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Walden University

College of Health Sciences

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April Gant

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Walden University
2016

Abstract

Educating Nurses About Spirituality's Effects on Quality of Life With Chronic Illness

by

April Gant

MS, Duke University, 2004

BS, North-Carolina A & T State University, 1996

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

February 2016

Abstract

Spirituality has been associated with wholeness, inner peace, and key elements of well-being or quality of life. Spirituality support is particularly important for patients with chronic illness and patients who view spirituality as a way of coping with suffering. Evidence-based education is lacking in schools of nursing and in places of nursing employment on spirituality interventions that nurses can use to improve patient quality of life. The purpose of this project was to determine whether an educational intervention would increase knowledge of spiritual care in a small sample of clinic nurses (n = 37). This project used Watson's caring theory, which is an explanatory, middle-range theory focused on human caring. Watson's caring theory supports the relationship between spirituality and quality of life in patients with a chronic illness. Staff nurses completed the Spirituality Care Competence Scale as a pretest evaluation of spirituality knowledge. Spirituality training, which included evidence-based handouts, articles, and assessments, was followed by a second completion of the Spirituality Care Competence Scale as a posttest evaluation of the training effectiveness. The pretest to posttest knowledge of spiritual care significantly increased ($p < .0001$) on the 10 questions as measured by a t test statistic. These findings may contribute to social change by guiding training strategies to meet organizational goals for increased nurses' knowledge of and skills in spiritual care delivery for chronically ill patients. Nurses will have increased competency to provide patients with quality holistic care that includes support of spirituality.

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Dedication

This paper is dedicated to my family members who were with me every step of the way, and continue to be by my side. I thank them for understanding the early mornings and the late nights, all babysitting duties that I was released from, and all of the homework time they allotted me to have on the weekends. They gave me the encouragement needed to focus and complete this exciting, educational endeavor. Thanks for tolerating my moods by giving me big hugs and big beautiful smiles that would turn my day around and make everything OK. I am grateful for my support system in which they understood my needs as I completed this challenging journey to social change. You guys are truly my inspiration. Thanks and I love you!

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Section 1: Nature of the Project

Spirituality is an essential aspect of a patient's health. However, nurses and health care professionals have only narrowly discussed or assessed the need for spirituality and the provision of rendering spiritual care to promote quality of life (QOL). The evidence to support the role of spirituality to improve QOL is abundant. Despite the findings in the literature that associate spirituality with QOL, research is needed to explore the competencies required to provide and implement spiritual care into nursing practice.

Religious beliefs and practices can be expressions of spirituality, but spirituality exists apart from religion. The consensus is that *spirituality* is defined as the manner by which persons seek meaning in their lives and experience transcendence to that which is beyond the self. Religion is best understood as adherence to an accepted formalized system of belief and practices (Christensen & Turner, 2008; Narayanasamy & Owens, 2001). Most nurse authors view spirituality as a universal phenomenon. Although all persons do not understand and accept the supernatural, all persons have needs for seeking meaning and acceptance in their lives. Nurses and clinical professionals, however, often have omitted the need to discuss or assess spirituality as an influence or contribution to improved QOL for their patients. International studies showed a lack of knowledge regarding nurses' perceptions of and interventions related to spiritual care (Christensen & Turner, 2008; Narayanasamy & Owens, 2001). Spirituality is inadequately addressed in most practices due to knowledge deficits, time issues, and lack of self-efficacy regarding the role of nurses in approaching patients regarding their spirituality needs (Christensen & Turner, 2008; Narayanasamy & Owens, 2001).

Research consistently has suggested that nurses' knowledge and skills related to spiritual care are not adequate because of poor role preparation. Despite recommendations by accrediting organizations such as the Association of American Medical Colleges, the National Association of Social Workers, and the Association of Professional Chaplains, well-defined curriculum focusing on interprofessional spiritual assessment is lacking (Lennon-Dearing, Florence, Halvorson, & Pollard, 2012). Literature has shown that nurses are limited from practicing spiritual care due to a lack of education, training, competency, and knowledge. Education through nursing courses and continuing programs of education are needed to ensure adequate understanding of spirituality in the nursing role (Mackinlay, 2007). In addition, the American Association of Colleges of Nursing (AACN, 2008) identified the creation of healing, humane environments as a research priority.

The purpose of the project was to provide nurses with evidence-based educational information. The evidence-based information enhances knowledge and competence in assisting patients to achieving better QOL through spiritual care. The impetus for this project arose from a survey completed by nurses at the project site that relates to their practice needs and addressed spiritual issues with patients. The organization is a home health care organization and a family medical clinic that serves more than 200 patients in the home health care department and more than 500 patients in the clinic setting. The organization has three physician providers and an estimated 40 nurses, 80 nurse assistants, and five medical assistants. The chronic diseases most often seen among the patients served by the organization are arthritis, diabetes, cardiovascular disease, and chronic pain syndromes. The prognosis of patients has been fair. The average age of the patients seen by the organization is 66 years. Sixty-three percent of the patients are African-

American, 27% are Caucasian, and 10% are other. Women make up 71% of the population, and men make up 29% of the population served.

The organization has an interest in this project because stakeholders found it beneficial for the staff to receive education on how to integrate spirituality into the care. The nursing staff believed they lacked education on spirituality. In addition, the nursing staff members have noted that most patients seen are spiritual and have voiced spiritual beliefs. Attention to spirituality, then, is important for ensuring nurses are delivering quality holistic care to their patients. The project assessed nurses' knowledge of spirituality in practice and provided education to fill educational deficits of staff nurses with regard to spirituality interventions to promote QOL in the chronically ill patients being cared for by the organization. This project also demonstrated how spirituality education could increase knowledge and confidence of the participating nurses in providing care in this setting.

Practice Problem

The practice problem addressed in the project, were nurses' lack education that prepared them to provide spiritual care (Tiew & Creedy, 2010). Spirituality is part of patients' ability to cope with the challenges of chronic disease and promotes QOL. Research indicated that religious and spiritual coping is associated with positive health outcomes (Green, Emery, Kozora, Diaz, & Make, 2011). Green et al. discussed how these practices are necessary for individuals to use in daily life to improve spirituality and QOL. The evidence indicated that 77% of patients want spiritual issues to be considered as part of their medical care (Lind, Sendelbach, & Steen, 2011). After nurses are knowledgeable about spirituality, they can recognize a patient's spiritual health. They can then encourage patients to identify the need to incorporate relevant spiritual practices

into their activities of daily life (Green et al., 2011). Bahrami (2011) noted nurses have defined the meaning of a patient's QOL as a reflection of the patient's overall happiness and satisfaction. Nurses must focus not only on the biopsychosocial, physical, and mental aspects of care, but also the spiritual aspects. This DNP project assessed nurses with knowledge of spirituality and provided evidence-based resources and materials for the nurses that will prepare them to incorporate spiritual care into practice. The effect of a nurses' knowledge regarding spirituality deserves attention due to its effectiveness in improving QOL of patients.

Purpose

The purpose of this quantitative descriptive project was to assess nurses' knowledge of spirituality and provide education to fill knowledge deficits. The project increased the nurses' preparedness and ability to provide spirituality assessments and care in a clinical practice setting.

Project Objectives

This project had three objectives: (a) to evaluate nurses' knowledge of spirituality, (b) to provide education to nurses on spiritual nursing care, and (c) to determine if training on spirituality improved nurse's knowledge of spirituality. The literature review found and the survey of the nurses at the project site corroborated a lack of knowledge among nurses related to spiritual nursing care. These findings established the need for the project. The project objectives were accomplished through the development of training materials, a Spiritual Care Competence Scale (SCCS) pretest and posttest, and an evaluation of the training. The collection of anonymous data protected the participants' privacy. The announcement of the in-service on spiritual care was posted in the break room, sent to staff via e-mails, and posted on the organization's website. Nurses and all other staff members were not paid or given an incentive to

attend the training. All staff nurses, administrative nurses, and nurse aides were invited to participate.

Project Question

The project question for this project in PICO format was: Will training nurses improve their knowledge of and confidence in using spiritual care to enhance the QOL for patients who have a chronic illness?

P = among nurses working in a clinic setting who serve patients with chronic illnesses.

I = will an educational intervention to increase spirituality knowledge (measured after the intervention with a posttest)?

C = compared with the current level of spirituality knowledge (measured before the intervention with a pretest).

O = result in a statistically significant improvement on the Spiritual Care Competency Scale total and subscale scores? (see Appendices A and B).

Significance of the Project

The current literature demonstrated that nurses lack education in spiritual care, organizations must provide training to enhance nurses' knowledge of spiritual care, and spiritual care is important in providing holistic care to enhance patients' QOL. The Joint Commission (2001) Press Ganey National inpatient data showed that patients place a high value on emotional and spiritual needs, (b) a strong relationship exists between the care of patients' emotional and spiritual needs and overall patient satisfaction, and (c) the lack of attention given to patients' emotional and spiritual needs constitutes a significant opportunity for improvement (Lind, Sendelbach, & Steen, 2011). Health care providers and clinicians can actuate change by

incorporating spiritual care to help individuals organize their lives and improve their QOL (Adegbola, 2006). This project addressed the gaps in spirituality education by training staff on ways to address spiritual and emotional needs of individuals in practice. Nurses and other health care professionals have been shown to face barriers, such as a lack of training in spiritual nursing, embarrassment, a lack of awareness of the need, fear, and a lack of time to provide the care (Cook et al., 2012). Many nurses have noted that learning needs occurred because of inadequate educational preparation in spiritual care (Belcher, & Griffiths, 2005).

