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EVALUATING THE IMPACT OF INNOVATIVE TEACHING STRATEGIES TO IMPROVE NURSING STUDENTS' PERCEPTIONS OF COMPETENCE AND CONFIDENCE IN PROVIDING SPIRITUAL AND EMOTIONAL CARE

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EVALUATING THE IMPACT OF INNOVATIVE TEACHING STRATEGIES TO IMPROVE

NURSING STUDENTS' PERCEPTIONS OF COMPETENCE AND CONFIDENCE IN

PROVIDING SPIRITUAL AND EMOTIONAL CARE

By

PALMIRA GOOD

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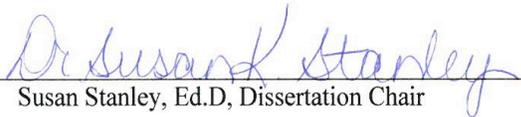in Curriculum and Instruction

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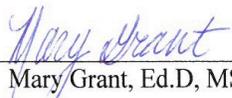EVALUATING THE IMPACT OF INNOVATIVE TEACHING STRATEGIES TO IMPROVE

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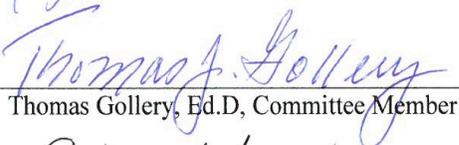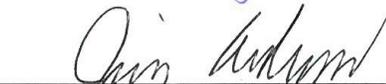
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DEDICATION

My dissertation is dedicated to Donna Hoffert. Donna made it possible for me to measure the success of the teaching strategies on providing spiritual and emotional care to patients. The first time I corresponded with Donna, I realized we shared a passion for teaching, especially giving students the tools needed to assess a patient for the resources and coping skills required to heal and recover after an illness. Not only did Donna permit me to revise the survey of students' perceptions of their competence and confidence in providing spiritual care to patients, but she enthusiastically provided me with the insight and guidance I needed to perform my research and complete my dissertation effectively. I know that our conversations were possible through divine intervention. Although we have never formally met, I feel that I know you very well. Blessings to you, Donna.

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My final words of appreciation go to the One who made it all possible through His divine guidance. He put me in the right place, at the right time, under the right conditions, and surrounded me with the right people so that I could be successful in achieving my goal. I knew I would grow professionally, but I had no idea how much I would grow spiritually. I am truly blessed, and I know that anything is possible when you share a relationship with Jesus.

ABSTRACT

Nurses are expected to respond to the spiritual and emotional needs of patients with

compassionate care. Patients yearn for a connection with their nurse that assures them they are

safe and will be provided with holistic care. A healing environment can be established for the

patient by providing spiritual and emotional care. Many practicing nurses state they are

uncomfortable addressing the spiritual and emotional needs of their patients. A gap exists

between what is taught to nursing students and the expectations of nurses in the clinical setting.

Students' perceptions of their confidence and competence in providing spiritual care to patients

was measured in three phases. Phase I provided a baseline, Phase II measured students'

perceptions of confidence and competence after reviewing the *Key Phrases and Caring

Behaviors*© chart. Phase III measured students' perceptions after participating in a simulation

focusing on spiritual distress. The simulation demonstrated statistically significant improvement

in students' perceptions. Integrating caring into all simulations is essential to have fully

competent and confident nurses prepared to provide spiritual and emotional care. The students

can be taught appropriate responses to a patient's emotional and spiritual needs by reviewing

suggested phrases and behaviors as a pre-simulation activity. Inserting holistic needs in

simulations is realistic because every patient in the clinical setting has spiritual and emotional

needs.

   Keywords: Spiritual care of patients, job satisfaction and caring, spiritual and emotional

   needs of patients, caring behaviors, nurses and caring, teaching nursing students caring

   behaviors, relationship between caring and patient satisfaction, nursing presence

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I. INTRODUCTION

According to the American Nurses Association (ANA) Code of Ethics, assuming responsibility for the care of patients requires more than meeting physical needs determined by a medical condition (ANA, 2015). Caring for patients requires the nurse to make a conscious response to the emotional and spiritual needs of another. The nurse must step out of his or her comfort zone to enter the patient's world and take up the patient's cause as confidante and advocate (Baldacchino, 2015; Lachman, 2012; O'Brien, 2014; Roach, 2007; Wolf, Palmer, & Handzo, 2015). Du Plessis (2016) described the activity the nurse performs to promote trust and demonstrate compassion as *presence*. The nurse must develop a relationship with the patient and family that contributes to the patient "feeling cared for" (Duffy, 2009, p. 18) and promotes the patient's and family's ability to place trust in the nurse (Baldacchino, 2015; Bennett & Thompson, 2015; Duffy, 2009; du Plessis, 2016; O'Brien, 2014).

Using Jesus as the Christian role model for caring, insight is gained into the love and compassion Jesus had for others by reading the account of the widow of Nain in Luke 7:11-23 (Holman Christian Standard Bible). Luke, the author of this biblical record, was a physician, well-educated, and a keen observer. His writing provides insight into the compassion Jesus demonstrated and His inner desire to connect and respond to the needs of others. Jesus was not obligated to care for people or heal them of physical, emotional, or spiritual distress. The group with Jesus had walked approximately 20 miles from Capernaum to Nain. As the group approached the gates of the city, a funeral procession exited the gates traveling toward them on the path to the cemetery. Jesus saw the dead body being carried and observed a woman following the bier weeping sorrowfully. Jesus was moved by the funeral procession, but He also connected with the woman on a deeper level because He understood her suffering. She was a

widow and was following the body of her only son. With no male left in the home, the widow would not have a source of support. Women did not work in the Middle Eastern culture, so she would be reduced to begging for food and other essentials. The followers of Jesus noticed how deeply moved Jesus was at the sight of the widow weeping over the loss of her son. They understood that He not only connected with her sorrow but also with the physical and cultural implications of her loss. As the group met the funeral procession, they began to move aside to allow it to pass. Jesus looked at the widow and said, "Don't weep" (Luke 7:13). He walked over to the body and spoke, "Young man, I tell you, get up!" (Luke 7:14). The young man arose and went to his mother. Jesus connected with the widow's pain and healed her physical, emotional, and spiritual distress because He cared.

Several national and international organizations have focused their efforts on strengthening the ability of nursing professionals to recognize the emotional and spiritual needs of the patient and respond to those needs appropriately. The Joint Commission (TJC, 2016), the primary accrediting agency for American hospitals, mandates that all admitted patients have their spirituality assessed. The American Association of Colleges of Nursing (AACN, 2016) issued a position paper stating that nurses must practice from a "holistic, caring framework" (p. 8).
The Code of Ethics for Nurses released by the American Nurses Association (ANA, 2015) states that establishing a therapeutic nurse-patient relationship is a fundamental expectation of nurses.

The positions of the agencies and organizations prompting nurses to provide spiritual and emotional comfort have a common theme. The words used are descriptive terms about "what" the nurse is to do, but the terms do not address "how" or the strategies needed for the nurse to perform the care. In an article by Good and Connors (2015), after nursing students participated in a simulation that provided an opportunity to address the spiritual and emotional needs of a

patient, a student stated, "You told us to care, but you never taught us how to care" (para. 6).

The difficulty of knowing how to demonstrate caring behaviors is not limited to nursing students.

Despite the abundance of relevant literature and directives for spiritual care, many practicing

nurses report feeling uncertain about and unprepared to intercede in meeting patients' spiritual

needs (Connors, Good, & Gollery, 2017; Costello, Antinaja-Faller, & Hedberg, 2012; LaBine,

2015; McSherry & Jamieson, 2011; Wolf et al., 2015).

A potential reason spirituality is missing from nursing care today may be that the nurse

has little academic preparation to connect with patients to promote spiritual and emotional

comfort (Baldacchino, 2015; Connors, 2017; Costello et al., 2012; Hoffert, Henshaw, &

Mvududu, 2007; Molzahn & Shields, 2008; Tiew, Creedy, & Chan, 2013). The term *spirituality*

is often unclear to faculty and students and is frequently confused with religion (Bennett &

Thompson, 2015; Costello et al., 2012; Hoffert et al., 2007; O'Brien, 2014). In LaBine's (2015)

research, nursing faculty admitted "they did not have sufficient training related to spiritual care.

Only half of the respondents indicated that they received spiritual care training while in their

initial nursing program" (p. 84). 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).

The Patient Protection and Affordable Care Act (PPACA), also known as the Affordable

Care Act (ACA), became law in March 2010. A primary focus of the ACA is the promotion of

quality healthcare services and improved patient satisfaction with care received. Since 1985,

Press Ganey Associates has studied how patient satisfaction, improved healthcare, and reduced

medical claims are related to a patient's social, cultural, emotional, and medical needs. Press

Ganey's contribution to understanding patient satisfaction with healthcare is the result of

evaluating over 4,000 articles, reviewing evidence-based data, and conducting interviews with patients to determine how high-performing healthcare organizations meet the emotional and spiritual needs of patients (Press Ganey, 2010). Press Ganey developed questions included on the patient experience survey, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The HCAHPS survey is the result of a requirement of ACA which mandates that an evaluation survey is given to patients after their experience with a healthcare agency regarding their satisfaction with the care received. The responses of the participants on the HCAHPS survey influence the reimbursement the agency receives for the care provided.

The HCAHPS survey is sent to every patient discharged from an acute care setting. Analysis of 1,732,562 patients' satisfaction data, collected by Press Ganey Associates Inpatient Database, indicated that patients place emotional and spiritual needs as a top priority, and patient satisfaction was closely related to the emotional and spiritual care they received (Bennett & Thompson, 2015; Clark, Drain, & Malone, 2003; Koenig, 2003; Press Ganey, 2010). According to Press Ganey (2010):

> Patient satisfaction with emotional and spiritual care can be influenced by every encounter throughout the hospitalization experience. Patients do not perceive a distinction between an 'emotional need' and a 'spiritual need.' The conclusions about emotional and spiritual needs are the result of review and analysis of the data from 3.1 million acute-care inpatient surveys from more than 2,000 U.S. hospitals and are solidly grounded in cognitive science, psychology, human emotions, and how patients perceive these needs. (pp. 2-3)

Press Ganey (2010) discovered that patients combine the broad concepts of emotional and spiritual needs together and include search for meaning, hope, alleviation of fear, feelings of

loneliness, and transcendence. Appropriate nursing responses to patients are identical for both spiritual and emotional needs and include caring, comfort, support, empathy, affirmation, and attentiveness to their unique needs (Bennett & Thompson, 2015; Dempsey, 2015; du Plessis, 2016; Koenig, 2003; Press Ganey, 2010). Further, because of the discovery of how patients view spiritual and emotional needs, the questions on the survey about emotional and spiritual needs are combined into one construct. Research supports the belief that a patient's unmet spiritual and emotional needs can lead to an increased risk of death, poor mental health, low quality of life, increased hospital length of stay, and delayed recovery after discharge (Abbasi, Farahan-Nia, Mehrdad, Gvari, & Haghani, 2014; Dempsey, 2015; Koenig, 2003).

This quasi-experimental study measured the impact on first-semester nursing students' perceptions of competence and confidence in providing spiritual and emotional care after the *Key Phrases and Caring Behaviors©* chart was introduced during the clinical experience. For this study, spiritual and emotional needs of patients were combined and viewed as one construct based on the results of the research performed by Press Ganey (2010) and the importance the HCAHPS survey has for healthcare organizations and the nurses employed in the organizations.

Background of the Study

Although providing spiritual care is a professional standard of nursing practice, few studies relate to teaching spiritual care to nursing students. Limited international studies have investigated the impact of spiritual care education on undergraduate nursing students (Baldacchino, 2015; Connors, 2017; Cooper, Chang, Sheehan, & Johnson, 2013; LaBine, 2015). Wu, Tseng, and Liao (2016), have suggested that additional educational material is needed to teach spiritual and emotional care. According to LaBine (2015), a gap in the literature exists

because few studies have been conducted on spiritual care in associate degree nursing programs. Good and Connors (2015) reported:

> Students are more comfortable following a checklist while performing specific skills and are hesitant and unsure when comforting or supporting patients and families. Unfortunately, emotions do not follow a set pattern of predictability because every patient is unique. Students need guidance to learn how to interact therapeutically in emotionally charged situations. (para. 6)

Spirituality is a universal phenomenon and is a unique characteristic of each person. An individual's spirituality is not visible and can easily go unnoticed during a casual interaction. Focusing on what is visible, such as a person's physical appearance, is much easier to address. People are holistic beings, meaning that all aspects of an individual make up the whole person. An alteration in the physical health of a person will impact the spiritual and emotional components, just as a change in a person's emotional or spiritual state will impact physical health (Press Ganey, 2010; Taylor, 2007; Watson, 2011; Wolf et al., 2015). If spiritual, emotional, or religious issues are ignored while administering physical care to an individual, a vital aspect of care is overlooked (Duffy, 2009; Hoffert et al., 2007; Press Ganey, 2010; Wolf et al., 2015).

The nurse with adequate preparation in spiritual care may promote a healing environment by assisting a patient to move from complete unawareness or even denial of spiritual needs to an understanding of the spiritual dimension that will foster healing and wellness (Duffy, 2009; O'Brien, 2014; Press Ganey, 2010; Taylor, 2007). Promoting spiritual well-being in a patient provides the individual with a powerful force that can be used by the body to promote wellness (O'Brien, 2014; Taylor, 2007). When the individual is fighting physical, spiritual, or emotional stress, the person's faith can provide support and promote coping strategies that may strengthen

the individual's ability to fight off the threat (Duffy, 2009). Interventions provided by nurses can support the individual's faith through a relationship which promotes hope and trust and consequently, can lead to increased spiritual energy and a healing environment (Baldacchino, 2015; LaBine, 2015; O'Brien, 2014; Wolf et al., 2015).

Nursing curricula must prepare nursing students to meet the spiritual needs of patients by first promoting an understanding of their spirituality (Baldacchino, 2015). Spirituality must be introduced into the curriculum early in the program and continue as a curriculum thread throughout the program (Baldacchino, 2015). The faculty must develop a multifaceted approach to teach spirituality and provide students with the skills necessary to address spirituality with their patients (Good & Connors, 2015; LaBine, 2015). Lectures about spirituality are not enough; students must have the opportunity to role play in an emotionally charged situation dealing with spiritual distress (Good & Connors, 2015; Eggenberger & Regan, 2010; Yilmaz & Gurler, 2014). The simulation experience for nursing students is frequently used to reinforce psychomotor skills and promote critical thinking. Integrating realistic scenarios depicting emotional and spiritual distress in the context of a simulation adds strength to the learning experience because of "expansion of simulation beyond the current state of emphasizing psychomotor skills to embrace caring—the vital core of nursing" (Eggenberger & Regan, 2010, p.551).

LaBine (2015) and Yilmaz and Gurler (2014) stated connectedness occurs with the patient when the nurse develops a relationship based on trust and respect to address the patient's spiritual and emotional needs. This connectedness can become a spiritually fulfilling experience for the patient but also can be spiritually fulfilling and promote the professional development of the nurse (Baldacchino, 2014; Duffy, 2009). Duffy (2006) performed research on a group of

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adult workers regarding their spirituality and career behaviors. He discovered that spirituality was found to "inspire a desire to serve others and positively relates to career coherence, or the finding of meaning and purpose in a career" (p. 55). Baldacchino (2015) addressed the characteristics of nursing, paramedical, and medical students "who are young with a lack of personal life experiences and with minimal attention to spiritual issues in life" (p. 597). Baldacchino (2015) suggested that "it is very important to equip students with information [on spirituality], but also attention needs to be given to their personal formation as spiritual individuals" (p. 597). When describing spirituality, Baldacchino (2015) emphasizes, "No one can give what he or she does not possess" (p. 597).

Theoretical Framework

The use of a simulated setting to teach students spiritual and emotional care has value because it exposes all students to the same situation and gives faculty the opportunity to guide students through reflection as well as sharing of thoughts and feelings on what happened in a safe, non-threatening environment (Bennett & Thompson, 2015; Costello et al., 2012; Jeffries, 2005; Mitchell, Bennett, & Manfrin-Ledet, 2006). The theoretical model that strongly supports the use of simulation in nursing education is the theory of learning developed by David Kolb. Kolb (1984) theorized that learners integrate knowledge through a sequence of learning steps that include actual experience and observation followed by reflection on the experience (Bennett & Thompson, 2015). Mastery of the task is accomplished by the student through observation and reflection in a simulated setting, testing new concepts and behaviors, and repeating the sequence until the student is comfortable with the new behaviors or concepts (Bennett & Thompson, 2015; Kolb, 1984).

A curriculum applying differentiated instruction allows the teacher flexibility in teaching specific content based on an assessment of the learners' needs (Hall, Vue, Strangman, & Meyer, 2003). Universal Design for Learning (UDL) is a curriculum approach that increases flexibility in teaching and decreases the barriers that frequently limit student access to materials and learning in classrooms (Dirksen, 2016). A gap in the education of nursing students on methods to provide emotional and spiritual care to patients has been identified (LaBine, 2015; Hoffert et al., 2007). The gap in learning does not always indicate a lack of information. Although the gap may be in knowledge, it may also be a skill gap. Bridging a skill gap is not always accomplished by giving more information (Dirksen, 2016).

Jesus was a role model for compassion and caring; His approach to providing comfort and healing physical, emotional, and spiritual distress was through presence, connections, and establishing a relationship with the person. In John 4:1-42, Jesus deliberately planned to meet a woman at a well in Samaria. He spoke to the woman and, in just a few moments, opened her eyes to the barriers in her life that prevented her spiritual and emotional well-being. Her relief and joy caused her to exclaim to her neighbors about the power of the Jewish man that she met at the well. This same power is available to nurses who are aware of their spirituality and seek to be fully present and connect with patients to establish a healing relationship.

Problem Statement

The purpose of this study was to introduce a reflective discussion and the *Key Phrases and Caring Behaviors*© chart to first-semester nursing students during the clinical post-conference on the third clinical day. The study also measured the impact of the chart on the perceptions of nursing students' competence and confidence in providing spiritual and emotional care to patients.

Significance of the Research to the Profession

Spirituality is an integral component of each individual. The spiritual dimension of an individual provides the lens used to view, understand, and interpret life's events. The experience and interpretation of life's events gives meaning and purpose to life and provides a foundation for the development of coping strategies (Duffy, 2009; Monareng, 2012). A relationship exists between an individual's spiritual, emotional, and physical health. Providing a healing environment for the patient requires addressing an individual's holistic needs. Spiritual care is an essential component of holistic care (O'Brien, 2014). Health professionals, especially nurses, interact with people who are suffering, and they are urged to provide physical care as well as spiritual and emotional comfort. Major nursing organizations and The Joint Commission urge nurses to provide physical support, as well as emotional and spiritual comfort to people in spiritual and emotional distress (TJC, 2011). Baldacchino (2015) stated, "Spiritual care is not merely the delivery of care that matters, but it also includes the *heart and spirit* by which holistic care is given" (p. 596). Some health professionals may intuitively be able to provide emotional and spiritual care to individuals, but all nurses may not understand how to apply this concept to clinical situations. Practicing nurses and nursing faculty admit a lack of knowledge and little or no instruction on providing spiritual care (Duffy, 2009; LaBine, 2015; Monareng, 2012; O'Brien 2014). Methods and strategies of providing spiritual and emotional care that can be active components integrated into nursing curricula must be identified (Baldacchino, 2015). According to DiFederico-Amicone Yates (2013), "students who actively participate in role-and simulations develop increased confidence in their ability to perform skills related to cognitive, psychomotor, and affective domains" (p. 2).

The need for research on spirituality performed in a nursing program in a publicly funded community college will provide insight into appropriate methods to promote the spiritual development of the student and potentially reveal strategies nurses can use to provide spiritual and emotional care to patients (Monareng, 2012). Changes in the students' perceptions of spiritual needs of patients will be measured as students are introduced to the concept of spiritual care and nursing interventions to provide spiritual comfort. The data may demonstrate a positive relationship between a student's spiritual growth and the nursing student's confidence and competence with providing spiritual care to patients.

Research Questions

For the researcher to address the stated research problem, the following questions were posed:

1. Will introducing the *Key Phrases and Caring Behaviors©* chart to first-semester nursing students after the initial two clinical days make a statistically significant impact on the perception of their ability to provide spiritual and emotional comfort to patients?

2. Which items on the survey instrument were most impacted from Phase I to Phase II of the study in which the *Key Phrases and Caring Behaviors©* chart was introduced?

3. Did the combination of the *Key Phrases and Caring Behaviors©* chart and a "simulation" instructional phase exert an overall effect upon participant perception of competence and confidence in addressing the spiritual needs of patients?

4. Did participant "age grouping" exert an effect upon overall change in perception across the three phases of the study?

5. Which of the three identified "dimensions" or "factors" manifested the greatest change of participants' perceptions from the baseline condition (Phase I) through the simulation condition (Phase III) of the study?

