THE DESIGN AND VALIDATION OF A FRAMEWORK OF COMPETENCIES IN SPIRITUAL CARE FOR NURSES AND MIDWIVES: A MODIFIED DELPHI STUDY

By

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ABSTRACT

This study aimed to develop a competency framework in spiritual care for nurses/midwives to address the lack of guidelines in nursing/midwifery education and clinical practice.

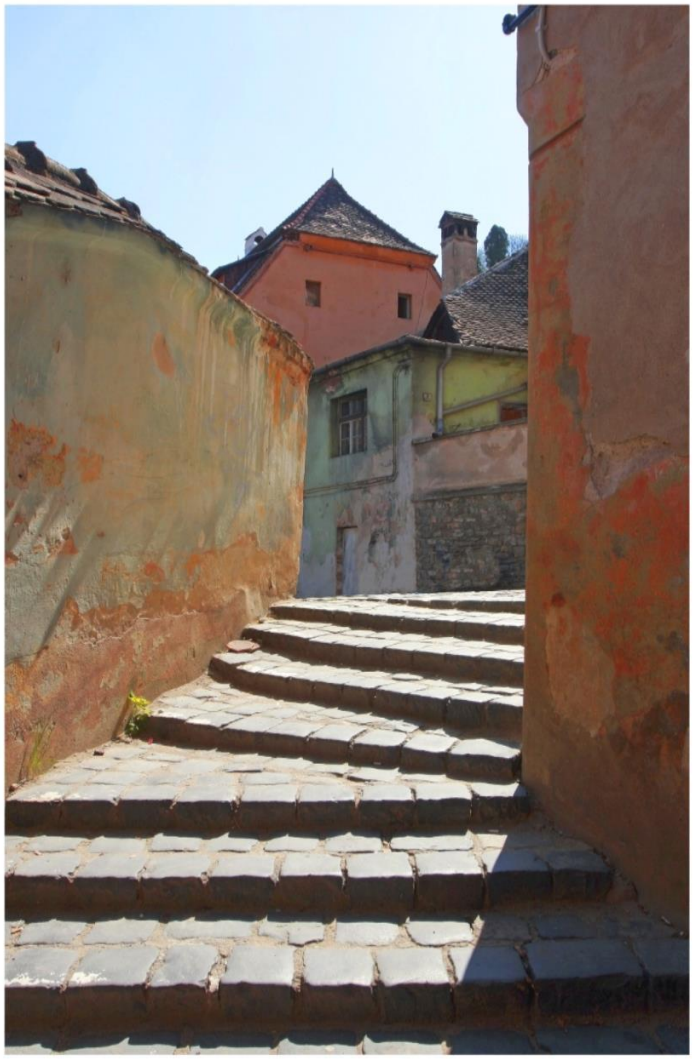
The study adopted a mixed methods approach, using an eclectic framework through three main phases. In **Phase 1**, spiritual care competencies were categorised under seven domains which were developed from an in-depth literature review and five focus groups with stakeholders.

In **Phase 2,** the competency framework underwent two rounds of consensus by experts using a modified Delphi method with high response rates (R1: 75.78%; n=241; R2: 85.06%; n=205). No significant differences were identified between the characteristics of Round 2 respondents and non-respondents which enhanced the reliability of the consensus reached on 54 competency items arranged in seven domains. Consensus was assumed if experts rated items within the highest region on a 7-point Likert form scale (5, 6, or 7) and a predetermined cut-off point of 75% threshold or greater. A six factor model was identified through the exploratory factor analysis which paralleled five of the original domains.

During consultation with international researchers in the field and modified Delphi educators (n=107) (**Phase 3**), 38 competency items were categorised as achievable at pre-registration level, the majority of which are consistent with existing pre-registration regulatory education requirements. Fifteen items were categorised as being achievable at post-registration level and one item was common at both levels. Thus, two competency frameworks were produced namely, a 39 item pre-registration framework and a 16 item post-registration framework. Thematic analysis identified enhancers/inhibitors to the implementation of the framework in education, research and/or clinical practice.

The development of a generic framework of competencies in spiritual care provides new knowledge on the delivery of spiritual care by nurses/midwives to guide education and clinical practice. Recommendations are given for education, clinical practice and policy. Further research is needed to test both the pre- and post-registration frameworks of competencies which emerged from the consultation phase of the study.

DEDICATION



Dedicated to those who suffer in different ways,
ways not always explicit to medicine,

Dedicated to those who are ready to welcome, treat and console those we encounter in our work journeying the steps through the shadows of life,

Lastly, dedicated to those who embrace and offer their generous contribution to the constant renewal of healthcare.

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Last, but not least I am most grateful to the many participants in the study who have taken the time to contribute to this area of research. In particular I would like to give tribute to the memory of two of my participants who are now deceased.

The contribution of each individual was invaluable. Without their assistance this research study would not have been possible.

DECLARATION

This is to certify that, except where specific reference is made the work described in this thesis is the result of my research. Neither this thesis, nor any part of it, has been presented, or submitted, in candidature for any degree at any other University.

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Josephine Attard (Candidate)

Date _____

LIST OF CONTENTS

CHAPTER 2 LITERATURE REVIEW (cont.)

CHAPTER 3 THEORETICAL FRAMEWORK

CHAPTER 4 METHODS

CHAPTER 4 METHODS (cont.)

CHAPTER 4 METHODS (cont.)

CHAPTER 4 METHODS (cont.)

CHAPTER 5 THE FINDINGS

CHAPTER 5 THE FINDINGS (cont.)

CHAPTER 6 DISCUSSION

CHAPTER 6 DISCUSSION (cont.)

CHAPTER 7 CONCLUSION

LIST OF APPENDICES (cont.)

LIST OF APPENDICES (cont.)

LIST OF TABLES

LIST OF TABLES (cont.)

LIST OF TABLES (cont.)

LIST OF FIGURES

LIST OF ABBREVIATIONS

ACCESS	Assessment, Communication, Cultural, Empathy, Sensitivity and Security.
ADL	Activities of Daily Living
ASSET	Spirituality and Spiritual Care Education and Training
CAM	Complementary and Alternative medicine
CAQDAS	Computer assisted qualitative data analysis software
CC	Cultural competence
CFA	Confirmatory Factor Analysis
CINHAL	Cumulative Index of Nursing and Allied Health Literature
CPD	Continuous Professional Development
DH	Department of Health
EFA	Exploratory Factor Analysis
EQF	Educational Qualification Framework
FACIT	Functional Assessment of Chronic Illness Therapy
FICA	Faith, Importance, Community and Address (assessment tool)
FCSC	Framework of Competency in Spiritual Care
HOPE	Sources of Hope, Organised religion, Personal spirituality, Effects on personal health (assessment tool)
ICM	International Council of Midwives
ICN	International Council of Nurses
IPR	Interpercentile Range
IPRS	Interpercentile Range adjusted for Symmetry
JCAHO	Joint Commission on the Accreditation of Healthcare Organisations
MDT	Multi-disciplinary team
MCCC	Marie Curie Cancer Care
MCH	Maternal and Child Health Services

LIST OF ABBREVIATIONS (cont.)

NHS	National Health System
NICE	National Institute for Health and Clinical Excellence
NGT	Nominal Group Technique
NMC	Nursing and Midwifery Council
PREP	Post-Registration Education and Practice
QAA	Quality Assurance Agency
QAAHE	Quality Assurance Agency for Higher Education
R1	Round 1
R2	Round 2
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCPsych	Royal College of Psychiatrists
RCT	Randomised Controlled Trial
SCCS	Spiritual care competency scale
SIGLE	System for Information on Grey Literature in Europe
SMS	Short Message Service
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
UREC	University Research Ethics Committee
US	United States
vs.	versus
WHO	World Health Organisation
WHO-QOL SRPB	World Health Organisation- Quality of Life Spiritual Religious Personal Beliefs

GLOSSARY

Accreditation

The process by which a statutory body or organisation scrutinises, evaluates and recognises an institution, programme or curriculum as meeting the standards necessary for providing an educational service.

Attitudes

Attitudes consists of the ability to use cognitive learning, to critically think in real life situations and to make appropriate decisions on the spot.

Clients/patients

For the purpose of this thesis, the terms 'patients' and 'clients' are used interchangeably. Rather than 'patient', 'client' is the preferred term and is the most appropriate term to refer to recipients of care in nursing/midwifery. The rationale for using this term is that 'clients' is an active word that connotes somebody with choices and contributions. The word 'patient' has traditionally been used to refer to recipients of healthcare. A patient is a person waiting for or receiving treatment and care from a qualified provider because of illness or injury. The word is believed to imply passiveness on the part of the sick or injured person. He/she is expected to accept decisions and services of health professionals, without making inputs (Berman et al., 2008). This is not acceptable in nursing, in an era of increased awareness of the public to health matters and especially in midwifery who consequently adopted the term 'client'.

Competence

The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions' (NMC, 2010, pp.45).

Competency/ ies

A broad composite statement in nursing/midwifery practice which describes a framework of skills reflecting knowledge and attitudes.

Curriculum

A totality of the educational programme that is coherent in structure, processes and outcome that links theory to practice in the professional education of a nurse or of a midwife.

Clinical learning

Part of the educational process that takes place in a practice setting in a hospital or in the community.

Experience

Practical experience derived from participation in events, as a basis of knowledge.

Faculty

The academic or teaching staff in a college or university, or in a department of a college or university.

Knowledge

The assimilation of information through learning. In the context of this framework, knowledge is the body of facts, principles, theories and practices in nursing and midwifery. Knowledge is described as theoretical and/or factual.

Learning/competency outcomes

Statements that refer to what a learner knows, understands (think) and is able to do on completion of a learning process, which are defined in terms of knowledge, skills and attitudes.

Programme

The complete course of study leading to qualification as a nurse or midwife.

Registration

A process by which the regulatory authority validates those nurses and midwives, official recognition/documentation of successful completion of the initial nursing and/or midwifery education programme.

Pre-registration level

A nursing or midwifery programme in a higher education institution leading to an academic award and registration as a nurse or midwife.

Post-registration level

Qualified registered nurses or midwives who are undertaking either an educational institution leading to an additional academic and/or professional award or an inhouse programme of professional development (Quinn & Hughes, 2007).

Religiosity

Religiosity is rooted in an established tradition in a group of people with common beliefs, practices and ritual concerning the sacred.

Spirituality

For the purposes of this study, spirituality is defined in terms of these three aspects which encompass elements from the definitions given by the WHO (2006) and RCN (2011):

- The intrapersonal aspect of spirituality is concerned with people's values, morality, belief and faith in self, others and in a higher power, meaning and purpose, hope and strength.
- The interpersonal aspect is concerned with peoples' sense of connection through relationships involving love, forgiveness and trust.
- The transpersonal (or transcendent) aspect is concerned with people's sense of wholeness/integration, awe and wonder, creativity/self expression.

Spiritual care

Spiritual care refers to: 'that care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.' [NHS Education for Scotland, 2009; p6].

Standard

Statement of a defined level of quality that articulates the expectations of initial nursing and midwifery programmes.

Skills

Refers to the ability to apply knowledge and use know-how to complete tasks and solve problems. In the context of this framework skills are described as cognitive (use of logic, intuitive and creative thinking) and practical involving dexterity.

CHAPTER 1: BACKGROUND AND OVERVIEW OF THESIS

1.1 Introduction

This chapter addresses the author's interest in developing a framework of competencies in spiritual care. The drivers responsible for the need to develop such a framework are explored and the possibility for such a framework to function as a guide to nursing/midwifery education and clinical practice are carefully considered by examining changes in society, healthcare policy and studying existing guidelines for professional practice in spiritual care. Finally, the aim of the study, as well as an overview of the various chapters within this thesis, are presented.

1.2 Author's interest in competencies in spiritual care

On reflection, my interest in the subject of competencies in spiritual care was stimulated during my midwifery training in the early 1980s, having completed my general nurse training. I can still recall my first experience as a midwifery student on the postnatal ward, when I was asked to accompany a mother to see her premature infant on the Neonatal Paediatric Intensive Unit. Unfortunately, during this visit, the baby died in her mother's arms. I did not know what to do or say to this woman or how to cope with this experience.

Years later, as a midwifery lecturer, I still question whether students are adequately prepared to cope with and manage such situations. These instances which challenge clients' sense of meaning, purpose and worth and which require compassionate and sensitive care are often recognised as 'spiritual'. These profound thoughts inspired the author to delve deeper into this subject by studying the importance of adequate educational preparedness of nurses/midwives when considering the spiritual dimension of care. The author also investigated the effects of enhancing nurses'/midwives' knowledge, skills and attitudes (competencies) required to take on this aspect of care within their professional roles. It is proposed that competencies in spiritual care may build confidence in providing quality spiritual

care, while satisfying the demands outlined by the nursing/midwifery accreditation bodies and the relevant healthcare policy.

1.3 Historical perspective

Inspired by the words of Sir Winston Churchill addressing the Royal College of Physicians in London in 1944, *'the longer you look back, the farther you can look forward'* (Churchill, 1944) we sometimes need to reflect to see how far we have come and how far we need to go. Therefore, reviewing and understanding the heritage of the spiritual/religious dimensions of human experience is paramount to nursing/midwifery, as these are practice-based disciplines which focus on human concerns, as seen by the following historical perspective of the spiritual dimension of care.

Ancient western philosophers, such as Plato, recognised the importance of treating people as holistic beings: body-mind-spirit where the body and soul were regarded as being inseparably linked.

> *As you ought not attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul … for the part can never be well unless the whole is well.* (Plato, 427-347BC, cited in Brisson, (1998) pp.79).

Historically, in the west, medical, nursing and midwifery care were delivered by religious and monastic communities which focused on caring for the whole person. During the Crusades, military nursing orders, such as the famous Hospitaller Knights of St John, which drew its membership from the orders of the knights, monks and brothers, were established in response to the healthcare needs of pilgrims in the Holy Land, where the body, mind and spirit were integrated in care.

Similarly, in the rest of Europe, the 18th century saw the era of the golden age of science which was dominated by an intellectual reawakening. This period saw an increase in medical research and knowledge, with emphasis being placed on a medical model of care that relied on disease processes and cure, rather than on the

spirit. During this time, hospital nursing care which was provided by religious nursing orders delivered care of the body and soul. However, attention to the soul declined, not only in response to the medical model of care but also due to a marked shift towards secular-rational values. The post-industrial phase of development which is associated with self-expression values (Paley, 2009), represented a challenge in healthcare and eventually, holistic care became suppressed.

In spite of the decline in the spiritual aspects of care, the last few decades have seen a renewed interest in spiritual/religious discourse, through the realisation that *'everyone has spiritual needs'* (Greenstreet 2006, p. 32) and that the human being is more than simply a set of physical processes. Hence, a holistic approach to care acknowledges the interplay of the mind, body and spirit where '*the whole is greater than the sum of the individual parts'* (McSherry & Ross, 2010, p6).

An example of such an approach to care is the hospice movement. While the concept of hospice has been evolving since the 11th century, hospice philosophy of care focuses on the 'palliation'of the terminally ill or seriously ill clients' pain and symptoms, while attending to their emotional and spiritual needs. Hospice was first applied to the care of the dying by Madame Jeanne Garnier who founded the Dames De Calaire in Lyon in France 1842. The work continued when Sister Mary Augustine (formerly Mary Aikenhead), with her Irish Sisters of Charity, opened Our Lady's Hospice in Dublin in 1879. St Joseph's Hospice, which opened in London in 1905, followed the same principles of care.

Many of the foundational principles by which modern hospice services operate were pioneered in the 1950s by Dame Cicely Saunders. Emphasis was placed on the patient, rather than on the disease and the notion of 'total pain' was introduced (Saunders, 1986), which included not only physical pain but embraced social, emotional and spiritual aspects of suffering which responded only to 'total care'. While in 1965, when Saunders was disseminating her theories and developing her world-renowned St Christopher's Hospice in the UK, the Swiss psychiatrist Elisabeth Kübler-Ross also began to consider the social responses to terminal illness, which

were inadequate in the US (Worth, 2005). This holistic focus is also the sentiment in the Hippocratic Oath currently sworn by doctors as a rite of passage in which they uphold a number of professional ethical standards and it was Florence Nightingale, the driving force and founder of modern nursing who emphasised that the needs of the spirit are as important to health as those individual parts that make up the body (Nightingale, 1969).

1.4 Re-emergence of the spiritual

When one reads healthcare journals and magazines or attends healthcare conferences, one will notice that spirituality is increasingly being discussed. Interest in spirituality within society may have been revitalised due to the emphasis of individuals' increased awareness of nurturing the inner self to reach personal fulfilment and full potential (Clarke, 2013). This is emphasised in the recent Royal College of Nursing Chief Nursing Officer for England's 6C's campaign for nurses and midwives (care, compassion, competence, communication, courage and commitment) which highlight core professional values and behaviours (Watterson, 2013).

The Equality Act (2010) reflected in the (UK) National Health System (NHS) patients' rights (2012), acknowledges the importance of individuals' 'religious and cultural beliefs' and has also made an important impact on the spiritual dimension. Malta, as in the UK, also adopts these patients' rights, based on the European Charter of Patients' Rights (2013).

The demand for different approaches to care is on the increase. For example, complementary and alternative therapies and allopathic medicine are becoming more popular. A nationwide mail survey (1998), involving a random sample of 1035 individuals in the US, revealed that the shift in popularity of Complementary and Alternative Medicine (CAM) was not due to dissatisfaction with conventional medicine as a primary reason, but that CAM approaches were more congruent with people's own beliefs, values and philosophy of life (Astin, 1998).

The increase in international media and communication has influenced people to become more aware about uncertainties about the world. For example, by witnessing or experiencing illness, financial crisis, unemployment, poverty and depression, individuals are more likely to seek approaches that help them to understand their own values and to live a more authentic and peaceful life (Clarke, 2013). Media headlines, have also triggered more recognition of spiritual/religious issues within Healthcare specifically, such as: *'Nurse suspended for prayer offer'* (BBC News, 1st February 2009), *'Nurse sacked for advising patient to go to church'* (News, 26 May, 2009; Nursing Times, 2009) *'British Medical Association to debate religion and prayer in NHS'* (News, 29 June, 2009; Nursing Times, 2009) and '*Muslim nurses can cover up, but Christian colleagues can't wear crucifixes'* (BBC News, Mail Online, 19 October, 2010).

This media interest may indicate that spiritual matters are perceived as important by people. Consequently, two large surveys involving nurses were conducted by the Nursing Times (Mooney, 2009) and the Royal College of Nursing (RCN, 2011). The high response rates in these studies demonstrate the importance given by nurses to spiritual/religious concepts of care. Both surveys revealed that nurses wanted more guidance on spiritual aspects of care. Therefore, the RCN commissioned the Spirituality Task and Finish Group which produced guidance in two forms, namely: The Spirituality in Nursing Care Pocket Guide (RCN, 2011) and an online resource (RCN, 2011).

Increased life expectancy may result in people living longer with chronic illnesses or conditions that limit their abilities or they may have to live with more pain and suffering. Life events seem to trigger a search for a source of inner strength, in order to find resilience in the face of stress and to restore meaning and purpose in life, hope and healing in the midst of serious and chronic illness, stress, old age and loss (Nolan & Holloway, 2014). The perspective of meaning and purpose in the spiritual dimension of ageing is endorsed in gerontology (Mackinlay, 2012). These spiritual principles are also integrated in management such as; communication and

workplace spirituality (Grant, O'Neil & Stephens 2004), leadership (Reave, 2005) and higher education (Kazanjian, 2006).

In an effort to counteract incidences of poor care standards in the UK, the Parliamentary and Health Care Ombudsman (2011) presented ten case study investigations which demonstrated disregard for dignity and compassion in nursing care. Emphasis was placed on the need for nursing care which reflects core values and principles of the National Health Services (NHS), as outlined in the NHS Constitution (DH, 2013). The Mid Staffordshire NHS Foundation Trust Public Inquiry known as The Francis Report, which was published on 6th February, 2013 in the UK, and Gullick and Shimandry (2008) recalled similar stories of undignified care and patients' suffering. The UK Government's response to the Parliamentary and Health Care Ombudsman (2011) report was to implement 204 of the 290 recommendations to ensure that patients were treated with dignity, and suffered no harm.

In midwifery, the Department of Health (1993a), Changing Childbirth Report by the House of Commons expert maternity panel has been a central focus of maternity care policy in the UK, following the demands of women requesting a more personalised and sensitive care, more involvement of the midwives and greater client choice.

On examination, the roots of dissatisfaction with care in all of the above reports can be traced to the neglect of the spiritual dimension in care such as shown by nurses'/midwives' lack of caring attitudes and values and lack of compassion in practice (Francis, 2013). A number of campaigns followed to voice these concerns such as, *The Dignity in Care Campaign* (Social Care Institute for Excellence 2006) launched in the UK, and *Maternity Matters* (DH.2009). These campaigns aimed to improve clients' experience of care by improving the quality of care, which seems to include an adherence to spiritual principles. A range of drivers followed, both from the government and professional sources which endorsed the core value of compassion and dignity in care delivery, concepts intricately linked with spirituality (RCN 2008; McSherry *et al.*, 2012; Walsh, 2012; RCM, 2013).

Other disciplines, such as social work, have also recognised the value of spirituality in palliative care (Holloway & Moss, 2010). This research study aspires to incorporate 'total' care to patients and their families. In psychiatry and mental health professionals are encouraged to recognise the need to regard patient's spirituality and religious lives as clinical resources (Griffith, 2012, Royal College of Psychiatrists PS03/2013).

New developments in modern counselling and psychotherapy are occurring in stress relief, which are related to spirituality and religion (West, 2012), in the spirituality of sick children and their siblings, (Fosarelli, 2012; Nash, 2013) and occupational therapy (Wilding, 2002). Thus, the significance and recognition of the spiritual dimension of care is steadily increasing across many disciplines, particularly in nursing where it features in nursing and midwifery models of care and theories.

1.5 Global policy initiatives

Healthcare organisations, such as the World Health Organisation (WHO), have acknowledged the importance of other dimensions besides the physical and their effects on the overall health of the patient The WHO defines health as: "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (WHO, 1948, p100). Although this definition has not been amended as yet, the quality of life questionnaire includes spirituality, religiosity and personal beliefs (WHO-QOL SRPB, 2002).

Spirituality also features in the WHO with work on various aspects of care, such as:

- Antenatal, peri-natal and postnatal care, for example as is outlined in: http://www.euro.who.int/data/assets/pdf_file/0013/131521/E79235.pdf;
- Palliative care: http://www.who.int/cancer/palliative/definition/en/;
- Disaster relief: http://www.who.int/en
- Ageing: http://www.who.int/ageing/activeageing/en/.

The spiritual dimension is also emphasised by the International Council of Nurses in '*talks of compassionate and ethical caring that includes meeting spiritual needs*' (2012, p2) and by the International confederation of midwives in the philosophy of midwifery care (2014) which recognises, *'Midwifery care is holistic and continuous in nature, grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women'* (ICM, 2014, p2).

1.6 European policy initiatives

At a European level, the spiritual aspect is given importance through the Human Rights Act, 2000, Act 9 (1) which was revised in 2012 in The European Convention on Human Rights and which provides a right to freedom of thought, conscience and religion. This includes the freedom to change a religion or belief and to manifest a religion or belief in worship, teaching, practice and observance, subject to certain restrictions that are *'in accordance with law*' and *'necessary in a democratic society'* (European Convention on Human Rights, Act 9 (1), 2012).

Healthcare chaplaincy brought about a shift from religious affiliation and authority, towards a less defined and more individual expression of religion and spirituality (Hay, 2002). Subsequently, it is no longer acceptable to just have a chapel in a healthcare institution. Many institutions have allocated a multi-faith room to accommodate individuals of diverse faiths and religions. In some places, a change in title from 'chaplaincy' to 'spiritual care services' has been adopted to incorporate both the religious and spiritual needs of patients, their families, as well as staff (NHS, Scotland, 2009). The growing interest in spiritual care is highlighted in the Guidance on Spiritual Care and Chaplaincy in the NHS in Scotland (2009), which affirms that spiritual care is a necessary and integral part of whole person care and is a significant NHS resource in an increasingly multi-cultural society. Wales has also produced spiritual care guidelines (Welsh Assembly Government, Guidance on capabilities and competences for healthcare chaplains/spiritual care givers 2010). Consequently, the NHS provides a twenty four hour chaplaincy service for individuals to maintain health and to cope with illness, trauma, loss and life transitions.

Such initiatives have implications for health services and encourage the provision of spiritual care. For example, in the UK, within a society often regarded as being secular, the results of an independent survey involving 73 health providers indicated that many of the respondents criticised the fact that many patients were unable to practise their faith during hospitalisation (Clayton, 2010). In spite of the small sample size of health professionals in this study, the results demonstrate that even as traditional religious affiliations change, there may still be a growing interest in spirituality.

1.7 Nursing/midwifery models and theory

Many nursing theorists, such as Leininger (1991, 2001), Roper, Logan and Tierney (2000) and Roy (1980), acknowledged the spiritual dimension and it forms part of their theory either implicitly or explicitly (Martsolf & Mickley, 1998). Other theorists, such as Newman (1986) and Neuman (1995) have not only integrated spirituality in their theory, but also in their model of care.

Theories of care, such as those presented by Jean Watson's (1985) 'Human Caring Theory' incorporates the spiritual aspect by referring to the caring presence of the nurse, transcendence, wholeness and meaning in life. The activities of daily living (ADL) model (Roper, Logan & Tierney 2000) considers spirituality as a factor influencing the ADL's with spirituality featuring specifically under death and dying (McSherry & Ross, 2012).

The philosophy of midwifery views women as whole beings and claims that: '*Birthing is the most profound initiation to spirituality a woman can have'* (Lim, 2010). Theories and models of care in midwifery capture the spiritual dimension by embracing the intimate interplay that exists between mother and baby during pregnancy, labour and birth, through continuity of care and carer (Sandall, *et al*., 2013). An in-depth critique of the place of spirituality within each theory or model is beyond the scope of this chapter. Both nursing/midwifery models and theories emphasise the importance of the spiritual dimension for individual health and well-

being. In the past years, this has received further recognition by various organisations across the world.

1.8 Codes of ethics

The spiritual dimension of care is recognised globally and is central to nursing/midwifery care. This is reflected in the nursing /midwifery Codes of Ethics which are based on the International Council of Nurses (ICN) Code of Ethics for Nurses (2012), and the International Council of Midwives (ICM) Code of Ethics in Midwifery (2014). For example:

- The Australian Nursing and Midwifery Code of Ethics (2008) and Australian Nursing Federation (2011);
- The Canadian Nurses Association, Position Statement on Spirituality, Health and Nursing Practice (2010);
- The American Nursing Association through the position statement providing expert care and counselling at the end of life (2010);
- The Hong Kong Nursing and Midwifery Association in the Code of Ethics for nurses/midwives in the New Millennium (2000).

The spiritual elements in the ICN (2012), and the ICM (2008) Codes of Ethics, are not explicit but implicit as demonstrated by the use of words which are characteristic of spirituality such as 'respect', 'dignity' and 'holistic.' For example: *"You must treat people as individuals and respect dignity"* (NMC, 2008, pp.3).

> *Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status* (ICN, 2012, pp.1).

> *Midwifery care combines art and science. Midwifery care is holistic in nature, grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women and based upon the best available evidence* (ICM, 2008, pp.2).

These statements reinforce the importance of nurses/midwives adopting a holistic client-centred approach to care, In the UK Principles of Nursing Practice, recognise dignity, respect, individual need and compassion and as key aspects of nursing care (RCN 2010). Respect for clients' religious and spiritual beliefs is also central to the codes of ethics in various European countries, such as the Netherlands, Norway and Malta and build upon the ICN (2012) code which specifies the nurses' role of respecting the human rights, values, customs and spiritual beliefs of the individual, family and community.

In Malta the Nursing and Midwifery Council Code for Nurses and Midwives (NMC, 1997) together with the National Health Systems Strategy (2014-2020) which aims to restructure health services, is similarity concerned with holistic patient-centred and humane care, respect, dignity and acknowledges that:

> *The patient/client as a unique person who is to be treated with respect and dignity, irrespective of age, nationality, creed, gender orientation, political inclination or any other factor, recognise and respect the uniqueness of every patient/client and adapt the care given according to the patient's/client's biological, psychological, social and spiritual status and needs* (NMC Malta, 1997, pp.3).

Therefore, from the above overview, it can be seen that authorities across the world emphasise the importance of the spiritual dimension for health and well-being. This, in turn, has led to its further integration in nursing/midwifery education.

1.9 Educational guidelines

Educational guidelines in nursing/midwifery seek to satisfy the recognition of the religious and spiritual beliefs as reflected in a country's Code of Ethics. For example, in the UK, the Nursing and Midwifery Council (NMC, 2010) expects that at point of registration, newly qualified nurses should be able to:

> *Carry out comprehensive, systematic nursing assessments that take account of the relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors* (NMC 2010, pp.18).

The Essential Skills Clusters for pre-registration nursing programmes identifies skills that are "*essential to be a proficient nurse*". Included under the *"care, compassion, and communication"* cluster is the expectation that the nurse will *"demonstrate an understanding of how culture, religion, spiritual beliefs … can impact upon illness and disability"* (NMC, 2010, p108). Similarly, in pre-registration midwifery programmes, women can expect newly qualified midwives "*to provide care that is delivered in a warm, sensitive and compassionate way".* Included in the cluster is that midwives should *"Work in partnership with women in a manner that is diversity sensitive and is free from discrimination, harassment and exploitation"* (NMC, 2010, pp.35). Moreover, the Quality Assurance Agency for Higher Education (Quality Assurance Agency, 2001, pp.10, 12) expects nurses to:

- *Undertake a comprehensive systematic assessment using the tools/ frameworks appropriate to the patient/client taking into account relevant […] spiritual needs.*
- *Plan care delivery to meet identified needs.*
- *Demonstrate an understanding of issues related to spirituality.*

In recognition of the importance of spirituality in health, guidance for specific groups has been produced by health services. For example in the UK, the National Institute for Health and Clinical Excellence (NICE) has produced guidance for the care of adults with cancer entitled 'Supportive and Palliative Care for Adults with Cancer' (NICE, 2004), while the Marie Curie Cancer Care (2003) developed 'The Marie Curie's spiritual and religious care competencies for specialist palliative care'. The UK National Service Frameworks provided standards for respecting people's privacy, dignity, religious and spiritual beliefs. These standards relate to vulnerable groups, such as the elderly (DH, 2001a), people with heart conditions (DH, 2000) and those with mental health problems (DH, 2001b).

In mental health, the position statement of the Royal College of Psychiatrists (2013) also affirms the value of spirituality and religion, as part of good clinical practice and the provision of guidance which clarifies the boundaries of practice. In addition,

organisations such as The Janki Foundation in the UK, a registered charity supporting research and awareness in the field of health and spirituality, has developed a modular training and resource package to help healthcare professionals explore how a spiritual model of healthcare can be used in practice (The Janki Foundation, 2014).

Despite the various guidelines, there is great variation and a lack of consensus in the spirituality component in nursing/midwifery education (Timmins & Neill, 2013). Notwithstanding these inconsistencies, spiritual care education is growing, as demonstrated in the increasing number of published debates.

1.10 Healthcare literature and research

An increasing body of literature and research suggests a positive relationship between a spiritual/religious life view, and physical and mental health, and quality of life (Balboni *et al*., 2007; Balboni *et al*., 2010; Balboni, *et al*., 2013; Koenig, 2012; Vallurupalli *et al*., 2012). However, this relationship has been questioned in a recent study involving a large sample of UK participants from the general public which found that people holding a spiritual understanding of life in the absence of a religious framework were more vulnerable to mental disorders than those with a religious or non-religious life view (King *et al*., 2013). These apparently conflicting findings highlight the complex nature of spirituality and the differences in contexts and cultures in which spirituality is practised. While research shows the importance of religion as part of the broad concept of spirituality (Koenig, 2012), Paley (2009) proposes a generic view of spirituality which tends to underestimate the religious dimension (Pesut, 2008; McBrien, 2010). Consequently, spirituality, and spiritual care may include or exclude the religious needs of clients and threaten holistic care (Holloway *et al*., 2011; Kalish, 2012).

Whilst the evidence base for spiritual care in nursing is on the increase, Ross (nee Waugh) in the late 80's/early 90's traced only two published research on spirituality by nurses, with only one American published study (Waugh, 1992). This escalated to 47 original research papers between 1983 and 2005 when the review was repeated

(Ross, 2006) and is still growing rapidly with an additional 80 papers between 2006 and 2010 (Cockell & McSherry, 2012). Whilst most research is American, this has extended to the UK and other European countries, Scandinavia, Australia and Japan.

Research has demonstrated that nurses/midwives often have difficulty in defining the concept of spirituality and spiritual needs often interpreting them as being synonymous with religion (Ross, 2006; Hall, 2006; Holloway *et al*., 2011). Similar findings were derived from an RCN study on a large sample of over 4000 nursing/midwifery participants who recommended the need for further spiritual care education (McSherry & Jamieson, 2011).

For many individuals, spirituality will come into sharper focus in times of illness and crises, situations considered to require a source of strength, hope and well-being (Ross, 2006; Baldacchino, Bonello & Debattista, 2014). Practising faith during hospitalisation was found to be of importance by those who followed a particular faith (Koenig, 2012; Baldacchino *et al*., 2013). Moreover, evidence indicates that spiritual needs were not adequately met. Although patients do not necessarily expect nurses to deliver spiritual care, when spiritual care is offered, it is valued (Ross *et al*., 2013). These findings indicate the underlying research gap in the educational preparation of nurses/midwives when it comes to spiritual care issues. This gap contradicts the expectations and demands of the accreditation bodies, the regulatory bodies, healthcare policies, the professional Code of Ethics and the views of nurses/midwives themselves who highlight the need to be competent in spiritual aspects of care (Hall & Mitchell, 2008; RCN, 2011).

Competency in spiritual care incorporates knowledge, skills and attitudes of professionals in order to deliver care to the standards required (Nolan & Holloway, 2014). Research on competencies in spiritual care is scarce. To date, only three studies were traced on competencies in spiritual care in nursing namely, the Marie Curie Spiritual Care Competencies (MCCC, 2003); van Leeuwen & Cusveller (2004) and Baldacchino, (2006).

Few authors have developed competencies from a cultural perspective (Adamson, Beddoe & Davys, 2012; Riggs *et al*., 2012) appropriate to the increasingly multi-cultural societies which exist today. This work has begun and can be seen in the development of competencies in bereavement (Brownhill *et al*., 2013), humanising birth (Behruzi *et al*., 2013), social work, (The College of Social Work, The Professional Capabilities Framework, 2012) and family medicine (Anandarajah *et al*., 2010).

The development of the above mentioned competencies, aimed at shaping the education and practice in this field, indicate the increased interest in spiritual care as a core concept when it comes to addressing clients' needs in a holistic manner. However, the major focus in the area of competency in spiritual care is on oncology or palliative care. While such work is invaluable, spiritual care appears to be the focus of death and dying which may add some bias to the research field (Cockell & McSherry, 2012). Since spirituality is a broad and useful concept, spiritual care competencies should be achieved by all healthcare givers and in particular, nurses/midwives who are constantly with clients.

The existing competencies in spiritual are limited as they have been developed by academics, managers, chaplains and other qualified members of staff and have not included service users. While participation of these professionals is valued, greater participation of clients would enhance the relevance of spiritual care competence, based on actual need rather than a professional discourse which may be meaningless to clients (Cockell & McSherry, 2012).

Other areas of concern pertain to the lack of scientific evidence in developing competencies, such as small sample sizes (Mitchell & Gordon, 2003; Gordon & Mitchell, 2004; Smith & Gordon, 2009; Cooper, Aherne & Periera, 2010; Brownhill *et al*., 2013; Kang *et al*., 2013), low response rates and diversity in participants' cultural and religious perspectives which limit generalisation of findings (Baldacchino, 2006; van Leeuwen *et al*., 2006; van Leeuwen *et al*., 2008; van Leeuwen *et al*., 2009; Puchalski *et al*., 2009; Behrui *et al*., 2011; Adamson, Beddoe & Davys, 2012).

Despite the importance and recognition of spiritual care in nursing/midwifery codes of ethics, healthcare policy, guidelines for professional practice and the current debate on various issues in spiritual care, there is an inconsistency in the nature of the spiritual component within the nursing/midwifery education programmes. Formal integration of spirituality within the nursing/midwifery curricula is recommended by research to enable competence in the delivery of spiritual care. Moreover, the existing competency frameworks, although valuable, do not address the spiritual needs of clients in the various contexts of nursing/midwifery.

Consequently, these research gaps will be addressed in this study by developing a rigorous and valid competency framework in spiritual care as a guide for the achievement of competencies by nurses/midwives at the point of registration. Development of this framework will be based on the available evidence in spiritual care to determine what nurses/midwives are expected to know, think, and do.

1.11 Establishing a working definition of spirituality and spiritual care

Clearly 'spirituality' and 'spiritual care' are on the healthcare agenda (as can be seen from Sections 1.1-1.10). Within nursing/midwifery whilst spiritual care is expected, there is little consensus about what 'spirituality' and 'spiritual care' entails and no single shared definition exists (McSherry and Ross, 2010). Consequently, these concepts have stirred much debate, not only have some authors claimed that constructing a universal definition of spirituality is not possible but may also be unhelpful (Swinton and Pattison, 2010). Key internationally recognised bodies, such as the World Health Organisation Quality of Life Spirituality, Religion and Personal Beliefs group and the RCN have identified various aspects of spirituality. The WHO (WHOQOL SRPB Group, 2006) has defined 'spiritual' as:

> *Connection, meaning and purpose in life, awe and wonder, wholeness and integration; spiritual strength; inner peace; hope and optimism, faith; love; kindness to others; death and dying (WHO, 2006).*

Similarly, the RCN (2011) draws upon the wide range of definitions which are available and has also defined aspects of the spiritual dimension as follows:

> *Hope and strength; trust; meaning and purpose; forgiveness; belief and faith in self, others, and for some this includes a belief in a deity/higher power; people's values; love and relationships; morality; creativity and self expression (RCN, 2011).*

Whilst considering the complexity of spirituality, the aspects of spirituality developed by the WHO (2006) and the RCN (2011) constitute considerable overlap. Three aspects of spirituality seem to emerge from these definitions relating to the intrapersonal, interpersonal and transcendent parts of the individual. Hence, for the purpose of this study spirituality is defined in terms of these three aspects which encompass elements of both as follows:

- The intrapersonal aspect of spirituality is concerned with: 'peoples' values, morality, belief and faith in self, others and higher power, meaning and purpose, hope and strength.'
- The interpersonal aspect is concerned with: peoples' sense of 'connection through relationships involving 'love, forgiveness and trust.'
- The transpersonal (or transcendent) aspect is concerned with: peoples' sense of 'wholeness/integration, awe and wonder, creativity/self expression.'

