual care is a global concern (Farokhzadian et al., 2025). Every patient should receive spiritual care to improve their quality of life (Zumstein-Shaha et al., 2020). Nurses desire to perform spiritual care, but they need to be trained to increase their confidence in providing spiritual care to patients (Alvarenga et al., 2024; Cerra et al., 2024; Damsma-Bakker & van Leeuwen, 2021; Elias et al., 2024; Ikbali & Sari, 2024; Jones et al., 2024; Riklikienė et al., 2020).

Conclusions

The impact of this DNP project to the project site was a self-reported increase in knowledge, skills, and attitudes to provide spiritual care to patients. Participants attended a 30-minute didactic education on spiritual care. Following the education session, all participants reported improved skills in their competence to complete a spiritual care assessment for their patients. Some changes they plan to incorporate are active listening,

providing resources to patients and families, assessing patients' spiritual needs, and documenting spiritual care.

Future recommendations for this organization include providing ongoing spiritual care education to all staff to enhance spiritual care assessments. The organization should consider including spiritual care education in orientation and nurse residency programs. The organization should continue offering education credits for future training sessions.

Future recommendations for modifications of this project include allowing more time for practice and debriefing. A question-and-answer period should be added to offer clarifications. Furthermore, all disciplines should be included in the spiritual care training.

The potential implications of this project on nursing practice include increasing nurses' understanding and confidence in providing spiritual care to patients. Spiritual care decreases anxiety and depression for seriously ill patients and their families, ultimately increasing their well-being (Jones et al., 2024). This DNP project verified that a 30-minute didactic staff education on the importance of providing spiritual care to patients increased nursing knowledge, skills, and attitudes of providing spiritual care. This DNP project can be replicated to offer it in other units and other facilities for improving the provision of spiritual care.

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Appendix A: Spiritual Care Education PowerPoint Presentation

INTRODUCTION SPIRITUALITY EDUCATION

PRESENTED BY REVREY AMEY, DNP STUDENT, WALDEN UNIVERSITY



CLASS BREAKDOWN:
PRE-TEST
PPT PRESENTATION
ROLE PLAY
POST-TEST
EVALUATION

Picture from Microsoft Stock Images

WALDEN UNIVERSITY
EDUCATION FOR GOOD



Note: Scan the QR code to view the PPT presentation. (Once the presentation is opened, click the PPT icon to listen to the presentation.)

Appendix B

Spiritual Needs Questionnaire (Screener)

Over the past 2 weeks, have you felt the need to...		No	If YES, how strong is this need?		
			some-what	strong	very strong
N2	talk with others about your fears and worries?	0	1	2	3
N6	plunge into beauty of nature?	0	1	2	3
N7	dwell at a place of quietness and peace?	0	1	2	3
N8	find inner peace?	0	1	2	3
N20	pray for yourself?	0	1	2	3
N21	participate at a religious ceremony (i.e. Sunday service)?	0	1	2	3
N23	turn to a higher presence (i.e., God, Allah)?	0	1	2	3
N11	talk with someone about the question of meaning in life?	0	1	2	3
N16	forgive someone from a distinct period of your life?	0	1	2	3
N17	be forgiven?	0	1	2	3
		0	1	2	3
PB1	to receive psychological / psychotherapeutic support?	0	1	2	3
SB1	to receive non-denominational / non-religious pastoral support?	0	1	2	3
SB2	to receive denominational / religious pastoral support?	0	1	2	3

Note: The Spiritual Needs Screener can be used for patients who are seriously ill. The full SpNQ by Dr. Arndt Büsing has 27 items and can be used for assessing patients who are not seriously ill. The SpNQ requires permission to use from the author.