Implications for Social Change

The project makes a significant contribution to social change by disseminating information on spirituality that contributes to the QOL of patients treated in health care practice. The project information provided ideas and resources for an organization to consider when implementing spirituality training for clinical staff members. The professional development that resulted from this project improved the knowledge of staff and helped increase confidence when providing spiritual care to patients. Spirituality training for the nurses is necessary for their preparation in providing spiritual care. The literature supported that patients have improved QOL when nurses have confidence in their ability to provide spiritual care.

This project gave me the opportunity to analyze effective ways to educate nursing staff members for provision of spiritual care. This project can be used to evaluate and establish best practice interventions for educating staff on spiritual assessments and interventions during patient care. The intent of the project was to provide well-designed and well-implemented spirituality training for organizations to use. The training also contributed to staff members' awareness of cultural diversity as it was related to individual spiritual beliefs and quality of life.

The findings of this project provided evidence that an educational intervention will improve nurses' spirituality assessment and intervention knowledge. Nurses and clinicians caring for individuals in the clinical practice setting need the essential skills and confidence to assess spiritual care deficits in patients to provide holistic spiritual care actions and interventions. Li-Fen, Yu-Chen, and Dah-Cherng (2012) found that education, experience, career interest in nursing, and career choice affect nursing student perceptions of spirituality and spiritual care. Nursing students have the responsibility to be holistic care providers. Integrating spirituality and spiritual care into the standard nursing curriculum is recommended to improve nursing care quality (Li-Fen et al., 2012).

The inclusion of spirituality in health care delivery addresses the needs of individuals of all faiths. Nurses must understand how to assess and acknowledge interventions that are dependent on the patients' spiritual preferences. Organizations may provide competency training and educational resources to position nurses with the ability to address the spiritual care of patients (Lind et al., 2011).

Definitions of Terms

The following terms are used in this project:

Spirituality is a process involving unity and harmony within the mind, body, and soul (Adegbola, 2006).

Quality of life is a feeling of overall life satisfaction, as determined by the mentally alert individual whose life is being evaluated (Meeberg, 1993).

Chronic illnesses are diseases of long duration and generally of slow progression (Vilhena et al., 2014).

Assumptions and Limitations

I assumed all participants desired to participate in the education. I assumed that systematic teaching and education of nurses would promote holistic spiritual care in practice. I also assumed that participants answered pretest and posttest questions independently with honestly and accurately. Finally, I assumed that the nurses will influence practice by using what is learned in the educational activity.

Limitations of the project included the time constraints for the training and a relatively small sample size. A limitation of the project training is the format of using handouts. This format lacked the ability of interaction between nurse-educators and learners.

Summary

Literature has shown that nurses lack knowledge in spiritual nursing care to promote QOL of patients. Wallace (2008) found that students need interviewing tools that can facilitate discovery of patients' spirituality and techniques to support individual strengths that promote their health. Although spirituality plays a critical role in how patients perceive and cope with health and illness, nursing students often do not have a strong foundation in this area. Spirituality assessment and intervention competency improve nursing practice by helping patients cope and increasing QOL. The findings of this project provide further evidence of the need for nursing education and training in spirituality to promote QOL in patients with chronic illnesses. Health care providers and clinicians can participate in social change by incorporating spirituality education and spiritual nursing care into practice. The long-term desired outcome is for nursing staff to increase their knowledge levels for promoting spirituality when addressing patients in practice. Nursing programs have done a commendable job keeping pace with the rapid advances

in disease management. However, spirituality has received far less attention in nursing curricula (Keefe, 2005) and nursing students often do not have a strong foundation in this area. The process of assessing the current levels of knowledge and then planning appropriate needs-based spirituality clinical education in the organization will give nurses tools to implement and embrace spiritual care in practice (Wallace et al., 2008).

In Section 2, I discuss the need for nurses to have knowledge of spirituality and how spirituality improves the QOL of individuals. I address nurses' knowledge and competency, as well as participation in influencing and supporting the importance of the patient's spirituality. I also review the objective of providing spiritual education and how it increases nursing knowledge for promoting QOL.

Section 2: Review of Literature and Theoretical Framework

This project was aimed at examining and improving the knowledge of home health and clinic nurses to improve their assessment skills and ability to provide spiritual care to patients with chronic illnesses. In this section, I review the literature on spirituality and the effect of spirituality on QOL. The intent of this section is to examine literature that shows how spirituality improves QOL and why the nurses' knowledge of spirituality is important in nursing care and clinical practice. For the last 20 years, research has consistently shown a positive association between spirituality, health care outcomes and integration of spirituality and implementation of spiritual care in nursing practice (Tiew & Creedy, 2010). Nurses have been limited in providing holistic care by insufficient training and the education needed to meet the spiritual needs of patients. The literature review identified factors that have affected nurses' spiritual care including a deficiency of a shared understanding of spirituality and a lack of emphasis on spirituality in nursing education (Tiew & Creedy, 2010).

The literature on spirituality assessment and nursing interventions falls into four categories: quantitative, interpretive research, qualitative, and exploratory. The databases I used for the literature review included CINAHL, EBSCO, MEDLINE, ProQuest, and the Cochrane Library. The keywords I used in the literature search were *spirit*, *spirituality*, *nursing education*, *knowledge*, *spiritual practice*, *quality of life*, and *chronic illness*. I searched the databases using the aforementioned keywords in various combinations until I reached saturation, which was when searches began to demonstrate a repetition of articles. My search covered literature published within the last 5 years.

I retrieved 156 articles. However, only 57 articles were relevant to my study. After reviewing the 57 articles, I found that 38 met the inclusion criteria that they provide evidence on why spirituality training is needed, the use of spirituality in nursing practice, where spirituality training is being used currently and its effects, or resources for training in spirituality.

Specific Literature

Spiritual care is an essential part of nursing care in practice. Vlasblom (2011) conducted a trial "spirituality and nursing care" training that was provided to nurses from nursing wards in a nonacademic, urban hospital. Prior to the training and 6 weeks after the training, nurses and all patients were asked to complete a questionnaire. The results of the comparison of totals before ($n = 44$) and after the training ($n = 31$) showed that the patients from the intervention wards experienced more receptiveness and support when asking questions about illness and meaning. Positive changes also occur in nurses' attitudes, and their knowledge base is improved. The changes in practice displayed a significant positive change in clinical practice, such as increased documentation of spiritual needs and a statistically significant increase in the number of referrals to the chaplains. The results indicated that training in spiritual care for nurses had positive effects on the health care that patients experienced. As a result of the spiritual training, patients had an increased feeling that nurses were supportive of their spiritual needs (Vlasblom, 2011).

Bahrami (2011) conducts an interpretive study to explore in-depth meanings and aspects of QOL expressed by oncology nurses. Participants were selected from different inpatient and outpatient oncology services and a palliative setting in Adelaide, South Australia. Bahrami concluded that several factors contributed to an individual's QOL. Psychological, spiritual, environmental, and social interactions were factors that affect QOL (Bahrami, 2011). The

researcher explored the in-depth meanings and aspects of QOL for cancer patients from the nurses' perspectives. Nurses expressed the view that spiritual aspects of life are important contributors to patients' QOL. Participants stated "there is also the spiritual part of quality of life and the psychosocial part of the quality of life with a lot of layers" (Bahrami, 2011, p. 78).

Participants talked about existential things such as death and dying. Nurses explained that their patients talked a lot about spirituality. Nurses realized that spirituality was both multifaceted and a pervasive aspect of patients' lives. This descriptive exploratory qualitative research study examined meanings and aspects of QOL for cancer patients as articulated by the nurses who cared for them. This research suggested that QOL is a broad and even intangible concept (Bahrami, 2011). It identified that spirituality would need to be covered extensively in practice and providing spiritual care choices to patients was important for the patients' QOL (Bahrami, 2011).

Attard, Baldacchino & Camilleri, (2014) conducted a similar study using the SCCS, which aimed to identify the predictive effect of pre- and post registration taught study units on spiritual care competency of qualified nurses and midwives. The study population consisted of 111 nurses and 101 midwives. The results showed that nurses and midwives who had undertaken the study units on spiritual care scored higher in their competency of spiritual care. Although not statistically significant, nurses scored higher in their overall competency in spiritual care than the midwives. Attard et al. (2014) concluded that study units on spiritual care in pre- or post registration nurse and midwifery education may contribute to the acquisition of competency in spiritual care.

A study by Lind et al. (2011) used the Avatar Likert scale to monitor patient satisfaction after spiritual care training of nurses. Respondents who strongly agreed that nurses addressed their spiritual and emotional needs increased by approximately 10% each quarter after spirituality training was given to nurses. The medical records were also checked for the number of times nurses consulted with pastoral care services and how often the spiritual care plan was used. The recorded use of the spiritual care plan increased from no previous use to one to four uses per month during the first 3 months after the spiritual training. Nurses stated that they were more comfortable with assessing spirituality needs and delivering interventions for spiritual care issues after the training.

Yardley, Walshe, and Parr (2009) conducted a study that provided palliative patient perspectives to strengthen recommended models of spiritual care delivery. Yardley et al. (2009) showed that user opinions on training could be helpful not only in deciding objectives, but also in discerning how to achieve them. This qualitative study of hospice patients used a structured, in-depth interview with an explicit focus on professional training for spiritual care delivery. The interviews were 30 to 105 minutes in length and were recorded and fully transcribed. Data were collected for 3 months in 2007 by the authors. The 20 patients who participated consisted of 13.8% of the hospice patient population (*n* = 145) during the study period. Patients were clear that spiritual care should be integral to hospice services. The patient's feelings and opinions of spirituality focused around meaning and purpose in life and answers to questions regarding spiritual care were often references to feelings such as, "Professionals should practice asking questions about spiritual care to find natural ways of engaging with patients." Patients' statements included, "All you can do is train somebody to recognize the individual and that they

have needs whether they are nine or ninety, and they need to be listened to and they need to be valued" (Yardley et al., 2009, p. 604). Therefore, delivery of training with a formal evaluation was seen as necessary in this study to assess the practical application of spiritual recommendations to patient care in practice. Provision of spiritual training, therefore, was considered to have the potential to lead developing standards and competencies for organizations on provision of spiritual care.

