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# EVALUATING THE IMPACT OF KEY PHRASES AND CARING BEHAVIORS© ON NURSING STUDENTS' PERCEPTION OF COMPETENCE AND CONFIDENCE IN PROVIDING SPIRITUAL CARE

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EVALUATING THE IMPACT OF *KEY PHRASES AND CARING BEHAVIORS*© ON  
NURSING STUDENTS' PERCEPTION OF COMPETENCE AND CONFIDENCE IN  
PROVIDING SPIRITUAL CARE

By

JOAN MARIE CONNORS

A doctoral dissertation submitted to the  
College of Education  
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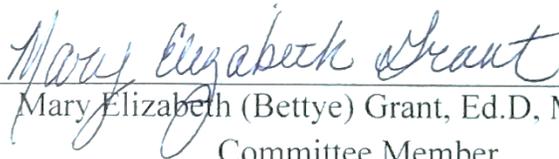
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## DEDICATION

I would like to dedicate this work to the Lord Jesus, through whom all things are possible. I pray that He is honored and that this dissertation helps further the cause of Christ with those who minister to the sick. This dedication is also to my faithful and Godly husband, Len, who encouraged me to pursue my educational dreams. You have filled my life with so much love and joy, I love you. A special thank you to my parents Bill and Ann Clayton for instilling in me the fortitude to finish what I start, and to our six children and seven grandchildren who keep me grounded in what is truly important in life. To my son Joseph, and daughter Rachel, who were both instrumental in helping me complete this manuscript.

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Many thanks are expressed for my dissertation chair, Dr. Susan Stanley and Dr. Mary Elizabeth (Bettye) Grant committee member for your mentoring and guidance in this work. Your actions have expanded the scope of spirituality in the nursing profession. Praise the Lord.

## ABSTRACT

Spirituality in nursing involves caring holistically for patients. Attention to the mind, body, and spirit, is a professional standard of care for nurses. Regulating agencies in the healthcare industry as well as professional code of conduct mandate that spiritual care will be addressed. While this is not a new concept to nursing, research revealed that the lack of education was one obstacle nurses identified that limited their ability to provide spiritual care. There is a lack of teaching resources to educate nurses on spiritual care. A previous study conducted by Connors, Good, and Gollery (2017), introduced the instrument *Key Phrases and Caring Behaviors*© during a simulation experience. It was determined that combining lecture and simulation were statistically significant in improving nursing students' competence and confidence in providing spiritual care. In order to provide the students' more opportunity to use the instructional material, the *Key Phrases and Caring Behaviors*© instrument was introduced earlier in the semester. While the data of this current study revealed no statistical significance, when compared to the prior study, it was determined that *Key Phrases and Caring Behaviors*© could be effective in maintaining students' competence and confidence in providing spiritual care.

Key Words: spirituality, simulation, associate degree nursing students, nursing education,

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## Chapter I. INTRODUCTION

### Context

Nursing is considered both an art and science (Peplau, 1987). The science of nursing includes technical skills and procedures to promote health and healing for the sick. The art of nursing incorporates caring for individuals. Nurses perform the task of fostering well-being by caring holistically for their patients. Holistic care is defined as providing care for the patient's body, mind, and spirit (Baldacchino, 2008; Mitchell, Bennett, & Manfiri-Ledet, 2006; O'Brien, 2014; van Leeuwen & Cusveller, 2003).

The root of caring comes from a Biblical perspective as Jesus cared for the sick and injured. Christ calls His followers to serve one another. “Whoever wishes to be great among you must be your servant, and whoever wishes to be first among you must be your slave; just as the Son of Man came not to be served but to serve” Mathew 20:6-27 (KJV). Addressed in this scripture is the manner of how one is to care for the infirmed. Current guidelines of *The American Nurses Association (ANA) Code of Ethics* state that nurses must put aside personal feelings and emotions to meet the needs of those entrusted to their care (ANA, 2015). Regardless of the nurse’s personal religious or spiritual convictions, addressing spirituality with their patients is a professional standard of care.

Nurses play a significant role in addressing the needs of patients who are in spiritual and emotional distress (Duffy, 2009; LaBine, 2015). Care that addresses spiritual needs is a nurse’s responsibility (Briggs & Lovan, 2014). Yilmaz and Gurler (2014) assert that spirituality is a “moral obligation of care” (p. 930). Hoffert, Henshaw, and Mvududu (2007) emphasize that

nursing graduates and those providing care to patients need to be ready to provide spiritual care. Yet there are few resources available to teach students how to provide spiritual care and even less research on the appropriate timing for when to introduce the topic of spiritual care to nursing students. “If we want nursing students to care, then we should give them the opportunities to practice” (Eggenberger & Regan, 2010, p. 557). These statements are drawn from studies that examine spirituality care, spiritual competence and confidence, and methods used in providing instruction for nursing students at secular and religiously affiliated colleges.

Efforts to incorporate spirituality into current professional nursing care have been the focus of several national and international organizations which include The Joint Commission (TJC), and the National Health Service or Scotland (NHS). Several agencies have position statements and recommendations for practicing nurses including the American Association of Colleges of Nursing (AACN, 2008) and the American Nurses Association (ANA, 2015). The Joint Commission accrediting agency for many American hospitals, mandates that all admitted patients will have their spirituality assessed (TJC, 2011). Nurses must practice from a “holistic, caring framework,” according to the American Association of Colleges of Nursing (AACN, 2016, p. 8). Establishing a therapeutic nurse-patient relationship is a basic expectation of nurses according to the AACN (2008), as stated in the *Code of Ethics for Nurses* by the American Nurses Association (ANA, 2015). However, the task of providing intangible spiritual care is often overlooked (Tiew, Creedy, & Chan, 2013; Yilmaz & Gurler, 2014). A deficiency of academic preparation was also mentioned as a reason that spirituality is void in nursing care (Hoffert et al., 2007; Tiew et al., 2013). Another reason possible to explain why spirituality is missing in curricula is the absence of a common definition of spirituality. The term spirituality is often unclear to nurses and nursing students. The meaning of spirituality and religion are

commonly confused (Costello, Atinaja-Faller, & Hedberg, 2012; Hoffert et al., 2007; Lemmer, 2002; Narayanasamy, 2006; O'Brien, 2014). Due to the ambiguity of defining spirituality, perhaps a simpler approach is to describe appropriate nursing actions when providing spiritual care. For the purpose of this research, the National Health Service (NHS) definition of spiritual care will be adapted and defined as “what is appropriate and whatever the person wishes” (NHS, 2010, p. 24).

Because people have diverse religious practices and faith-based beliefs that differ from the nurses' beliefs, many nurses might not be comfortable with matters involving spiritual care (Boswell, Cannon, & Miller, 2013; Narayanasamy, 2006). Du Plessis (2016) suggested *presence* as a beginning activity for introducing spiritual care at the bedside. Well established in nursing literature, *being present* with patients is a central theme to several nursing theories including Watsons' *Theory for Transpersonal Caring*, Rogers' *Science of Unitary Human Beings*, and Parse's *Theory on Human Becoming* (du Plessis, 2016). *Presence* is being intentional while with patients, focusing on their needs that includes physical, emotional and spiritual attention. *Presence* is a tangible means of demonstrating humane caring and emotional support by the nurse to individuals. Practicing presence is one avenue to providing spiritual care regardless of the nurses' religious beliefs. Further research was suggested to explore the interpretation and implementation of presence by nurses (du Plessis, 2016).

### **Background of the Study**

Very few studies have been conducted related to teaching spiritual care to nursing students, even though providing spiritual care is a professional standard of care. Limited international studies have investigated the impact of spiritual care education on undergraduate nursing students (Cooper, Chang, Sheehan, & Johnson, 2013). Wu, Tseng, and Liao, (2016)

suggested that additional educational material was needed to teach spiritual care. According to LaBine (2015), there was a gap in the literature on studies conducted on spiritual care related to associate degree nursing programs. Further “research related to spiritual care in community colleges will expand the knowledge and highlight the need for current and effective training for nurses” (LaBine, 2015, p. 27).

### **Overview of the Problem**

Spiritual care is an essential part of holistic care (O’Brien, 2014). Studies conducted described several reasons for the lack of attention to patient’s spiritual needs. Despite the need for spirituality content in nursing schools, the subject is rarely taught (Baldacchino, 2008; Blesch, 2015; Hoffert et al., 2007; Kitchener, 2016; Lovanio & Wallace, 2007; McSherry & Jamieson, 2011; Yilmaz & Gurler, 2014). More than one half of the nurse practitioners (master’s level or higher) surveyed felt inadequately educated on matters of spirituality (Stranahan, 2001).

This finding was reiterated by LaBine (2015) when she surveyed 206 nursing faculty of accredited associate degree programs across the southeastern United States. Of faculty responding to the survey, 84% reported that they had not received adequate direction to cover spiritual content. Further, one-half of the faculty surveyed felt that nurses should provide spiritual care, even though the majority stated that spirituality should be included in holistic care, with religiosity as one aspect of spirituality. However, there was a lack of spiritual integration in nursing programs (Callister, Bond, Matsumura & Mangum, 2004; McSherry & Jamieson, 2011; Yilmaz & Gurler, 2014).

Many nurses felt ill-prepared to provide spiritual care (Baldacchino, 2008; McSherry & Jamieson, 2011; Tiew et al., 2013; Yilmaz & Gurler, 2014). Nurses that are not able to interpret or manage their own spiritual and emotional needs may find it uncomfortable or stressful to

address the patient's spiritual needs (Boswell, et al., 2013; Narayanasamy, 2006). LaBine (2015) cited one reason spirituality was disregarded was due to the advanced technological and scientific aspects of nursing care. Hoffert et al. (2007) stated that the lack of attention to spiritual nursing care might be attributed to the need for a clear definition of spirituality, the fact that nurses were uncomfortable with their own spirituality, or a deficiency of educational preparation.

LaBine (2015) surveyed community colleges in the Southeastern United States and found very little education in spiritual care was being taught. The most frequently used instructional method was lectures on spirituality. Content was taught more often at private colleges with baccalaureate nursing programs affiliated with a particular religion. Further LaBine (2015) stated, there was a gap in the literature related to spirituality in nursing conducted at public community colleges in the southeastern United States. LaBine (2015) reported nurse educators conveyed that there was very little preparation in teaching spiritual content, and there was also a lack of resources to teach spiritual content to nursing students.

### **Professional Significance of the Study**

Many students desire to care for patients but lack the knowledge to do so. Bennett and Thompson (2014) revealed that nursing students can be taught how to provide spiritual care irrespective of the teaching methodology. One common teaching strategy used in nursing education is simulation. Nurse educators used simulation to create opportunities for experiential learning and repetitive practice (Eggenberger & Regan, 2010; Gore & Thomson, 2016). This method of instruction promoted student learning for today's rapidly changing health care environment. The use of simulation teaches students how to respond and react in a safe environment away from direct patient care (Blesch, 2015; Brannan, White & Long, 2016; Gore & Thomson, 2016).

While simulation was an effective instructional strategy, there was an opportunity to help students transfer knowledge learned in simulation to the bedside of those to whom they were providing care. To help bridge the academic-practice gap, researchers Good and Connors (2017) developed an instructional instrument *Key Phrase and Caring Behaviors*© as a means of introducing first semester nursing students to appropriate responses when caring for patients. The instrument contains suggestions for what to say and how to demonstrate caring in nursing. Essentially, students were introduced to spiritual care using *Key Phrase and Caring Behaviors*© as a means to incorporate the concept of *presence* into their developing practices.

In Connors et al. (2017), first semester nursing students at a public state supported state college were surveyed in three phases. Phase I was prior to any instruction in the beginning of the term, Phase II was after a lecture on spirituality around the middle of the term, and Phase III was administered after students participated in a simulation activity. The simulation experience introduced students to *Key Phrase and Caring Behaviors*© and was conducted at the end of the semester. Using a pre-post posttest study design of repeated measures, findings revealed that students reported an increased level of competence and confidence after the simulation experience (Connors et al., 2017).

During informal student interviews and focus groups held after the simulation, students suggested that *Key Phrase and Caring Behaviors*© be introduced earlier in the term. In an effort to determine which instructional method made the biggest impact on students' competence and confidence, *Key Phrase and Caring Behaviors*© and the simulation experience were separated within the term.

This study was conducted as a follow-up to determine if the *Key Phrases and Caring Behaviors*© instrument would have the same impact on students' competence and confidence if

introduced earlier in the semester. To determine the impact of introducing the teaching instrument *Key Phrases and Caring Behaviors*© to students earlier in the semester, the instrument was removed from the simulation experience (at the end of the semester) and distributed during the spiritual lecture that was taught in week two of a 16-week semester.

Participants of the current study included 23 first semester nursing students at a public, state supported college. While the instructional methods used to teach spiritual content remained intact, only the order by which the material was delivered was changed. Determining the impact on students' competence and confidence with regard to the sequence of instruction, was investigated. Using data previously collected, a comparison of the two studies was conducted. It is the intent of the researcher that the knowledge gained from this quantitative study will provide valuable insight to nurse educators on when to introduce the teaching instrument *Key Phrases and Caring Behaviors*© to strengthen nursing students' competence and confidence when providing good care to their patients.

The andragogical model of the adult learner was contemplated when moving the teaching instrument *Key Phrase and Caring Behaviors*© earlier in the semester. Constructs of adult learners were queried when moving the order of the spiritual content. Merriam & Bierema (2014) described Knowles' assumptions of adult learners as life experiences, readiness to learn and problem-centered orientation, and internal motivation. More importantly, the issue of the "need to know" (p. 55) was considered for the students participating in this study (Merriam & Bierema, 2014). The decision to introduce the teaching strategy *Key Phrase and Caring Behaviors*© earlier in the term was made considering adult motivation to learning.

## **Purpose Statement**

The purpose of this study was to determine the impact on students' competence and confidence when *Key Phrases and Caring Behaviors*© was introduced early in the term to first semester nursing students.

## **Research Questions**

I. Will introducing *Key Phrases and Caring Behaviors*© impact first semester nursing students' perception regarding their competence and confidence in providing spiritual care prior to the exposure to the simulation activity?

II. Will introducing the simulation activity after exposure to *Key Phrases and Caring Behaviors*© produce a statistically significant change in first semester nursing students' perception of competence and confidence in providing spiritual care?

III. Will the combination of both instruction using *Key Phrases and Caring Behaviors*©, and a structured simulation activity exert a statistically significant improvement in first semester nursing students' perception of competence and confidence in providing spiritual care to patients?

## **Research Hypotheses**

There is a difference in first semester nursing students' perception regarding their competence and confidence in providing spiritual care dependent on the timing of the exposure of the *Key Phrases and Caring Behaviors*© instrument.

## **Null Hypothesis**

There will be no difference in first semester nursing students' perception regarding their competence and confidence in providing care to those in spiritual and emotional crisis.

H<sub>0</sub>1: Introducing *Key Phrases and Caring Behaviors*© prior to exposure to a simulation activity and instructional design will not promote a statistically significant difference in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>a</sub>1: Introducing *Key Phrases and Caring Behaviors*© prior to exposure to a simulation activity and instructional design will promote a statistically significant difference in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>0</sub>2: Introducing the simulation activities after the first semester nursing student has been exposed to *Key Phrases and Caring Behaviors*© will not promote a statistically significant difference in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>a</sub>2: Introducing the simulation activities after the first semester nursing student has been exposed to *Key Phrases and Caring Behaviors*© will promote a statistically significant difference in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>0</sub>3: The combination of both instruction using *Key Phrases and Caring Behaviors*©, and a structured simulation activity will not exert a statistically significant improvement in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>a</sub>3: The combination of both instruction using *Key Phrases and Caring Behaviors*©, and a structured simulation activity will exert a statistically significant improvement in first semester nursing students' perception of their ability to provide spiritual care.

## **Overview of Methodology**

### **Subjects:**

Nursing students enrolled in an associate degree nursing program at a state college in central Florida were surveyed using the *Spiritual Confidence and Competence Survey Phase I, II, and III*© online. The population included approximately 90 first semester nursing students

enrolled in Adult Health I. The purposive, convenience sample included students that completed *Spiritual Competence and Confidence Survey Phase I, II and III*© online. The Phases were predetermined based on the timing of the delivery and application of spiritual content within the semester. Phase I was a baseline assessment of students' perception of how competent and confident they were in performing spiritual care prior to any instruction. Phase I was administered during the second week of the 16-week semester. Phase II was conducted after a classroom lecture that included an introduction to *Key Phrases and Caring Behaviors*©, and after students performed a spiritual assessment of a patient while in the clinical setting. Phase II was administered during the fourteenth week of the 16-week term. The final survey was Phase III, after students participated in a simulation experience. Administered at the end of the first nursing course, Phase III contained questions regarding the simulation activity, during week fifteenth of the 16-week semester.

### **Instrumentation**

The instrument used to measure students' perceptions of competence and confidence when delivering spiritual care was the *Spiritual Competence and Confidence Survey Phase I, II, and III*©. This instrument was adapted with permission from an instrument first introduced in the article by Hoffert et al. (2007). The tool contained 10 core Likert-type questions related to students' perceptions of competence and confidence in providing spiritual care, and each survey added five additional questions that pertained to the prior knowledge or exposure to educational materials. For example, the five additional questions in *Spiritual Competence and Confidence Survey Phase I*© pertained to the student's prior beliefs and ability to recognize and perform spiritual care. *Spiritual Competence and Confidence Survey Phase II*© contained five additional questions that pertain specifically to *Key Phrases and Caring Behaviors*©. *Spiritual*

*Competence and Confidence Survey Phase III*© contained five additional questions that inquire as to the student's feelings about the simulation as well as application of the instrument *Key Phrases and Caring Behaviors*©.