Based on the extensive literature and research over the years, The RCN, (2012a, b) also provides guidance on the practice of 'spiritual care' and adopts the NHS Education for Scotland, (2009) definition as it captures the main elements of spiritual care covered in the literature and defines spiritual care as:

> *'that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.' [NHS Education for Scotland, 2009; p6].*

This definition of spiritual care is adopted as terms of reference to this study without further amendment.

1.12 Structure of the thesis

Chapter 2 provides a review of the relevant literature on the concepts of spirituality and spiritual care in nursing/midwifery practice and education whilst analysing the spiritual component in curricula and identifying the research gaps.

Chapter 3 presents the selection of and justification for the theoretical framework of the study. It provides a description of the main tenets of these theories and ideas drawn from The Theory of Skill Acquisition: Novice to Expert (Benner, 1984) and Taxonomy of Educational Objectives: Cognitive and Affective Domains (Bloom, 1956).

Chapter 4 gives an overview of the aims and objectives of the study and discusses the research process. The findings are presented in **Chapter 5** and are discussed in relation to the existing literature in **Chapter 6.**

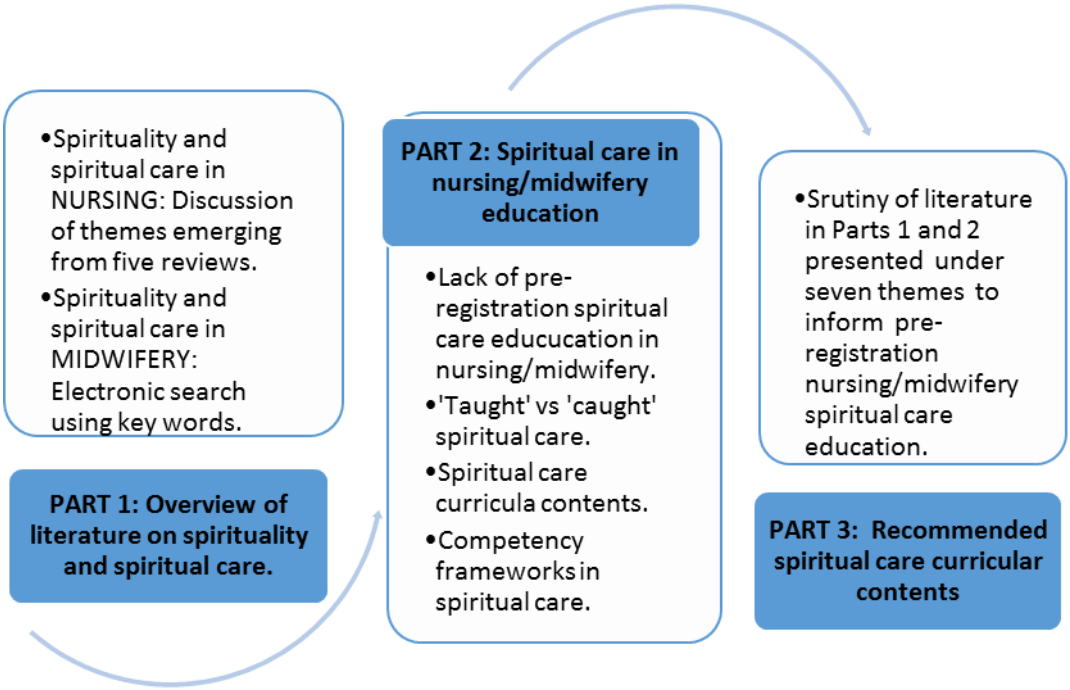
Finally and as a conclusion, the study's key findings, the various strengths and limitations, the contribution of the study to knowledge, a list of recommendations for future research, education and clinical practice, as well as the author's personal reflections on the subject will be presented in **Chapter 7**.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Having shown, in the introductory chapter, that there is a need for the provision of adequate education in spirituality and spiritual care in nursing/midwifery, this chapter reviews the existing literature in order to examine the current evidence underpinning the education of the spiritual dimension of care in nursing/midwifery. This will be achieved by exploring the literature in **three interconnected parts** (Figure 2.1). **Part 1** focuses on key elements emerging from the literature on spirituality and spiritual care in nursing/midwifery. **Part 2** examines spirituality and spiritual care education, while **Part 3** scrutinises and uses this literature as a basis for recommendations, with regard to pre-registration curricular contents in spiritual care in nursing/midwifery education.

Figure 2.1 An overview of the literature review



2.2 PART 1: Overview of literature on spirituality and spiritual care

This section presents an overview of published articles on spirituality and spiritual care in nursing/midwifery to identify and explore emerging key themes in this area of research. It also provides pointers for direction in the recurring need of nurses/midwives to be properly educated in spiritual care.

2.2.1 Search strategy and review procedure

Literature from various sources were scrutinised using a range of search methods. First, electronic databases (specifically Academic Search Complete, Age line, BioMed Central, CINHAL, Cochrane database of systematic reviews, Medline, PubMed, PsycINFO, and SocINDEX), were searched using the terms 'spirituality,' 'spiritual care,' 'nursing', and 'midwifery'. Terms were used alone and in combination. This yielded 227 resources, dating between 2000 and 2014. Duplicates, articles not written in the English language, editorials and conference abstracts were eliminated, reducing the number of articles to 195 records. The abstracts of these articles were read and those deemed relevant for inclusion totalled 124. These were subjected to a quality appraisal process, described below, resulting in 86 records. The majority of nursing literature on spirituality and spiritual care were written by authors from the UK and the US, expanding to other European countries, as well as Australia and Japan. The search was conducted more than once, as electronic search engines can give different results on different days (last search, April 2014). Four midwifery articles were found at this stage of the search (April, 2014).

Another search based on the key words: 'spirituality', 'spiritual care', 'maternity' and 'midwifery care' was conducted separately. The search yielded 34 hits which dated between 2000 and 2014. After eliminating duplicates, articles not specific to midwifery, those not written in the English language and conference abstracts, the search yielded 20 records. These were subjected to the eight point criteria of quality appraisal of the literature (Table 2.1) and 14 met the required criteria.

The majority of the studies were from the UK, Europe, and the US. Most studies found in midwifery were exploratory and descriptive, with many of the elements of spirituality and spiritual care overarching with nursing literature. Two Cochrane reviews in midwifery were identified and were subjected to the eight point criteria of quality appraisal of the literature (Table 2.1). These reviews explored the spiritual element of 'support' (Hodnett *et al*., 2007; Hodnett *et al*., 2011).

A manual search was also undertaken by referring to reference lists in published works. The records which were found were interdisciplinary, mostly from nursing, chaplaincy and/or social work. Besides this, 'Grey' literature was also accessed through the 'System for Information on Grey Literature in Europe' (SIGLE) which yielded four PhD nursing theses dating from 1992 and 2001.

2.2.2 Selection of studies included in this study

Different critical appraisal tools are designed and used to analyse all research designs such as, Polit and Beck, (2009) and Critical Appraisal Skills Programme (CASP) (2013). While such tools are valuable some are needlessly lengthy and detailed (Walsh & Down 2006). Thus, the researcher developed an abridged eight criterion appraisal tool based on the existing appraisal tools (Polit & Beck, 2009) to rank and scrutinise the studies (Table 2.1). The quality appraisal criteria shown in this table were applied to each article and recorded on the Data Extraction Sheet (Appendix 1). The total score possible for each article was between 0-20. **Column** ① represents the eight quality appraisal criteria used to rank each study. Aspects of the appraisal criteria, such as the research design, validity, reliability and rigour will be discussed in detail in Chapter 4 (Methods). **Column** ② provides a description of each criterion and **Column** ③ shows the rating score between 0-4 and a description of the score awarded to each criterion during scrutiny of the articles. The Grey literature which was based on research was also appraised in this way. An article scoring a total of 10 points or more was included for the purpose of the literature review. A total of 102 research articles met the criteria and were reviewed.

Table 2.1 The eight point criteria of quality appraisal of the literature

THE EIGHT POINT CRITERIA FOR QUALITY APPRAISAL OF THE LITERATURE						
① CRITERIA	② DESCRIPTION	③ SCORE				
		0	**1**	**2**	**3**	**4**
Research design	Qualitative or quantitative or both methods or literature review		Opinion articles or essays	Qualitative or quantitative or literature review	Mixed methods	
Research question	Clear research question or clear aims and objectives	Not defined	Defined			
Validity	Content / Predictive / Concurrent / Construct		One type (Low) (>0.5)	One type (Modest) (0.5 – 0.75)	One type (High) (<0.75)	Two types (High)
Reliability	Internal consistency / stability / equivalance		One type (Low) (>0.5)	One type (Modest) (0.5 – 0.75)	One type (High) (<0.75)	Two types (High)
Rigour	Credibility dependability / transferability / confirmability		One type (Low)	Two types (Modest)	Three types (High)	Four types (High)
Recommendations	Practical / feasible	Not practical / not feasible	Practical / feasible			
Peer review	National / international	Not peer reviewed	National peer reviewed	International peer reviewed		
Publication	Scientific nursing / midwifery / medical journal	Not published in scientific journal	Published in scientific journal			

2.2.3 Search findings

Most studies were oriented towards palliative care, oncology and mental health. Five literature reviews on spirituality and spiritual care in nursing conducted between 2006 and 2012 were identified. These studies reviewed an array of literature which dates between 1983 and 2011. Other literature dating between 2012 and April 2014 were included in the discussion of the literature findings. A template was created as the means of reviewing each literature review. The template included information on the author and year of publication, country, dates considered in the review, the discipline and setting, design, number of studies reviewed and the main themes that emerged. These are presented in Table 2.2 and discussed in greater detail throughout this section.

A significant increase in the amount of research conducted by nurses, midwives, doctors, professions linked to medicine, chaplains/clergy, social workers and anthropologists is evident by the amount of research collated in the five identified literature reviews and other research which was identified through electronic and manual literature searches. However, critics point out that much of the research in nursing is small-scale compounded by low response rates and is mainly exploratory and descriptive in design using qualitative methods (Ross, 2006; Draper, 2011). However, qualitative research on spirituality and spiritual care in nursing/midwifery is useful as it aims to understand how individuals derive meaning from their surroundings and how their meaning may influence their behaviours. Few Randomised Controlled Trials (RCTs) were traced mostly conducted by medical research focusing on the effects of religion and faith on various health outcomes, such as Koenig, (2012). The main themes emerging from the literature are summarised in Table 2.2 and are briefly discussed.

Table 2.2 Themes emerging from the analysis of the literature

Author, dates and country	Ross (2006), UK
Dates covered in review	1983 - October 2005
Discipline & setting	NURSING - Various settings
No. of articles reviews	47 empirical studies
Themes identified	5 themes were identified

RESULTS:

1. **NURSES:** 14 studies were identified which focused on perceptions / definitions, awareness and responses of nurses to patient / client spiritual / religious needs. Awareness of own spirituality influenced the care given.

2. **PATIENT / CLIENTS / CARERS**: 23 studies explored the meaning of spirituality and spiritual needs, spiritual care, spiritual coping / growth to patients, clients and carers. The spiritual dimension was found to be important to their lives.

3. **CLINICIAN AND PATIENT / CLIENT / CARER**: 5 studies were identified which focused on perspectives on the meaning of spirituality and the delivery of spiritual care.

4. **NURSE EDUCATION**: 3 papers were found which explored nurses' awareness and the preparation undertaken to meet spiritual needs. How, what, where and when spiritual care should be taught. Nursing competencies.

5. **INSTRUMENT DEVELOPMENT**: 2 studies were located. 1 study involved a measure of spiritual coping strategies and another study focused on a measure to assess nurses' perceptions of spirituality and spiritual care.

Table 2.2 Themes emerging from the analysis of the literature (cont.)

Author, dates and country	Pike (2011), UK
Dates covered in review	2006 - April 2010
Discipline & setting	Nursing - Adult nursing
No. of articles reviews	11 research studies, 14 literature reviews, 20 opinion articles
Themes identified	4 themes were identified

RESULTS:

1. **CONCEPT CLARIFICATION:** Little agreement on the definition and application of spirituality and spiritual care when it comes to practice.

2. **RELIGION AND SPIRITUALITY**: Concepts used interchangeably, yet both concepts are separate as the nurse provides spiritual care in the absence of a belief system.

3. **NURSE EDUCATION**: Overwhelming need for students to receive some instruction what constitutes spirituality. Emergence of ethical issues in relation to the teaching of spirituality.

4. **SPIRITUAL CARE-GIVING**: Disciplinary role conflicts as to who should provide spiritual care. Language to express spiritual needs was lacking. Use of assessment tools and models of care proposed. Difficulty in differentiating between spiritual care giving and psychological care.

Table 2.2 Themes emerging from the analysis of the literature (cont.)

Author, dates and country	Holloway *et al*., (2011), UK
Dates covered in review	2000 – 2010
Discipline & setting	Nursing, social work, chaplaincy, end-of-life spiritual care
No. of articles reviews	248 [113 empirical studies] commentary, policy / strategy documents, books, guidance documents. case study, webpage]
Themes identified	5 themes were identified

RESULTS:

1. **DISCIPLINARY AND PROFESSIONAL CONTEXTS**: Nursing has nurtured interest in contemporary spirituality and implications for spiritual care. However, it is having to respond to criticism regarding conceptual confusion. Chaplaincy has broadened its remit in response to increasing secular work environments. The field of social work remains cautious as it is concerned to distinguish psychosocial from spiritual care, however it has addressed cultural issues.

2. **CONCEPTS AND DEFINITIONS:** Debate continues over defining and exploring the concept of spirituality and its relationship with religion.

3. **SPIRITUAL ASSESSMENT**: A large body of material was identified which was concerned with assessing spiritual needs, including spiritual distress although there is a lot of controversy with regards to efficacy and appropriate spiritual care. There is general agreement that identifying and responding to spiritual needs is the responsibility of every worker. There is a growing interest in competency models of assessment.

4. **SPIRITUAL INTERVENTIONS**: Rather a smaller body of literature on spiritual care interventions was identified. These usually refer to integrated models of care which spiritual care embedded in the care model or specific spiritual care model. There is little literature on the evaluation of these models in practice.

5. **EDUCATION AND TRAINING**: There is evidence of the need for education and training in all aspects of spiritual care.

Table 2.2 Themes emerging from the analysis of the literature (cont.)

Author, dates and country	Cockell & McSherry (2012), UK
Dates covered in review	2006 – 2010
Discipline & setting	Nursing
No. of articles reviews	80 original research papers
Themes identified	6 themes were identified

RESULTS:

1. **NURSING EDUCATION:** SCCS effective to assess competencies in nurses. Nurses' awareness of own spirituality improves delivery of spiritual care.

2. **CARE OF HEALTHCARE PROFESSIONALS:** Recognising spiritual needs of nurses enables nurses to improve care offered to patients**.**

3. **DESCRIPTIVE AND CORRELATIONAL STUDIES**: Most research studies on spirituality, spiritual care and spiritual needs were descriptive. Correlational studies describe relationships between perception of care spirituality and care delivery.

4. **ASSESSMENT TOOLS:** Most researchers create their own tools without testing for validity or reliability which may lead to bias. Only 1 tool was tested.

5. **PALLIATIVE CARE AND ONCOLOGY**: Most research is in palliative care and oncology which may bias the research field in spiritual care. Needs to be used in other contexts if spiritual care is a useful concept.

6. **CULTURE:** Culture of patients, nurses and ward culture have an important role in the delivery of spiritual care

Table 2.2 Themes emerging from the analysis of the literature (cont.)

Author, dates and country	Kalish (2012), US
Dates covered in review	June 2010 - December 2011
Discipline & setting	Medicine, nursing, chaplaincy, evidence-based spiritual care
No. of articles reviews	Not specified
Themes identified	5 themes were identified

RESULTS:

1. **CONCEPT CLARIFICATION**: Absence of consensus in the field regarding the definition of spirituality and spiritual care.

2. **DISCIPLINARY ROLE CLARIFICATION**: A discrepancy exists between the provision of spiritual care and the theoretical commitment of practitioners to offer such care. Practitioners continue to view spiritual care as part of their role to a greater extent than they provide it. Investigation and conceptualisation of interdisciplinary roles and the provision of spiritual care is needed to optimise collaborative care.

3. **CARE-GIVERS' OWN SPIRITUALITY**: Research has indicated that explorations by care givers of their own spirituality correlate with the provision of spiritual care.

4. **EDUCATION FOR NURSES AND DOCTORS**: Inadequate education for nurses and doctors about spiritual care was identified. More knowledge is needed about how to effectively teach spiritual care.

5. **DEVELOPMENT AND EVALUATION OF ASSESSMENT TOOLS:** Developing, testing and evaluating spiritual care assessment tools with other medical populations in diverse religious, cultural and national contexts.

2.2.4 Results of reviews in nursing

This ever-growing body of research concerned with describing aspects of spirituality, spiritual care or spiritual needs has contributed a great deal to the understanding of the spiritual dimension of nursing/midwifery care. However, the majority of this research (Table 2.2) has been small-scale, using small, homogenous samples and is compounded by low response rates which may have resulted in bias and the inability to generalise the results.

Many studies focused on a specific context, particularly palliative care. Findings from a specific context of study may yield useful information, however, it is not easily transferred to other contexts or situations. After reviewing this literature and other literature pertaining to spirituality and spiritual care in nursing, the following themes emerged:

- Nurses' perceptions and response to clients' spiritual needs.
- Concept clarification and role issues.
- Clients' perceptions of the spiritual dimension of care.
- Spiritual assessment and interventions.
- Culture and spiritual care research.
- Education and training on spiritual care issues.

A brief overview of these themes follows. These will be further discussed in Part 2 and Part 3 of this literature review.

2.2.4.1 Nurses' perceptions and responses to clients' spiritual needs

Research on nurses' perceptions and awareness of spiritual needs revealed that nurses tended to focus on religious needs with only few studies reporting nurses' ability to identify and respond to non-religious spiritual needs (Ross, 2006; Holloway *et al*., 2011; Pike, 2011; Kalish, 2012). Nurses either did not respond to clients' spiritual needs at all, responded haphazardly or involved others by referring to

other professionals. The fear of getting emotionally involved with clients' problems, caused nurses to neglect spiritual care (McSherry, 2006) as nurses perceived spiritual care as an 'added extra' rather than an integral part of care (Clarke, 2013). The provision of spiritual care by nurses was determined by the ability of nurses to prioritise the spiritual dimension of care and the degree of spiritual care education (Swinton, 2001). However, throughout the literature, nurses were reported as consistently feeling unprepared to address spiritual needs, as they were often unclear of the concept of spirituality and their role in spiritual care.

2.2.4.2 Concept clarification and role issues

The literature focuses on conceptualisation and the definition of spirituality and its relationship with religiosity, embracing holistic care and cultural issues (Tanyi, 2002; Pike, 2011; Holloway *et al*., 2011; Kalish, 2012). The complexity of the concept of spirituality yielded a lack of consensus with regard to a universal definition, whereby a taxonomy of spirituality was issued, ranging from theistic to mystical spiritual components (McSherry & Cash, 2004). This lack of clarity impeded the development of a theoretical framework as a guide to effective spiritual care (Ross, 1994; Narayanasamy, 2004). The ambiguity between spiritual care and psychosocial care has rendered the model of spiritual care in nursing to be 'too large, too existential, and too inclusive to be manageable in clinical practice' (Clarke, 2009, pp.1672). However, one suggested way forward is to develop a 'thin, vague and functional understanding of what this word (spirituality) and its cognates might connote and do in the world of healthcare' (Swinton & Patterson, 2010, pp.227).

Notwithstanding the complexity of the spiritual dimension of care in the absence of an agreed definition, nurses are expected to address this aspect of care. Literature generally considers spiritual care as an integral aspect of nurses' practice, giving nurses a clear, legitimate role to diagnose those spiritual and religious needs which affect care (Baldacchino, 2009). However, in a survey involving 685 nurses, Ross (1994) discovered that nurses were inclined to interpret spiritual needs in religious terms.

These nurses referred clients to the clergy, as they did not generally understand their role in spiritual care. However, a study involving 230 nurses and 997 other healthcare participants from other disciplines identified various factors which influenced referral to clergy namely, the professional discipline, the hospital's religious affiliation and self-reported spirituality (Galek *et al*., 2007).

Whilst chaplains are the major providers of spiritual care services (NHS, Scotland, 2009), nurses also have a key role in spiritual care (Baldacchino, 2009). This is supported by a more recent and larger survey (n=4,054) of RCN members, whereby nurses felt responsible for responding to the spiritual needs of patients in liaison with chaplains, family and friends and other healthcare professionals and as such:

> *Nurses do not feel that they have a monopoly with regard to spiritual care and they are also aware of the need to liaise and collaborate with other healthcare professionals, such as chaplains, to support patients in this area* (McSherry & Jamieson, 2011, pp.1762).

The paucity of research on chaplaincy recognises chaplains as accountable professionals and collaborators with other healthcare professionals (Mowat & Swinton, 2005; Mowat & Swinton, 2007; Fitchett, 2011; King, 2012; Nolan & Holloway, 2014) to address clients' spiritual needs.

2.2.4.3 Clients' perceptions of the spiritual dimension of care

Research on clients' spiritual needs focused mainly on end-of-life or palliative care (Puchalski *et al*., 2009; Nixon & Narayanasamy, 2010; Cobb, Dowrick & Lloyd-Williams, 2012), older adults (Hodge *et al*., 2012; Erichsen & Bussing, 2013; Baldacchino, Bonello & Debattista, 2014) and renal dialysis (Tanyi *et al*., 2006; De Cassia *et al*., 2010; Saffari *et al*., 2013).

This body of research is predominantly qualitative with sample sizes of less than twenty participants. The spiritual dimension of care was found to be important to believers and non-believers (Ross, 2006; Draper, 2011). Clients' spiritual needs

consisted of finding meaning in their life and illness, through a relationship with God, spiritual practices such as prayer, maintaining connection with their family and friends (Hodge *et al*., 2012), morality, death and dying (Ross, 1997).

In the absence of religious affiliation, clients' needs were being respected by the withholding of prayers and reference to God. There was also preference for physician-assisted suicide (Smith-Stoner, 2007). Thus, acknowledging diversity in clients' spirituality is important in spiritual care, which, however, tends to make spiritual assessment more complex (Draper, 2011).

2.2.4.4 Spiritual assessment and interventions

Research in spiritual care shows an emergence of several tools designed to measure and rate quantitatively or qualitatively the client's spirituality, spiritual distress and spiritual coping (Baldacchino & Buhagiar, 2003; Taylor, 2008; Puchalski *et al*., 2009; van Leeuwen *et al*., 2009; McSherry & Ross, 2010). Some tools underwent psychometric testing, such as van Leeuwen *et al*., (2009) whilst others, for example, Taylor (2008) have not been tested. Not testing the tools which are being developed may leave the research open to bias and question the value, efficacy and appropriateness of these tools (Draper, 2012).

While there is general agreement that the assessment of spiritual needs is the responsibility of every healthcare professional, there is a growing interest in competency models which differentiate levels of engagement (Gordon & Mitchell, 2004; NHS, Scotland, 2009). Formal assessment tools are in use although Informal methods of assessment using generic questions, narratives or 'story-telling' approaches are also emerging (Puchalski et al., 2009; Holloway *et al*., 2011).

There is less evidence on spiritual care interventions designed to respond to spiritual needs. Literature identifies spiritual assessment as an integral part of the intervention, while other forms of spiritual interventions that are considered potentially helpful to the provision of spiritual care are integrated models of care

(Davidson *et al*., 2004; Clarke, 2007; Puchalski, 2007-2008). These aspects will be further discussed in Section 2.4.5.

2.2.4.5 Cultural and spiritual care research

Research in spirituality and spiritual care reflects a growing stance which mostly consists of descriptive and correlational studies. This is indicative of the current understanding of the content and the nature of research in this field.

The relational nature of spirituality and culture indicates a relevant interplay between the two variables which necessitates more in-depth research, as sensitivity to cultural or religious diversity might inhibit nurses/midwives from responding to spiritual needs (Narayanasamy, 2003; Cockell & McSherry, 2012). Researchers are exploring spirituality in different countries, both for collaborative and comparative work (Ross *et al*., 2013; Baldacchino, Bonello & Debattista, 2014). This research provides information on the similarities and differences in clients' spirituality, cultural and ideological perspectives.

2.2.4.6 Education and training on spiritual care issues

The literature reviewed by Ross (2006), Draper (2011), Pike (2011), Holloway *et al*., (2011) and Kalish (2012) over a span of thirty years demonstrates that the pivot towards the provision of spiritual care is in the education of healthcare professionals, particularly nurses/midwives who are the first point of encounter with the client.

Research by McSherry and Jamieson (2011) indicates that while nurses believed that spiritual care enhanced the quality of nursing care, they lacked the educational preparedness to meet patients' spiritual needs. Consequently, most of the literature is oriented towards the inadequate education of nurses and the overwhelming need for students and qualified staff to receive education in this aspect of care. This is discussed in more depth in Part 2 of this review.

2.2.5 Spirituality and spiritual care in midwifery

For centuries, the spiritual dimension of care has been acknowledged within midwifery in ancient religious and philosophical writings which have emphasised the powerful nature of birth in the creation of new life (Mullin, 2002). Hence, the commitment of midwives to provide spiritual care which is grounded in holistic care, is echoed and reflected in existing maternity care policies (DH, 2010; NMC, 2012).

As with other areas of healthcare, such as nursing, the concept of spirituality in midwifery is difficult to define, since it has various meanings for different people and is synonymous with religion. Existing research on the spiritual aspect of midwifery care is of a small-scale exploratory descriptive pattern which utilises qualitative methods. Some literature consists of women's birth narratives claiming that connection between childbearing and spirituality exists (Rosato *et al*., 2006; Schneider, 2012). Women reported that they regarded the birth experience to be sacred and a spiritual experience (Kitzinger, 2000a; Klassen, 2001; Gaskin, 2004; Semenic *et al*., 2004), birth as a life-changing event, a rite of passage and a move to a new social status (Hall, 2006). These findings cannot be generalised and need to be explored further.

Research on the spiritual/religious nature of labour and birth is limited (Callister & Khalif, 2010). However, a similarity is found in the definition of spirituality between nursing and midwifery. Spirituality is regarded by authors to be a broad concept which includes: meaning and purpose (Breen, Price & Lake, 2007; Lydon-lam, 2012), existential meaning (Prinds *et al*., 2014), 'transcendence of hope and dream into a real living being' (Ayers-Gould, 2000, pp.16), renewed hope and 'peace of mind that enables people to accept and live with otherwise insolvable problems' (Flandermeyer, 2008, pp.122).

For women with a religious belief, the influence of religiosity on birth suggests that birth may bring women closer to a higher being (Klassen, 2001; Baumiller, 2002; Cioffi, 2004; Semenic, Clark-Callister & Feldman, 2004). Whilst considering the

methodological limitations of this research, the positive relationship of spirituality/religiosity and childbirth indicates that the spiritual dimension of care is important to women in both uncomplicated and complicated pregnancies and birth (Carver & Ward, 2007; Jesse, Schoneboom & Blanchard, 2007; Price *et al*., 2007). This is consistent with the research, whereby a positive relationship is found between spirituality/religiosity and health (Koenig, 2012).

Similarly, the findings of a review (Hodnett *et al*., 2007) which included sixteen randomised controlled trials (RCT's) from eleven countries and involved 13,391 women, highlighted that the spiritual care which was delivered by midwives during labour was shown through continuous support and trust, the midwife's presence and active listening which appeared to be effective in birth outcomes. Research in the value of the midwife's presence which was conducted by Callister and Khalif (2010) through a secondary analysis of published and unpublished narratives of cross-cultural childbearing women found that the midwife's presence incorporates intimacy, respect, patience and creates a physical and emotional space which is conducive to birth, while maintaining professional boundaries (Wilkins, 2010; McSherry & Jamieson, 2013).

The importance of the midwife's presence is further emphasised in an update of the Cochrane review by Hodnett *et al*., (2011) involving a meta-analysis of twenty two randomised controlled trials from sixteen countries and involving over 15,000 women. This update showed that the midwife's presence and continuous support during labour resulted in a decrease in caesarean births, less use of pharmacological analgesia, fewer babies having a low Apgar score at birth and a shortened duration of labour. Women experienced a more positive birth experience which, in turn, increased the rate of successful breast feeding (Anderson, 2006). A positive experience at birth has also been correlated to higher levels of religious and spiritual resources in women, which subsequently showed reduced rates of post-natal depression (Jesse *et al*., 2005).

Research on peri-natal bereavement showed that spiritual/religious resources also enhanced a coping mechanism in women experiencing pregnancy loss (Dailey & Stuart, 2007). Although such research is small-scale, the positive relationship between spiritual /religious resources and coping is well recognised in nursing research (Koenig, 2012; Baldacchino, Bonello & Debattista, 2014).

Some research into the different organisational models of midwifery care indicate the benefits of communication and interpersonal relationships between the midwife and client (Huber & Sandall, 2006; England & Morgan, 2012), compassionate care (Hall, 2013) and companionship with women (Hunter, 2002; Walsh, 2012). The concept of companionship is cited in the nursing literature (Baldacchino, 2010) as the journey of 'being with women, not doing to women' (Fahy, 1998, pp.12). Other new research areas in midwifery include workplace spirituality such as the birthing place (Hammond *et al*., 2013) and the neonatal care environment (Caldeira & Hall, 2012).

Similar to nursing research, the lack of attention to clients' spiritual needs in midwifery has been attributed to the lack of consensus on a definition of spirituality (Hall, 2006), medicalisation of birth (Hodnett *et al*., 2002), lack of continuity of care (Hatem *et al*., 2008; Dahlberg & Aune, 2013) and the lack of midwifery education on the spiritual aspect of care (Hall & Mitchell, 2008; Hall, 2010).

Research recommends the integration of spirituality in midwifery education, incorporating the following:

- Religious, cultural practices and beliefs of women influencing birth (Hollins, 2006).
- Freedom to practise rituals significant to the woman's beliefs at home or in hospital (Gaskin, 2002; Hall & Taylor, 2004).
- Spiritual assessment (Jesse, Schoneboom & Blanchard, 2007; Hall, 2010; Lydon-Lam, 2012).

- Childbirth choices and decision-making influenced by religion (Miller & Shriver, 2012).
- Midwives' self-awareness to prevent imposing own beliefs on the birth, in order to give priority to the perceived spirituality of women (Klassen, 2001; Mitchell & Hall, 2007).

Hence, the research indicates that the lack of preparedness and competence to provide spiritual care is attributed to the lack of education on spirituality and spiritual care in nursing/midwifery educational programmes.

2.3 PART 2: Spiritual care in nursing/midwifery education

This section will analyse the research which addresses components relevant to spirituality and spiritual care education in nursing/midwifery.

2.3.1 Spiritual care in pre-registration nursing/midwifery education

The predominant theme transpiring in the available nursing/midwifery literature is that spiritual care is relevant and important but it seems to lack the systematic attention it merits in education and practice (Carson, 2011; Cockell & McSherry, 2012; Cooper *et al*., 2013), although there is evidence of systematic research into nursing students and nursing education (Draper, 2011). The inclusion of spiritual care in pre- and post-registration nursing/midwifery programmes has been affirmed for almost three decades (Waugh, 1992; Shelly & Fish, 1988).

An extensive and much quoted survey (RCN, 2010), using a mixed method research approach, explored its members' views on spirituality and spiritual care in nursing practice. Of the 4,054 respondents, which included nurses, students, healthcare assistants, midwives and academics, 79.3 per cent reported that they did not receive sufficient education and training on spirituality and spiritual care issues and they felt inadequately prepared to deal with clients' spiritual needs. Consequently, 79.8 per cent of nurses demanded its inclusion in nursing/midwifery education.

The lack of spiritual care education in pre-registration nursing/midwifery curricula may be because of barriers cited by nurses/midwives in clinical practice (Edwards *et al*., 2010; Baldacchino, 2011; Balboni *et al.*, 2014). These include: lack of knowledge, lack of time, failure by staff to be in touch with their own spirituality resulting in imposing their own spirituality in their clients' care, as well as misconceptions about the nurses' role in providing spiritual care and finally, the lack of competence which makes them avoid spiritual matters, in practice (Taylor *et al.,* 2009; Baldacchino, 2008; McSherry, 2007). Despite the interest and research in the area (Carson, 2011; Cockell & McSherry, 2012; Cooper *et al*., 2013; Callister *et al*., 2004; Wasner *et al*., 2005; Wallace *et al.*, 2008) spiritual care education needs further investigation in a co-ordinated and systematic manner characterised by research across countries.

Although nursing/midwifery educational and professional bodies have identified spiritual care as an area that merits competence at the point of registration, Lemmer (2002), after exploring 132 randomly selected baccalaureate nursing programmes in the US, claims that few faculties define how to perceive spirituality and employ sufficient knowledge to adequately develop spiritual competency.

This may be the result of discrepancy between the teaching and assessing of the complex concept of spirituality and spiritual care, ensuring competence at the point of registration and its delivery in clinical practice (Timmins & Neill (2013). Few studies identified the content of the pre- and post-registration learners' teaching on spirituality and spiritual care (Lovanio & Wallace, 2007; Hall & Mitchell, 2008; Mooney & Timmins, 2007; O'Shea *et al*., 2011; Vlasblom *et al*., 2011; Baldacchino, 2011). More rigorous research is needed to provide guidelines on how competencies in spiritual care should be achieved.

Barriers to the education of spirituality and spiritual care were also identified: The lack of formal preparation of nurse lecturers to teach spiritual care, the use of explorative methods of teaching, such as by 'trial and error' (Papadopoulos & Copp, 2005; Baldacchino, 2011) and the teaching of spirituality generated solely through academic institution initiatives who have an interest in the topic (McSherry, 2006).

These small scale studies shed light on the educational process of spirituality. However, further cross-cultural and longitudinal research is needed on a larger scale to explore nurse/midwife educators' understanding of the complexity of spirituality education, and methods of teaching, both in theory and clinical practice.

2.3.2 'Taught' vs. 'caught' spiritual care

Bradshaw (1997) argues that spirituality is 'caught' rather than 'taught' whereby, emphasis is placed on learning through role models in clients' care in clinical placements. The effectiveness of learning through role models cannot be disputed provided that knowledge, skills and attitudes necessary for spiritual care are demonstrated in clinical practice by the clinical staff who act as role models (Giske, 2012). However, research on education and educational programmes in curricula with relevance to spiritual care issues shows, that a 'taught' component in spiritual care may also have a positive impact on the learning of pre- and post-registration nursing/midwifery students (Baldacchino, 2011; Attard, Baldacchino & Camilleri, 2014).

Education may provide students with the tools to identify and strengthen their resources through direct educational and reflective programmes, which is beneficial to clients receiving spiritual care (Baldacchino, 2008; Wallace *et al*., 2008; Booth-LaForce *et al*., 2010; Burkhart & Schmidt, 2012) and to the nurse/midwife with enhanced job satisfaction (Vlasblom *et al*., 2011).

Research generated from the various studies using a mixed method and qualitative research approach which provide in-depth information about education, showed positive outcomes on spiritual knowledge and attitudes, following the introduction of a specific programme in spiritual care (Catanzaro & McMullen, 2001; Pesut, 2002; Baldacchino, 2007; Wallace *et al*., 2009; Taylor *et al*., 2009; Ross *et al*., 2013; Attard, Baldacchino & Camilleri, 2014). Therefore, Bradshaw's (1997) views of 'caught' vs. 'taught' is disputed by McSherry (2006) who argues that if spirituality is allowed to be 'caught' in practice through exposure and experience by 'role modelling' practices, there is the possibility that spiritual awareness and the development of

competence (knowledge, skills and attitudes) in spiritual care may not occur. When 'role modelling' of spiritual care practices is inappropriate or missed, addressing spiritual needs of clients may be constantly inadequate or neglected.

These views may not necessarily match the views of some nursing students, who have reported that they may rely on their own experiential understanding and intuition of spirituality and how it is applied in practice (McSherry *et al.,* 2008). Whilst considering the limitations of the existing research, these findings indicate the need for a formal integration of spiritual care pre-registration nursing/midwifery education, followed up by continuing professional development (Joyce, 2012). This may nurture nurses'/midwives' confidence and attitudes in delivering spiritual care (van Leeuwen *et al*., 2008; Giske & Cone, 2012; Cooper *et al*., 2013). Therefore, an education programme needs to include the relevant contents and methods of teaching spiritual care.

2.3.3 Curricula contents in spiritual care education

Having discussed the literature on the shortcomings in the provision of spiritual care education and the integration of spirituality and spiritual care in pre-registration nursing/midwifery education (Section 2.3.1), this section will analyse the literature pertaining to curricular contents in spiritual care education. Nurses/midwives have an interest and motivation to provide spiritual care (Timmins, 2010; McSherry & Jamieson, 2011). It is important that nurses/midwives take up this role following specific guidelines in education and clinical practice (Pesut & Sawatzky, 2006). However currently, nurses/midwives lack competencies in this area (RCN, 2011) and in the absence of clear guidance the extent to which pre-registration education prepares students for this role is unclear. Consequently, interest in spirituality and spiritual care curricular contents in nursing/midwifery is increasing, as indicated in the following literature: Lovanio and Wallace, (2007), Hall and Mitchell, (2008), Mooney and Timmins, (2007), O'Shea *et al*., (2011), Vlasblom *et al.,* (2011), Baldacchino, (2011).

Some researchers have outlined their experiences in teaching spiritual care to nursing/midwifery students (Hall & Mitchell, 2008; Mooney & Timmins, 2007). Greenstreet (1999) sets the teaching of spirituality as a broad concept encompassing the religious aspect. Fundamental to the understanding of the concept is the search for meaning of spirituality facilitated by reflective exercises on students' own spiritual status and awareness; the meaning and purpose of life events; communication and building meaningful relationships; knowledge of world religions and providing spiritual care using the nursing process framework. Puchalski, Dorff and Hendi (2004) emphasis on communication with clients is to ensure that students become competent in listening to what is important to patients that they respect their spiritual beliefs, provide compassionate care and communicate effectively with patients about their spiritual beliefs and their preferences at the end-of-life. Nurses' need for their own spiritual support must not be overlooked in such demanding situations.