Spirituality and self-efficacy are both identified as factors that contribute to the management of chronic illnesses and QOL (Adegbola, 2011). Literature showed that the care of patients requires a complex, multidisciplinary team approach with a focus not only on physiological, psychological, and social needs, but also on spiritual needs. Individuals who reported high levels of spirituality and self-efficacy reported high levels of QOL (Adegbola, 2011).

The pretest and posttest SCCS questionnaire (Appendices A and B) was used as the tool to measure nurses' knowledge in providing spiritual care to patients (van Leeuwen, Tiesinga, Middel, Jochemsen, & Post, 2008). The scale was developed in the Netherlands using a sample of students from two bachelor-level nursing schools (n = 197). Construct validity was evaluated by factor analysis and internal consistency was estimated with Cronbach's alpha and the average correlation. In addition, the test-retest reliability of the measure was determined at a 2-week interval between baseline and follow-up (n = 109).

The pretest and posttest SCCS questionnaire consists of 10 questions about spirituality that evaluate the participant's understanding. The pretest and posttest SCCS questionnaire measures six core domains of spiritual care-related nursing competencies. These domains are

labeled as (a) assessment and implementation of spiritual care (Cronbach's alpha = 0.82), (b) professionalization and improving quality of spiritual care (Cronbach's alpha = 0.82), (c) personal support and patient counseling (Cronbach's alpha = 0.81), (d) referral to professionals (Cronbach's alpha = 0.79), (e) attitude toward patient's spirituality (Cronbach's alpha = 0.56), and (f) communication (Cronbach's alpha = 0.71) (van Leeuwen et al., 2008). These subscales showed strong internal consistency, sufficient average interitem correlations, and sufficient test-retest reliability.

Wallace et al. (2008) conducted a study that evaluated a program's effectiveness in improving nursing student's knowledge of spiritual care among older adults, using pretests and posttests to measure students' knowledge about spirituality and spiritual care. The study used a 17-item pretest and posttest tool with a 5-point Likert-like scale that asked respondents to choose an answer from strongly disagree (1) to strongly agree (5) based on their opinion about the item. Construct validity was tested on a sample of 549 nurses. Paired *t* tests were used to compare pretest and posttest junior and senior student scores before and after the spirituality and spiritual care were added to the curriculum. The *t* test results showed a statistically significant positive difference between the pretest and posttest scores. The nursing students had more knowledge and were more comfortable with practicing spirituality interventions after completing the curriculum.

General Literature

I found a growing body of evidence regarding the connection between spirituality and QOL in the literature review. The World Health Organization (WHO, 1998) proclaimed that the definition of *health* included four domains of well-being: physical, mental, social, and spiritual. Many health care education organizations have not encompassed spiritual care as part of their

competency curriculum, although spirituality is a significant aspect of individual well-being. Vilhena et al. (2014) identified psychosocial factors associated with QOL. The study found that patients who demonstrated more positive attitudes had additional social support, adequate treatment, better treatment adherence, a feel-good spirit, were more accepting of disease conditions and, consequently, had increased QOL. The findings contributed to understanding and improving the processes associated with QOL.

A qualitative study by Sterba et al. (2014) explored African-American breast cancer survivors’ and the caregivers’ QOL in the post treatment period with a focus on social and spiritual well-being. The study showed that religiousness and spirituality played a major role in both survivors’ and caregivers’ lives. Beyond practical and emotional support, the provision of spiritual care was essential to overall care. Reviewing the importance of spiritual beliefs and practices with nurses was appropriate to provide nurses with the knowledge necessary to promote spiritual well-being in practice.

Historically, the effect of religion on nursing has been and continues to be profound (Pesut, 2013). However, the spiritual needs of patients are often neglected by health care professionals who are already overstretched by the physical demands of their roles. Despite spirituality being a core component of palliative care national policies, health care professionals have expressed difficulties in delivering the spiritual care by omitting it in practice. A patient’s perspective on professional training to address difficulties was sought in a study by Yardley et al. (2009). This study described each patient’s suggestions for the development and training to deliver spiritual care. For some, spirituality was seen as the root of all that brings meaning.

Wright (2012) expressed that spirituality was a key element to improving nurses' abilities to cope under pressure and remain compassionate toward patients. Spirituality was an addition to the physical care that was provided. A seven-point manifesto for spirituality in nursing was set in place for spirituality in health care, and it called for changes in education and training to allow all nurses to see themselves and patients as needing spiritual support (Wright, 2012). Nurses and students have voiced feelings about providing spiritual care. Wallace et al. (2008) found that nursing students offered a variety of thoughts about how nurses could meet the spiritual needs of their patients; one student believed that it first required having "specific education in spirituality, as well as understanding their feelings about the issue." Five overall themes emerged from the responses, which were listening, understanding and respecting your patient, facilitating, responding, and being a resource. Wallace et al. found that most students believed it was crucial to begin the assessment by listening to patients talk about the things that were most important to them. In addition, spiritual care training was recommended for health care professionals to meet the spiritual needs of patients (Wallace, 2008). Hubbell et al. (2006) argued that inadequate educational preparation might cause nurses to perceive themselves as being incompetent and avoid spiritual matters.

According to Williams (2008), spirituality is a principle-based and intrinsic factor that should be integrated into daily life. It involves motivation and meaning. Spirituality addresses personal needs by providing strength and inspiration (Williams, 2008). Patients may not have spiritual needs met due to the nurses' lack of a strong foundation to provide them with the confidence to deliver spiritual nursing care. Nurses need tools that can facilitate discovery of patients' spirituality; however, spirituality plays a critical role in how patients perceive and cope

with health and illness, nursing students often do not have a strong educational foundation in this area (Wallace et al., 2008).

The challenges to spiritual education are consistent with the barriers reported in the literature, which are barriers related to the nurse and the work environment (Cone & Giske 2013).

Conceptual Models and Theoretical Frameworks

The theory used in the project development was Watson's caring theory. Popular nursing works such as Jean Watson's *Caring Science as Sacred Science* (2005) provided moral grounding for caring (Pesut, 2013). The philosophy and science of caring model has four major notions: the being, health, environment/society, and nursing. The Watson theory was relevant to my project as it promotes holistic health care. The model was used to address the patients' level of overall physical, mental, and social functioning. By using the Watson theory, the staff nurses were assessed for the presence of efforts leading to the absence of illness as it relates to the patients' spirituality. The use of this theory was reflected in how nurses in the project utilized holistic care to meet the spiritual care and needs of the patients.

The installation of caring and promotion of holistic care was essential to the care and cure process for patients with chronic illness. Watson's work is a middle-range explanatory theory that focuses on the human component of caring and the moment-to-moment encounters between the one who is caring and the one who is being cared for, especially the caring activities performed by nurses as they interact with others (Fawcett, Jacqueline, & DeSanto-Madeya, 2012). The nurses in the project were encouraged to use caring as a basis from which to provide

a sense of well-being through assessment of and support for the patients' individual spiritual beliefs.

Summary

Health care professionals have expressed difficulties in delivering spiritual care. Patients would like for the caregivers to have professional training to address both physical health and spiritual health. This project provided spirituality training to nurses so that they could incorporate spiritual care as well as physical care in holistic nursing practice to patients with chronic illnesses.

In this section, I discussed the models and theories used to support the development and conduct of the project. Watson's theory was used to help discuss the relationship between caring and spirituality. Watson's caring model also supported the need for holistic nursing that includes spiritual care. In the next section, I cover the project design and methods. I also discuss the strategies for gathering and analyzing data to evaluate project outcomes.

Section 3: Methodology

The long-term goal of this project was to promote spirituality assessment and nursing interventions to improve outcomes for patients with chronic illnesses seen in a clinic setting. The short-term goal of the project was to increase the knowledge of nurses based on an educational needs assessment that identified a lack of knowledge related to spiritual care.

In this section of the paper, I cover the project design and methods. I also address the strategies for gathering and analyzing data for this project. I use a descriptive methodology to identify the outcomes of the project. Nurses are asked during a staff meeting to participate voluntarily in a spirituality assessment and training. The nurse manager distributed the training information. The content delivered is consistent with evidence-based literature on spirituality and providing care and planning for interventions to promote spiritual care.

Project Design and Methods

I used a pretest/posttest, descriptive quantitative design that compared test scores before and after spirituality training. Construct validity demonstrates assurance by using the SCCS as the pretest/posttest questionnaire. The managers helped to deliver the "SCCS pretest questionnaire," the training evaluation, and the "SCCS posttest questionnaire" to participants. The participants' scores on the questionnaire were compared before and after the spirituality training to determine whether the educational intervention increased spirituality knowledge. The potential participants were asked to participate after approval from the Walden University Institutional Review Board (IRB) was obtained. Approval from the organization where the project occurred was also required and was obtained prior to data collection. During a selected nursing staff meeting, the nurses were asked to participate voluntarily.