General Null Hypothesis

No difference will be identified in first-semester nursing students' perceptions regarding their competence and confidence in providing spiritual care when the *Key Phrases and Caring Behaviors*© chart is introduced in the clinical setting.

H_a1: Introducing the *Key Phrases and Caring Behaviors*© chart after the initial two clinical days will promote a statistically significant difference in first-semester nursing students' perceptions of their ability to provide spiritual care.

H_a2: Statistically significant differences will occur on survey questions between Phase I and Phase II in first-semester nursing students' perceptions of the ability to provide spiritual and emotional care to patients.

H_a3: Statistically significant changes will occur in first-semester nursing students' perceptions about their competence and confidence in addressing the spiritual needs of patients after the *Key Phrases and Caring Behaviors*© chart and the "simulation" instructional phase has been completed.

H_a4: A research participant's age will exert a statistically significant effect upon perceived comfort of providing spiritual care across the three phases of the study.

H_a5: A statistically significant difference will be identified from the baseline (Phase I) of the survey in students' perceptions of their ability to provide spiritual and emotional comfort in one or more of the survey's "dimensions" or "factors."

Definitions of Key Terms

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

Key Phrases and Caring Behaviors© chart: A teaching instrument providing appropriate suggestions for interventions that implement presence and therapeutic use of self. Verbal and non-verbal communication strategies to be used by the nurse are categorized according to the patients' and or family members' actions or statements (Connors et al., 2017).

Presence: A nursing intervention with an 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).

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

Religious practice or religiosity: Personal beliefs or behaviors associated with a specific religious tradition or denomination (O'Brien, 2014).

Spiritual care: Being with patients, listening to patients, using appropriate touch, humor, and compassion to promote a connection with a patient (Murphy & Walker, 2013; O'Brien, 2014; Tayray, 2009). Spiritual care seeks to develop an understanding of what is important to the patient and promotes spiritual well-being (NHS, 2010).

Spiritual and emotional distress: Occurs when a person experiences an unexpected or unpleasant event. May be expressed as crying, withdrawing, or anger (NANDA-International, 2016). Spiritual needs include the same broad psychological concepts as emotional needs such as hope, alleviation of fear, and search for meaning (Press Ganey, 2010).

Spirituality: A universal phenomenon that is a unique characteristic of each person (Pesut, 2008; Schaefer, Stonecipher, & Kane, 2012; Van Leeuwen & Schep-Akkerman, 2015). Highly individualized, spirituality is defined as whatever the patient describes it to be (NHS, 2010). Spirituality includes personal feelings about one's relationship to a higher being and a search for meaning and purpose (Koenig, 2003; Press Ganey, 2010). While not necessary, spirituality can be related to religion, but addresses the inner core of the person. Spirituality has also been defined as a "source of connection that brings faith, hope, peace, and empowerment" (Astin, Astin, & Lindholm, 2011, p. 4).

Spiritual well-being: The ability to experience and integrate meaning and purpose in life through connectedness with self, others, nature, or a power greater than oneself (NANDA-International, 2016).

II. REVIEW OF LITERATURE

Chapter two represents an overview of current literature as it pertains to spiritual and emotional care in nursing. First, the historical, educational, and Biblical influences on nursing were discussed. Next, the definitions and descriptions of spiritual care behaviors, expectations from patients, as well as regulatory and governmental agencies that impact spiritual care were explained. Studies that examined current trends in teaching spirituality to nursing students, attributes of nurses that enable the provision of spiritual and emotional care, and a patient's perception of caring behaviors were introduced. Finally, the relationship between job satisfaction and providing spiritual and emotional care to patients, and the relationship of the nurse's spiritual development with the ability to provide spiritual and emotional comfort to patients were presented. The conceptual framework for this study was based on David Kolb's (1984) theory on mastering skills, Dirksen's (2016) Universal Design for Learning (UDL), and the responses used by Jesus that enabled a connection with others to provide emotional, spiritual, and physical comfort.

In her book, *Notes on Nursing: What it is and What it is Not,* Florence Nightingale (1860) described the importance of a nurse connecting with the patient through compassion and understanding to meet the individual's physical, emotional, and spiritual needs. She related a story of the nurse who failed to understand her role in establishing a healing environment:

> I once told a 'very good nurse' that the way in which her patient's room was kept was quite enough to account for his sleeplessness, and she answered quite good-humoredly that she was not at all surprised at it—is as if the state of the room were, like the state of the weather, entirely out of her power. Now in what sense was this woman to be called a 'nurse'? (p 79)

In contrast, Florence Nightingale (1860) clearly defined her expectation of the lengths a nurse could go in responding to a patient's spiritual or emotional yearning:

> I remember a case in point. A man received an injury to the spine from an accident, which after a long confinement ended in death. He was a workman—had not in his composition a single grain of what is called 'enthusiasm for nature'—but he was desperate to 'see once more out of a window.' His nurse got him on her back and managed to perch him up at the window for an instant 'to see out.' The consequence to the poor nurse was a serious illness, which nearly proved fatal. The man never knew it; but a great many other people did. Yet the consequence in none of their minds, so far as I know, was the conviction that the craving for variety in the starving eye is just as desperate as that of food in the starving stomach and tempts the famishing creature in either case to steal for its satisfaction. No other word will express it but 'desperation.' And it sets the seal of ignorance and stupidity just as much on the governors and attendants of the sick if they do not provide the sick-bed with a 'view' of some kind, as if they did not provide the hospital with a kitchen. (p. 61)

Nursing History

The spiritual dimension was a major component of caring for the sick when nursing care and nursing education was conducted primarily by religious orders (Connors, 2017; Kalisch & Kalisch, 1986; LaBine, 2015). Nurses giving spiritual care can be traced to pre-Christian times when care given to the sick included not only herbs associated with healing, but also a prayer to the deities. Christianity has been considered the first religious movement to understand the care of the ill as a spiritual charge. Throughout nursing literature, the spiritual dimension was

determined to have great importance in promoting hope, love, faith, and trust in individuals who were facing emotional and spiritual stress, physical illness, or death (Kalisch & Kalisch, 1986).

Prior to the formation of the order of the Sisters of Charity in 1633, care of the sick was performed by untrained servants or assistants. The Sisters of Charity required two months' probation, eight months of instruction, and a brief period of supervised clinical practice for students who wished to care for the sick; this approach remained the acceptable standard of training for 200 years. In 1836, Lutheran Pastor Theodore Fliedner opened the first deaconess training center in Kaiserworth, Germany. The training center was modeled after the work of the Moravian deaconess movement that sought to deliver spiritual care to the needy and sick. The curriculum used in Fliedner's training center included teaching numerous practical skills and procedures, reviewing rules regarding practice, introducing a code of conduct, and employing measures to support the spiritual development of the students (Graves, 2007). Theodore Fliedner's method of training continued until the emergence of modern nursing founded by Florence Nightingale in 1860 (Drumm, 2006). Florence Nightingale, who is sometimes referred to as the "Mother of Nursing," helped to establish the nursing profession as having a commitment to caring and treating the sick. Nightingale had a profound sense of unity with God, which gave her strength, vision, and guidance in her work (Drumm, 2006). Nightingale believed that every person drawn to ease the pain or suffering of another is an instrument of healing, regardless of whether he or she was a healthcare professional and whether he or she practices a religious faith (Nightingale, 1860).

At the age of seventeen, Florence Nightingale felt spiritually called to model the generosity and greatness of God through service to the sick. Florence Nightingale (1860) considered the spiritual dimension an essential part of man and believed that, when caring for an

individual's spiritual needs, the nurse gives support to a potent resource for healing. Nightingale perceived spirituality in nursing as being present in the form of love, admiration, reverence, and trust (Watson, 2011). She emphasized the importance of the spiritual and emotional state of patients in her instructions on how to care for the patient:

> Apprehension, uncertainty, waiting, expectation, fear of surprise do a patient more harm than any exertion. Remember, he is face-to-face with his enemy all the time, internally wrestling with him, having long imaginary conversations with him. You are thinking of something else. Ridding him of his adversary quickly is a first rule with the sick. (Nightingale, 1860, p. 37)

Nightingale received her nurse training at the Daughters of Charity of St. Vincent de Paul in France and the Deaconess School in Kaiserworth, Germany. In her search for the historical roots of spirituality in nursing, Patricia Maher (2006) discovered that "before the 19th century little beside spiritual care [existed] with which to heal. Within an overtly religious society, spiritual care was a formidable and a credible endeavor and people were suspicious of medical care for good reason" (Maher, 2006, p. 419). Maher (2006) recognized Florence Nightingale as being "one of the first to bring spirituality and science together to improve the care of the sick" (p. 419).

Nightingale (1820-1910) began her career as a nurse at the same time Joseph Lister, who is known as the "Father of Antiseptic Surgery," developed standards of practice for surgical procedures and administration of anesthesia. Both Nightingale and Lister believed in handwashing and clean air when treating the sick. After Nightingale opened the first nursing school in 1860, Lister mandated that only nurses educated in Nightingale's school could assist him in surgery (Meehan, 2012). Upon arriving at a hospital in a British military camp during the

Crimean War, Nightingale recorded that 600 out of every 1000 soldiers were dying. Upon investigation, Nightingale discovered the soldiers were not dying from their injuries but rather from Typhus, dysentery, and malnutrition. She introduced standards of medical asepsis and, in four months, the mortality rate in the hospital decreased from 60% to 42% and continued to decrease until it was estimated to be as low as 2.2% (Asad-Zandi, 2014; Karimi & Alavi, 2015).

Nightingale's school was based on the apprenticeship model. "A year of training (probationary) and three years of hospital service was part of the obligation" (Bevis & Watson, 1989, p. 20). The curriculum was adopted and used by nurse training centers all over the world until 1917, when the Education Committee of the National League for Nursing (NLN) published a curriculum that specified objectives, content, and methods for teaching nursing courses.

The endless tributes, quotes, and stories about Florence Nightingale are rich and give insight into her wisdom. Henry Wadsworth Longfellow (as reported in O'Brien, 2014), wrote of the power of Florence Nightingale's healing presence in his famous poem *Santa Filomena* (1857). The poem was based on factual reports from wounded British soldiers in the Scutari hospital. In letters to their families, the young men described the comfort and relief they felt when the shadow of the "Lady with the Lamp" fell across their cot (O'Brien, 2014). Faithful to Nightingale's legacy, in her book *Spirituality in Nursing: Standing on Holy Ground*, O'Brien (2014) articulated the sacred interface between the nurse and patient when they interact within the spiritual dimension of care: "The nurse stands as a surrogate and as a vehicle for His words and His touch of compassionate care" (p. 10).

Nightingale (1860) viewed a nurse's calling to the profession as an extension of his or her Christian faith and personal relationship with Jesus. In a personal letter sent to nursing

students, 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. We dishonor Him when we do not do our
>
> best to relieve suffering—even in the meanest creature. Kindness to a sick man, woman,
>
> and child came in with Christ. (Nightingale, 1900, p. 1)

Just as Nightingale indicated, Biblical demonstrations of caring serve as a foundation for the practice of nursing (Murphy & Walker, 2013). Approximately one-third of the New Testament in the Bible describes the ministry of Jesus as a holistic healer (Murphy & Walker, 2013; O'Brien, 2014). Several scriptures portray Jesus as a living example of the principles of servant leadership and compassion for others. How did He perform good works? He stopped what He was doing, looked at the person, listened to the person, touched the person, spoke with gentleness and understanding, demonstrated compassion and concern that was readily recognized by others, and intervened for the person by asking His Father to bestow emotional, physical, and spiritual healing. Matthew 14:14 wrote, He fed the hungry, gave drink to the thirsty, healed the sick, and comforted those suffering emotional and physical torment. The followers of the teaching of Jesus are told that when they respond to the needs of others, it is as if they are ministering to Jesus:

> For I was hungry, and you gave me something to eat; I was thirsty, and you gave me
>
> something to drink; I was a stranger and you took me in, I was naked and you clothed
>
> me; I was sick and you took care of me; I was in prison and you visited me. (Matthew
>
> 25:35-36)

Jesus instructed his followers, "Whoever wants to become great among you must be your

servant, and whoever wants to be first among you must be your slave; just as the Son of Man did not come to be served, but to serve." (Matthew 20:26-27)

An obligation to care for others with tenderness and compassion is a basic tenet of the Christian faith (Murphy & Walker, 2013). In his letter to the Galatians, Paul tells us to be humble in our approach to the less fortunate: "For you were called to be free, brothers and sisters; only don't use this freedom as an opportunity for the flesh, but serve one another through love" (Galatians 5:13). Numerous nursing historians believe that "organized nursing" was a direct response to the teachings of Jesus and the altruistic values demonstrated by the early Christian movement (Duffy, 2006; Maher, 2006; Nightingale, 1860; O'Brien, 2014). Jesus was a solitary man whose public life demonstrated loving kindness and only lasted three years, but His impact on mankind prevails more than 2000 years later.

The National League of Nursing (NLN) is the official organization for nursing education and nurse educators. In 1988, NLN adopted Ralph Tyler's curriculum development model as the preferred model for instruction to nursing students. Tyler's model asserts that all learning is manifested by changes in behavior (Oliva & Gordon, 2013). His model provided nursing with the basis for initially identifying behaviors nursing students must acquire and ends with an evaluation of the students for the performance of the behaviors. At the NLN convention in 1990, nurse leaders called for, proposed, and unanimously passed a resolution identifying the relationship between caring as a core value in healthcare policy and the need to include caring in nursing education. The resolution shifted the focus of the nursing curriculum to incorporate not only predictable psychomotor behavioral outcomes, but also to contain behaviors of the affective domain (Drumm, 2006).

The belief that many are drawn to the profession of nursing because of a "spiritual calling"

or "vocation" to care for the sick has re-emerged in the twenty-first century despite the high use of technology, cost containment initiatives, and the rapid pace of current hospital care (Duffy, 2006; Herrick, 2013; Meyer, 2003; Murphy & Walker, 2013; O'Brien 2014; Rhodes, Morris, & Lazenby, 2011). O'Brien (2001) stated the spiritual dimension of care is part of the covenantal relationship the nurse has with patients. The nurse's covenant is reflected in the Florence Nightingale Pledge that is recited by nursing students at their graduation ceremony: "I solemnly pledge myself before God…to devote myself to the welfare of those committed to my care" (Kalisch & Kalisch, 1986, p. 117). "The nurse-patient covenant is a partnership of trust based on the spiritual nature of the caregiving relationship" (O'Brien, 2001, p. 12). According to O'Brien (2001), the concept of covenant means an "unconditional commitment to be of service" (p. 12).

The Christian nurse can continue the covenantal commitment that the Father began in sending His Son to heal the brokenness of the world. The sacredness of the nurse-patient relationship provides the forum for the nurse to become a symbol of Christ's faithfulness in responding to the Father's mission. Murphy and Walker (2013) described this level of care as focusing "on 'being' as opposed to 'doing'" (p. 147). Murphy and Walker (2013) stated holistic care for the Christian nurse can be "care…for the whole patient that is guided by the Holy Spirit" (p. 147). When nurses provide nursing care in such an intimate manner, they are indeed providing holistic care (Costello et al., 2012; Murphy & Walker, 2013; O'Brien, 2014; Watson, 2010). Nightingale saw the connection between the physical and spiritual domains and their impact on restoring the person to wellness, just as astute nurses in today's nursing environment acknowledge the interconnection of these healing dynamics by addressing the holistic needs of the patient (LaBine, 2015; Murphy & Walker, 2013; Nightingale, 1860; O'Brien, 2001; Watson,

2010; Van Leeuwen & Schep-Akkerman, 2015). O'Brien (2001) described how a nurse in today's healthcare environment practices holistic nursing described by Nightingale:

> Ministering to patients is not a discrete task. It is embedded in the careful administration of medications, the wiping of the brow, asking the right questions, the acknowledgment of the patient's humanness, and what is being experienced in their sickness. It is a desire to alleviate suffering, convey hope, and bring love. Through our nursing, we recognize the spiritual side of ourselves and others. (p. 21)

Art and Science of Nursing

The profession of nursing is both an art and a science (Peplau, 1987). The science component of nursing practice focuses on using evidence-based approaches when caring for patients with acute or chronic medical conditions (Meyer, 2003). Evidence-based nursing yields precise responses and actions to treat a condition (Serber, 2014; Stevens, 2013). Each intervention includes a procedure the nurse follows. Medical treatments and approaches to the physical needs of patients are learned from lectures and textbooks. Nurses spend many hours developing skills required for practice in their area of expertise. Nurses are proud of their competence in administering medications, interpreting laboratory and diagnostic reports, and operating multiple pieces of equipment at the bedside (Rhodes et al., 2011). Patients appreciate the nurse's proficiency with skills and procedures when they observe the nurse demonstrate competence and expertise at the bedside (Malott & Ayala, 2010). When a nurse starts an intravenous (IV) line on a patient who is known to have challenging veins, the nurse feels an internal satisfaction as a reward for the accomplishment.

The artistic side of nursing practice is evident when the nurse comforts, supports, nurtures, and consoles the patient (Murphy & Walker, 2013). The artistic side of nursing

requires the "therapeutic use of self" (Van Leeuwen & Cusveller, 2004, p. 236); no procedures are followed because the heart guides the actions (O'Brien, 2001; Pesut, 2008). The art of nursing is the "creative application" (Roach, 2007, p. 12) of the scientific knowledge used to promote a caring relationship with the patient (Freshwater & Stickley, 2004; O'Brien, 2001; Watson, 2010). Practicing the art of nursing involves moving beyond personal barriers or transcending (Watson, 2010; Murphy & Walker, 2013; O'Brien, 2001) to genuinely and thoroughly caring for another (O'Brien, 2001; Pesut, 2014; Tayray, 2009). The mandate to address the professional dimension of care is not just specific to nursing; the medical profession also has its roots in spirituality. The modern version of the Hippocratic Oath as noted in Blumberg (2016) states, "I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug" (para. 9).

"Nursing and caring are grounded in a relational understanding, unity, and connection between the professional nurse and the patient" (Tayray, 2009, p. 417). The nurse invests emotionally and spiritually to develop a therapeutic relationship and connection with patients through words, behaviors, and touch (Serber, 2014; Taylor, 2007). The connection is critical to adequately provide comfort and support to someone who is in emotional or spiritual distress (Omari, AbuAlRub. & Ayasreh, 2013).

According to Tayray (2009), the exchange between the nurse and patient distinguishes the nurse's role beyond task-centered responsibilities:

During a professional nurse's routine workday, this exchange [connection] occurs continuously with each nurse-patient interaction. As nurses enter new patient relationships or develop existing ones, he or she [*sic*] strives to balance a diverse set of

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nursing functions and caring behaviors. In achieving this balance, professional

fulfillment is realized. Commitment to this balance keeps caring in nursing. (Tayray,

2009, p. 417)

When the nurse is committed to caring and has embraced caring for his or her nurse identity, the

nurse's spiritual well-being is promoted when a connection with the patient is made on a spiritual

and emotional level (du Plessis, 2016; O'Brien, 2001; Tayray, 2009; Watson, 2010), nourishes

the nurse's spirit, is physically exhilarating, and promotes the nurse's professional growth

(Cassidy, 1988; Duffy, 2009; du Plessis, 2016; Taylor, 2007; Tayray, 2009). Establishing a

healing environment for the patient motivates, empowers, and energizes the nurse to continue

implementing patient-specific caring behaviors with the goal of optimizing the patient's holistic

health (Watson, 2011). The nurse's reward is heart-felt (O'Brien, 2001) and so significant that it

is as if the heart receives a paycheck as the result of making a difference in a patient's life (Good

& Connors, 2015).

When nurses are asked why they chose nursing as a profession, the answers usually

include "I want to help people," "I want to make a difference," and "I want to comfort people

who are sick." The answers never include "I want to interpret laboratory tests," and "I want to

administer medications" (Rhodes et al., 2011). The part of the nurse that desires to impact

another person's life in a positive way yearns to be satisfied (Rhodes et al., 2011; Tayray, 2009).

Several nurse theorists address spirituality and caring in addition to Florence Nightingale.

In her Theory of Human Caring, Jean Watson (2011) acknowledged that the nurse must care for

the whole patient. Specifically, Jean Watson (2011) cites *loving kindness for self and others* and

equanimity as essential components necessary for a nurse who desires to integrate her love/heart-

centered approach to patients into his or her nursing practice (O'Brien, 2001; Watson, 2011).

The competencies within the broad concept of loving kindness include: being open to connecting with others, treating self and others with loving kindness, listening respectively, demonstrating respect to others, and recognizing the vulnerabilities of others (Boeck, 2014; Burnell, 2011; du Plessis, 2016; Roach, 2007; Watson, 2011). Equanimity refers to the balance or harmony the patient and the nurse must have to promote healing and health. Watson's (2010) theory proposes that love is healing, and its positive effect lives beyond the moment for both the giver and receiver (O'Brien, 2001). The nurse demonstrates equanimity when viewing the broad scope of expectations and tasks, appraises the situation, understands what needs to be done for the patient, and utilizes the information to deliver individualized interventions to the patient (Watson, 2010).