These studies shed light on some of the available educational programmes in spirituality and spiritual care. However, these findings need to be interpreted with caution due to various limitations, such as: the use of a convenience sampling technique and the lack of randomised controlled trials. Few had pre-test/post-test designs (Lovanio & Wallace, 2007; O'Shea *et al*., 2011; Vlasblom *et al.,* 2011) some had descriptive exploratory designs using small homogenous samples (Baldacchino, 2011). Few studies used a creative teaching approach through the use of art encompassing spirituality in the philosophy of holistic care (Mooney & Timmins, 2007; Hall & Mitchell, 2007) and orientation towards the Judeo-Christian religion which may inhibit generalisation of results. Despite inconsistencies regarding the spiritual component within nurse/midwife education, there is agreement that nurses/midwives should receive guidance to provide spiritual care and that there is a need for it to form part of the pre-registration programme (RCN, 2010; Li-Fen, Yu-Chen & Dah-Cherng, 2012; NMC, 2010).

The absence of clear guidelines about the development of competency and its manifestation in clinical practice has been recognised as a research gap which exists

in this field and which needs to be addressed through further research (Timmins & Neill, 2013). Competencies (knowledge, skills and attitudes) have guided the educational programmes of healthcare professionals in many areas of care, including spiritual care. This is in line with the EU Tuning Project which facilitated the generation of generic and specific competencies at undergraduate and postgraduate educational cycles (EU Tuning Project, 2014). However, rigorous research is needed to develop relevant spiritual care competencies and identify effective ways of integrating them into nursing/midwifery education and practice.

2.3.4 Competency in spiritual care

Competence is defined by the NMC (2010) as:

> The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions (Nursing & Midwifery Council, 2010, pp.45).

Debate and controversy on the concept of competence in nursing/midwifery practice has existed for well over two decades, with inconsistencies and a lack of clarity over its definition (Cowan, Norman & Coopamah, 2007; Garside & Nhemachema, 2013; Smith, 2012; Attard, Baldacchino & Camilleri, 2014). The benefit of this ongoing debate is that the concept has been explored from multiple perspectives, suggesting that levels of competence are achieved over time (Smith, 2012). It is argued that consensus should be reached on a definition of competence (Cowan, Norman & Coopamah, 2007). Many authors have attempted to define competence. However, conclusions drawn from this debate is that the emphasis of any specific definition, including the concept of competence is the context in which it is applied (Garside & Nhemachema, 2013).

Development of competency in spiritual care is still in its infancy. Research is demanding a framework of competencies to equip nurses/midwives with knowledge, skills and attitudes (NMC, 2010). A competency approach in education is a means of guiding the education of clinical healthcare professionals by creating specific outcomes of learning, assessing the degree of learning in theory and

practice and constructing curricula grounded in students' and practitioners needs (Kelly, 2012; Ross *et al*., 2013). This philosophy implies that it is the choice of the competence-based approach which reflects '*the backbone for the EU Tuning Initiative*' (EU, Tuning, 2014 pp.291).

Competencies provide a benchmark against which performance may be measured (Kerry, 2001). Consequently, healthcare professional regulatory bodies, such as the Nursing and Midwifery Council (NMC, 2010), the Quality Assurance Agency (QAA, 2001), the International Council of Nurses (ICN, 2006) and the International Confederation of Midwives (ICM, 2013) have recommended the need for a competency-based approach to undergraduate education. However, whilst a competency-based approach is beneficial for learning, it may be reductionist in approach, disparate in nature and may restrict the quality of the client-caregiver relationship (Kelly, 2012).

Driven by the demands of healthcare professional regulatory bodies for a competency-based approach in pre-registration education and notwithstanding the limitations identified earlier, a literature search using CINAHL database was conducted to explore the evidence on the work on competencies in spiritual care in nursing/midwifery. Using keywords: 'competencies', 'spiritual care', 'nursing' and 'midwifery', thirty four articles were identified. The abstracts were scanned and duplicates were removed. Articles which were not written in the English language, those without an abstract, articles excluding nursing/midwifery participants or research were excluded. The remaining twenty five articles were then subjected to the eight point research quality criteria previously described (Table 2.1). Eighteen studies were deemed suitable for review. A template was developed which included information about the author, the year of publication, country, research design, sample, study focus, key findings and study limitations (Table 2.3).

2.3.5 Search findings in competencies in spiritual care

The first competency framework in spiritual care was developed in 2003 by Marie Curie Cancer Care in the UK (MCCC, 2003). Competency frameworks raised the

profile of spiritual care and enhanced the integration of holistic care within palliative care. The profile recognises that different healthcare workers operate at different spiritual care competency levels and it laid the foundations for the formulation of the *Spiritual and religious care capabilities and competences for healthcare chaplains* (NHS Education for Scotland, 2008). However, the profile lacked scientific evidence due to small sample size and service users did not participate in the study.

In the Netherlands, following an extensive literature review, van Leeuwen and Cusveller (2004) developed a spiritual care competency framework for use in pre-registration nurse education which incorporated three core domains and six sub-domains of nursing competencies. This framework underwent psychometric testing and it is now available to assess student nurses' perceived competency in spiritual care. Although the tool was tested on Christian students only, it was found to be effective when assessing pre-registration nursing students' competency in spiritual care, while revealing areas of nurses' weaknesses.

In Malta, Baldacchino (2006) investigated the spiritual care competency of nurses which confirmed two (awareness and self-handling, and the spiritual dimension of nursing) of the three domains found by van Leeuwen and Cusveller (2004). Other domains were revealed (nurses' competency in communication with patients, the interdisciplinary team and educators and safeguarding ethical issues in care). However, both frameworks (van Leeuwen & Cusveller, 2004; Baldacchino, 2006) constitute spiritual care competencies of Christian orientation.

As outlined in Chapter 1 and as shown in Table 2.3, Puchalski *et al.*, (2009), Buhruzi *et al*., (2011), Adamson, Beddoe & Davys, 2012, Riggs *et al*., (2012), Cooper *et al*., (2013), Biro, (2012), Brownhill *et al*., (2013) and Kang *et al*., (2013) tried to develop competencies in spiritual care. However, due to the methodological limitations which were addressed earlier in this chapter, the authors caution generalisation of the competencies. The development of a rigorous, validated competency framework in spiritual care is required which can then be applied to the various

contexts of nursing/midwifery in order to enhance competent, sensitive spiritual care provision. Involving service users and a wider range of participants from other healthcare disciplines will enrich the diverse perspectives of spiritual needs and specific spiritual care delivered by nurses/midwives.

Table 2.3 Overview of competencies in spiritual care

Name, date & country	**Mitchell & Gordon (2003), Scotland UK**
Design	Qualitative (Focus groups)
Sample	Marie Curie Hospice, working party (nurse managers, chaplains and nurse lecturers)
Study Focus	Development of spiritual & religious care competencies for specialist palliative care

FINDINGS AND LIMITATIONS:

AIMS: To develop a tool in order to assess the competence of hospice healthcare workers in spiritual and religious care. To identify training and development of spiritual and religious needs.

FINDINGS: The competencies are grouped into knowledge, skills and actions. Four levels of competence are identified relating to aspects of patient & family / carer level who should demonstrate: appropriate understanding of the concept of spirituality, awareness of own spirituality, recognise personal limitations, when to refer and documenting perceived needs referral and interventions.

LIMITATIONS: Although growing, competencies in palliative care with its holistic and multidisciplinary focus, is still small. Many lack scientific evidence. Sample size - small. Findings cannot be generalised. Lack of clients' and families' participation in sample.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**Gordon & Mitchell (2004), Scotland**
Design	Qualitative: Reflective seminars (pilot study)
Sample	24 hospice carers, doctors, nurses, healthcare assistants, chaplain, physiotherapist, students from different disciplines.
Study Focus	Familiarisation with MCCC competencies and assessment tool.

FINDINGS AND LIMITATIONS:

AIM: Consider implications for the delivery of the competencies within the hospice, utilise the competency document as a tool to improve practice and identify further training needs and understanding of spiritual care.

FINDINGS: competencies reflected upon were: understanding of the concept spirituality; awareness of own spirituality; recognition of personal limitations; referral, documenting needs and interventions.

LIMITATIONS: Findings may not reflect a true picture based on the sample audit tool in the competencies suggests only one aspect of how competence could be measured and too small a sample size which excludes the voice of the client.

Name, date & country	**van Leeuwen & Cusveller (2004), Netherlands**
Design	Qualitative literature review
Sample	Online Literature Invert and Picart Medline and CINAHL
Study Focus	Identifying competencies in spiritual care

FINDINGS AND LIMITATIONS:

AIM: To identify which competencies nurses need to provide spiritual care.

FINDINGS: 3 domains were identified - Awareness and use of self, spiritual dimension of nursing, assurance of quality and expertise.
Six competencies emerged from the domains:
- Nurse able to collect spiritual information from the patient.
- Nurse able to discuss with patient and team how care is provided.
- Nurse able to provide spiritual care and evaluate care.
- Nurse able to handle own values and convictions.
- Nurse able to address spirituality with patients of different cultures.
- Nurse able to contribute to quality assurance and expertise in spiritual care.

LIMITATIONS: Results pertain to specific contexts of nursing care and are not a survey of clinical practice. The practical validity of the profile remains to be tested.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**Baldacchino (2006), Malta**
Design	Mixed methods: Questionnaire (n=77), Interviews (n=14)
Sample	77 qualified nurses in acute/medical wards
Study Focus	Main nursing competencies

FINDINGS AND LIMITATIONS:

AIM: To reveal the main nursing competencies for spiritual care, which emerged from data from interviews with qualified nurses in Malta.

FINDINGS: The four main nursing competencies identified were associated with the role of the nurse as a professional and as an individual person, delivery of spiritual care by the nursing process, nurses' communication with patients, inter-disciplinary team and clinical/educational organisations and safeguarding ethical issues in care. Nurses recommended further education for nurses to abide by the nursing medical ethics in care in order to nurse patients with dignity. These competencies partially support the findings of van Leeuwen and Cusveller (2004) who identified three core domains and six core competencies from their literature review.

LIMITATIONS: The experiences of Maltese qualified nurses in the care of patients with myocardial infarction shed light on the competencies for spiritual care, however, the participants' experiences of their delivery of spiritual care were collected retrospectively in both parts of the study. Thus, total accuracy of past experiences may be limited. The poor response rate of 36% to the open-ended questionnaires in the first part of the study limits the generalisation of results. The findings apply to the Maltese culture and to other countries with a Christian religious background and may therefore lack generalisation of findings. Also, further exploration of nursing competencies is suggested involving other qualified nurses from other clinical areas, such as surgery and inter-disciplinary team members and clients.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**van Leeuwen *et al*., (2006), Netherlands**
Design	Qualitative (Focus groups interviews).
Sample	67 nurses, patients and chaplains in neurological, cardiology oncology wards
Study Focus	Nurses' role in providing spiritual care

FINDINGS AND LIMITATIONS:

AIM: To explore the role and responsibility of the nurse in providing spiritual care.

FINDINGS: Domains competencies which were identified: self-awareness of nurses; communication with patients; spiritual dimension in nursing process; quality assurance and development of expertise in spiritual care.

LIMITATIONS: Convenience sample and drop-outs from the focus groups might have biased the results and rules out an ability to generalise the results. Lack of participants in the study with an Islamic background may also present a biased representation of the true views in the Netherlands as a substantial section of the population is of Muslim faith. Another limitation is the relatively wide range of professional experience between nurses and the duration of the hospital stay of patients. This might have influenced the difference in experience with aspects of spiritual care.

Name, date & country	**Carr (2008), Canada**
Design	Qualitative phenomenological analysis of interviews
Sample	29 nurses, patients, family and chaplains in oncology and hospital administration
Study Focus	Dimensions of spiritual care

FINDINGS AND LIMITATIONS:

AIM: To reveal the meaning of spiritual nursing care.

FINDINGS: Analysis reveals that spiritual nursing care involves a complexity of social processes, of which developing caring relationships is core:
Developing caring relationships, fostering connections; expressing our X-factor, exchanging healing energy, and honouring the sacred and the transcendent.
Receptivity: Spiritual nursing care is about being there.
Humanity: Spiritual nursing care is about meeting humanity.
Competency: We cannot comfort the spirit if we cannot properly care for the body.

LIMITATIONS: Small sample size.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**van Leeuwen *et al*., (2008), The Netherlands**
Design	Quantitative quasi-experimental longitudinal observational design
Sample	97 nursing students
Study Focus	Effectiveness of an educational programme on spiritual care

FINDINGS AND LIMITATIONS:

AIM: To determine the effects of an educational programme on spiritual care competency and the factors that might influence the effects.

FINDINGS: Competencies identified in the competency profile (van Leeuwen & Cusveller, 2004) relating to: assessment and implementation of spiritual care; professionalisation and improving quality of spiritual care; personal support and counselling of patients; referral to professionals and attitudes towards the patient's spirituality and communication were measured using the spiritual care competence scale (SCCS).

In this study, experience in spiritual care and a holistic approach of nursing showed as positive predictors of certain competencies. However, a statistically significant difference was observed between the groups. Outcomes raise questions regarding the content of the education on spiritual care, the measurement of competencies and factors influencing the development of competency.

LIMITATIONS: This study contributes to the need of a debate on the aspect of spiritual care in patient care and the required competencies necessary to provide this care. This study actually highlighted the general lack of spiritual care in clinical practice and educational nursing curricula. Results of this study may be biased by the religious background (Christians) of the students involved and therefore findings cannot be generalised. Follow up research is needed to include students from other spiritual and secular background.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**Smith & Gordon (2009), Scotland, UK**
Design	Qualitative online learning and interactive learning activities focus groups
Sample	12 participants from the MCCC hospice
Study Focus	Putting the Marie Curie Cancer Care competencies in practice.

FINDINGS AND LIMITATIONS:

AIM: To integrate the Marie Curie Cancer Care (2003) spiritual and religious care competencies into practice through both online and in the classroom to explore this aspect of holistic care depth.

FINDINGS: Multi-professional focus groups, including hospice volunteers, healthcare assistants and registered nurses, were held to determine the level and content of the proposed study unit. Emerging themes shaped the content. Self-awareness, communication skills, theoretical knowledge, professional role and reflection were key features and part of the overall process to improve competency.

The features of the virtual learning environment (VLE) used were video, which facilitated discussion and direct links to key articles and documents, while interactive classroom activities built on prior learning. It was found that the majority of staff and volunteers attending the study unit demonstrated a need to enhance their skills at level 2 of the competency framework.

Evaluations from this learning event have shown the benefit of the blended approach, where classroom learning can be enhanced by electronic features, such as video and online discussion.

LIMITATIONS: Participants were positive in relation to content and delivery methods. As a result of the success of the pilot, this short unit was eventually integrated in the national portfolio of learning events offered by Marie Curie. However, online learning is a new area in education and results are not as yet proven.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**van Leeuwen *et al*., (2009), The Netherlands**
Design	Mixed Methods Survey: Cross sectional and observational longitudinal study
Sample	197 nursing students
Study Focus	Development of a valid and reliable tool to assess nurses' competencies in providing spiritual care.

FINDINGS AND LIMITATIONS:

AIM: To develop a valid and reliable instrument, the spiritual care competence scale (SCCS), to assess nurses' competencies in providing spiritual care.

This study focused on designing and psychometric testing of a new instrument which assesses spiritual care competencies in nursing students. The instrument was based on the nursing competency profile for spiritual care that was previously described by van Leeuwen and Cusveller (2004). This competency profile distinguished three domains of spiritual care, namely awareness and self-handling, spiritual dimensions of nursing and assurance of quality and expertise and six sub-domains of nursing competencies.

FINDINGS: The spiritual care competence scale comprises six spiritual care-related nursing competencies.

1. Assessment and implementation of spiritual care. (Cronbach's α 0.82)
2. Professionalisation and improving the quality of spiritual care. (Cronbach's α 0.82)
3. Personal support and patient counselling. (Cronbach's α 0.81)
4. Referral to professionals. (Cronbach's α 0.79)
5. Attitude towards the patient's spirituality. (Cronbach's α 0.56)
6. Communication. (Cronbach's α 0.71)

This study which was conducted in a nursing/student population demonstrated good homogeneity as well as valid and reliable scales for the measurement of spiritual care competencies.

LIMITATIONS: The instrument was tested on Christian nursing students who do not represent the total population of nursing students. Since this study was carried out using an English version of the questionnaire for the Dutch participants, a recognised limitation was that this might have caused some linguistic issues which might have brought about some bias in the results. Clinical and life experience is generally limited among nursing students which could bias results. Other multi-disciplinary professionals, such as chaplains and other religious staff were not involved in this study and this could therefore have affected the validity and reliability of the scale.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**Puchalski *et al*., (2009), US**
Design	Qualitative Consensus conference
Sample	40 leaders from all US universities, including physicians, nurses, psychologists, social workers, chaplains, clergy and health care administrators.
Study Focus	Advance the delivery of quality spiritual care in palliative care.

FINDINGS AND LIMITATIONS:

AIM: To identify points of agreement about spirituality as it applies to healthcare and to make recommendations to advance the delivery of quality spiritual care.

FINDINGS: Five literature-based categories of spiritual care (spiritual assessment, models of care and care plans, inter-professional team training, quality improvement, and personal and professional development), were identified and provided the framework of the conference.

Spiritual care should be integral to any compassionate and patient-centred health care system, honouring the dignity of all people, screening for and treating spiritual struggle or religious struggle routinely. Spiritual care models should be interdisciplinary.

Health carers should adopt and implement structured assessment tools to facilitate documentation of needs and evaluation of outcomes of treatment.

Spiritual screening, histories and assessments should be documented in patient records e.g. charts and computerised databases, placed in a centralised location for use by all clinicians.

Other findings: Policies should be developed to facilitate networking, communication and coordination among spiritual care providers. The creation of healing environments and team spirit in the workplace.

Integration of education, training and research in spirituality in health care professions. Emphasise the importance of personal and professional development, and spiritual formation of health care providers. Consider also ethical issues and the application quality improvement strategies in spiritual care.

LIMITATIONS: Many important aspects of spiritual care delivery identified which in themselves could be limited in other countries and communities.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**Cooper, Aherne & Pereira (2010), Canada**
Design	Qualitative web-based modified Delphi study
Sample	12 leaders in provision of spiritual care to hospice palliative care
Study Focus	Competencies required by hospice palliative care providers.
FINDINGS AND LIMITATIONS: **AIM:** To provide access to high quality spiritual care of the dying and their families. **FINDINGS**: 14 major areas of responsibility, 81 major tasks, desirable characteristics of hospice palliative care professionals and broad knowledge and skills needed by these professionals. **LIMITATIONS**: Competencies were developed by leaders in hospice palliative care. This may be limiting as participation of other service provider and the patients and family may have contributed to other competencies.	
Name, date & country	**Adamson, Warfa and Bhui (2011), UK**
Design	Mixed methods structured and semi-structured questionnaires
Sample	372 nurses, doctors, occupational therapists, psychologists, social therapists and healthcare support workers, directors and senior nurse managers.
Study Focus	Cultural competence
FINDINGS AND LIMITATIONS: **AIM:** To examine staff perceptions of cultural competence (CC) and the integration of CC principles in a mental healthcare organisation. **FINDINGS:** Clinical staff was engaged in culturally competent activities and there seems to be a growing awareness of cultural competence amongst staff, in general. However, strategic plans and procedures that promote cultural competence tended to not be well communicated to all staff. Further work is needed to embed cultural competence principles and practices at all levels of the organisation. **LIMITATIONS**: Potential biases to the generalisation of the findings include the use of selective sampling; the local focus of the study and the limited response rate to the study questionnaire. The use of a US tool to a UK study questions the validity of the tool.	

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**Riggs *et al*., (2012), Australia**
Design	Qualitative focus groups interviews
Sample	87 mothers
Study Focus	Cultural competence towards refugee families

FINDINGS AND LIMITATIONS:

AIM: To explore experiences of using maternal and child health services (MCH), from the perspective of families from refugee backgrounds and service providers.

FINDINGS: Four themes were identified: Facilitating access to MCH services; promoting continued engagement with the MCH service; language challenges; and what is working well and could be done better. A systems-oriented, culturally competent approach to service provision would improve the service utilisation experience for parents and providers.

LIMITATIONS: Potential biases to generalisation of findings due to language and cultural diversity.

Name, date & country	**Polzer-Casarez & Engebretson (2012), US**
Design	Qualitative discourse analysis
Sample	Healthcare providers
Study Focus	Ethical issues on spirituality and religion in clinical practice

FINDINGS AND LIMITATIONS:

AIM: To analyse the scholarly discourse on the ethical issues of incorporating spirituality and religion into clinical practice.

FINDINGS: The discourse analysis revealed four themes: Ethical concerns of omission (not offering holistic care); ethical concerns of commission (coercion and overstepping one's competence in offering spiritual care); conditions under which health providers prefer to offer spiritual care (if the patient requests spiritual care); and strategies to integrate spiritual care (such as listening and remaining neutral and sensitive to spiritual issues).

LIMITATIONS: Ethical issues are very sensitive to cultural differences and therefore may not be applied universally.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**Biro (2012), Canada**
Design	Qualitative
Sample	Nursing research, reports from various countries
Study Focus	Good nursing and spiritual care

FINDINGS AND LIMITATIONS:

Aim: To note similarities and differences in the literature on nursing and spiritual care.

FINDINGS: A nurse's spirituality and nurse/patient relationship are integral to spiritual care and good nursing. There are many commonalities between nursing and spiritual care. Personal attributes of the nurse are described in similar terms in research on spiritual care and nursing. Professional attributes common to good nursing and spiritual care are the nurse/patient relationship, assessment skills and communication skills.

LIMITATIONS: Good nursing through spiritual care is facilitated by personal spirituality, training in spiritual care and a culture that implements changes supportive of spiritual care. Further research is needed to address limitations in the scope of literature.

Name, date & country	**Brownhill *et al*., (2013), Australia**
Design	Qualitative semi-structured interviews
Sample	10 community nurses providing bereavement care home visits
Study Focus	Competencies in bereavement care

FINDINGS AND LIMITATIONS:

AIM: To conduct in-depth examination of an existing data set generated from semi-structured interviews of ten community nurses providing follow-up bereavement care home visits within the region of Sydney, Australia.

FINDINGS: A decision-making model was generated which highlights an interaction between 'the relationship', 'the circumstances' (surrounding the bereavement), 'the psychosocial variant', 'the mix of nurses', 'the workload', and 'the support' available for the bereaved and for community nurses, and elements of 'the visit'. The decision model has the potential to inform community nurses in their support of informal carers, to promote reflective practice and professional accountability, ensuring continuing competence in bereavement care.

LIMITATIONS: Small sample size. Findings cannot be generalised.

Table 2.3 Overview of competencies in spiritual care (cont.)

Name, date & country	**Behruzi *et al*., (2013), Canada**
Design	Mixed methods interviews, field notes, participant observations, self-administered questionnaire, documents and archives.
Sample	17 professionals, 157 women
Study Focus	Humanising birth care

FINDINGS AND LIMITATIONS:

AIM: To explore factors that influence the childbirth experience in hospitals particularly, the concept of humanised birth care.

FINDINGS: The greatest facilitating factors found were caring and family-centred model of care facilities to provide a pain free birth, companionship and visiting rules, dealing with the patients' spiritual and religious beliefs.

The most cited barriers were: shortage of staff, lack of sufficient communication among the professionals, the stakeholders' desire for specialisation rather than humanisation, over-estimation of medical performance, the training environment of the hospital leading to the presence of too many healthcare professionals and consequently, a lack of privacy and continuity of care.

LIMITATIONS: In spite of the various research methodology used, findings cannot be generalised as they do not reflect the practice of all obstetric wards. Room for bias as cultural diversity of women may affect her birth choices.

Name, date & country	**Kang *et al*., (2013), Korea**
Design	2 phase Delphi study
Sample	15 hospice and palliative care professionals - doctors, nurses, social workers and members of the clergy
Study Focus	Developing competencies in hospice palliative care

FINDINGS AND LIMITATIONS:

AIM: To develop a competency-based assessment to improve performance and standardise educational programmes for hospice and palliative care.

FINDINGS: 11 domains and 16 sub-domains for physicians, 11 domains for nurses, 5 domains and 15 sub-domains for social workers and 3 domains and 5 sub-domains for spiritual care providers.

LIMITATIONS: Small sample size with a response rate (70%). This limits generalisation of the findings to apply them to multi-disciplinary healthcare professionals.

2.4 PART 3: Recommended spiritual care curricular contents

The need to develop competencies as a direct guidance is recommended (NMC, 2009; NMC 2010). This section of the review scrutinises the literature referred to in Parts 1 and 2 of the literature review and uses findings as a basis for recommendations for developing competencies in spiritual care.

'The six phase content thematic analysis framework' (Braun & Clarke, 2006) was adapted for the process to identify themes and competency items in spiritual care from the literature:

1. Initially *familiarisation with the selected research articles* was achieved by reading the articles and noting down the initial themes and potential competencies in spiritual care.
2. *Generation of initial codes* by systematic manual coding of potential competencies were then collated to the relevant code.
3. *The Searching for themes* by sorting collated codes into potential levels of themes was achieved by collating main over-arching themes and sub-themes within them.
4. *The themes and competency items* were reviewed by collating competencies for each theme and the development of a thematic map, while considering the validity of each theme in relation to the identified competencies in spiritual care.
5. *Defining and naming of themes* followed, involving ongoing analysis to determine whether each theme captures the content of the competency items identified.
6. *The final stage involved reporting the identified themes/domains and competency items* as they emerged from Part 1 and 2 of the review. Seven domains were identified and a discussion of these domains follows. The competency items collated under these domains are presented in Chapter 5 Table 5.1.

The domains in spiritual care include:

1. Body of knowledge in spiritual care (Section 2.4.1)
2. Self-awareness in spiritual care (Section 2.4.2)
3. Interpersonal relationships and communication (Section 2.4.3)
4. Ethical and legal issues in spiritual care (Section 2.4.4)
5. Assessment and implementation of spiritual care (Section 2.4.5)
6. Quality assurance in spiritual care (Section 2.4.6)
7. Informatics in spiritual care (Section 2.4.7)

2.4.1 Body of knowledge in spiritual care.

The following themes emerged from the literature on healthcare and spirituality. The literature defines the concept of spirituality by embracing the concept of holism, identifies the ambiguities surrounding the concept of spirituality and spiritual care, while highlighting the positive relationship between spirituality, health and well-being.

Spirituality within nursing/midwifery care originates from the philosophies of caring which embrace the concept of holism as a central core value. (Attard & Baldacchino, 2014). There is no universal definition of spirituality (McSherry, Cash & Ross, 2004; Sessanna *et al*., 2011). Spirituality may or may not include religion, depending on the world view of the individual. Spirituality and religion are sometimes perceived as separate, but they are connected entities (Swinton, 2012).

Religion involves 'beliefs, practices and rituals related to the sacred' (Koenig, 2009). Religion is often organised and practised either privately or within a community with common beliefs and practices concerning the sacred. Hence, spirituality is subjective and exists both within and outside traditional religious systems (MCCC, 2003) which complicates further its definition. Over the years, the meaning of spirituality has changed across time from culture to culture without uniformity. This has resulted in it becoming a complex concept (Pesut, 2008). In the research, it is defined in many ways (McSherry & Cash, 2004).

Some examples include: living according to one's beliefs and values (Puchalski *et al*., 2009) finding meaning and purpose in life (Burkhart & Schmidt, 2013), connection to a higher power (Murray & Sheikh, 2008), disconnected from the rules, regulations and responsibilities associated with religion (Pesut, 2008). Thus, *'spirituality .... has no definition on which all can agree but many definitions in which all can share'* (Burke, 2007, pp.3). This may be due to culture, upbringing of individuals and life experiences (Narayanasamy, 2006).

A degree of consensus on the definition of spirituality is, however, suggested by the WHO (1948), NHS, Scotland (2009, pp.5-6) and the RCN's definition (2011). The definitions acknowledge spirituality to be important as other dimensions of the person, is inclusive for all individuals as its focus is on the whole person. Although complex, spirituality has been associated with enhanced coping with illness and crisis situations (Baldacchino, 2003), enhanced quality of life (Puchalski *et al.*, 2009), self-esteem (Ellison, Burdette & Hill, 2009), reduced anxiety and better mental health and well-being (Koenig, 2004; Koenig, 2012).

Research into the elements of spirituality and spiritual care interventions include: searching for meaning and purpose in life, meaningful relationships with others, 'being there' for the client (Carr, 2008) promoting a 'positiveness' and instilling hope, integrating beliefs and prayer, and practising faith traditions (Taylor, 2006; Burkhart, Schmidt & Hogan, 2008). It is argued that the positive impact of spirituality and spiritual care may be due to various factors which may or may not be related to religion (Swinton, 2012).

Practising religious beliefs may present challenges for healthcare professionals in clients' medical decision-making such as, the acceptance of blood or blood products by Jehovah's Witnesses; non-acceptance of antibiotics or immunisation by members of the Orthodox Reformed Church; and Faith Assembly religious group followers not seeking prenatal care resulting in high maternal and perinatal mortalities (Koenig, 2007). Consequently, health care professionals should know about their clients' religious beliefs and their relationship with health and care

(Reimer-Kirkham *et al*., 2012). Thus, education of healthcare practitioners should incorporate spirituality/religiosity and spiritual care in order to respect clients holistically.

Therefore, McSherry & Cash (2004) suggests that teaching should reflect the diversity of views and opinions requiring a broad universal approach surrounding the teaching of spirituality, without overly generalising the concept while explaining the impact of spiritual/religious beliefs and practices in decisions that may affect care. Hence, education on the world's major religions, beliefs and practices may be beneficial for students to understand and demonstrate competency in providing spiritual care to their clients.

2.4.2 Self-awareness in spiritual care

Although the literature acknowledges the need for self-awareness, there is little guidance about the definition of this competence and how it should be implemented (Pesut, 2008). In nursing/midwifery, self-awareness refers to how well nurses/midwives understand themselves, their strengths, weaknesses, beliefs and values in order to better address clients' needs with empathy, compassion and a trusting nurse-client relationship (Puchalski *et al.,* 2009). The literature on self-awareness and spirituality highlights the following:

- Nurses'/midwives' awareness of their own spirituality/religiosity.
- Importance of not imposing nurses'/midwives' beliefs on clients.
- Awareness in the provision of cultural sensitive spiritual care.
- Teaching approaches that enhance self-awareness in nurses/midwives.

The inclusion of self-awareness as an important domain in achieving competency in spiritual care is evidenced by the research findings which indicate that the nurse/midwife's own spirituality may be influential in the provision of spiritual care (Ross, 1994; van Leeuwen & Cusveller, 2004; van Leeuwen *et al.,* 2006; van Leeuwen *et al.,* 2009; Baldacchino, 2006). Consequently, research emphasises the

importance of nurses'/midwives' self-awareness of their own spirituality and professional boundaries to prevent imposition of their own beliefs in care and other nursing/midwifery intervention (McSherry & Ross, 2012).

Literature on self-awareness and spiritual care incorporates awareness of cultural issues to be acknowledged as an element of spiritual care (Riggs *et al.*, 2012; Adamson, Beddoe & Davys, 2012). This facilitates and enhances spiritual care in a cosmopolitan society as a result of emigration, immigration, social migration and asylum seeking. Therefore, nursing/midwifery students need to become culturally aware by demonstrating openness to different cultures and adapting their attitudes accordingly, whilst avoiding stereotypical assumptions (van Leeuwen & Cusveller, 2004; van Leeuwen *et al.,* 2006; van Leeuwen *et al.,* 2009; Baldacchino, 2006; Narayanasamy, 2003; Narayanasamy & White, 2005; Narayanasamy, 2006; Cockell & McSherry, 2012).

Hence, nurse/midwife education should incorporate teaching and learning that is responsive to diversity through spiritual and cultural assessment criteria, in order to respond to the clients' and their family existential questions in the quest of seeking meaning and purpose in life (Narayanasamy & White, 2005; Narayanasamy, 2006; Narayanasamy & Narayanasamy, 2012; Narayanasamy *et al*., 2012).

A reflective model for nurse education is proposed to enhance cultural responsive care (Chambers, Thompson & Narayanasamy, 2013). Critical reflection in clinical practice was identified as an important process to enhance spiritual practice (Baldacchino, 2011; Tiew, Creedy & Chan, 2013). Reflective practice allows people to become self-aware by examining and exploring their feelings, beliefs and attitudes.

Two models were developed: the Actioning Spirituality and Spiritual Care Education and Training, (ASSET) (Narayanasamy, 1999) and the Assessment, Communication, Cultural Negotiation and Compromise, Empathy and Respect, Sensitivity and Security (ACCESS) models (Narayanasamy, 2006), which guide spiritual care

education and transcultural care practice. However, for nurses/midwives to be culturally competent, they must also learn to suspend their own cultural values and traditions and to reflect on any differences that may exist between their clients' values and their own (Barber, 2008; Chambers, Thompson & Narayanasamy, 2013). They should acknowledge their own biases, enable safe expression and meaning and enhance cultural competence through interpersonal relationships and teamwork (Pesut & Reimer-Kirkham, 2010).

2.4.3 Interpersonal relationships and communication

A central theme permeating from the delivery of spiritual care is the use of interpersonal and communication skills which involve:

- The effective, reciprocal, verbal interaction between client and carer.
- The forming of nurse/midwife-client relationships which evoke feelings of companionship, compassion and compassionate care.
- The development of spiritual care skills, such as sharing, caring empathy, listening, touch and presence.

Effective communication is defined as a reciprocal interaction involving both a speaker and a communication partner (Leonard, Graham & Bonacum, 2004). However, in spiritual care, health care professionals need to be equipped with advanced communication skills to address the complexity of spiritual care of clients (Ford *et al*., 2012). Additionally, spiritual care demands relationships which evoke feelings of companionship, compassion and compassionate care (NMC, 2010; Puchalski, 2001) through the development of spiritual care skills, such as empathy and active presence (Clarke, 2013) and the establishment of a trustful and non-threatening culture (van Leeuwen & Cusveller, 2004; Baldacchino, 2006; Carr, 2008).

Impaired spiritual care skills, such as lack of humane presence, empathy and caring behaviour may impede nurses'/midwives' spiritual care and have a negative impact on clients who, in turn, may report feelings of frustration, lack of control / self-

determination and overall poor effects on their recovery (McCabe, 2004; Greenstreet, 2006; Papastavrou *et al*., 2012; Clarke, 2013). Additionally, a caring environment is needed to foster therapeutic nurse/midwife-client relationships to facilitate disclosure of innermost concerns and to meet clients' needs holistically (Mok & Chiu, 2004; Attard, Baldacchino & Camilleri, 2014).

The nurse/midwife-client relationship is the core for the provision of spiritual care in nursing/midwifery (Chism & Magnan, 2009; Biro, 2012; Scholmerich *et al.,* 2012). The interaction is described as a 'dynamic lived reality characterised by a sense of spiritual connection, which is expressed as a bond of energy' (Halldorsdottir, 2008, pp.643). The relationship facilitates the capability to address clients' emotional needs (van den Heever, Poggenpoel & Myburgh, 2013) including the negative emotions (Adams *et al*., 2012) and spiritual concerns (Chism and Magnan, 2009). This in turn will have a positive impact on clients' care (Puchalski, Dorff & Hendi, 2004; Taylor & Walker, 2012). This connection is indicated through verbal and non-verbal expressions, such as eye contact, body language, warmth of the voice, praying with the client (Taylor, 2003) and the use of humour which may enhance coping with illness (Johnson, 2007; Taney *et al.,* 2014).

Presence, touch and listening were found to be essential for a caring conversation (Clarke, 2013). In fact, 'presencing' is one of the eight competencies identified by Benner (1984), which constitutes the helping role of nurses/midwives. It is argued that nurses are often trained to believe that they are most effective when they are *doing* things for the patient (Benner, 1984). However, several nurses in Benner's (1984) study noted that the essential importance is *being* with a patient. The author summarises that 'the nurses in the study saw the value of their presence for their patients' (pp.57). Presence is defined as a caring, healing presence which involves 'being there' and 'being with' the client (Ross, 1994; Ross, 1997; Hunter, 2002; Pembroke & Pembroke, 2008; Baldacchino, 2010; Hall, 2012), grounded by the full attention of the nurse/midwife in a relationship that promotes mutual respect, honesty, dignity and hope (Pembroke & Pembroke, 2008; Zyblock, 2010).

Nurses also pointed to the importance of touch and person-to-person contact between patient and nurse (Benner, 1984). If a person's culture permits, touch in care is of important and is viewed as the first means of communicating caring, such as between a mother and her infant. Touch is a means of communicating empathy, caring, affection and concern and enhances a caring relationship. However, caution must be taken in the use of touch, due to cultural aspects which may inhibit the reception of touch (Edvardsson, Sandman & Rasmussen, 2003).

Compassionate listening is also part of active presence, which helps the carer to understand clients' lived experiences and encourages them to confide their spiritual concerns, in order to alleviate their fear and anxiety (Kimble & Bamford-Wade, 2013). These, may, however, entail consideration to the ethical and legal issues in spiritual care as discussed in the following section.

2.4.4 Ethical and legal issues in spiritual care

The complexity of spirituality and spiritual care is related to individualised care which is guided by ethical and legal principles for the safety of clients' and practitioners. The literature postulates the following:

- That healthcare providers have an ethical obligation to attend clients' needs holistically and therefore omitting spiritual care is unethical.
- That competence in spiritual care is needed to abide by the ethical and legal issues.
- That the development of guidelines in spiritual care is needed by qualified staff, educators and students to abide by the ethical and legal code of professional conduct.

The literature emphasises the importance of ethics in spiritual care (Baldacchino, 2006; Puchalski *et al.*, 2009; Polzer-Casarez & Engebretson, 2012). Thus competencies should safeguard clients' and healthcare providers' ethical and legal rights and obligations to protect clients' vulnerability and maintain professional

boundaries to guard clients' dignity, autonomy and privacy (Beauchamp & Childress, 2009).

Five ethical principles of spiritual care were outlined by Sulmasy (2012). These include: *patient-centeredness* related to clients' spiritual needs as the focus in care, *holism* which addresses the totality of needs as whole persons; *discretion* pertaining to the referral of clients to other professionals if deemed necessary; *accompaniment* or journeying with clients through their illness/experience; and *tolerance* by being respectful and attentive to the spiritual needs of people with diverse spirituality/religions. This set of ethical principles is consistent with the literature (Puchalski *et al*., 2009; Polzer-Casarez & Engebretson, 2012; Sulmasy, 2012).