Population and Sampling

Project participants were recruited through a staff meeting, posters, e-mails, and website announcements. The nurse participants were at least 18 years of age and able to read and write English. Participants who voluntarily participated were given a consent form to review and to keep as their record of consent. The survey was given to the nursing staff at a staff meeting. The managers helped to deliver the “SCCS pretest questionnaire,” the training evaluation, and the “SCCS posttest questionnaire” to participants at the end of the staff meeting. I gave the staff 1 week to complete the training. Nurses who missed the staff meeting were allotted 1 week to complete the pretest, the training, the posttest, and the training evaluation. Participants who were not able to attend the staff meeting placed their completed surveys in a designated locked box. An invitation e-mail was sent to all staff members related to the training before the staff meeting, and another e-mail was sent letting staff know that they had 1 week to volunteer for participation in the training. The training material was linked in the invitation e-mail. Therefore, additional volunteers participated by printing the spiritual training and anonymously placing the SCCS pretest and posttest (Appendices A and B) and the training evaluation in a locked mailbox that was located in the break room (Appendix C). The mailbox remained in the break room for 1 week after the initial distribution of the training during the monthly in-service. I recruited an anonymous convenience sample of 37 nurses, which was at least 25% of the care staff.

Data Collection

Subjects were recruited from a clinical organization. The recruitment process was completed by staff at the organization via e-mail invitations and posters hanging in the offices and break rooms throughout the organization. Participants received training materials in the form

of a packet of information on spirituality and spiritual care that could be used in the practice setting when working with patients who have a chronic illness. The packet included the directions, the informed consent form, the pretest, the posttest, the training materials, and the course evaluation. Participants were invited to participate via e-mail or at a staff meeting. The participants were given a pretest and then the education material. The posttest followed after completion of the pretest and review of the training material in the packet. Participants were then asked to give their opinion of the training by completing an evaluation survey that was at the back of the training packet. There were no incentives offered or given for participation in the project.

The educational content was delivered at the monthly staff meeting/in-service. The spirituality handout was based on the literature (AACN, 2008; Adegbola, 2008, 2011; Barnum, 2010; Li-Fen et al., 2012; van Leeuwen et al., 2009). The pretest and posttest SCCS questionnaire (Appendices A and B) was used as the tool to measure nurses' knowledge in providing spiritual care to patients (van Leeuwen et al., 2008). The scale was developed in the Netherlands using a sample of students from two bachelor-level nursing schools ($n = 197$). Construct validity was evaluated by factor analysis and internal consistency was estimated with Cronbach's alpha and the average interitem correlation. In addition, the test-retest reliability of the measure was determined at a 2-week interval between baseline and follow-up ($n = 109$).

The pretest and posttest "SCCS questionnaire" consists of 10 questions about spirituality that evaluate the participant's understanding. The pretest and posttest SCCS questionnaire measures six core domains of spiritual care-related nursing competencies. These domains are labeled as (a) assessment and implementation of spiritual care (Cronbach's alpha = 0.82), (b)

professionalization and improving quality of spiritual care (Cronbach's alpha = 0.82), (c) personal support and patient counseling (Cronbach's alpha = 0.81), (d) referral to professionals (Cronbach's alpha = 0.79), (e) attitude toward patient's spirituality (Cronbach's alpha = 0.56), and (f) communication (Cronbach's alpha = 0.71) (van Leeuwen et al., 2008). These subscales showed good internal consistency, sufficient average correlations, and good test-retest reliability.

Key concepts in the education handouts included information that defined the meaning of *spirituality*. The mandates from the International Council of Nurses and the American Nurses Association about spiritual care were included in the training material. Information about how nurses relate to spiritual care and how nurses rate their competency to address spirituality was included. Some barriers to delivery of spiritual care were also reviewed in the educational materials. The participants received some information on interventions for spirituality and a review of the HOPE Spirituality Assessment that could be used in practice. Communication, referrals, and cultural and spirituality sensitivity were important topics also covered in the education handouts. The information reviewed how spirituality affects QOL in chronic illness and how nurses can assist with spiritual care when necessary.

The educational material included a pocket size HOPE Spirituality Assessment for participants to keep. The evidence-based training materials were available for distribution at the end of the monthly staff in-service and online and the tests were collected in a locked box in the organization's break room. An evaluation survey, using Likert scale responses was available to all participants after the educational intervention was completed. The evaluation of the training was completed immediately after completion of the posttest. The evaluation survey was also

anonymous and was placed in the allotted locked box that was located in the break room. The evaluation survey was used to solicit feedback on the training.

Pretests and posttests were administered to evaluate the program's effectiveness in improving participants' knowledge of spiritual care with chronically ill adults. A standard instrument called the "SCCS questionnaire" was used as the pretest and posttest. The pretest and posttest "SCCS questionnaire" was used as a tool to measure nurses' knowledge in providing spiritual care to patients (van Leeuwen et al., 2008).

Permission was obtained from the creators of the instruments as required by the IRB. The "SCCS questionnaire," by van Leeuwen et al. (2009) required permission. Renee van Leewen granted permission via e-mail. All other instruments used in the study were open to the public for use. The instruments were used according to guidelines from the developers. The unidentified data collected will be kept for 5 years on a password protected memory stick as required by the Walden University IRB policy.

Data Analysis

The primary instruments used for data collection and analyzes in the project were the pretest and posttest SCCS questionnaires. As noted in Appendix A, the questions on the SCCS are related to the training that was delivered on spirituality, spiritual care, and caregiving practices. The Likert scale seen in Appendix C was used to evaluate the effectiveness of the training. I entered the answers and analyzed them using the Survey Monkey data analysis tool. This tool generated descriptive statistics, which demonstrated respondents' knowledge of spirituality. Due to my professional relationship with the project organization and to ensure that the participants remained anonymous, the questionnaire did not collect names or other

identifiable data. Ordinal measurement using a Likert scale as seen in Appendix B is used by the student's to evaluate how nurses rank their knowledge before and after education and to evaluate the education intervention. I used *t* tests to compare pretest and posttest measures of scores on the SCCS. I also used the raw data to examine the answers provided by the participants from the pre- and post questionnaire regarding their knowledge of spiritual care.

Protection of Human Subjects

Eliminating the use of names in the project protected the nurses who participated. Allowing participants to chose an anonymous ID number's protected each subject's identification. This number was also used for the Likert survey evaluation tool and the pretest and posttest questionnaires. The nurse manager helped to ensure the delivery and return of the tests. A Likert evaluation of the training was attached to each training handout. The organization administrator signed the data use agreements. Consents were included in the educational information and given to each participant.

Walden University IRB approval was obtained prior to delivery of the training and the collection of pretest, posttest, and evaluation data. The Walden University IRB approval number for this project was 05-21-15-0364978.

Project Evaluation Plan

To evaluate the program's effectiveness in improving participants' knowledge of spiritual care with chronically ill adults, pretests and posttests were administered using the SCCS. The data were compared using a *t* test statistic. The summative evaluation assessed whether the educational intervention was an effective method to strengthen the nurses' knowledge of spirituality and spiritual care. The pretest and posttest SCCS questionnaires completed by the

participants provided information on the effectiveness of the educational intervention and its delivery. I analyzed the data and responses that students furnished on pre- and posttest questionnaire.

Summary

In Section 3, I discussed the project design, population, sample, and data collection methods and analyses. This project was designed to provide the education necessary to support spiritual health care delivery by providers in a clinic setting. Organizations must significantly invest in spirituality and assessment training and workshops for clinical staff to improve approaches related to using spirituality in nursing care to promote QOL. This project provided an opportunity to gather information and organize it in a manner that is presentable and acceptable to trainees. I collected evidence-based information on spirituality in nursing and the importance of spiritual care, and I collected information on how to deliver effective spiritual care in practice. Opportunities to engage nurses in learning activities may result in an increased level of comfort for nurses and improved outcomes for patients. It is important that nurses provide holistic care, which includes attention to the mind, body, and spirit. Nursing students and professionals must receive appropriate training to develop their abilities to provide spiritual care (Li-Fen et al., 2012).

Section 4: Findings, Discussion, and Implications

The purpose of the project was to determine whether training would change nurses' understanding of the role of spirituality in nursing practice. Nurses from one organization that worked with chronically ill patients took a pretest, then read educational materials, and afterward retook the test. The project allowed me to compare the pretest and posttest results to determine whether nurses demonstrated a better understanding of practicing spirituality in the project setting after the training. The training was offered to all of the nursing staff through e-mail, a flyer posted in the break room, a posting on the organization website, and an invitation delivered by the nurse manager to participate in a staff meeting. A link provided in the project information allowed access to the pretest and posttest questionnaire, which was created and posted on Survey Monkey. The nurses were asked to participate voluntarily in the training after a monthly in-service staff meeting. The staff meeting and training were conducted during regular work hours to eliminate the barrier of not having free time after work to complete the training and questionnaires.

Participants' answers to the pretest and posttest questions were anonymous, and no identifying information was collected. The data analysis included individual responses (n = 37) from nurses employed in one organization. The data is analyzed by using the Survey Monkey tool, which provides result summaries.

Survey Results

Participant Characteristics

A total of 37 nurses participated in the training and 100% completed the entire training, the pretest and posttest questionnaires, and the course evaluation. The majority of the

participants were female (86.49%); more than half (62.16%) were African Americans; Caucasians were the second largest racial/ethnic group in attendance (16.22%). The remaining 21.62% were Asian, Hispanic, Native Americans, and other. The mean age for participants was between 30 and 39. Participants were also asked their age as seen in Table 1. Tables 1 through 29 depict the pretest and the posttest data for each of the questions.