A nurse who avoids or is unable to spend time comforting others or dodges the room of a patient in need of support is ignoring or avoiding the opportunity for the fulfillment that comes with connecting with others (Omari et al., 2013; Reader & Gillespie, 2013). The failure to practice nursing beyond tasks and procedures may cause the nurse's spirit to become wounded, causing the joy of nursing to fade over time. Eventually nursing may become an unfulfilling job (Omari et al., 2013; Tayray, 2009). Taylor (2007) stated, "Suppressing, distancing, or desensitizing oneself from others' feelings are signs of professional burnout" (p. 14) and contributes to a loss of job satisfaction. Burnout has been described as "an erosion of the spirit…and involves a loss of faith in the very enterprise of helping" (Taylor, 2007, p. 15). Ephesians 2:10 states that we are created to perform the good works that God has planned for us in our walk through life. Consequently, the nurse who walks away from or ignores the need to comfort a patient or family member in spiritual or emotional distress may understandably develop a wounded heart and dissatisfaction with his or her career.

Spirituality, Caring, and Compassion

Spirituality is a universal phenomenon and is a unique characteristic of each person (Pesut, 2008; Schaefer et al., 2012; Van Leeuwen & Schep-Akkerman, 2015). An individual's spirituality is not visible and can easily go unnoticed during a casual interaction. Focusing on what is visible, such as a person's physical appearance, is a much easier task (Monareng, 2012; Schaefer et al., 2012). In her article, Narayanasamy (2001) revealed that individuals should be regarded as "biopsychosocial-spiritual beings…to support the premise that there must be a balance of mind, body, and spirit for the maintenance of health" (p. 447). With this concept in mind, nurses must respond to a patient using a "holistic approach in restoring a harmonious balance" (Narayanasamy, 2001, p. 447) as well as improving the quality of life for the patient (O'Brien, 2001; Oswald, 2004; Schaefer et al., 2012). People are holistic beings, meaning that all aspects of an individual make up the whole person (Nightingale, 1860; Schaefer et al., 2012; Watson, 2011). An alteration in the physical health of a person will impact the spiritual and emotional components, just as an alteration in a person's emotional or spiritual state will impact physical health (Drumm, 2006; Press Ganey, 2010; Roach, 2007; Taylor, 2007; Watson, 2011). If the patient's spiritual, emotional, or religious needs are ignored by the nurse, a vital aspect of the patient's care is being overlooked (Duffy, 2009; Tuck, Pullen, & Wallace, 2001; Watson, 2010; Young, Wiggins-Frame & Cashwell, 2007). According to Clark, Drain, & Malone, (2003), "emotional and spiritual needs have a profound effect on patients' health outcomes and deserve the attention of healthcare professionals" (p. 661).

Most people have experienced the frustration and angst that a simple cold or a bout with the flu can cause; imagine the impact an illness requiring hospitalization or surgery has on a person's emotional and spiritual health. The nurse can assess a surgical wound and determine

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whether the wound is healing or not, but determining the extent of emotional or spiritual pain that an illness has produced is far more complicated (Clark et al., 2003; Van Leeuwen & Cusveller, 2004). According to Press Ganey (2010), all patients have emotional and spiritual needs, whether the condition is expected, traumatic, planned, or sudden. The patient has physiological responses due to the fear, anguish, embarrassment, sadness, or anger experienced due to the medical condition. The physiological changes as the result of the feelings the patient has are aberrations to the normal such as increased heart rate, increased blood pressure (Erci et al., 2003), changes in bowel motility, muscular tension, insomnia, and changes in appetite. Caring behaviors demonstrated by the nurse such as support, compassion, affirmation, and empathy can evoke feelings of being cared for (Duffy, 2009), safety, peace, and comfort for hospitalized patients (Erci et al.,2003; Nightingale, 1860; Press Ganey, 2010). The positive feelings associated with compassionate care can promote the onset of the relaxation response in the patient (Duffy, 2009), which can normalize the physiological changes to the stress associated with hospitalization and the medical condition (Erci et al., 2003; Press Ganey, 2010).

The goal of holistic patient care is to improve health, support emotional well-being, and alleviate suffering. The nurse must approach the patient with an openness to understand the perceptions and feelings of the patient and accept the emotions as whatever the patient describes or experiences. In the study by Bergland, Westin, Svanstrom, and Sundler (2012), increased suffering occurred in patients who perceived they were distrusted, mistreated, or not listened to, or that the perspective about their illness was not affirmed or acknowledged by the nurses caring for them. Absence of spiritual and emotional care violated the patients' dignity and self-worth (Reader & Gillespie, 2013) and caused the patients to be reluctant to complain because of feeling powerless and objectified (Bergland et al., 2012). Patients who feel powerless and objectified by

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their caregivers suffer in silence for fear of repercussion (Bergland et al., 2012). Patients in vulnerable health situations yearn to be comforted by nurses and suffer emotional wounds when spiritual and emotional needs are ignored or rejected. A patient's suffering can be reduced if healthcare workers are provided with opportunities to gain insight into the emotional and spiritual needs of patients and are given the tools to comfort, nurture, and support patients. The study by Bergland et al. (2012) advised healthcare workers to develop the professional skills and attitudes necessary to understand the person behind the disease and affirm and respond to the patient and his or her emotional and spiritual needs. "This suffering caused by care is unnecessary, and it prevents the healing processes. The delivery of healthcare is influenced by the healthcare professionals' values and beliefs" (Bergland et al., 2012, p. 10) because they guide the caregivers' approach to patients. Thus, a key to responding to the holistic needs of patients in a caring manner is for the nurse to understand his or her own spiritual and emotional needs (LaBine, 2015; O'Brien, 2014; Puchalski, 2001; Taylor, 2007).

Jesus is a mentor for Christian nurses; He was the ultimate Good Samaritan (Jeremiah, 2017). When Jesus met people who were suffering spiritual, emotional, and physical distress, He visibly demonstrated compassion by gazing at the person. Numerous passages in the Bible note Jesus demonstrating compassion before He said anything to the individual or crowd (Jeremiah, 2017). Jesus saw more than the exterior of those who were suffering; He understood and responded with compassion to their emotional, physical, and spiritual pain. Jesus told the story of the Good Samaritan who responded to the needs of the injured traveler (Luke 10:25-27). The Good Samaritan did not just bandage the traveler's wounds, but he disregarded his own plans to take the traveler to safety, arrange for his continued care, and assure the debts for the traveler's care were settled. The ministry of Jesus was one focused on healing.

The Christian roots of nursing were introduced when Jesus taught his followers to serve, love, and care for others. The caregiver invests in the individual through an intentional and focused presence, a fundamental component of providing spiritual and emotional care. According to legend, Veronica of Jerusalem demonstrated heroism and courage because she risked physical punishment as she broke through the crowd to wipe the bleeding face of Jesus with her veil as He was carrying the cross. O'Brien (2014), believing Veronica was the prototype for nurses, wrote, "I believe that only one deeply imbued with the calling to provide care for the sick and suffering would have had the courage and the compassion to…risk the wrath of spear wielding Roman soldiers, to comfort her injured Rabbi" (p. 30).

Numerous nurse theorists cite the ministry of Jesus as an exemplar for the nursing profession. Burnell (2011) described compassionate care as actions the nurse takes to establish a bond of caring with each patient. The actions include: being with the patient (Murphy & Walker, 2013), being nonjudgmental, using attentive listening (Murphy & Walker, 2013), and touching the patient physically as well as spiritually (Burnell, 2011; O'Brien, 2014). Compassion is the essence of caring (Burnell, 2011; Monareng, 2012; Roach, 2007), not something the nurse does (Murphy & Walker, 2013) but what the nurse gives (Tayray, 2009). Compassionate care lies in the nurse's ability to fully appreciate the pain and suffering that the patient is experiencing and is the very heart of nursing (Burnell, 2011; Health Care Chaplaincy Network, 2017; Murphy & Walker, 2013).

Roach (2007) developed a theory of caring based on the six C's: compassion, competence, conscience, confidence, commitment, and comportment. Roach (2007) defined *compassionate care* as imitating God by loving others. O'Brien (2014) interviewed nurses who described the belief that part of their role in patient care was to "minister to the spiritual needs of

patients" (p. 92). Patients have described nurses who made a difference by making them feel

cared for (Duffy, 2009), respected, safe, and understood (du Plessis, 2016; O'Brien, 2014).

Unfortunately, when a patient's life is upset by a medical condition, the only potential source of

true compassion might be the nurse, someone who barely knows the patient. The hands and

heart of the compassionate nurse bring a "touch of the divine" (Burnell, 2011, p. 24) to the

patient's bedside (Murphy & Walker, 2013; O'Brien, 2001).

For nurses, caring requires a conscious response to the need of another (Baldacchino,

2015; Boykin, & Schoenhofer, 2001; Drumm, 2006; Duffy, 2009; Lachman, 2012; Monareng,

2012; Murphy & Walker, 2013; Roach, 2007). The nursing response is a demonstration of

caring feelings. Lachman (2012) cites "a care orientation is fundamental to the nurse-patient

relationship and the nursing profession itself" (p. 112). The International Council of Nurses

(ICN) *Code of Ethics for Nurses* specifies the nurse's role of promoting "an environment in

which the human rights, values, customs, and spiritual beliefs of the individual, family, and

community are respected" (ICN, 2000, p. 5). The *Code of Ethics for Nurses* developed by the

American Nurses Association (ANA) calls for every nurse to treat every patient with

compassion. "The measures nurses must take to care for the patient enables the patient to live

with as much physical, social, emotional, and spiritual well-being as possible" (ANA, 2015, p.

7). Assuming responsibility for the care of patients requires more than meeting physical needs

that are determined by a medical condition (ANA, 2015).

The description of the value of the connection that occurs between a nurse and a patient is

given by Duffy (2009):

When the nurse relates to the patient in a caring manner, the patient registers that the help

provided was genuine and sincere. This positive emotion allows the patient to relax and

feel noticed and secure; it provides the foundation and leads the way to future caring interactions. Relationships comprised of caring factors benefit not only patients but also nurses. (p. 73)

In the story of the Good Samaritan, the priest, the Levite, and the Samaritan all "looked" at the wounded traveler. Only the Samaritan "saw" the injured and helpless traveler and responded with compassion. In the passage, no mention is made of the increased suffering the injured traveler experienced as the result of being ignored or being the victim of "caring neglect" (Reader & Gillespie, 2013, para. 5). The concept of caring neglect in healthcare is important because it is contrary to the expectations of patients and their families. Nursing staff who are observed moving about on a busy unit may appear to be appropriately tending to the needs of patients, but the perceptions of the patients may be quite different (Reader & Gillespie, 2013). Caring neglect may not be readily observed in healthcare organizations because it involves behaviors that are intangible such as body language, facial expressions, tone of voice, and delayed response (Dempsey, 2015; Press Ganey, 2010; Reader & Gillespie, 2013). Patient neglect can be portrayed through patient-staff interactions that demonstrate indifference, lack of engagement, or unresponsiveness to the patient's concerns or fears. Caring neglect may cause negative patient outcomes because of the emotional devastation incurred from loss of dignity, feelings of unworthiness, or feeling uncared for when the patient is in an unfamiliar place and dependent on strangers for food, water, pain medications, and therapeutic procedures (Berglund, Westin, Svanstrom, & Sundler, 2012; McDonough-Means, Kreitzer, & Bell, 2004).

Central to caring neglect is the culture of the healthcare organization combined with the interactions, perceptions, and beliefs of the healthcare staff that demonstrate a lack of caring or compassion. The culture of a work environment that does not support or indorse healing through

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an emphasis on caring and compassion may result in staff burnout and patient neglect (Wolf, 2017b). An unrealistic or high workload is the most frequent cause of burnout (Bergland et al., 2012; Carnevale, 2013; Press Ganey, 2010; Wolf, 2017b). A state of mental exhaustion arising from an inability to meet the demands of a work setting results in negative attitudes, emotions, and behaviors towards one's work (Carnevale, 2013; Maloni & Mukwato, 2016; Reader & Gillespie, 2013). Nurses generally suffer high levels of burnout caused by high patient-to-nurse ratios, heavy workload, conflict, emotional demands, job insecurity, and low job satisfaction (Wolf, 2017b). Healthcare workers who suffer from burnout develop detached and cynical attitudes as well as a lack of empathy or compassion. Regarding patient neglect, burnout results in a decreased ability to empathize and demonstrate compassion to patients (Carnevale, 2013; Maloni & Mukwato, 2016; Reader & Gillespie, 2013).

Monareng (2012) performed research on the concept of spiritual care in nursing and discovered that the nursing profession places a high priority on procedures, protocols, principles, and policies, but it gives the intangible needs of spiritual and emotional care a lower degree of importance. Monareng (2012) urged the nursing profession to accept that love and concern for patients is an important component of holistic care and that compassion is essential to connect with the patient on a spiritual level (Dempsey, 2015; Murphy & Walker, 2013; Watson, 2010). O'Brien (2014) described the nurse's role as "serving as a 'bridge' and facilitating communication with the patient's family and friends" (p. 83). The nurse has the "opportunity to guide, advise, teach, or support an ill patient regarding a variety of emotional, sociocultural, and even financial concerns that may interfere with the individual achieving a sense of spiritual well-being in the illness experience" (O'Brien, 2014, p. 83). Duffy (2009) emphasized that the primary role of nursing "is relationship-building" (p. 16) and "relationships with patients and

families is a foundation for clinical decision-making" (p. 15). The relationship contributes to the

patient "feeling cared for" (Duffy, 2009, p. 18) and promotes the patient's and the family

members' ability to place trust in the nurse (Baldacchino, 2015; Bennett & Thompson, 2015;

Duffy, 2009; O'Brien, 2014). Once the trusting relationship has been established, the nurse has

endless opportunities to connect spiritually with the patient (Briggs & Lovan, 2014). According

to Meehan (2012), "spirituality is timelessly woven with nursing and health" (p. 990).

Patients crave compassionate care from the nurse and expect the nurse to notice, feel, and

respond to the suffering of others (Bennett & Thompson, 2015; McClelland & Vogus, 2014;

Omari et al., 2013). The Health Care Chaplaincy Network (2017) stated, "Patients yearn for an

interpersonal, trusting relationship with their nurse, and this relationship is a prerequisite to

[patients] revealing their spiritual needs" (p. 13). Christy Dempsey (2015) identified

Compassionate Connected Care™ as nurse behaviors that successfully address the spiritual and

emotional needs of patients and promote patient satisfaction:

- Coordinated care is reassuring. Patients want to see evidence that the nurse is

  "tuned in" to their needs and the staff is communicating with each other.

- Body language matters. Sitting down and being with the patient is as important as

  asking the patient how he or she is feeling.

- Anxiety is suffering. Patients are afraid and must be reassured by the healthcare

  team that they are safe and in the best place to receive the best care by the best team.

- Caring transcends diagnosis. Patients want their caregivers to demonstrate real

  caring by knowing more about them as a person rather than knowing them as having

  a certain diagnosis.

- Autonomy reduces suffering. Preserving the dignity of the patient gives him or her as much independence and control as possible.

Dempsey (2015) acknowledged that nurses understand that patients suffer due to their medical conditions, but it is essential that the healthcare system avoid causing more suffering. "Nurses make the difference when providing compassionate and connected care" (p. 6). Nurses who do not understand the emotional and spiritual needs of patients may potentially add to the suffering of a patient by delivering care without regard to a patient's dignity or by ignoring a patient's need (Bergland et al., 2012; Rhodes et al., 2011). Patients expect nurses to offer comfort and deliver care with respect. When the nurse fails to demonstrate respect, the patient feels wounded, vulnerable, powerless, mistrusted, and mistreated (Bennett & Thompson, 2015; Bergland et al., 2012). Work environments and healthcare organizations must provide nurses with the resources to focus on delivering patient-centered care as well as communicating to nurses they are expected to meet the holistic needs of their patients (Bennett & Thompson, 2015; Bergland et al., 2012; Grigsby & Megel, 1995; Kieft, de Brouwer, Francke, & Delnoij, 2014; McClelland & Vogus, 2014; Molzahn & Sheilds, 2008). Nurses are often very aware of the suffering the patient is experiencing, but, in some cases, they may feel distracted or impeded by the management and systems of the healthcare organization to perform the care needed by the patient. Sometimes the difficulty lies in the fact that the nurse may seek a remedy or antidote for the patient's condition, but there isn't an easy fix for spiritual and emotional distress because it is both difficult to witness and hard to ease. As a result, nurses often avoid those who suffer because of the belief that there is "nothing that can be done" (Blumberg, 2016).

The exchange of soul-to-soul communication establishes a method to meet the needs of the patient's mind, body, and spirit (Costello et al., 2012; LaBine, 2015; O'Brien, 2001).

Nursing requires a closeness with the patient that is not usually experienced outside of relationships with intimate friends and family members. The intimacy with patients promotes a connection and serves as the foundation for nurses to enable others to change, to accept, to grow, or to die peacefully. According to Goldberg (1998), communicating with patients about subjects our culture considers very personal and rarely shared with strangers "may be the hardest part of nursing" (p. 839). Cassidy (1988) offered the analogy of the nurse staying with patients who are suffering to standing at the foot of the cross with Jesus during His last hours of life. Du Plessis (2016) stated the consequences of presence include "healing environment, improved mental and physical well-being of the healthcare user, and improved mental well-being of the nurse" (p. 50). A nurse who feels impeded by the culture of the healthcare organization to perform care ethically suffers from moral distress that can lead to burnout (Carnevale, 2013; Wolf, 2017b).

Patient's Expectations and Satisfaction

As medical research introduces new technologies to treat and diagnose medical conditions, healthcare professionals of the 21st century heavily focus on biomedical and technical data (Koenig, 2003; Puchalski, 2001). Gradually, over time, the holistic person in the bed has become less and less visible. When the healthcare worker can stand on the other side of the computer, read questions off the screen, and type in the patient's responses, an entire nurse-patient or doctor-patient interaction can take place with little or no eye contact (Koenig, 2003). The toll is devastating to the patient's satisfaction and confidence in healthcare and is causing increased rates of burnout in nurses and physicians (Omari et al., 2013; Wolf, 2017b).

The Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act (ACA), became law in March 2010. A primary focus of the ACA is the promotion of quality healthcare services and improved patient satisfaction with care received. Since 1985,

Press Ganey Associates has been interested in understanding how patient satisfaction, improved

healthcare, and reduced medical claims are related to a patient's social, cultural, emotional, and

medical needs. Press Ganey's contribution to understanding patient satisfaction with healthcare

is the result of evaluating over 4,000 articles, reviewing evidence-based data, and conducting

interviews with patients to determine how high-performing healthcare organizations met the

emotional and spiritual needs of patients (Press Ganey, 2010). Press Ganey developed questions

included in the patient experience survey, the Hospital Consumer Assessment of Healthcare

Providers and Systems (HCAHPS). The HCAHPS survey is the result of a requirement of ACA

that mandates an evaluation survey is given to patients after their experience with a healthcare

agency regarding their satisfaction with the care received. Through the Hospital Value-Based

Purchasing initiative, Medicare also gathers data from hospitals to determine their adherence to

specific quality standards of care (Center for Medicare and Medicaid Services [CMS], 2015).

Medicare determines patient satisfaction scores based on the responses of the participants to the

HCAHPS survey. All hospitals which receive federal funding are subject to having their

reimbursement impacted by the combined score of the Value-Based Purchasing data and the

HCAHPS survey. Thirty percent of a hospital's score reflects the patients' perceptions of the

quality of care received during hospitalization, and 70% of the score is determined by the

hospital's adherence to quality measures. The hospitals are held accountable for the patient

satisfaction survey responses, and the survey responses are reported publicly on the Medicare

website (CMS, 2017). Posting the scores allows the public to compare individual hospitals to

other facilities. As of 2017, a poor rating on the patient satisfaction survey penalizes the

healthcare organization by withholding 2% of the expected reimbursement dollars for the care

provided. Healthcare organizations with exceptional patient satisfaction scores receive a portion

of the dollars that are withheld from poor performing organizations as a "bonus." Consequently, an agency can never recover the lost funds.

The HCAHPS survey is sent to every patient discharged from an acute care setting. Analysis of 1,732,562 patients' satisfaction data, collected by Press Ganey Associates Inpatient database, indicates that patients place emotional and spiritual needs as a top priority, and patients' satisfaction scores are closely related to the emotional and spiritual care they receive (Bennett & Thompson, 2015; Clark et al., 2003; HealthCare Chaplaincy Network, 2017; Koenig, 2003; Press Ganey, 2010).