Puchalski *et al*., (2009) points out the power imbalance in the relationship between the healthcare professional and clients' vulnerability which demands the role of advocacy, whereby power is used in the interest of the client. Omission of holistic care, commission or coercion in providing spiritual care situations under which healthcare professionals are likely to offer spiritual care, such as in terminal illness, inappropriate strategies in the provision of spiritual care, such as being insensitive and judgemental, have been identified as issues impinging on beneficence towards the clients (Pesut, 2006; Polzer-Casarez & Engebretson, 2012).

Other ethical concerns were identified in the literature, such as: *confidentiality* in spiritual care, and referring to the documenting of spiritual needs and interventions (Puchalski *et al*., 2009; McSherry & Ross, 2002), clients' decline to receive spiritual care from healthcare professionals (McSherry & Ross, 2002), imposition of care givers' own spiritual/religious beliefs on their clients and / or family (Milligan, 2004; Hubbell *et al*., 2006) and health carers who are unaware of their own spirituality while they are assigned to provide holistic care (McSherry, 1996). In such situations referrals to chaplains or any other appropriate specialist is essential (Jankowski, Hanzo & Flannelly, 2011; Polzer-Casarez & Engebretson, 2012).

The use of prayer as a therapeutic intervention by nurses/midwives must be considered with local policies and protocols (Taylor, 2003; Narayanasamy, 2011). Respecting religious beliefs in the clients' decision-making about their care and medical treatment complies with ethical and legal conduct as clients' autonomy is respected (Hayes, 2004).

Ethical and legal issues concerning spiritual care in clinical practice pose similar issues in the education of spiritual care. Although reaching competence in spiritual care is a professional requirement for pre-registration nursing/midwifery students (NMC, 2010) teaching and learning about spiritual issues is a challenge as spirituality and its religious connotations are 'value laden terms' and is therefore ethically sensitive (McSherry *et al*., 2008).

Nursing/midwifery students' diversity or absence of a religious affiliation, together with the right to hold their own views of spirituality and spiritual care, may pose ethical and legal implications concerning the teaching and learning of spiritual care (Lantz, 2007). In this situation, on-going support through debriefing sessions and meetings for the multi-disciplinary team have been suggested (Rogers *et al*., 2008) while the development of guidelines and policies which reflect the respective spiritual and religious perspective of clients, may help care givers abide by the ethical and legal code of conduct in the delivery of spiritual care (Kirkham, 2009).

2.4.5 Assessment, implementation and evaluation of spiritual care

There is general agreement in the literature that identifying and responding to spiritual needs is the responsibility of every health carer. In nursing, the nursing process (Ross, 1997; Narayanasamy, 1999; O'Shea *et al.*, 2011; Baldacchino, 2011) and the use of competency frameworks in spiritual care (van Leeuwen & Cusveller, 2004; Baldacchino, 2006) may be used for the assessment, planning, implementation and evaluation of spiritual care. The literature focuses on:

- Formal and informal spiritual assessment and the use of spiritual care models highlighting their strengths and limitations.

- Spiritual interventions to promote, support and develop evidence based spiritual care practice.
- Evaluation of spiritual care interventions.

Spiritual assessment of the client's spiritual needs and spiritual interventions may be guided by spiritual models of care, accompanied by a therapeutic relationship (Draper, 2011). The literature provides various models to support this, such as the bio-psychosocial-spiritual model (Sulmasy, 2002), the inpatient spiritual care implementation model (Puchalski *et al*., 2009) and The Neuman Systems Model of Care (Neuman, 1974).

The literature tends to assign spiritual assessment to the nurse's role by the use of assessment tools. However, this role is debated as literature assigns this role to the multi-disciplinary team, including the chaplains and nurses/midwives, as part of holistic care (Cavendish *et al*., 2006; Baldacchino, 2009).

Spiritual assessment may be formal or informal. Formal spiritual assessment may be conducted using four approaches: generic, qualitative, quantitative and domain-based (Holloway & Moss, 2010; Draper, 2012). The generic approach to spiritual assessment uses open ended questions to identify spiritual needs and coping resources, such as: FICA (Faith, Importance, Community, Address) (Puchalski & Romer, 2000; Puchalski, 2006) and HOPE (Sources of Hope, Organised religion, Personal spirituality, Effect of medical care) (Anandarajah & Hight, 2001). These tools recognise and acknowledge any spiritual issues the client may have and identify any resources on which to draw from.

Assessment of spiritual crisis may be referred to a chaplain who is qualified to deal with complex spiritual and religious issues (Hermann, 2006; Puchalski *et al*., 2009; Monod *et al*., 2011). The strength of generic tools is that they may be used on people of 'all faiths and none' (Swinton, 2010) and may identify both needs and coping resources (Draper, 2012). However, these may be limited in that

inappropriate assumptions may be carried out during the assessment of spiritual needs, due to the lack of an explicit definition of spirituality (Draper, 2012).

Various quantitative assessment tools are being used in clinical practice (Monod *et al*., 2011), for example, 'The Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being' (FACIT-Sp) (Peterman *et al*., 2002) which measures spiritual well-being in oncology patients, and 'The Spirituality Index of Well-Being' (SIWB) (Daaleman & Frey, 2004), related to health quality of life. However, psychometric testing of these tools may be limited to the group studied and not applicable to other groups of different cultures (McSherry & Ross, 2010; Draper, 2012).

Qualitative approaches to spiritual assessment are found to explore meaning and purpose, relationship with God, spiritual practices, religious obligations, interpersonal connection, and staff interactions (Hodge & Horvath, 2011). However, while in-depth data is obtained, this approach is time consuming and dependent on a skilled assessor, with a degree of overlap which indicates a degree of consensus on the spiritual nature of assessment (Draper, 2012).

The fourth approach to formal spiritual assessment, the domain-based approach, involves understanding the client's spirituality within domains, such as physical, emotional, family and community. Thus, spiritual assessment requires expertise in healthcare professionals to be able to interpret the data appropriately (Byrne, 2008). It is argued that spirituality and spiritual well-being may change throughout life, especially during illness. Hence, ongoing assessment is needed, supported by a close nurse/midwife-client relationship (Caroll, 2001; Puchalski *et al*., 2009; McBrien, 2010).

Spiritual assessment is challenged by various dilemmas, such as performing the assessment (Hoffert, Henshaw & Mvududu, 2007) and ethical issues in documentation, confidentiality, time of assessment and the assessors (McSherry & Ross, 2010), which may inhibit appropriate spiritual interventions which are planned according to the individual needs of the client.

Research suggests various spiritual care interventions such as: evidence-based spiritual care practice (Cavendish *et al*., 2003), connectedness with a higher power (Narayanasamy, 2004; Breen, Price & Lake, 2007; Yousefi & Abedi, 2011; Callister & Khalif, 2010; Miller & Shriver, 2012), participation in prayer (Ladd & McIntoch, 2008; Narayanasamy, 2008; Miller & Shriver, 2012; Schneider, 2012), caring attitudes such as empathy, touch and compassion (Conner & Eller, 2004; Pitkanen *et al.*, 2008). Additionally, alternative therapies, such as meditation, remedies, music and creative art are related to spiritual interventions (Puig *et al*., 2006). Therefore, evidence based spiritual care is highly beneficial (Cavendish *et al*., 2003) in order to individualise interpretations, according to the needs of the believers and non-believers (McSherry *et al.*, 2008).

Research on evaluation of spiritual interventions is limited and mainly includes the areas of addiction (Galanter, 2007), HIV/AIDS (Tarakeshwar, Hansen & Kochman, 2005) and anxiety disorders (Koszycki *et al.,* 2010). Evaluation of spiritual care interventions involves making a judgment about outcomes of the medical and healthcare interventions and needs to be done on an ongoing basis (Narayanasamy, 2004). It requires observation and communication skills, in order to identify the extent of goal achievements, set in the planning phase, and is demonstrated through clients' spiritual integrity displayed through internal peace, acceptance and restoration of meaningful behaviour (Narayanasamy, 2004).

2.4.6 Quality assurance in spiritual care

Quality assurance (measurement and evaluation of the care given) includes standards in the form of procedures and protocols aimed at assuring quality of care defined as activities aimed at achieving, promoting and maintaining a quality service (Caspari, Eriksson & Naden, 2006). This is currently measured by assessing the levels of clients' and nurses' satisfaction or the lack of it in the provision of care (Heyland *et al*., 2002; Wall *et al*., 2007; Astrow *et al*., 2007; Lazar, 2010; Vlasblom, Van der Steen & Jochemsen, 2012; Aiken, Rafferty & Sermeus, 2014a).

The complexity of spiritual care process demands competence of healthcare givers which need to be audited like other types of care, such as medical care, in order to maintain safety and quality standards in spiritual care. Quality assurance implies expertise in helping to develop spiritual care at the institutional level (Pesut, 2008). The desire for clinical excellence and accountability (NICE, 2004) in the form of clinical governance and evidence-based practice has yielded auditing of nursing/ midwifery care to raise standards, reduce risks to clients and enhance accountability by health professionals.

However, in the literature, although spiritual care is complex and integral to holistic care, auditing is infrequent with the consequences of limited competence and quality standards in care. Thus, research recommends enhancement of the quality of delivery of spiritual care by achieving a consensus on the definition of spirituality (RCN, 2011), specifying the role of health carers in the provision of spiritual care (McSherry & Ross, 2010), integrating spirituality in nursing/midwifery programmes (Giske & Cone, 2012; Cooper *et al*., 2013; Attard, Baldacchino & Camilleri, 2014), developing competency framework as a guide to education and clinical practice of nurses/midwives (van Leeuwen & Cusveller, 2004; van Leeuwen *et al*., 2008, van Leeuwen *et al*., 2009; Baldacchino, 2006) and further research to provide evidence-based practice which fosters competence and safety in dealing with ethical issues in spiritual care (Smeets, Gribnau & van der Ven, 2011).

In an attempt to address quality assurance in spiritual care, generic competencies were developed for education (van Leeuwen & Cusveller, 2004; van Leeuwen *et al*., 2008), policy (NHS, Scotland, 2009) and clinical practice (MCCC, 2003; Puchalski *et al*., 2009). These competencies guide healthcare professionals to care for clients therapeutically, in liaison with the multi-disciplinary team (Kuuppelomaki, 2001; Stirling, 2007). Emotional labour is important in establishing therapeutic nurse/midwife-client relationships when providing spiritual care but carries the risk of 'burnout' if prolonged or intense. This is reflected in policies that facilitate coordination of emotional intelligence among spiritual care providers, allowing emotions to surface to foster self-regulation demonstrating respect for dignity and

creation of spiritual healing environments in the work place (Lundmark, 2006; Codier, Muneno & Freitas 2011; Walsh, 2012). The concept of a spiritual healing environment originates from the philosophy of Florence Nightingale (1859) which may alleviate and lessen stress, which ultimately may improve clients' outcomes (Ulrich & Zimring, 2004; Zborowsky & Kreitzer, 2008; Marberry, 2006). Also, spiritual care may enhance teamwork, with increased quality of spiritual care (Lombardo & Eyre, 2011). This spiritual healing environment may include the use of technology across the stages of delivery of spiritual care.

2.4.7 Informatics in spiritual care

The accessibility of the internet and other new technologies may support spiritual care by, for example the RCN online educational resource in spiritual care for nurses (2011). Research on the use of informatics in spiritual care is still in its infancy. Two studies were found that specifically focused on informatics in spiritual care (Burkhart & Androwich, 2009; Smith & Gordon, 2009). In these studies, informatics theory was applied to spiritual care to guide documentation and facilitate a virtual learning environment (VLE) for students and qualified staff in assessment of spiritual needs and related interventions to be implemented (Burkhart & Androwich, 2009).

New spiritual care web-based programmes are being evaluated to enrich their outcomes and to guide future evidence-based practice. These mostly include areas such as: supportive mental health services, informative websites, online self-help groups, virtual counselling services and automated therapy programmes for various types of crises situations (Wagner & Maercker, 2007) for example, dealing with perinatal death (Kersting *et al*., 2011), victims of sexual abuse (Lange & Ruwaard, 2010) and post-traumatic stress (Knaevelsrud & Maercker, 2010).

Education in spiritual care, such as the online 'pocket guide' and online resource (RCN, 2011) may enhance the feasibility of students and qualified staff learning through online forums and self-centred learning. This is supported by research which demonstrates the beneficial effects of the media and educational tools, such

as, videos and interactive formative activities (Bloomfield, Roberts & White, 2010). Digital story telling encourages service users to tell their stories and to share their personal experiences and knowledge (Christiansen, 2010). This may be a powerful learning resource for students to gain empathetic understanding, to develop effective interpersonal skills and to provide client-centred care (Mezirow, 2000). When these programmes are accompanied by reflection on practice constructive, changes in the approach to care may occur.

The development of a pilot blended learning event by Smith and Gordon (2009) sought to integrate competencies in spiritual care into practice by providing opportunities, both online and in the classroom and to explore in-depth the aspect of holistic care. The virtual learning environment (VLE) and interactive classroom activities built on prior learning yielded positive feedback on the content and teaching methods. However, these innovative teaching methods need to undergo evaluative audit and research to enhance learning.

However, the use of informatics in education and delivery of spiritual care were found to have various limitations, such as self-distancing from the emotional aspect of the caring impact on clients' care. Although online support groups and memorial websites of bereaved individuals are frequently used (Krysinska & Andriessen, 2010), these have been criticised for their quality standards. Also the lack of physical presence of the care giver may increase loneliness and reduce social interaction, potentially reducing needed social support for the bereaved (Schut *et al*., 2001).

Frustration with technical difficulties due to inadequate computer skills may render dissatisfaction with information technology and the decreased use of the programme (Moule, Ward & Lockyer, 2010). These innovative healthcare programmes demand competence in informatics in order to yield effective spiritual and nursing/midwifery education.

2.5 Summary of key points, limitations and research gaps

This three phase literature review analysed the current evidence underpinning the education of the spiritual dimension of care in nursing/midwifery.

Part 1 of the review analysed literature on 'spirituality' and 'spiritual care' in nursing/midwifery in order to identify emerging themes and pointers for direction in the education of nurses/midwives in spiritual care.

Key themes emerged from this review, namely: nurses' perceptions and response to clients' spiritual needs namely, concept clarification and role issues; clients' perceptions of the spiritual dimension of care; spiritual assessment and interventions; culture and spiritual care research; and education on spiritual care.

Key messages from the review are that:

- There is a need for consensus on a universally accepted definition of spirituality.
- Spiritual care is an integral part of the nurse/midwife's role which includes collaboration with the multi-disciplinary team, especially chaplaincy.
- Discrepancies exist between the perceived importance of spiritual care and its delivery.
- Despite being a statutory requirement, the education of nurses/midwives in spiritual care is currently inadequate and it is unclear how competency in spiritual care might be assessed.

Part 2 analysed the research addressing components in spirituality and spiritual care pre-registration education in nursing/midwifery which appears to be limited. Thus, spirituality and spiritual care are misunderstood and very often misinterpreted with the consequence of inconsistency in its delivery. This is attributed to various factors, such as:

- Limited formal preparation of lecturers who revert to teach spiritual care through trial and error.

- Lack of educators' awareness about their own spirituality which limits the delivery of spiritual care and misconceptions about their role in spiritual care.
- Absence of clear guidance In spite of interest in spirituality and spiritual care, curricular contents in nursing/midwifery are limited.
- The extent to which pre-registration education prepares students for their role in delivering spiritual care is unclear
- Absence of rigorous and validated competencies in spiritual care to guide the education of nurses/midwives.

Therefore, this study attempts to guide spiritual care education by the development of competencies in spiritual care to be achieved at the point of registration. Consequently, **Part 3** utilised the findings derived from Parts 1 and 2 of the literature review to identify the following seven domains and their respective competencies (shown in Chapter 5), guided by the adapted six phase content thematic analysis framework (Braun & Clarke, 2006). These domains include:

- **A body of knowledge in spiritual care** addressing the ambiguities in defining spirituality and spiritual care, while highlighting the positive relationship between spirituality, health and well-being.
- **Self-awareness in spiritual care** incorporating awareness of personal spirituality/religiosity, preventing imposition of one's own beliefs on clients as well as awareness of culturally sensitive spiritual care.
- **Interpersonal relationships and communication** involving effective reciprocal verbal interaction, forming of nurse/midwife-client relationships and developing spiritual care skills, such as sharing, caring and empathy.
- **Ethical and legal issues in spiritual care** postulating healthcare providers' ethical obligation to attend clients' needs holistically and the need for competence to abide by the professional code of conduct.

- **Assessment and implementation of spiritual care** encompassing formal and informal methods of spiritual assessment, development and evaluation of spiritual interventions and provision of evidence-based spiritual care.
- **Quality assurance in spiritual care** demanding the need for guidelines and quality standards in knowledge, skills and attitudes to meet clients' needs, holistically.
- **Informatics in spiritual care** incorporating informatics theory to facilitate a virtual learning environment (VLE) for students and qualified staff in the assessment and documentation of spiritual needs and related interventions. The use of new spiritual care web-based programmes may guide future evidence-based practice of spiritual care.

The overwhelming message emerging from the literature review is that education of nurses/midwives in spiritual care is not only a statutory requirement but is called for by the nurses/midwives themselves, who acknowledge the importance of this aspect of their practice. The NMC and QAA require that nurses/midwives are competent in spiritual care at the point of registration, yet it is unclear how this is to be achieved and assessed. In the absence of this knowledge, the purpose of this investigation is to develop spiritual care competencies for nurses/midwives, using a rigorous systematic research process. This was guided by the theoretical framework which is presented in Chapter 3.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 Introduction

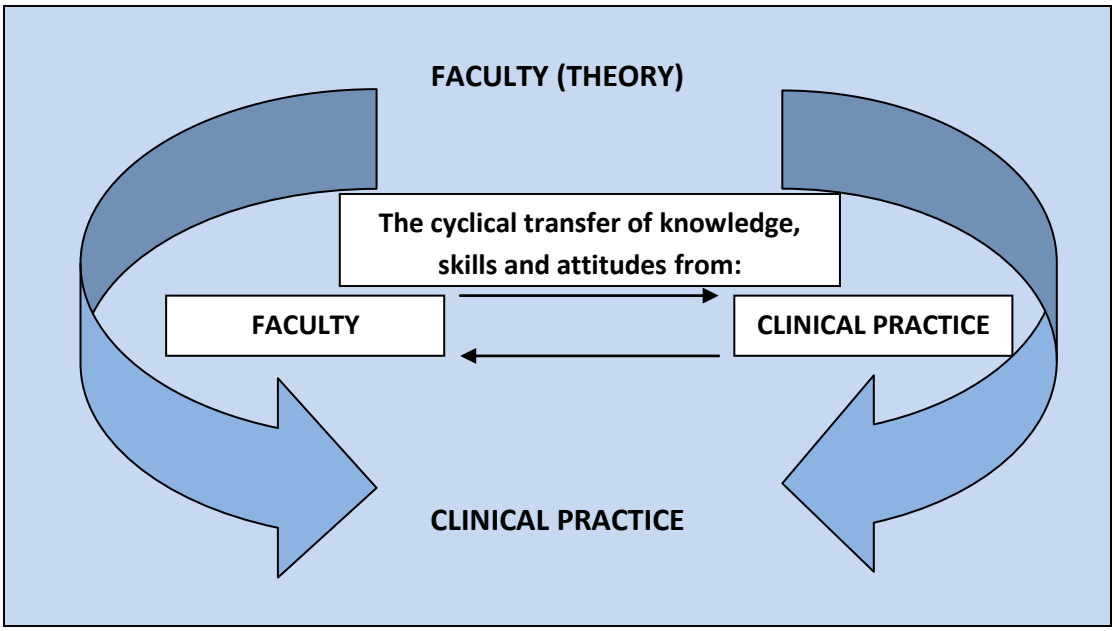
This chapter outlines the theoretical conceptual framework which will guide and assist the author in the development of competencies in spiritual care. This will, in turn, address the educational needs of nurses/midwives in providing spiritual care to clients and their families. This aspect of care has not only been recognised as a requirement by the statutory bodies (Chapter 2) but has also been acknowledged by nurses/midwives as being currently inadequate within their educational development.

No single theory supports the formulation process of a theoretical framework of competencies in spiritual care. The selection process for a relevant theoretical framework was based on the extent to which theories support the development of a competency-based approach framework, specific to the education of spiritual care, rather than a generic theory applicable solely to adult learning. The theoretical framework which was selected is based on two educational theories namely the:

- Theory of skill acquisition: From novice to expert (Benner, 1984);
- Taxonomy of educational objectives: Cognitive and affective domains (Bloom, 1956).

This theoretical framework may potentially be applicable to both nursing/midwifery education and clinical practice. Attention was given to the characteristics of the theories which may facilitate learning of knowledge in spiritual care at pre- and post-registration levels of nursing/midwifery education and clinical practice. This involves the cyclical transfer of knowledge, skills, attitudes and behaviour from faculty to clinical practice and clinical practice back to faculty and then once again to clinical practice (Figure 3.1).

Figure 3.1 Cyclical transfer of knowledge, skills and attitudes



3.2 Theoretical foundations in nursing/midwifery education

The foundations and traditional ways of education are based on the underpinning theoretical psychology namely, the schools of behavioural, cognitive and humanistic psychology. Behaviourism emphasises the importance of associations between stimulus and response. For example, in 1913, Watson an American psychologist outlined the major features of 'Classical behaviourism' which focuses on overt behaviour, disregarding inner feelings and experiences and features as:

> *Its theoretical goal is the prediction and control of behaviour. The behaviourist, in his efforts to get a unitary scheme of animal response, recognises no dividing line between man and brute (Watson, 1913, pp.158).*

Therefore, the concept of the mind is rejected as being unnecessary for explaining behaviour. Cognitive psychology rejects the reductionist views of behaviourism and emphasises internal mental processes rather than observable, measurable behaviour. In a learning situation, cognitive approaches, for example Gagne (1985), are concerned with the thinking aspects and the performance outcomes. These omit feelings, attitudes and values and are in direct contrast to humanistic approaches (Quinn & Hughes, 2007) which consider the person as having thoughts,

feelings and experiences (Rogers, 1983). The theories of Carl Rogers, Malcolm Knowles and Abraham Maslow in the humanistic approach to education were 'intuitively right' as they support the general ideas about what is 'uniquely human' in a student-lecturer relationship. These, however, lack empirical evidence (Quinn & Hughes, 2007).

Other conceptual theories were considered, for example Bandura's social learning theory (1986) based on role modelling and learning by observational methods. However, as argued in Section 2.3.2, if spiritual care is 'caught' rather than 'taught' (Bradshaw, 1997), learning about the spiritual dimension in care through role modelling is hard to achieve. These schools of thought were examined in relation to their contribution towards the theoretical framework in spiritual care in nursing/midwifery education. Only certain aspects of these theories were seen to be relevant to this study and they were therefore excluded.

More subject specific frameworks such as Gordon & Mitchell (2004) and Smith & Gordon (2009), based on the familiarisation, assessment and putting the Marie Curie Cancer Care competencies (MCCC, 2003) in practice were also rejected as these focused on death and dying which may add some bias to the research field (Cockell & McSherry, 2012). Since spirituality is a broad and useful concept, spiritual care competencies should be achieved by all health caregivers and in particular, nurses/midwives who are constantly with clients in the various contexts of health care. These competency frameworks also lack scientific evidence due to methodological limitations as outlined in Sections 1.10 and 2.3.5. Therefore, other theoretical foundations underlying a new framework of competencies that captures spirituality and spiritual care as a broad concept was deemed necessary.

3.3 Theoretical foundations of the selected theories

The two selected theories were therefore seen to address the needs of the study, namely the Theory of skill acquisition: From novice to expert (Benner, 1984) and Taxonomy of educational objectives: Cognitive and affective domains (Bloom,

1956). The criteria used in the merging of the two theories for the framework of competencies in spiritual care are presented in the following sections.

3.3.1 Theory of skill acquisition: From novice to expert (Benner, 1984)

Benner's (1984) model of skill acquisition based on Dreyfus and Dreyfus (1981) has been presented as a framework for Project 2000 course programmes. Despite the absence of objective validation of the model, it has generally been accepted uncritically by nurse educationalists. The novice to expert model identifies similarities between Benner's model and the recommended structure of the Post Registration Education and Practice (PREP) (NMC, 2011) and suggests that the model provided by Benner and Dreyfus supports the lifelong learning.

Since currently nursing/midwifery registration programmes are at least fifty percent practice-based, it is crucial to understand and apply the evidence of how students learn and develop competencies in practice (EU Tuning Project, 2014). The Benner's theoretical model is more student-oriented whereby the learner moves from one stage to the next depending on competence, not according to the collegial teaching programme although nurses/midwives are still expected to attain pre-determined stages of development by set times. The strength of Benner's model is its emphasis on clinical nursing/midwifery care, which only assumes meaning in the context of the ward environment. Isolated theoretical instruction is of limited value and it only becomes meaningful to the nurse/midwife when applied to the clinical setting. Thus, Benner promotes the concept of holistic nursing/midwifery as being more pertinent, more meaningful than task allocation and therefore applicable to spiritual care. In view of Benner's (1984) five stage model of skill acquisition: From novice to expert is adopted to guide this study in the acquisition competency in spiritual care, by nurses/midwives at point of registration.

Benner (1984) defines the term '*skill*' to not only mean psychomotor skill performance but all practical aspects of practice, including knowledge, behaviours, values and attitudes. The characteristics of performance consist of five different levels of proficiency namely, 'novice, advanced beginner, competent, proficient and

expert'. As the learners progress through these levels, they demonstrate changes using concrete experiences. Learners move from analytic, rule-based thinking to intuition. The learner's perception changes from a situation composed of equally relevant parts to a complex whole in which certain parts are more relevant than others and as a result, they move from a detached observer to an actively involved performer (Benner & Wrubel, 1989).

Competence is defined as 'the ability to perform the task with desirable outcomes under the varied circumstances of the real world' (Benner, 1982, pp. 304), and places competence in the middle of the continuum. According to Benner (1984), competent practitioners are consciously able to plan their actions. However, according to Eraut (1994), such practitioners lack the flexibility and speed. Hence, the practitioner is described as 'tolerably good but less than expert' (Eraut, 1994, pp. 160). However, when a practitioner becomes competent, there is still more to be attained. This supports the achievement of two other levels: proficiency and expertise (Benner, 1984).

Benner's (1984) theory has some limitations such as: the lack of social knowledge or structure, difficulty in testing, methodological difficulties and a bias toward the positive (English, 1993; Cash, 1995). The expert nurse is proposed as demonstrating excellence in nursing care. However, while the stages to become an expert are clearly presented, these stages are merging points on a continuum which impede measurement. Although aspects of expertise are described, expertise is not clearly defined. A feature of the expert is his/her recourse to intuition, but intuition as a concept remains ambiguous (English, 1993). **T**he strengths of this theory make it relevant to the development of the framework of competencies in spiritual care. Benner's theory is simple and captures some aspects of experts' development, namely the progression of problem solving behaviour. It emphasises holistic clinical nursing as an educational aim, the need for continuing post-registration education as a means of achieving excellence in practice. It also describes specific stages of development and does not lose sight of the value of caring for clients. It also provides insights into the complex interaction between nursing theory and practice, while emphasising the role of

emotions. Therefore, Benner, Tanner & Chesla (2009) emphasised the importance of nurse/midwife-client relationships by knowing the clients and by being emotionally involved in the**ir** intuition.

While beginners' emotions are characterised by anxiety which impedes their practice, more advanced nurses can rely on a larger repertoire of emotional responses, which are used as informative and guiding cues when it comes to attending to spiritual needs. These cues may enhance nurses' perceptual awareness: shape their clinical know-how, ethical comportment, and emotional involvement with clients and their families. Emphasis is placed on learning in context which is highly applicable to the education of spiritual care, as it counterbalances the habitual focus on theoretical instruction (English, 1993). Benner (1984) utilises the qualitative subjective approach and the quantitative objective measures, such as students' outcomes which is relevant to this study. The benefits of this theory in providing a competency-based approach to spiritual care at both pre- and post-registration levels of nursing/midwifery education, outweigh its limitations and thus it was selected to this study **(Table 3.1).**

Table 3.1 From novice to expert competency levels (Benner, 1984)

POST-REGISTRATION LEVEL		
	**LEVEL 5 EXPERT**	Characterised by a deep understanding and intuitive grasp of the total situation. Not all nurses and midwives are capable of becoming experts.
	LEVEL 4 PROFICIENT	Able to perceive situations holistically - normally found in nurses / midwives who have worked in a specific area for several years.
	**LEVEL 3 COMPETENT**	Characterised by conscious, deliberate planning, able to identify priorities and manage their work.
	LEVEL 2 ADVANCED BEGINNER	Has had sufficient prior experience of a situation to deliver marginally acceptable performance. Needs adequate support from supervisors.
	LEVEL 1 NOVICE	Rule-governed behaviour as a novice, has no experience of situation. Adherence to principles and rules.
PRE-REGISTRATION LEVEL		

Source: Adapted from: Quinn & Hughes (2007)

On completion of nursing/midwifery programmes, learners are expected to reach Level 3 of competence, as shown in Table 3.1. This is due to the fact that higher levels of proficiency (Levels 4 & 5) can only be achieved after several years of working in a specific area of clinical practice (Benner, 1984). Therefore, Levels 4 and 5 may be more appropriate to post-registration nursing/midwifery education. Descriptors for each level are based on knowledge, skills and attitudes which have been derived from the 'Taxonomy of educational objectives' (Bloom, 1956).

3.3.2. Taxonomy of educational objectives: Cognitive domain (Bloom, 1956)

A review of the literature indicates that one of the most common frameworks underpinning competency acquisition/development and/or learning objectives is that of the knowledge, attitudes, and skills approach (Bloom, 1956). While recognising its vintage, and seminal contribution, this theory to date can be found with conspicuous regularity underpinning the curricula of various inter professional disciplines such as mental health nursing, counselling psychotherapy, general nursing and midwifery (Cutcliffe & Sloan, 2014). Competencies in spiritual care as developed by educators are based on knowledge, skills and attitudes to be achieved by students on completion of an educational programme. Thus, the 'Taxonomy of educational objectives' (Bloom, 1956) is considered to be a foundational and essential element within the education community (Quinn & Hughes, 2007). These educational objectives are classified in three domains:

- **Cognitive**: Mental skills (*Knowledge*)
- **Affective**: Growth in feelings or emotional areas (*Attitude or self*)
- **Psychomotor**: Manual or physical skills (*Skills*)

Bloom's taxonomy is a systematic way of describing how a learner's performance develops from simple to complex levels in their affective, psychomotor and cognitive domains of holistic learning, starting from the simplest behaviour to the most complex. Similar to Benner's (1984) theory (the acquisition of competencies

knowledge, skills and attitudes), and together with Bloom's taxonomy (1956), guidance is provided in the formulation of competencies and educational objectives in spiritual care, arranged in hierarchical levels.

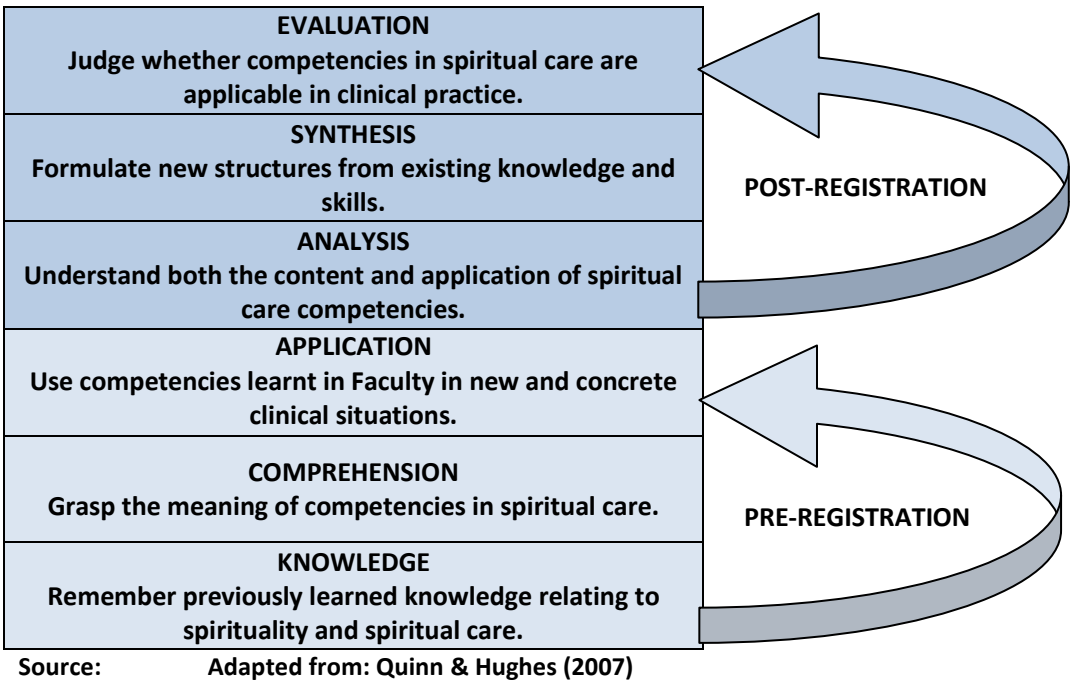
A common criticism of nursing/midwifery care is the priority given to the physical and technical skills, with less attention to the individual person, neglecting the spiritual dimension of health, well-being and holistic care (Polzer-Casarez & Engebretson, 2012; Attard, Baldacchino & Camilleri, 2014). Furthermore, secularisation, modernism and the medical model of care are reported to have shifted the caregivers' attention from the individual person to sophisticated technical equipment which focuses primarily on the physical perspective (Carr, 2008). This is a legitimate concern and a balance must be struck between being technically competent and spiritually in tune. While it is acknowledged that consistent competent physical care may contribute to both a comforted body and spirit (Carr, 2008; Clarke, 2013). For the purposes of this study, the psychomotor domain (Bloom, 1956) is excluded in this theoretical framework in an attempt to counter balance the over emphasis in nursing/midwifery curricula on physical care delivery, at the expense of other aspects of holistic care such as, the spiritual dimension (Cooper, *et al.,* 2013). Nonetheless, the psychomotor is an important domain and should be addressed in future studies.

Skills in the **cognitive domain** are oriented towards knowledge, comprehension, and critical thinking. There are six levels of objectives in Bloom's cognitive domain (Table 3.2). Level 1 is **knowledge** in which the most basic facts are defined and described. Level 2 refers to **comprehension** which incorporates understanding of the taught information which may be verbalised. Level 3 is the **application** of the concepts and principles into clinical practice. Level 4 consists of **the analysis,** breaking down and discriminating between important aspects from less important information to clarify meaning. Level 5 encompasses the **synthesis** of information combining various parts into a new whole. Finally, Level 6 comprises **evaluation** which demonstrates the ability to make coherent judgments on given information.

The cognitive domain in Bloom's taxonomy was criticised for the existence of these categories, whereby the existence of a sequential, hierarchical link was questioned. The three lowest levels namely, 'knowledge, comprehension and application', (Table 3.2) are hierarchically ordered, whilst the three higher levels are given as parallel (Anderson *et al*., 2001). Additionally, the distinction between the categories is too narrow since any given cognitive task may entail a number of processes.

In this study, the six cognitive levels in Bloom's taxonomy (1956) (Table 3.2), correspond to 'from the novice to expert' competency levels (Benner, 1984). Table 3.1 provides guidance to the respective competencies suitable to be taught at pre- and post-registration level. Levels at a higher hierarchy in the Bloom's cognitive domain (analysis, synthesis and evaluation) may be more feasible to be achieved at post-registration nursing/midwifery education, as these require a degree of educational and practical experience. Lower levels in the domain; 'knowledge, comprehension and application' may be achieved at pre-registration level, as nursing/midwifery students are embarking on new knowledge and clinical experience in their professional life (EU Tuning Project, 2014).

Table 3.2 Taxonomy of educational objectives: Cognitive domain (Bloom, 1956)



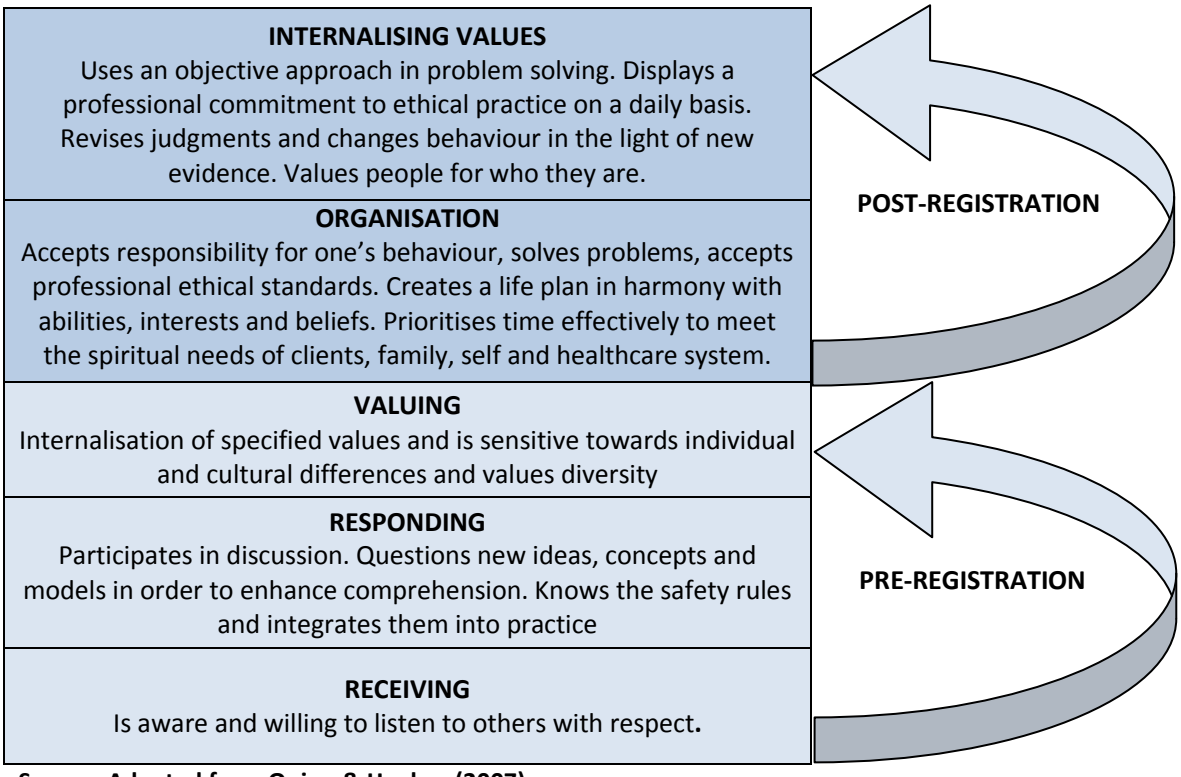
Source: Adapted from: Quinn & Hughes (2007)

3.3.3 Taxonomy of educational objectives: Affective domain (Bloom, 1956)

The affective domain involves active listening, being non-judgmental, respecting diversity and valuing individuals as persons. This requires nurses/midwives to demonstrate genuineness and unconditioned acceptance of all healthcare clients which is fundamental to spiritual care (Clarke, 2013). The affective domain (Bloom, 1956) includes the emotional aspect in clients' care, such as feelings, values, appreciation, enthusiasm, motivation and attitudes applicable to achieving competency in spiritual care (Baldacchino, 2010).