Table 1

Age of Participants

N = 37

Answer choices	Responses
≤17 y	0.00%
18–20 y	2.70%
21–29 y	27.03%
30–39 y	35.14%
40–49 y	16.22%
50–59 y	13.51%
≥60 y	5.41%

Table 2

I show unprejudiced respect to a patient's spirituality/religious beliefs regardless of his or spiritual background

N = 37	Pretest	Posttest
Strongly disagree	2.70%	0.00%
Disagree	10.81%	0.00%
Neither	35.14%	5.41%
Agree	37.84%	43.24%
Strongly agree	13.51%	51.35%

	M	*SD*	*p* value
Pretest	3.42	0.95	
Posttest	4.46	0.60	
			<.0001

Table 3

I am open to patient's spirituality/religious beliefs even if they differ from my own.

N = 37	Pretest	Posttest
Strongly disagree	2.70%	0.00%
Disagree	16.22%	0.00%
Neither	32.43%	5.41%
Agree	37.43%	43.24%
Strongly agree	10.81%	51.35%

	M	*SD*	*p* value
Pretest	3.38	0.97	
Posttest	4.46	0.60	
			<.0001

Table 4

I can listen actively to a patient's "life story" in relation to his/her illness/handicap.

N = 37	Pretest	Posttest
Strongly disagree	5.41%	0.00%
Disagree	13.51%	0.00%
Neither	35.14%	2.70%
Agree	35.14%	35.14%
Strongly agree	10.81%	62.16%

	M	*SD*	*p* value
Pretest	3.32	1.01	
Post test	4.59	0.54	
			<.0001

Table 5

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

N = 37	Pretest	Posttest
Strongly disagree	5.41%	0.00%
Disagree	13.51%	0.00%
Neither	40.45%	00.0%
Agree	29.73%	45.95%
Strongly agree	10.81%	54.05%

	M	*SD*	*p* value
Pretest	3.37	1.00	
Posttest	4.54	0.50	
			<.0001

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Table 6

I can report orally or in writing on a patient's spiritual needs.

N 37	Pretest	Posttest
Strongly disagree	16.67%	0.00%
Disagree	22.22%	2.78%
Neither	33.33%	5.56%
Agree	22.22%	52.78%
Strongly agree	5.56%	38.89%

	M	*SD*	*p* value
Pretest	2.78	1.13	
Post test	4.28	0.69	
			<.0001

Table 7

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

N = 37	Pretest%	Posttest%
Strongly disagree	16.22%	0.00%
Disagree	35.14%	5.56%
Neither	32.43%	8.33%
Agree	10.81%	50.00%
Strongly agree	5.41%	36.11%

	M	*SD*	*p* value
Pretest	2.54	1.06	
Posttest	4.17	0.80	
			<.0001

Table 8

I can provide patients with spiritual care.

N = 37	Pretest	Posttest
Strongly disagree	13.51%	0.00%

Disagree	32.43%	5.56%
Neither	35.14%	13.89%
Agree	13.51%	52.78%
Strongly agree	5.41%	27.78%

	M	*SD*	*p* value
Pretest	2.65	1.05	
Post test	4.03	0.80	
			<.0001

Table 9

I can help a patient continue his or her daily spiritual practices (including providing an opportunity for rituals, prayer, meditation, reading spiritual literature, listening to spiritual music).

n = 37	Pretest	Posttest
Strongly disagree	16.22%	0.00%
Disagree	29.73	2.70%
Neither	32.43%	24.32%
Agree	16.22%	45.95%
Strongly agree	5.41%	27.03%

	M	*SD*	*p* value
Pretest	2.65	1.10	
Posttest	3.97	.79	
			<.0001

Table 10

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

N = 37	Pretest	Posttest
Strongly disagree	16.22%	0.00%
Disagree	32.43%	0.00%
Neither	32.43%	21.62%
Agree	16.22%	51.35%
Strongly agree	2.70%	27.03%

	M	*SD*	*p* value
Pretest	2.57	1.03	
Posttest	4.05	.70	
			<.0001

Table 11

Within the department, I can identify problems related to spiritual care in a peer discussion session.

N = 37	Pretest	Posttest
Strongly disagree	18.92%	0.00%
Disagree	29.73%	8.11%
Neither	32.43%	21.62%
Agree	16.22%	40.54%
Strongly agree	2.70%	29.73%

	M	*SD*	*p* value
Pretest	2.54	1.06	
Posttest	3.92	.91	
			<.0001

All results were statistically significant. More than 90% of the participants on the posttest either agreed or strongly agreed that they show unprejudiced respect for a patient's spiritual beliefs/background. This was an increase from 51.35% of participants on the pretest. More than 95% of the participants on the posttest either agreed or strongly agreed with being able to listen actively to a patient's "life story" about his/her illness/handicap. This was an increase from 45.95% of participants on the pretest. One hundred percent of the participants on the posttest either agreed or strongly agreed with the need to have an accepting attitude in dealings with a patient (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere, and personal). This was an increase from 40.54% of participants on the pretest. More than 90% of the participants on the posttest either agreed or strongly agreed they had the competency to report orally or in writing on a patient's spiritual needs. This was an increase from 27.78% of participants on the pretest. More than 86% of the participants on the posttest either agreed or strongly agreed they know when they should consult a spiritual advisor

concerning a patient's spiritual care. This was an increase from 16.22% of participants on the pretest. At least 77% of the participants on the posttest either agreed or strongly agreed with having competency in providing patients with spiritual care. This was an increase from 18.92% of participants on the pretest. More than 70% of the participants on the posttest either agreed or strongly agreed with having the competency to help a patient continue his or her daily spiritual practices. This was an increase from 21.63% of participants on the pretest. Over 70% of the participants on the posttest either agreed or strongly agreed with being able to attend to a patient's spirituality during the daily care. This was an increase from 18.92% of the participants on the pretest. At least 70% of the participants on the posttest either agreed or strongly agreed that they had the competency to identify problems related to spiritual care in a peer discussion session. This was an increase from 18.92% of the participants on the pretest. Ninety percent of the participants on the posttest either agreed or strongly agreed with being open to a patient's spirituality/religious beliefs even if they differed from their own. This was an increase from 48.24% of participants on the pretest.

Training Evaluation

Participants completed the training evaluations after they had completed the training session. The questions in the SCCS scale were asked to get feedback from participants on how they viewed the training. Feedback will be helpful with future staff education and training regarding spiritual care. When asked on the evaluation about the environment of the training, 100% of the respondents either somewhat agreed, agreed, or strongly agreed that the environment was comfortable. The following tables present the responses from participants about the training session.

Table 12

Q1 The training environment was comfortable.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	*n* = 37	
0.00%	0.00%	0.00%	8.11%	43.24	43.24%		
						M	5.41
						SD	0.63

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Table 13

Q2 The training material was informative.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	*n* = 37	
0.00%	0.00%	0.00%	5.41%	40.54%	54.05%		
						M	5.49
						SD	0.60

Table 14

Q3 I will use the information obtained from this training in practice.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	*n* = 37	
0.00%	0.00%	0.00%	16.22%	43.24%	40.54%		
						M	5.24
						SD	0.71

Table 15

Q4 Spiritual care is an essential component of holistic nursing.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	*n* = 37	
0.00%	0.00%	0.00%	0.00%	35.14%	64.86%		
						M	5.65
						SD	0.48

Table 16

Q5 Spiritual wellbeing is an important part of health promotion.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	n = 37	
0.00%	0.00%	0.00%	2.70%	32.43%	64.86%		
						M	5.62
						SD	0.54

Table 17

Q6 I am able to identify spiritual distress.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	n = 37	
0.00%	0.00%	0.00%	18.92%	40.54%	40.54%		
						M	5.22
						SD	0.74

Table 18

Q7 I am not interested in the topic of spirituality.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	n = 37	
62.16%	16.22%	5.41%	0.00%	8.11%	8.11%		
						M	2.00
						SD	1.64

Table 19

Q8 I feel adequately prepared to provide spiritual care.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	n = 37	
0.00%	0.00%	0.00%	24.32%	35.14%	40.54%		
						M	5.16
						SD	0.79

Table 20

Q9 I may respond to spiritual distress by listening and being concerned.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	*n* 37	
0.00%	0.00%	0.00%	0.00%	54.05%	45.95%		
						M	5.46
						SD	0.50

Table 21

Q10 I feel that spirituality is a personal matter but it can be discussed with a patient.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	*n* = 37	
2.70%	0.00%	0.00%	0.00%	56.76%	40.54%		
						M	5.30
						SD	0.87

Findings in the Context of the Literature

The project results indicated that some participants did understand that spiritual care is a significant aspect of care; however, they would refer the patients to a spiritual advisor or professional who they deemed to be more qualified to address the issues. The results showed that the participants did not feel that they were prepared at pretest measurement to provide the spiritual care for patients. These findings align with those of White (2006) who stated that usually nursing staff recognized spiritual concerns but many felt unable to respond personally.

The nursing profession has always required competencies and continuing educational hours; however, there continue to be barriers to obtaining the necessary professional training and competencies needed for certain areas of practice. The stakeholders of organizations must understand the competencies that the nurses they employ have and need. The stakeholders must be accountable for providing competency evaluations and then the required time for staff to

receive the proper training. Nurses play a very important role in each patient's wellbeing and assessment of each patient's needs. For nurses to meet these needs, training and competency in spiritual care may be needed. Nurses and staff would like to be able to provide effective care, and they are willing to participate in training when the time and resources are available and provided by the stakeholders of the organizations. An important outcome of this project was to show that training could improve nurses' knowledge of how to provide comprehensive, holistic, spiritual care.

Nurses may be reluctant to provide spiritual care due to a lack of knowledge. However, many patients believe in a higher power (Lind et al., 2011). The spirituality training material provided the nurses with solutions to the misgivings that they had in responding to the needs of the patients as it affected the quality of their care delivery. The project examined how nurses felt about having the ability to provide spiritual care. The project also highlighted the practice issues nurses have with providing care to a patient who relies on their spirituality for healing and wellbeing.