Appendix C

Spiritual Care Competence Scale

1 = completely disagree/2 = disagree/3 = neither agree or disagree/4 = agree/5 = fully agree

Attitude towards patient spirituality

1) I show unprejudiced respect for a patient's spiritual/religious beliefs regardless of his or her spiritual/religious background

1 - 2 - 3 - 4 - 5

2) I am open to a patient's spiritual/religious beliefs, even if they differ from my own

1 - 2 - 3 - 4 - 5

3) I do not try to impose my own spiritual/religious beliefs on a patient

1 - 2 - 3 - 4 - 5

4) I am aware of my personal limitations when dealing with a patient's spiritual/religious beliefs

1 - 2 - 3 - 4 - 5

Communication

5) I can listen actively to a patient's 'life story' in relation to his or her illness/handicap

1 - 2 - 3 - 4 - 5

6) I have an accepting attitude in my dealings with a patient (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere and personal)

1 - 2 - 3 - 4 - 5

Assessment and implementation of spiritual care

7) I can report orally and/or in writing on a patient's spiritual needs

1 - 2 - 3 - 4 - 5

8) I can tailor care to a patient's spiritual needs/problems in consultation with the patient

1 - 2 - 3 - 4 - 5

9) I can tailor care to a patient's spiritual needs/problems through multidisciplinary consultation

1 - 2 - 3 - 4 - 5

10) I can record the nursing component of a patient's spiritual care in the nursing plan

1 - 2 - 3 - 4 - 5

11) I can report in writing on a patient's spiritual functioning

1 - 2 - 3 - 4 - 5

12) I can report orally on a patient's spiritual functioning

1 - 2 - 3 - 4 - 5

Referral

13) I can effectively assign care for a patient's spiritual needs to another care provider/care worker/care discipline

1 - 2 - 3 - 4 - 5

14) At the request of a patient with spiritual needs, I can in a timely and effective manner refer him or her to another care worker (e.g. a chaplain/the patient's own priest/imam)

1 - 2 - 3 - 4 - 5

15) I know when I should consult a spiritual advisor concerning a patient's spiritual care

1 - 2 - 3 - 4 - 5

Personal support and patient counselling

16) I can provide a patient with spiritual care

1 - 2 - 3 - 4 - 5

17) I can evaluate the spiritual care that I have provided in consultation with the patient and in the disciplinary/multi-disciplinary team

1 - 2 - 3 - 4 - 5

18) I can give a patient information about spiritual facilities within the care institution (including spiritual care, meditation center, religious services)

1 - 2 - 3 - 4 - 5

19) I can help a patient continue his or her daily spiritual practices (including providing opportunities for rituals, prayer, meditation, reading the Bible/Koran, listening to music)

1 - 2 - 3 - 4 - 5

20) I can attend to a patient's spirituality during the daily care (e.g. physical care)

1 - 2 - 3 - 4 - 5

21) I can refer members of a patient's family to a spiritual advisor/pastor, etc. if they ask me and/or if they express spiritual needs

1 - 2 - 3 - 4 - 5

Professionalization and improving the quality of spiritual care

22) Within the department, I can contribute to quality assurance in the area of spiritual care

1 - 2 - 3 - 4 - 5

23) Within the department, I can contribute to professional development in the area of spiritual care

1 - 2 - 3 - 4 - 5

24) Within the department, I can identify problems relating to spiritual care in peer discussions session

1 - 2 - 3 - 4 - 5

25) I can coach other care workers in the area of spiritual care delivery to patients

1-2-3-4-5

26) I can make policy recommendations on aspects of spiritual care to the management of the nursing ward

1 - 2 - 3 - 4 - 5

27) I can implement a spiritual-care improvement project in the nursing ward

1 - 2 - 3 - 4 - 5

Note: The Spiritual Care Competence Scale is a 27-item survey that can be used to evaluate nurses' self-perceived assessment of their knowledge, skills, and attitudes to perform spiritual care to patients. The tool is a reliable and validated tool by Professor Rene' van Leeuwen and requires permission to use.

Appendix D

Permission to use the SpNQ

Hallo. Thanks for your interest. Find them attached.

And please, share your findings later on!

Best wishes

Arndt Büssing

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Note: Permission to use the Spiritual Needs Questionnaire (SpNQ) was granted by Dr. Arndt Büssing per an email response requesting permission.

Appendix E

Permission to use the Spiritual Care Competency Scale

From:rrvleeuwen@kpnmail. Date: Sunday, March 16, 2025 at 06:49 AM CDT

Dear Revrey Amey,

Thank you for your email. You have my permission to use the SCCS for your purpose. I would be pleased to receive the outcomes of your study.

Best wishes for the execution of your research.

Kind regards,

René van Leeuwen

Professor in nursing emeritus.

Note: Permission to use the SCCS from Professor Rene' van Leeuwen received via email.