### **Procedures**

The *Spiritual Competence and Confidence Surveys Phase I, II, and III*© were sent electronically to the students enrolled in the first semester of nursing school, Adult Health I. Beginning nursing students were surveyed three times in the following phases:

- 1) Phase I: Administer the electronic Pre-test *Spiritual Competence and Confidence Survey Phase I*© that served as a baseline of student understanding of spirituality and spiritual caregiving. Using a Likert-type scale, the initial test consists of ten core questions that asked how students rate their ability to care for spiritual needs and included five questions about how students defined their own spirituality. Phase I was administered in week one of a 16-week semester during the first term of nursing school.
- 2) Phase II: Administered an electronic *Spiritual Competence and Confidence Survey Phase II*©. Using a Likert-type scale ten core questions and five questions about the students' perception of *Key Phrases and Caring Behaviors*© participants were asked after the classroom lecture and a small group activity on spiritual care in nursing and introduction of *Key Phrases and Caring Behaviors*©. Phase II was administered during week fourteen of a 16-week semester during the first term of nursing school.
- 3) Phase III: Administer the *Spiritual Competence and Confidence Survey Phase III*© which consisted of ten core questions and five questions about students' perceptions of a simulation and application of *Key Phrases and Caring Behaviors*©. The simulation was a role-play of a

situation that included a patient and family member in emotional distress. Phase III was administered during week fifteen of a 16-week semester during the first term of nursing school.

The current study was compared to data collected in the Connors et al. (2017) action research project that revealed a difference in nursing students' perceptions of spiritual care between Phase I (baseline) and Phase III (simulation). However, during that study there was little change in Phase II (lecture and clinical performance). To influence Phase II, the current study examined the impact of including *Key Phrases and Caring Behaviors*© with the spiritual lecture taught earlier in the first term of nursing school. A comparison of the data between Phase I, II and III of the prior study and this current study measured changes in students' perception of competence and confidence when providing spiritual care.

### **Analysis Methods**

Study data were analyzed using both descriptive and inferential statistical techniques. Descriptive techniques were centered on frequencies and percentages for comparative purposes. Descriptive data from the demographic items on the survey was compiled based on the following: age, gender, highest degree obtained, and religious affiliation. Research question one was analyzed using inferential techniques focused on repeated measure techniques: the T-Test of Dependent Means for the comparison of change for statistical significance from Phase I (Baseline Condition) to Phase II (Post Lecture and introduction of *Key Phrases and Caring Behaviors*©) and Phase III (Post Simulation) of the study; and the Repeated Measures ANOVA for the determination of statistical significance across all three treatment phases. Data were analyzed, interpreted, and reported exclusively utilizing IBM SPSS (23). Comparisons of item responses of nursing students was compared to students that participated in the study previously.

## **Definitions of Key Terms**

**Spirituality:** Personal feelings about one's relationship to a higher being. While not necessary, spirituality can be related to religion, but addresses the inner core of the person. Highly individualized, spirituality is defined as whatever the patient describes it to be (NHS, 2010).

**Holistic care:** caring for the mind, body, and spirit of the person (O'Brien, 2014).

**Religion:** An organization or group of people that share similar beliefs, practices and traditions, or a faith or belief system that connects people with God or a higher power (Narayanasamy, 2004).

***Key Phrases and Caring Behaviors***©: A teaching instrument providing appropriate suggestions for interventions that implement presence. Verbal and non-verbal communication strategies are categorized according to the patient's and or family members' actions or statements (Good & Connors, 2017).

***Presence:*** Intentional focus on the physical, emotional and spiritual needs of the patient. Presence is a tangible means of demonstrating humane caring and emotional support by the nurse to individuals (du Plessis, 2016).

**Spiritual care:** Being with patients, listening to patients, using appropriate touch, humor, and tender-heartedness to help to connect patient to others and God or higher being (O'Brien, 2014). Spiritual care seeks to develop an understanding of what is important to the patient (NHS, 2010).

**Spiritual and emotional distress:** When one experiences an unexpected or unpleasant event. May be expressed as crying, withdrawing, or anger (NANDA-International, 2016).

## **Nature of the study**

Various entities that govern nursing programs and healthcare institutions have determined that spirituality is important in nursing. Recent mandates require that spiritual assessments are implemented by hospital accrediting bodies (TJC, 2011). Applying the concepts of spiritual care is a professional nursing as well as patient expectation. Limited resources exist to teach nurses spiritual care. Very few studies have been done with public, non-religious, associate degree nursing programs (LaBine, 2015). A previous study conducted by Connors et al. (2017), introduced the instrument *Key Phrases and Caring Behaviors*© during a simulation experience. It was determined that the instrument was an effective teaching tool that was statistically significant in improving nursing student competence and confidence in providing spiritual care. Upon completion of the simulation, students responded with candid remarks during informal interviews. Their comments were positive concerning the instrument and many indicated they wished they had the *Key Phrases and Caring Behaviors*© instrument while they were in the clinical setting. Students suggested that *Key Phrases and Caring Behaviors*© be introduced earlier in the semester. The findings of the study conducted by Connors et al. (2017) serve as the basis for the current study. The primary purpose of the study was to determine if the *Key Phrases and Caring Behaviors*© instrument would have the same impact on student competence and confidence if introduced earlier in the semester.

## **Summary**

In summary, there is a need for spiritual care training (Baldacchino, 2008; Blesch, 2015; Hoffert et al., 2007; Kitchener, 2016; Lovanio & Wallace, 2007; McSherry & Jamieson, 2011; Yilmaz & Gurler, 2014). Governmental regulations, hospital accrediting bodies, and nursing

professional guidelines all mandate that nurses provide spiritual care. Addressing spiritual needs is not only a professional responsibility, but it is the very essence of nursing (O'Brien, 2014). Nurses in current practice are hesitant to address spiritual issues with patients due to many causes, including lack of educational preparation (Baldacchino, 2008; Blesch, 2015; Hoffert et al., 2007; Kitchener, 2016; LaBine, 2015; Lovanio & Wallace, 2007; McSherry & Jamieson, 2011; Yilmaz & Gurler, 2014). Previous research demonstrated that simulation was an effective teaching strategy (Blesch, 2015; Kitchener, 2016; Connors et al., 2017). To combat the deficiency of spiritual care training, one teaching instrument *Key Phrases and Caring Behaviors*© was created by researchers Good and Connors (2017). During informal interviews students expressed a desire for the teaching instrument *Key Phrases and Caring Behaviors*© to be introduced earlier in the first term of nursing school (Connors et al., 2017). The impact on first semester nursing students' competence and confidence was measured when the instrument *Key Phrases and Caring Behaviors*© was introduced in the beginning of the semester.

This research was carried out in three phases using an online survey administered at specific timeframes. The major research question examines the impact of moving *Key Phrases and Caring Behaviors*© earlier in the semester. The dissertation was organized with a review of literature that includes a brief history of caring in nursing and Biblical perspective. Also included was the impact of laws, governmental agencies, influences from hospital reimbursement, accrediting bodies and professional nursing guidelines pertaining to spirituality. Conducted at a large, public state supported, associate degree nursing program, the results of this study included a comparison of the previous Connors et al. (2017) study. In conclusion, a dialogue of the findings, recommendations for nurse educators, and areas of future research were discussed. The next chapter will provide a detailed discussion of supporting literature.

## CHAPTER II. REVIEW OF LITERATURE

Chapter two represents an overview of current literature as it pertains to spiritual care in nursing. First, the Biblical and historical influences on nursing were discussed. Next, the definitions and descriptions of spiritual care behaviors as well as regulatory and governmental agencies that impact spiritual care were explained. Also contained within this chapter were studies that examined current trends in teaching spirituality to nurses. The conceptual framework for this study was based on Knowles' andragogy assumptions and Bandura's *Social Cognitive Theory* (Merriam & Bierem, 2014).

### **Art and Science of Nursing**

Often nursing is described with the terms *art* and *science* (Peplau, 1987). The two terms represent interpersonal relationships between the nurse and patient and including scientific knowledge. According to Peplau (1987), when working with clients, nurses are required to practice "self-awareness and sophisticated self-discipline" (p. 9). Peplau (1987) stated that "the art seeks to know the unique and highly personal variations of pattern of difficulty and behavior of individuals" (p. 14). She defined the components of the art of nursing as *medium*, *process*, and *product*. *Medium* was characterized as the nurse's interaction with the patient. The nurse created an environment that prompted trust through "sensitivity, intuition, imagination, resourcefulness, versatility and innovation" (Peplau, 1987, p. 10). The nurse that included spiritual care provided hope in seemingly hopeless situations. The *process* of nursing was defined as how the nurses presented themselves and carried out duties. What nurses said and did communicated their engagement with the patient. "There is an absence of haste in movement,

precision in technique, confidence in action, and concentration on the other person—a congruency of complex nursing performances with needs of a client at a given moment” (Peplau, 1987, p. 9-10). Jean Watson’s (2010) *Theory of Human Caring* called for nurses to focus on patients and be “authentically present” (“Watson Caring Science,” 2010). *Presence* was being intentional while with patients, focusing on their physical, emotional and spiritual needs. Presence was a tangible means of demonstrating humane caring and emotional support by the nurse to individuals. Du Plessis (2016) suggested that one avenue to teaching spiritual care was through presence.

The final result of the art of nursing was the *product* or inner feelings of the client as a result of the nurse’s interaction. A personalization of care delivered was recognized. Watson (2010) described this phenomenon as instillation of hope and faith. Many times, the *product* was the connection the patient felt with the caregiver’s, “tender-hearted” (Peplau, 1987, p. 14) way of caring. Unfortunately, with the advances in technology and increased demands on the nurses’ time, the art of nursing was threatened. “A division or a mere juxtaposition should be avoided” (Peplau, 1987, p. 14). Effective and competent nurses have mastered the art and science of nursing by demonstrating concern, compassion, devotion and adaptability when providing care (Peplau, 1987). It is, therefore, the task of nurse educators to teach novices how to merge the art with the science of nursing. Attempts to blend the art and science of nursing were developed under the term holistic care. Holistic care is a component of the art of nursing, and was lost in academia. To better understand holistic care, a chronological perspective of spirituality in nursing including a Biblical viewpoint and excerpts from writings of nursing theorist, Florence Nightingale was provided.

## **Historical view of spirituality in nursing: Called to serve**

### **Biblical perspective**

Societal behavior has been instructed by the Golden Rule, as recorded in the Bible. “Therefore, whatever you want people to do for you, do the same for them, because this summarizes the Law and the Prophets” Luke 6:31 (NIV). Nursing is commonly described as a calling that follows the example of Christ (O’Brien, 2008). First demonstrated by Jesus as He led by example to meet emotional, physical, and spiritual needs, even when caring for the people might have been inconvenient. He said, “Let the little children come to me...” Matthew 19:14 (English Standard Version). Jesus became involved in the lives of those around Him by being an advocate to the less fortunate. This example of servant leadership, as well as emotional intelligence, could be inspirational to nurses intentionally addressing the patient’s emotional needs while performing tasks of patient care.

Biblical demonstrations of caring established the foundation for nurses. Several scriptures illuminate the principles of servant leadership, compassion, and caring. Jesus patterned caring behaviors by meeting basic human needs. He fed the hungry, gave drink to the thirsty, acknowledged foreigners (Matthew 25:35), and healed the sick with compassion (Matthew 14:14). “I was sick and you took care of me... Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to Me” Matthew 25:36, 40 (KJV).

Christ was specific with His call to followers as they serve one another. “Whoever wishes to be great among you must be your servant, and whoever wishes to be first among you must be your slave; just as the Son of Man came not to be served but to serve” Mathew 20:6-27 (KJV). This scripture speaks to the attitude of how one is to care for the infirmed. “For you,

brothers, were called to freedom. Only do not turn your freedom into an opportunity to gratify your flesh, but through love make it your habit to serve one another” Galatians 5:13 (ISV).

Another scripture passage, found in Luke 10:25-37, encourages Christians to help those that are hurting. Jesus told the story of a Samaritan man that stopped to render aid to a man that had been beaten and left wounded alongside the road. He bandaged the injuries, placed the man on his donkey and took him to an inn keeper. Once the battered man was settled in a room, the Good Samaritan paid the account. Jesus emphasized that the two men were of different cultures, yet despite the diverse backgrounds, care was provided. Our current law titled the *Good Samaritan Law* was fashioned after this story. Before the *Good Samaritan Law* was enacted, healthcare workers who delivered emergency care outside their place of employment, were held liable for their actions. The law offers liability protection to healthcare professionals assisting someone who might be injured if untoward consequences result from the actions of the “Good Samaritans” (“Definitions legal,” n.d.). An obligation to care for others is a basic tenant of the Christian faith. Nurses must put aside personal feelings and emotions to meet the needs of those entrusted to their care (Code of Ethics, ANA, 2015).

### **Nightingale’s impact**

One of the first nurses, Florence Nightingale, believed that spiritual care was an integral part of the nursing profession (Bennett & Thompson, 2014; O’Brien, 2014). Nightingale began to practice nursing during the Crimean War when she noticed the suffering of the soldiers. Also known most famously as the “Lady with the Lamp,” Nightingale was given this name as she made nightly rounds on the sick and injured soldiers of the Crimean War (Nightingale, 1890).

Part of her service to nursing was to document actions of nurses. Because Nightingale empathized with the weak and infirmed, she was disheartened and wrote about the common state

of caregivers of her day. Nightingale described nurses of the 19<sup>th</sup> century as being “too old, too weak, too drunken, too dirty, too stupid or too bad to do anything else” (“Nightingale letter,” 1900). Up to this time in history, due to the intimate nature of providing care to others, physical care was performed by family members or servants. For a wealthy young lady to be involved in the private physical care of strangers was a departure from the norms of society (Meehan, 2012).

Nightingale began her career as a nurse at the same time Lister (The Father of Antiseptic Surgery) developed standards for anesthesia and the operating room. Both Nightingale (1820-1910) and Lister (1827-1912) were Christians living in England. Their leadership and visionary focus created a perfect environment for medicine and nursing to grow. Nightingale established the first nursing school in 1860 and nursing began as a secular occupation (Meehan, 2012). The combination of the development of Nightingale’s nursing school and Lister’s requirement that only educated nurses could work with him in surgery resulted in a reduction in post-operative complications (“Notes on Nursing,” 1890). Lister’s standards for qualified nurses in the operating room created a need for formally trained nurses. For the first time in history, Lister and Nightingale connected the educational preparation of nurses to patient outcomes and quality of patient care.

Because Nightingale was one of the first nurse educators, she wrote large amounts of text for nurses. In her books and letters, Nightingale highlighted her views of nursing. In *Notes on Nursing*, (1890), Nightingale described best practices for nurses, some of which are still practiced today. Nightingale also felt that nursing was a calling and connected the nurse’s motivation to care with one’s personal relationship to Christ. She wrote:

Christ was the author of our profession, we honor Christ when we are good nurses. We dishonor Him when we are bad or careless nurses. We dishonor Him when we do not do

our best to relieve suffering—even in the meanest creature. Kindness to sick man, woman and child came in with Christ (“Nightingale letter,” 1900).

Further, Nightingale cited that prior to Christ, the treatment of lepers in the Bible was the practice of isolation and alienation. She described how inhumane and cruel nations were in abandoning lepers (“Nightingale Letter,” 1900). Nightingale wrote that Christ changed the way the world cared for the sick and infirmed. Christ said, “And whosoever shall give to drink unto one of these little ones a cup of cold water only in the name of a disciple, verily I say unto you, he shall in no wise lose his reward” Matthew 10:42 (KJV).

Nightingale was one of the first nurses to describe how nurses were to care for their patients. Even the foulest tempered, angry patient deserves a “good nurse.” In Nightingale’s work, she penned meticulous nurse’s notes and described the attitudes nurses should adapt. She followed the Biblical principle expressed in the New Testament “And do this not only to please them while they are watching, but as servants of Christ, doing the will of God from your heart. Serve with good will, as to the Lord and not to men” Ephesians 6:7 (Berean Study Bible). Nightingale felt that Christ exemplified compassion as He healed the sick, bound their wounds, and introduced compassion as central to the theme of those providing care.

### **Contemporary influences**

A current day nurse impacting spirituality is Sr. Mary Elizabeth O’Brien. Nursing care that added the dimension of spirituality was considered holistic care (O’Brien, 2014). Holistic care was defined as providing care for the person’s body, mind, and spirit (O’Brien, 2014). Nurses played a significant role in addressing the needs of patients experiencing spiritual and emotional distress (LaBine, 2015). One way patients felt cared for was when nurses addressed their emotional and spiritual needs. Spirituality in nursing was essential and required that nurses

address the patient as a whole or holistically (Baldacchino, 2008; Lyndon-Lam, 2012; McSherry, 2006; Mitchell et al., 2006; O'Brien, 2014). Dr. Christina Puchalski (2001) defined spiritual care synonymously with compassionate care as “serving the whole person” (p. 352). The work of Duffy (2009) illuminated the need for nurses to care holistically for their patients as individuals. Duffy (2009) wrote:

Caring, on the other hand, is implicitly tied to *human beings* as they exist in relationship to each other, communities or groups, and the universe. Human as multidimensional are worthy individuals who vary in terms of characteristics, unique experiences, beliefs, and attitudes. Using this variance, caring relationships enhance quality by bringing into play normal everyday human interactions that provide feedback about life experiences and human advancement (p. 194).