Watson's (1999) theory of caring was used to develop the capstone project. The Watson caring theory emphasized the need to understand one's transpersonal self and spiritual practices as a requirement for a caring conscious mind. Watson (1999) wrote that human caring requires one to be truly present in supporting the patient's belief system and enabling a personal interaction between the self (nurse) and the one being cared for (patient). Watson's theory discussed going past the ego self and unlocking others' feelings with sensitivity and compassion. The development and maintenance of a helping, trusting, and thoughtful, and kind relationship are important aspects of the human caring theory. Watson (1999) explained that being present

and supportive of the patient's expression of both positive and negative feelings shows the patient creative use of self to promote healing. She expressed how caring-healing practices and genuine interaction in a teaching-learning experience are all aspects of human caring. Creating a subtle healing environment whether it is physical or non-physical is the basis of the theory. Watson believed in supporting the patients' basic needs with an intentional caring consciousness that included ministering to human needs such as comfort, dignity, and peace. Nurses should review the human caring theory periodically to ensure that their practice provides care to the patient's mind, body, soul, and spirit.

Implications for Policy

The practicing spiritual care nurse may be able to function as a coordinator between state clinical nurses and national organizations supporting spiritual care and curriculums. Spiritual care nurses may be an advocate for required education and training within the higher degree educational systems. Particular actions consist of developing common principles associated with spiritual nursing care and improving outcomes for patients with chronic illnesses. Leadership established by actions, promote access to spiritual care, which may include competency programs, certifications, and ongoing training. Experienced spiritual care nurse leaders can be an activist for direct change in legislation as well as policy. This leadership can decrease gaps across clinical organizations and increase the quality of spiritual care to meet the needs of patients. This translation of knowledge into policy and practice may promote spiritual and cultural understanding and reduce health disparities globally and locally.

Implications for Practice

Chaplains are often available in hospitals, and, therefore, nurses have frequently steered away from providing spiritual care directly to their patients. However, with the lack of resources and the changes in health care policy, the resources and funds have been limited. Providing certain needed services for effective spiritual health care has decreased and the decrease in services has resulted in decreased employment of an adequate number of chaplains. Therefore, it would be economical for organizations to provide nurses with the right tools, resources, and training to provide spiritual care at the bedside. Adequate tools and training may enhance a nurse's confidence in providing holistic care that includes spiritual care.

Watson is a well-known theorist who was successful in differentiating medicine from nursing. She maintained her belief that nursing "needs to emerge as a developed health profession that has been proficient in collaborating with the medical profession" (Watson, 1996, p. 146). A spiritual care nurse will be enabled to utilize Watson theory of caring to apply analytic methods that may identify, develop, implement and evaluate the best spiritual care practices to advance health care. Training in spiritual care will allow nurses to practice and partner with other clinical professionals to cultivate interprofessional teams that can exchange information effectively to promote health and develop patient outcomes. Watson's work was an attempt to express a "nursing-qua-nursing" perspective rather than what she regarded as the current "nursing-qua-medicine" perspective embraced by so many nurses, (Watson 1996, 1999). Therefore, nurses may develop skills by utilizing the "Watson's caring theory" to practice spiritual nursing care. Finally, the results of this project can influence stakeholders to perform

spirituality competency evaluations and initiate spiritual care training of staff based on the identified gaps in knowledge.

Implications for Future Research

The findings applied from this project will enhance future research by expanding nursing knowledge related to the spiritual scope of practice of nurses. Further research on spirituality training and interventions is necessary to determine how nurses can engage effectively in the practice of spiritual care. This DNP project allowed me to collect data that would supply solutions to the barriers that disallow nurses to get proper training in spiritual care. The findings of the DNP capstone can significantly contribute to evidence-based spiritual nursing care being provided to chronically ill patients. This project has provided a solution to the decreased competency and knowledge that nurse’s hold to provide quality spiritual care. The competency skills found through this project can significantly increase the knowledge and ease feelings of incompetency when assessing and intervening in a patient’s spiritual needs. The project revealed that nurses have an interest in learning and providing spiritual care as revealed by responses to the survey that was administered. The next step in spiritual care and holistic care is certifications that will ensure proper training.

Implications for Social Change

Spiritual training and practice opportunities provided to nurses and other health care professionals will help the development and confidence of providers and professionals to provide holistic spiritual care that may have a positive impact on chronically ill patients’ QOL. The philosophical underpinnings of nursing have positioned the profession well to implement spiritual interventions in practice, propel the development of theory, and build a body of

evidence to promote the QOL for persons with chronic illnesses (Adegbola, 2002). Nurses can improve care by incorporating interventions that will heal the spirit and create a balance that has the potential to improve QOL. Dharma-Warden et al., (2004) agreed that patients' QOL serves as a predictor, providing prognostic input regarding survival, well-being and QOL. Spiritual intervention's may also give persons affected with chronic illnesses the opportunity to experience overall satisfaction.

Implications for Education and Training

Nurse leaders must follow, translate, and apply findings of spiritual care and its benefits to patient care. Nurse educators can serve as preceptors of spiritual care, and they can provide continuing education. Educators can perform a self-assessment of teaching skills to educate others. Leadership is demonstrated by participation or development of spiritual nursing care education in local, regional, and national venues. Nursing leaders and educators can participate in the development of spirituality nursing curricula for nurses. Spiritual nursing care for patients who believe in spiritual healing is essential for coping with their chronic condition.

The most challenging barriers to initiating spirituality training for the agency nurses in this project were the time constraints. Stakeholders must allow time for staff training or make this training a part of the organization's orientation program. All of the participants agreed that they would use the information obtained from the training in practice. All of the participants also agreed that spiritual health is an essential aspect of health promotion.

Project Strengths and Limitations

Strengths

All of the participants volunteered to take part in the education and did not feel obligated

to do so. They all appeared to be very interested in the training. Some wanted to share their experiences and the different situations that they had encountered regarding spirituality during patient care. The participants all agreed that spiritual care is a vital factor in the delivery of holistic nursing and, therefore, they were interested in learning how to provide it as part of quality care. All participants completed the entire training and answered all of the questions on the pretest and posttest independently without discussion until the training was complete by each participant. The training was offered right after a mandatory staff meeting during work hours, which meant that a reliable number of participants were able to partake in the training. Participants were honest on the pretest, admitting that they did not know how to provide spiritual care. Finally, over 80% of the participants answered that they would use the information in their practice.

Limitations

Time constraint was one of the limitations and therefore the complete survey was not given to the students. The project did not use all of the questions in the SCCS survey that was used to assess knowledge of spiritual care. The questionnaire was shortened due to the time constraints for the training. Another limitation was that the training was presented to only one agency in the surrounding area. There are over 50 clinics within a 30-mile radius that could have participated. However, only one agency was presented this training. One agency does not represent the true diversity of agencies and nurses in Cumberland County who serve chronically ill patients. Therefore, the lack of using other organizations may have prevented obtaining representative feedback from nurses working in clinics and home health care organizations.

An additional limitation was the self-study teaching handouts that were used to present

the training. The self-study format did not allow interaction with learners and eliminated the opportunity for them to ask or get answers to questions. A final limitation was that the training was deliberately brief to recruit an increased number of participants (Shi et al., 2001).

Recommendations

According to the results of the survey, most participants felt that they were not prepared adequately to provide spiritual care. Therefore, I would recommend nurse-educators present an interactive training of at least 60 minutes in length. Nurse educators should be encouraged to interact with the nurse participants to ensure all questions are addressed by a professional trained in provision of spiritual care. Interaction will also allow the instructor to evaluate competency in spiritual care during the training and provide additional information or education as necessary. Carson et al. (1986) stated that spiritual care is a vital dimension of health that has been neglected in the nursing school classroom due to a lack of appropriate teaching methods and emphasis. Recommendations for future implementation of spiritual care training would include the use of the SCCS questionnaire to evaluate outcomes. I also recommend presenting this training program to a variety of stakeholders and agencies to allow feedback from diverse organizations and nurses.

Analysis of Self

Scholar

The doctoral project allowed me to apply scholarship to practice. The project enabled me to identify a clinical problem and implement training to address the problem, which was a nursing knowledge and skill deficit. The project enabled nurses to obtain training on spirituality in nursing care and answer questions on the pretest and posttest that were significant to spirituality

in nursing practice. This project can be adopted and implemented in other practice settings to educate nurses on ways to attend to patients' spiritual needs. Growth in scholarship exhibited through the production of an educational training module can be used successfully to increase spiritual care knowledge, an area of significance to quality nursing practice. The evaluation of the project resulted in positive peer responses to my work. Participants responded positively to the material, the time it took to review the material, and the environment in which it was presented.

As a DNP student scholar, I was enabled to recognize gaps in spiritual care and the need for education and to develop training materials for nurses. I was able to use my scholarly education to collect as well as analyze appropriate data to develop, deliver, and evaluate a spirituality nursing care educational training using evidence-based literature. The data derived from a sample of practicing nurses demonstrated a lack of knowledge in spiritual nursing care; however, the nurses had a great interest in learning to address patients' spiritual needs in practice.

Practitioner

Nurses may be reluctant to provide spiritual care due to a lack of knowledge. However, many patients believe in a higher power. The project allowed me to explore the knowledge that nurses have as it relates to providing spiritual care. This project gave me an opportunity to reevaluate my spirituality and how I relate to others who require spiritual care. I found evidence-based literature that supplied tools and training materials to support nurses who are interested in spiritual nursing care. Spiritual care, therapeutic touch, holistic care, and spiritual healing and wellbeing have always been of interest to me. The project brought me closer to my passion of

spiritual care by giving me courage and knowledge to expand my nursing practice. I will continue to search for evidence-based spiritual nursing care literature to assist the patients that I serve and educate the peers that I encounter.