According to Press Ganey (2010):

Patient satisfaction with emotional and spiritual care can be influenced by every encounter throughout the hospitalization experience….Patients do not perceive a distinction between an 'emotional need' and a 'spiritual need.' The conclusions about emotional and spiritual needs are the result of review and analysis of the data from 3.1 million acute-care inpatient surveys from more than 2,000 U.S. hospitals and are solidly grounded in cognitive science, psychology, human emotions, and how patients perceive these needs. (p. 3)

Patients combine the broad concepts of emotional and spiritual needs such as search for meaning, hope, alleviation of fear, loneliness, and desire to maintain religious practices (Press Ganey, 2010). The staff behaviors that patients believe to be appropriate responses are identical for both spiritual and emotional needs and include: caring, comfort, support, sensitivity, empathy, and affirmation (Bennett & Thompson, 2015; Dempsey, 2015; du Plessis, 2016; Press Ganey, 2010). Further, because of the discovery of how patients view spiritual and emotional needs, the questions addressing emotional and spiritual needs on the patient satisfaction survey

(HCAHPS) were combined into one construct. Unmet spiritual and emotional needs can lead to

an increased risk of death, poor mental health, low quality of life, increased hospital length of

stay, and delayed recovery after discharge (Abassi et al., 2014; Dempsey, 2015; HealthCare

Chaplaincy Network, 2017; Koenig, 2003).

 Malott and Ayala (2010) noted a direct connection between the patients' satisfaction

with the care received in an acute care setting and with how information was provided and how

compassionate care was given by nurses:

> Patients want a caring and knowledgeable staff. They desire a skilled nurse who provides
>
> not just information, but also assurance and comfort. They want members of their care
>
> team to act as a team. They want to see cooperation and communication and know that
>
> all of this is because the staff truly care about the patient as a person. (p. 15)

When patient satisfaction is dependent on the patient's perception of the care received

and is directly tied to agency reimbursement, the power of the nurse at the bedside becomes

extraordinary. The data reveal that patients want to establish a good rapport and have a trusting,

personal relationship with healthcare providers, especially with the nurses who serve as a

connection and voice with the physician and healthcare agency (O'Brien 2014; Reade, 2013).

Most hospitals in the United States receive a large percentage of reimbursement dollars from the

Centers for Medicaid and Medicare Services (CMS). According to Clark et al. (2003), research

by TJC revealed that patients become disillusioned with hospitals that do not meet their

emotional and spiritual needs (Abassi et al., 2014). Patients who believed their care was

impersonal in the hospital were more likely to pursue malpractice lawsuits because the patient

and family felt abandoned by the healthcare staff and physicians (McDonough-Means et al.,

2004; Panjinkihar, Stiglic, & Vrbnjak, 2017). In many cases, the patients and family members

revealed that better interpersonal communication by the staff would have decreased the risk of litigation even when medical errors occurred (Panjinkihar et al., 2017).

By surveying patients and integrating the data from Press Ganey's (2010) research, information can be used to reduce suffering and enhance a healthcare organization's ability to gain insights into unmet patient needs and to improve the safety, quality, and experience of healthcare (Dempsey, 2015). Many hospitals have acknowledged the importance customers (patients) place on receiving compassionate care and are becoming more customer-focused by integrating words such as "compassion" and "caring" into the mission, vision, and values statements of their organizations. But the words are not enough; healthcare organizations are finding it necessary to change their culture (HealthCare Chaplaincy Network, 2017; Lee, 2017). A positive correlation exists between a better patient experience and the positive outcomes of patient care (Carnevale, 2013; Dempsey, 2015; HealthCare Chaplaincy Network, 2017; Lee, 2017; Reader & Gillespie, 2013). The insight Press Ganey received into the operational factors and the core values of successful healthcare organizations emphasize the importance of the engagement of physicians, nurses, and other personnel. According to Lee (2017):

> People who are proud of their organization, who believe it is committed to quality and safety, and who consider teamwork a core value—perform better. If they believe that the organization cares about quality and safety, and if core values include compassion for patients and teamwork, there is a good chance that better quality and financial performance will follow. (para. 11)

Malott and Ayala (2010) reported that Press Ganey data identified the primary source of patient satisfaction with healthcare as timely provision of information and treatment with compassion. Due to the dire consequences associated with poor data on the HCAHPS survey,

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hospitals have become sensitized to the emotional and spiritual needs of their customers and seek to reduce the patients' suffering and improve the patients' experience with the healthcare system. Healthcare organizations are beginning to realize that the driving force behind positive patient experiences with clear and measurable good patient outcomes is a positive and supportive organizational culture. In a survey of U.S. hospitals, Wolf (2017b) reported "caregiver burnout" and "stress" were identified as roadblocks to positive patient care experiences. Wolf (2017b) described the devastating effects of an organizational culture that does not nurture staff members:

> If we are unable to care for those providing care, how will we ever be effective in the provision of care itself? From our perspective, burnout comes from a number of places including workload, systemic constraints, and distance from the purpose that drove so many to choose healthcare as a profession. (p. 17)

Never before has nursing care been quantified or given the slightest consideration for hospital charges or reimbursement. Indeed, when a patient is admitted to a hospital, the nursing care is lumped in with housekeeping and dietary services as part of the room charge. The focus placed on the importance of the type of nursing interface experienced by a hospitalized patient is significant and becomes an opportunity for nurses to define, describe, and clarify exceptional nursing care. Nurses must recognize the critical role they play in enhancing the long-term financial health of their employers (Wolosin, Ayala, & Fulton, 2012).

Nursing Education

Several national and international organizations have focused their efforts on strengthening the ability of professional nurses to recognize the emotional and spiritual needs of patients and respond to those needs appropriately. The Joint Commission (TJC, 2011), the

primary accrediting agency for American hospitals, mandated that all admitted patients have a spiritual assessment. The American Association of Colleges of Nursing (AACN, 2016) issued a position paper stating nurses must practice from a "holistic, caring framework" (p. 8). The *Code of Ethics for Nurses* released by the American Nurses Association (ANA, 2015) states that establishing a therapeutic nurse-patient relationship is a basic expectation of nurses (AACN, 2008). The National Health Service of Scotland (NHS, 2010), a World Health Organization, released a position paper stating:

> 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)

Spirituality content currently is 3-5% of the blueprint for the nursing National Council Licensure Exam (NCLEX-RN) with the percentage continuing to increase with each revision of the exam. Nursing students are taught to develop a nursing diagnosis and a nursing plan of care for their assigned patients in the clinical setting. Spiritual care is considered a recommended component of the nursing care plan for patients (Murphy & Walker, 2013). Spiritual distress, risk for spiritual distress, and readiness for enhanced spiritual well-being are included in the North American Nursing Diagnosis Association's (NANDA) list of nursing diagnoses that specifically address the construct of spirituality. These diagnoses are most commonly used when patients are suffering from spiritual pain, anger, loss, and despair, with the signs and symptoms that include a broad range of emotions such as crying, withdrawing, preoccupation, anxiety, hostility, apathy, and a feeling of pointlessness and hopelessness (Ackley & Ladwig, 2013; Murphy & Walker, 2013).

Theory to Practice Gap in Spiritual and Emotional Care

One of TJC's (2017) standards specifies that the spiritual needs of the patient must be addressed in the medical record of hospitalized patients. Although this appears to be a mandate to trigger healthcare organizations to encourage or promote meeting the spiritual needs of patients by their staff, TJC does not specify how the agency is to comply. Consequently, the electronic medical record of most healthcare organizations meets this standard by adding one question to the medical record about whether the patient's minister should be notified of the patient's admission. A potential reason spiritual and emotional concerns of the patient were not addressed in the past may be that the focus was on technical innovations and the implementation of the medical plan of care. Prior to the HCAHPS survey, no tangible method of measuring whether the spiritual and emotional needs of the patient were met existed, no method of connecting patient satisfaction with nursing care existed, and no scale for reimbursement based on patient satisfaction and quality of care existed (HealthCare Chaplaincy Network, 2017).

Currently, no protocols exist in the literature describing how spiritual care from nursing staff should be provided. Although national and organizational guidelines indicate that attention should be given to the spiritual needs of patients, little information exists to direct spiritual care (Phelps, et al., 2012; Puchalski, Vitillo, Hull, & Reller, 2014). Phelps et al. (2012) reported that although most nurses (85.1%) believe routine spiritual care would positively impact patients, only 25% of patients have reported receiving spiritual care. Phelps et al. (2012) also concluded that increased education on spiritual care in nursing has been associated with nurses developing more positive perceptions of spiritual care. Research suggests that formal spiritual care training and education are rare, although training staff to recognize spiritual issues and the needs of religious groups were viewed as important. Literature about spirituality in nursing education is

limited (Connors, 2017; LaBine, 2015; Puchalski, et al., 2014; Reade, 2013; Wu, Liao, & Yeh-Cherng, 2012).

The research performed by Press Ganey (2010) revealed specific information about the emotional and spiritual needs of patients who are dealing with illness, disability, and dependence. Koenig (2003) reports the patient's concerns include the following:

- A need to make sense of the illness. Patients are concerned about the impact of the illness on their future and their families' future.

- A need for purpose and meaning out of the illness experience. Patients want to know they still have a purpose and can continue to contribute despite the illness. Religious and spiritual beliefs often lie at the core of what gives life purpose.

- A need for spiritual beliefs to be acknowledged, respected, and supported. Spiritual beliefs and rituals offer hope and support coping with life events.

- A need to transcend the illness and the self. Patients need to get their mind off the illness. Reflection on spiritual matters help to place the illness into perspective.

- A need to feel in control and give up control. Hospitalization and illness take away the patient's control and arouse anxiety. Spiritual beliefs can help a patient accept the situation and reduce anxiety.

- A need to feel connected and cared for. Hospitalization and illness makes patients feel isolated. Visits from friends, relatives, and pastor helps re-establish a connection with others. A lack of connection and support can cause the patient spiritual and emotional distress.

- A need to acknowledge and cope with the possibility of dying. Fear of death and dying can be terrifying. Spiritual beliefs help patients make sense of life, death, and suffering.

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Patients may also have a fear of punishment for past sins or worry about their relationship with God.

- A need to forgive and be forgiven. Illness forces the individual to face his or her mortality. The patient may view the illness as a punishment or seek others to receive or give forgiveness. Inability to perform closure with family or friends can cause spiritual and emotional distress.

- A need to be thankful amid the illness. Being thankful and grateful for relationships and health the patient retains allows for the patient to adapt more quickly to the illness and maintain a positive outlook.

- A need for hope. Hope fuels motivation. Without hope, people give up, become angry, or neglect personal needs. Spiritual beliefs yield a powerful source of hope.

A common theme is noted in the positions of the agencies and organizations prompting nurses to provide spiritual and emotional comfort. The words used are descriptive terms about "what" the nurse is to do, but the terms do not address "how" or the strategies needed for the nurse to perform the care. The task of providing intangible emotional and spiritual care continues to be overlooked (Baldacchino, 2015; Bennett & Thompson, 2015; Press Ganey, 2010; Tiew et al., 2013; Yilmaz & Gurler, 2014). The expectation is for nurses to rely on their intuition to know how a patient, who may be a stranger or from a different culture, should be approached to identify and address his or her emotional and spiritual needs (Draper & McSherry, 2002).

Despite the abundance of relevant literature and directives for spiritual care, many practicing nurses report feeling uncertain about and unprepared to intercede in meeting patients' spiritual needs (Costello et al., 2012; Greasley, Chiu, & Gartland, 2001; LaBine, 2015; McSherry

& Jamieson, 2011; Molzahn & Sheilds, 2008; Narayanasamy, 2006; Prentis, Rogers, Wattis,

Jones, & Stephenson, 2014). Nursing literature repeatedly reports that nurses do not know what

to say to the patient, feel uncomfortable with silence, do not want to pry into the patient's

personal life, and are reluctant to touch the patient or enter the individual's personal space to

offer comfort (Barber, 2008; Blesch, 2015; Connors, 2017; Gore, 2013; LaBine, 2015; Lemmer,

2010). In one study, nurses confessed that 92% of the time they felt inadequately prepared to

meet patients' spiritual needs (McSherry & Jameson, 2010). Some literature suggests nursing

programs do not sufficiently prepare nurses to address matters of spirituality (Blesch, 2015;

Connors et al., 2017; LaBine, 2015; Mitchell et al., 2006; Prentis et al., 2014). According to

McBrien (2006), in order to make a difference in nursing practice, nurse clinicians must develop

care plans specifying interventions to use to provide spiritual and emotional care to patients. In

the article by Good and Connors (2015), nursing students were given a simulation that provided

an opportunity to address the spiritual and emotional needs of a patient and family member.

During debriefing as students were reflecting on appropriate and inappropriate responses, a

student stated, "You told us to care, but you never taught us how to care" (para. 6).

Malott and Ayala (2010) reported that Press Ganey data identifies the primary source of

patient satisfaction with healthcare as the provision of information and treatment with

compassion (Dempsey, 2015). Due to the dire consequences associated with poor data on the

HCAHPS survey, hospitals have become sensitized to the emotional and spiritual needs of their

customers and seek to reduce the patients' suffering and improve the patients' experience with

the healthcare system. According to Dempsey (2015), nursing care was directly related to a

patient's satisfaction with the care received in the hospital, and patient satisfaction is measured

and linked with hospital reimbursement. When nurses have the time to demonstrate caring

behaviors to patients, not only are patients satisfied with their care, but patients have fewer complications and shorter lengths of stay (Dempsey, 2015).

Teaching Nursing Students to Meet the Emotional and Spiritual Needs of Patients

Although the nursing profession has its roots in spirituality and a longstanding and ongoing commitment to address a patient's care holistically (Carson & Koenig, 2008), the spiritual dimension of holistic nursing is an area that has been neglected by both practicing nurses and nurse educators. When nursing students are neither taught how to meet the spiritual and emotional needs of patients nor given the opportunity to practice comforting and compassionate responses to suffering, caring behaviors may be absent from clinical practice (Bennett & Thompson 2015; Callister, Bond & Matsumura, 2004; Cockell & McSherry, 2012; Connors, 2017; LaBine, 2015; Murphy & Walker, 2013; Yilmaz & Gurler, 2014). Nursing education must offer specific academic preparation for behaviors to use to connect with patients to promote spiritual and emotional comfort (Baldacchino, 2015; Connors, 2017; Costello et al., 2012; Hoffert et al., 2007; Molzahn & Shields, 2008; Tiew et al., 2013; Van Leeuwen & Schep-Akkerman, 2015). A survey of healthcare professors revealed that 90% (26/29) of respondents agreed or strongly agreed that spiritual values were relevant to their subject area; however, only 17% (5/29) admitted spiritual values were integrated into their curricula (Prentis et al., 2014). The concept of spirituality tends to be controversial among nursing faculty, which may be explained by the absence of a common definition of spirituality by the nursing profession. The term spirituality is often unclear to faculty and students and is frequently confused with religion (Bennett & Thompson, 2015; Costello et al., 2012; Hoffert et al., 2007; Lemmer, 2002; Molzahn & Sheilds, 2008; Narayanasamy, 2006; O'Brien, 2014). According to Tuck, Pullen, and Wallace (2001):

In fact, much of research today examines religion when addressing spirituality and its effects on health. The confusion over the concept of spirituality may explain why nurses are hesitant to provide spiritual interventions although they value them as important components of holistic care. (p. 442)

According to Yilmaz and Gurler (2014), a debate existed in the literature regarding spiritual care in nursing education, including the content taught on spirituality, the methods used (Baldacchino, 2008; Mitchell et al., 2006; Narayanasamy, 1999), and the organization of the curricula covering the spiritual needs of the patient (Callister et al., 2004; Connors, 2017; Hoffert et al., 2007; LaBine, 2015; Lemmer, 2002; Ross, 2006). Indeed, research is limited examining the format of how the education should be carried out (Baldacchino, 2008; Callister et al., 2004; Connors 2017; LaBine, 2015).

Nursing students can readily explain the necessity of giving holistic care to patients. However, nursing students find it more difficult to answer a question about how to give holistic care or how to develop a nursing presence. Spiritual and emotional care is intangible (Monareng, 2012), yet caring is the essence of nursing (Bucco, 2015). Stowe (as cited in Rhodes et al., 2011) investigated the effect of teaching strategies used to promote caring in nursing students and concluded that the efforts to "impact a more consciously caring individual for our society is invaluable" (Caring section, para 1). Presence is more than a face-to-face interaction with a patient (du Plessis, 2016); the nurse must be completely or authentically present physically (Watson, 2011) through touch (Gillespie, 2010) as well as mentally by actively focusing on communication with the patient (Bennett & Thompson, 2015; Bucco, 2015; du Plessis, 2016; Watson, 2011). Some of the defining characteristics of presence include caring, empathy, compassion, listening attentively, responding quickly, and nurturing (Bennett &

Thompson, 2015; Boeck, 2014; Bucco, 2016; du Plessis, 2016; Rogers & Wattis, 2015; Watson, 2011). The therapeutic use of self or presence does not require a religious interaction and can be performed equally well by nurses who participate in religious practices, nurses who prefer not to share religious beliefs, and nurses who do not participate in religious beliefs or practices (du Plessis, 2016). Presence can be readily applied in all areas of nursing practice and across the entire process of the nurse-patient relationship with flexibility and adaptability as the nurse responds to the uniqueness of the situation or the specific needs of the patient (du Plessis, 2016; Wood, 2016). The therapeutic use of presence is "an integral element of spiritual care" (du Plessis, 2016, p. 47), promotes the development of the patient's trust and confidence in the nurse, and yields a connection between the nurse and patient (Duffy, 2009; O'Brien, 2001). Brown (as cited in HealthCare Chaplaincy Network, 2017) noted that a script does not exist to demonstrate empathy and compassion; the verbal and non-verbal responses communicate to the patient that "You are not alone" (p. 13).

Much of spirituality research within nursing has focused upon descriptive and qualitative research studies (Albaugh, 2003; LaBine, 2015; Narayanasamy & Owens, 2001; Ross, 2006). This type of research is beneficial in both defining and examining relevant issues of the concept of spirituality. However, very little quantitative research has been performed in the United States examining spirituality and spiritual care from a nursing perspective (Bennett & Thompson, 2015; Connors, 2017; LaBine, 2015; Mitchell et al., 2006). Indeed, according to LaBine (2015), a gap exists in research performed in nursing programs of publicly funded community colleges on providing spiritual comfort (Connors, 2017; LaBine, 2015; Mitchell et al., 2006; Molzahn & Sheilds, 2008).

Costello, Antinaja-Fuller, and Hedberg (2012) discovered "very few published studies whose investigators evaluated methods of teaching spiritual care in nursing" (p. 278). Similar research suggests giving nursing students opportunities to provide spiritual and emotional care in an actual clinical or simulated setting (LaBine, 2015; Lovanio & Wallace, 2007; Mitchell et al., 2006). Despite the fact that the American Association of the College of Nursing encourages providing information to nursing students on the relationship between spirituality, health, and healing (AACN, 1998), the teaching strategy frequently used is the discussion of spiritual concepts in the classroom (Connors et al., 2017; LaBine, 2015). The student is only introduced to the concept of providing care and comfort to individuals in spiritual or emotional distress, not instructed on how to provide the care (Baldacchino, 2008; Gore, 2013; Hoffert et al., 2007; Lovanio & Wallace, 2007). If experienced nurses admit they struggle to find the right words to comfort patients and their family members, understandably nursing students may be unable to apply the concepts of spiritual care without practicing the behaviors (Connors, 2017; Connors et al., 2017; Good & Connors, 2015). During a patient simulation in which students practiced providing spiritual comfort, a student requested the nursing faculty to "teach me to pray" (Good & Connors, 2015, p. 3). According to LaBine (2015), "it is vital that nursing students are exposed, didactically and clinically, to the spiritual care of patients" (p. 16). Mitchell, Bennett, & Manfrin-Ledet, (2006) stated that when instructing nursing students how to provide spiritual care, the teaching strategies should include storytelling, role-playing, reflective discussions, and case studies.

Unfortunately, nursing faculty express a lack of confidence in performing the skills associated with compassion and presence (Rogers & Wattis, 2015). In LaBine's (2015) research, nursing faculty admitted "they did not have sufficient training related to spiritual care. Only half

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of the respondents indicated that they received spiritual care training while in their initial nursing program" (p. 84). Further, "research related to teaching spiritual care in community colleges will expand the knowledge and highlight the need for current and effective training for nurses" (p. 27). Because of the uncertainty about the definition of spirituality as well as the interventions to use when providing spiritual and emotional care, successful approaches to the academic quandary must include reflective discussions, role playing (Mitchell et al., 2006), and the introduction of appropriate nursing actions to use when providing spiritual and emotional care (Connors, 2017; Connors et al., 2017).