As the largest group of healthcare providers to contribute to patient care, nurses had intimate knowledge of patient needs (Duffy, 2009; Peplau, 1987). Nurses spent time at the bedside delivering patient care and were in a unique position to go through traumatic, and many times, unexpected events with patients when they were most vulnerable (Briggs & Lovan, 2014; LaBine, 2015; O'Brien, 2014; Peplau, 1987; Rogers & Wattis, 2015). Treating patients' and families' emotional needs required that nurses listened to their patients (McSherry, 2006; Watson, 2010) and developed a relationship with them (Peplau, 1987; Rogers & Wattis, Tiew et al., 2013). Once the trusting relationship had been established, the nurse had endless opportunities to connect spiritually with the patient (Briggs & Lovan, 2014). According to the National Health Service (NHS, 2010) of Scotland,

The provision of spiritual care by NHS staff is not yet another demand on their hard pressed time. It [spiritual care] is the very essence of their work and it

enables and promotes healing in the fullest sense to all parties, both giver and receiver, of such care (p. 4).

Duffy (2009) described the phenomenon of the nurse-patient relationship as “feeling cared for,” as the nurse delivered care (p. 18). According to Meehan (2012) “spirituality is timelessly woven with nursing and health” (p. 990).

### **Barriers to spiritual care in nursing**

Several factors contributed to barriers in spirituality in nursing. Hoffert et al. (2007) stated that the lack of attention to spiritual nursing care might be related to the need for a clear definition of spirituality, a deficiency of educational preparation, or the fact that nurses were uncomfortable with their own spirituality. Several more studies documented that many nurses felt ill-prepared to provide spiritual care (Baldacchino, 2008; Tiew et al., 2013; Yilmaz & Gurler, 2014). Nurses that were not able to interpret or manage their own spiritual and emotional needs may have found it uncomfortable or stressful to address the patient’s spiritual needs (Boswell et al., 2013; Narayanasamy, 2006). LaBine (2015) cited one reason spirituality was disregarded was due to the advanced technological and scientific aspects of nursing care. Regardless, most hospitalized patients expected the professional to attend to their emotional needs (Cavendish et al., 2003).

According to Bennett and Thompson (2014), one predictor for nurses to address the spiritual needs of their patients was the nurse’s self-awareness. Research revealed that nurses uncomfortable with the personal nature of spirituality were hesitant to inquire about such a personal topic and were untrained on techniques that provided spiritual care (Barber, 2008; Blesch, 2015; Gore, 2013; LaBine, 2015; Lemmer, 2010; McSherry & Jamieson, 2011; Narayanasamy, 2006). In many cases, nurses may not know what to say to the patient, may not

want to pry into the patient's personal life, or feel hesitant to invade the patient's private space (Callister et al., 2004; McSherry & Jamieson, 2011). Therefore, researchers stated that novice nurse were ill-prepared to meet the spiritual needs of their patients (Barber, 2008; LaBine, 2015; Lemmer, 2010; McSherry & Jamieson, 2011). Moreover, Rogers and Wattis (2015) posited that inattention to spirituality could cause one suffering, more emotional distress.

## **Regulating Agencies**

### **Industry regulations**

Nursing is currently undergoing a fundamental structural change in caregiving (McSherry, 2006). Heindel (2015) reported that "the healthcare environment is in a critical period of transition" (p. 4). This change in caregiving had come about as a result of recent governmental influences that drove healthcare reimbursement. The *Patient Protection and Affordable Care Act* (PPACA), also known as the *Affordable Care Act*, or *Obama Care*, was signed into law in March, 2010. Even though recently elected President Donald Trump promised to repeal and replace the law, until such time, the law significantly impacts healthcare. The *Affordable Care Act* addresses accessing healthcare, improving the quality of care, reducing medical expenses, documenting the medical record electronically, in addition to a myriad of healthcare changes. One area of the PPACA involved an evaluation from patients about the care that was given. With the passing of this law, caregivers' quality of care is being evaluated and incentivized. Centers for Medicaid and Medicare Services (CMS) or "Medicare" reimbursement dollars are now attached to Hospital Consumer Assessment of Healthcare Providers and Systems' (HCAHPS) scores. The HCAHPS survey asks recently hospitalized patients about the care they received while hospitalized. Patient perception gathered from individual hospitals is then compared to other facilities and reported publicly. Data collected is used in determining the

facilities overall patient satisfaction and constitutes 30% of the Total Performance Score (“HCAHPS online,” 2016). Never before has nursing care been quantified or tied to reimbursement. The financial impact for nursing is significant (Wolosin, Ayala, & Fulton, 2012).

### **Spirituality in Nursing: The new standard of care**

While it has been important to care and connect with patients, nurses are now being held to a higher standard of care. Nurses must put aside personal feelings and emotions to meet the needs of those entrusted to their care (Code of Ethics, ANA, 2015). In addition to the financial impact of HCAHPS, compliance with hospital accreditation agencies was also concerned with providing spiritual and emotional care (TJC, 2011). Further, it is the nurses’ responsibility to provide spiritual care (Briggs & Lovan, 2014; O’Brien, 2014). One regulatory agency, The Joint Commission, has mandated that admitted patients have a spiritual assessment (Barber, 2008; Cavendish et al., 2003; TJC, 2011). To ensure compliance, acute care providers require that spiritual assessments be performed and documented on every patient upon admission (Kitchener, 2016). Most facilities demonstrate compliance by asking patients about their religious preference and if they would like to receive a visit from a chaplain, upon admission. Regardless of the nurse’s personal religious or spiritual convictions, addressing spirituality with their patients was a standard of care (Code of Ethics, ANA, 2015).

The Joint Commission mandate was significant because TJC accredits hospitals and awards a certification that is required for institutions to receive Medicare reimbursement funding from the federal government (“HCAHPS online,” 2016). In effect, spirituality in nursing has financial implications. While meeting imposed guidelines was highly recommended, more important, nurses need to address the patient’s spiritual needs, because it is the right thing to do.

In addition to meeting patient expectations, efforts to incorporate spirituality into nursing care have been the focus of several national and international organizations which include The Joint Commission and the National Health Service of Scotland. Regulating agencies in the United States required that spirituality be taught within the nursing program (TJC, 2011).

### **National Assessment: Impact on schools of nursing**

Nursing programs are also under scrutiny to perform well. One motivating factor for schools of nursing within the United States is how to best prepare students for the end-of-program test for licensure. This examination for registered nurses is called the National Council Licensure Examination-RN (NCLEX-RN®). Nursing graduates must pass the examination successfully before a license to practice nursing is granted. Graduates first attempted scores are reported by the nursing school from which they graduated. Pass rates of NCLEX-RN® are posted quarterly on the National Council of State Boards of Nursing (NCSBN) website (NCSBN, 2017). All nursing programs within each state are rated and compared against all other nursing programs' NCLEX-RN® scores. In addition, the NCSBN publishes a Test Plan every three years. The 2016 NCLEX-RN® Test Plan includes the distribution of content information. Spiritual content is currently tested on NCLEX-RN®. Nursing schools include spiritual content to ensure their graduates have adequate knowledge of subject matter on which graduates will be tested.

In addition to nursing students, practicing nurses were also directed in how to provide spiritual care. The American Association for Colleges of Nursing (2016) outlined expectations for nurses in the *Code of Ethics for Nurses*. Guidelines for ethical treatment of patients were established for professional nurses. National nurse experts met in 2015 to revise the *Peaceful Death: Recommended Competencies and Curricular Guidelines for End-of-Life Nursing Care*.

The curricular resource provided strategies for nurse educators as they prepare students for end-of-life care. According to the AACN Competencies (2016) necessary for nurses to provide high quality care to patients and families facing serious illness, undergraduate nurses should:

... recognize one's own ethical, cultural and spiritual values and beliefs about serious illness and death, demonstrate respect for cultural, spiritual and other forms of diversity for patients and their families in the provision of palliative care services. Educate and communicate effectively and compassionately with the patient, family, health care team members, and the public about palliative care issues. Respect the patient and family values, preferences, goals of care and shared decision-making during serious illness, assess, plan, and treat patients' physical, psychological, social and spiritual needs to improve quality of life for patients and their families (p. 4).

While these guidelines were intended to teach nursing students in the context of death and dying, the principles of spirituality are applicable in any setting. Cockell and McSherry (2012) reviewed practitioner studies that were focused in the fields of oncology and palliative care. One recommendation from the study's findings was that leaders in nursing could apply concepts to positively impact other areas of nursing (Cockell & McSherry, 2012).

Another document published by the AACN (2008), *The Essential of Baccalaureate Education*, also addressed the need for students to be prepared to give spiritual care. Being responsible to meet patients' spiritual needs was outlined in the *Standards of Proficiency for Pre-Registered Nursing Education*, published by the Nurse and Midwifery Council (NMC) in the United Kingdom (NMC, 2015). The *Standards* outlined basic criterion for nursing students as they care for their patients, giving attention to their spiritual and emotional needs. These organizations specified that spiritual content would be covered. However, there was little

instruction on how to meet this obligation (Gore, 2013; Heindel, 2015; Kitchener, 2016; LaBine, 2015; McSherry & Jamieson, 2011).

The Health and Medicine Division (HMD) of The National Academy of Sciences, Engineering, and Medicine, formerly known as the Institute of Medicine, was an independent organization that recommended best practices for the medical profession, including nursing education. The emphasis of the HMD was to increase safety, patient care, informatics, teamwork, and quality of care in educating future nurses (“The National Academies,” 2017). In a report brief from the HMD entitled *Dying in America – Improving Quality and Honoring Individual Preferences Near the End of Life* (2014), person-centered, family-oriented end-of-life care was recommended. In order to achieve the highest quality of life possible, “health care should harmonize with social, psychological, and spiritual support” (para 7).

### **International influences**

Internationally, spirituality was recognized as the standard of care as well. In Scotland, the National Health Service provided recommendations for practice. The NHS Health Scotland was a World Health Organization Collaborating Centre for Health Promotion and Public Health Development. In the training publication, *Happy to Ask Happy to Tell* (2012), providers were informed of the Equality Act 2010. The Equality Act ensured that individuals were not discriminated against for their religious beliefs. The educational module stated that the nurse would not be aware of the patients’ religious preferences if the patients were not asked. It was further suggested that it might be unlawful if the provider did not inquire as to the patients’ preferences, as there would be an inability to meet their needs (NHS, 2012). Another resource published by the National Health Service for Scotland was the workforce development training called *Spiritual Care Matters-An Introductory Resource for All NHS Scotland Staff* (2010).

Scottish providers at all levels of healthcare were encouraged to provide spiritual care that was within their scope of practice (NHS, 2010).

### **Defining Spirituality in Nursing**

Despite the requirements to address spirituality of patients, there was no common definition of spirituality. Moreover, spirituality was often confused with religion (Reinert & Koenig 2013; Timmins & Neill, 2013). McSherry and Jamieson (2011) reported that nurses used the terms *religious* and *spiritual* interchangeably. Providing a definition of spiritual care was referred to as a challenge (Bennett & Thompson, 2014). Spirituality was defined as a personal sense of meaning, value, purpose, and interconnection (Hoffert et al., 2007), and spirituality applied to all people, religious or not (Bennett & Thompson, 2014). According to LaBine (2015), “spirituality is a way of describing the organizing center of a person’s life, bringing unity, and helping to make sense of life” (p. 17). Narayanasamy (2006) provided this definition of spirituality:

Spirituality is rooted in an awareness which is part of the biological make-up of the human species. Spirituality is present in all individuals and it may manifest as inner peace and strength derived from perceived relationship with a transcendent God or an ultimate reality or whatever an individual values as supreme. The spiritual dimension evokes feelings which demonstrate the existence of love, faith, hope, trust, awe and inspirations, therein providing meaning and a reason for existence. It comes into focus particularly when an individual faces emotional stress, physical illness or death (p. 845).

Biro (2012) stated there were international influences as nurses developed and shared knowledge. Thus, the need to understand how spirituality was utilized among nursing

professionals world-wide was important. To this end, the National Health Service Education for Scotland provided the following definition of spirituality:

Spiritual care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging one-to-one human contact in compassionate relationship, and moves in whatever direction need requires (NHS, 2010, p. 24).

One global nursing organization that offered suggestions on how nurses care for patients is NANDA International, Inc (NANDA-I, 2016). NANDA-I is the professional organization that creates nursing diagnosis and definitions of patient phenomena. These published guidelines for practice included definitions of nursing diagnoses. NANDA-I labeled certain conditions, such as spiritual distress and spiritual wellbeing (NANDA-I, 2016). NANDA-I (2016) defined spiritual distress as life interruptions impacting the whole person both psychologically and physically. Accompanying the definitions, appropriate suggestions were included on how to deal with a patient experiencing the symptoms described. NANDA-I (2016) did not provide a definition for the term *spirituality*. Appropriate nursing interventions that were suitable for the diagnosis of spiritual distress, encouraged nurses to stay with the patient, physically touch the patient's hand or arm, pray for patients, and provide active listening (NANDA-I, 2016; O'Brien, 2014).

Nurses can listen for and use implied spiritual content in a patient's language and conversation as an opportunity to meet spiritual needs (Hodge, 2013). O'Brien, (2014) encouraged nurses to show respect and ask for permission prior to praying with or for patients. The prayer should be consistent with how the patient would personally pray (Gore, 2013).

## **Defining the Term: Spiritual Care**

Confusion exists over the definition of spiritual care in nursing, because no common definition of spirituality in nursing existed (Costello, Atinaja-Faller, & Hedberg, 2012; Hoffert et al., 2007; Lemmer, 2002; Narayanasamy, 2006; O'Brien, 2014). Spiritual care in nursing is ambiguous. McSherry, Cash, and Ross (2004) described vagueness in the definition of spirituality, and stated that the academic discourse is “subjective, diverse and complex” (p. 940). Perhaps, due to the individual nature of spirituality, Cohen and Koenig (2003) described the spirituality as “idiosyncratic” (p. 217) and presented challenges when attempting to define two closely related terms such as *religiosity* and *spirituality*.

Spiritual care differs from religious care. Religious care is related to supporting a formal organization or group of people that share similar beliefs, practices and traditions. *Spirituality* can include some of the practices and philosophies of ones' religious preferences, but is not dependent on scripted or well-defined beliefs. An example of one method taught to nurses in Britain was informally questioning patients on their view of spirituality. One such question was: “Do you have a way of making sense of things that happen to you?” (Timmins & Neill, 2013, p. 501), which was described as the dialogue for nurses with their patients about spiritual issues. Nurses needed to be sensitive to the religious practices of the patient's faith community by providing what is appropriate and what a person wishes (NHS, 2010).

One way to distinguish the individuality of spirituality was an approach taken by the NHS. The National Health Service for Scotland compared assessing one's spirituality to a common pain assessment tool. First introduced by McCaffery (1968), the suggestion was made that nurses describe pain with the following standard definition: “Whatever the experiencing person says it is, existing whenever the experiencing person says it does” (as cited in Bernhofer,

2012, p. 95). McCaffery's (1968) approach avoided nursing biases toward the individual and rather focused on the patient's personal definition. For the purpose of this research, the NHS definition of spiritual care will be adapted and defined as "what is appropriate and whatever the person wishes" (NHS "Spiritual Care Matters," 2010, p. 24). Due to the ambiguity of defining spirituality, one method used to avoid confusion over the terms is by focusing on activities that exhibit caring.

NANDA-I (2016) described appropriate nursing interventions for one experiencing spiritual distress. Actions, such as spending time with the patient (Tiew et al., 2013), appropriate physical touch, such as holding hands, and talking about matters important to the patient, demonstrate care (Puchalski, 2001). Further, Puchalski (2001) described compassionate care for physicians as one "walks with people in the midst of their pain" (p. 352). The same description can be applicable to bedside nurses. The National Health Service of Scotland (2010) encouraged all caregivers to engage one-on-one when providing spiritual care.

### **Describing acts of spiritual care and caring behaviors**

"There is now an urgent need for clarification of how nurses can implement spiritual care in practice" (Meehan, 2012, p. 991). The acts of providing spiritual care included verbal and non-verbal communication. Sharing hopes and fears, family stories, gestures or humor or sadness, accepting recognition of culture or faith, seeing the patient as a person, valuing the person and responding to their individual situations, are various forms of providing spiritual care. Duffy (2009) described caring as nurses' care for patients through relationships. As more tasks were being delegated, Duffy and Hoskins (2003) declared that the very heart of nursing was missing.