Project Developer and Manager

In this project, I assumed the role of an advocate for the promotion of spiritual care. I realized that nurses have much knowledge; however, there may be additional information needed to enhance spiritual nursing practice that could increase the potential to deliver quality spiritual patient care. Therefore, competency testing is an important aspect of the delivery of spiritual nursing care. I learned that project development and implementation take time and are complex. It takes patience and a clear view of the purpose to make changes in an organization. I will continue to research and develop spiritual nursing training tools. This project has given me the confidence to manage, implement, and evaluate programs in an organization.

Professional Development

This project has enhanced my knowledge and assisted in my growth as a professional nurse educator and researcher. The capstone project allowed me to collect and analyze data to support the importance of having nurses trained in spirituality. The findings of the capstone project will also allow me to disseminate to agencies throughout the community what I have learned throughout this educational journey. I will provide the results of my research to the organization in which I conducted the project. The organization may adopt the training and implement staff development on the topic. This education will significantly decrease the anxiety or fear that the nurses may have when addressing spirituality with a patient. The research will be disseminated to various agencies and in peer-reviewed journals, such as the Journal of Religion

and Health. Publishing my article will allow other scholar-practitioners who read peer-reviewed journals to use the work that has been done to deliver similar trainings. I desire to continue research in this significant area of inquiry related to how spirituality training and interventions contribute to nursing practice. Publishing and presenting the results of the project will be an important step in my professional development.

Summary and Conclusions

This project contributed to the development of spiritual care competence among professional caregivers. The project provided nurses with training that gave them the opportunity to explore and enhance their knowledge of spiritual care. The methodology included a convenience sample of participants from a single organization that cared for chronically ill patients. The training that was given in one single session that took approximately 15 to 30 minutes and was given immediately after a staff meeting. The participants were also able to take the training electronically.

The results of the project showed that participants had a better understanding of spiritual care after they completed the training. Nurses were asked pre and post training to rate their knowledge of the following: spiritual care assessment; implementation; professionalization; cultivating personal care; spiritual attention; patient therapy; referral to specialists; approaches toward the patients' spirituality; and rapport. The project conducted in the health care organization was with nurses who worked with patients suffering from chronic conditions. The results demonstrated that nurses were lacking the education and training needed to provide quality spiritual care when needed among the population that was being served. However, after training, nurses did demonstrate a better understanding of spiritual care. Therefore, spiritual care

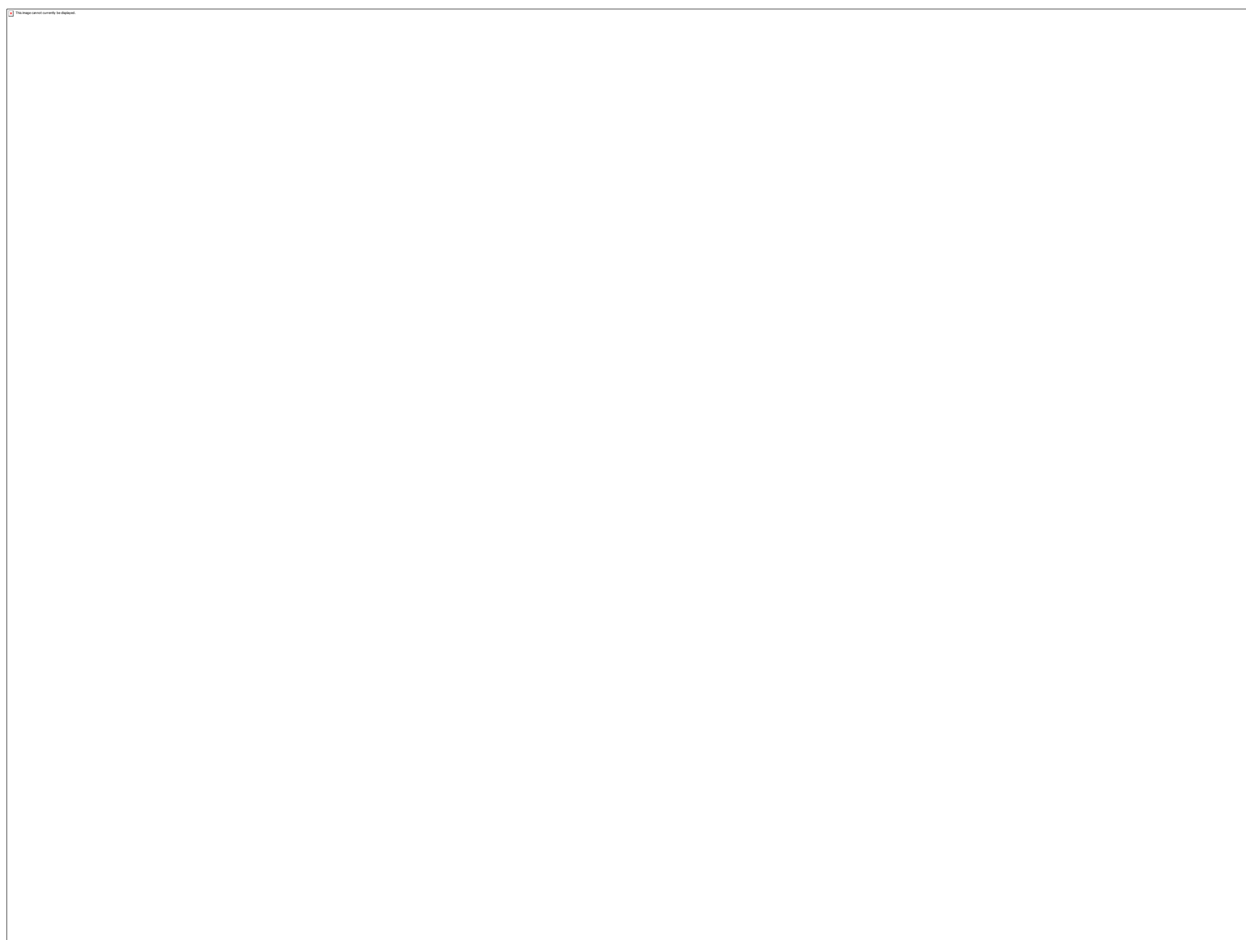
training and continuing education can be used in agencies and organizations to improve the knowledge and skills to provide quality holistic care.

Section 5: Scholarly Product

The purpose of the project was to provide nurses with evidence-based educational information to enhance knowledge of and competence in assisting patients to achieve better QOL through the use of spiritual care. The spirituality educational training program was delivered using handouts. The handouts included a PowerPoint presentation, pretest and posttest questionnaires, the HOPE Spiritual Assessment, and a sample spiritual nursing care plan. This training package provided information to help the students understand spirituality and how nurses can provide spiritual care.

The package of training materials and evaluation tools are attached as Appendices A, B, C, D, E, F, and G. In addition to delivering the training package to the nurse manager, the project results will be presented to nurses and other stakeholders in the organization who served as the site for this project. A poster board has been created as a scholarly product to use for dissemination at conferences and for presentation of findings to organizational stakeholders. These stakeholders will determine whether to continue with spiritual training and assessments at the clinical site.

Poster Board Presentation



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Appendix A: Spiritual Care Competence Scale

Pretest competency evaluation tool

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

Please circle the number based on your current knowledge before the training.

Attitude towards patient spirituality

1 I am open to a patient's spiritual/religious beliefs, even if they differ from my own
1-2-3-4-5

2. I am aware of my personal limitations when dealing with a patient's spiritual/religious beliefs
1-2-3-4-5

Communication

3. I can listen actively to a patient's 'life story' in relation to his or her illness/handicap
1-2-3-4-5

4. 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

5. I can report orally and/or in writing on a patient's spiritual needs
1-2-3-4-5

6. I can tailor care to a patient's spiritual needs/problems through multidisciplinary consultation
1-2-3-4-5

Referral

7. I know when I should consult a spiritual advisor concerning a patient's spiritual care
1-2-3-4-5

Personal support and patient counseling

8. 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

9. I can attend to a patient's spirituality during the daily care (e.g. physical care)
1-2-3-4-5

Professionalization and improving the quality of spiritual care

10. Within the department, I can contribute to quality assurance in the area of spiritual care
1-2-3-4-5

Thank you!

Appendix B: Spiritual Care Competence Scale

Posttest competency evaluation tool

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

Please circle the number based on your current knowledge before the training.

Attitude towards patient spirituality

1. I am open to a patient's spiritual/religious beliefs, even if they differ from my own
1-2-3-4-5

2.. I am aware of my personal limitations when dealing with a patient's spiritual/religious beliefs
1-2-3-4-5

Communication

3. I can listen actively to a patient's 'life story' in relation to his or her illness/handicap
1-2-3-4-5

4. 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

5. I can report orally and/or in writing on a patient's spiritual needs
1-2-3-4-5

6. I can tailor care to a patient's spiritual needs/problems through multidisciplinary consultation
1-2-3-4-5

Referral

7. I know when I should consult a spiritual advisor concerning a patient's spiritual care
1-2-3-4-5

Personal support and patient counseling

8. 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

9. I can attend to a patient's spirituality during the daily care (e.g. physical care)
1-2-3-4-5

Professionalization and improving the quality of spiritual care

10. Within the department, I can contribute to quality assurance in the area of spiritual care
1-2-3-4-5

Thank you!