The major five categories namely, 'receiving, responding, valuing, organisation and internalising values' in Bloom's (1956) affective domain extends from the simplest to the most complex emotional behaviour and like the cognitive domain (Bloom, 1956) which was discussed in Section 3.3.2 provides guidance to the respective competencies suitable to be taught at pre- and post-registration levels (Table 3.3).

Table 3.3: Taxonomy of educational objectives: Affective domain (Bloom, 1956)



Source: Adapted from Quinn & Hughes (2007)

It is important that nursing/midwifery educators are aware of the importance of the affective domain (Bloom, 1956) when supporting the process of achieving competence in spiritual care. Evidence demonstrates that values, attitudes and behaviour integrated in this domain, affect professional practice and is related to students' ability to focus in self-reflection, to become self-aware of their own values in life by engaging, in self-monitoring, self-regulation and learning from experience (Bandura, 1986).

Self-awareness is emphasised by various models of spiritual care, such as, the ASSET model (Actioning, Spirituality and Spiritual care in Education and Training) presented by Narayanasamy (1999) and the Open Journey Theory by Giske and Cone (2012). These theories claim that self-awareness is generated through self-reflection which is fundamental when delivering effective spiritual care. This is because reflection and reflective practice focus on the students' own personal values and find meaning and purpose in life. Eventually, students may then be able to recognise cues to instil hope and support to clients and their families (Clarke, 2013).

While considering the complexity of spiritual care the two theories namely, 'Taxonomy of educational objectives: Cognitive and affective domains' (Bloom, 1956) and **'**The theory of skill acquisition: From novice to expert' (Benner, 1984) are integrated to provide a guide for this research study which focuses on the development of competencies in spiritual care to be achieved at point of registration by nursing/midwifery students at Level 3 in the European Qualification Framework for lifelong learning (2008) as shown in Table 3.4.

Table 3.4 Learning outcomes relevant to Level 3 (EQF, 2008)

	Knowledge	Skills	Competence/behaviour (Attitudes)
Level 3	To have a good knowledge of facts, principles, processes and general concepts, in a field of work or study.	To possess a range of cognitive and practical skills required to accomplish tasks which solve problems by selecting and applying basic methods, tools, materials and information.	To take responsibility for completion of tasks in work or study. To adapt own behaviour to circumstances in solving problems.

Source: European Education Framework (EQF, 2008)

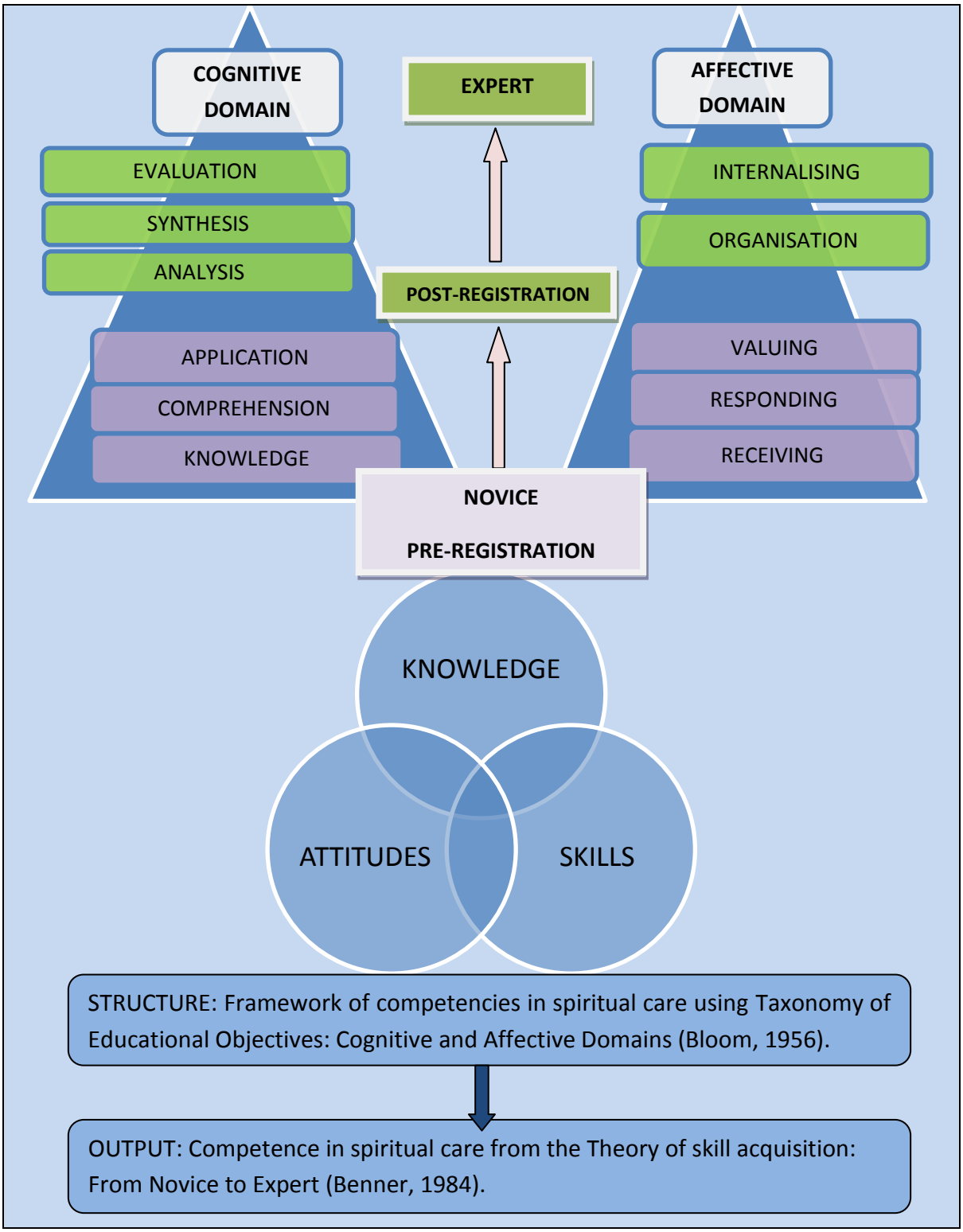
3.4 The theoretical framework for development of competencies

Figure 3.2 summarises the theoretical framework for the development of competencies in spiritual care which underpin this study. The first phase of the framework is the **structure** which incorporates the identified list of competency domains and items guided by the cognitive and affective domains (Bloom, 1956). This assists the nursing/midwifery educators by providing the content of the teaching and learning experiences.

The second phase is the **output** oriented towards the achievement of the personal competency in spiritual care. This is achieved along the continuum from novice to expert and along the continuing professional development of the nurse/midwife.

Between the **structure** and the **output,** there is the **process** phase which informs ***the how*** and ***the why*** of the educational methodology and the teaching-learning experience.

Figure 3.2 **Theoretical framework for the development of competencies**



Source: Adapted from Benner, (1984); Bloom, (1956)

3.5 Summary

The ultimate relevance of any theory is the extent to which empirical studies support its basic assumptions. Thus, the theoretical framework is composed of two theories, namely the 'Theory of skill acquisition: From novice to expert' (Benner, 1984) and the 'Taxonomy of educational objectives: Cognitive and affective domains' (Bloom, 1956) which guide the research process in the development of a framework of competencies in spiritual care.

The taxonomy of educational objectives: Cognitive and affective domains (Bloom, 1956) were integrated with the continuum of 'Novice to Expert' (Benner, 1984), to inform the structure and outcome phases of competence in spiritual care to be achieved at Level 3 (EQF, 2008) by nursing/midwifery students at pre-registration. This theoretical framework contributes towards rigour of the research process as explained in Chapter 4.

CHAPTER 4: METHODS

4.1 Introduction

This chapter presents the research aim and objectives. It provides details of how the various participants were recruited as well as giving an overview of the research design adopted to address the various aspects relevant to this three phase study (Figure 4.1).

The aim of this study is:

- To design and develop a valid and reliable framework of competencies (knowledge, skills and attitudes) in spiritual care to guide pre-registration nursing/midwifery education.

In order to achieve the aim of the study the following objectives were set to:

- Identify and formulate potential competencies in spiritual care through a review of the literature and collaboration with key stakeholders and clients.
- Validate identified competency items in spiritual care, using the modified Delphi method.
- Obtain a pragmatic view on the identified framework of competencies in spiritual care:

  - By consulting with experts in the field in order to identify which competencies should be acquired at pre- or post-registration level and which competencies are not essential at either level.
  - By identifying factors that may enhance or hinder implementation of the framework in education, research and /or clinical practice. The research questions are:

The research questions are:

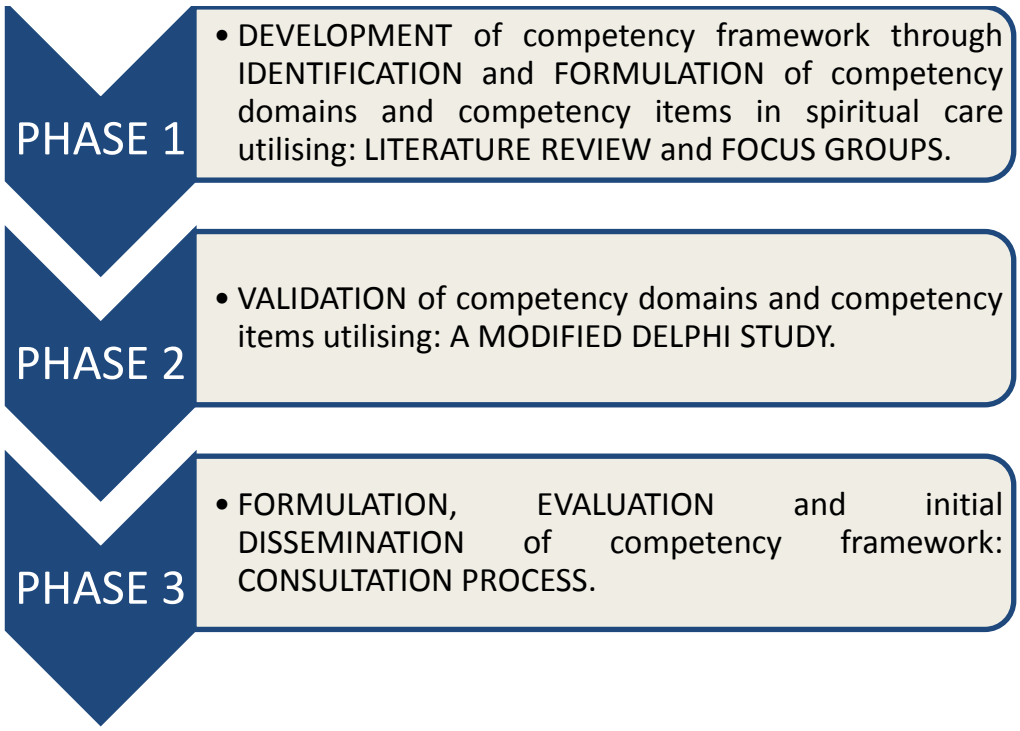
1. Which competencies are needed by nurses/midwives to meet clients' spiritual needs?
2. How can these competencies be validated?
3. Which competencies should be acquired at the point of registration by nursing/midwifery students?
4. Which factors may enhance or hinder the implementation of the competency framework in education, research and/or clinical practice?

4.2 Research design

The holistic and multiple perspectives relevant to the nature of competencies in spiritual care require flexibility of the methods utilising both the positivist (quantitative) and post-positivist (qualitative) research paradigms. The design of mixed methods is frequently used, due to the emerging notions that research methods do not carry a completely fixed epistemological and ontological assumption (Bryman, 2006).

Quantitative research has been criticised for its authoritarian and paternalistic elements, claiming objectivity and the ability to use quantitative measures to study subjective phenomena while qualitative research is committed "to seeing the world from the perspective of the participants within that world and getting close to the participant's experience" (Simmons, 1994, pp.839) and places importance on interpersonal relationships and communication. Guba and Lincoln (2005) suggest that inter-linking and re-contextualising two opposing approaches may fill in the gaps when one method cannot sufficiently answer the research question. Hence, the use of a triangulation in research by the combination of qualitative and quantitative methods and different participants increases credibility and validity of the study (Polit & Beck, 2014). Consequently, this study adopted an eclectic approach framework having four developmental phases relevant to the framework of competencies in spiritual care. A collaborative and participatory process was adopted to identify, validate, formulate, and disseminate the competency framework (Figure 4.1).

Figure 4.1 Three strategy competency framework development



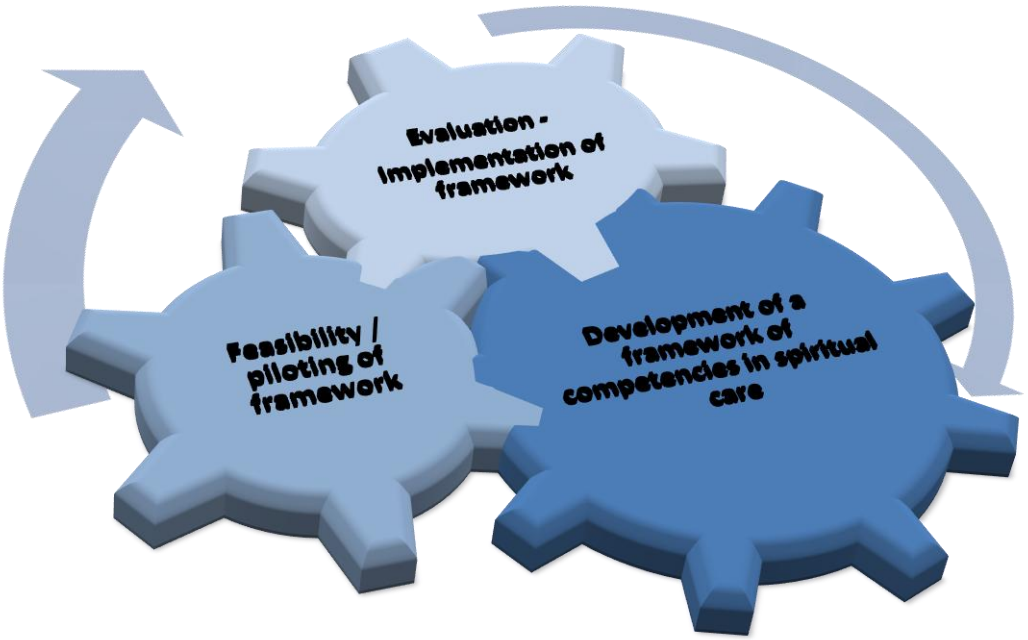
The focus of the three strategy model is primarily on the design and development of a competency framework in spiritual care. Whilst it is acknowledged that nursing/midwifery researchers are challenged to develop knowledge, followed by action research to implement findings in practice (Hallberg, 2009) however, successful implementation of the framework in education and clinical practice may be influenced by various factors such as: changing behaviours of nurses/midwives; barriers and facilitators to change and the expertise to develop strategies to implement change (Michie *et al.,* 2005). Over the last ten years, a great deal of thought has been given to research methods which investigate how to develop and determine the efficacy of 'complex interventions' (MRC, 2008). Complex interventions such as producing a framework of competencies in spiritual care to guide nurses/midwives in providing holistic care to their clients are usually described as activities that contain a number of component parts.

These components have the potential for interactions between them which, when applied to the intended target population, produce a range of possible and variable

outcomes. Recently, the recommended research approach to complexity in healthcare delivery is that complex interventions should be investigated through an intergrated process of development, feasibility/piloting, evaluation and implementation, where there is a non-linear and dynamic interchange between stages (Figure 4.2).

Whilst the focus of this study is on the developmental phase of the competency framework of spiritual care, the study also attempted to explore the feasibility for future piloting implementation and the evaluation of the competency framework in education and clinical practice by identifying the opportunities and barriers as suggested by the Medical Research Council in the complex intervention model (2008).

Figure 4.2 The complex intervention model in spiritual care



Adapted from the Medical Research Council (2008)

4.3 Overview of the study methods

The study was conducted in three phases as presented in Table 4.1.

Table 4.1 Overview of the research study

Framework of competencies in spiritual care for nurses and midwives PHASE 1: Identification of domains and competency items in spiritual care		
Objectives	**Methods**	**Data Analysis: Qualitative data**
Stage 1: Identify and formulate potential competencies in spiritual care.	Literature review in three interconnected parts.	Research studies on spirituality, spiritual care and competencies were arranged in categories. These provided themes in key aspects of spiritual care, which for the purpose of this study were systematically arranged in seven key areas (domains). Competency items in spiritual care were generated from these themes and categories.
Stage 2: Collaborate with stakeholders and clients to obtain in-depth perceptions of spiritual care, in order to elicit competencies in spiritual care.	Five focus groups with clients and stakeholders of spiritual care.	Thematic analysis of the focus groups (Krueger & Casey, 2009). Trustworthiness of data gathered.
Stage 3: 'Cleaning' and 'collapsing' of the data. Competencies generated from focus groups were compared with competencies which were determined from the literature review.		Competencies which were generated through the focus groups and which were not identified in the literature were added to the list. Formulation of the modified Delphi questionnaire.

Table 4.1 Overview of the research study (cont.)

Framework of competencies in spiritual care for nurses and midwives PHASE 2: Seek consensus of competency items in spiritual care using a modified Delphi approach		
Objective:	**Method:**	**Data analysis:** **Quantitative and qualitative data**
To seek consensus on the identified competency items in spiritual care by the expert panel.	A 2-round modified Delphi study using a panel of experts. The 'experts' included: ▪ Nursing/midwifery educators; ▪ Clinical nurses/midwives; ▪ Spiritual and religious leaders; ▪ Policy makers in nursing/midwifery; ▪ Representatives of patients; ▪ Clients of nursing/midwifery	**Testing the research tool:** **Pre-test, reliability and stability of the research tool using SPSS software, Version 21.** ***Measuring of central tendency:*** Computation of the mean, standard deviation, 95% confidence interval of the mean, % of agreement for each competency item in Rounds 1 and 2. Computation of the % increase / decrease for each item in R2 over R1. ***Consensus:*** *Determined* as having the proportion of experts rating each item within the highest region of the scale on a 7-point Likert scale (5, 6 or 7) and ***equated to be a threshold of 75% or greater.*** ***Internal consistency (homogeneity) of R1 and R2.*** ***Stability of responses in R1 and R2 using Spearman's rho correlation test.*** ***Construct validity of the competency framework using Exploratory Factor Analysis (EFA) of R2.*** ***Thematic content analysis of qualitative data*** using Braun and Clarke (2006) Thematic content analysis framework.

Table 4.1 Overview of the research study: (cont.)

<table>
<tr><th colspan="2">Framework of competencies in spiritual care for nurses and midwives:
PHASE 3: Evaluation, implementation and preparation for dissemination
of competency framework through a consultation process</th></tr>
<tr><th>Objectives</th><th>Method</th></tr>
<tr><td>Stage 1:
Obtain a pragmatic perspective of views on the identified domains and competency items in spiritual care.</td><td>A consultation process with international researchers in the field of spiritual care and modified Delphi experts with a background in education responded to an online web survey or postal questionnaire.</td></tr>
<tr><td>Stage 2:
Identify which competencies in spiritual care should essentially be acquired at PRE-registration level (i.e. at the point of registration), which competencies should essentially be left at POST-registration level (i.e. after graduation as qualified staff) and which competencies are not essential at either level.</td><td rowspan="2">Data Analysis
Quantitative data were analysed using frequencies and percentages.

A calculation of the differences in responses between the two groups of participants was also carried out.

SPSS software Version 21 was utilised.

Qualitative data was analysed using thematic content analysis framework (Braun & Clarke, 2006).</td></tr>
<tr><td>Stage3:
Identify factors that may enhance or hinder implementation of the framework in education, research and /or clinical practice.

Pave the way to the initial dissemination and implementation of the competency framework through networking with local and international experts in the field and to instigate further future research in this field.</td></tr>
</table>

4.4 PHASE 1: Literature review and focus groups

4.4.1 Introduction

Competencies in spiritual care were identified from the literature review and from the focus groups which took place between January 2010 and June 2011.

4.4.2 Stage 1: Competency item generation through literature review

Phase 1 of the research study involved the generation of competency items in spiritual care through a critical literature review on spirituality, spiritual care and competencies in spiritual care in nursing/midwifery.

4.4.3 Stage 2: Competency item generation through focus groups

The literature review identified several factors which may influence the provision of spiritual care in nursing/midwifery practice. Since the focus group method originated from a non-positivist paradigm, qualitative data are generated through an inductive approach with relevant experts in the field (Babbie & Mouton, 2001). Qualitative data were collected under the guidance of a moderator within a permissive and undirected atmosphere (Krueger & Casey, 2009).

Focus groups generate in-depth data which incorporates the experience, values and needs of stakeholders by discussing the phenomenon from the participants' point of view (Polit & Beck, 2014). The main aim of focus groups is to encourage divergent thinking and to encourage the disclosure of personal perceptions. It also offers the opportunity to explore the meanings, beliefs and cultures that may influence the feelings, attitudes and behaviours of individuals through their lived experiences. Thus, the use of focus groups was deemed necessary as it:

- Created information from different groups of participants on their views, experiences and attitudes, in relation to the topic of spirituality and spiritual care.

- Clarified the perceptions of the participant's experiences of spirituality, spiritual needs and spiritual care in times of illness, loss and other life stressors.
- Supported the information generated from the literature review.

Additional to the moderator, communication between the researcher and participants was important. Participants were encouraged to orientate their data towards the 'real-life scenarios' provided by tapping into the spiritual aspect of care by asking questions, exchanging and clarifying views and commenting on each other's experiences and opinions. Similarities and differences were identified in the discussion which indicated the complexity of spiritual care and therefore, the related competencies which nursing/midwifery students need to achieve.

4.4.3.1 Research site and access

Both local and foreign institutional permissions were obtained, namely from the former University and Glamorgan (University of South Wales) UK, University of Malta and from the directors of nursing/midwifery and hospital management in Malta to access the relevant research participants and sites (Appendices 2 & 3). Focus groups were carried out in designated rooms at the University of Malta and Malta general state hospital for the convenience of the participants who either worked in academia, or in the clinical wards and/or within the community.

4.4.3.2 Sample size and sampling method

The literature review identified various elements influencing spiritual care competence. In particular, spiritual, religious and cultural diversity may impact the provision of spiritual care. For example, the majority of the Maltese population is affiliated with the Roman Catholic religion (Gouder, 2013). The recent influx of refugees and displaced persons in Malta has brought about the need that spiritual care is orientated towards diverse religions, beliefs and cultures.

In the absence of rigorous and validated competencies to guide the education of nurses/midwives in spiritual care and which is applicable to the various contexts of

nursing/midwifery in Malta and globally, the researcher attempted to recruit study participants that represent these diversities. Consequently, the researcher also recruited international experts in spiritual care in nursing/midwifery from different geographic locations across the globe.

In Phase 1 of the study, the approach taken to select participants to the focus groups relates to the concept of 'applicability' in which subjects were selected purposively. These were identified as key informants and were selected on the basis of their knowledge and experience in spiritual care (Krueger & Casey, 2009). Thus, five groups of participants namely nurses/midwives, educators, chaplains, clients and informal carers who satisfied the criteria outline in Table 4.2 were invited to participate (Appendix 4). A signed consent letter was received from those who were interested to participate (Appendix 5). The purposive sampling technique yielded a homogenous group which facilitates sharing and understanding of participants' experiences with a free-flowing discussion among participants (Morgan, 2013).

Table 4.2 Inclusion criteria of participants in focus groups

Focus groups	Characteristics
Qualified nurses/midwives (Pilot study)	Qualified nurses working in surgical, medical and mental health settings in a state hospital in Malta. Qualified midwives working on the maternity unit.
Chaplains and spiritual leaders	Resident hospital chaplains, leaders of other religions and faiths and spiritual leaders who deal with the religious and spiritual needs of healthcare providers and clients in Malta's state hospital.
Nursing/midwifery educators	Educators of undergraduate nursing/midwifery students in Malta (i.e. pre-registration).
Nursing/midwifery clients	Persons who have received care for a medical, surgical, or mental health condition /or maternity care at Malta's state hospital.
Parents and informal carers	Parents of babies or parents who have sustained the loss of their child and informal carers of dependents with a medical, surgical, mental health problem or with life threatening conditions.

Potential nurse/midwife participants, clients and parents and informal carers of dependents were approached using the snowball technique, while nursing/midwifery educators were contacted by the head of the respective departments. Hospital chaplains and spiritual leaders were identified through a list which is to be found in the hospital wards. The resident Catholic chaplains were contacted by the Head of Chaplaincy, whilst the spiritual leaders of other faiths (Church of Scotland, Church of England, Baptist church, Coptic orthodox, Islam, Judaism, Jehovah Witnesses) were contacted individually by an e-mail invitation which was sent by the researcher.

4.4.3.3 Procedures for carrying out the focus groups

The optimum number of participants for a focus group may vary but smaller groups show greater potential (Baldacchino, Bonello, & Debattista 2014). A group of six to eight participants allows for the sharing of views and observations, whilst the moderator can control the discussion better than with larger groups (Krueger & Casey, 2009). Finch & Lewis (2003) suggest groups of six to ten participants. In this study, the number of participants ranged between seven and eleven in each group and this fostered an atmosphere that encouraged focused discussion.

Two weeks before the scheduled focus group, potential participants were invited by e-mail. The aim and objectives of the study were included in this e-mail. Participation was on a voluntary basis and participants were free to refuse or to withdraw from the study at any point, without any questions being asked. Participants were informed that discussions would last approximately one and a half hours. No financial payment or any other form of remuneration for the participants' involvement was given. Small tokens, such as scented candles, were given at the end of the session as a sign of appreciation for the time dedicated to this study.

To enhance response rate, participants were reminded of the meeting one week in advance by an e-mail, followed up by a text message on the eve of the meeting. To

address the attrition rate Morgan (2013) suggests over- recruitment by 20 per cent. Thus, a total of 55 participants were invited to participate to the five focus groups.

4.4.3.4 Data collection

Table 4.3 shows the focus group data collection schedule.

Table 4.3 Focus groups data collection

Focus Group	Participants	Date of discussion
1	Qualified nurses and midwives (Pilot study)	14th September, 2010
2	Chaplains and spiritual leaders	16th November, 2010
3	Nursing/midwifery educators	31st January, 2011
4	Nursing/midwifery clients	28th February, 2011
5	Parents and informal carers	14th March, 2011

All focus groups were scheduled during lunch breaks to enhance attendance. Some introductory snacks and refreshments were served at the beginning of the meeting which encouraged the group to mix and get to know each other (Krueger & Casey, 2009). The researcher took on the role of group facilitator and thus introduced herself and explained the purpose of the session. She introduced the members to each other and handled the roles of the facilitator and note taker within the group. The ground rules for the session were agreed by all; the discussion was facilitated to focus on spiritual care. The group dynamics were managed by the researcher in order to maintain a trustful environment which enriches the generation of in-depth data (Krueger & Casey, 2009).

One of the researcher's supervisors acted as the moderator. After the first twenty minutes, more refreshments were offered while the moderator and the researcher evaluated how the focus group was proceeding so as to enhance equality in the participation of each individual and to prevent dominance from some during the discussion.

In lieu of a lack of a clear definition of spirituality and spiritual care, each participant in the group was given a written definition of spirituality and spiritual care to provide a frame of reference. The RCN (2011) and the NHS, Scotland, (2009) definitions of spirituality and spiritual care were used (Appendix 6). Real-life case scenarios reflecting medical, surgical, mental health and maternity conditions were used to stimulate group discussions. Stories were selected, ensuring that collectively they would span various branches of nursing/midwifery specialisations, as well as various life stages (birth, infant/child, young person, adult, older person, end-of-life) and to prevent bias on the part of the researcher (Kirk *et al.,* 2013).

Ten case scenarios which were developed by McSherry (2006) and Gaskin (2004) were analysed. Six of these were selected against agreed criteria, in order to adopt a broad perspective of spiritual care and clinical diversity (Appendix 6). Each participant was given the opportunity to read the case scenario / story which was relevant to the participants' area of expertise and to answer the following questions:

- What are the client's spiritual needs? (including family members and carers).
- What does the nurse / midwife need to know, think and do to meet those needs?

Following the presentation of the scenarios, the discussion included the participants' individual experiences to build on the discussion. Initially, each participant was asked to share his/her views with the rest of the group. This gave each participant the opportunity to gain confidence to speak and hence prevent

dominance in the discussions which hinders data collection and limits reliability and validity of the data. Eventually, participants felt more confident and comfortable in the group and the discussion flowed more spontaneously. Participants were allowed to discuss their views in either Maltese or English (or both), so as to ensure that they expressed experiences and perception as confidently as possible.

Following the saturation of data collection, the focus group was terminated after approximately 70-80 minutes. An audio recording was made of each focus groups. At the end of the discussion, the researcher reiterated the purpose of the focus group, she summarised the key points of the data and thanked the group verbally and gave each participant a small gift.

The researcher's faculty counsellor was also available for debriefing services when this was deemed necessary. The researcher informed participants of her commitment to keep them informed of the research progress and the dissemination of findings. Finally, at the end of the focus group the researcher and the moderator summarised the key aspects of the discussion and planned for the transcription of the data which was to be validated by the participants. Data analysis was planned to be undertaken using qualitative content analysis (Krueger & Casey, 2009)

4.4.3.5 Pilot study of the focus group

The first focus group which took sixty minutes acted as a pilot work. The aim was to enhance the style and flow of questions and to recognise inappropriate interactions and avoid pitfalls in subsequent discussions (Krueger & Casey, 2009). After the first thirty minutes of the first focus group and while the participants were having their refreshments, the researcher and the moderator spent some time evaluating the discussions which had just taken place.

Recommendations by the moderator were taken on board by the researcher. These included allowing enough time for each and every participant to express his/her views and also to add further knowledge rather than to query what was being said

as there is no right or wrong perception when it comes to meeting clients' spiritual needs. Then, at the end of the session, a questionnaire was distributed to evaluate this pilot focus group (Appendix 7).

The pilot questionnaire evaluated various aspects of the focus group, namely the clarity of the ground rules and instructions at the beginning of the discussion, as well as during the discussion, the disposition of the researcher and moderator, group size, organisation and running of the group discussion and the choice of case scenarios. The participants had to mark their evaluation of each of these by ticking one of three boxes (Yes, No, Unsure). There was also a section in which the participants could add their comments about the adequacy of the information provided in the information sheet given and about the focus group in general.

All participants (n=9) of the pilot study completed the questionnaire which revealed very positive comments. They noted that they felt that they were encouraged to express themselves and that they enjoyed listening to the views of others. They requested more time for such discussions and also recommended regular similar group discussions since they considered them to be beneficial, both on a personal level as well as recognising that such discussions could help them improve on their client care. Since there was one participant who wished that he had had more time to express himself, the time of the other focus groups was extended to 80 minutes. Since minimal changes were required, data from the first group was included as part of the main data collection.

4.4.3.6 Data analysis

Analysis of focus groups involves bringing order to the data to uncover and illuminate meaning from the data collected. Paucity of available frameworks is surprising, considering the long history of focus group research (Doody, Slevin & Taggart, 2013). To date, few frameworks were traced to describe the qualitative analysis techniques of focus groups (Onwuegbuzie, Johnson & Collins, 2009).

Various approaches are available when it comes to the analysis of qualitative data and most researchers use a combination of approaches to strengthen the rigour of the findings (Green & Thorogood, 2004). Krueger & Casey's (2009) framework of focus group analysis was used to analyse qualitative data which was generated from the five focus groups (Appendices 8-13).

The framework provides a systematic process to assist the researcher when it comes to managing the large amounts of data generated by minimising potential bias in data analysis and the interpretation of focus groups, suggesting that analysis should be systematic, sequential, verifiable and continuous (Krueger & Casey, 2009). This pathway provides a trail of evidence and contributes towards dependability, consistency and confirmability (Lincoln & Guba, 1985).

The first step in establishing a trail of evidence is the development of a clear data analysis procedure, so that the process is documented and understood (Krueger & Casey, 2009). The process of data analysis continued during the collection of the data by carefully facilitating the discussion through the case scenarios approach. The collection of data occurred through detailed note-taking during the discussions, as well as the audio recording of each focus group. The two approaches provided a reliable method of being able to check data in case of mechanical failure or human error.

The researcher examined the notes, she transcribed the data *verbatim* herself and received validation of the accuracy of the transcripts from the participants. Feedback was received from ten participants who represented the various focus groups and confirmed that a true account of the discussions had been given. The Maltese transcripts derived from the groups of nurses/midwives, the clients and informal carers were then translated into English by professional linguists. Both the English and Maltese versions were examined by the moderator who confirmed that the original content of data. Then, familiarisation of the data was achieved by listening to the recordings, the transcripts were read repeatedly by the researcher to clearly understand the participants' perceptions.

The researcher also carefully reviewed the notes which had been drawn up during the discussions, as well as the summary notes which had been written together with the moderator after each focus group. The next stage involved coding of the data and then identifying a thematic framework. Memos or short notes were hand-written in the margin of the text in the form of descriptive short phrases and concepts which the researcher gleaned from the text. These notes are referred to as *codes.* This method facilitated analysis by allowing the researcher to think about the data in new and different ways and allowed the identification of 'threads throughout the codes' (Graneheim & Lundman, 2004) to form categories (Hsieh & Shannon, 2005).

Categories are referred to as groups of content that share common meaning (Krippendorff, 2013), representing the data derived from the majority of the focus group. Categories were identified and those which were similar (*sub-categories*) were integrated to obtain broader categories which eventually were grouped together to form *themes* as a way to link the underlying meanings.

The next stage involved sifting the data, highlighting and sorting the quotations, followed by lifting the quotations and re-arranging them under the newly developed themes. Competencies were then developed through these categories, themes and quotations. To increase internal validity and to verify the consistency of the findings, the moderator read the transcripts and notes without referring to the literature findings (Plummer-D'Amato, 2008). The findings of the analysis were compared and agreement was reached on the content and competencies elicited. Transcripts were analysed concurrently by the local supervisor and one of the supervisors from the University of South Wales who are experts in the field. These competencies were then compared to the competencies generated through the literature review. Competencies which had not been identified through the literature review were added to the list. Therefore, competencies were derived from the literature review and the focus groups. These competencies indicated the role of nursing/midwifery students in the delivery of spiritual care to be achieved at the point of registration.

4.4.3.7 Cleaning, collapsing data and the formulation of the research tool

Competency items generated from the literature review and the focus groups were listed (Appendix 14). The purpose of this stage of the study involved:

- Detecting and removing duplicate or irrelevant representation of competency items in each group.
- Carrying out a selective process of grouping items under seven distinct groups identified from the analysis of the literature in Section 2.4 which were identified as: knowledge in spiritual care, self-awareness, communication and interpersonal skills, quality assurance, assessing, implementing and evaluating spiritual care, ethical and legal issues and informatics.

Following the cleaning and grouping of the data, the list of competencies yielded too many items which needed to be collapsed to formulate a feasible modified Delphi questionnaire. Thus, the researcher re-examined the competency items exploring similarities in concepts. The complexity of the resultant spiritual care competencies rendered some items to contain several elements. Consequently, participants were asked to consider each item as a WHOLE.

4.5 PHASE 2: Modified Delphi approach

4.5.1 Introduction

The aim of Phase 2 was to evaluate the research tool developed in Phase 1 using a modified Delphi approach. This section presents the justification for the choice of a modified Delphi approach and explains its philosophical basis.

The research instrument and the recruitment process of the expert panel are outlined. The data collection procedures; data analysis, construct validity and reliability testing of the tool are also presented.

4.5.2 The consensus approach

Validation of a research tool prior to its use, can be obtained through advice and consensus from relevant experts in the field, through a Delphi study, Nominal Group Technique (NGT) and consensus conference. Consensus approaches, in particular Delphi and NGTs, have been used in a variety of healthcare settings to reach agreement and develop guidelines (Kirk, Tonkin & Skirton, 2014). The Delphi method is used to make accurate predictions of the future while the NGT is useful to prioritise issues within a group which may include dominant individuals with influential personalities (Powell, 2003). Both techniques are iterative in nature but differ in that the Delphi method is usually used for a longer term forecasting topics of a more abstract nature which may take longer to achieve consensus.

Delphi techniques were used to develop competencies in midwifery registration (Pincombe *et al.*, 2007); renal nursing (Lindberg *et al.*, 2012); emergency nursing (O'Connell & Gardner, 2012) and family practice nursing (Moaveni *et al.,* 2011). The NGT was used to revise the genetics / genomics competencies for nurse education (Kirk, Tonkin & Skirton, 2014) and to identify performance indicators in nursing and midwifery (McCance *et al.,* 2012). Additionally, mixed methods were used together to enhance the reliability of the findings such as, the use of Delphi method with NGT to identify quality standards in child and adolescent mental health (Sayal *et al.,* 2012). In this study, triangulation of the data was carried out by utilising the Delphi method approach, NGT and focus group approaches to facilitate the contribution of experts in use of a hybrid Delphi technique to resolve problems associated with the Delphi and NGTs (Landeta, Barrutia & Lertxundi, 2011).

This study required a rigorous approach to validate the generated list of competencies in spiritual care. The NGT which involves the capturing and aggregating opinions from a group of experts was an option but experts were required to physically be present in a particular place and time. It requires much prior organisational preparation in terms of setting up the venue and incurring financial expenses. NGTs may also be limited, as they lend to a single topic meeting, leading to a less creative and stimulating group process, limited time due to the

risks of group distraction which limits discussion and the full development of ideas. Conformity pressure in decision making may also prove challenging to the group leader and participants. Consequently, the Delphi technique, which is a structured process of communication between the researcher and the group of expert participants through a series of questionnaires or rounds together with controlled feedback undertaken until consensus is reached on competencies in spiritual care, was considered the most appropriate for this study.