McSherry (2006) described the importance of using “all forms of communication and interpersonal skills to identify and evaluate the problem” (p. 155). She termed three major types of communication as attentive listening, non-verbal communication, and presence. Attentive listening was described as focusing on the style and methods used by the patient during communication without preconceived ideas. As one paid attention and sat silently at the bedside, patients were allowed freedom of expression. The same characteristics of attentive listening were mirrored as Duffy (2009) described the nurse’s availability as attentive reassurance. Duffy stated that when nurses noticed their patients, actively listened, and anticipated their needs, the therapeutic relationship was encouraged. Further, the active listening phase displayed an interconnectedness of the nurse-patient relationship. During the episode of attentive listening, observations of non-verbal behavior were also useful in determining the congruency of the message. Non-verbal clues included eye contact, posture, and body language, which helped to determine the patient’s state of spirituality (McSherry, 2006).

Finally, presence, or making time for the patient, was used to convey caring when communicating with patients (Bennett & Thompson, 2014; du Plessis, 2016; McSherry, 2006; O’Brien, 2014). Giving attention to one experiencing a spiritual need involved hearing what was said and seeing what was said with distinct sensitivity. Once a trusting relationship had been established, many patients expressed their spiritual concerns (Bennett & Thompson, 2014). In Elizabeth Taylor’s book, *What Do I Say? Talking with Patients about Spirituality* (2007), she stated that one was to listen more to the “feelings than for thought, more for process of speech than for its content” (p. 29). Nurses that took time to listen to their patients, connected on a deeper level met the spiritual and emotional needs of those to whom they cared (Duffy, 2009). The same type of attentiveness was described as Puchalski (2001) encouraged physicians to

demonstrate caring, by walking alongside the patient and going through the suffering with the patient.

In 2008, the Minnesota Baccalaureate Psychomotor Skills Faculty Group evaluated junior-level baccalaureate nursing students using the instrument *Caring Behaviors During Blood Pressure Measurement*. They assessed whether students incorporated caring behaviors when measuring blood pressure. Using a pretest posttest quasi-experimental design, students' behaviors were rated on a scale, exposed to the caring behaviors content, and then administered the posttest. Even though the posttest conditions were inconsistent, results revealed that students demonstrated an increase in subjective and objective caring behaviors after instruction.

### **Educational Methods Teaching Spirituality**

While attention to physical care was important, nurses needed to address psychosocial and emotional/spiritual needs as well (O'Brien, 2014); however, for various reasons, failed to do so (Balacchino, 2010; Kitchener, 2016; Tiew et al., 2013). In the context of technological advances of modern medicine, nurses often neglected the intangible spiritual aspect of patient care; they, instead, focused on performing skills (Baldacchino, 2008; O'Brien, 2014; Hoffert et al., 2007; LaBine, 2015; Lemmer, 2002). This was especially true with new nurses or those uninformed or uncomfortable with spiritual matters. According to Eggenberger and Regan (2010), it was possible to introduce beginning nursing students to both caring behaviors and psychomotor skills simultaneously. They found that in order for students to be taught how to reach clinical competence with skills acquisition, intentional instruction of caring behaviors were taught using the framework of Knowledge, Action and Reflection (KAR) with a simulation experience. Kitchener (2016) states,

If nurses were as educationally prepared to provide basic care in the spiritual domains as they are prepared to provide care in the other four domains, it is likely that well documented barriers to addressing the patient's spiritual needs such as lack of time, fear of proselytizing and fear of offending might become less pervasive (p. 88).

Nurses were unsure how to provide spiritual care, because they had not been taught spiritual content in their courses of study (Kitchener, 2016). Taylor, Mamier, Bahjjar, Anton, and Peterson (2009) reported that there were no current studies that discussed how to have the conversation with patients about their spirituality. Because nurses were ill-prepared to provide for the spiritual needs of their patients (McSherry & Jamieson, 2011), many times they did not know what to say to their patients in emotional or spiritual distress. Timing, format of presentation, and language considered most appropriate, were central to health teaching and counseling (Peplau, 1987). There was a lack of instruction on how to provide spiritual care (Gore, 2013; Hoffert et al., 2007; Kitchener, 2016; LaBine, 2015; McSherry & Jamieson, 2011). The phenomenon of lack of attention to spirituality by nurses was explained as nurses possessed limited competencies to provide spiritual care (van Leeuwen & Cusveller, 2003). According to the literature, spirituality was within the purview of the nurses' scope of practice, and was an essential aspect of holistic care (Bennett & Thompson, 2014; Briggs & Lovan, 2014; Hoffert et al., 2007; LaBine, 2015; O'Brien, 2014; Yilmaz & Gurler, 2014). Hoffert et al. (2007) stated that nursing faculty must intentionally incorporate content that teaches spiritual care into the curriculum.

Traditionally, schools of nursing focused on teaching skills and techniques required for job performance. In addition, while in the clinical environment, nursing students and novice nurses performed procedures and treatments or diagnostic tests, gave medications, and

completed other important tasks while being observed by a registered nurse. Many nurses that were new to the role of professional caregiving concentrated on acquiring skills necessary for their new job (Benner, 1984; Hoffert et al., 2007; McSherry & Jamieson, 2011). In doing so, the emotional needs of the patient were often neglected. Eggenberger and Regan (2010) stated, “if nursing is equally about caring and relationships as it is the tasks, then our educational approaches must reflect the teaching of caring processes of family nursing” (p. 551).

Many nursing programs avoided educating on the subject matter of spirituality and spiritual care (Baldacchino, 2008; Blesch, 2015; Connors et al., 2017; Hoffert et al., 2007; LaBine, 2015; Lovanio & Wallace, 2007; McSherry & Jamieson, 2011; Yilmaz & Gurler, 2014). Also, many nursing curricula were void of teaching on prayer, reading the Bible, or using spiritual assessment tools (LaBine, 2015). Costello, Atinaja-Faller, and Hedberg (2012) reported a “lack of true instruction to prepare nurses” (p. 278). A literature review conducted by Bennett and Thompson (2014) indicated that “spiritual care must be integrated into the nursing curricula throughout the didactic and clinical nursing education” (p. 26).

Because spirituality is so broadly described, ambiguous terminology could be a factor in the lack of educational preparation. In one article, McSherry and Jamieson (2011) reported findings from a large online survey commissioned by the Royal College of Nursing in the United Kingdom. More than 4,000 nurses responded to the online questionnaire *Spiritual and Spiritual Care Rating Scale* (SSCRS). Findings revealed that 92% of nurses responding felt that spiritual care was the responsibility of healthcare providers, chaplains, as well as with patients and family members. Most nurses reported caring for patients with spiritual needs, yet less than 5% felt confident to meet their patient’s spiritual issues. Even though the structure of training nurses

changed in the United Kingdom, nurse respondents stated that spiritual care was missing from their educational preparation (McSherry & Jamieson, 2011).

Spirituality was reported as an intangible concept that required one to have self-awareness, and emotional intelligence (Benson, Martin, Ploeg & Wessel, 2012; Freshwater & Stickley, 2004). Self-efficacy and confidence was also useful to determined ones' ability to recognize and engage with the patient (Bandura, 1986). Unfortunately, nursing students had difficulty blending skills acquisition with therapeutic communication (Benner, 1984).

Many multi-cultural influences were imposed on spirituality within nursing (Biro, 2012) and these were to be considered by schools of nursing when developing spiritual curriculum. In a literature review conducted by Timmins and Neill (2013), due to an "increased secularization in Europe" (p. 499), it was recommended that as nurses are educated on spiritual matters, a variety of cultural influences should be taken into consideration. There was "scanty evidence" (p. 1,132) to guide spiritual care education for nurses (Taylor et al., 2009). There was little information about what should be taught and how it could be taught when three different approaches to teaching nursing were examined (Timmins & Neill, 2013). Educators were encouraged to thread spirituality throughout the curricula by placing an emphasis in both didactic and clinical instruction, to best prepare nurses to address spiritual needs of patients (Bennett & Thompson, 2014; Callister et al., 2004; Salladay & Poole, 2011). Teaching nursing students followed a prescriptive pathway, however at most universities, spiritual content was void (Callister et al., 2004; LaBine, 2015). There was a lack of spiritual integration in nursing programs (LaBine, 2015; Yilmaz & Gurler, 2014). Nurses were commonly instructed in clinicals at local healthcare facilities (Connelly, 2015). Due to the early exposure to patient care without adequate preparation, students' competence and confidence were often compromised.

Coupled with the lack of spiritual integration in nursing programs (Yilmaz & Gurler, 2014), students were not prepared to assess and address spiritual needs of patients.

Several studies concluded that intentional instruction about spiritual care improved student competence in delivering spiritual care (Baldacchino, 2008; Connors et al., 2017; Hoffert et al., 2007; Mitchell et al., 2006; Narayanasamy, 2006; van Leeuwen & Cusveller, 2003; Yilmaz & Gurler, 2014). Bennett and Thompson (2014) conducted a literature review on spirituality in nursing. The results determined the same outcome found by Lemmer (2002), in that a variety of teaching methods were effectively utilized when teaching spirituality in nursing. Educational strategies included lectures, self-reflection, case studies, simulation, and exposure to research conducted on spirituality. Findings revealed that nursing students could be taught how to provide spiritual care irrespective of the teaching methodology. As student nurses' knowledge increased, students became more focused on providing patient-centered care (Bennett & Thompson 2014; Lemmer, 2002).

LaBine (2015) surveyed community colleges in the southeastern United States and found very little education in spiritual care was being taught. Some institutions had guest speakers teach the subject. Content was taught more often at private colleges with baccalaureate nursing programs affiliated with a particular religion. Further, LaBine stated that there was a gap in the literature related to spirituality in nursing conducted at public community colleges in the south. Nurse educators reported very little preparation in teaching this content (LaBine, 2015).

Briggs and Lovan (2014) conducted a study of first semester nursing students using guided reflection. Students were encouraged to write about their personal feelings about spiritual matters. Study findings suggested that when nursing students examined their personal spiritual beliefs prior to entering the clinical setting, they were better prepared to address spiritual needs

of patients and families. Students reported an improved confidence in discussing spiritual matters with patients. One recommendation was for nursing faculty to use guided reflection to prepare first semester nursing students before initial patient care (Briggs & Lovan, 2014). Guided reflection was an appropriate strategy, as many nursing students are in the late adolescence and early adulthood stage of development and can be in a stage of spiritual immaturity, questioning their own spiritual beliefs (Briggs & Lovan, 2014). Reflections were also used by Eggerberger and Regan (2010), when instructional methods included both psychomotor skills and relational caring with first semester nursing students.

An international study using a quasi-experimental two-group research design was conducted by Yilmaz and Gurler (2014). Spiritual content was integrated into the curriculum of half of senior baccalaureate nursing students in Turkey. Students were exposed to the information over the course of three years. Instructional methods included small group discussions, several lectures, concepts and patient scenarios. Upon completion of the nursing program, students participating in the intervention group were better able to articulate the definition of spirituality and spiritual care than students with no spiritual instruction. Even though the study included only females in the population, the generalizability can be applied to both genders. Recommendations for nurse educators included integrating spirituality into content throughout the course of the curriculum to prepare future nurses to meet the spiritual needs of their patients (Yilmaz & Gurler, 2014).

Rogers and Wattis (2015) offered suggestions for nurses continuing professional development to increase spiritual competency. Ideas for incorporating spiritual sensitivity into practice began with a personal spiritual assessment for nurses. Next, nurses were encouraged to be attentive to the patients' desires and wishes without imposing ones' personal beliefs. Finally,

nurses were to write reflectively to increase spiritual awareness and competency. By following these steps, nurses better understood spirituality, and the purpose and meaning of their work (Rogers & Wattis, 2015).

Barber (2008) conducted a qualitative study with senior year nursing students. Barber examined how a specific teaching project influenced the student nurses' ability to address the spiritual needs of their patients after participating in a spirituality workshop and an oral history project. Barber's dissertation examined the impact of one intervention suggested to treat spiritual distress with eleven nursing students in the midwestern United States (Barber, 2008). To positively impact their patients, student nurses needed to understand their own spirituality to become proficient at recognizing spiritual distress in their patients. In addition, Barber noted that the students participating in the research developed an awareness of their own spirituality, as well as began to value the time spent with their patients. Utilizing one of the NANDA-I (2016) recommendations, the students involved in the study listened as an adult volunteer spoke about their beliefs and what brought meaning to their lives, through reminiscing and story-telling. Active listening and presence were two suggested behaviors for nurses to meet the spiritual needs of their patients (Cavendish et al., 2003; Narayanasamy, 2006). Participation in the patient's spirituality by actively listening produced feelings of contentment within the students. The teaching methods and activities used in the study afforded the nursing students the opportunity to incorporate spiritual care into their practice through storytelling and reflective conversations (Barber, 2008). Listening as the patients told their life stories, respecting the patients' religious and non-religious preferences, were key elements that demonstrated spiritual caring for patients (Narayanasamy, 2006).

The principle of listening aligns with the scripture passage, “Finally brethren, whatsoever things are true, whatsoever things are honest, whatsoever things are pure, whatsoever things are lovely, whatsoever things are of good report; if there be any virtue, and if there be any praise, think on these things” Philippians 4:8 (King James Version). Self-reflection and story-telling are practical means of applying scriptural concepts. By permitting patients to remember and discuss memories, both student and patient are following scriptural principles. Specifically, nursing students that provided spiritual care seemed to have benefitted from the connection made with their patients (Barber, 2008).

Principles of self-reflection were also implemented in a different study. Van Leeuwen and Cusvellar (2003) suggested instruction of didactic information that defined nursing behaviors with an application of the content to reinforce the knowledge through a student engagement activity. As students became involved in the clinical experience, utilizing self-reflection after a patient interaction was an effective teaching strategy that encouraged critical thinking. Educational courses that used methods that allowed for a reflective style of learning were beneficial in allowing students to explore personal spiritual beliefs (van Leeuwen & Cusvellar, 2003).

Cockell and McSherry (2012) conducted an overview of international research published between 2006 and 2010 on spiritual care in nursing. Eighty global studies were classified into themes, including nursing education, care of health-care practitioners, palliative and oncology, and spiritual and cultural research. Discovery of current evidence-based research was the basis to recommend best practices for providing spiritual care. Implications for nurse managers were compiled as a result of the literature reviewed. Research demonstrated that educating nurses on spiritual care impacted quality patient care and nursing care. Further, the health care providers

also benefitted from the spiritual care training personally. Next, current spiritual assessment tools used could be beneficial in helping nurse managers develop competencies and train nursing staff. Finally, the preponderance of research in palliative care and oncological settings, could be applied to other areas of patient care. Mirroring and dispersing best practices from end-of-life care into other nursing specialties was recommended (Cockell & McSherry, 2012).

Bennett and Thomas (2014) published ways to teach the significance of spirituality to nursing students:

- Give a comprehensive understanding of what is meant by spirituality, its connection to health and wellbeing and how to deliver spiritual care.
- Use methodical teaching to prepare students to assess patients spiritually.
- Educate students to recognize and act on spiritual cues.
- Keeping a respectful and therapeutic relationship and sensitive communication can assist students to discover what is significant to the client.
- Make spiritual assessment and interventions more obvious in the clinical practice.
- Have students finish a spiritual assessment as a piece of the nursing admission history.
- Discuss spiritual concerns in pre and post-conference.
- Teach students what has been identified as meaningful spiritual interventions such as: care, comfort, coping, connectedness, listening, reassurance, presence, prayer, religious worship and referral for chaplaincy services.
- Communicate cognitive therapies that can be used for spiritual interventions: mindfulness, reflective reading, art and music.

- Promote a calm and restful healing environment as part of spiritual care such as allowing patients to see a garden, feel pets, watch flowers bloom or look at beautiful paintings.
- Implement graduate nurse residency programs to increase skills and comfort of the novice nurse that includes the significance of spirituality (p. 29).

While these statements provided some guidelines for those practicing nursing, there was lack of educational material and training that taught students how to provide spiritual care (Heindel, 2015; LaBine, 2015; McSherry & Jamieson, 2011; Timmins & Neill, 2013; Wu, Tseng, & Liao, 2016). Du Plessis (2016) suggested that one avenue to teaching spiritual care was through the concept of presence. Basic behaviors that are observed provided clues to the emotional state of the patient. Teaching nursing students to recognize these clues provided the motivation for the current investigation.

### **Theoretical Framework**

Instructing students to be cognizant of and react appropriately to the behaviors of others is difficult. Several factors impact learning new behaviors. In the book, *Social Learning Theory*, Bandura (1977) discussed the process for learning through social means. Several areas of learned responses included observation and predicting outcomes, motivation, and reinforced function. Bandura (1986) introduced the phenomenon of triadic reciprocal causation. The relationship that impacted learning was between the student's cognitive and other personal factors, environment, and behavior. While represented in a triangular fashion, the weight or influence of each of the three parts was not always equal (Bandura, 1986). Rather, the influence was independent of the other and exerted influence simultaneously. Self-efficacy or confidence

in one's ability was enhanced with focus on any of the three influential components impacting learning.

Teachers have the opportunity to structure learning by influencing one or more of the parts of the triad. By focusing on the environment, in the case of teaching new behaviors, students can be influenced by the actions of others as they interacted within the boundaries of the classroom. As students learn a new behavior, it is important to remember the content taught. Bandura (1986) suggested cognitive rehearsal as one method by which students can reproduce appropriate responses. Practicing what to say and do will help novice nursing students respond appropriately as they learn how to give appropriate spiritual care.