Appendix C: Student Survey of Spiritual Care (SSSC) Meyer, 2003

Please circle how you rate each question about the training by using the scale:

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

1. The adequacy of training material is sufficient for nursing practice

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

2. The training environment was comfortable

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

3. The training material was informative

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

4. I will use the information obtained in practice

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

5. Spiritual care is an essential component of holistic nursing care

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

6. Spiritual wellbeing is an important part of health promotion

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

7. I have sufficient knowledge to conduct a spiritual assessment

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

8. I am able to identify spiritual distress

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

9. I feel adequately prepared to provide spiritual care

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

10. I feel spirituality is a personal matter that should be discussed with the patient

1=strongly disagree 2= disagree 3= somewhat disagree
4= somewhat agree 5= agree 6=strongly agree

Additional comments on helping us improve the training are welcome

____

____

Thanks for your evaluation of the training. Have a spirit filled day!

Appendix D: Spirituality Training Nursing Care Plan Handout

Nursing care plan used to provide spiritual care

Subjective/Objective Assessment	Nursing intervention's
1) Expressing concerns about the meanings of life, belief and value systems, life goals, suffering, death; or verbalizing feelings of meaninglessness, directionless, objectiveless, hopelessness, or helplessness	(1) Helping patients to search for the meanings of life, beliefs, value systems, or death, and set reachable life goals by writing down (a) their perceived contemporary self and the expected self from their own and others' perspectives, (b) the most important and the least important things in life, (c) how to spend time on the most important and the least important things in life (d) short and long-term goals and workable strategies to achieve these goals
(2) Expressing a sense of absent-mindedness, loneliness, psychological pain, guilt feelings, sense of shamefulness, or inner conflicts about beliefs/value systems	2) Introducing the following books to or reading them to patients: biographies of successful persons, joke books, humorous writing, comic books, poems, impromptu verse and
(3) Expressing having no will to change, modify or give up his/her beliefs, value systems, or life goals	(3) Encouraging the patients to practice positive instead of passive or negative thinking daily (a) Taking the initiative in expressing concerns and understanding towards the patient's value systems, or life goals.
(4) Expressing lack of motivation to love, such as caring, assisting or forgiving himself/ herself or other persons, significant others in particular	(4) Encouraging patients' significant others to take the initiative in expressing their concerns and love towards the patients and calmly listening to the patients concerns and meaning of love.
(5) Expressing not knowing how to love himself/ herself or others	(5) Encouraging the patients to practice self-encouraging thinking' and sharing the meaning of appreciation and forgiveness with the patients
(6) Describing being unable to accept love such as caring, assistance or forgiveness from others	(6) Inviting humanitarian volunteers (including religious and non-religious groups) to talk with the patient about hospice care in the nursing home.
(7) Expressing concern with the fact that he/she is unable to die at home	(7)Initiating family and church friends and a spiritual support group
(8) Expressing concern with the absence of his/her significant others (family members in particular) during his/her dying	(8)Initiate family to help patient to complete a living will.
(9) Asking for help in making living wills and managing his/her belongings	(9) Assess the patients' spiritual life of physician-assisted death (non-natural death) concerns and needs and incorporate spiritual care by listening in a compassionate empathetic manner.

Appendix E: HOPE Spiritual Assessment

H- Sources of hope, meaning, comfort, strength, peace, love and connection

We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support?

What are your sources of hope, strength, comfort and peace?

What do you hold on to during difficult times?

What sustains you and keep you going?

For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?

O- Organized religion

Do you consider yourself part of an organized religion?

How important is this to you?

What aspects of your religion are helpful and not so helpful to you?

Are you part of a religious or spiritual community? Does it help you?

Do you have personal spiritual beliefs that are independent of organized religion? What are they?

Do you believe in God? What kind of relationship do you have with God?

P-Practices

What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g., prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)

E- Effects on medical care and end-of-life issues

Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?)

As a doctor, is there anything that I can do to help you access the resources that usually help you?

Are there any specific practices or restrictions I should know about in providing your medical care? (e.g., dietary restrictions, use of blood products).

Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?

If the patient is dying: How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months?

Appendix F: Permission letter

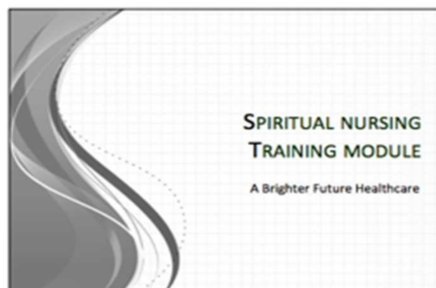
From: "Leeuwen van, R" <r.vanleeuwen@viaa.nl>
Date: February 26, 2015 at 2:59:37 AM EST
To: APRIL GANT <aprilgant@icloud.com>
Subject: Re: Requesting permission

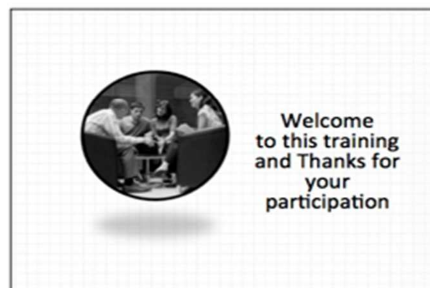
Dear April,

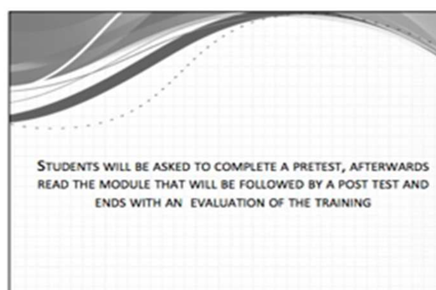
Thanks. I am fine. I am grateful to give you my permission to use the SCCS. The only thing I will ask you is, to send me your paper/report of your study after you have finished it.
I wish all the best by doing your research.

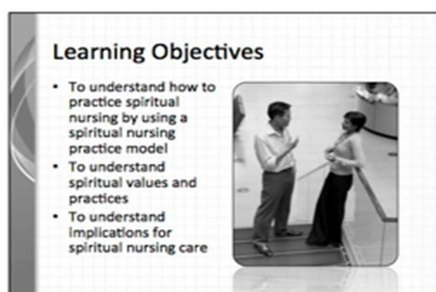
Rene van Leeuwen

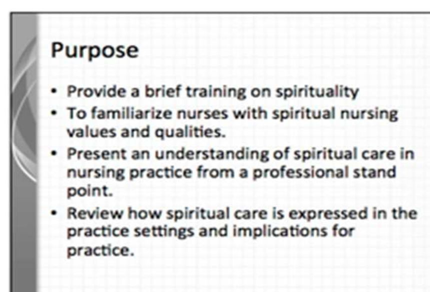
Appendix G: Spirituality Slides











10/4/15

Caring for the human being

- Nurses must develop the habit of being mindful of their relationships with patients.
- Nurses must be able to distinguish all aspects of holistic clinical care, and know how to attend to all areas of care such as physical, mental and spiritual .

Spiritual Caring

- A person is more aware of the outward life of the physical world and experience a less awareness of the inward life of mind and spirit.
- The inward life surfaces during times of silence, contemplation, meditation or prayer.
- It encompasses the person's awareness of the inner spirit and the presence what is happening or the feeling in the present moment.

Spiritual Caring

- Nurses must develop awareness, of the love, purposefulness and healing when caring for clients.
- The spiritual form of the inward life is fundamental and gives rise to the inherent unity of the person as a unique individual.

Spiritual nursing values

- Compassion
- Loving kindness
- Patience
- Tenderness
- Spiritual heart
- Peacefulness
- Human dignity
- Ethical
- Cultural Diversity
- Calmness
- Self care

Compassion/Loving kindness

- Compassion
  - Compassion can be described as the heartfelt experience of the other's misery which, thereby, impels a person to provide compassion. It also encompasses graciousness, joyfulness and peacefulness.
- Loving kindness
  - Loving kindness can be described as a person's expression of unreserved benevolence and kindness to one another. This feeling arises through a deeply held awareness of infinite love and a transcendent reality in which a person wishes to share with others.

Tenderness

- Tenderness
  - Tenderness is important in practice as it suggests to be a beautiful description of an unexpected encounter of a nurse with her own tenderness in a highly pressured practice setting and its deep appreciation by a chronic or acutely ill patient.

Implications

- Nurses and clinical managers must implement spiritual nursing values that can be shared and developed in practical ways so that they become truly integrated into everyday nursing practice
- Nurses should find ways to share understandings of spirituality with their nursing colleagues and with patients.

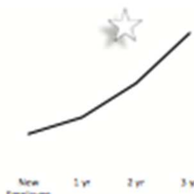
Implementation

- Spiritual care can be implemented with a team effort.
- New Employee spiritual care training
- Yearly spirituality and cultural diversity in-service
- Yearly spiritual care competency evaluations
- Patient Spiritual Assessments

Goals Towards Mastery in Spiritual Care

Training and competency

The Spiritual care learning curve



Conclusion

Spirituality is a part of the care that nurses provided. This training suggests spiritual values as a model that is useful in assisting nurses to reach an understanding of spirituality and a spiritual approach to nursing practice.

In closing

- Define your spiritual values
- Set goals to achieve competency in spiritual nursing care
- Quality care is holistic care which includes spiritual care
- Assess a clients spirituality and participate in spiritual practices without judging and putting aside any differences, to get a better understanding of how to meet the clients spiritual needs.
- Care for self and know your own spiritual values
- Practice meditation
- Listen to your clients to get a better understanding of their spiritual beliefs.
- Show compassionate empathy and sympathy in an appropriate manner at the appropriate time.
- Show respect for another's spirituality or cultural beliefs and practices
- Take the time to learn different cultures so that you can respect their spiritual beliefs and practices.

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