The main advantage of the Delphi method is that there is no need for participants to meet up (Ferri *et al.,* 2005). It is a relatively inexpensive method of gaining a large number of responses and allows the involvement of participants from disparate geographical areas and has been used in international health research. Participants are generally contacted by mail or by the Internet, they are consulted repeatedly, they have the flexibility to change or withdraw their statements as they are allowed a period of 'considered thought'. The Delphi method overcomes the problem of a few individuals who dominate discussions. However, the use of rounds involves a coding system which limits anonymity in data collection. Research tends to concentrate on the consensus findings, supported by limited information on the design, inclusion criteria, sampling technique and data analysis (Hardy *et al.,* 2004).

4.5.2.1 Philosophical foundations of the Delphi method

Various definitions to the Delphi technique have been in use such as the collection of informed judgement. This method obtains the most reliable consensus of opinion of a group of experts by a series of intensive questionnaires interspersed with controlled feedback and a process of communication to deal with a complex problem (Linestone & Turoff, 1975). The process involves interaction between the researcher and a group of identified experts, usually through a series of questionnaires to gain consensus where the opinions and judgments of experts and practitioners are necessary for the development of a competency framework in spiritual care. The philosophical basis of the Delphi research approach pertains to Inquiry Systems such as the Lockean and Leibnizan 'Inquiry Systems' (Mitroff & Turoff, 1975).

The Lockean philosophy is based on the premise that truth is experiential thus the content of a system is entirely associated with its empirical content. Every complex proposition can be broken down to simple empirical observations. The validity of simple observations is obtained by agreement between human observers. The truth of the model does not rest on any theoretical considerations but uses raw data in the form of expert opinion and the validity of the resulting judgment is measured by the levels of consensus between experts (Mitroff & Turoff, 1975).

In contrast, the Leibnizian philosophy is based on the premise that truth is analytical and therefore it is based on theory. The truth of a model is based on its ability to offer a theoretical explanation for a range of general phenomena. The theoretical model is not only considered to be separate from the raw data but is considered to be prior to it (Mitroff & Turoff, 1975). The Leibnizian philosophy is often used to criticise the scientific nature of the Delphi studies.

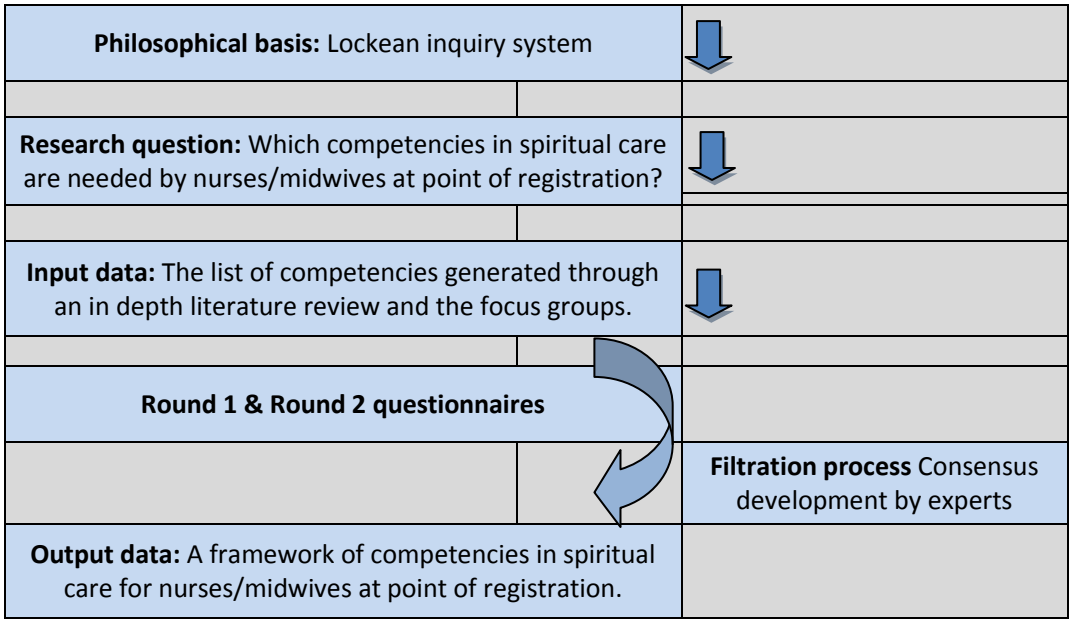
This study adopted a Lockean inquiry based on the writings of the philosopher, John Locke as it uses raw data in the form of expert opinion and the validity of the resulting judgment is measured in terms of the consensus between experts (Mitroff & Turoff, 1974). The problem of lack of competencies in spiritual care is well documented and a strong consensual position exists on the nature of this situation. This makes a consensus-oriented Delphi appropriate for forecasting a framework of competencies in spiritual care.

The Model of a Lockean inquiry system (Mitroff & Turoff, 1975), (Figure 4.3) has inputs, processes and outputs. The output of an inquiring system is knowledge. One of the most important characteristics of an inquiring system design is the inclusion of mechanisms which generate 'valid' knowledge. This scientific inquiry is generally based on the use of the scientific method to ensure that results are reliable. The inquiry system approach fosters the provision of outputs which are consistent with the philosophy, to generate reliable knowledge across time.

For the purpose of this study the Inquiry System begins with raw data consisting of a list of competencies in spiritual care which were generated through the literature

review and the focus groups. This is followed by the filtering of the raw data in order to input the collapsed data into the model. Therefore, the model in this research study evolved through a process of filtering and transforming the information through a 2-round questionnaire where experts (decision makers) had the opportunity to reconsider their judgments through controlled feedback. The validity of the results was measured by the extent of consensus reached among the experts.

Figure 4.3 The Delphi approach using the Lockean inquiry philosophy



Source: Adapted from Mitroff & Turoff, (1975)

4.5.2.2 Classification of the Delphi techniques

Keeney, Hasson & McKenna (2011) identified ten main types of the Delphi approach including classical, modified, decision, policy, real time, e-Delphi, technological, online, argument and disaggregative categories (Table 4.4).

The modified Delphi technique (McKenna, 1994) adopted in this study is similar to the conventional Delphi in terms of procedure (i.e. a series of rounds with selected experts) and intent (i.e. to predict future events and to arrive at a consensus). The major modification was made in the beginning of the process with a set of carefully

selected items drawn from various sources, including related competency profiles, synthesised reviews of the literature and focus groups.

The advantages of this modification to the Delphi is that it typically improves the initial round response rate, especially when topics are ambiguous and there is no guarantee that forecasts produced from the first round will be relevant to the research focus (Hardy *et al.,* 2004). Large amounts of information from the open-ended first round may lead to numerous subsequent rounds. This is likely to place a strain on participants which in turn, will threaten the validity and reliability of the study (Keeney, Hasson & McKenna*,* 2001).

Modification of this classical approach by giving the panel members some pre-existing information in Round 1 is gaining acceptance, especially when information is generated from the literature (Hardy *et al.,* 2004; Keeney, Hasson & McKenna*,* 2006). Consequently, this study adopted a modified Delphi approach. Strategies for minimising respondent bias included providing panellists with the opportunity to comment, using a 7-point rating scale with a 'Don't Know' option, whilst avoiding pressure to reach an agreement (Keeney, Hasson & McKenna*,* 2006).

Table 4.4 Classification of Delphi designs

Design type	Aim	Target panellists	Administration	No. of rounds	Round 1 design
Classical (Dalkey & Helmer, 1963)	To elicit opinion and gain consensus.	Experts selected based on aims of research.	Traditionally postal	Employs three or more rounds	Open qualitative first round, to allow panellists to record responses.
Modified (McKenna, 1994)	Aim varies according to project design, from predicting future events to achieving consensus.	Experts selected based on aims of research.	Varies, postal, online etc.	May employ fewer than three rounds.	Panellists provided with pre-selected items, drawn from various sources, within which they are asked to consider their responses.
Decision (Rauch, 1979)	To structure decision-making and create the future in reality rather than predicting it.	Decision makers, selected according to hierarchical position and level of expertise.	Varies	Varies	Can adopt similar process to classical Delphi
Policy (Turoff, 1970)	To generate opposing views on policy and potential resolutions.	Policy makers selected to obtain divergent opinions.	Can adopt a number of formats including bringing participants together in a group meeting.	Varies	Can adopt similar process to classical Delphi
Real time / consensus conference (Turoff, 1972)	To elicit opinion and gain consensus.	Experts selected based on aims of research	Use of computer technology that panellists use in the same room to achieve consensus in real time rather than by post.	Varies. Can adopt similar process to classical Delphi.	n.a.

Source: Adapted from Keeney, Hasson & McKenna (2011)

Table 4.4 Classifications of Delphi designs (cont.)

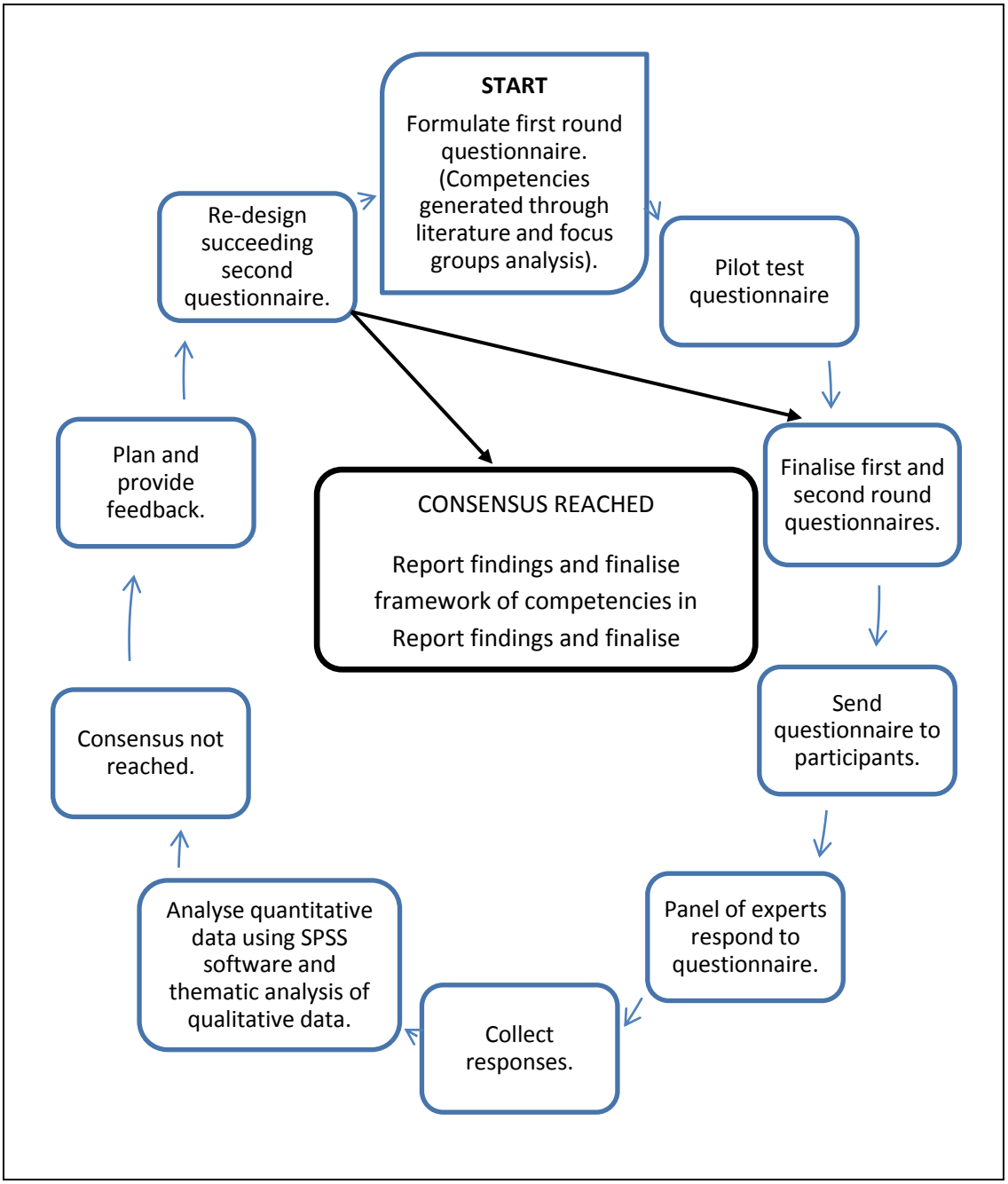
Design type	Aim	Target panellists	Administration	No. of rounds	Round 1 design
e-Delphi	Aim can vary depending on the nature of the research.	Expert selection can vary depending on the aim of the research.	Administration of Delphi via email or online web survey.	Varies. Can adopt similar process to classical Delphi.	n.a.
Technological	Aim varies according to project design, from predicting future events to achieving consensus.	Experts selected based on aims of research.	Use of hand-held keypads allowing responses to be recorded.	n.a.	Can adopt similar process to classical Delphi.
Online	Aim varies according to project design, from predicting future events to achieving consensus.	Experts selected based on aims of research.	Implementation of the technique on any online instrument, such as a chat room, or forum.	Varies	Can adopt similar process to classical Delphi.
Argument (Kuusi, 1999)	To develop relevant arguments and expose underlying reasons for different opinions on a single issue.	Panellists should represent the research issue from different perspectives.	Varies	Varies	Can adopt similar process to modified Delphi i.e. first round involves expert interviews.
Dis-aggregative policy (Tapio, 2002)	Constructs future scenarios in which panellists are asked about their probable and preferable future.	Expert selection can vary depending on the aim of the research.	Varies	Varies	Adoption of modified format using cluster analysis.

Source: Adapted from Keeney, Hasson & McKenna (2011)

4.5.2.3 The sequence model (Couper, 1984)

Although the Delphi technique has been widely used in healthcare, very few models have been presented to capture its sequential process. Couper, (1984) designed a model to clarify the method and provide guidelines for implementation. This model was used in this study, as it facilitates the process application by enabling further refinement of the relevant dimensions of the process as described in Figure 4.4.

Figure 4.4 The modified Delphi sequence model



Adapted from Couper (1984): The sequence model

4.5.2.4 The modified Delphi technique

While considering the advantages of the Delphi method (Section 4.5.2), some limitations are identified, such as: defining the level of group consensus, group selection, number of 'experts' and number of rounds of data collection.

4.5.2.5 Defining level of group consensus

Consensus may be achieved in a variety of ways (Keeney, Hasson & McKenna, 2011), for example, by aggregating the judgments of respondents generating a pre-determined level of consensus or with the application of the subjective level of central tendency and by measuring the consistency of responses between successive rounds.

Measuring the stability of the responses through a series of rounds is documented as a more reliable indicator of consensus (Keeney, Hasson & McKenna, 2011). There is less variance in the results in higher levels of consensus. However, decreased variance may be due to the attrition rate and hence, produce an inaccurate consensus. The use of inferential statistics, such as the level of central tendency has also been criticised, believing that it would not reflect resistance accurately (Keeney, Hasson & McKenna, 2011). However, various statistical tests have been applied to report a move towards consensus, such as the median, standard deviation and chi-square. Keeney, Hasson & McKenna (2006) suggest the use of confidence intervals as a means to determine the cut-off point for consensus, however, selecting the most appropriate statistical measure has been controversial for years (Murphy *et al.,* 1998).

In the absence of a universal agreement on how to measure the level of consensus, a commonly accepted method is by computing a percentage value which may range from 51% (McKenna, 1994) to 100% (Williams & Webb, 1994) level of agreement. Since the decision is often arbitrary (Keeney, Hasson & McKenna, 2001), it is recommended to state clearly the method of reaching a consensus, prior to data analysis to enhance the credibility of the Delphi results.

Five methods were identified to measure achievement of consensus from a literature review conducted by Boulkedid *et al.,* (2011) as follows:

- Obtaining a median score above a pre-defined threshold and a high level of agreement among panel members (N=62, n=22) (35%).
- Having only a median score greater than a pre-defined threshold (N=62, n=10) (16%).
- Having the proportion of experts who rated the item within the highest region of the scale which had to be greater than a pre-defined threshold (e.g. 75% or more of the experts giving the item scores of 7, 8 or 9 on a 9-point Likert scale) (N=62, n=9) (15%).
- Using the Rand UCLA criteria for agreement (9-member panel using a 9-point Likert scale, no more than 2 members rate the item outside the 3-point region 1-3; 4-6; 7-9, containing the median) (N=62, n=8) (13%).
- Using the Interpercentile Range (IPR) and Interpercentile Range adjusted for Symmetry (IPRS) with an IPR value greater than the IPRS value indicating that the item was rated with disagreement (N=62, n=2) (13%).

Issues in relation to identifying and measuring consensus in Delphi method are still debatable with no clear conclusions and thus, further research is required. Consequently, the decision on how the level of consensus should be achieved or at what level should consensus be reached, must be determined in consultation with the literature, the aims and objectives of the study and the conviction that consensus is reached when the researcher's pre-determined level of consensus is gained on a specific item or topic, prior to data collection (Keeney, Hasson & McKenna*,* 2011). The findings of Boulkedid *et al.* (2011) were utilised as a guide for this study. Following consultation with the statistician and the researcher's supervisors it was determined that the mean was used to measure the group's opinion, the standard deviation and confidence interval would be used to represent the extent of agreement within the panel.

Consensus in this study is determined as having the proportion of experts who rated the item within the highest region of the scale on a 7-point Likert scale (i.e. 5, 6 or 7) and equated to be of a 75% or greater threshold. Scheibe, Skutsch & Schofer (1975) argue that percentages alone are inadequate to measure consensus in Delphi analysis. Thus, the measurement of the stability of the panels' responses between rounds is recommended. Stability in this context does not refer to the level of agreement between expert panel members but refers to the 'within-subject' level of agreement in the expert panel. Taking on board these suggestions, the stability of responses between rounds was calculated using correlational statistics to demonstrate the reliability of the findings.

4.5.2.6 The panel of 'experts'

The recruitment of the panel of 'experts' is fundamental to the validity and reliability of the Delphi approach, as it relies on consensus having been reached by experts in the field. Published Delphi studies do not present the selection criteria and operational definitions of 'experts' (Keeney, Hasson & McKenna 2001). The concept of experts is still not adequately defined which threatens reliability and validity of the studies (Landeta, Barrutia & Lertxundi, 2011).

Mead and Moseley (2001) claim that experts can be defined by their hierarchical positions and public acknowledgement. Keeney, Hasson & McKenna (2001) in a literature review cites definitions of an expert as an informed individual, a specialist in the field, or someone who has knowledge about a specific subject. The key themes that emerge from the various definitions of an 'expert' include '*knowledge'* and '*experience'* and 'the ability to influence *policy'* (Kennedy, 2004; Baker, Lovell & Harris, 2006).

The key themes of *knowledge* and *experience* apply to competencies in spiritual care and so both are fundamental characteristics in the selection of 'experts' in this modified Delphi study. Characteristics of knowledge and experience in an expert are based on the theories of the theory of skill acquisition, 'from novice to expert' (Benner, 1984) and the theory of 'patterns of knowing' (Carper, 1978).

4.5.2.7 Theories underlying the selection of 'experts'

Two theories that guide knowledge and experience in nursing/midwifery practice include Carper's 'patterns of knowing' (1978) and Benner's (1984) five levels of nursing experience 'from novice to expert'. For the purposes of this study, these theories will underlie the selection of participants in the expert panel.

4.5.2.8 Theory of patterns of knowing (Carper, 1978)

Carper (1978) in her seminal paper on patterns of knowing in nursing identified four 'patterns of knowing,' namely:

- Empirical: The science of nursing.
- Ethical: The moral knowing.
- Aesthetic: The art of nursing.
- Personal knowing: The knowledge of self.

'Empirical knowing' represents knowledge that is publicly verifiable, objective, factual, research based and that can be replicated by others (Carper, 1978). 'Ethical knowledge' involves the examination and evaluation of what is right and wrong and the type of good, valuable and desirable end goals. 'Aesthetic knowledge' acknowledges the expression of the art as subjective, individual and unique. Intuition, interpretation, understanding and valuing are central components of aesthetics. Similarly, 'personal knowing' is subjective and refers to self-awareness and ways of relationships with others. Personal knowing incorporates self-consciousness and promotes respect, empathy and holism in a nurse/midwife-client relationship (Carper, 1992). Thus, expertise in nursing/midwifery incorporates knowledge which is associated with theoretical, practical and personal experiences which is consistent with Benner (1982).

4.5.2.9 Theory from novice to expert (Benner, 1982)

Benner's (1982) 'from novice to expert' theory considers an 'expert' nurse as one who develops skills and understanding of patient care over time through a sound educational base and a multitude of experiences. The expert is able to integrate

various aspects of patient care into a meaningful whole (Benner, 1982). Knowledge and skills (knowing how) may be gained by experience without learning the theory (knowing that). The development of knowledge in applied disciplines, such as medicine and nursing, is composed of the extension of practical knowledge (know how) through research and the characterisation and understanding of the 'know how' of clinical experience. Thus, emphasis is put on experience as a prerequisite to becoming an expert.

This theory shifted professionals' understanding of an expert from a nurse receiving a high salary or with a prestigious position, to a nurse who provides "the most exquisite nursing care" (Benner, 1984, pp.6). Professional experience is often linked with a professional qualification (knowledge) and years of experience which may qualify him / her as an expert. However, it is argued that clinical experience without continuing education limits the nurses'/midwives' competence in providing quality care (Attard, Baldacchino & Camilleri, 2014). The nature of an individual's experience still needs to be explored by research. However, clinical practice may help the nurse/midwife to make valuable judgments based on their experience.

Carper's (1978) 'four patterns of knowing' namely, Empirical, Ethical, Aesthetic, and Personal contributed towards the aspects of knowledge and experience of an expert identified in client-centred care evidence-based practice and the various definitions of an 'expert' (Baumann, 2006). Consequently, the two theories Carper's 'four patterns of knowing' (1978) (Section 4.5.2.8) and Benner's (1982) 'from novice to expert' (Section 4.5.2.9) were selected in this study to define expertise of the study participants

4.5.3 Spiritual Care Competency Scale (van Leeuwen *et al.,* 2008)

As the topic of spirituality and spiritual care in nursing and in particular in midwifery has started to be taught recently, the researcher was not entirely confident with the level of knowledge and expertise of qualified nurses/midwives as potential 'experts' in the area of spiritual care. Furthermore, an expert is poorly defined sometimes identified through peer assessment which presents with methodological

shortcomings (Benner, 1984). Consequently, nurses'/midwives' competency in spiritual care was therefore assessed utilising the Spiritual Care Competency Scale (SCCS) (van Leeuwen *et al.,* 2008).

The SCCS is a reliable tool which may be used for practical, educational and research purposes to assess competencies in the provision of spiritual care. Permission to use the tool was granted from the authors (Appendix 15). Since the original SCCS tool was formulated for nurses, permission to adapt the format of the tool so as to include the terminology relevant to midwifery was requested and granted by the authors (Appendix 15).

In order for nurses/midwives to participate as experts in this modified Delphi study, a purposeful sample of nurses/midwives was selected. As not all nurses/midwives are capable of becoming experts in the field (Benner, 1984), qualified nurses who underwent a study unit on spiritual care during the course of their nursing education programme were invited to participate. Since only a few midwives had undertaken the study unit and the number of midwives is relatively small when compared to nurses, they were all asked to participate. Nurses'/midwives' level of competency in spiritual care was assessed using the SCCS tool. Potential nurses and midwives were sent a letter inviting them to participate. (Appendix 16) This was sent in a sealed envelope, containing an information letter, a consent form (Appendix 5) and a stamped addressed envelope. Those who consented to participate were then sent the SCCS (van Leeuwen *et al.,* 2008) questionnaires (Appendices 17 & 18).

A web survey was also available should participants prefer to respond in this way (Appendices 19 & 20). Three reminders were sent in an attempt to improve the response rate. The first reminder was sent a week after the distribution of the first questionnaire and another two subsequent reminders were sent at two week intervals. These included a note of gratitude to those who had submitted their response, whilst redistributing the questionnaire to the non-respondents to enhance the response rate.

4.5.3.1 Structure of Spiritual Care Competency Scale

The tool consists of six dimensions and 27 related items in spiritual care rated on a 5-point Likert scale (1=Completely Disagree; 2=Disagree; 3=Neither Agree or Disagree; 4=Agree; 5=Fully Agree). The dimension of 'The attitude towards patient spirituality' (Items 1-4) is a component of spiritual care which is regarded as an important aspect of nursing competency (van Leeuwen & Cusveller, 2004; Baldacchino, 2006; McSherry, 2006). Personal spirituality was found to be an important predictor of effective spiritual care (Meyer, 2003; Wasner *et al.*, 2005; Puchalski *et al.*, 2009). Therefore, personal spirituality may be linked with the type of communication and presence of the nurse with patients (Items 5-6).

The assessment and implementation of spiritual care dimension (Items 7-12) refers to the ability to determine patients' spiritual needs and to plan spiritual care in liaison with the multi-disciplinary team. This includes written and inter-professional communication of spiritual needs and spiritual care with the patient's family members, the healthcare team and hospital chaplain. The referral dimension (Items 13-15) relates to the cooperation with other disciplines in healthcare that take responsibility for spiritual care. The 'personal support and patient counselling' dimension (Items 16-21) indicates the actual delivery and evaluation of spiritual care with patients and their relatives. 'The professionalisation and improving the quality of spiritual care' dimension (Items 22-27) contains the nurses' activities aimed at quality assurance, professional practice and policy development in spiritual care (van Leeuwen *et al.,* 2008).

Assessment of competence in spiritual care may be subjective, as shown by the qualitative data in the study by van Leeuwen *et al.* (2008). Participants may have interpreted the items differently, influenced by their attitudes towards patients' spirituality, their own spirituality which was predominantly religious and a broader perspective rather than their own religious convictions. Some items were formulated negatively which may have yielded a socially acceptable answer. Other factors that may influence scores of the items according to the author refer to the respondents' experience of clinical practice.

Respondents without clinical experience were noted to score themselves on the basis of their own opinions. Some students scored themselves on their own ways of dealing with spiritual experiences in clinical practice. Some respondents perceived themselves as being less competent after their clinical experience and so scored themselves with a lower competency level in the questionnaire than during the interview which followed. Those without clinical experience used their perceptions, feelings or personal life experiences to communicate with patients on spirituality as they perceived it as a personal concept.

The psychometric testing of the SCCS showed good internal consistency of the tool and sufficient average inter-item correlations and a good test-retest reliability in the six dimensions of the tool namely:

- Attitude towards patient's spirituality: Cronbach's alpha 0.56
- Communication: Cronbach's alpha 0.71
- Assessment and implementation of spiritual care: Cronbach's alpha 0.82
- Referral to professionals: Cronbach's alpha 0.79
- Personal support and patient counselling: Cronbach's alpha 0.81
- Professionalisation and improving quality of spiritual care: Cronbach's alpha 0.82

The tool was considered a valid and reliable tool to be used on nurses/midwives to measure their perceived competencies which was equivalent to their level of expertise in spiritual care, based on their knowledge and clinical experience (Attard, Baldacchino & Camilleri, 2014).

4.6 Sampling techniques in the modified Delphi study

4.6.1 Selection of participants: Nurses/midwives

Nurses/midwives who satisfied the following established assessment criteria (Tables 4.5 & 4.6), indicated by the shaded boxes were recruited to the panel of experts in the modified Delphi study.

Table 4.5 Assessment criteria of nurses/midwives using SCCS

Dimension	Items	Score				
		1	2	3	4	5
1. Attitudes towards patient spiritual care	**1-4**					
2. Communication	**5-6**					
3. Assessment and implementation of spiritual care	**7-12**					
4. Referral	**13-15**					
5. Personal support and patient counselling	**16-21**					
6. Professionalisation and improving quality of spiritual care	**22-27**					

Source: van Leeuwen *et al.,* 2008

Since the dimensions 'Attitude towards patient spiritual care' and 'Communication' (Items 1-6) are considered as important predictors of quality spiritual care (van Leeuwen *et al.,* 2008; Clarke, 2013) respondents were expected to score these dimensions at the higher levels of the scale (4 or 5).

The remaining four dimensions and items (Items 7–27) 'Assessment and Implementation of spiritual care,' 'Referral,' 'Personal support and patient counselling' and 'Professionalisation and improving the quality of spiritual care' a midway level of the scale score (3) was allowed in line with van Leeuwen *et al.,* (2008) these competencies may be dependent on the influence of their clinical experience. Hence, for the purpose of this modified Delphi study, qualified nurses and midwives who satisfied at least the minimum score column of the scoring system (Table 4.6) were recruited to participate as experts.

Table 4.6 Nurses'/midwives' scores utilising the SCCS

Item numbers	Maximum score	Minimum score
1-6	30	24
7-27	105	63
1-27	135	87

Adapted from van Leeuwen *et al.,* 2008

4.6.2 The modified Delphi experts and inclusion criteria to the study

Figure 4.5 represents the panel of experts recruited for the purpose of this modified Delphi study while Table 4.7 shows the inclusion criteria to participate in the study. Each potential participant had to satisfy one of the first six criteria. All participants had to satisfy criteria number seven in order to be eligible to participate in the study.

Participants were to be recruited according their knowledge and experience of spiritual care guided by the 'patterns of knowing' in nursing' (Carper, 1978), the theory 'from novice to expert' (Benner, 1982) and the 'Spiritual Care Competency Scale' (SCCS) (van Leeuwen *et al.,* 2008). The Delphi research often concentrates on professional expertise (qualification and experience) and clients tend to be excluded despite their valuable knowledge and experiences (Mead & Moseley, 2001). Consequently, clients or service users were invited as part of the panel of experts.

Their direct experience as clients receiving spiritual care qualifies them as experts (Carper, 1978) as they may provide valuable insights into competencies that are important in spiritual care. Additionally, policy makers were seen as a vital component in targeting change and policy (Mullen, 2003). Since this study would eventually move in this direction, nursing/midwifery policy makers were also included in the study.

Figure 4.5 The modified Delphi groups of 'experts'

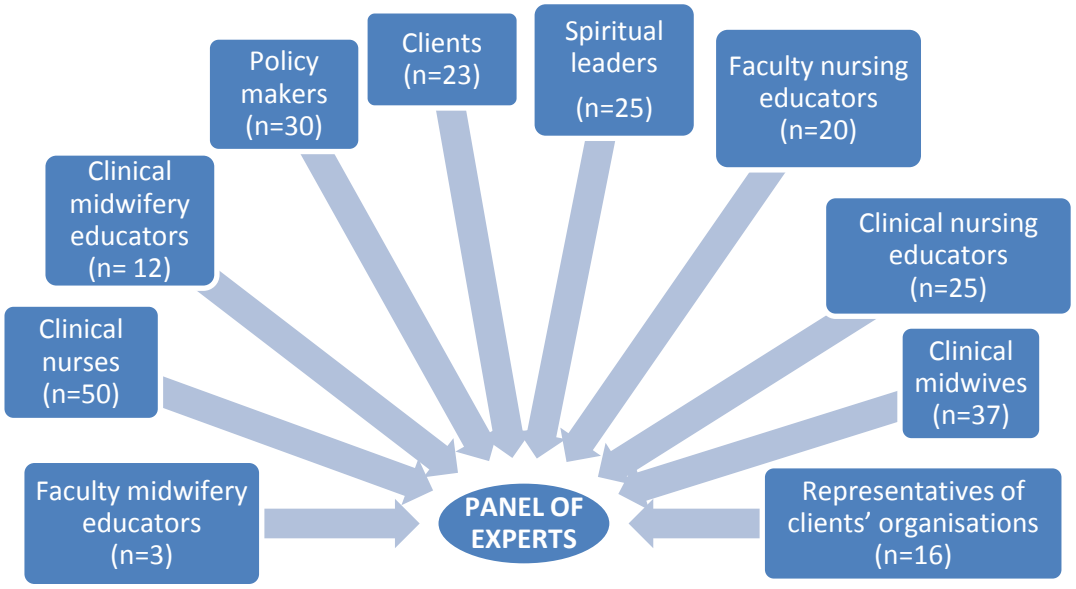


Table 4.7 Inclusion criteria: The modified Delphi study.

1.	Qualified nurses/midwives directly involved with the care of clients in a medical/surgical/mental health/palliative or maternity care settings in hospital and public healthcare sector and who have demonstrated the required level of competency in spiritual care through the Spiritual Care Competency Scale (SCCS) set selective criteria (van Leeuwen *et al.*, 2008).
2.	Nursing or midwifery educators involved in the teaching of pre-registration nursing/midwifery students at the Faculty and clinical practice.
3.	Chaplains and spiritual leaders of different religious denominations assisting clients in hospital and the public healthcare setting and persons considered by colleagues as an authority in the area of spirituality in nursing/midwifery, such as the hospital psychologist, counsellors, bereavement midwife and persons involved in pastoral care.
4.	Policy makers in nursing/midwifery, such as managers, directors, representatives of nursing and midwifery unions and client organisations.
5.	Representatives of patients' organisations, such as breast cancer, organ transplant, asthma and support groups for those suffering from diabetes.
6.	Clients who have received care in a medical/surgical/mental health/palliative or maternity department in a public and/or private healthcare setting. Participants must have a good command of the English language.
Participants had to have a good command of the English language, be willing to participate and had sufficient time to participate in the study.	

4.6.3 Sample size and recruitment

The group size in a Delphi study does not depend on statistical power, but rather on group dynamics to arrive at consensus among experts (Keeney, Hasson & McKenna, 2006). Although there are no guidelines on the appropriate sampling size in a Delphi study, the literature recommends 10 to 18 experts on a Delphi panel (Keeney *et al.,* 2006). However, the larger the sample the better the reliability of the panel's judgment (Powell, 2003).

Recent researchers using the Delphi technique (Keeney, 2009; Cowman *et al.,* 2011) recommend a heterogeneous sample with a large sample size to enhance the validity of the findings**.** However, a small number of participants from a homogeneous group or a large number from a heterogeneous group who possess relevant information about the variable studied may be a representative sample (Kadam, Jordan, & Croft 2006).

Since the study is conducted in Malta, where 95% of population are Catholics (Gouder, 2012) a heterogeneous group of experts of diverse professional, cultural and religious backgrounds was recruited. A heterogeneous group fosters consistency in the findings (Linstone & Turoff, 1975) which may be applicable to various nursing/midwifery care settings of diverse cultures/religions.

A high attrition rate is documented in Delphi methods which may affect the follow up response rate over successive rounds yielding a response bias (Polit & Beck, 2014). A purposive sampling technique was adopted and participants who satisfied the respective inclusion criteria (Table 4.7) were recruited in a process of five steps (Table 4.8).

Therefore, individuals who were oriented towards spiritual care and fitted the inclusion criteria were identified by the researcher's contacts and sent an information letter (Appendix 21). Certain participants also recommended other potential participants who were then invited by the researcher to participate in the study.

Table 4.8 Process adopted for the selection and recruitment of 'experts'

Step No.	Process adopted
Step 1: Identify the relevant potential experts in spiritual care in nursing/midwifery.	• Identify the relevant providers and clients of spiritual care in hospital. • Identify relevant academics and stakeholders. • Identify relevant organisations representing the providers and clients' organisations.
Step 2: Populate with names	• Ask contact persons to nominate potential experts from the identified groups of participants. • Populate with names.
Step 3: Rank potential experts.	• Categorise potential experts to the appropriate group. • Rank experts within each group, based on their knowledge and experience underpinning Carper's 'four patterns of knowing' and Benner's 'from novice to expert' theories. • Identify any limitations in the groups of potential experts. • Institute further measures to ensure 'expertise.'
Step 4: Identify other interventions needed.	• Permission to use the SCCS tool and to adapt terms for midwifery was sought and granted by the author. • Nurses and midwives submitted to van Leeuwen *et al.,* (2008) Spiritual Care Competency Scale to ensure expertise.
Step 5: Invite experts to participate.	• Invite experts for each group: • Stop soliciting experts after two letters requesting participation were sent.

Adapted from Polit & Beck, 2014

Written information was provided and posted to the participants. Those who agreed to participate were asked to sign a consent form and were asked whether they would prefer to receive and return their questionnaire by hand, by postal mail or by web survey. Whilst taking into consideration the attrition rate, 760 individuals were invited to participate in the study from which 241 consented participants were assigned to ten groups and participated in R1 of the modified Delphi study (Appendix 22). Potential participants were provided with a full explanation of the study which included the aims and objectives and the nature of their participation. This was to give them a sense of ownership and commitment and to enhance the response rate (Keeney, Hasson & McKenna, 2006).

4.6.4 Procedure for the modified Delphi study

The aim of this modified Delphi study was to generate consensus building of perceptions among experts on competencies in spiritual care. A two phase modified Delphi approach, which is similar to the classical Delphi in terms of procedure and intent, was adopted. The list of pre-selected competency items generated in Phase 1 of the study was tested by the experts in two modified Delphi rounds.

4.6.5 The research instrument

The self-administered questionnaire and the web survey included three sections (Appendices 23 & 24). The first section consisted of the demographic information, which included the name, gender, age, occupation and place of work. The second section incorporated the list of competency items identified through the literature and focus groups which were collapsed into 55 items, each with a 7-point Likert scale ranging from 1 ('Not Important At All') to 7 ('Extremely Important'). Only the numbers (1-7) were included to foster the actual personal opinion of respondents. Seven points were used to allow respondents to make subtle distinctions between items and to offer them the opportunity to change their responses in subsequent Delphi rounds (Mead & Moseley, 2001). A 'Don't Know' option for each item was included for participants with no opinion on a particular point. Only the competency items were included to prevent the 'halo effect' on the responses being influenced by the nature of the domain (Polit & Beck, 2004). The complexity of spirituality and spiritual care rendered multiple statements in many competency items. Therefore, participants were requested to answer each competency item as a WHOLE. Participants were invited to add other competencies which may not have been identified and to add any additional comments in the final section.

4.6.6 Methodological rigour of quantitative data: Reliability and validity

'Reliability' refers to the consistency of measurement within a study and refers to the degree to which a measurement given repeatedly remains stable over time (Polit & Beck, 2014). Reliability may be tested using four main approaches. These include:

1. Test-retest when the test is administered on two occasions to the same sample.
2. Internal consistency which assesses consistency of results over time within the test.
3. Inter-observer which requires rating of the same information by two different raters consistently.
4. Parallel form (alternate) requiring two instruments designed to test same information and produce same results.