Simulation was one teaching method commonly used when training nursing students (Brannan, et al., 2016; Gore & Thomson, 2016). Retention of knowledge could be enhanced by “rehearsing coded information” (p. 61). Remembering new behaviors while in the clinical environment could be maximized as students have the opportunity to experience and practice the skills. Bandura (1986) asserted that the factors influencing learning can be improved to increase knowledge retention yet “it takes time for a causal factor to exert its influence” (p. 25). Exposing students to spiritual content throughout the curriculum was supported by Bandura's theory (1986).

### **Instructional methods to teach spirituality**

In one study, students in a baccalaureate program were instructed to complete a self-study entitled *What Do I Say? Talking with patients about spirituality* (Taylor, 2007). Taylor et al. (2009) stated that there were sparse resources to train nurses how to communicate when patients express spiritual concerns. Further, there was little empirical data available to guide educators to train students in this subject matter. The self-study, an independent resource, took about 10

hours to complete (Taylor et al., 2009). Students were recruited from several religious and non-religious universities. While the study showed an improvement in students completing the extensive training, the program was time prohibitive in most colleges (Taylor et al., 2009).

Recognizing those in spiritual distress and providing spiritual care to the patient in need is a function of nursing (LaBine, 2015; O'Brien, 2014; McSherry, 2006). However, there was a lack of educational preparation for nurses. Nursing students needed specific content covering spirituality to learn how to address the patient's needs (Baldacchino, 2008; Hoffert et al., 2007; Lovanio & Wallace, 2007; Narayanasamy, 2006; Timmins & Neill, 2013). There was a lack of formal training in interpersonal relationships and methods that taught students how to care for patients (Heindel, 2015; LaBine, 2015; Timmins & Neill, 2013). McSherry (2006) described a "growing debate is whether spirituality should be 'taught' or is something that is 'caught' in practice?" (p. 195).

As a result of ambivalence toward spirituality in an increasingly secular society, nurses were less likely to converse with patients about matters of spirituality. A literature review was conducted by Timmins and Neill (2013) that included years 2007-2012. Three main articles examined the instructional methods of teaching spirituality in nursing schools. Their conclusion was that there was little research on teaching students how to care spiritually for their patients (Timmins & Neill, 2013). The results of Timmins and Neill (2013) were confirmed by LaBine (2015) as she conducted her dissertation research in an online survey with nursing professors at community colleges across the southeastern United States. Surveys were sent to colleges and distributed to faculty. Results showed that few colleges were teaching spirituality in the nursing program. No studies were found that investigated how to introduce and prepare students to care

for patients' spiritual and emotional needs among state supported (community) colleges (LaBine, 2015).

A Brazilian study conducted by Tomasso, Beltrame, and Lucchetti (2011) compared the attitudes of nursing professors and nursing students. The vast majority of participants declared a religious preference and were convinced that one's state of health is influenced by spiritual beliefs. While many wanted to discuss spirituality with patients, less than half of the nurses surveyed said they were prepared to do so, citing deficient nursing education as the cause. In addition, other reasons for not addressing spirituality, many participants stated they were afraid of proselytizing or offending patients. The study concluded that nursing instructors felt that nursing students should be taught how to care for the spiritual needs of patients. However, of the educators questioned, many agreed there was a lack of instructional tools. Further noted was a need to implement teaching methods to better equip nurse educators and students to provide holistic patient care (Tomasso et al., 2011).

### **Spiritual assessments**

Having students complete a spiritual assessment with a live patient after attending a lecture on spirituality was another method of learning how to deliver spiritual content. Such was the case with the Hoffert et al. (2007) study. The impact of a spiritual seminar, combined with a student self-assessment and client spiritual assessment, measured the comfort level of 38 junior level nursing students. A pretest-posttest design was used to compare results of student respondents. Data revealed an increase in student comfort and confidence in providing spiritual care. This survey was conducted at a faith-based baccalaureate-nursing program.

Along the same teaching format, Barber (2008) performed a qualitative study that examined the effectiveness of a spirituality workshop and an oral history project on student

nurses' ability to address the spiritual needs of their patients. The study was conducted with eleven nursing students in the midwestern United States. Students conducted an interview to complete a patient's history. Afterwards, students were interviewed, and they reported having a connection with their patient because of hearing patients tell their stories and reflecting on the conversations (Barber, 2008).

### **Simulation**

One teaching method considered appropriate for students about communication and caring is simulation. Simulation provided students with situations that emulate real-life experiences (Brewer, 2011) and allowed nursing students an opportunity to authenticate practice in a safe environment (Shapira-Lishchinsky, 2014; Sivertsen & McNeill, 2016). Endorsed by the National Council of State Boards of Nursing, simulation was commonly used in training nurses to provide the opportunity to practice skills away from the bedside (Gore & Thomson, 2016).

Chmil, Turk, Adamson and Larew (2015) found that simulation encouraged student engagement and promoted nursing clinical judgment in pre-licensure nursing students. The study utilized innovative teaching strategies to include all four elements of Kolb's learning cycle. Thinking, planning, performing, and debriefing were applied to a control group. In addition, the study implemented two 15-minute planning and thinking activities. The group that participated in the traditional simulation, utilized unstructured activities for learning. Using the *Lasater Clinical Judgement Rubric* to measure growth, students that participated in the experimental design had significantly higher clinical judgment than those who participated in traditional simulation methods (Chmil et al., 2015).

Sivertsen and McNeill (2016) described the value of permitting students the occasion to "ReDo" (p. 34) the simulation. Repeated role playing gave students a second opportunity to

correctly perform skills. This instilled a renewed sense of self-confidence about their performance. Oermann (2016) stated that simulation was common in teaching nursing skills and feedback was necessary to improve student performance. Brannan et al. (2016) discovered that simulation created an environment that encouraged student engagement regardless of students' learning styles. Engaged learning through simulation was an effective teaching strategy that utilized kinesthetic, affective, and cognitive learning (Gore & Thomson, 2016). Timmins and Neill (2013) stated that the needs of society and the professional nurse should be discussed when teaching spiritual care.

Nurses need to be taught how to deliver spiritual care (Frouzandeh, Aein, & Noorian, 2015; Timmins & Neill, 2013). These findings were like that of Hoffert et al. (2007) which reported that students scored higher on spiritual competence and confidence after receiving a lecture on spirituality. Connors et al. (2017) posited that student perception of spiritual competence and confidence significantly increased after participation in a simulation. In Kimhi et al. (2016) research was conducted in Israel and determined that simulation conducted either before or after exposure to the clinical setting promoted self-confidence in nursing students (Kimhi et al., 2016).

Simulation had emerged as an effective method of teaching spirituality (Blesch, 2015; Connors et al., 2017; LaBine, 2015). Using the *Situation, Background, Assessment and Recommendation* (SBAR) tool, Blesch (2015) led junior-level nursing students to participate in a simulation with a patient experiencing an emotional crisis. While two of the participants responded appropriately, many students were reportedly unable to discern clues or apply appropriate nursing interventions. One student documented "awkward silence" (p. 234) during the simulation. In the post-simulation debriefing, students acknowledged that they were not sure

how to address the emotional and spiritual needs of the patient. Further, students indicated that they did not realize they were permitted to address the spiritual needs present during the simulation. By giving students the opportunity to discuss the simulation in a debriefing, a plan was formulated for future encounters with patients (Blesch, 2015).

Costello, Atinaja-Faller, and Hedberg (2012) piloted a study with 52 maternal-health nursing students using role-play with a high-fidelity mannequin. The instruction included The Joint Commission (2003) spiritual assessment recommendations. Pretest-posttest design measured students' confidence using the *Spiritual Care Confidence Scale* (van Leeuwen & Cusvellar, 2003). Students experienced a significant change in their perceptions of spirituality and perceived competence after instruction. Simulation facilitated spiritual instruction successfully (Costello et al., 2012).

Because people are of a variety of faiths and religious backgrounds that differ from the nurses' beliefs, many nurses were not comfortable with matters involving spiritual care (Kitchener, 2016). Du Plessis (2016) suggested *presence* as a beginning activity for introducing spiritual care at the bedside. Presence happened as nurses intentionally focus on the patient's needs; taking time to connect to the patient while addressing physical, emotional and spiritual needs. Presence was a tangible means of demonstrating humane caring and emotional support by the nurse to individuals. Practicing presence was an avenue to providing spiritual care regardless of the nurses' religious beliefs. Further research was suggested to explore the interpretation and implementation of presence by nurses (du Plessis, 2016). Innovative teaching methods *Key Phrases and Caring Behaviors*© were used effectively to teach nursing students how to be authentically present at the bedside of the patient (Connors et al., 2017).

### ***Key Phrases and Caring Behaviors*©**

Many students who are new to patient care, struggle with what to do and say to the patients they encounter. In a study conducted by Connors et al. (2017), a variety of instructional activities were used to teach spiritual content. During the study, students participated in a lecture, performed a spiritual assessment of a patient while in the clinical setting, and experienced a simulation, to learn how to care for the patient's spiritual needs. Using a pre-test posttest posttest design, students' perception of competence and confidence were compared over three phases. The survey tool *Spiritual Competence and Confidence*© used to collect data was fashioned after the instrument first introduced by Hoffert et al. (2007). While there was little gain in students' perception of competence and confidence after a lecture on spirituality, a significant difference was recognized after the simulation experience. One innovation within the simulation was the instrument *Key Phrases and Caring Behaviors*©, containing instructional interventions for appropriate communication techniques (Connors et al., 2017). Students were introduced to spiritual care using *Key Phrases and Caring Behaviors*© to incorporate the concept of *presence* into their developing practices.

### **Summary of Literature**

It is evident from the literature reviewed that spirituality was an integral part of nursing (Bennett & Thompson, 2014; NHS, 2009; "Nightingale letter," 1900, O'Brien, 2014). Biblical examples instruct societal behaviors, such as the Golden Rule, found in Luke 6:31. O'Brien (2014) described nurses as being called by Christ. Nurses are at the bedside when patients are the most vulnerable (Briggs & Lovan, 2014; LaBine, 2015; Peplau, 1987; Rogers & Wattis, 2015). Treating patients' and families' emotional needs required that nurses listen to their patients (McSherry, 2006; Watson, 2009) and develop a relationship with them (Peplau, 1987;

Rogers & Wattis, Tiew et al., 2013). Once the trusting relationship was established, the nurse had endless opportunity to connect spiritually with the patient (Briggs & Lovan, 2014).

Agencies that regulate academic practices, set ethical standards, and accredit healthcare institutions agreed that spiritual care was within the purview of nurses. Bennett and Thompson (2014) created a chart of standards and measures of spiritual care of agencies that address spiritual care. Included were The Joint Commission (2003), *Essentials of Baccalaureate Education* (AACN, 2008), *Scope and Standards of Nursing Practice* (ANA, 2004), *Nurses Social Policy Statement* (ANA, 2003), *Nurses Code of Ethics* (ANA, 2004), World Health Organization (2012) and International Council of Nurses Code of Ethics (2012). Instituted mandates of care required documentation of spiritual care for every hospitalized patient (TJC, 2011). Obamacare has tied spiritual care to Medicare reimbursement by requiring hospitals to ascertain patient satisfaction scores through a survey (“HCAHPS online,” 2016). Applying the concepts of spiritual care is a professional nursing standard and patient expectation. Never has nursing care had financial implications (Wolosin et al., 2012).

Despite the emphasis on providing spiritual care, nurses reported lack of competence and confidence in attending to their patients’ spiritual needs (Stranahan, 2001; Tiew et al., 2013). Barriers exist that hinder student nurses and licensed nurses from performing spiritual care giving. Lack of time (LaBine, 2015), fear of proselytizing, and confusion over the terms *spirituality* and *religion* were reasons cited for not addressing spirituality (Cohen & Koenig, 2003; Costello et al., 2012; Hoffert et al., 2007; Lemmer, 2002; McSherry et al, 2004; Narayanasamy, 2006; O’Brien, 2014). Another frequently mentioned reason nurses failed to provide spiritual care was lack of education (Connors et al., 2017; Hoffert et al., 2007).

Limited instructional resources existed to teach nurses spiritual care (Gore, 2013; Hoffert et al., 2007; Kitchener, 2016; LaBine, 2015; McSherry & Jamieson, 2011; Taylor et al., 2009; Timmins & Neill, 2013; Wu et al., 2016). A gap in the literature was clear concerning the needs for further exploration and refinement of spirituality teaching instruments (LaBine, 2015). There was no study that taught the efficacy of how to train nursing students to converse with patients experiencing emotional and spiritual crisis and how to express care for the spiritual dimension of nursing care. Very few studies have been done with public, non-religious, associate degree nursing programs (LaBine, 2015).

A prior study conducted by Connors et al., (2017) was conducted at a large public state-supported college. Associate degree seeking nursing students participated in a lecture, performed a spiritual assessment of a patient while in the clinical setting, and experienced a simulation to learn how to care for the patient's spiritual needs. Using a pre-test posttest posttest design, students' perception of competence and confidence were compared over three phases. While there was little gain in students' perception of competence and confidence after a lecture on spirituality, however, a significant difference was recognized after the simulation experience. Students were introduced to spiritual care using *Key Phrases and Caring Behaviors*© to incorporate *presence* into their emerging practices. Students expressed interest in having the instrument *Key Phrases and Caring Behaviors*© available earlier in the term. The research contained herein, adds to the body of knowledge for nursing education by determining when to introduce the instrument. The methodology for obtaining quantitative data on the introductory timing for *Key Phrases and Caring Behaviors*© will be explored in the following chapter.

## CHAPTER III. METHODOLOGY

The purpose of the current investigation was to determine the impact on students' competence and confidence when *Key Phrases and Caring Behaviors*© were introduced early in the school's instructional term, and prior to first semester nursing student exposure to a simulation activity. A repeated measures quasi-experimental quantitative study was utilized to explore the best time to introduce *Key Phrases and Caring Behaviors*© to first semester nursing students. This study attempted to answer questions raised in the published research of Connors, et al. (2017), as well as informal student comments collected at the end of the simulation experience. The current research adds to the knowledge of when and how to more appropriately utilize the teaching instrument *Key Phrases and Caring Behaviors*©. Researchers were focused on determining how students' perception of competence and confidence was impacted with early introduction to *Key Phrases and Caring Behaviors*©.

### **Participants**

A voluntary, non-probability sample, convenience and purposive in nature, was comprised of 25% of possible first semester nursing students enrolled in a public state supported associate degree nursing program located in central Florida. Female participants comprised 80% of the study's sample, with over 40% of participants occupying the 18-21 age group. Students who were repeating the course were not excluded from the study. However, students with prior exposure to the innovative teaching instrument may have ranked themselves as more competent and confident in providing spiritual care. Prior knowledge and experience in healthcare may have caused participants to rank themselves higher when surveyed about their competence and

confidence in providing spiritual care. In addition, students with prior clinical experience in the healthcare industry were not disqualified from the study.

A survey created by Hoffert et al. (2007), *Enhancing the Perceived Comfort and Ability of Nursing Students to Perform a Spiritual Assessment: Spiritual Questionnaire Evaluation Tool* was the basis for the current online survey entitled *Spiritual Competence and Confidence Survey Phase I, II, and III*©. Revisions were made with permission of the author and included varying three questions to better address the areas of the current study.

The survey included 15 items that addressed students' competence and confidence in providing spiritual care. The survey included 10 questions that were constant in all three phases. An additional five questions that were specific to each phase were added to the 10 questions. A section that allowed free text was also included, which asked the participant to include any other information or thoughts not previously shared. The survey was emailed to students at specific times during the semester, and the timeframes were identified as three Phases. The first survey, Phase I was considered the baseline, and was sent during the first week of the semester. Phase II was sent in the fourteenth week of the semester. Phase III was sent at the end of the semester, during week fifteen.

Phase I was administered before any spiritual content had been delivered as a pretest (see Appendix A). Phase II was administered after the lecture, small group activity, introduction of *Key Phrases and Caring Behaviors*© after students conducted a spiritual assessment on a patient in the clinical setting as a post test (See Appendix B). Phase II focused on five additional questions that related to the instrument *Key Phrases and Caring Behaviors*©. Phase II was administered in week fourteen of the semester. Phase III was administered after simulation (See Appendix C). Simulation is a frequently used teaching strategy in nursing education that allows

students a safe venue to practice skills and demonstrate competency away from the bedside (Blesch, 2015; Brannan et al., 2016; Gore & Thomson, 2016). The simulation used in this study was a role-play of a situation that included a patient and family member in emotional distress.

## **Procedures**

Phase I was the baseline phase in the beginning of the semester during week one of class. Phase II tested student perception of competence and confidence after the spiritual content was delivered via lecture. The teaching instrument *Key Phrases and Caring Behaviors*© was introduced during the spirituality lecture. The survey was sent out electronically during week fourteen of the semester. Phase III was defined by the introduction of the simulation activity in week 14 of the semester. Data were collected via online survey and recorded via college Informational Technology department, in which study participants were enrolled.

All first semester nursing students enrolled in the Adult Health I course were invited to participate via email with the online survey attached. Participant identity was protected, as students were encouraged to use the last four digits of their social security number or phone number as their identifier. Researchers did not have access to the students' personal information. The invitations to participate were sent by the director of the nursing program at three distinct time frames. The first invitation was sent during the first week of school of the fall semester of 2016. The second invitation/survey was emailed after the lecture was given during the fourteenth week of class. The final invitation to participate was distributed to the class during the fifteenth week of a 16-week semester. Reminders were sent after each initial email encouraging participation in the study. Students were assured that there was no positive or negative impact on their grade for participation or refusal to participate in the survey.