The therapeutic use of physical presence is a technique that can be utilized as the first step in teaching nursing students how to address a patient's emotional and spiritual needs (du Plessis, 2016). The development of presence is fostered by the foundational values of nursing such as respect for individual differences, unconditional positive regard, emphasis on promoting self-care, and empowering the patient (du Plessis, 2015; Monareng, 2012). Initially, the students can be introduced to the motivating factors bringing each of them to the nursing profession (Rhodes et al., 2011). The desire to intentionally interact and intervene with patients who express spiritual and emotional distress is "one of the main antecedents to presence" (du Plessis, 2016, p. 49) and one of the stated reasons people are drawn to nursing (Rhodes et al., 2011; Tayray, 2009). The actions demonstrated by the nurse who is practicing presence may appear to be "little things," including visiting the patient voluntarily, eye contact, smiling, listening attentively, answering questions, and promoting comfort, but the actions are transparent and communicate caring and compassion to the patient (Bucco, 2015; du Plessis, 2016; Rankin & DeLashmutt, 2006). Presence transforms the healthcare environment, the patient, and the nurse, thus having the potential to facilitate the healing process (du Plessis, 2016). Presence is

transformative for the patient by its calming effect, restoration of hope, reduction of stress, improved coping ability, and the promotion of healing, bonding, and support (du Plessis, 2016). The transformative effects of the use of presence on the nurse include resilience, job satisfaction, decreased stress, spiritual and professional maturation, self-confidence, and feeling revitalized by the ability to effect change (du Plessis, 2016). Therapeutic use of presence requires the nursing student to have an inner sense of calm, be comfortable with silence, be able to listen attentively, and use a quiet tone of voice (du Plessis, 2016).

Despite the technology and complex medical conditions of modern nursing, nurses can potentially bring the same healing presence attributed to Florence Nightingale when the wounded soldiers wrote in letters to their families about how their pain and suffering was eased as they saw her shadow cross their cot (O'Brien, 2104). The nursing interventions a student can use to promote a healing environment is to cease the activity being performed and listen to the patient attentively to communicate to the patient that he or she is fully present. The nurse becomes the intervention when he or she focuses on "being with" the patient through listening, displaying compassion, and exhibiting caring behaviors (Gillespie, 2010; Murphy & Walker, 2013; Tayray, 2009). Being with the patient can be just as powerful as the act of "doing for" the patient (Abbasi et al., 2014; Baldacchino, 2008; du Plessis, 2016; Gillespie, 2010). The nurse must make a conscious effort to interact in a reciprocal, genuine, and meaningful way with the patient (du Plessis, 2016; Gillespie, 2010). Boeck (2014) explained that "nursing presence is an immersion in the entirety of the situation, seeing beyond the moment of care and delving into the patients' perceptions of their greatest need at the time" (p. 3). The consequences of the nurse successfully demonstrating physical and emotional presence includes the promotion of a healing environment (Bucco, 2016), improved physical and mental well-being of the patient and a

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greater sense of satisfaction with the healthcare received, as well as an improved sense of well-being for the nurse (Bennett & Thompson, 2015; Boeck, 2014; du Plessis, 2016; Rankin & DeLashmutt, 2006).

Patients and families who face illness and suffering seek resources to assist with coping. Nurses can provide spiritual and emotional support as well as reinforce positive coping strategies that include the use of religious practices and rituals (Rogers & Wattis, 2015). The article by Callister, Bond, and Matsumura (2004) suggested when nurses provide spiritual and emotional care to patients it can restore hope, promote positive health behaviors, and reduce behaviors that threaten health (Gillespie, 2010). One method to increase spiritual sensitivity in nursing students is requiring reflection after actual or simulated clinical experiences (Callister et al., 2004; Mitchell et al., 2006; Rogers & Wattis, 2015).

A curriculum applying differentiated instruction allows the teacher flexibility in teaching specific content based on an assessment of the learners' knowledge (Hall et al., 2003). Universal Design for Learning (UDL) is a curriculum approach that increases flexibility in teaching and decreases the barriers that frequently limit student access to materials and learning in classrooms (Dirksen, 2016). A gap in methods of teaching nursing students how to provide emotional and spiritual care to patients has been identified (Connors et al., 2017; LaBine, 2015). According to Dirksen (2016), the gap in learning is not always a lack of information. Although the gap may be knowledge, it can also be a skill gap. Bridging a skill gap is not always accomplished by giving more information. In addition, a nursing curriculum based on UDL offers support for the faculty to develop a multifaceted approach to teach spirituality and give students the skills necessary to address spirituality with patients (Abassi et al., 2015; Dirksen, 2016; Good & Connors, 2015). Lectures about spirituality are not enough; students must be introduced to role-

playing in an emotionally charged situation dealing with spiritual distress to develop appropriate responses (Abassi et al., 2015; Bennett & Thompson, 2014; Good & Connors, 2015; Yilmaz & Gurler, 2014). Students must also be given the opportunity to role play in situations when there is not an obvious action or medical intervention to perform but rather requires the use of presence and attentive listening while demonstrating compassion. Role playing in situations requiring intangible skills helps the student learn how to convey respect and develop a trusting relationship with the patient. LaBine (2015) and Yilmaz and Gurler (2014) state that connectedness with the patient occurs when the nurse develops a relationship of trust and respect with the patient and provides spiritual care. The connectedness that occurs can become a spiritually fulfilling experience for the patient but can also become spiritually fulfilling and promote the professional development of the nurse (Baldacchino, 2014; Duffy, 2009; Mitchell et al., 2006).

Du Plessis (2016) suggested ways to promote the practice of presence in nursing students by describing the appropriate behaviors, praising students who describe patient care situations when a connection was made, and providing support and reinforcement for future patient care interactions. Nurses go through intrapersonal and ethical processes to have a therapeutic presence with and for the patient (du Plessis, 2016). According to Bright (2012):

The processes are unique to each circumstance and cannot be reduced to a series of steps that can be memorized by students. However, it is possible that the capacity to be present with a patient can be cultivated through reflective practices and an ethical orientation. If nursing presence is to be promoted at the undergraduate level, it must be done in a way that is more than a set of behaviors to be memorized, mimicked, and measured. While presence itself consists of a unique experience each time and may not be teachable, the

capacity of a nurse to have presence may be cultivated through techniques that can be

taught. (p. 27)

Students may gain insight and understanding into their behaviors that contribute to a therapeutic

presence in patient interactions through reflective discussions (Callister et al., 2004; Mitchell et

al., 2006). When students can retrace a positive patient encounter verbally, insight may be

provided into the personal fulfillment of the experience as well an understanding of the meaning

of the experience for the patient.

The use of a simulated setting to teach students spiritual and emotional care has value

because it exposes all students to the same situation and gives faculty the opportunity to guide

students in a safe non-threatening environment through reflection and sharing of thoughts and

feelings on what happened (Bennett & Thompson, 2015; Costello et al., 2012; Jeffries, 2005;

Mitchell et al., 2006). The theoretical model that strongly supports the use of simulation in

nursing education is the theory of learning developed by David Kolb. Kolb (1984) theorized that

learners integrate knowledge through a sequence of learning steps that includes actual experience

and observation followed by reflection on the experience (Bennett & Thompson, 2015). Mastery

of the task is accomplished by the student through reflection, testing new concepts and

behaviors, and repeating the sequence until the student is comfortable with the new behaviors or

concepts (Bennett & Thompson, 2015; Kolb, 1984). In the research performed by Connors,

Good, & Gollery, (2017) and Connors (2017), although students were "prepared for simulation

with a classroom lecture, group activity, and pre-simulation activity that mirrored the simulation,

the students were visibly anxious in the simulation because they did not know what to say or do

to provide comfort to patients in spiritual distress" (p. 63). In the research performed by Connors

et al. (2016), students' perceptions of their confidence and competence scores in providing

spiritual care demonstrated "significant improvement" (p. 60) only after the students completed the simulation experience. In the research by Connors (2017), the students were given the *Key Phrases and Caring Behaviors©* chart prior to any clinical experience. When considering differentiated learning and UDL it may be that students lacked a readiness for the chart because they had no previous clinical or simulated experience with patients (Bennett, & Thompson, 2015; Dirksen, 2016). When faculty expect the learner to demonstrate proficiency with a skill, an opportunity must be given to the learner to practice, preferably a structured practice session (Dirksen, 2016). Students must have the opportunity to practice using the *Key Phrases and Caring Behaviors©* chart before they can demonstrate comfort using the techniques (Dirksen, 2016).

According to the research performed by Chmil, Turk, Adamson, and Larew (2015), Kolb's model of experiential learning was applied by actively involving the students in the preparation for the simulation through the introduction of a planning activity followed by participation in the simulation experience and debriefing using reflective observation and discussion. The researchers found that following Kolb's model using the structured activities effectively produced clinical competencies and the development of clinical nursing judgment in the nursing students (Chmil, Turk, Adamson, & Larew, 2015). An important component of Kolb's model is the use of reflection. Asking students to reflect on what they observed is not enough when addressing the nonverbal and verbal interactions necessary to provide emotional and spiritual care. "Many student journals demonstrate minimal reflection about learning, instead focusing on the chronological details of a clinical experience" (Lasater & Nielsen, 2009, p. 40). Reflection is essential for a student to learn from experience, "particularly in situations that are ill-defined, multilayered, and complex" (Lasater & Nielsen, 2009, p. 40). During

debriefing after a simulation, a reflective discussion can be led by faculty. The students can be asked specific questions about the shared experience that can help them process learning both verbal and nonverbal behaviors. Debriefing is the key component for learning and considered the heart and soul of a simulation (Coutinho, Martins, & Pereira, 2016). Applying the constructivist or active learning philosophy to the simulation experience, students can combine previous knowledge with current interactions to develop or rebuild skills. Students can achieve the constructivist premise by sharing their perspectives with others as faculty establish an active dialogue to facilitate knowledge development (Coutinho et al., 2016). Applying the principles of adult learning to the simulation experience, the use of experiential learning and reflective practice promote the integration of cognitive, affective, and psychomotor knowledge (Coutinho et al., 2016). Debriefing integrates the stages of Kolb's model by focusing on the concrete experience, using reflective observation, applying abstract conceptualization, and encouraging active experimentation (Coutinho et al., 2016). Debriefing after a simulation is not only a formative assessment involving interaction and discussion between the students and the faculty but also a learning activity that assists students to improve their performance in the clinical area (Coutinho et al., 2016). According to Brannan, White, and Long (2016), simulations lead to increased self-efficacy which increases the students' confidence and translates into improved quality of patient care.

In the article on structured debriefing, Coutinho, Martins, & Pereira (2016) discovered that:

The students…believe that [structured debriefing] is a method that minimizes fear and distress and increases their confidence. They are comfortable enough to ask questions and be self-reflective, identifying their own mistakes while connecting practice to theory

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and developing teamwork skills….It also allows for a closer relationship between colleagues, with a critical-reflective spirit and teacher-student interaction in a safe and relaxed environment, providing more self-confidence. (p. 132)

In the 19th century, Florence Nightingale stressed that spiritual education and spiritual development were essential in the training of nurses. Not until the end of the 20th century, in 1998, did the World Health Organization (WHO) determine the necessity of adding the spiritual dimension to the definition of health as follows: "Health is a dynamic state of complete physical, mental, spiritual, and social wellbeing and not merely the absence of disease or infirmity" (para. 1). The International Council of Nurses' *Code of Ethics for Nurses* (2013) reported that the need for nursing care is universal and stated that professional nurses are responsible for promoting an environment in which the human rights, values, customs, and spiritual beliefs of the individual, family, and community are respected. The absence of health in the physical, mental, spiritual, or social dimension will prevent the patient from obtaining a state of complete health (Gillespie, 2010). Contemporary nursing theory supports holistic nursing care that includes attention to the spiritual dimension (McEwen, 2005; Rankin & DeLashmutt, 2006; Watson, 2011). Nursing literature stipulates the need to educate nursing students regarding spiritual care (LaBine, 2015; Rankin & DeLashmutt, 2006), and the positive impact of such education is widely recognized (Baldacchino, 2008; LaBine, 2015; Lovanio & Wallace, 2007).

Spiritual Development

A nurse who understands his or her spirituality will be more comfortable ministering to the spiritual needs of others (Callister et al., 2004; O'Brien, 2014). Often Jesus is described as the Divine Physician (O'Brien, 2001). In an address to her students, Florence Nightingale identified Jesus as a nurse. Nurses may be considered handmaidens to the Divine Physician

(O'Brien, 2001). "Gentle hands-on caring, caring from the heart, by a nurse, as modeled in the life and teachings of Jesus of Nazareth, is needed more now than any other time in the history of healthcare" (O'Brien, 2001, p. 42). The nurse who is aware of his or her own spiritual frame of reference can use it as a resource when establishing a therapeutic relationship with patients (Callister et al., 2004). O'Brien (2014) stated, "Holistic nursing is supported by and alternately [confirms] the intimate connection of the body, mind, and spirit" (p. 9). Thus, when the nurse is planning the holistic care of the patient, the needs of the spiritual dimension of the patient must be addressed.

A persons' woundedness serves as a foundation for developing compassion for the suffering of others (Burnell, 2011; Puchalski, 2007; Taylor, 2007). According to Taylor (2007), "Health care professionals cannot hear, never mind respond, to a patient's spiritual pain unless they hear and respond to their own pain" (p. 9). The literature states nursing curricula must prepare nursing students to meet the spiritual needs of patients by first promoting an understanding of their own spirituality (Abassi et al., 2015; Baldacchino, 2015). Research supports the belief that the way nurses perceive their own spirituality affects the extent that they can recognize and successfully meet a patient's spiritual needs (Chung, Wong, & Chan, 2006; Reade, 2013; Rogers & Wattis, 2015). O'Brien (2001) stated that by gaining an understanding of his or her own wounds, the nurse develops an increased ability to identify the wounds or suffering of the patient. Compassionate care has been described as suffering alongside the patient and opens up the possibility that the nurse will also experience pain (O'Brien, 2001). Spirituality must be introduced into the curriculum early in the program and continue as a curriculum thread throughout the program (Baldacchino, 2015; Mitchell et al., 2006).

Lemmer (2002) suggested that "the developmental stage of the nurse and the nurses' life experiences may also affect the provision of spiritual care" (p. 489). In the research performed by Gillespie (2010), patients preferred to address spiritual needs with an older nurse because they felt older nurses addressed their spiritual needs more effectively. Indeed, older nurses have more clinical experience and may feel more comfortable addressing emotional and spiritual pain. According to Benner (2001), the longer a nurse practices, the more adept he or she becomes at recognizing patterns of a patient's needs and identifying interventions that produce the best patient outcomes (Gillespie, 2010; Murphy & Walker, 2013; Van Leeuwen, Tiesinga, Middel, Post, & Jochemsen, 2009). The literature supports the view that practitioner comfort with his or her personal spirituality is a critical factor influencing the ability to provide spiritual care (Abassi et al., 2015; Baldacchino, 2015; Bennett & Thompson, 2015; du Plessis, 2016; Molzahn & Shields, 2008; Monareng, 2012; Puchalski & Guenther, 2012; Tuck et al., 2001; Van Leeuwen & Schep-Akkerman, 2015; Van Leeuwen et al., 2009).

In research on parish nurses, Tuck et al. (2001) discovered, "The interventions made by parish nurses are an extension of their personal spiritual growth and the expression and manifestation of the caring and holism characteristic of a common nursing paradigm" (p. 595). The study also reported that the ability to provide spiritual and emotional comfort had a significant relationship with age, indicating older individuals scored higher on the *Spiritual Well-Being Survey* (SWBS) (McSherry & Jamieson, 2013; Tuck et al., 2001; Van Leeuwen & Schep-Akkerman, 2015). Baldacchino (2015) addressed the characteristics of nursing, paramedical, and medical students "who are young with a lack of personal life experiences and with minimal attention to spiritual issues in life" (597). Baldacchino (2015) suggested that "it is very important to equip students with…information, but also attention needs to be given to their

personal formation as spiritual individuals" (p. 597). In the research performed by Van Leeuwen and Schep-Akkerman (2015), nurses who were atheist, agnostic, or designated no faith "scored lower on their level of connectedness to nature and others and a lower score for their personal spirituality" (p. 1355) than those who acknowledged being members of a faith. When describing the importance of spirituality and spiritual development for nurses, Baldacchino (2015) emphasized, "No one can give what he or she does not possess" (p. 597).

In the article by Astin, Astin, and Lindholm (2011), the spiritual qualities of college students were assessed by measuring the spiritually related qualities of Compassionate Self-Concept and Ethic of Caring. Twenty-three percent of the college students were classified as high-scorers in Compassionate Self-Concept, which included the behaviors of compassion, kindness, generosity, and forgiveness. Thirty-one percent of the students were high scorers in the Ethic of Caring concept which included the behaviors of commitment to help others in difficulty, reducing suffering in the world, and seeking to make the world a better place. According to The National League for Nursing (NLN), the organization supporting nursing education, 58% of nursing students in associate degree programs are under 30 years of age, and 82% of nursing students in baccalaureate degree programs are under 30 years of age (NLN, 2014). Many students state they chose nursing because of a desire to help others. However, the young ages reflected in the demographic information of nursing students in the United States provides potential insight into their spiritual development and the conceivable inability to identify or address the spiritual needs of patients. This insight may help nursing faculty to develop methods to close the gap between a nursing student's desire to provide comfort to the patient experiencing emotional and spiritual distress with the student's ability to provide appropriate nursing interventions (du Plessis, 2016).

The emphasis of a class on spiritual development for nurses should focus on supporting the ability to perform a more holistic, complete patient assessment (Bennett & Thompson, 2015; Puchalski & Guenther, 2012). One of the main goals for courses in spirituality is that a healthcare professional address his or her own spirituality first to be able to show compassion and be present to a patient's suffering (Abassi et al., 2015). In addition, spirituality classes ideally should include assignments requiring the student to engage in reflective work to identify personal values, beliefs, and attitudes (Bennett & Thompson, 2014; Puchalski & Guenther, 2012; Reade, 2013)

Rankin and DeLashmutt (2006) developed a clinical experience for senior nursing students to foster the students' comprehension of spirituality and further develop the students' understanding of themselves as spiritual beings. After classroom activities and a lecture followed by assignments requiring reflection, students were assigned to interact with patients in a homeless shelter. Student evaluations of the experience yielded insight into the transformation that occurs when the nurse successfully connects with the patient: "My ability to help my patient increased my sense of being and self-worth. . . . Everyone should be given the ability to discover themselves" (p. 285). Through touch, active listening, verbal and nonverbal language, and connection with the patients' distressed circumstances, students revealed that they were providing spiritual care, addressing spirituality, and increasing their ability to be present with patients. Students realized that spiritual care was given with intangible, small, and often unnoticed acts (Rankin & DeLashmutt, 2006). The use of active listening and therapeutic communication skills promote the development of a relationship with the patient. When the nurse strives to connect with the patient, there is a risk and vulnerability because the nurse relies on his or her intuition about what the patient needs. The nurse must be willing and open to the

therapeutic use of self through the act of investing in another (du Plessis, 2016). A successful nurse-patient relationship fosters the development of the nurse's confidence and trust in using intuition about the appropriate way to respond to a patient's spiritual and emotional needs (du Plessis, 2016; Rankin & DeLashmutt, 2006).

With adequate preparation in spiritual care, the nurse may promote a healing environment by assisting a patient to move from complete unawareness or even denial of spiritual needs to an understanding of the spiritual dimension that may promote healing and wellness (Abassi et al., 2015; Duffy, 2009; O'Brien, 2014; Press Ganey, 2003; Taylor, 2007). When a patient taps into his or her spiritual energy, a powerful force is accessed that can be used by the body to promote restoration and recovery (O'Brien, 2014; Taylor, 2007). When the individual is fighting physical or emotional stress, his or her faith can provide support and the development of coping strategies that may strengthen the ability to fight off the threat (Duffy, 2009). Interventions provided by nurses can strengthen the individual's faith through a relationship that promotes hope and trust and, consequently, can lead to increased spiritual energy and a healing environment (Duffy, 2006; LaBine, 2015; O'Brien, 2014). The Bible informs the Christian nurse in 2 Corinthians 4:15-16:

> Indeed, everything is for your benefit so that, as grace extends through more and more people, it may cause thanksgiving to increase to the glory of God. Therefore, we do not give up. Even though our outer person is being destroyed, our inner person is being renewed day by day.

The student must be aware that ministering to others can be physically, emotionally, and spiritually draining. Nurses must take care of their emotional, physical, and spiritual well-being to maintain the energy necessary to minister to others (Baldacchino, 2015; Gillespie, 2010).

Job Satisfaction

Duffy (2006) found limited studies linking job satisfaction with spirituality and religion; but, in general, a positive relationship existed between spirituality and religion and career decision, self-efficacy, career values, and job satisfaction. According to the data gathered by Duffy promoting spiritual development in nurses has the potential to improve spiritual well-being that will, in turn, improve job satisfaction. Duffy performed research on a group of adult workers regarding their spirituality and career behaviors. He discovered that spirituality was found to "inspire a desire to serve others and positively relates to career coherence, or the finding of meaning and purpose in a career" (p. 55).