Since the framework of competencies in spiritual care identified is new, reliability was tested using test-retest and internal consistency which demonstrates the homogeneity of the tool. Consequently, same questionnaire was completed twice at an interval of three weeks (17^{th} April - 8^{th} May 2012) by the same sample of participants (n=30).

'Validity' is defined as the extent to which the tool measures what it actually means to measure (Polit & Beck, 2014). Thus, the aim of this study sought to design and develop a framework of competencies in spiritual care. There are various types of validity testing, such as 'face validity', whereby the tool appears to be addressing the aims of the study. This is confirmed by 'content validity', whereby the experts examine the extent to which the content covers the variable under investigation. 'Construct validity' identifies the factors of the tool by statistical analysis (McIntire & Miller, 2005).

Although gauging rigour for a Delphi technique remains elusive, due to the ongoing debate and modifications to the technique, establishing methodological rigour reliability, validity and trustworthiness of this modified Delphi study to produce dependable results is crucial (Hasson & Keeney, 2011). Therefore, for the purposes of this study, 'content' and 'construct validity' were the most important validity testing of the tool. Since the framework of competencies is fairly new to research, criterion-related validity testing was not possible as 'Criterion-related validity' involves the comparison of the tool with a similar variable.

'Construct validity' of the framework identified the domains in spiritual care which were tested in the second round of the modified Delphi method. Due to the complexity of spiritual care, the literature suggests that the Delphi findings should be compared with relevant published research (Powell, 2003) to enhance the ability to generalisability/transferability of the findings or to identify whether further additional research is required to validate or refine the findings (Engles & Kennedy, 2007).

4.6.7 Approaches to rigour used in the modified Delphi study

Quantitative data were computed using the Statistical Package for Social Sciences (SPSS) Version 21. The theoretical framework of systemic thematic content analysis (Braun & Clarke, 2006) was used to analyse qualitative data. Measures were taken to maintain rigour in qualitative and quantitative data (Table 4.9).

Table 4.9 Approaches to rigour used in the modified Delphi study

Objective	Tests
TESTING THE MODIFIED DELPHI QUESTIONNAIRE **1. ADEQUACY** of the information provided in the participant information sheet, clarity of the instructions and items included. Adequacy of the response options and time taken for completion.	Summative content analysis from the feedback received from the thirty respondents.
2. RELIABILITY OF THE RESEARCH INSTRUMENT.	I. Stability of the research instrument. II. Internal consistency of the research instrument. KOLMOGOROV-SMIRNOV TEST USED TO TEST NORMAL DISTRIBUTION OF THE DATA. SPEARMAN'S rho correlation test used as scores highly negatively skewed. Cronbach's alpha coefficient.

Table 4.9 Approaches to rigour used in the modified Delphi study (cont.)

Objective	Tests
ROUND 1: Modified Delphi Study	
1. Description of the demographic characteristics and participation rates of the sample.	Frequency, percentages, mean, skew and kurtosis.
2. Measurement of responses.	- Measures of central tendency: mean, standard deviation, confidence interval of the mean, % of agreement. - Thematic analysis of qualitative data.
ROUND 2: Modified Delphi study	
1. Description of demographic characteristics, participation rates. 2. Description of non-respondents. 3. Calculation of non-respondent bias.	Frequency, percentages and mean. Frequency, percentages and mean. Chi-square test.
4. Measurement of responses.	Measures of central tendency: mean, standard deviation, confidence interval of the mean, % of agreement and % increase / decrease in agreement over Round 1.
5. Assessment of internal consistency of responses.	Cronbach's alpha reliability co-efficient
6. Stability of responses.	Non parametric Spearman's rho correlation test.
7. Analysis of the correlation between the competency domains and items at the underlying constructs (construct validity).	Exploratory factor analysis.

4.6.8 Testing the modified Delphi questionnaire (pilot study)

The modified Delphi questionnaire was piloted on thirty participants. A purposive sample of three participants was selected from each of the ten sub-groups of experts of the modified Delphi study (Table 4.10).

Table 4.10 Pilot study participants

Participants	Number	Groups	Number
Qualified nurses	3	Faculty midwifery educators	3
Qualified midwives	3	Spiritual leaders	3
Nurse clinical educators	3	Policy makers	3
Midwife clinical educators	3	Patients' organisations	3
Faculty nursing educators	3	Clients	3

Feedback was given by all thirty participants (100% response rate) on adequacy of the information sheet, clarity of instructions, items included, adequacy of response options and time taken for completion. A separate section was included, enquiring about these aspects and any changes participants thought were needed. Qualitative data derived from the questionnaire underwent thematic analysis, as described in Section 4.7.3.

4.6.9 Stability of the research instrument

The stability of the research instrument is the extent to which similar results are obtained on two separate administrations (Polit & Beck, 2008). The instrument was administered on two occasions with an interval of three weeks to the chosen purposive sample of thirty participants i.e. three participants from each of the ten groups of the modified Delphi panel. Ideally, a larger sample could have enhanced the reliability of results. However, recruiting a larger sample would have endangered recruitment and retention of participants for repeated measurements during the modified Delphi rounds (Walter, Eliasziw & Donner, 1998). The optimum period of time between test and retest depends on the variable being measured and whether change is to be expected (Funk & Dennis, 1999).

A major concern in assessing test-retest reliability of a questionnaire is the possibility of a true change occurring in the attribute being measured during the retest interval which threatens its reliability coefficients. A short time interval between tests such as, one week, might lower the risk of a change in the variable

but increases the risk that respondents may remember the questions and their answers. The test-retest interval may be influenced by four cognitive processes involved in responding to questions such as: comprehension, retrieval, judgment and selection from response options (Tourangeau, Lance & Rasinski, 2000). Consequently, test 1 responses are 'unrehearsed' while retest responses (test 2) may be more readily understood and retrieved as personal data. The Response shift is a change in a person's self evaluation of the construct rather than a change in the construct itself as a result of altered priorities. The attrition of respondents in test 2, is another challenge to maintain reliability of the tool.

Many health researchers adopted an interval of one week or two weeks based on consultation with experts (Polit & Beck, 2014). In this study, although minimal change was expected from expert opinion across time, a three week period was considered sufficient for participants to forget the first responses of test 1 questionnaire. Therefore a three week interval contributed towards maintaining conformity, dependability and stability of the test-retest scores (Kline, 2000).

The Spearman's rho correlation test was chosen to estimate the stability between test and retest responses. The scores were initially tested for normality using the Kolmogorov-Smirnov test. The null hypothesis specifies that the distribution of rating scores is normal and acceptable, if the p-value exceeds the 0.05 level of significance. Conversely, the alternative hypothesis specifies that the distribution of rating scores is non–normal when the p-value is less than the 0.05. Since the results were higher than p=0.05, non-parametric tests were performed using Spearman's rho correlation tests to test the stability of the questionnaire across time.

4.6.10 Internal consistency of the research instrument

The most widely used method for evaluating internal consistency or homogeneity of the instrument is by the reliability coefficient alpha (Cronbach's alpha). The internal consistency demonstrates the consistency of the various items which construct the tool. In this study, the scoring system for Cronbach's alpha was interpreted according to the guidelines of George & Mallery (2003) (Table 4.11).

Table 4.11 Interpretation of Cronbach's alpha scores

Cronbach alpha score	Internal reliability
>0.9	Excellent
0.8-0.9	Good
0.7-0.8	Acceptable
0.6-0.7	Questionable
0.5-0.6	Poor
<0.5	Unacceptable

Adapted from George & Mallery, 2003

The Cronbach alpha of Test 1 and Test 2 were both high, demonstrating good to excellent homogeneity of the tool across time.

4.7 The modified Delphi study: R1

Following completion of Phase 1 of the study that is; the development of the seven domains and 55 competency items through the literature review and focus groups as well as the pilot study, Round 1 of the modified Delphi questionnaire was delivered to the participants according to their preference that is; by hand, by post or by web survey. The researcher considered that the use of a mixed mode design would enhance the response rate. However, differences in responses may be the consequence of the use of these different modes. To minimise this risk, the questionnaire formats were kept as similar as possible (Appendices 23 & 24).

4.7.1 R1: Sample size and procedure for data collection

Ten participant groups from Malta were recruited by virtue of their knowledge and experience and guided by the various theories. Of the 760 invited participants, 241 were eligible and consented to participate in R1 of the modified Delphi study. The

framework of competencies was distributed via postal mail or web survey, as preferred by participants (Appendices 23 & 24).

4.7.2 R1: Quantitative data analysis

Quantitative data analysis was carried out using SPSS Version 21. The data for the expert panel was analysed by computing the mean, standard deviation, 95% confidence interval of the population mean and the percentage of agreement for each competency item. The mean score is used to demonstrate the average group evaluation for each item. The standard deviation measures the dispersion of the scores from the mean of each item.

In this study, consensus for retaining an item was achieved if more than 75% of the participants rated the item in the range between 5 to 7. In this 7-point scale, the scores 5, 6, 7 display moderate to strong agreement. The lower and upper 95% confidence interval level of the mean scores was computed to justify the middling rating score of 4 (Appendix 25). The level of consensus for each item at that phase of the study was also computed to note higher or lower consensus in Round 2.

4.7.3 R1: Qualitative data analysis

Content thematic analysis is a method for identifying, analysing and reporting patterns (themes) within the data and interprets various aspects of the research questions (Braun & Clarke, 2006). Various frameworks were considered for the process of analysis. For example: 'The fourteen stage content thematic analysis' (Burnard, 1991); 'The three approaches to qualitative content thematic analysis' (Hsieh & Shannon, 2005); and 'The six phase content thematic analysis framework' (Braun & Clarke, 2006).

All these frameworks share similarities through the coding phase process to create established, meaningful patterns from gathered data. However, 'The six phase content thematic analysis framework' by Braun & Clarke (2006) is the chosen method of analysis for this study.

This framework is particularly useful to this study since:

- It provides a flexible and relatively easy and quick method to learn. It is also quite straight forward to administer, especially when the researcher has limited experience of qualitative research.
- It is a useful method for working within a participatory research paradigm, such as the modified Delphi study, since participants are regarded as collaborators in the development of the competency framework.
- It summarises key features of a large body of data which were mainly obtained in Phase 3 of the study.
- It highlights similarities and differences across the sets of data, while generating unanticipated insights.
- It allows for social, as well as psychological interpretations of data, producing qualitative analyses. This is suitable when it comes to policy development in the integration of competencies in spiritual care in nursing/midwifery curricula and clinical practice.
- Its results are feasible and accessible to the educated general public, such as the clients group participating in the modified Delphi study.

Computer assisted qualitative data analysis software (CAQDAS), such as Atlas.ti and NVivo7 and XSig could have been used to facilitate the systematic, efficient coding and complex analyses of the qualitative data. Whilst acknowledging that these are effective tools when compared to manual methods of data analysis, one method does not reify the advantages over the other (Welsh, 2002). Measures were taken across the process of the study (shown in Table 4.12) to enhance the strengths of the methods used to ensure the reliability and validity of the findings which will be presented in Chapter 5.

Table 4.12 Procedure for thematic content analysis

Phase	Description of the process
1. Familiarisation with the data	This phase involved reading and re-reading the responses and noting down initial ideas.
2. Generating initial codes	Systematic manual coding of the interesting features in the responses was carried out. Data were also collated to the relevant code.
3. Searching for themes	Sorting of collated codes into potential levels of themes i.e. main overarching themes and sub-themes within them.
4. Reviewing the themes	This phase involved two levels: • reviewing the collated extracts for each theme for coherence in the pattern and the development of a thematic map. • considering the validity of each theme in relation to the data.
5. Defining and naming of themes	Ongoing analysis to determine the essence of what the theme is about and whether each theme captures the proposed scope and content of the data.
6. Reporting of themes	Selection of vivid and compelling extracts to demonstrate the prevalence of the theme and discussion of findings.

Adapted from the framework presented by Braun & Clarke (2006)

4.8 The modified Delphi study: R2

The aim of this round was to examine the level of consensus with the items in the framework of competencies in spiritual care amongst the expert panel. In the second round, participants were provided with feedback from their own mean score against the group's mean score for each item, thus allowing them to change their opinion after becoming aware of the group's mean scores. This allowed for convergence of opinion from Round 1 to Round 2 (Powell, 2003).

Participants were also provided with feedback on the comments from other participants. Whilst giving feedback may lead to group conformity, it may threaten

the validity and reliability of results. However, feedback was important as the aim of the Delphi study is to achieve informed decision making (Duffield, 1993). An instruction sheet accompanied each questionnaire, so as to indicate systematically what was expected of the participants (Appendix 26).

4.8.1 R2: Sample size and data collection procedure

The tool was distributed to the modified Delphi participants who responded in Round 1 of the study (n=241). The same methods of distribution, time to respond and the sending of reminders were adopted for Round 2 of this modified Delphi study, as described in Section 4.7.1.

4.8.2 R2: Data analysis

Data analysis involved the computation of the mean, standard deviation, 95% confidence interval of the population mean, percentage of agreement for each competency item, together with the percentage increase / decrease for each item when compared to Round 1. Non-respondents bias was tested using chi-squared test to identify differences in characteristics from the respondents.

The items were assessed for the degree of importance attributed to them by the panel of experts. Items to which participants had not responded or who had answered 'Don't Know' were entered as missing data (Futrell, 2008). 'Don't Know' responses may indicate clearly an 'attitude' towards the variable studied.

Therefore, to treat 'Don't Know' responses as a valid response in the scale may influence the factor analysis of the tool as these have a different character to the 1-7 scale. Furthermore, respondents had the option of choosing the mid-point (i.e. neutral) point on the scale. Instead, they chose 'Don't Know' which may probably be qualitatively different from 'neutral' and may indicate ambivalence or apathy towards responding to the questionnaire or the variable under study.

In the initial planning of the study, the level of consensus was pre-determined and set at 75%. This consensus was reached if more than 75% of the participants scored

in the range between 5 to 7 for each item and had a mean rating score higher than the lower 95% confidence limit of the population mean. Items scoring less than 75% agreement and a mean rating score which was lower than the lower 95% confidence limit of the population mean were excluded from the framework. Guidelines for establishing the level of consensus and the importance of items could not be traced. Thus, following consultation with the statistician and supervisors who were involved in this study, a decision was taken on the basis of this study.

4.8.3 R2: Quantitative data analysis

This section describes the descriptive analysis of the nominal data of the demographic data; the respondents and non-respondents bias; the internal consistency of the framework of competency in Round 2; the stability of responses between Round 1 and 2 and the factor analysis of the framework in Round 2.

4.8.4 Demographic data analysis and comparison with non-respondents

The attrition bias of respondents in Round 2 threatens the reliability and validity of the findings. Differences in the 'characteristics' between the respondents and non-respondents in a modified Delphi study may threaten external validity, while the differences in the 'relationships' between variables in the samples may threaten internal and external validity of the findings (Cuddeback *et al.,* 2004). Hence, non-respondent bias was calculated using chi-square test.

4.8.5 Assessment of the internal consistency of the framework in R2

The reliability of the framework in Round 2 was assessed by the Cronbach's alpha coefficient. A coefficient of at least 0.7 indicates an acceptable internal consistency (or homogeneity) of the tool.

4.8.6 Stability of responses using Spearman's rho correlation test

The Kolmogorov-Smirnov test was calculated to determine whether the rating scores distribution were normally distributed. A non-parametric test was used since the distribution of rating scores for each item was negatively skewed, since a large proportion or the respondents scored items between 5 and 7. Few respondents

provided low rating scores which were less than 4. Therefore, the Spearman's rho correlation test, which is a non-parametric statistical test, was used to calculate the relationships between Rounds 1 and 2 of the responses.

4.8.7 Exploratory Factor Analysis in R2

The framework of competencies in spiritual care at this stage of the study consisted of 54 competency items grouped under seven domains which were retained following completion of the second round of the modified Delphi study. The final framework following Round 2 was tested for construct validity by factor analysis (Hurley *et al.,* 1997; Bryman & Cramer, 2001). Exploratory Factor Analysis (EFA) is used to 'identify the factor structure or model for a set of variables' (Bandalos, 1996, pp. 389).

Confirmatory Factor Analysis (CFA) was beyond the scope of this study as it should be performed on a separate sample to that of the EFA (Henson & Roberts, 2006). Thus, further research is suggested on a separate sample to confirm the construct of this framework.

A number of steps were taken to ensure the suitability of the data for EFA. Measures were taken to maintain as large a sample size as possible so as to achieve a large expert opinion on competencies in spiritual care and enhance rigour (Floyd & Widaman, 1995). Round 2 data were screened for any errors by rechecking it against the questionnaires (Roberts *et al.,* 1999). Descriptive statistics were applied to the data: Means, standard deviations, standard error of the mean and coefficients of variance for each item were supported by histograms to identify any entries outside the expected range (Roberts *et al.,* 1999).

The first stage of factor analysis involves **factor extraction** which condenses highly interrelated variables in the data correlation matrix into factors. A correlation matrix with Spearman's correlation coefficients was used as the basis of the analysis in preference to a variance–covariance matrix, which may produce inconsistent results (Pett, Lackey & Sullivan, 2003). The number of factors retained must be

small enough to achieve parsimony, but large enough to explain the inter-item correlations (Fabrigar *et al.,* 1999). The decision on the number of factors to retain is critical, as there is currently no consensus on the method which should be used to determine this (Hayton, Allen & Scarpello*,* 2004).

A commonly used method for determining the number of factors to retain is Cattell's (1966) Scree test, which although criticised for its subjectivity, is based on the computation of eigenvalues of the reduced correlation matrix, with communalities in the diagonal which are plotted sequentially in descending order against the factor number (Russell, 2000).

The graph was examined to determine the point at which the magnitude of the eigenvalues decreased substantially, with the curve flattening out (Pett, Lackey & Sullivan*,* 2003). The number of factors retained was based on the number of eigenvalues antecedent at this point (Russell, 2000). The cut off point for factor extraction was established at eigenvalues greater than 1.00.

The second phase of factor analysis is **factor rotation.** The selected factors were rotated to improve interpretability of the solution through a structure in which each variable loads highly on one factor and has less loading on the remaining factors (Henson & Roberts, 2006). Both oblique and orthogonal rotations were compared. Oblique rotation was carried out using Promax rotation and the results were compared to that of the orthogonal rotation, using Varmiax rotation. Following the initial orthogonal rotation, the loadings were calculated by kappa (*k)* coefficient.

The entries under each factor (**factor loadings**) were estimated by counting the low (-0.10 to +0.10) factor loadings on the set of factors from the factor pattern matrix. Those variables with loadings of at least 0.40 on at least one factor were retained. The items were also assessed for cross loading. Although there is no consensus about the strategy to use when items cross load, the item which cross loaded was assigned to the factor to which it appeared to be theoretically related (Pett, Lackey & Sullivan*,* 2003).

Following factor analysis, the three items with the highest loading on each factor were identified as these shared more variance with the factor than items with lower loadings (Pett, Lackey & Sullivan, 2003). Then, the researcher referred to the results of the modified Delphi to **interpret the factors** identified and the domains were identified. The factors emerging following EFA were named accordingly.

When more than three items loading on a factor were labelled as undefined, this was considered to be a new factor and was named accordingly. Factor analysis therefore confirmed some of the proposed domains, while reviewing the construction of domains indicating the Maltese culture.

4.9 PHASE 3: Consultation with experts

4.9.1 Introduction

The aim of Phase 3 of the research study was to obtain a pragmatic view on the identified framework of competencies in spiritual care through a consultation process with international researchers in spiritual care and the modified Delphi experts who were invited to participate in this study (Appendix 27). The aim of their participation was to:

- Examine which competencies should essentially be acquired at **pre-registration or post-registration level** and which competencies are not essential at either level.
- Identify factors that may enhance or hinder implementation of the framework in education, research and /or clinical practice.
- Instigate the initial steps for dissemination and implementation of the framework.

Consensus to determine which competencies were rated as suitable at pre-registration or post-registration or not suitable for either level was set at a threshold of 51% and over.

4.9.2 Research approach

A descriptive survey was used on a purposive sample of national and international researchers in the field of spiritual care and the modified Delphi participants who had a background in education.

4.9.3 Research instrument

The framework of competencies questionnaire consisted of three sections (Appendices 28 & 29) as follows:

Section A: This included the demographic data, i.e. name, professional occupation, nationality and area of research specialisation.

Section B: This contained the 54 competency items retained from the modified Delphi study. The scoring criteria of each item ranged from 'Essential at pre-registration level' to 'Essential at post-registration level' and 'Not essential at either level.' Participants were requested to identify the appropriate level that nursing/midwifery students should achieve for each competency item.

Section C: This consisted of three open-ended questions on the potential integration of the competency framework in education and clinical practice. Participants were requested to express their views on the proposed framework of competencies and to identify factors that may enhance or hinder the implementation of the framework in education and/or clinical practice.

A space was provided for participants to express their views about possible issues which may not have been covered by the researcher.

A self-administered questionnaire (Appendix 28) or, in certain cases, a web survey (Appendix 29) was used for the local experts participating in this phase of modified Delphi study. For the international researchers, a web survey was always used. To reduce the risk of differences in responses as a result of questionnaire / web survey formats, the two formats were kept as similar as possible.

Discussions with the research supervisory team led to the modification of the questionnaire. This included rephrasing the information letter, as well as rewording the response options which provided face and content validity. Various factors were identified as possibly resulting in lowering the response rate by the respondents, namely: the impersonal method of recruitment of international researchers by e-mail, having busy work schedules and receiving many requests to participate in various other studies.

Following consideration of the limitations in the method of recruitment of the local and international participants, efforts were made to avoid this as much as possible by providing international postage stamps for the return of the questionnaire and by creating a web survey for the international researcher participants.

4.9.4 The web-based version of the questionnaire

The greatest potential limitation of web surveys is sampling technique and low response rate limiting the generalisation of the results (Couper *et al.,* 2007). Issues of sampling were of concern since some researchers' e-mail addresses were sometimes incorrect or unavailable through the internet. Thus, participants were asked to forward the questionnaire to other known researchers who satisfied the inclusion criteria.

Non-response bias is a threat when a researcher is attempting to determine comparisons between online surveys and traditional surveys, especially when recruiting a 'specialist' population. This is documented in research and demonstrated by the meta-analysis, which indicates that the difference in response rate is the function of the population of the study, rather than the mode of the survey (Shih & Fan, 2009).

Therefore, irrespective of the lower response rate, the results of web and other mode surveys are found comparable (Fielding, Lee & Blank*,* 2008). In view of the potentially low response rate, measures were taken to enhance it by adopting a user-friendly method of completion web survey software operating system.

4.9.5 Sampling technique

For the purposes of this consultation phase, the tool was distributed to two groups of purposive samples of participants. The two groups consisted of the modified Delphi experts having a background in nursing/midwifery education that is; having completed the Continuous Professional Development (CPD) module in Teaching and Assessing (N=109).

The second group consisted of international researchers who satisfied the following inclusion criteria:

- Published research on spiritual care in nursing/midwifery in English (2007-2012).
- Had an available e-mail address.

General purpose electronic databases (specifically CINHAL and Pub Med) were searched to identify potential participants using keywords 'spiritual care', 'nursing', 'midwifery' to access publications. Terms were used alone and in combination. This yielded 544 records with 266 e-mail addresses. After deleting 46 e-mails which were doubles and receiving 33 returned e-mails, 187 international researchers were recruited (n=187).

4.9.6 Data collection by postal survey

The invitation letter (Appendix 27), including information on the study, the questionnaire (Appendix 28) and a self-addressed stamped envelope were sent by post to the modified Delphi experts. Three reminders were sent at one and two week intervals, accompanied by a copy of the questionnaire and information letter.

4.9.7 Data collection by web survey

A personalised invitation (Appendix 29) was e-mailed to each potential participant to enhance the response rate, as it appears to generate value and importance to the individual's participation (Johnson & Reips, 2007). Information was given about the aims of this consultation phase, as well as the requested contribution and the

estimated time to complete the survey. A password was used to limit access to the respective participants so as to promote a sense of security and confidentiality. Even though reminders in web surveys are not usually regarded as being as effective as postal surveys since they are often regarded as unsolicited (spam) mail (Crawford, Couper & Lamias, 2001), three follow-up e-mails (reminders) were sent at weekly intervals. These included a note of gratitude to those who had submitted their response, as well as the response rate which had been obtained to date and the importance of achieving a high response rate.

4.9.8 Data analysis

As described above, data analysis therefore involved two processes:

1. Quantitative data analysis using SPSS Version 21.
2. Qualitative data analysis which was obtained from the three open-ended questions. As discussed in Section 4.7.3, these were analysed using the 'Six phase content thematic analysis framework' (Braun & Clarke, 2006).

4.9.9 Quantitative analysis of 'experts' and international researchers

The demographic data and the 54 competency items scores from both groups of participants (international researchers and the modified Delphi experts) underwent descriptive and inferential statistics. These were the frequency and percentage of responses against the demographic data and chi-squared test which identified differences in responses between the two groups of participants. Consensus was pre-determined for each competency item at a threshold of 51% or greater (McKenna, 1994). Competency items scoring 51% or over which were identified as 'Essential at pre-registration level' were included in the pre-registration competency framework and achievable at the point of registration in nursing/midwifery. These competencies were cross-referenced with NMC Standards for pre-registration nursing (2010) education and midwifery (2009) education in conjunction with the essential skills clusters (NMC, 2008), In this manner, competencies in spiritual care would embrace the statutory requirements in the context of UK pre-registration nursing/midwifery education.

Competency items scoring 51% or over which were identified as 'Essential at post-registration level' were included in the post-registration competency framework, achievable at the post-registration in nursing/midwifery. Competencies scoring 51% or over identified as 'Not essential at either level' were discarded.

4.9.10 Methodological rigour: Trustworthiness of qualitative data

The study used a mixed method approach, generating both quantitative and qualitative data. Despite the various valuable contributions to qualitative research, various authors still question the credibility and trustworthiness of this paradigm. One of the reasons behind this could be that the concept of reliability, validity and generalisability cannot be addressed in the same way as in quantitative research (Wolcot, 2001). Some authors have demonstrated ways how to determine the quality of qualitative data (Angen, 2000).

Trustworthiness of qualitative data is explained by the four criteria proposed by Lincoln and Guba (1985) namely: credibility, dependability, transferability and confirmability. These criteria were applied during the collection and analysis of qualitative data as a result of the focus groups, the comments made by the modified Delphi experts in Phase 2 and the responses of the consultation experts in Phase 3 of the study. This set of criteria is an analogy to the traditional quantitative criteria (Table 4.13).

Table 4.13 Criteria for judging quantitative and qualitative research

Traditional Criteria for Judging Quantitative Research (Polit & Beck, 2014)	Alternative Criteria for Judging Qualitative Research (Lincoln & Guba, 1985)
Internal Validity	Credibility
External Validity	Transferability
Reliability	Dependability
Objectivity	Confirmability

Source: Polit & Beck, (2014); Lincoln & Guba (1985)

4.9.10.1 Credibility

Credibility establishes that the results of qualitative research are credible or believable from the perspective of the research participants and the researcher as creators of the analytical process (Patton, 2002). In Phase 1, the ***credibility*** of the focus groups was ensured by taking field notes during the discussions and a moderator was present to monitor the questioning technique and group participation to minimise bias.

The choice of research participants with various experiences and perspectives increased the possibility of shedding light on meeting clients' needs, as well as the provision of spiritual care by nurses/midwives. Credibility was achieved by the systematic process of data analysis which generated themes and categories that covered the whole data. No relevant data were excluded or irrelevant data included and judging similarities within and differences between categories.

This has been approached by selecting representative quotations from the given text and seeking validation and agreement on:

- Validation of transcription of discussions by the participants.
- Agreement was then achieved on the resultant themes, categories and competencies between the researcher, supervisors with expertise in the field of competencies in spiritual care, whereby the findings were unambiguous, exhaustive and mutually exclusive (Cavanagh, 1997).

The results were presented in the form of tables, including exemplars of the codes, categories, themes, and competency statements.

4.9.10.2 Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts or settings (Lincoln & Guba, 1985). The purposive sampling technique and the variety of focus groups which were recruited, including

the clients, generated a broader perspective of competencies in spiritual care which may be applied in different contexts, such as hospital and community care and caring for clients with different religions. Also, consultation with international researchers and educators who validated and classified the findings in pre- and post-registration competencies strengthens the application of the framework to a global perspective and gives direction to the level of their achievement.

4.9.10.3 Dependability

Dependability is "the degree to which the stability of the data is maintained over time and alterations made in the researcher's decisions during the analysis process." (Graneheim & Lundman, 2004, pp. 110). In Phases 1 and 3 of the study, an audit trail was maintained to evaluate the decisions taken throughout the analysis of qualitative data and to assess the dependability of the data. This included the raw data in the form of printouts of the participants' responses and notes on the development of the coding frame. The study supervisors checked the coding and categorisation of the data.

4.9.10.4 Confirmability

'Confirmability' refers to the objectivity of the data and the degree to which the results could be confirmed or corroborated by others. This was achieved by the audio recordings of the focus groups, to enhance the accuracy of data collection. The researcher's experience as a qualified nurse, midwife, educator and client of nursing/midwifery care, helped when it came to understanding the language, nature and culture of the participants who were involved in the study. However, attention was paid to reflexivity (Gerrish & Lacey, 2006). This was achieved by the researcher who constantly evaluated her perceptions and tried her best to interpret the findings in a neutral manner and with minimal bias.

Participants were free to express their opinions and experiences in Maltese or in English. Then a translation was performed rigorously by a linguistic professional and confirmed by the local supervisor. Additionally, discussions took place to finalise the findings derived from the transcribed and translated data.

4.9.10.5 Validity

Focus groups are reported to have high face validity which refers to whether the instrument "looks as though it is measuring the appropriate construct" (Polit & Beck, 2008, pp. 458). Thus, case scenarios were used to guide the focus groups and address directly the content of clients' needs and related spiritual care, from which competencies were then generated. The focus groups discussions were a useful method for deriving collective opinions, values and beliefs from a homogenous group of experts.

'Content validity' is concerned with the "degree to which an instrument has an appropriate sample of items for the construct being measured" (Polit & Beck, 2004, pp. 423). This was achieved through an in-depth literature review as well as through focus groups discussions which captured the content of the identified competency domains and competencies in spiritual care. In Phase 3 of the study, the views of the local and international experts contributed to the content validity of the framework of competencies in spiritual care at pre- and post-registration levels.

Other types of validity have been identified by Maxwell (1992). These were used to monitor the validity of qualitative data in this study. These involve 'descriptive validity,' which refers to the factual accuracy of the discussion account which was achieved by the:

- Audio recorded focus groups which were subsequently transcribed verbatim by the researcher.
- The Maltese version transcripts which were translated into English were validated by the moderator to ensure that the original Maltese version which was expressed by participants was retained.

'Interpretive validity' refers to the discussion accounts grounded in the participants' language and the use of direct connotations of participants. This is supported by theoretical validity which provides rationale to the findings. A balance between the

direct connotations of participants and their scientific interpretations were presented in the study's findings chapter and discussion chapter.

4.10 Ethical issues involved in the study

The researcher should promote ethical practice and be committed to an ethical approach (Bowling, 2009). The main ethical issues were self-determination, anonymity and confidentiality. To safeguard participants' self-determination they were recruited by a mediator to avoid feeling pressurised to participate. This was especially important as most of the local participant nurses/midwives and all the local nursing/midwifery educators were known to the researcher. Participants were informed about the aims and objectives of the study and their role as participants. They were informed that participation was voluntary and that they could refuse or withdraw from the study at any time without giving any reason and without any consequences. Their written consent to participate was obtained. Personal letters and follow-up e-mails and Short Message Service (SMS) were the communication methods used to contact potential participants. Non-respondents were sent three reminders as a follow up and with the intention to improve the response rate.

It was not possible to maintain anonymity, as participants in the three phases of the study were known to the researcher. Participants in the focus groups became acquainted with one another during the discussions. However, measures were taken to maintain confidentiality and quasi-anonymity (Vernon, 2009) to prevent the identification of participants. Names were replaced by codes and the modified Delphi process responses were password protected. Personal and identifying information, such as audio recordings, were locked away at all times and access was prohibited to third parties. These recordings will be erased on the successful completion of the study. Participants were assured that the researcher will abide by the requirements of the Data Protection Act, 1998 and The Privacy and Electronic Communications (EC Directive) Regulations, (2003).

Ethical approval for the three phases of the study was sought and granted from the University of Malta and the former University of Glamorgan Faculty Research Ethics

Committee (UREC). Locally, institutional permissions were obtained from the Head of Nursing/Midwifery, the Departmental Nursing/Midwifery Officers and the various chairpersons of the medical, surgical, mental health and obstetric services.

4.11 Summary of the methods

Phase 1 addressed the first research question and focused on the development of a competency framework for spiritual care in three stages. The first stage involved competency item generation through analysis of the literature and research (Chapter 2). The second stage involved further competency item generation through five focus groups which took place between 14th September, 2010 and 14th March, 2011, followed by analysis using the qualitative content analysis framework (Krueger & Casey, 2009). The third stage involved 'cleaning' and 'collapsing' of the numerous competency items generated into holistic items which demonstrates the complexity of spiritual care. The modified Delphi research tool resulted in 55 competency items, which were grouped manually into seven domains.

Phase 2 utilised a modified Delphi approach to evaluate the identified competency items. Experts were recruited on the basis of: Knowledge and experience of spiritual care guided by the 'fundamental ways of knowing' (Carper, 1978), the theory 'from novice to expert' (Benner, 1984) and the 'Spiritual Care Competency Scale' (SCCS) (van Leeuwen *et al.,* 2008). Data underwent descriptive, inferential and non-parametric statistics, namely: the mean, standard deviation, 95% confidence interval of the population mean and the percentage of agreement for each competency item. Consensus was set at a threshold of 75% or greater in both the modified Delphi rounds. This was achieved by the scores within the highest region of the scale on a 7-point Likert scale (5, 6, or 7).

The second round of data underwent reliability testing by Cronbach alpha coefficient, which demonstrated an acceptable homogenous tool. In addition to this, Round 2 data underwent construct validity testing, which demonstrated the cultural dimension in spiritual care in Malta. This will be tackled in greater detail in Chapter 5.

Phase 3 consisted of an exploratory consultation survey to obtain a pragmatic view on the identified framework of competencies in spiritual care. Three options were offered to participants to rank each item of the framework as 'Essential at pre-registration level,' 'Essential at post-registration level' and 'Not essential at either levels.' Consensus was set at a 51% or greater threshold. Therefore, the items were classified as competencies achievable at pre- or post-registration levels in nursing/midwifery.

The qualitative data from the questionnaire identified the influencing factors which may enhance or hinder the potential integration of the competency framework in education and clinical practice. This will be considered in greater detail in the subsequent chapter.

CHAPTER 5: THE FINDINGS

5.1 Introduction

The quantitative and qualitative findings of the three phases of the study are presented in this chapter as follow:

Phase 1 involved item generation through a three phase literature review and five focus groups.

Phase 2 consisted of the process of consensus by the modified Delphi study.

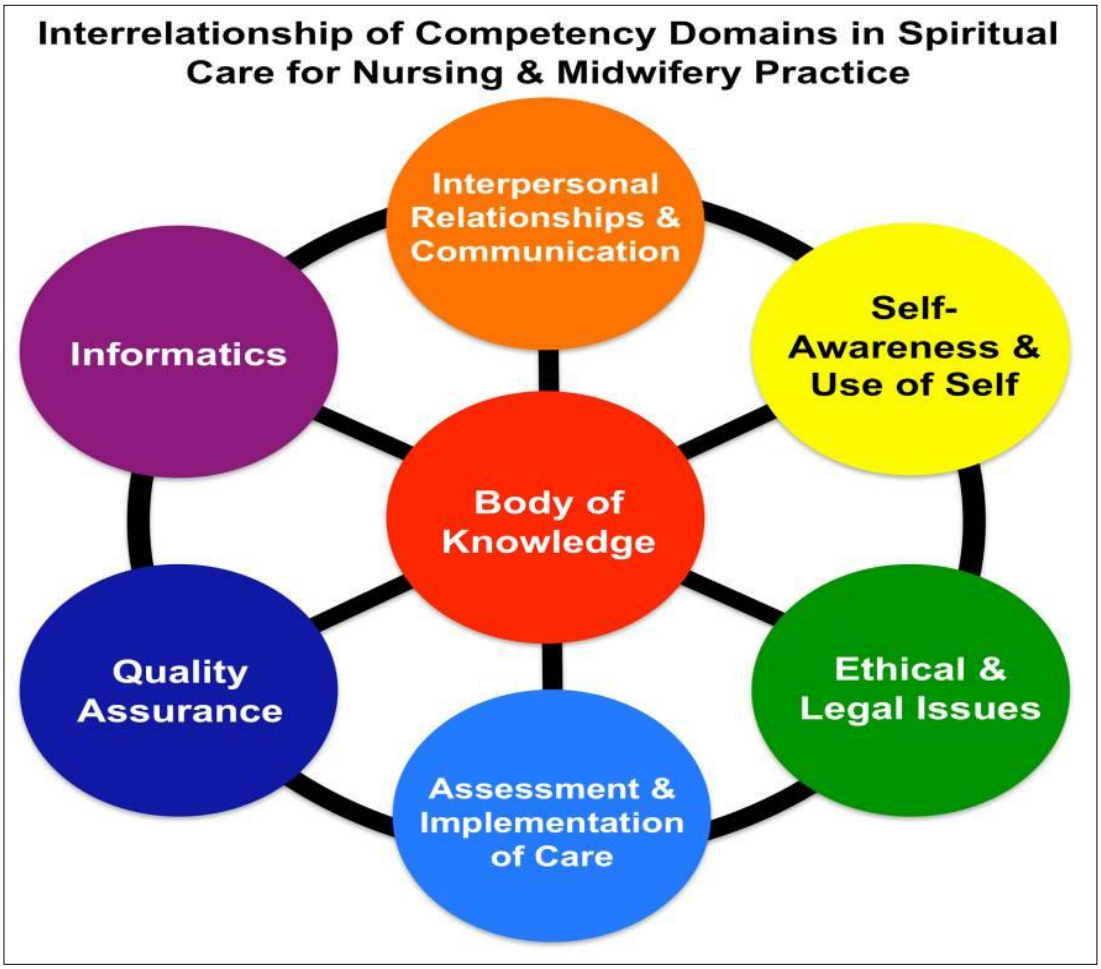
Phase 3 reports the consultation process with international researchers and the modified Delphi experts with a background in education, regarding the developed framework of competencies in spiritual care at point of registration and post-registration levels.