The instrument used to measure students' perceptions of competence and confidence when delivering spiritual care was the *Spiritual Competence and Confidence Survey Phase I-II-III*©. This instrument was adapted with permission from an instrument first introduced in the article by Hoffert et al. (2007). Changes to the survey removed some questions on the original tool. The questions were removed because they did not support the direction of the study. The tool contained a core of 10 Likert-type questions related to students' perceptions of competence and confidence in providing spiritual care. In addition, the first survey included five additional questions concerning the students' knowledge and comfort level of spiritual care. The second survey contained five additional questions pertaining to the particular phase of the study, while the third survey contained an additional five questions pertaining to the simulation and usage of *Key Phrases and Caring Behaviors*© while in the clinical setting. Nursing students were surveyed three times in the following phases:

- 1) Phase I: This initial phase was characterized by the administration of an electronic pre-test *Spiritual Competence and Confidence Survey Phase I*© to serve as a baseline of student understanding of spirituality and spiritual caregiving (see Appendix A). The survey was sent electronically to all students enrolled in the first semester nursing course, Adult Health I. Using a Likert-type scale, the initial survey consisted of ten core questions that required students to rate their ability to care for spiritual needs and five additional questions pertaining to how students defined their own spirituality.
- 2) Phase II: The second phase of the study was defined by the administration of the *Spiritual Competence and Confidence Survey Phase II*© (see Appendix B). The survey was sent electronically to all students enrolled in the first semester of nursing school. Using a Likert-type scale, there were ten core questions and five additional questions about the students' perception

of the teaching instrument *Key Phrases and Caring Behaviors*©. Participants were asked to complete the survey after the classroom lecture, a small group activity designed to introduce spiritual care in nursing, and after performing a spiritual assessment with a patient in the acute care setting. The teaching instrument *Key Phrases and Caring Behaviors*© was distributed after the lecture, before class dismissed.

3) Phase III: The study's third phase involved the administration of the *Spiritual Competence and Confidence Survey Phase III*© (see Appendix C), which consisted of ten core questions and five questions about students' perceptions of the simulation experience. The simulation was a role-play of a clinical situation that included a patient and family member in emotional distress.

### **Data Analysis**

The initial analysis of data in the current investigation centered upon matters of missing data, internal reliability of participants' response, and exploratory factor analysis (EFA). To assess the extent and effect of missing data yielded by the research instrument, both expectancy maximization (EM) and multiple imputation (MI) were used to analyze participant response to survey items across all three phases of the study. Little's MCAR statistic was used to evaluate the randomness of missing data. The internal consistency (reliability) of participant response was evaluated using Cronbach's Alpha test statistic. Exploratory Factor Analysis (EFA) was conducted using principal components analysis (PCA) specifically.

The following research questions were posed to address the stated research problem:

I. Will introducing *Key Phrases and Caring Behaviors*© impact first semester nursing students' perception regarding their competence and confidence in providing spiritual care prior to the exposure to the simulation activity?

II. Will introducing the simulation activity after exposure to *Key Phrases and Caring Behaviors*© produce a statistically significant change in first semester nursing students' perception of competence and confidence in providing spiritual care?

III. Will the combination of both instruction using *Key Phrases and Caring Behaviors*©, and a structured simulation activity exert a statistically significant improvement in first semester nursing students' perception of competence and confidence in providing spiritual care to patients?

All three research questions were addressed using descriptive statistical techniques. Frequency counts, percentages, and measures of central tendency (Mean) and variability (Standard Deviation) represented the primary means by which data were analyzed. The following hypotheses were stated to accompany respective research questions:

### **General Hypothesis**

There is a difference in first semester nursing students' perception regarding their competence and confidence in providing spiritual care dependent on the timing of the exposure of the *Key Phrases and Caring Behaviors*© tool.

### **Null Hypotheses**

The Null Hypothesis addressing the General Hypothesis statement was:

There will be no difference in first semester nursing students' perception regarding their competence and confidence in providing care to those in spiritual and emotional crisis.

Null and Alternative Hypotheses by research question posed were stated as follows:

H<sub>0</sub>1: Introducing *Key Phrases and Caring Behaviors*© prior to exposure to a simulation activity and instructional design will not promote a statistically significant difference in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>a1</sub>: Introducing *Key Phrases and Caring Behaviors*© prior to exposure to a simulation activity and instructional design will promote a statistically significant difference in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>o2</sub>: Introducing the simulation activities after the first semester nursing student has been exposed to *Key Phrases and Caring Behaviors*© will not promote a statistically significant difference in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>a2</sub>: Introducing the simulation activities after the first semester nursing student has been exposed to *Key Phrases and Caring Behaviors*© will promote a statistically significant difference in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>o3</sub>: The combination of both instruction using *Key Phrases and Caring Behaviors*©, and a structured simulation activity will not exert a statistically significant improvement in first semester nursing students' perception of their ability to provide spiritual care.

H<sub>a3</sub>: The combination of both instruction using *Key Phrases and Caring Behaviors*©, and a structured simulation activity will exert a statistically significant improvement in first semester nursing students' perception of their ability to provide spiritual care.

Hypotheses one and two were addressed through inferential statistical means, specifically the application of the t-test of Dependent Means. The threshold for evaluating the statistical significance was set at the alpha level of  $p < .05$ . The third set of hypotheses were addressed through inferential statistical means, specifically through the use of a multivariate, repeated measures ANOVA statistical technique. The threshold for evaluating the statistical significance was set at the alpha level of  $p < .05$ . The magnitude of treatment effect across all three phases of the study was evaluated using the  $\eta^2$  statistic.  $\eta^2$  values of .14 and beyond are indicative of a large magnitude of treatment effect.

## Summary

The purpose of the study was to determine the impact on students' competence and confidence when *Key Phrases and Caring Behaviors*© was introduced early in the school's instructional term, and prior to first semester nursing students' exposure to a simulation activity. A repeated measures quasi-experimental quantitative study was utilized to explore the best time to introduce *Key Phrases and Caring Behaviors*© to first semester nursing students. This study sought to answer questions raised in the published research of Connors et al. (2017), as well as informal student comments collected at the end of previous simulation experiences.

The survey instrument was created by revising the questionnaire first used by Hoffert et al. (2007), *Enhancing the Perceived Comfort and Ability of Nursing Students to Perform a Spiritual Assessment: Spiritual Questionnaire Evaluation Tool*. The online tool used in the current study was entitled *Spiritual Competence and Confidence Survey Phase I, II, and III*©. First semester nursing students were questioned three times over the course of the 16-week term. The three surveys were identified as distinct phases. Phase I served as a baseline of student understanding of spirituality and spiritual caregiving. Phase II questioned students after spiritual content was provided, along with *Key Phrases and Caring Behaviors*©, and once the student had conducted a spiritual assessment with a patient in the clinical setting. Phase III was at the end of the term and asked the participants about the experience of the simulation.

Three research questions were addressed using descriptive statistical techniques. Frequency counts, percentages, and measure of central tendency (Mean) and variability (Standard Deviation) represented the primary means by which the data were analyzed. In addition, inferential statistical means, a multivariate, repeated measures ANOVA statistical technique was utilized as well.

Research was conducted to determine the baseline of students prior to any instruction and the significance of the timing of introducing *Key Phrases and Caring Behaviors*©. The impact of simulation was also analyzed. The results of the research findings will be discussed in the subsequent chapter.

## CHAPTER IV. RESULTS

### Demographic Data

Within the study's sample, eight in 10 participants were female. Most participants, seven in 10, described themselves as being associated with a "Christian" faith denomination. The two other categories of religion were agnostic/atheist 10%, and other 10%. Nearly 70% possessed either an associate's or bachelor's degree (56% associate degree). Approximately 80% of participants were ages 18-30, with the single greatest age range represented was 18-21 (40%).

### Preliminary Analyses

The initial analysis of data in the current investigation centered upon matters of missing data, internal reliability of participants' response, and exploratory factor analysis (EFA). To assess the extent and effect of missing data yielded by the research instrument, both expectancy maximization (EM) and multiple imputation (MI) were used to analyze participant response to survey items across all three phases of the study. During the first two phases of the study, participant response to each survey question was completed at a rate of 100% (0% missing data). In the study's third phases, missing data were minimal (1.4%) and sufficiently random nature (Little's MCAR  $\chi^2(24) = 32.92; p = .11$ ). Imputation of missing data was therefore not deemed necessary.

The internal consistency (reliability) of participant response was evaluated using Cronbach's Alpha. The internal consistency is considered very high across all three phases of the study (Alpha range = .89 - .96) (see Figure 1).

**Figure 1.** Internal Consistency of Response by Phase

Phase #	A	F
I	.89	3.03***
II	.96	1.34
III	.94	1.77*

\* $p < .05$  \*\*\* $p < .001$

*Figure 1.* Internal consistency of response rate by phase using Chronbach's Alpha.

Exploratory Factor Analysis (EFA) was conducted using *Principle Components Analysis* (PCA) specifically. The factoring model met the threshold for sample size and sufficiency of correlation (KMO= .475; Bartlett's Test of Sphericity  $\chi^2 (105) = 229.90; p < .001$ ). A total of four distinct factors, accounting for 72.83% of variance was noted in the analysis. The four respective factors identified in the analysis were role in spiritual care, competence and confidence, comfort level and responsibility. Figure 2 categorizes each survey question in the corresponding factors identified.

**Figure 2.** Survey Question Loadings by Factor and Variance

Factor	Survey Questions	Variance Contribution
Role in Spiritual Care	3; 6; 10; 11; 13; 14	27.54%
Competence/Confidence	1; 5; 8; 15	20.39%
Comfort Level	7; 9; 12	14.90%
Responsibility	2; 4	10.00%

*Figure 2.* Chart of survey questions results by factors of role in spiritual care, competence and confidence levels, comfort level, and responsibility.

### **Analyses by Research Question Posed**

The purpose of the current investigation was to determine the impact on students' competency and confidence when *Key Phrases and Caring Behaviors*© were introduced early in the term to first semester nursing students. To address the stated research problem of the current investigation, three distinct research questions were posed:

Research Question #1:

Will introducing *Key Phrases and Caring Behaviors*© impact first semester nursing students' perceptions regarding their competency and confidence in providing spiritual care prior to their exposure to a simulation activity?

Hypothesis

H<sub>0</sub>: Introducing first semester nursing students to *Key Phrases and Caring Behaviors*© prior to exposure to a simulation activity will not produce a statistically significant change in their perceived competence and confidence in providing spiritual care to patients.

H<sub>a</sub>: Introducing first semester nursing students to *Key Phrases and Caring Behaviors*© prior to exposure to a simulation activity will produce a statistically significant change in their perceived competence and confidence in providing spiritual care to patients.

The treatment variable, *Key Phrases and Caring Behaviors*© was introduced in the instructional phases of the current investigation (Phase II), and prior to participating nursing student exposure to the planned simulation experience. The change in participant perceived competence and confidence in providing spiritual care to patients was minimal (Mean Difference = .02) and was not found to be statistically significant ( $t_{(14)} = 0.21; p = .84$ ). Therefore, the null hypothesis (H<sub>0</sub>) was sustained in light of the non-statistically significant finding, and the alternative research hypothesis (H<sub>a</sub>) was rejected (not enough evidence to support the alternative hypothesis). Table 1 demonstrates the Pre Test (Phase I) and Post Test (Phase II) comparisons by survey question.

With regard to factor categorization of survey questions and comparisons of participant perceptual change, none of the four factors manifested statistically significant change from the Pre Test (Phase I) to Post Test (Phase II) condition of the study. Two factors (#2 and #3) manifested perceptual mean score decreases from the Pre Test to Post Test condition of the study. The most robust increase within factors from the Pre Test to Post Test condition of the study was manifested in Factor #4 (+.35).

The mean score comparison of participant response to respective survey items by factors identified in the preliminary EFA in the Pre Test (Phase I) and Post Test (Phase II) study conditions (see Figure 3).

**Figure 3.** Mean Score Changes by Factor (Phase I to Phase II)

Factor	Mean Difference	T
1- Role in Spiritual Care	+0.03	0.16
2- Competence/Confidence	-.21	1.23
3- Comfort-Level	-.12	0.69
4- Responsibility	+0.35	3.89

*Figure 3.* Survey results comparing Mean score changes of Factors from Phase I to Phase II. Responsibility was the Factor with the most robust change.

Research Question #2:

Will introducing the simulation activity after first year nursing students have been exposed to the *Key Phrases and Caring Behaviors*© promote a statistically significant improvement in perceived competence and confidence in providing spiritual care to patients?

Hypotheses:

H<sub>0</sub>: The introduction of the simulation activity to first semester nursing students after they have been exposed to *Key Phrases and Caring Behaviors*© will not promote a statistically significant improvement in perceived competence and confidence in providing spiritual care to patients.

H<sub>a</sub>: The introduction of the simulation activity to first semester nursing students after they have been exposed to *Key Phrases and Caring Behaviors*© will promote a statistically significant improvement in perceived competence and confidence in providing spiritual care to patients.

The simulation activity was introduced in the third phase of the current investigation, following participation exposure to the instructional technique *Key Phrases and Caring Behaviors*© (Phase II). Comparisons of participation change in perception regarding competence and confidence in providing spiritual care patients was statistically significant from

Phase II (*Key Phrases and Caring Behaviors*©) to Phase III (Simulation) of the study ( $t_{(14)} = 3.66; p < .001$ ). Therefore, in light of the statistically significant finding, the null hypothesis ( $H_0$ ) is rejected, and the alternative research hypothesis ( $H_a$ ) is retained.

The complete comparison of mean differences between respective phases in the current investigation is illustrated in Figure 4.

**Figure 4.** Phase Comparisons

Phase Comparison	Mean Difference	<i>T</i>
Phase I- Phase II	.02	0.21
Phase I-Phase III	.24	2.67*
Phase II- Phase III	.26	3.66***

\* $p < .05$  \*\*\* $p < .001$

*Figure 4.* Comparison of Mean scores across all three phases. There was a statistically significant difference between Phase I and Phase II. The most significant change was between Phase II and Phase III once simulation was introduced.

With regard to factor categorization of survey questions and comparisons of participant perception change, one of the four (Factor #2); (“Competence/Confidence”) manifested statistically significant change from Phase II to Phase III condition of the study. Mean perceptual increases were manifest in all four factors from Phase II to Phase III of the study is shown in Figure 5.

**Figure 5.** Mean score difference by Factor (Phase II to Phase III).

Factor	Mean Difference	<i>T</i>
Role in Spiritual Care	+.26	1.81

Competence/Confidence	+.23	4.65*
Comfort-Level	+.33	1.40
Responsibility	+.26	1.19

---

\* $p < .05$

Figure 5. Mean scores differences by Factor in Phase II to Phase III demonstrate perceptual increases in all four Factors. Only the competence/confidence Factor was statistically significant.

Research Question #3:

Will the combination of both instruction using *Key Phrases and Caring Behaviors*© and a structured simulation activity exert a statistically significant improvement in first semester nursing student perception of competence and confidence in providing spiritual care to patients?

Hypothesis

H<sub>0</sub>: The combination of both instruction using *Key Phrases and Caring Behaviors*©, and a structured simulation activity will not exert a statistically significant improvement in the first semester nursing student perception of competence and confidence in providing spiritual care to patients.

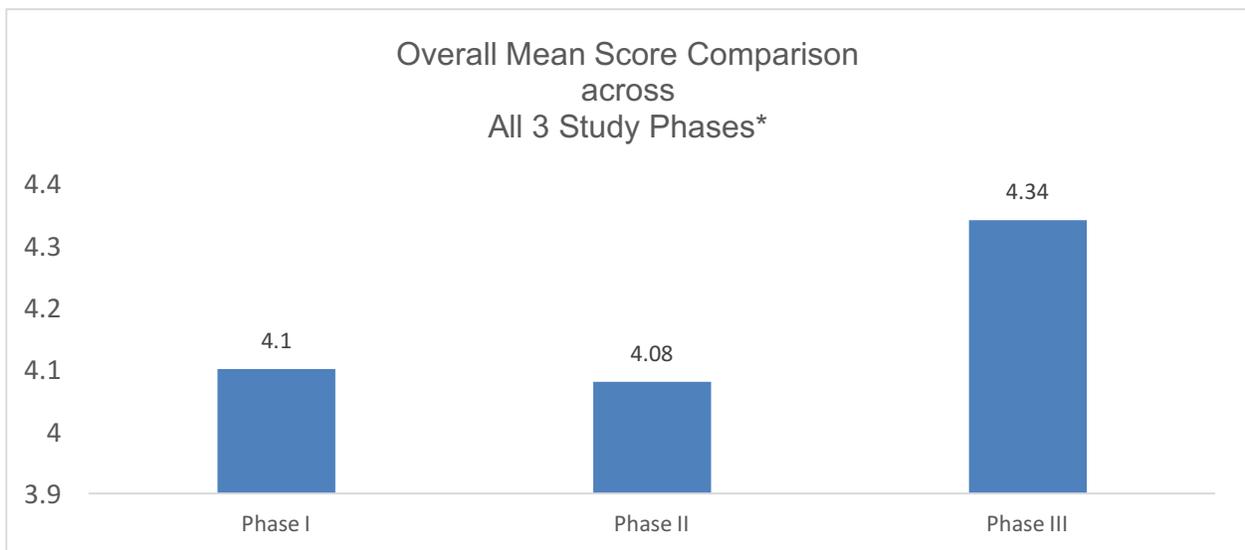
H<sub>a</sub>: The combination of both instruction using *Key Phrases and Caring Behaviors*©, and a structured simulation activity will exert a statistically significant improvement in the first semester nursing student perception of competence and confidence in providing spiritual care to patients.