Individuals who view their career choice as a vocation, calling, or a career chosen for them by God typically reported greater satisfaction with their job and their life (Duffy, 2006). Spirituality influences values and purpose, respect for human dignity, human rights, and a reverence for life, which in turn influences an individual's work. When a person views his or her job as a calling, work has a purpose beyond earning money, and the individual considers work a reflection of personal values and a sense of self as well as a contribution to the world (Duffy, 2006; Rhodes et al., 2011). In Rhodes et al. (2011), nursing students identified themselves as caring individuals with statements such as, "I have a caring heart" (Motivation section, para.1). Patients can benefit when the nurses who care for them are aware of the meaning and purpose of their job, are aware of their own spiritual needs, and work in a healthy caring environment (Baldacchino, 2015; Puchalski, 2007; Timmins & McSherry, 2012).

In the article by Small and Good (2013), in an effort for nurses to develop a safe work environment for new hires, the preceptors were taught about the importance of applying the concept in Jean Watson's theory of loving-kindness to caring for themselves. The premise of the

effort was to develop a culture of safety focused on the nurses while, at the same time, developing a caring environment for new hires and a safe environment for patient care (Kieft et al., 2014; Small & Good, 2013; Timmins & McSherry, 2012). When patients feel safe and observe that the caregivers support each other and work as a team, patient satisfaction with care improves (Dempsey, 2015; Koenig, 2003). In the article by Kieft, de Brouwer, Francke, & Delnoij, (2014), nurses identified essential elements they believed "would improve the patient experience: collaborative working relationships, autonomous nursing practice, adequate staffing, patient-centered culture, and administrative and managerial support" (para. 3). Nurses felt patient care was compromised when they were placed in a position of being forced to choose between cost efficiency and a patient's needs (Kieft et al., 2014).

In Omari et al. (2013), nurses admitted that when therapeutic responses were used with patients in spiritual and emotional distress, the quality of care and their personal feelings of accomplishment and well-being was enhanced. The spiritual fulfillment that nurses experience when making a heart-to-heart connection with a patient is energizing and provides satisfaction and joy (O'Brien, 2001). In addition, nurses stated that when successful in developing a therapeutic relationship with patients, personal and professional satisfaction and love for nursing were enhanced (Omari et al., 2013).

Carnevale (2013) discussed moral distress in nurses when they were confronted with a work environment that impeded them from acting on their own ethical standards. In truth, nurses must be morally engaged in their professional practice. Moral distress may indicate a problem in the healthcare organization because nurses know the right thing to do for their patients but the work environment may prevent the actions. Spiritual and emotional care may become irrelevant when the nurse does not have adequate time to establish a presence and a therapeutic relationship

with the patient (Molzahn & Shields, 2008; Schoonover-Schoffner, 2017). According to Duffy (2009), "All too often nurses are so lost in the *doing* that the *being* [caring] of the profession is forgotten" (p. 76). Nurses suffering from moral distress feel powerless, angry, frustrated, and guilty because nurses believe the only choice is to comply with demands of the work environment. Nurses believe they have a "duty to follow medical and administrative directives; it is not their place to question authority, and they must find ways to accept their work conditions or consider changing jobs" (Carnevale, 2013, p. 35). Nursing is a morally complex profession rooted in self-sacrifice, duty, and service. Moral distress is a significant concern in nursing because it can lead to burnout. Listening and providing emotional and spiritual comfort to patients takes time; a healthcare organization that focuses on targets of quantity or completion of tasks forces staff to have "tunnel vision" on task completion instead of caring activities (Carnevale, 2013; Schoonover-Schoffner, 2017). Research on patient satisfaction and staff engagement identifies an unsupportive work environment as fostering patient neglect, poor job satisfaction, and poor patient outcomes. According to Reader and Gillespie (2013), high workloads, stress, lack of resources, and poor leadership prevent nurses from acting on their ethics and providing compassionate care to patients.

Data reveal a significant positive relationship between patient experiences and quality of care. The information is so reliable that agencies can use the patient experience data to determine the quality of care in a healthcare organization (Kieft et al., 2014; Wolf, 2017b). According to Kieft et al. (2014) and Wolf, (2017b), a healthy work environment for nurses is a determining factor for a positive patient experience. A healthy work environment was defined as a work setting that enables nurses to address spirituality, provide spiritual care (Nyirenda & Mukwato, 2016; Timmins & McSherry, 2012) to achieve the goals of the organization, and

derive personal satisfaction by focusing on the patients' needs (du Plessis, 2016). A healthy

work environment must be supportive and nurture the nurses so that they can, in turn, provide a

healing environment where the patient feels cared for and supported (Dempsey, 2015; Kieft et

al., 2014). A healing environment is created when patients feel they have been comforted and

supported by their caregivers and they understand that they can rely on nurses to be resources

during times of hopelessness and despair. The bottom line is that patients do not know how

much knowledge nurses need to care for them, but patients do know when they have been cared

for (Good & Connors, 2015).

A key to improving the nurse's performance and patient care is to provide a positive and

supportive work environment. According to Nyirenda and Mukwato (2016), job dissatisfaction

can cause nurses to perceive their work as tiresome and repetitive and may lead to frustration and

discouragement. When nurses have "negative attitudes towards their work, it negatively affects

the quality of care they provide" (p. 160). The attitude of the nurse influences the quality and the

extent of emotional, physical, and spiritual help the patients receive from the nurse (Nyirenda &

Mukwato, 2016). Factors that have a negative impact on nursing care include a non-supportive

workplace culture (Wolf, 2017b), shortage of staff, heavy workloads, low salaries, lack of

support and respect from managers, inter-staff conflict, poor quality of equipment, and lack of

resources (Nyirenda & Mukwato, 2016). According to the research performed by the Beryl

Institute, a rapid rise of employee engagement has become a top priority of healthcare

organizations since 2015 (Wolf, 2017a). The senior leaders of healthcare organizations are

demonstrating a strong and sustained effort of self-reflection and self-healing as they seek

improvement in the culture of their organizations to promote employee and patient satisfaction.

The implications of this commitment reveal the belief that the people who deliver patient care

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must be considered important if the goal is a positive patient experience (Wolf, 2017a).

According to Wolf (2017b), the shift in focus demonstrated a realization by the leadership of healthcare organizations that "happy people beget good experiences" (p. 7).

Florence Nightingale (1860) believed that individuals who are called to nursing are bound by a sacred covenant to serve those under their care. In the study by Rhodes et al. (2011), nursing students identified reasons they chose the nursing profession that included caring for others and having positive interactions with patients. Most importantly, the student nurses stated that caring is a critical component of nursing and is essential for the nurse to watch over the patients under their care to keep them safe (Puchalski et al., 2014; Rhodes et al., 2011). People who are attracted to nursing because of a desire to help others yearn for the time, resources, and support from their work environment to provide spiritual and emotional care to their patients. Spiritual and emotional care must be integrated throughout the nursing curriculum. One of the roles of the nurse educator is to provide learning experiences that promote the development of a therapeutic presence and the competence and confidence necessary to provide spiritual and emotional comfort to patients. The teaching strategies of simulation, role-playing, and reflective discussion provide an opportunity for students to practice caring behaviors and discover the fulfillment associated with making a difference in someone else's life.

Nurses will not remain in a work environment that prevents them from meeting the demands of the work setting and providing emotional and spiritual care to patients (Carnevale, 2013; Nyirenda & Mukwato, 2016; Reader & Gillespie, 2013; Wolf, 2017b). Currently, there is a global nursing shortage. Unfortunately, one of the contributing factors to the shortage is the high attrition rate in the nursing profession. Approximately 20% of newly licensed nurses leave the profession in the first year of practice, and another 30% leave in the next two years (Tuten,

2011). Caring is the essence of nursing, and developing a trusting relationship and the

therapeutic use of self (presence) are the strategies used to provide spiritual and emotional care

(Bucco, 2015; du Plessis, 2016). The frustration felt by novice and experienced nurses who are

placed in conditions where they are unable to keep patients safe causes ethical and

compassionate individuals moral distress and a desire to leave nursing.

III. METHODOLOGY

The purpose of the study was to determine the impact on first-semester nursing students' competence and confidence of providing spiritual and emotional care by introducing reflective discussions and the *Key Phrases and Caring Behaviors©* chart during the clinical post-conference on the third clinical day. Also explored whether the competence and confidence in providing spiritual and emotional care significantly improved after the introduction of the *Key Phrases and Caring Behaviors©* chart in clinical or during a simulation at the end of the term.

A repeated measures quasi-experimental quantitative study design was utilized to explore the best time to introduce the Key *Phrases and Caring Behaviors©* chart to first-semester nursing students. The study represented an attempt to answer questions raised in the published research by Connors et al. (2017) and Connors (2017) as well as informal student comments made after the simulation experience in previous semesters. The findings of the current study may add to the knowledge related to nursing strategies to be used when teaching nursing students about spiritual and emotional care by answering the questions of when and how to more appropriately utilize the *Key Phrases and Caring Behaviors©* chart. As such, the study attempted to duplicate the effect of the simulation experience in previous studies on students' competence and confidence in providing spiritual and emotional care by introducing reflective discussions and the *Key Phrases and Caring Behaviors©* chart earlier in the semester during post-conference on the third clinical day.

Participants

A voluntary, non-probability sample, convenience and purposive in nature, comprised of 25% of possible first-semester nursing students enrolled in a public state-supported associate

degree nursing program located in central Florida. The students who completed Phases I, II, and III of the study were all female (100%). The study's sample included 41.7% of the participants between 18 to 21 years of age and 33.3% in the 22 to 30 age range. The remaining 25% of participants were in the 31 to 45 age range. Two-thirds (66.7%) of participants indicated that they had an AA degree, with the remaining one-third (33.3%) holding a bachelor's degree. Students repeating the course were not excluded from the study. However, students repeating the course had prior exposure to the teaching instrument and may have ranked themselves as more confident and competent in providing spiritual and emotional care on the survey.

All first-semester nursing students enrolled in the Adult Health I course were invited to participate in the study by the director of the program via email with a link to an online survey. The identity of the participants was protected, as students were encouraged to use the last four digits of their social security number as the identifier on the survey. The researcher did not have access to the personal information of the students.

Instrumentation

The survey created by Hoffert, Henshaw, & Mvududu, (2007), Enhancing the Perceived Comfort and Ability of Nursing Students to Perform a Spiritual Assessment: Spiritual Questionnaire Evaluation Tool, was the foundation for the current online survey entitled *Spiritual Competence and Confidence Survey©* Phase I, Phase II, and Phase III (see Appendix A). The original tool contained 10 core Likert-type questions related to students' perceptions of competence and confidence in providing spiritual care from 4 (strongly agree) to 1 (strongly disagree). The tool with the 10-core questions demonstrated a high degree of internal reliability ($\alpha = .91$) in the previous study performed by Connors et al. (2017) and Connors (2017).

Revisions were made to the original survey with permission from the author. Four questions were added to each survey that addressed the students' perceptions of relevance of spiritual beliefs to nursing practice and the relevance of spiritual well-being to an individual's health. All questions on the *Spiritual Competence and Confidence Survey*© Phase I, Phase II, and Phase III were identical. The survey included 14 questions, and the total possible score on the survey tool was 56 with the lowest possible score being 14.

Very few studies have been conducted 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*© chart during a simulation experience after the completion of the students' clinical rotation. The instrument was determined to be an effective teaching tool, producing data at a statistically significant level reflecting improvement in nursing student competence and confidence in providing spiritual care. Upon completion of the simulation, students were encouraged to participate in a candid discussion about the relevance and helpfulness of using the chart. The students' comments were positive concerning the instrument and many indicated they wished they had the *Key Phrases and Caring Behaviors*© instrument earlier in the semester to use in the clinical setting. The findings of the study conducted by Connors et al. (2017) and Connors (2017) served as the basis for the current study. The primary purpose of this 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 during the clinical rotation.

The survey was emailed at specified intervals during the semester with the timeframes identified in three phases. The phases were predetermined based on the timing of the delivery and application of spiritual content within the semester. Phase I provided a baseline assessment

of students' perceptions of how confident and competent they felt in performing spiritual care prior to any instruction. Phase I was administered during the second week of the 16-week semester. Phase II was administered during week 10 of the 16-week semester after the students received a classroom lecture describing the components of a spiritual assessment followed by a small group activity in the classroom. Later, a reflective discussion with the introduction to the use of the *Key Phrases and Caring Behaviors*© chart was introduced to the students during post-conference on the third clinical day. The final survey, Phase III, was administered during week 13 of the 16-week semester. In Phase III, students were administered the survey after participating in a simulation experience. The simulation used in the study required students to respond to a patient and family member demonstrating emotional and spiritual distress. The simulation offered students the opportunity to demonstrate the use of the verbal and non-verbal responses introduced to them in Phase II of the study. Simulation offers a safe milieu to practice skills; LaBine (2015) reported that "it is vital that nursing students are exposed, didactically and clinically, to the spiritual care of patients" (p. 16).

Reminders were sent electronically during the survey period to all students, encouraging participation in the survey. Students were assured that their grade in the course would not be affected by the refusal or agreement to participate in the study.

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 in Adult Health 1. Beginning nursing students were surveyed three times in the following phases:

1)   Phase I: The electronic pretest *Spiritual Competence and Confidence Survey* Phase

I was administered. The Phase I survey served as a baseline of the student's perception

of his or her confidence and competence in providing spiritual care to patients, the relevance of spiritual beliefs to nursing practice, and the relevance of spiritual well-being to an individual's health. Using a Likert-type scale, the initial test consisted of 14 core questions that asked how the student perceived his or her comfort in providing spiritual care to patients, perception of preparedness/personal impact of providing spiritual care, and the role of spiritual care in nursing. Phase I was administered in week two of a 16-week semester during the first term of nursing school.

2)   Phase II: An electronic *Spiritual Competence and Confidence Survey* Phase II was administered. The Phase II survey determined the student's perception of his or her competence and confidence in providing spiritual care after being provided with spirituality content in lecture and with the *Key Phrases and Caring Behaviors©* chart introduced by the researcher during a post-conference after a reflective discussion (see Appendix B). The reflective discussion was a guided discussion introducing students to the basic principles of nursing care established by Florence Nightingale (1860), including the power of creating a therapeutic presence and a healing environment for the patient. The relationship between patient satisfaction, caring behaviors, and hospital reimbursement was introduced and examined in the context of nursing care (Dempsey, 2015). The Phase II survey included the same questions that were asked on the Phase I survey. Phase II was administered during week 10 of a 16-week semester during the first term of nursing school.

3)   Phase III: The *Spiritual Competence and Confidence Survey* Phase III was administered electronically. The questions on the Phase III survey were identical to the questions asked on Phase I and Phase II surveys. Phase III was administered during week

13 of the 16-week semester of the first term of nursing school. The survey was administered after the student participated in a simulation that offered the student the opportunity to use the Key *Phrases and Caring Behaviors*© chart. The simulation involved role-playing that included a patient and family member in emotional and spiritual distress. In the study by Costello et al. (2012), the use of simulation to teach spiritual care was considered effective in increasing student competence. The study by Costello et al. (2012) also discovered a significant change in the attitude of students about the importance of providing spiritual care to patients. Brannan et al. (2016) reported that "simulation with debriefing encourages reflection and critical thinking and expands the student's ability to recognize and act" (p. 71).

The current study made comparisons of data collected in the Connors et al. (2017) action research project and research in the Connors (2017) that revealed a difference in nursing students' perceptions of spiritual care between Phase I (baseline) and Phase III (simulation). However, during that study, little change occurred in Phase II (lecture and clinical performance). To influence Phase II, the current study examined the impact of introducing the *Key Phrases and Caring Behaviors*© chart after a reflective discussion in the clinical setting during the third week of clinical in the first term of nursing school. A comparison of the data between Phase I, II, and III of the prior study and the current study measured changes in students' perceptions of competence and confidence when providing spiritual care, perceptions of preparedness/personal impact of providing spiritual care, and the role of spiritual care in nursing.

Analysis Methods

The study data were analyzed using a combination descriptive, inferential, and associative/predictive statistical techniques, dependent upon the specific question/hypothesis

posed. A variety of preliminary analyses were conducted with the research questions and hypotheses of the proposed investigation. Specifically, assessments of essential demographics, missing data, and internal consistency (reliability) of participant responses were conducted. Additionally, an Exploratory Factor Analysis (EFA) using Principal Components Analysis (PCA) was conducted to determine the presence of factors or dimensions present within the data set. The internal consistency of participant response was evaluated using Cronbach's alpha test statistic.

Research Questions 1 and 2 were addressed using both a descriptive and inferential technique. Frequency counts, percentages, mean scores, and standard deviations represented the most prominent descriptive statistical techniques used for comparative purposes. Inferential statistical techniques associated with the repeated measures design were employed in the study to assess the statistical findings in Research Questions 1 and 2. Specifically, the *t*-test of dependent means was used to address the statistical significance or difference in mean scores from the pretest (Phase 1) to the first posttest (Phase II).

Research Question 3 was addressed using the repeated measures ANOVA test statistic and Pillai's trace to identify a statistically significant effect of the numerous teaching strategies used that included lecture, combination of reflective discussion and the introduction of the *Key Phrases and Caring Behaviors*© chart in the clinical setting, and simulation.

Research Question 4 was addressed using the Repeated Measures ANOVA test statistic and Pillai's Trace to determine changes in the participants' perceptions according to age grouping. A one-way ANOVA was conducted to address the between subjects' feature of Question 4.

Question 5 was addressed using the *t*-test of dependent means to identify the "dimensions/factors" to determine the statistical significance of change from the baseline (Phase 1) through the concluding simulation activity (Phase III). The dimensions of the current study included changes in students' perceptions of competence and confidence when providing spiritual care, perceptions of preparedness/personal impact of providing spiritual care, and the role of spiritual care in nursing. The statistical significance of mathematical relationship in Research Questions 4 and 5 was assessed using the alpha level of $p < .05$ as the threshold for a statistically significant finding.

IV. RESULTS

The purpose of the study was to introduce the *Key Phrases and Caring Behaviors©* chart during the clinical rotation of first-semester nursing students, measuring the impact of the chart on the perceptions of nursing students' confidence and competence in providing spiritual and emotional care to patients, including nursing students' insight into the relevance of spirituality in themselves and their patients.

Prior to addressing the formally stated research questions and hypotheses pertaining to the research problem, preliminary analyses were conducted. Specifically, missing data, internal reliability of participant response, essential demographic information, and dimension reduction of survey items were the focus of analysis and reporting.

Missing Data

Initial screening of participant response to survey items was necessary in light of the imbalance of participant representation across the three phases of the study. Although the initial pretest was comprised of 88 participants, the final participant sample included in all three phases of the study was 24 due to attrition and errors of coding.

Missing data are considered minimal at 0.30% (n = 3) and sufficiently random in nature (Little's MCAR $x^2_{(81)} = 4.51; p = 1.00$). As such, imputation of missing data was not deemed necessary for ensuing analytical purposes.

Internal Reliability

Using the Cronbach's alpha *(a)* test statistic, the internal reliability of participant response is considered very high ($a \leq .80$) and at statistically significant levels. Table 1 contains a summary of internal reliability values for each of the three phases of the study:

Table 1

Internal Reliability by Study Phase

Study Phase	a
I	.80***
II	.99***
III	.94[a]
Overall	.91***

***$p < .001$ [a]$p = .06$

Essential Demographics

All of the study's 24 participants were female. Nearly half (41.7%) of the participants were between18 and 21 years of age, a third (33.3%) of the participants were between the ages of 22 and 30. The remaining 25% of participants fell within the 31 to 45 age range. Two-thirds (66.7%) of participants indicated that they had an AA degree, with the remaining one-third (33.3%) indicated having a bachelor's degree.

Dimensions of Survey Items

The study's survey instrument was comprised of 14 distinct items. Exploratory Factor Analysis (EFA) using Principal Components Analysis (PCA) was conducted to determine if dimensions or factors existed within the study's response set. In the wake of EFA analysis using PCA, three distinct dimensions or factors emerged, accounting for nearly 90% of the explained variance in the factoring model.

Table 2 contains a summary of the EFA findings for study survey items by dimension, survey items loading on respective factors, and respective explained variance within domains and for overall factoring model:

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Table 2

EFA Findings for Survey Items

Domain	Survey Items	Explained Variance
"Role of Spiritual Care in Nursing"	3, 4, 10, 11, 13, 14	33.86%
"Comfort in Providing Spiritual Care"	5, 6, 7, 8	26.72%
"Preparedness/Personal Impact of Providing Spiritual Care"	1, 2, 9, 12	25.49%
Total		86.06%

Analyses by Research Question

Research Question 1

Will introducing *Key Phrases and Caring Behaviors©* to first-semester nursing students after the initial two clinical days make a statistically significant impact on their perceptions of their ability to provide spiritual and emotional comfort to patients?

H_o1: Introducing *Key Phrases and Caring Behaviors©* after the initial two clinical days will not promote a statistically significant difference in first-semester nursing students' perceptions of their ability to provide spiritual care.

H_a1: Introducing *Key Phrases and Caring Behaviors©* after the initial two clinical days will promote a statistically significant difference in first-semester nursing students' perceptions of their ability to provide spiritual care.

The data supported the null hypothesis. The data revealed no statistically significant increase in first-semester nursing students' perceptions of their ability to provide spiritual care

after introducing the *Key Phrases and Caring Behaviors©* chart in post-conference after the initial two clinical days.

The *t*-test of dependent means was used to address the statistical significance of difference in mean scores from the pretest (Phase I) to the first posttest (Phase II) inherent in Research Question 1. Participants' perceptions decreased by 0.13 points from Phase I to Phase II of the study. The following table contains a summary of findings for Research Question 1:

Table 3

Mean Score Comparison of Participant Perception Phase I to Phase II

Study Phase	Mean	SD	SE	t
Phase I (pretest)	4.16	0.36	0.08	-0.50[b]
Phase II (posttest)	4.03	1.01	0.22	

[b] $p = .62$

Research Question 2

Which items on the survey instrument were most impacted from Phase I to Phase II of the study in which *Key Phrases and Caring Behaviors©* was introduced?

H_o2: No items on the survey instrument will demonstrate a statistically significant change from Phase I to Phase II of the study in which *Key Phrases and Caring Behaviors©* was introduced.

H_a2: Items on the survey instrument will demonstrate a statistically significant change from Phase I to Phase II of the study in which *Key Phrases and Caring Behaviors©* was introduced.

The data supported the null hypothesis for research question two. The data revealed no statistically significant increase in nursing students' perceptions of their ability to provide spiritual care between Phase I and Phase II of the study.

The *t*-test of dependent means was used to address the statistical significance of difference in mean scores from the pretest (Phase I) to the first posttest (Phase II) inherent in Research Question 2. As a result, three of the 14 survey items were impacted positively from the pretest (Phase I) to post *t*-test (Phase II) condition of the study. However, none of the three mean increases in participants' perceptions relative to the items were found to be statistically significant. Table 4 contains a summary of survey items impacted by the introduction of *Key Phrases and Caring Behaviors©:*

Table 4

Survey Items Impacted Positively after Introducing Key Phrases and Caring Behaviors ©

Survey Item	Pretest Mean	Posttest Mean	Mean Difference	t	p
Recognition, Addressing, and Diagnosing Patient Spiritual Distress	4.21	4.25	0.04	0.14	.89[b]
I feel Comfortable Asking Questions about Spirituality	3.67	3.89	0.21	0.82	.42[b]
Taking Care of Patients has had an impact upon My Spiritual Beliefs	3.92	4.08	0.17	0.78	.45[b]

[b] *p* > .05

Research Question 3

Does the combination of *Key Phrases and Caring Behaviors©* and a simulation instructional phase exert an overall effect upon participant perception of comfort and confidence in addressing the spiritual needs of patients?

H_o3: The combination of *Key Phrases and Caring Behaviors©* chart and a simulation instructional phase will not exert an overall effect upon participant perception of comfort and confidence in addressing the spiritual needs of patients.

H_a3: The combination of *Key Phrases and Caring Behaviors©* chart and a simulation instructional phase will exert an overall statistically significant effect upon participant perception of comfort and confidence in addressing the spiritual needs of patients.

The data revealed a statistically significant impact on the participants' perception of comfort and confidence in addressing the spiritual needs of patients between Phase I and Phase III and Phase II and Phase III of the study.

Using the repeated measures *ANOVA* test statistic, an overall statistically significant effect was found for the combination of instruction and simulation (Pillai's Trace $F_{(2, 20)} = 27.89$; $p < .001$). In light of the violation of the assumption of sphericity (Mauchly's $w = 0.33$; $p < .001$), an adjustment for the violation using the Greenhouse-Geisser test statistic was made with the original multivariate finding. The adjusted finding similarly depicts an overall effect upon participants' perceptions for the combination of instruction and simulation (Greenhouse-Geisser $F_{(6.58; 1.20)} = 7.27$; $p = .009$). The overall magnitude of effect (effect size) is considered large ($d = 1.19$). The most robust changes in participants' perceptions across the survey items were manifest from Phase II to Phase III (Mean Difference = 0. 72) and from Phase I to Phase III (Mean Difference = 0. 59). Both comparisons were at a statistically significant level.

The following table contains a summary of findings in the post hoc pairwise comparisons of participants' perceptions by study phases.

Table 5

Pairwise Comparisons by Study Phases

Comparison	Mean	SD	t	d/Δ
Phase I	4.16	0.36	-0.50	0.36
Phase II	4.03	1.01		
Phase II	4.03	1.01	3.16**	0.71
Phase III	4.75	0.37		
Phase I	4.16	0.36	6.53***	1.61[a]
Phase III	4.75	0.37		

$**p = .005$ $***p < .001$ [a] Very Large Effect Size ($d \leq 1.30$)

Research Question 4

Did participant age grouping exert an effect upon overall change in perception across the three phases of the study?

H_o4: The research participants' age group will not demonstrate a statistically significant predictor of confidence in providing spiritual care.

H_a4: The research participant's age group will present as a robust predictor of confidence in providing spiritual care.

Statistically significant changes in perception were discovered across all three phases of the study by age grouping.

A repeated measures ANOVA was used to determine if statistically significant participant change in perceptions were manifest across the three phases of the study by age grouping. All three age groups represented in the study manifested statistically significant

changes across the three phases of the study. The magnitude of effect was considered large for

participants 22 to 30 years of age, and very large for participants 18 to 21 and 31 to 45 years of

age. The single greatest change in participants' perceptions across survey items and all three

study phases was manifested by participants in the 31 to 45 age group. The following table

contains a summary of findings for participants' change in perceptions across the three phases of

the study by age group.

Table 6

Participant Perceptual Changes across Study Phases by Age Group

Age Group	Pillai's Trace Value	df	F	d
18-21	0.65	2, 6	5.64*	1.34[aa]
22-30	0.65	2, 6	5.64*	1.06[a]
31-45	0.90	2, 4	18.81***	6.0[aa]

*$p < .05$ ***$p = .009$ [a] Large Effect Size ($d = .80$) [aa] Very Large Effect Size ($d \leq 1.30$)

When the difference between the age groups was evaluated, a One-Way ANOVA *(1 x 3)*

was conducted to address the between-subjects' aspect of Research Question 4. As result, no

statistically significant effect for participant age group was evident for participants' mean score

change in perceptions across the survey items and three phases of the study. The single greatest

mean score change in perception across the three phases was manifested by participants

identified as the 31 to 45 age group (0.80). The following table contains a summary of findings

for Research Question 4.

Table 7

Comparison of Participant Perceptual Change across Phases by Age Group

Age Group	Mean Score Change	SD	F	f
18-21 (n = 9)	0.45	0.47	1.18[b]	.11[c]
22-30 (n = 8)	0.54	0.48		
31-45 (n = 6)	0.80	0.30		

[b] $p > .05$ [c] Small Effect Size

Research Question 5

Which of the three identified dimensions or factors manifested the greatest change of participant perception from the baseline condition (Phase I) through the simulation condition (Phase III) of the study?

H$_o$5: No statistically significant differences in the students' perceptions of their ability to provide spiritual and emotional comfort will be noted in any of the "dimensions" or "factors" from the baseline of the survey.

H$_a$5: A statistically significant difference from the baseline of the survey in the students' perception of the ability to provide spiritual and emotional comfort will be identified in one or more of the survey's dimensions or factors.

The data revealed statistically significant improvement in the students' perception of their ability to provide spiritual and emotional care to patients in all of three dimensions of the survey after Phase III of the study.

A *t* test of dependent means was conducted on the study dimensions/factors of the survey to determine the statistical significance of change from the baseline (pretest) condition through

the concluding simulation condition (Phase III). As a result, all three dimensions/factors

manifested statistically significant changes in participant perception ($p \leq .001$) from Phase I

through Phase III of the study. The most significant perceptual changes, however, were

manifested in Dimension 2 (Comfort in providing spiritual care). The magnitude of effect size is

considered very large, with a mean score change of 0.71. The following table contains a

summary of finding for Research Question 5.

Table 8

Participant Perceptual Changes by "Dimension/Factor" from Baseline Condition to Post Simulation Training

Dimension/Factor	Mean	SD	t	d
Role of Spiritual care in Nursing (Pretest)	4.44	0.44	4.00**	0.96[a]
Role of Spiritual care in Nursing (Sim Posttest)	4.82	0.35		
Comfort in providing Spiritual Care (Pretest)	3.95	0.59	5.38***	1.33[aa]
Comfort in providing Spiritual Care (Sim Posttest)	4.66	0.47		
Preparedness/Personal Impact of Providing Spiritual Care (Pretest)	4.14	0.45	4.86***	1.15[a]
Preparedness/Personal Impact of Providing Spiritual Care (Sim Posttest)	4.71	0.54		

**p = .001   ***p < .001   [a] Large Effect Size (d = .80)   [aa] Very Large Effect Size ($d \leq 1.30$)

V. DISCUSSION

The purpose of this study was to introduce the *Key Phrases and Caring Behaviors©* chart during the post conference of the third day of the clinical rotation of first-semester nursing students'. After the chart was reviewed with the students, their competence and confidence in providing spiritual and emotional care to patients was measured, including nursing students' insight into the relevance of spirituality in themselves and patients. The study explored whether their competence and confidence in providing spiritual and emotional care significantly improved after the introduction of the *Key Phrases and Caring Behaviors©* chart in clinical or during a simulation at the end of the term. This chapter briefly reviews the methodology used in the study, summarizes the results, and discusses the implications of the results.

A repeated measures quasi-experimental quantitative study was utilized to explore the best time to introduce the Key *Phrases and Caring Behaviors©* chart to first-semester nursing students. This study attempted to answer questions raised in the published research by Connors et al. (2017) and Connors (2017) as well as informal student comments made after the simulation experience in previous semesters. The current research adds to the knowledge of when and how to more appropriately utilize the teaching instrument the *Key Phrases and Caring Behaviors©* chart. This research attempted to duplicate the effect of the simulation experience in previous studies on students' competence and confidence in providing spiritual and emotional care by introducing reflective discussions with an overview of the *Key Phrases and Caring Behaviors©* chart during post-conference on the third clinical day.

The participants in the study consisted of a voluntary, non-probability sample, convenience and purposive in nature, and comprised 25% of first-semester nursing students enrolled in an associate degree program in a state-supported college in central Florida. The

students who completed Phases I, II, and III of the study were all female (100%). The questions

on the Spiritual Competence and Confidence Survey Phase I, Phase II, and Phase III were

identical. The survey link was emailed at specified intervals during the semester with the

timeframes identified in three phases. The phases were predetermined based on the timing of the

delivery and application of spiritual content within the semester. Phase I provided a baseline

assessment of students' perception of how competent and confident they felt in performing

spiritual care prior to any instruction. Phase I was administered during the second week of the

16-week semester. Phase II was administered during week 10 of the 16-week semester after the

students received a classroom lecture describing the components of a spiritual assessment,

participated in a small group activity, shared in a reflective discussion, and received an

introduction of the use of the *Key Phrases and Caring Behaviors©* chart in post-conference on

the third clinical day. The survey in Phase III was administered after a simulation experience

requiring students to respond to a patient and family member demonstrating emotional and

spiritual distress.

Summary of Findings

Data collected from a sample of first-semester nursing students enrolled in Adult Health I

were analyzed. The demographic information is reviewed, followed by a discussion of

significant findings for each research question.

Essential Demographics

The demographic information collected from the survey included age range, gender,

previous college degrees, religious affiliation, and healthcare experience. Twenty-four female

students, or 25% of the eligible first-semester students, completed Phases I, II, and III of the

study. The study's sample included 41.7% of the participants between 18 to 21 years of age and

33.3% in the 22 to 30 age range. The remaining 25% of participants fell in the 31 to 45 age

range. Two-thirds (66.7%) of participants indicated that they had an AA degree, with the

remaining one-third (33.3%) identifying with a bachelor's degree.

Seventy-five percent of the participants were between the ages of 18 and 30, and 25% of

the participants were between the ages of 31 and 45. Age is a significant factor to consider when

measuring an individual's comfort with spirituality. As Tuck et al. (2001) discovered, the ability

to provide spiritual and emotional comfort had a significant relationship with age, indicating

older individuals scored higher on the Spiritual Well-Being Survey (SWBS). The young ages

reflected in the demographic information of nursing students in the current study provided

potential insight into their spiritual development and their conceivable inability to identify or

address the spiritual needs of patients. This insight may help nursing faculty develop methods to

close the gap between a nursing student's desire to provide comfort to the patient experiencing

emotional and spiritual distress with the student's ability to provide appropriate nursing

interventions (du Plessis, 2016).

Other demographic information retrieved from the survey was not used to develop the

results of the study because of the small number of participants and the wide variation in answers

deeming it impossible to determine a relationship between the data.

Discussion of Data

Research Question 1

Will introducing *Key Phrases and Caring Behaviors*© to first-semester nursing students

after the initial two clinical days make a statistically significant impact on their perceptions of

their ability to provide spiritual and emotional comfort to patients?

In the study by Connors (2017), the *Key Phrases and Caring Behaviors*© chart was introduced to the students before they had any experience in the clinical setting. The instrument was intended to be used as a resource for students when communicating with patients and families. This study introduced the *Key Phrases and Caring Behaviors*© chart to students with clinical experience because the researcher believed that after patient care experiences the students would sense the need to know what to "say" or "do" to comfort patients. By introducing the chart and leading students in a reflective discussion, the researcher believed the students would find the chart a beneficial tool and perceptions of their ability to provide spiritual care would increase. In the study by Connors (2017), the clinical instructors did not reinforce the use of the *Key Phrases and Caring Behaviors*© chart. During the current study, all clinical instructors were present for the reflective discussion and the introduction of the *Key Phrases and Caring Behaviors*© chart. Although examples of using the chart were discussed with the students, encouraging more student participation in the post-conference activity through role-playing may have provided the students a better understanding of how to use the chart and may have improved their perception of competence and confidence in providing spiritual and emotional care. Returning to the clinical setting later in the term to continue a reflective discussion on using the *Key Phrases and Caring Behaviors*© chart may have been helpful. More importantly, the literature emphasized the importance of addressing spirituality throughout the term and program. The introduction of the spirituality content for the first-semester students that participated in this study was only reinforced by the researcher and was not included as content in any other context during the term.

During the presentation of the chart in the clinical setting, the researcher perceived the students were engaged and seemed to develop insight into the connections they remembered

having with patients. Many students were tearful as they recalled stories of times they felt they

had made a difference in their patients' lives. Unfortunately, the mean score for Phase I was

4.16 points, and the mean score in Phase II was 4.03 points. The difference (0.13 points) in

mean scores reflects a decrease in perceived confidence and competence between Phase I and

Phase II. The difference in scores indicates a decreased confidence level with students after they

attended a lecture, participated in small group activities and a reflective discussion about spiritual

and emotional care, and were introduced to the *Key Phrases and Caring Behaviors©* chart. This

decline in confidence level also occurred between Phase I and Phase II of the Connors et al.

(2016) and Connors (2017) studies after introducing the *Key Phrases and Caring Behaviors*

chart (Connors et al., 2017; Connors, 2017). Despite the data failing to demonstrate a positive

response to the teaching strategies used in the three studies, the information is relevant and must

be considered in order to develop future teaching and learning strategies that will successfully

improve the students' perception of competence and confidence in providing spiritual care to

patients.

Many students in the current study stated they chose nursing because of a desire to help

others and view themselves as caring and compassionate. However, the young ages reflected in

the demographic information of nursing students in this study provided potential insight into

their spiritual development and their conceivable inability to identify or address the spiritual

needs of patients. Consequently, the students lacked confidence in providing spiritual and

emotional care to patients. Another factor that may have caused the mean score to drop between

Phase I and Phase II is that the students may have realized that comforting a patient is more

difficult and challenging than comforting a friend or a relative. In addition, exposure to the

clinical area may cause the students to focus primarily on the performance of tangible

(psychomotor) skills, and students may recognize that there is much more to do in the clinical milieu than perform the skills associated with emotional and spiritual care. Finally, students may not have consistently observed nurses taking the time to stop and listen attentively to patients in the clinical setting. This observation may have caused students to presume that caring behaviors are not valued by the profession.

As reported by Abassi et al. (2015), Baldacchino (2015), Callister et al. (2004), and O'Brien (2014), the nurse must understand his or her own spirituality before being able to minister to others. Ideally, spirituality must be introduced into the curriculum early in the nursing program and continue as a curriculum thread throughout the program. Introducing the *Key Phrases and Caring Behaviors©* chart, reflective discussions, and role-playing in the first semester with the concept reinforced throughout the program are the best teaching strategies to use with students and may lead to competence and confidence in providing spiritual and emotional care by the end of the program. More importantly, first-semester nursing students may benefit by reflecting on their own spiritual needs and woundedness early in the semester followed by the introduction of a patient's spiritual needs later in the first semester.

Research Question 2

Which items on the survey instrument were most impacted from Phase I to Phase II of the study in which *Key Phrases and Caring Behaviors©* was introduced?

According to Meyer (2003), "Emphasis on spirituality in the nursing program as rated by students and faculty served as the most significant environmental predictor of the students perceived ability to provide spiritual care" (p. 187). A comparison of the survey answers for Phase I and Phase II reveals an increase in the students' perception of confidence and competence in providing spiritual care to three questions (see Table 4). Although the change in

the students' perception is not statistically significant, the type of questions where changes occurred reveal an improved basic understanding of the need to address a patient's spiritual and emotional needs, "I feel Comfortable Asking Questions about Spirituality." A subtle change was identified in the students' perceptions of the affect that providing spiritual and emotional care to patients has on their own spiritual beliefs, "Taking Care of Patients has had an Impact Upon My Spiritual Beliefs." Although these are small increases, they demonstrate tiny steps toward spiritual awareness. According to Meyer (2003), the greatest predictor of students' ability to provide spiritual care was an awareness of their own spirituality. Having a level of understanding of one's spirituality indicates an early change toward spiritual awareness. The nursing student must understand that an individual's emotions are not separate from his or her physical needs. Addressing spiritual needs by making a change in physical circumstances is only treating the symptoms through distraction, ignoring spiritual and emotional needs will not make them go away (Kraft, 2007). If the nursing student responds inappropriately to his or her own spiritual needs, expecting the student to respond to the spiritual needs of patients appropriately is not realistic (Puchalski, 2007). With the insight provided by the survey responses, perhaps a focus of teaching and learning strategies emphasizing the students' awareness of personal spiritual needs and how those needs are satisfied should be introduced during the first semester or the early part of the first semester.

Research Question 3

Did the combination of *Key Phrases and Caring Behaviors*© chart and a simulation instructional phase exert an overall effect upon participant perception of comfort and confidence in addressing the spiritual needs of patients?

When the *Key Phrases and Caring Behaviors*© chart and simulation are used together, a statistically significant improvement occurs in the students' perception of their ability to provide spiritual and emotional care to patients. The simulation experience in this study introduced a realistic scenario depicting emotional and spiritual distress and added strength to the learning experience because it expanded the simulation beyond teaching psychomotor skills to include caring. The use of a simulated setting to teach students spiritual and emotional care exposes all students to the same situation and gives faculty the opportunity to guide students through a reflective discussion in a safe, non-threatening environment (Bennett & Thompson, 2015; Costello et al., 2012; Jeffries, 2005; Mitchell et al., 2006). Using Kolb's theory in the current study, the learners obtained knowledge through a sequence of learning steps that included actual experience and observation followed by reflection on the experience. Reinforcement of the task occurred through reflection, testing new concepts and behaviors, and repeating the sequence until the student was comfortable with the new behaviors.

The current study duplicated the results of the research performed by Connors et al. (2017) and Connors (2017) and validated the power of learning in the context of a realistic situation. Although students were "prepared for simulation with a classroom lecture, group activity, and pre-simulation activity, the students were visibly anxious in the simulation because they did not know what to say or do to provide comfort to patients in spiritual distress" (Connors et al., 2017, p. 63). In the current study, as well as the two previous studies, the students' scores measuring perceptions of their confidence and competence in providing spiritual care demonstrated "significant improvement" (Connors et al., 2017, p. 60) only after students completed the simulation experience (Connors et al., 2017; Connors, 2017). In the research by Connors (2017), the students were given the *Key Phrases and Caring Behaviors*© chart prior to

any clinical experience. When considering differentiated learning and UDL, there is a possibility that the students lacked a readiness for the chart because they had no previous clinical or simulated experience with patients (Dirksen, 2016). When faculty expect the learner to demonstrate proficiency with a caring response, there must be an opportunity for the learner to practice, preferably a structured practice session (Dirksen, 2016). Utilizing Dirksen's theory (2016) to teach caring behaviors to nursing students, the research confirmed that the students must have the opportunity to practice using the *Key Phrases and Caring Behaviors©* chart before they can demonstrate providing comfort using the techniques in the clinical setting.