The current investigation's inclusion of both the *Key Phrases and Caring Behaviors*© instructional element, along with the structured simulation activity exerted a statistically significant effect upon first semester nursing student perception of competence and confidence in providing spiritual care to patients (Pillai's Trace  $F_{(2, 13)} = 8.14; p = .005$ ). Moreover, the

magnitude of effect upon the first semester nursing student perception of competence and confidence in providing spiritual care to patients is considered “large” ( $\eta^2 = .56$ ). Therefore, in light of the statistically significant finding related to the research question, the null hypothesis ( $H_0$ ) is rejected, and the alternative hypothesis ( $H_a$ ) is retained.

The mean change of first semester nursing student perception of competence and confidence in providing spiritual care to patients across the three phases of the current investigation is illustrated in Figure 6.

**Figure 6.** Overall Mean score compared across all three study phases.



\* Pillai's Trace  $F_{(2, 13)} = 8.14$ ;  $p = .005$

*Figure 6.* Graph of Means score comparisons across all three phases. The most significant change was in Phase III.

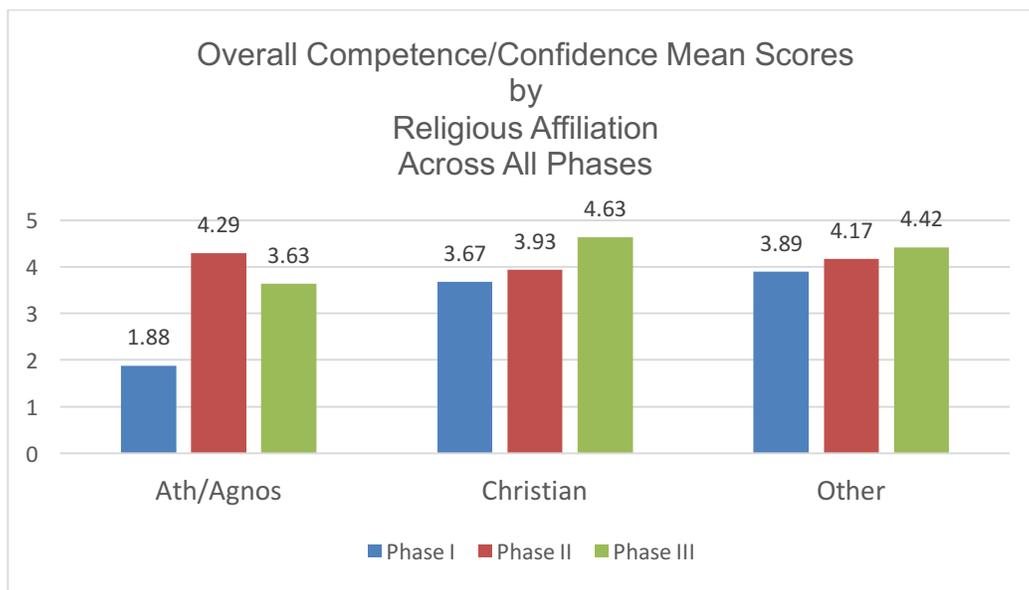
See Table B for the line graph that illustrates the mean perception of first semester nursing students regarding their competence and confidence in providing spiritual care to patients across the three phases of the current investigation by respective survey question. Increases in participant mean scores were manifest in 80% of the survey question from Phase II

to Phase III of the study (12 of 15). With regard to the mean score increases from Phase II to Phase III, 75% were statistically significant (9 of 12).

To further parse out the impact of religion on students participating in the study, mean scores of all three phases were also compared. Participants that disclosed their religion to be Christian were compared to those students that selected agnostic/atheist and other religions. The mean score of Phase I of the students that identify themselves as Christian was 3.67. The mean score of Phase I of the students that identify themselves as Agnostic/Atheist was 1.88. While the mean score of Phase I of the students that selected “other” as their religion was 3.89.

Atheist/agnostics scored the lowest baseline mean score, the highest mean score in Phase II, and the lowest mean score in Phase III. Figure 7 demonstrates the overall mean scores of competence and confidence of students that identified themselves as atheist/agnostic, Christian, and other.

**Figure 7.** The overall competence/confidence Mean scores by religious affiliation.



*Figure 7.* Mean scores of competence/confidence comparison of atheist/agnostics, Christians, and others. The most growth experienced was with the atheist/agnostic group between Phase I and Phase II. Christians experienced the highest gain of all three groups compared.

## Summary

The purpose of the current investigation was to determine the impact on students' competence and confidence when *Key Phrases and Caring Behaviors*© was introduced early in the school's instructional term, and prior to first semester nursing student exposure to a simulation activity. The stated research problem of the current investigation addressed three distinct research questions with accompanying hypotheses. Preliminary analysis on the data set depicted missing data as minimal, and sufficiently random. Internal consistency of participant response was very high across all three treatment phases of the study. Four distinct factors were evident in the data set, role in spiritual care; competence and confidence; comfort level; and responsibility. Table 2 demonstrates a mean score comparison by survey question across all three phases of the study.

The resultant analyses did not provide support for the efficacy on introducing the instructional component *Key Phrases and Caring Behaviors*© earlier in the instructional process. However, when the results of the published study are compared to the current study, Phase I to Phase II results may be interpreted differently. When *Key Phrases and Caring Behaviors*© are introduced earlier in the term students maintained their perception of competence and confidence. It appears that *Key Phrases and Caring Behaviors*© prevented a decline in student competence and confidence in providing spiritual care. In addition, statistically significant findings were manifested with the increase in participant perceptions of their competence and confidence in providing spiritual care in the wake of participating in a simulation activity. It was also found that a combination of both instructional technique, *Key Phrases and Caring Behaviors*© and the study's simulation activity exerted a statistically significant effect upon participant perceptions of competence and confidence in providing spiritual care to patients in the nursing environment. Key factors that impacted the study's implementation and results will be discussed in the final chapter.

## V. DISCUSSION

### **Discussion of Findings**

Evidence exists that intentional instruction exposing nursing students to concepts of spirituality are essential for nurse educators (Connors, et al., 2017; Hoffert et al., 2007; O'Brien, 2014). A repeated measures, quasi-experimental, quantitative design was used to determine the impact on first semester nursing students' competence and confidence in providing spiritual care when *Key Phrases and Caring Behaviors*© were introduced early in the term. This chapter provides a summary of the study findings, implications, and recommendations for further studies, nursing education, and others that have direct patient contact. The potential influence of the results for nurse educators teaching spiritual care and suggestions for future research will conclude the chapter.

### **Summary of Findings**

Data collected from a sample of first semester nursing students enrolled in Adult Health I of an associate degree nursing program at a state supported college in central Florida were analyzed. Students' rated their competence and confidence in a pretest posttest research design. The overall demographic information will be reviewed as well as significant findings of each research question will be discussed.

#### **Impact of demographics**

Demographic information included age, race, gender, previous college degrees, and prior experience in healthcare. Of the freshmen students eligible to participate, only 25% completed all three phases of the study. In the sample, 80% were female, with most participants between the ages of 18-21. There were 8 in 10 participants between the ages of 18-30. Age was

significant in this study, because younger college students may over-estimate their capabilities and social maturity, which could directly impact one's competence and confidence scores. This was evident when comparing the first and second phase of the study. There was a decrease in the overall mean score from Phase I to Phase II. The mean score of the first phase was 4.1, and the mean score of the second was 4.08. Students' difference in these scores could possibly be that in the beginning of the semester students were eager to please. Another possible explanation for the result could be that after terminology and explanations and expectations of spiritual care in nursing were defined and operationalized instructionally, the students realized they did not know as much as they first thought when questioned in Phase 1.

Other demographic information about the study participants included educational preparation and religious affiliation. Of the student participants, 70% either possessed an associate's or bachelor's degree. Most students described themselves as being affiliated with a denomination of a Christian faith. However, nearly 10% of students answered that they were atheistic or agnostic. With such a high percentage of students that identified themselves as Christians, the mean score of the initial phase of the study could have been exaggerated if compared to a more homogeneous population.

When the mean scores of Christians were compared to agnostic/atheists, the agnostics/atheists were considerably lower in Phase I, but higher than Christians in Phase II. When comparing the mean scores of Christians to agnostic/atheist group in Phase III, the agnostic/atheist group scored lower than the Christian group. The agnostic/atheists demonstrated the most growth of any religious group in the study. This finding validates studies conducted by Bennett & Thompson (2014) and Lemmer, (2002) that supported the notion that students could be taught spirituality.

## **Comparison of Findings with Previous Research**

The mean score of Phase I was higher than the previously published study by Connors et al. (2017). The student participants largely declared themselves to be affiliated with the “Christian” belief system. The high percentage of Christians in the current study could account for the increase of baseline data collected in this study when compared to Connors et al. (2017) study. This increase could be due to the ethos of caring innate in the Christian belief system. Having such a high percentage of students identifying themselves as religious might have accounted for the mean score of the first Phase to be 4.08. Most of the participants considered themselves to align with Christian principles, and the ethos of caring could explain the high self-appraisal for competence and confidence in providing spiritual care.

A large portion of the students described themselves as adhering to Judeo-Christian beliefs. Selection bias was a factor as a large percentage of students that identified themselves with the Christian belief system was not representative of the student population found in most public, state-supported, colleges. It is possible that participants in the study were not representative of most of nursing students within the college. The small sample size limits the potential to generalize the findings to the current and other institutions.

Study results revealed that all three groups of religious affiliation identified experienced growth in their perception of competence and confidence in providing spiritual care. This finding reiterated the study findings published by Bennett & Thompson (2014) in which spiritual concepts were taught to nursing students. While the variation of mean scores between Phase I and Phase II was nominal, as compared to the first study published by Connors et al. (2017), the finding in the current investigation was still clearly beneficial, because it validated the findings of the first study. Students’ perception of competence and confidence when providing spiritual

care decreased in Phase II in both studies. However, the decrease in mean scores noted in Phase II of the current study were not as large as drop in the mean scores of Phase II of the published study. A possible reason that the students expressed greater competence and confidence in the second study might be attributed to the introduction of *Key Phrases and Caring Behaviors*© earlier in the term. By introducing the teaching method earlier in the semester, students could have utilized and applied the content in a more meaningful, efficient manner during the semester. When comparing both studies, one reason for the decrease in mean scores in Phase II might possibly be because students were not fully aware of the implications and delivery of spiritual care. Once students attended the lecture, participated in small groups, then performed a spiritual assessment on a patient in the clinical setting, it would appear much more likely that they recognized that they did not understand as much as they thought when questioned during Phase I.

### **Limitations**

The results of this study were limited by several factors. First, the small study size (N=23) represented about 25% of the total enrollment of first semester nursing students, which may not be large enough for generalization to a larger population. One reason for the low student participation could be attributed to the timing of the second two phases. The second phase was administered during the fourteenth week of school, and Phase III was sent out one week later during the fifteenth week of school. The reason that the second survey was sent out later in the term was to allow the students the opportunity to perform a spiritual assessment of a patient while in the acute care clinical rotation. Since the second and third surveys were sent in succession and during the weeks immediately before and after Thanksgiving holidays, students might have mistakenly thought that they had already completed the survey. The third phase was sent out during the fifteenth week of the sixteen-week term.

Survey “fatigue” or confusion between the second and third surveys may have resulted in lower participation rates. Students may also have been confused by the request to complete three very similar surveys. The first 10 questions were identical in all three surveys. The second survey was sent out in week 14 of the semester, which was the week prior to Thanksgiving holidays. Even though a reminder was sent, the survey scheduling could have been inconvenient that close to the school break. Timing of the third survey may have been problematic due to students preparing for end-of-course examinations and skills check-offs. The current attrition rate of first term nursing students is 10% and should be taken into considered when examining the lower response during the final phase limiting the number of eligible participants.

Another factor that may have led to lower participation might be due to strong verbalizations and negative attitudes expressed openly by a few students when the topic of spirituality in nursing was addressed in the classroom. Opposing views expressed in a classroom could have exerted negative influence of other student’s participation in the current investigation. In addition, students who were not affiliated with a particular belief system might have abstained from participation due to the nature of the study.

The sample size  $N=23$  was low, due to in-part the attrition across all three phases of the study. Moreover, the number of participants was small due to a numbering anomaly. To maintain confidentiality students were asked to randomly select a four-digit number as their personal code to use with each survey. Even though they were encouraged to use the same common four-digit number, such as the last four digits of their social security number or phone number, many students did not retain that number over the course of the three phases. While there was a great number of students that participated in the study during each phase, it was nearly impossible to track student responses across all three phases because a common identifier

was not used. Nearly one half of the student responses completed could not be connected to previous phase responses, therefore the responses were invalidated and not included in the study's analyses. A recommendation for future studies would be to assign a number or use the students' college identification number to reduce the likelihood of losing data.

### **Discussion of Each Research Question**

#### Question #1:

Will introducing *Key Phrases and Caring Behaviors*© impact first semester nursing students' perceptions regarding their competency and confidence in providing spiritual care prior to their exposure to a simulation activity?

The educational goal of this study was to better prepare students to recognize and address spiritual needs of their patients. It was believed that introducing the teaching instrument *Key Phrases and Caring Behaviors*© early in the academic term, would improve students' perception of competence and confidence in providing spiritual care. Introducing the instrument *Key Phrases and Caring Behaviors*© earlier in the term was recommended as further research by Connors et al. (2017).

One limitation might be that the instrument *Key Phrases and Caring Behaviors*© was administered too early in the semester of first year nursing students. The instrument was designed to be used as a resource for students when communicating with patients and families. When the instrument was introduced, the students were not engaged in a clinical rotation, and the significance of the teaching instrument had not yet been acknowledged.

The first two weeks of the first semester in nursing school is a time dedicated to introducing students to the language and behaviors of nursing. This transition is often overwhelming for many students. Learning basic skills in preparation of attending a clinical

rotation is the focus for most programs of nursing. The vast amount of paperwork and technical skills nursing students are expected to know can be overpowering. In addition, caring for the sick and the infirmed for the first time can be an emotional experience for some students. It was during the first two weeks that the instrument *Key Phrases and Caring Behaviors*© was first introduced. Future recommendations are to reconsider the timing of introducing the instrument. Consider the introduction of *Key Phrases and Caring Behaviors*© one or two weeks prior to the start of the clinical rotations.

During this study, it was discovered that students were not reminded to use *Key Phrases and Caring Behaviors*© at any time during the semester. When questioned later, students reported that none of the clinical instructors, previously instructed on the use of *Key Phrases and Caring Behaviors*© used the resource while in the hospital. Even though students completed a weekly clinical log that prompted them to reflect on how they responded to their patient's spiritual needs, it was evident that students were not familiar with the instructional practice guide.

According to Bandura's (1986) *Social Cognitive Theory*, person and environment are important to knowledge retention. The environment in nursing school is highly competitive and considered a stressful learning community. Stress impacts students' ability to learn or retain knowledge. As such, students were unsuccessful at "consciously attending" (p.175) to all the paperwork distributed during that timeframe, including the teaching instrument *Key Phrases and Caring Behaviors*© (Merrian & Bierema, 2014). Therefore, by virtue of the limitations of the working memory, first semester nursing students' experienced great difficulty in moving the enormous amounts of information to the long-term memory (Merrian & Bierema, 2014). Using the *Information Processing Theory* as a foundation, particularly in the area of working memory,

students were overloaded and the instructional value of presented with *Key Phrases and Caring Behaviors*© earlier in the term was not recognized. In addition, when one is emotionally overwhelmed or overworked, the brain seeks the flight or fight mode to protect the individual. Learning new information while in a fight or flight state of mind, was difficult (Merriam & Bierema, 2014).

Even though the current research did not produce statistically significant results, when compared to the published Connors et al. (2017) study, students' perception of competence and confidence did not decrease at the rate observed in the published study. It appears that introducing *Key Phrases and Caring Behaviors*© earlier in the instructional period was beneficial in helping students maintain their baseline level of competence and confidence. Student competence and confidence levels were vital when teaching a new skill (Bandura, 1986).

Research Question #2:

Will introducing the simulation activity after first year nursing students have been exposed to the *Key Phrases and Caring Behaviors*© promote a statistically significant improvement in perceived competence and confidence in providing spiritual care to patients?

Research is replete with evidence on support of the notion that simulation represented a valuable tool to train nursing students (Connelley, 2015; Connors et al., 2017). Nurses need to be taught how to deliver spiritual care (Frouzandeh, et al., 2015; Timmins & Neill, 2013). The current study revealed that students rated the simulation experience statistically significant in its ability to improve competence and confidence in providing spiritual care. The simulation experience was near the end of the semester after students had completed their clinical rotation. This finding mirrors that of the published study by Connors et al. (2017).

Research Question #3:

Will the combination of both instruction using *Key Phrases and Caring Behaviors*© and a structured simulation activity exert a statistically significant improvement in first semester nursing student perception of competence and confidence in providing spiritual care to patients?