The simulation for the previous two studies and this research contained numerous roles, but the primary roles were two staff nurses, the patient, and one family member. The preparation for the simulation included a pre-simulation activity in the form of a case study that mirrored the actual simulation. The patient in the simulation was a new admission with stable vital signs and not in need of any physical interventions. Two students were assigned to the nurse role and asked to perform an admission history and physical assessment of the patient. The patient and family member displayed emotional and spiritual distress; the nurses tended to be quite focused on the physical tasks they were assigned to perform. In many cases, students were baffled and distressed by the distraction of the patient and family member and their inability to perform the admission history and physical assessment. The simulation was interrupted by the researcher, and the students were given the *Key Phrases and Caring Behaviors©* chart to review with a brief discussion of how to apply the information on the chart to the situation. The simulation was replayed, and students were able to effectively use the information on the chart to calm the patient and family member and perform the assigned physical tasks. The students were able to observe the power of kind words and caring behaviors. The unique approach to the simulation

followed the suggestion from Eggenberger and Regan (2010): "If we want nursing students to care, we must give them the opportunity to practice" (p. 557).

Similar to the research performed by Chmil et al. (2015), the current study applied experiential learning by actively involving the students in the preparation for the simulation through the introduction of a planning activity, participation in the simulation experience, and debriefing using reflective observation and discussion. An important component of Kolb's model is the use of reflection. The nursing literature emphasizes that clinical learning is richest when students are asked to reflect on a specific incident (Lasater and Nielsen, 2007). Asking students to reflect on what they observed is not enough when addressing the nonverbal and verbal interactions necessary to provide emotional and spiritual care. A student must reflect on the feelings he or she believed the patient demonstrated and recall his or her feelings in the situation. Without guidance from faculty, a student typically demonstrates minimal reflection about learning, instead a student will focus on the chronological details of a clinical experience without recognizing the implications for clinical practice (Lasater & Nielsen, 2007). Nursing faculty must guide a student's reflection in order for the student to link intuition with nursing theory and practice. Reflection is essential for a student to learn from experience, "particularly in situations that are ill-defined, multilayered, and complex" (Lasater & Nielsen, 2009, p. 40). During debriefing after the simulation, the researcher used guided reflection to promote a discussion with the students that focused on feelings. The students in the current study were asked questions about the shared experience to help them process their learning of the verbal and non-verbal behaviors used in the simulation. Debriefing after a simulation is not only a formative assessment involving interaction and discussion between the students and the faculty but also a learning activity that assists students to improve their performance in the clinical area.

Florence Nightingale (1860) believed that individuals who are called to nursing are bound by a sacred covenant to serve those under their care. In the study by Rhodes et al. (2011), nursing students identified reasons they chose the nursing profession that included caring for others and having positive interactions with patients. Most importantly, the student nurses stated that caring is a critical component of nursing and it is essential for the nurse to watch over the patients under their care to keep them safe (Rhodes et al., 2011). People who are attracted to nursing because of a desire to help others yearn to provide spiritual and emotional care to patients. Integrating spiritual and emotional care throughout the nursing curriculum is essential. One of the roles of the nurse educator is to provide learning experiences for the student that promotes the development of a therapeutic presence and the competence and confidence necessary to provide spiritual and emotional comfort to patients. The teaching strategies of simulation, role-playing, and reflective discussion provide an opportunity for students to practice caring behaviors and discover the fulfillment associated with making a difference in someone else's life.

Research Question 4

Did participant age grouping exert an effect upon overall change in perception across the three phases of the study?

The participants in the research ranged in age from 18 to 45, with 25% of the participants falling in the age range of 31 to 45. The older group of participants (age 31 to 45) demonstrated the greatest improvement in their perception of competence and confidence in providing spiritual care to patients. The data were consistent with the evidence discussed in the research on parish nurses which revealed that older nurses had a higher score on the *Spiritual Well-Being Survey*

(SWBS) (McSherry & Jamieson, 2013; Tuck et al., 2001; Van Leeuwen & Schep-Akkerman, 2015).

As noted in the research by Tuck et al. (2001), older nursing students in this study may have been more aware of their own spirituality and, consequently, had a higher degree of readiness to develop confidence and competence in providing spiritual and emotional care to others. The simulation and reflective discussions used in this research gave the students information about spirituality but also fostered the development of verbal and non-verbal communication.

Research Question 5

Which of the three identified dimensions or factors manifested the greatest change of participant perception from the baseline condition (Phase I) through the simulation condition (Phase III) of the study?

The participants demonstrated the greatest magnitude of improvement in confidence and competence in the survey's dimension of "comfort in providing spiritual care." The mean score change of 0.71 points was the greatest between the Phase I and Phase III of the study, yielding a very large effect size. The improvement was in the dimension with the lowest (3.95 points) mean score in Phase 1 of the study. The opportunity to practice providing spiritual care in the simulation may have increased the students' comfort in providing spiritual care. Since many individuals are drawn to nursing because of their desire to help people in a meaningful way, the students may have wanted to improve the most in the area of being comfortable providing spiritual care.

Students demonstrated statistically significant improvement in the dimensions of "role of spiritual care in nursing" and "preparedness/personal impact of providing spiritual care."

Students had the opportunity to observe the positive emotional changes in the family member and the patient during the simulation in response to the verbal and non-verbal communication methods used from the *Key Phrases and Caring Behaviors*© chart. The students in the role of the nurse may have felt "empowered" because of the changes they observed in the patient and family with just a few comforting words or caring behaviors.

Bennett and Thompson (2014) reported a greater integration of content and longer lasting and more meaningful learning for students when they were provided with opportunities for both cognitive and affective learning. Cognitive and affective learning was provided in the simulation by allowing students to repeat the simulation and use the suggested caring phrases and behaviors to observe the change in the patient's demeanor. The simulation offered a safe environment for the students to discuss their feelings and observations during the simulation. Students must have the opportunity to share their feelings and perceptions with other students in order to have a transformative learning experience (Bennett & Thompson, 2014).

Recommendations for Further Research

Clearly, the nursing profession must decide on a definition of spirituality, how spirituality is different from religion, and how spiritual and emotional care must be addressed by nurses (Puchalski et al., 2014). Since nurses admit being unsure of how to address the spiritual and emotional needs of patients, offering classes on how to provide emotional and spiritual care to nurses in the practice setting would be a logical option. Initially, nurses can be introduced to using a learning tool such as the *Key Phrases and Caring Behaviors*© chart. The classes should include didactic content on spirituality but also include reflective discussions, case studies, and simulation activities in which caring strategies are applied. An effective tool to evaluate the comfort of practicing nurses in providing spiritual care would be the use of the *Competence and*

Confidence Spiritual Assessment© tool. Press Ganey (2010) stated that every encounter in a healthcare organization contributes to a patient's perception of the facility and the satisfaction with the care received. With this fact in mind, all healthcare workers should receive some training about appropriate interactions to promote feelings of being "cared for" in the patient. An interesting study that would reveal the impact or effectiveness of the teaching is to provide the teaching to staff of a poor performing unit with low patient satisfaction scores. After the training, the satisfaction scores would measure the impact of the training.

Students cannot be expected to learn how to identify and respond to the spiritual and emotional needs of patients in the clinical area without guidance and reinforcement of caring behaviors in class labs as well as the clinical area. The simulation on caring for the first-semester students in this study was the only simulation that included caring behaviors. Although students may have a desire to address a patient's emotional and spiritual needs, if the behaviors are not mentored in the clinical area or reinforced by instructors in the classroom and clinical area, compassionate care will not occur. Students are followers of behavior patterns, not leaders or trailblazers.

Conclusion

Nursing care is experiential. Patients are holistic beings with unique responses to illness, hospitalization, or disability. Consequently, certain characteristic signs and symptoms of a disease or medical condition can be learned from a textbook or a lecture, but individual patient behaviors and emotional reactions are not predictable. Nursing responses to patients' needs are spontaneous and intuitive. When the nurse's response is heart-centered and compassionate, the patient's healing and coping ability are supported. Nurses learn how to reply to a patient by observing how well the patient receives verbal and non-verbal caring behaviors. When the

patient reacts favorably, the nurse perceives the relaxation and comfort of the patient and consciously or subconsciously stores the information to be used in a future patient interaction. Hood (2004) stated that, whether nurses are aware of it or not, they are addressing a patient's spiritual and emotional needs while providing routine care. Compassionate and caring behaviors foster healing. Nurses who ignore or dismiss the patient's emotional and spiritual needs can inflict harm and emotionally devastate the patient (Berglund et al., 2012; McDonough-Means et al., 2004; Wolf, 2017b). A successful response to a patient who yearns for spiritual and emotional comfort is simply being fully present (Dempsey, 2015; Watson, 2011). Spiritual and emotional needs of patients are the chief issues addressed by the HCAHPS survey. Patient satisfaction scores are tied to hospital reimbursement and, consequently, are a primary focus when organizations seek to meet the quality and caring standards required for full reimbursement for the care they provide to patients.

Nursing students who participate in learning activities promoting spiritual care to patients report a growing sense of personal development and spiritual awareness (Hood, 2004). Nurses connect with patients through the therapeutic use of self in a deliberate and patient-centered way. Spiritual and emotional growth or development is an ongoing and continuous process. Nurses can provide a healing environment that will foster emotional and physical healing for patients by appropriately responding to the patients' emotional and spiritual needs (Duffy, 2009; O'Brien, 2014; Press Ganey, 2010; Taylor, 2007). Successfully establishing a healing environment for the patient motivates, empowers, and energizes the nurse to continue implementing patient-specific caring behaviors with the goal of optimizing the patient's holistic health (Watson, 2011). The nurse's reward is heart-felt (O'Brien, 2001) and so significant that it is as if the heart receives a paycheck as the result of making a difference in a patient's life (Good & Connors, 2015). The

nurse can actually become the intervention when he or she focuses on "being with" the patient

through listening, displaying compassion, and utilizing caring behaviors (Gillespie, 2010;

Murphy & Walker, 2013; Tayray, 2009).

First-semester nursing students must be introduced to the spiritual and emotional care of

patients by first understanding their own spiritual and emotional needs (Baldacchino, 2015;

Puchalski & Guenther, 2012). Nursing students in associate and baccalaureate programs in the

United States tend to be young and spiritually immature (Astin et al., 2011; Baldacchino, 2015).

Spiritual development or an awareness of one's own spirituality cannot take place through

lectures alone. Students must be guided to reflect on their own "woundedness" because it serves

as the foundation for developing compassion for others (Burnell, 2011; Puchalski, 2007; Taylor,

2007). Many faculty do not feel prepared to discuss or teach spirituality to students. The

nursing curriculum must have clear objectives with specific learning and teaching strategies to

support the skill development associated with the spiritual and emotional care of patients. Many

practicing nurses admit spiritual and emotional care of patients is important, but they feel

uncomfortable or avoid addressing patients' spiritual and emotional needs. Consequently,

students will not consistently observe emotional and spiritual care of patients in the clinical

setting. Clinical nursing instructors must have the information and the skills to mentor caring

behaviors to students in the clinical setting. Clinical instructors will be able to assist the students

in developing competence and confidence in providing spiritual care by using reflective

discussions, role-playing, and case studies in post-conference.

The simulation was the most effective method used in this study to improve the

confidence and competence of providing emotional and spiritual care to patients. The key to

achieving fully competent and confident nurses is to integrate spiritual and emotional care in all

simulations throughout the entire nursing program. The students should be expected to demonstrate the ability to respond appropriately to a patient's emotional and spiritual needs using the suggested responses on the *Key Phrases and Caring Behaviors©* chart in each simulated experience. This realistic approach mirrors the clinical area because every patient in the clinical setting has spiritual and emotional needs. A measurement tool such as the *Competence and Confidence Spiritual Assessment©* tool could be administered to students at the beginning and end of each term to monitor the progress of the students' perception of their confidence and competence in their ability to provide spiritual and emotional care.

Students should also be evaluated on their use of appropriate responses to patients' emotional and spiritual needs by the clinical instructor in the clinical setting. A reflective discussion should be included in every post conference as a form of reinforcement. If students know that they will be graded or evaluated on specific content, they will be more inclined to prepare to demonstrate competence.

Never before has nursing care been quantified or given the slightest consideration for hospital charges or reimbursement. Indeed, when a patient is admitted to a hospital, the nursing care is lumped in with housekeeping and dietary services as part of the room charge. The focus placed on the importance of the type of nursing interface experienced by a hospitalized patient is significant and becomes an opportunity for nurses to define, describe, and clarify exceptional nursing care. Nurses must recognize the critical role they play in enhancing the long-term financial survival of healthcare organizations (Puchalski et al., 2014; Wolosin et al., 2012).

One of the resources that was quite useful in this study was the article by the HealthCare Chaplaincy Network (2017). Many nursing references were used in the publication because nursing was the focus of the article. Indeed, many nurses will observe spiritual and emotional

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distress in patients and call the hospital chaplain or the patient's minister or priest. The article

stated that nurses are the spiritual care generalists and chaplains are the spiritual care specialists,

and the author emphasized that we must work together. The final words of the article are

haunting:

> Moving forward, one of the greatest and most urgent areas of need is for more proactive
>
> collaboration between researchers exploring spirituality in nursing practice and those
>
> from the professional chaplaincy community. The majority of nursing articles cited in
>
> this paper arise from research that is siloed, and does not involve the profession of
>
> chaplaincy, either those practicing alongside the clinical researchers or those involved in
>
> the research field. (p. 18)

Nurses have not done very well striving to improve the provision of emotional and spiritual care

to patients without collaborating with the chaplaincy profession. Perhaps collaboration with the

HealthCare Chaplaincy Network should be the next step.

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Appendix A

Providing Spiritual Nursing Care

Last four digits of social security number_____

Please circle the information that best describes you.

Age range: (18-21) (22-30) (31-45) (46-55) (55 and above)

Gender: Female   Male

Degree in other area: Associate   Bachelor's   Master's   Doctorate   FIELD_____

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

_____

Please identify your religious affiliation (optional) _____

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

4 = Strongly Agree; 3 = Agree; 2 = Disagree; 1 = Strongly Disagree

Statement	Strongly Agree	Agree	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.				

1. I feel comfortable asking questions about spirituality.				
2. I can provide a patient with spiritual care.				
3. I am comfortable supporting spiritual beliefs that differ from my own.				
4. I would benefit from the opportunity to practice spiritual caregiving in the simulated environment				
5. I believe a person's spiritual beliefs have an influence on their health.				
6. Taking care of patients has had an impact on my spiritual beliefs.				
7. I believe I can bring a healing presence to patients.				
8. I believe a person's spiritual or religious beliefs can be a source of strength, support, and guidance.				

Appendix B

Reflective Discussion: Post-Conference

Press Ganey is the organization that developed the HCAHPS survey that is used by the federal government to reimburse hospitals for the care provided to patients. Thirty percent of the reimbursement is dependent on the experience of the patient, it is frequently called patient satisfaction. The Press Ganey scores affects the life line of the hospital because their reimbursement is determined by their scores. There are five dimensions of the patient experience identified by Press Ganey that are directly dependent on the nursing team:

- Communication with nurses
- Responsiveness of hospital staff
- Pain management
- Communication about medication
- Overall rating of the hospital (would you recommend this hospital to someone else, would you return to this hospital for care)

Ask students:

What do those components address about the patient's experience? (*feelings; PERCEPTION of care*)

What do these feelings do to the patient's attitude toward the hospital? (*determines if they will return or recommend the hospital*)

What does that say about the care we give? (*Caring is VERY important, we are ambassadors and can make or break the hospital, as of 2017, 2% of reimbursement is withheld from poor performing hospitals*)

So what does that mean to nurses? (*When we enter the room we must lead with our heart and give heart-centered care to the patients and family. Heart-centered care is the care you would expect your grandmother or your baby to receive as a patient*)

The *Student Nurse* magazine published an article by Christy Dempsey, Chief Nursing Officer of Press Ganey, in October, 2015 titled "The nurse's role in the patient experience." In the article Dempsey states, "**Communication with nurses leads the other four measures. This means that when a hospital aims improvement efforts at the 'communication with nurses' dimension, it will likely see associated gains in performance in the other four dimensions in the cluster.**"

Research reveals that patients who **perceive** a better experience also have lower readmission rates, lower lengths of stay, higher safety scores, and lower instances of hospital acquired complications (falls, skin breakdown, infections).

Florence Nightingale had a healing presence. During the Crimean War in France, Florence Nightingale cared for British soldiers in the Scaturi hospital. The first change she made was to introduce handwashing, clean bed linen, clean water, and fresh air. She loved research and calculated the mortality rate in the hospital to be 60%, out of 1000 soldiers 600 died. Her changes lowered the mortality rate to 40%. But she did something more than introduce medical asepsis; she had a healing presence. The soldiers knew instinctively they were being cared for by someone who cared. In the letters the soldiers sent to their families they told of feeling peace and comfort at night when they saw the shadow of the "Lady with the Lamp" cast over their cot.

Ask students:

We also have the power to have a healing presence. When we walk in the room and the patient says, "I am so glad you are here today, what is he or she saying to you?" (**The patient perceives that you care and that they are safe under your care. They can relax and concentrate on healing.**)

Can you identify ways that you can connect with your patients? (**Find something you have in common with the patient.ne student recalled a patient in the long-term care center who was holding a teddy bear. When she began assisting the patient with her AM care she carefully placed the bear sitting on the bed facing the patient when she finished she placed the bear carefully in the patient's arms. She understood the importance the bear had for the patient because she still cherished her favorite teddy bear. A young male nursing student had special compassion for a young male where he worked who was in an accident and was paralyzed from the neck down. The staff put off going into his room because he had so many tasks that had to be performed for him. He told the student that he was always relieved when he knew he was working**)

When the patient relaxes emotionally what physical changes occur? (**Decreased heart rate, slowed respiration, decreased stress, decreased cortisol production, decreased blood sugar, and improved immune response. All of these changes can promote healing**)

Spiritual and emotional distress cannot be managed by giving medications for anxiety, depression, or pain. According to Press Ganey, patients do not perceive a difference between their emotional and spiritual needs, they fall under the same broad psychological concepts.

According to Press Ganey, patients describe the feelings associated with spiritual and emotional distress as being the same: loss of hope, search for meaning, fear, loneliness, isolation, desire to maintain religious practices, and presence of God.

Research by Press Ganey (2010), reveals that caring for patients' emotional and spiritual needs invokes identical behaviors from the staff: demonstration of caring, comfort, support, sensitivity, kindness, talking and listening, authenticity, physical presence, timely responses to requests, empathy, affirmation, and attentiveness to their UNIQUE needs.

Patients are comforted by the presence of the nurse who gives support, demonstrates compassion, and stays at the bedside even when there is no solution or answer to the patient's questions. This is also called the therapeutic use of self.

The essence of presence is a healing relationship. Presence has a positive impact on recovery, remission, healing, and trust. Patients state presence is more important than specific technical care or skill unless the patient is in ICU or an emergency setting (Rankin & DeLashmutt, 2006). When the nurse is fully present with the patient the patient knows that the nurse cares and understands their needs.

When nurses make a connection with their patient it causes professional and spiritual growth of the nurse and promotes healing and comfort in the patient. People are drawn to nursing because they want to help others and to make a difference. That part of you must be nourished, it is a spiritual need and when that need is met, the nurse flourishes because he or she was successful in making a difference for the patient.

"Healers do not need to have the same experiences as patients but, to be compassionate, they do need to recognize how they have shared similar emotions" (Taylor, 2007, p. 13).

Ask students if they have had experiences with patients, friends or family that they would like to share.

Student Activity

Case Example 1: Ms. Rodriguez a lady of Mexican descent is an 88-year-old woman with sepsis, acute renal failure, and colon cancer. Her prognosis is poor. In the morning report, the nursing student learned that the physician met with the family and patient the prior evening about her poor prognosis. The patient's children verbalized their mother's desire not to receive life support. The staff nurse also reported that since the family left late last evening, the patient has been restless, picking at the sheets, and mumbling the same thing over and over, which the nurse could not understand.

Ask the students:

Share how you would feel about this patient assignment?

What thoughts would you have about how you would approach the patient?

Continue scenario

The nursing student, fluent in Mexican, identified through her initial assessment that Ms. Rodriguez was not "mumbling and picking at the sheets," but was speaking Mexican and searching for her rosary, which she had lost in her bedsheets the prior evening. During the spiritual assessment the nursing student asked "What is a strength for you?" patient stated in Mexican "Prayer." "What type of prayer?" the patient answered in Mexican "Saying the rosary." The patient added in Mexican "pray with me"

Nursing Diagnosis: Spiritual Distress R/T miscommunication between staff and patient D/T language and cultural barrier.

Goal: Spiritual needs will be met.

Objective(s): Obtain rosary and pray with the patient.

Intervention: Plan uninterrupted quiet time for prayer. Hang a "Do not disturb" sign on door. Pray with the patient.

The student found the patient's rosary under the top sheet at the foot of the bed and prayed in Mexican with Ms. Rodriguez.

Evaluation: Rosary was found and placed in the patient's hands. Recited the rosary in Mexican with patient. Patient was resting quietly and comfortable at end of shift.

During the next clinical week, the staff reported to the student that the patient had remained calm for the duration of that evening and had died peacefully during the night.