Using a combined approach to teach spiritual care with multiple opportunities to expose students to the content, yielded significant results. Participants' perceptions reflected an increase in mean scores from Phase II to Phase III with 75% of the items tested. Phase III was conducted after the simulation experience. The use of simulation was an effective teaching strategy commonly used to train nursing students (Blesch, 2015; Brannan et al., 2016; Connelley, 2015; Eggenberger & Regan, 2010; Gore & Thomson, 2016).

Learning was most effective when both sides of the brain were engaged (Merriam & Bierema, 2014). Simulation uses experiential dimensions that involves psychomotor and verbal responses. In the particular simulation used in this study, there were many ways in which students participated. Some students observed the action, while others portrayed a character in the scenario and responding to the situation. The use of creativity was encouraged throughout the simulation. This allowed students to learn, form attitudes (Merriam & Bierema, 2014), and practice cognitive rehearsal (Bandura, 1977) while experiencing the simulation experience. "If we want nursing students to care, then we should give them the opportunities to practice" (Eggenberger & Regan, 2010, p. 557). The concept of simulation follows principles discussed by Bandura (1986) in the *Social Cognitive Theory*. Bandura (1986) stated that adults learn from the environment. Further, as adult learners watching others they "regulate their own behavior to some extent by visualizing self-generated consequence" (p. 392). Providing students with the

opportunity to practice first before performing skills at the bedside was a common strategy used in nursing education (Blesch, 2015; Brannan et al., 2016; Connelley, 2015; Eggenberger & Regan, 2010; Gore & Thomson, 2016).

In Sivertsen and McNeill (2016) students were allowed the opportunity to Re-Do the simulation. Opportunities to practice skills correctly builds confidence and competence in students. Kimhi et al. (2016) also used simulation with nursing students in Israel. The findings of that study revealed that simulation conducted either before or after exposure to the clinical setting promoted self-confidence in nursing students (Kimhi et al., 2016).

### **Future Recommendations**

Educators were encouraged to thread spirituality throughout the curricula by placing an emphasis in both didactic and clinical instruction, to best prepare nurses to address spiritual needs of patients (Bennett & Thompson, 2014; Callister et al., 2004; Salladay & Poole, 2011). Recommendations for future studies would be to include spiritual instruction in a variety of educational venues. In determining a more appropriate time to introduce the instrument *Key Phrases and Caring Behaviors*©, perhaps a better approach would be to introduce *Key Phrases and Caring Behaviors*© at the time that students begin the clinical rotation, usually around week four of the sixteen-week semester. The anticipation of attending clinical training would incentivize the student's "need to know" (p. 55) the content, and "problem centered" (p. 53) immediacy of the clinical rotation would promote learning and retention (Merriam & Bierema, 2014). In addition, support and education needs to be offered to the clinical instructors to ensure they are familiar with the teaching tool *Key Phrases and Caring Behaviors*©. Verification that students are using the instrument while in the clinical setting and having an opportunity to discuss the impact of the instrument in a small group setting was a recommendation to facilitate

reflective practice (Merriam & Bierema, 2014). Statistically significant findings may have been attained from Phase I to Phase II in the study had the sample size been greater. A more diverse population in a replicated study may also add to the richness of findings.

It is obvious that a common definition of spirituality needs to be developed. A shared meaning of terms and clear language would benefit nursing students, nurse educators, and nurses in current practice world-wide. The opportunity to clarify the confusion of spiritual terminology is present and will continue until the concepts of spirituality, spiritual care, and care are elucidated.

Nurses are expected to provide spiritual care, yet without educational training, nursing students are ill-prepared to perform caring behaviors. Students are expected to configure care to the professional practice standards. If students are not taught how to perform spiritual care, they cannot be expected to perform it when in practice (Eggenberger & Regan, 2010).

One recommendation for future studies is to adhere to Cockell and McSherry (2012), who endorse taking best practices from one specialty and applying them to other areas of nursing care. Thus, one area of future research would be to teach *Key Phrases and Caring Behaviors*© to licensed registered nurses currently practicing in an acute care facility. Another venue for a study would be to apply the teaching strategies, simulation, and *Key Phrases and Caring Behaviors*© to other healthcare personnel currently working in an acute care facility, as an opportunity for professional development. The need for an educational program that addressed the needs of the community was outlined in a discussion paper published by the National Academy of Medicine (2017). A collaborative partnership between health professional schools and community hospitals should create community-engaged health education that is mutually beneficial.

Community-engaged health professional education requires more than just a community-oriented curriculum. It requires learning and service to be located in the community.

With thoughtful pedagogy, the immersion of learning in and with communities, focused on areas of common interest and importance, is intended to be synergistic where students learn from community members while providing them a valued service in the community's environment (Talib et al., 2017, p. 3).

In addition, the Talib (2017) suggested that the principles of caring can and should be applied to all healthcare personnel that have direct patient contact.

Another possible future study would be a phenomenological study to explore student attitudes about providing spiritual care. Given the opportunity to discuss the barriers to practice and reasons for avoiding practicing spiritual care could lend insight to nurse educators teaching spiritual care. Asking questions and listening to student responses could influence future teaching of content and preparation for teaching spiritual content to nursing students.

### **Conclusion**

Nursing is considered both an art and science (Peplau, 1987). The science of nursing involves technical skills and application of best practices in nursing. The art of nursing is realized when the nurse connects with the patient. Holistic nursing involved caring for the mind, body, and soul (Baldacchino, 2008; Mitchell et al., 2006; O'Brien, 2014; van Leeuwen & Cusveller, 2004). Holistic nursing encompassed spiritual care, and spiritual care is an expectation for quality healthcare (Briggs & Lovan, 2014; O'Brien, 2014; McSherry, 2006; Yilmaz & Gurler, 2014). Spiritual care has been described as a one-on-one relationship between the nurse and patient that offers hope to one suffering emotionally (Duffy, 2009).

Regulating agencies, accrediting bodies, and the end-of-program national test, NCLEX-RN®, require that spirituality be included in content of nursing programs (AACN, 2016; ANA, 2015; NCSBN, 2017). In addition, patients desire to converse about their spiritual care. Never has nursing care been tied to reimbursement, but the passage of Obamacare emphasized spiritual care assessment (“HCAHPS online,” 2016.). Therefore, spiritual needs of the patient must be addressed (Baldacchino, 2008; Kitchener, 2016; Lyndon-Lam, 2012; McSherry, 2006; Mitchell et al., 2006; O’Brien, 2014; Puchalski, 2001; TJC, 2011).

A review of the literature revealed there was a lack of attention to spiritual needs for a variety of reasons (Baldacchino, 2008; Barber, 2008; Blesch, 2015; Boswell et al., 2013; Gore, 2013; LaBine, 2015; Lemmer, 2010; McSherry & Jamieson, 2011; Narayanasamy, 2006; Tiew et al., 2013; Yilmaz & Gurler, 2014). First, researchers agreed that there is confusion over the definition of the terms, *spirituality* and *religion* (Cohen and Koenig, 2003; McSherry and Jamieson, 2011; Reinert & Koenig 2013; Timmins & Neill, 2013). For the purpose of this research, the NHS definition of spiritual care was adapted and defined as “what is appropriate and whatever the person wishes” (NHS, 2010, p. 24). Limited educational resources and guidance were cited as another cause for decreased attention to spirituality (Connors et al., 2017; Gore, 2013; Heindel, 2015; Hoffert et al., 2007; Kitchener, 2016; LaBine, 2015; McSherry & Jamieson, 2011). Inadequate educational resources indicate a need for innovative teaching methods (Connors et al., 2017; Hoffert et al., 2007; Taylor et al., 2009).

Connors et al. (2017) previously measured competence and confidence of first semester nursing students at three different times during the first semester of nursing school. The results were statistically significant and students reported that the simulation was an effective teaching strategy to improve competence and confidence when providing spiritual care. During the

simulation, the teaching instrument *Key Phrases and Caring Behaviors*© was used as part of the instruction. After the simulation, during informal student discussion groups, students expressed that they needed the teaching instrument sooner in the semester. It was due in part to students' feedback that the current study was conducted.

While methods used in the study were similar to Connors et al. (2017), the sequence of instruction, mainly when to introduce *Key Phrases and Caring Behaviors*©, was examined. To distinguish the impact of the teaching instrument *Key Phrases and Caring Behaviors*©, introduction was earlier in the term and separate from the simulation experience. Even though the findings suggested that introducing the instructional technique *Key Phrases and Caring Behaviors*© before the simulation did not exert a statistical significance upon participant perception, an interesting finding was made evident. When *Key Phrases and Caring Behaviors*© was included with the spiritual content, a spiritual lecture (Phase I), students maintained their perception of competence and confidence in providing spiritual care in Phase II. Whereas when comparing the current study to the published study Connors et al. (2017), students reported a decrease in competence and confidence after the spirituality lecture in Phase II. This provides possible credence to the conclusion drawn that *Key Phrases and Caring Behaviors*© benefited students by helping them to maintain their competence and confidence in providing spiritual care in Phase II.

In addition, simulation was valued by the participants. One possible rationale for this phenomenon could be that when *Key Phrases and Caring Behaviors*© was combined with simulation, students had multiple opportunities to learn and manipulate the material presented. Experiential learning strategies, as employed during simulation, proved to be an asset when students rated their competence and confidence in providing spiritual care.

A review of the professional literature revealed a lack of educational preparation and resources to teach spiritual care to students. Du Plessis (2016) suggested presence as a beginning activity for introducing spiritual care at the bedside. Well-established in nursing literature, being present with patients is a central theme to several nursing theories, including Watsons' *Theory for Transpersonal Caring*, Rogers' *Science of Unitary Human Beings*, and Parse's *Theory on Human Becoming* (du Plessis, 2016). Presence is described as being intentional while with patients, focusing on their physical, emotional and spiritual needs. Presence is a tangible means of demonstrating care and emotional support by the nurse to individuals. To help bridge the academic-practice gap, researchers Good and Connors (2017) developed an innovative teaching instrument *Key Phrase and Caring Behaviors*© to teach those providing direct patient contact how to incorporate the concept of presence into their developing practices. The current study demonstrated the effectiveness of introducing *Key Phrases and Caring Behaviors*© early in the first semester of nursing school as well as the importance of simulation in teaching spiritual care to those providing patient care.

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## APPENDICES

## Appendix A

### Spiritual Assessment: Phase I

**Pre-Assessment**

**ID Code** \_\_\_\_\_

**Please circle the information that best describes you.**

Age range: (18-21) (22-25) (26-30) (31-35) (36-40) (41-45) (46-50) (47-55) (56-60) (61+)

Gender: Female Male

Degree in other area: Associate Bachelor's Master's Doctorate FIELD \_\_\_\_\_

Religious Affiliation: Atheist Agnostic Christian Catholic Jewish Muslim Pentecostal

Other: \_\_\_\_\_

If you have had experience in the healthcare field, please identify the type of work you performed. \_\_\_\_\_

**Please place an **X** in the box that best matches your belief about the following statements.**

**5 = Strongly Agree; 4 = Agree; 3 = Neutral; 2 = Disagree; 1 = Strongly Disagree**

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I feel prepared to address the spiritual aspect of a patient's care.					
2. I can address my patient's spirituality without preaching					
3. A patient's overall care is enhanced when spiritual needs are addressed					
4. Nurses should recognize, diagnose, and address spiritual distress just like chest pain or shortness of breath.					
5. I am able to respond to someone in spiritual distress.					
6. Providing spiritual care is part of my responsibility.					
7. I feel comfortable asking questions about spirituality.					
8. I can provide a patient with spiritual care.					
9. I am comfortable supporting spiritual beliefs that differ from my own.					
10. I would benefit from the opportunity to practice spiritual caregiving in the simulated environment					

11. It is important for nursing students to consider their own beliefs about spiritual matters prior to entering the clinical setting.					
12. I can distinguish spiritual well-being and spiritual distress.					
13. I feel comfortable praying with my patients.					
14. I believe the body, mind and spirit are connected.					
15. I know who to call for help in providing spiritual care					

## Appendix B

### Spiritual Assessment: Phase II

**Key Phrases and Caring Behaviors**

**ID Code** \_\_\_\_\_

**Please circle the information that best describes you.**

Age range: (18-21) (22-25) (26-30) (31-35) (36-40) (41-45) (46-50) (47-55) (56-60) (61+)

Gender: Female Male

Degree in other area: Associate Bachelor's Master's Doctorate FIELD \_\_\_\_\_

Religious Affiliation: Atheist Agnostic Christian Catholic Jewish Muslim Pentecostal

Other: \_\_\_\_\_

If you have had experience in the healthcare field, please identify the type of work you performed. \_\_\_\_\_

**Please place an **X** in the box that best matches your belief about the following statements.**

**5 = Strongly Agree; 4 = Agree; 3 = Neutral; 2 = Disagree; 1 = Strongly Disagree**

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I feel prepared to address the spiritual aspect of a patient's care.					
2. I can address my patient's spirituality without preaching					
3. A patient's overall care is enhanced when spiritual needs are addressed					
4. Nurses should recognize, diagnose, and address spiritual distress just like chest pain or shortness of breath.					
5. I am able to respond to someone in spiritual distress.					
6. Providing spiritual care is part of my responsibility.					
7. I feel comfortable asking questions about spirituality.					
8. I can provide a patient with spiritual care.					
9. I am comfortable supporting spiritual beliefs that differ from my own.					
10. I would benefit from the opportunity to practice spiritual caregiving in the simulated environment.					

11. It is important for nursing students to consider their own beliefs about spirituality prior to entering the clinical setting.					
12. <i>Key Phrases and Caring Behaviors</i> © heightened my awareness about spiritual issues and/or question with which my patients may be dealing.					
13. <i>Key Phrases and Caring Behaviors</i> © contain suggestions I can use with my patients.					
14. I feel that <i>Key Phrases and Caring Behaviors</i> © should be continued in this course.					
15. I feel that <i>Key Phrases and Caring Behaviors</i> © are simple and easy to use.					

Please take this opportunity to tell us your thoughts about the *Key Phrases and Caring Behaviors*© not previously asked.

## Appendix C

### Spiritual Assessment: Phase III

**Perception of Simulation Activity**

**ID Code** \_\_\_\_\_

**Please circle the information that best describes you.**

Age range: (18-21) (22-25) (26-30) (31-35) (36-40) (41-45) (46-50) (47-55) (56-60) (61+)

Gender: Female Male

Degree in other area: Associate Bachelor's Master's Doctorate FIELD \_\_\_\_\_

Religious Affiliation: Atheist Agnostic Christian Catholic Jewish Muslim Pentecostal

Other: \_\_\_\_\_

If you have had experience in the healthcare field, please identify the type of work you performed. \_\_\_\_\_

**Please place an **X** in the box that best matches your belief about the following statements.**

**5 = Strongly Agree; 4 = Agree; 3 = Neutral; 2 = Disagree; 1 = Strongly Disagree**

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I feel prepared to address the spiritual aspect of a patient's care.					
2. I can address my patient's spirituality without preaching					
3. A patient's overall care is enhanced when spiritual needs are addressed					
4. Nurses should recognize, diagnose, and address spiritual distress just like chest pain or shortness of breath.					
5. I am able to respond to someone in spiritual distress.					
6. Providing spiritual care is part of my responsibility.					
7. I feel comfortable asking questions about spirituality.					
8. I can provide a patient with spiritual care.					
9. I am comfortable supporting spiritual beliefs that differ from my own.					

10. It is important for nursing students to consider their own beliefs about spirituality prior to entering the clinical setting.					
11. It is important for nursing students to consider their own beliefs about spirituality prior to entering the clinical setting.					
12. Spiritual simulation heightened my awareness about spiritual issues and/or question with which my patients may be dealing.					
13. I was prepared for the simulation activity.					
14. I feel the simulation activity should be continued in this course.					
15. I have used <i>Key Phrases and Caring Behaviors</i> in a clinical situation.					

Please take this opportunity to tell us your experience with the simulation activity or clinical situation involving spiritual care.

Table 1

*Pre Test/ Post Test Comparisons by Survey Question*

Question #	Paired Differences		95% Confidence Interval of the Difference		<i>t</i>
	Mean	Std. Deviation	Lower	Upper	
Question 1	.13043	1.05763	-.32692	.58779	.591
Question 2	.13043	.91970	-.26727	.52814	.680
Question 3	.04348	1.10693	-.43519	.52215	.188
Question 4	.43478	1.30823	-.13094	1.00050	1.594
Question 5	-.13043	1.14035	-.62356	.36269	-.549
Question 6	.13043	1.01374	-.30794	.56881	.617
Question 7	-.13043	1.01374	-.56881	.30794	-.617
Question 8	-.26087	1.05388	-.71660	.19486	-1.187
Question 9	.04348	1.02151	-.39825	.48521	.204
Question 10	.04348	1.22394	-.48579	.57275	.170
Question 11	.34783	.88465	-.03473	.73038	1.886
Question 12	-.13043	1.05763	-.58779	.32692	-.591
Question 13	-.08696	1.20276	-.60707	.43316	-.347
Question 14	.73913	1.35571	.15288	1.32538	2.615*
Question 15	-.43478	1.34252	-1.01533	.14577	-1.553

\* $p < .05$

Table 2

Mean Score Comparison by Survey Question Across All 3 Phases