The aim of Phase 1 (Section 5.2: Phase 1/Stage 1) is to generate competency items and domains in spiritual care in nursing/midwifery from an in-depth literature review. A list of items is then generated from the discussions of the five focus groups with service users and service providers (Section 5.3: Phase 1/Stage 2). Consequently, this phase will generate a list of competency items and domains to be evaluated by a panel of 'experts' through the modified Delphi approach.

5.2 PHASE 1/STAGE 1: Item generation from the literature review

The aim of a three phase literature review was to identify substantial information from research to formulate a list of competencies and domains on what nurses/midwives should know, be able to do and think on the provision of spiritual care to clients and their families, in liaison with the members of the multidisciplinary team (MDT). Based on the literature reviewed in Chapter 2, seven key competency domains in spiritual care in nursing/midwifery were identified (Section 2.4) and are shown in Figure 5.1.

Figure 5.1 Competency domains derived from literature review



5.2.1 Competency domains and items identified from literature review

These competency domains and items aim to address the educational deficit identified in research, as outlined in Chapters 1 and 2. Table 5.1 presents the seven domains and 116 competency items which were identified in Section 2.4.

Table 5.1 Competency items elicited from literature review

Domain 1:	Body of knowledge in spiritual care
1	Demonstrate a broad understanding of spirituality integral to holistic care (Burkhart, Schmidt & Hogan 2008).
2	Demonstrate knowledge and understanding of the main world faiths (Reimer-Kirkham *et al*., 2012).
3	Appreciate that all individuals have a spiritual dimension and some have a religious element to their spirituality (Swinton, 2012).
4	Appreciate the role of chaplains and spiritual leaders in providing spiritual care (Jankowski, Hanzo & Flannelly, 2011).
5	Demonstrate knowledge in responding to questions of life's meaning and purpose clients might pose (Narayanasamy *et al*., 2012).
6	Demonstrate knowledge of different beliefs and practices with particular reference to their influence during illness and birth (Miller & Shriver, 2012).
7	Seek resources that will inform nurses regarding health care options in line with the client's religious/spiritual beliefs and practices (Koenig, 2012).
8	Demonstrate knowledge of formal spiritual assessment tools (McSherry & Ross, 2010).
9	Demonstrate knowledge of Informal methods of assessment using generic questions on clients' feelings and concerns (Holloway *et al*., 2011).
10	Demonstrate knowledge in helping skills as attributes integral of spiritual (Biro, 2012).
11	Recognise the importance of prioritising the spiritual dimension of care in providing care (Swinton, 2001).
12	Recognise that religion may be a significant element in the clients' life (Koeing, 2012).
13	Recognise nurses/midwives' role in providing spiritual care integral to holistic care (Baldacchino, 2009).
14	Value the importance of a psycho-social approach to care while recognising the ambiguity between spirituality and psychosocial care (Clarke, 2009).
15	Recognise the spiritual dimension of care is important to believers and non-believers (Draper, 2011).
Domain 2:	Self-awareness and use of self
16	Recognise importance of own spirituality and use of self in providing spiritual care (van Leeuwen & Cusveller, 2004).
17	Recognise own limitations and access assistance from the appropriate members of the multi-disciplinary team (Baldacchino, 2006).
18	Demonstrate the ability not to impose own beliefs in care (McSherry & Ross, 2012).
19	Demonstrate personal awareness of one's own values and beliefs (Ross, 2006).
20	Recognise that their own spirituality may affect how they interact with clients beliefs (Kalish, 2012).
21	Appreciate the value of own experiences without imposing such experiences on others (Chambers, Thompson & Narayanasamy, 2013).
22	Appreciate the importance of seeking reflective activities in meeting one's inner feelings in order to move on (Tiew, Creedy & Chan, 2013).

Table 5.1 Competency items elicited from literature review (cont.)

Domain 3:	Communication and interpersonal relationship in spiritual care
23	Identify self-awareness as a resource to understand clients' inner feelings (van Leeuwen *et al.,* 2009).
24	Understand the importance of verbal and non-verbal communication (Leonard, Graham & Bonacum, 2004).
25	Able to develop trusting relationships with clients and family in order to journey the illness with them (Baldacchino, 2006).
26	Able to listen actively, connect and maintain presence with the client (Clarke, 2013).
27	Acknowledge the importance of clients narrating their sufferings and pray with the client if he/she requests (Taylor, 2006).
28	Demonstrate support and presence in being with the client (Carr, 2008).
29	Assess barriers to effective communication, such as language, culture and religion and make appropriate adaptations (Narayanasamy, 2006).
30	Listen to clients and their family, empathise and demonstrate presence (NMC, 2010).
31	Recognise spiritual/religious resources as a coping mechanism in clients and their families experiencing loss (Dailey & Stuart, 2007).
32	Understand the importance of active listening to the clients' narratives (Hodnett *et al*., 2007).
33	Recognise the need for companionship, support, trust and encouragement to clients and their families (Baldacchino, 2010).
34	Recognise that effective therapeutic nurse/midwife-client is the core for the provision of spiritual care (Biro, 2012)
35	Adapt barriers to effective communication (such as fear) by demonstrating active listening and empathy (Papastavrou *et al*., 2012)
36	Demonstrate ability in building trustful relationships with clients and their families (Attard, Baldacchino & Camilleri, 2014).
37	Demonstrate good communication skills, such as good questioning techniques to elicit clients' life stories (Holloway *et al*., 2011).
38	Recognise the essentials for a caring conversation such as communicating in language and terms they can understand, presence, touch and listening (Clarke, 2013).
39	Recognise connection with clients through verbal and non-verbal expressions, such as eye contact, warmth of the voice and praying with the client (Taylor, 2003).
40	Recognise the importance of a trustful relationship with clients to assess clients' inner thoughts and feelings (Mok & Chiu, 2004).
41	Demonstrate compassionate listening through attention, interest and time to dialogue with clients (Kimble & Bamford-Wade, 2013).
42	Demonstrate understanding of clients' lived experiences to confide their spiritual concerns to alleviate their fear and anxiety (Kimble & Bamford-Wade, 2013).
43	Appreciate touch as a means of communicating empathy, caring, affection and concern if not inhibited by clients' culture (Edvardsson, Sandman & Rasmussen, 2003).
44	Provide empathy, time, courage, therapeutic touch to clients (Puchalski *et al.,* 2009).
45	Acknowledge the importance to practice rituals significant to clients' beliefs during hospitalisation or in the community (Hall & Taylor, 2004).

Table 5.1 Competency items elicited from literature review (cont.)

Domain 3:	**Communication and interpersonal relationship in spiritual care**
46	Recognise spiritual care integral to any compassionate and client -centred health care system, honouring the dignity of all people (Puchalski, 2009).
47	Demonstrate ability to address spirituality with clients of different cultures (van Leeuwen & Cusveller (2004).
48	Ensure that clients have therapeutic presence of family, friends (Baldacchino, 2006).
49	Appreciate the value of therapeutic presence and non-verbal communication in promoting clients' positive self-concept - hope, courage and support (Taylor, 2006).
50	Demonstrate an accepting non – judgemental attitude while communicating with clients' life concerns (van Leeuwen *et al.,* 2008).
Domain 4:	**Ethical and legal issues in spiritual care**
51	Show respect for clients' diverse religions, beliefs and practices.
52	Demonstrate non-judgmental behaviour towards clients' diversity (Narayanasamy & Narayanasamy, 2012).
53	Respect clients' right for information when reaching decisions regarding their illness, care and treatment (Koenig, 2007).
54	Respect right to decline spiritual care (McSherry & Ross, 2002).
55	Demonstrate sensitivity and respect for diversity in care choices and health beliefs (Hayes, 2004).
56	Respect and acknowledge the role of clergy and spiritual leaders in providing spiritual care (Jankowski, Hanzo & Flannelly, 2011).
57	Restrict barriers to spiritual care such as lack of time among stake holders' desire for specialisation rather than humanisation (Behruzi *et al.,* 2013).
58	Demonstrate sensitivity and respect for the client's diverse healthcare choices influenced by religious/spiritual beliefs and practices (Puchalski *et al*., 2009).
59	Demonstrate sensitivity and respect to clients' decisions in their care, free from manipulation and coercion (Polzer-Casarez & Engebretson, 2012).
60	Demonstrate non-judgmental attitudes to diverse spiritual beliefs (Pesut, 2006).
61	Acknowledge and respect confidentiality issues in addressing clients' spiritual healthcare needs (Puchalski *et al*., 2009).
62	Acknowledge and respect clients' confidentiality when disclosing personal information to members of the multi-disciplinary team (Baldacchino, 2006).
63	Recognise the ethical obligation to attend to clients' holistic needs abiding with the ethical and legal principles (Sulmasy, 2012).
64	Restrict presence of too many healthcare professionals with consequent lack of privacy and continuity of care (Behruzi *et al.,* 2012).
65	Demonstrate sensitivity and responsiveness to clients' spiritual and health needs free from manipulation and coercion (Polzer-Casarez & Engebretson, 2012).
66	Identify intersections of legal, ethical, religious/spiritual concerns and beliefs and seek advice (Pesut, 2006).
67	Protect clients' vulnerability in particular in times of illness and sufferings (Beauchamp & Childress, 2009).

Table 5.1 Competency items elicited from literature review (cont.)

Domain 4:	Ethical and legal issues in spiritual care (cont.)
68	Demonstrate tolerance and respect for clients' individual characteristics in their way of thinking (Sulmasy, 2012).
69	Provide consistent information about clients' welfare (Cockell & McSherry, 2012).
70	Demonstrate a non-judgmental attitude towards clients and their families (van Leeuwen *et al.,* 2006).
71	Identify and respect clients' religious beliefs and practices that promote a positive self-concept and integrity (Narayanasamy, 2004).
72	Safeguard healthcare providers' ethical and legal rights to protect and maintain professional boundaries (Beauchamp & Childress, 2009).
73	Respect and guard clients' right for autonomy and dignity (Beauchamp & Childress, 2009).
74	Disclose consistent information regarding the clients' welfare in a sympathetic and tactful way (Puchalski *et al*., 2009).
75	Maintain confidentiality when documenting clients' spiritual needs and interventions (McSherry & Ross, 2002).
Domain 5:	**Quality assurance in spiritual care**
76	Identify personal education, training and development needs in spiritual care and identify resources to access them (RCN, 2011).
77	Participate in group discussion and experiential exercises to enhance spiritual awareness (Mooney & Timmins, 2007).
78	Recognise the role and responsibility of nurses/midwives in the provision of spiritual care (McSherry & Ross, 2010).
79	Appreciate the role and responsibility of other members of the care team in the provision of spiritual/religious care (Jankowski, Hanzo & Flannelly, 2011).
80	Collaborate with members of the healthcare team in providing spiritual/religious care (Fitchett, 2011).
81	Recognise the role of chaplains, social workers and other members of the multi-disciplinary team in the provision of spiritual/religious care (Nolan & Holloway, 2014).
82	Recognise the need for spiritual support of healthcare professionals (Puchalski, Dorff & Hendi, 2004).
83	Collaborate in the integration of spirituality in nursing/midwifery programmes (Cooper *et al*., 2013).
84	Demonstrate an ability to maintain appropriate professional boundaries (McSherry & Jamieson, 2013). .
85	Understand the importance of reflection on own practice in relation to meeting spiritual needs (Smith & Gordon, 2009).
86	Demonstrate personal growth, high moral values and lives directed to spiritual principles (Ross, 2006).
87	Understand the importance of reflection on own practice and make changes as required (Tiew, Creedy & Chan, 2013).
88	Demonstrate attributes of understanding, caring, courage, reassurance and empowerment with clients (Pitkanen *et al.*, 2008).

Table 5.1 Competency items elicited from literature review (cont.)

Domain 5:	Quality assurance in spiritual care (cont.)
89	Demonstrate a 'positiveness' with clients by being genuine, instilling hope, integrating beliefs and prayer, and practising faith traditions (Burkhart, Schmidt & Hogan, 2008).
90	Demonstrate a professional attitude of trust and conduct (NMC, 2010).
91	Appreciate the vocational elements of the profession in clinical nursing/midwifery basic care (Clarke, 2013).
92	Appreciate the contribution of alternative therapies, such as meditation, music and creative art as spiritual care interventions (Puig *et al*., 2006).
93	Participate in the creation of a supportive, caring environment for clients and their families (Attard, Baldacchino & Camilleri, 2014).
94	Participate in the creation of a spiritually healthy workforce, teamwork and support systems available (Lombardo & Eyre, 2011).
95	Foster an environment that determines spiritual well-being through calmness and quietness (Mok & Chiu, 2004).
96	Understand the importance of own life experiences in own practice in relation to spiritual care (Baldacchino, 2006).
97	Recognise the need to participate in learning events on spiritual care (Smith & Gordon 2009).
98	Emphasise the importance of personal and professional development, and spiritual formation of health care providers (Puchalski *et al.,* 2009).
Domain 6:	**Assessment and implementation of spiritual care**
99	Acknowledge the role of nurses/midwives in assessing of clients' spiritual needs (Baldacchino, 2009).
100	Acknowledge the use of formal and informal methods of spiritual assessment (Draper, 2012).
101	Identify distinctions between spiritual and religious needs (McSherry & Ross, 2010).
102	Demonstrate ability to formally assess spiritual/religious needs (Pike, 2011).
103	Demonstrate ability to assess spiritual/religious needs informally by observing cues and listening to clients' life experiences (Holloway *et al*., 2011).
104	Recognise spiritual conflict and distress in clients and their family (van Leeuwen *et al*., 2009).
105	Ensure privacy, confidentiality and adequate time for spiritual assessment, planning and implementing spiritual/religious interventions (McSherry & Ross, 2010).
106	Plan and provide interventions that meet the clients' and family spiritual needs (Draper, 2012).
107	Provide caring interventions to meet clients' needs in a humane way through their suffering whilst keeping up realistic hope (Puchalski *et al.,* 2009).
108	Comply with clients' request for prayer and other religious mementoes significant to the clients (Miller & Shriver, 2012).
109	Identify the need to consult the chaplain/spiritual leader or members of the multidisciplinary team as often as the client requests (Fitchett, 2011).
110	Assist clients' to find meaning and purpose in their grief and sufferings (Hodge & Horvath, 2011).

Table 5.1 Competency items elicited from literature review (cont.)

Domain 6:	Assessment and implementation of spiritual care (cont.)
111	Evaluate care given and make adaptations to meet unmet spiritual/religious needs (Narayanasamy, 2004).
112	Identify met spiritual/religious needs through clients' spiritual integrity displayed through internal peace, acceptance and meaningful behaviour (Narayanasamy, 2004).
Domain 7:	**Informatics in spiritual care**
113	Identify the importance of information technology to enhance knowledge on spiritual care (Smith & Gordon, 2009).
114	Use information technology to inform and guide nurses/midwives future evidence-based practice in various crises situations (Wagner & Maercker, 2007).
115	Acknowledge the use of information technology as a valuable learning tool, when dealing with spiritual care issues (NCN, 2011).
116	Acknowledge the use of information technology as a means of documenting spiritual care delivered (Burkhart & Androwich, 2009).

5.3 PHASE 1/STAGE 2: Item generation from the focus groups

Following the generation of the competency items from the literature review, five focus groups were conducted to collaborate with service providers and service users to obtain in-depth perceptions in order to elicit competencies in spiritual care namely: qualified nurses/midwives, pre-registration nursing/midwifery educators, chaplains and spiritual leaders, clients of nursing/midwifery and parents/informal carers.

A total of 46 participants contributed to the discussions. 17 were males and 29 were females who were between 24 and 54 years of age. The service providers participating in these focus groups had a mean 14.4 years of working experience. The next section presents the findings of Focus Group 1 (Tables 5.2 - 5.5) which was also used as a pilot study. Details of Focus Groups 2 to 5 are included in Appendix 13. summarises the emerged focus groups categories and themes relating to each domain.

Further developments need to be undertaken to ensure that competencies identified through the literature review and focus groups are collapsed in order to formulate a list of competencies in spiritual care for validation using the modified Delphi approach.

5.3.1 Focus Group 1: Qualified nurses/midwives

5.3.1.1 Focus Group 1: Demographic data

Table 5.2 shows the demographic characteristics of Focus Group 1 (nurses/midwives).

Table 5.2 Demographic characteristics of Focus Group 1

Focus Group 1: Qualified nurses/midwives	
Characteristics	**Findings**
Gender	
Males	2
Females	7
Total number of participants	**9**
Clinical experience (Years)	Mean = 10.4 Range: 6.5- 18 years
Age	Mean = 36.2 Range: 24-52 years
Clinical Experience (Area)	
Medical	1
Surgical	1
Mental health	1
Paediatric	1
Maternity	5

Seven of the nine participants were female (n=7). All had over six years' clinical experience and worked in various clinical settings.

5.3.1.2 Focus Group 1: Results of thematic analysis

Four themes emerged from Focus Group 1, which involved qualified nurses/midwives with the necessary skills required to deliver meaningful spiritual care. These themes determine the quality of spiritual care interventions and also include the various barriers which may inhibit the quality of spiritual care (Tables 5.3 – 5.4).

Table 5.3 Codes, categories and themes generated from Focus Group 1

Focus Group 1: Qualified nurses/midwives Codes	Categories	Themes
Spiritual himself/herself, use of self, respect for diverse religions, beliefs and practices.	**1.1** Personal spirituality.	**1.** Nurses'/ midwives' personal characteristics when providing spiritual care.
Understanding, wise, caring, warm, knowledgeable, standing up for the client, responsible, respectful, trustful, resourceful, reflective, client-focused, empowering, has a holistic and individualised view of care, cheerful, non-judgmental, creative, reassuring, supportive, emotionally mature, feeling responsible, guilt feelings, emotionally moved, empathetic, expressing feelings of fear, breaking bad news, tending to negative/strange reactions of grief.	**1.2** Personal attributes.	
Holistic care, meaning of spirituality, knowledge of the world's main religions, knowledge of religious/spiritual movements, access for support from colleagues, spiritual director, counsellor.	**2.1** Need for knowledge on spiritual/ religious issues.	**2.** Requirements for providing spiritual care.
Experiential learning, multi-disciplinary participation in support groups and multi-disciplinary discussions, CPD in spiritual issues, how to access spiritual support, Reflective practice, keeping of reflective diaries, inclusion of spirituality in training, spiritual development of students, quality vs. quantity training of students, self-awareness sessions, clinical supervision, participating in voluntary work, access and use of internet by the younger generation. No access to internet on the wards.	**2.2** Education on spiritual care.	
Holistic care, individualised care vs. task allocation, continuity of care, privacy, enriching people, identify spiritual/religious/psychological/ ethical needs, diagnose spiritual distress, referral to other members of multi-disciplinary team (MDT), providing care, reflective practice, dignity of patients, Helping people get through difficult times, referral to spiritual/religious advisor.	**2.3** Organisation of spiritual care.	

Table 5.3 Codes, categories and themes generated from Focus Group 1 (cont.)

Focus Group 1: Qualified nurses/midwives Codes	Categories	Themes
Trusting relationship, being with, presence, connection, silence, touch, reassuring, lost for words, tactful with words, active listening, journey with client, questioning, responding, intuition, storytelling, praying with clients.	**3.1** Therapeutic client-nurse/midwife relationship	**3.** Spiritual care interventions
Support, company, guilt, anger, isolated, finding meaning and purpose, body image, comfort, coping with spiritual distress, access to spiritual practices/routines.	**3.2** Dealing with clients' emotional needs	
Truth vs. hope, withholding information to 'protect' patient vs. right for information, decisions to withhold treatment, last wishes, questions surrounding resuscitation, acceptance of treatment, 'ethical' group to decide, decline spiritual care.	**3.3** Clients' need for information to reach decisions	
Giving hope, team spirit, calm, access to counsellors, chaplains, bible praying, acceptance, music, painting, scenery, praying, at peace with oneself, maintaining religious and non-religious practices, positive ward culture, close team.	**3.4** Creating a spiritual environment for clients and staff.	
Lack of time, lack of continuous and continuity of spiritual support, lack of knowledge, intolerance.	**4.1** Barriers to spiritual care	**4.** Barriers to the provision of spiritual care

Table 5.4 Themes, categories and exemplars generated from Focus Group 1

Focus Group 1:	**Qualified nurses/midwives**
THEME 1:	**Personal characteristics of nurses'/midwives' in providing spiritual care.**
Category 1.1	**Nurses'/midwives' personal spirituality**
Exemplar: "*I think that on the midwife's side, there was the need for her personally. The midwife used herself just to be with the mother even if this practically meant doing and saying nothing." (P1)*	
Category 1.2	**Nurses'/midwives' personal attributes**
Exemplars: "*I think that there was already a trustful relationship between her and the midwife. She surely needed a lot of support when she came to face the truth and in her (the midwife), she found someone who would face it with her. She reassured her that she is going to journey with her whatever the situation. She had a lot of security." (P1).* "*I think you need to empathise. This means to feel the same thing that they would feel in the same situation. The midwife needs spiritual help because since the midwife got attached to the mother she would feel responsible that perhaps she should have done something to change the situation. Perhaps tell her to come before (to hospital), you will start having these question marks. Could I have done something else?" (P2)*	
THEME 2:	**Requirements for providing spiritual care.**
Category 2.1	**Nurses'/midwives' need for knowledge on spiritual/religious issues**
Exemplars: "*Lately we got to know that spiritual care is part of holistic care, we didn't know it before" (P2).* "*In the Malta we are having people of different religions. I came across a case where I asked the mother to baptize the baby (normal practice when baby is in critical condition). She replied that she does not believe in baptism. I kept thinking about her reply. I found out that she belonged to the Evangelist church. I don't know anything of this religion. You need to respect the different needs They (members of the multi-disciplinary team) have to be reachable because they are available. I have no idea how to reach a psychologist" (P7).*	
Category 2.2	**Nurses'/midwives' need for education on spiritual care**
Exemplars: "*When you are on the wards you will immediately find yourself in these situations whether you're a qualified staff or student. So you cannot wait to address spiritual needs through experience. We need to review our training, we need lessons on spirituality. If you are alone you have to face the situation, you are not going to be accompanied by someone with experience" (P2).* "*We need something like a reflective dairy not so academic, in the sense we have to do an assignment with the references. But perhaps a reflective dairy can share more their personal experience because otherwise you're going to lose the spiritual touch. We also need to get them out and perhaps do voluntary work like the experience we had in Lourdes" (P4).*	

Table 5.4 Themes, categories and exemplars generated from Focus Group 1 (cont.)

Focus Group 1: Qualified nurses/midwives
THEME 2: Requirements for providing spiritual care.
Category 2.3 Organisation of spiritual care
Exemplars: "*I like to leave the couple alone to give them privacy and time together to come to terms with the situation (P3).*" *"Not all clients want to be alone. The couple I had did not want to stay alone. They had the baby (stillborn), and when they came to have their second baby they wanted me as the midwife. I thought that they would want to avoid me, not to bring memories of their previous experience. But it wasn't like that" (P6).*
THEME 3: Spiritual care interventions
Category 3.1 Therapeutic client-nurse/midwife relationship
Exemplar*:* *"I prefer first to hear their view even just by touching their hand and listen to them because it is important to be aware of their expectations as they come up with many questions. It is true that sometimes you don't know the answer, but at least you are aware what they are going through" (P3).*
Category 3.2 Dealing with clients' emotional needs
Exemplar: *"Two important spiritual aspects that I see is 'What have I done to deserve this? And why me?' I was there trying to support this woman who had just lost her baby. All of a sudden and in a very angry tone of voice he shouted to his wife 'Stop acting this way, leave this baby, this time will pass, and we will have another one' I kept wondering why he [had] reacted in that way. I was driven [taken] aback as it seemed that he needed some help too" (P4).*
Category 3.3 Clients' need for information to reach decisions
Exemplar: "*We have a 50 year old lady suffering of Huntington. Her parents, brothers and sisters come to visit every day. Her parents do not know that their children have decided that their sister is not for resuscitation. On the other hand her parents tell us to do everything possible" (P3).*
Category 3.4 Creating a spiritual environment for clients and staff
Exemplar: "*I suggest that there should be reflective groups in the hospital and in the wards where they would be able to discuss and be able to refer actual cases to different members of a multi-disciplinary team, like the chaplain, spiritual advisors, psychologist and bereavement midwife. On the wards, team spirit is also very important to work in harmony will all members of the multi-disciplinary team*" (P4).

Table 5.4 Themes, categories and exemplars generated from Focus Group 1 (cont.)

Focus Group 1: Qualified nurses/midwives	
THEME 4:	**Barriers to the provision of spiritual care**
Category 4.1	**Barriers to spiritual care**
Exemplars: *"The problem is that till the news is broken you will find support but then because of the workload, midwives are busy [and] support stops. From a personal experience, I remember that once back at home we were told to contact the bereavement midwife and found out that no support groups were going on. So now what do we do?" (P5)* *"A patient may find comfort in music or painting. We should encourage this and not complain and maybe the patient is told off because she is making a mess" (P7).*	

5.3.1.3 Focus Group 1: Generated competencies

Table 5.5 presents thirty one competency items derived from Focus Group 1 which involved nine nurses/midwives). Twenty five items were similar to those identified from the literature review (Appendix 8). However, six new items (shown with an asterisk [*] and marked in bold) were added to the list of competencies (Table 5.1).

Table 5.5 Competencies in spiritual care derived from Focus Group 1

Focus Group 1: Nurses/midwives	
1	Recognise importance of own spirituality and use of self in providing spiritual care.
2	Show respect for clients' diverse religion, beliefs and practices.
3	Demonstrate attributes of wisdom, reassurance, warmth, joy, responsibility, trust, respect, support, understanding, and caring for clients.
4	Demonstrate a reflective, holistic and individualised view of care.
5	***Stand up for the client, empowering clients to reach decisions in their own care.**
6	Demonstrate non- judgmental behaviour towards clients' diversity.
7	Demonstrate creativity in purposeful activity, such as keeping with clients' traditions, beliefs, work and routines.
8	***Be emotionally mature by having the capacity to witness and endure distress while sustaining an attitude of hope.**
9	Demonstrate empathy, support and responsibility when dealing with complex life issues.

Table 5.5 Competencies in spiritual care derived from Focus Group 1 (cont.)

Focus Group 1: Nurses/midwives	
10	***Be able to give without feeling drained, grieve appropriately and let go.**
11	Understand the importance of verbal and non-verbal communication.
12	Able to develop trusting relationships with clients and family in order to journey the illness with them.
13	Able to listen actively, connect and maintain presence with the client.
14	Acknowledge the importance of clients narrating their sufferings and pray with the client if he/she requests this.
15	Able to recognise and respond appropriately to emotions of anger, isolation and conflict in clients and families.
16	Able to discern and address complex spiritual needs in situations of spiritual distress.
17	Assist clients and families to make sense of and derive meaning from experiences, including illness.
18	Demonstrate an awareness of spiritual resources and how these can be accessed.
19	Respect clients' right for information in reaching decisions regarding their illness, care and treatment.
20	***Offer support, comfort and realistic hope to clients and families.**
21	Respect right to decline spiritual care.
22	Able to recognise complex ethical issues and refer appropriately.
23	Demonstrate a broad understanding of spirituality integral to holistic care.
24	Able to recognise spiritual, religious, psychological and ethical issues.
25	Recognise own limitations and access assistance from the appropriate members of the multi-disciplinary team.
26	***Assist in the provision and supervision of members in the team engaged in spiritual care.**
27	Identify personal education, training and development needs in spiritual care and identify resources to access them.
28	Acknowledge reflective diaries as a source to reflect on spiritual care.
29	Identify the importance of information technology to enhance knowledge on spiritual care.
30	Participate in group discussions and experiential exercises to enhance spiritual awareness.
31	***Assist in the spiritual development and growth of students.**

5.4 Overview of focus groups

Overall, the narratives by the five different participant groups generated themes and categories presented in Table 5.6. These themes and categories complemented the range of issues raised during the discussions by the service users and service providers of spiritual care which generated the lists of competency items. These themes, categories and competency items from the literature review and focus groups were further analysed and collapsed as shown in the following sections.

5.5 Phase 1/Stage 3: Cleaning and collapse of data

Data and theoretical triangulation methods of data collection enriched the generation of competency domains and items in spiritual care (Polit & Beck, 2014). The literature review identified the preliminary set of competency items. However, the focus groups with the various experiences of spiritual care givers, educators in nursing/midwifery and the clients helped to obtain in depth data which generated a wider perspective of a set of competency items (Appendices 8-13). These items were submitted to experts in the field to reach consensus on a final set of competencies to be achieved by students at point of registration.

5.5.1 Collapse of categories and themes in spiritual care domains

As shown in Table 5.6, the categories and themes generated from the focus groups are summarised and classified into seven domains which were agreed by the research supervisors and an international expert in the field as follows:

- Domain 1: Body of knowledge in spiritual care
- Domain 2: Self-awareness and use of self in spiritual care
- Domain 3: Communication and interpersonal relationship in spiritual care
- Domain 4: Ethical and legal issues in spiritual care
- Domain 5: Quality assurance in spiritual care
- Domain 6: Assessment and implementation of spiritual care
- Domain 7: Informatics in spiritual care

Table 5.6 Summarised categories and themes relating to each domain

Domain 1: Body of knowledge in spiritual care		
Categories	**Themes**	**Domain**
Nurses'/midwives' need for Knowledge on spiritual/religious issues. Knowledge of spiritual/religious aspects of care. Nurses'/midwives' need for spiritual care education at pre- and post-registration. Knowledge of spiritual/religious issues relevant to clients' illness.	Elements in the educational preparation of nursing/midwifery students on spiritual/religious issues.	**BODY OF KNOWLEDGE IN SPIRITUAL CARE**
Domain 2: Self-awareness and use of self in spiritual care		
Categories	**Themes**	**Domain**
Nurses/midwives personal spirituality Vocational calling of nurse/midwife Meaning of spirituality/ religiosity Knowledge of spiritual/ religious interventions and access to resources Knowledge and respect for diverse beliefs and decisions that affect care Maintain professional barriers	The role of nurses/midwives in providing spiritual care Nursing/midwifery as vocational professions Educational preparation of nurses/midwives in spiritual/ religious issues	**SELF-AWARENESS AND USE OF SELF IN SPIRITUAL CARE**

Table 5.6 Summarised categories and themes relating to each domain (cont.)

Domain 3: Communication and interpersonal relationship in spiritual care		
Categories	**Themes**	**Domain**
Effective nurse/midwife-client communication. Dealing with clients' emotional needs. Being with the client and their family. Communication and interpersonal skills. Therapeutic client-nurse/midwife-relationship. Responding to cultural diversity. Nurses/midwives as healers.	Client's need for effective communication and interpersonal skills. Being with the client and their family. Responding to cultural diversity. Maintaining a good client – nurse/midwife relationship while respecting boundaries.	**COMMUNICATION AND INTERPERSONAL RELATIONSHIP IN SPIRITUAL CARE.**
Domain 4: Ethical and legal issues in spiritual care		
Categories	**Themes**	**Domain**
Ethical and legal issues that protect clients and staff. Clients' need for information to reach decisions. Respect for clients' spiritual/religious beliefs and decisions in their care. Respect for Issues pertaining to confidentially, dignity, information, clients' wishes.	Ethical and legal responsibilities relating to spiritual care in relation to the client, the family and team. Clients' rights for confidentiality, privacy, informed choice and dignity.	**ETHICAL AND LEGAL ISSUES IN SPIRITUAL CARE.**

Table 5.6 Summarised categories and themes relating to each domain (cont.)

Domain 5: Quality assurance in spiritual care		
Categories	**Themes**	**Domain**
Creating a spiritual environment for clients and staff. Nurses'/midwives' as providers of humane holistic care. Vocational calling of the nurse/midwife. Providing a multi-disciplinary approach to spiritual care. Maintaining professional boundaries. Professional and educational responsibilities of staff.	Nursing/midwifery as vocational professions. Nurses/midwives as providers of holistic care adopting a multi-disciplinary approach. Nurses'/midwives' responsibility in creating a spiritual environment for clients and staff. Responsibility of nurses/midwives to participate in continuing professional education to improve practice. Maintaining professional boundaries as outlined in the code of ethics.	**QUALITY ASSURANCE IN SPIRITUAL CARE**
Domain 6: Assessment and implementation of spiritual care		
Categories	**Themes**	**Domain**
Organisation of spiritual care. Assessment, implementation and evaluation of spiritual care. Spiritual assessment of clients and their families. Implementation of spiritual care and provision of interventions. Support for clients, their families and professionals. Implementing spiritual/religious interventions to clients and their families in hospital and community. Referral to spiritual leaders and other resources. Barriers to spiritual care.	Assessment of spiritual needs of clients and family. Organisation and Implementation of spiritual/religious interventions in hospital and community to assist clients find meaning and purpose. Referral to spiritual leaders and other members of the multi-disciplinary team.	**ASSESSMENT AND IMPLEMENTATION OF SPIRITUAL CARE**

Table 5.6 Summarised categories and themes relating to each domain (cont.)

Domain 7: Informatics in spiritual care		
Categories	**Themes**	**Domain**
Use of video conferencing as a resource for learning about spiritual care	Information technology a resource to assist spiritual care.	**INFORMATICS IN SPIRITUAL CARE**

5.5.2 Collapse of competency items

A total of 116 competency items were generated through the literature review. 231 competency items were generated from the five focus groups of which 117 items were similar to competencies elicited through the literature review. Hence, 54 'new' items were added to the list of competencies identified through the literature review which totalled 170 competencies.

After exploring, examining connections and combining similar concepts, these competencies were collapsed into 55 generic competency items in spiritual care which were then formulated using the modified Delphi questionnaire (Appendix 14). Due to the complexity of many of the spiritual care competency items, some of them contained several elements. Consequently, the expert participants were asked to interpret each item as a WHOLE (Table 5.7).

For the purposes of the study, only the list of competency items was given to the participants. They were presented with the list of 55 items without the domain headings, so as to minimise the influence of this on their responses.

Table 5.7 Domains and collapsed generic competencies in spiritual care

Core competencies in spiritual care **Domain 1: Body of knowledge in spiritual care (Competencies: 1-14)**
1. Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised (*personalised)* view of care, attentive to the body-mind-spiritual healthcare setting.
2. Identify the influence of the world's major faiths/ religions (*e.g. Christianity, Islam, Judaism, Hindu and Buddhism*) cultural beliefs and practices in the appropriate clinical context and along the lifespan continuum (*from conception to death*).
3. Demonstrate knowledge of the basic spiritual needs of individuals which include: ▪ A meaningful philosophy of life (*values and moral sense*). ▪ A sense of the transcendent (*outside of self, view of deity/higher power and something beyond the immediate life, having hope*). ▪ Belief and faith in self, others and for some a belief in a deity/higher power. ▪ A relatedness to nature and people (*friendship*). ▪ Experiencing love and forgiveness (*a sense of life meaning*).
4. Recognise the importance of the spiritual dimension (*with or without religion*) that sustains physical and mental well-being.
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/her behaviour in dealing with spiritual needs.
7. Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA, RESPECT and HOPE tools*) and informal methods (e.g. *listening to clients*.)
8. Demonstrate knowledge and understanding of the grieving process (*denial, anger, bargaining, depression and acceptance*).
9. Demonstrate knowledge and understanding of spiritual/religious development of individuals and assist spiritual/religious growth.
10. Demonstrate knowledge of complex theories of spirituality, such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations.
11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (*e.g. What have I done to deserve all this?*)
12. Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care.
13. Demonstrate knowledge of resources, support systems/agencies that inform nurses/midwives to access spiritual care for clients, their families and staff in all healthcare settings (*e.g. place for worship, Church and support groups*).
14. Demonstrate knowledge on assisting clients in healthcare according to the clients' religious/spiritual, cultural beliefs, such as the use of complimentary/alternative therapies, diets, nutritional supplements and prayer.

Table 5.7 Domains and collapsed generic competencies in spiritual care (cont.)

Core competencies in spiritual care **Domain 2: Self-awareness and the use of self (Competencies: 15-19)**
15. Be aware of own spirituality and use of self (*e.g. own strengths, limitations, values, beliefs*) as a resource for spiritual care.
16. Recognise the possible impact of the nurse/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care.
17. Acknowledge and respect the influence of clients' diverse cultural world views, beliefs and practices in the expression of their spirituality in healthcare.
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (*e.g. psychologists, chaplains, counsellors, spiritual leaders*) as deemed necessary.
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care.
Core competencies in spiritual care **Domain 3: Communication and interpersonal relationship (Competencies: 20-24)**
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/families in their spiritual needs and sufferings.
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/religious readings and prayer as a means of encouragement and hope.
22. Assess barriers to effective communication in providing spiritual care (*e.g. language, beliefs, culture, anxiety, fear and anger*) and adapt accordingly by active listening, empathy and/or referral to other members of the multi-disciplinary team.
23. Understand and apply the principles of a therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey.
24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/midwife-client relationship (abiding by the professional ethical/legal codes of conduct).
Core competencies in spiritual care **Domain 4: Ethical and legal issues (Competencies: 25-30)**
25. Appreciate the uniqueness of each person and their right to decline spiritual care.
26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/spiritual beliefs, values, practices and lifestyles (*e.g. diet, sexual orientation*).
27. Demonstrate sensitivity, support and respect for the clients' autonomous and diverse healthcare decisions/choices influenced by religious/spiritual beliefs and practices (*e.g. blood transfusion, childbirth practices, chemotherapy*).
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (*self-esteem and self-respect*) and integrity (*adherence to moral and ethical principles*).

Table 5.7 Domains and collapsed generic competencies in spiritual care (cont.)

Core competencies in spiritual care Domain 4: Ethical and legal issues (Competencies: 25-30)
29. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (*self-esteem and self-respect*) and integrity (*adherence to moral and ethical principles*).
30. Acknowledge and respect the clients' right for information and informed consent to empower them and facilitate decision-making regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices.
Core competencies in spiritual care Domain 5: Quality Assurance (Competencies: 31-38)
31. Disclose clients' spiritual/religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team while maintaining confidentiality to safeguard clients' welfare.
32. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/midwife.
33. Implement professional caring behaviour demonstrating altruism (*a sense of giving*), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues.
34. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on.
35. Recognise the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care.
36. Take initiative top participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilise the evidence to bring about practice improvement.
37. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity, such as creative art (*e.g. painting*).
38. Acknowledge the importance of evaluating the environment to determine the extent of spiritual well-being of clients, their families and health carers and modify accordingly.
Core competencies in spiritual care Domain 6: Assessment and implementation of spiritual care (Competencies: 39-51)
39. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all healthcare systems.
40. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) and informal (*listening to the clients' experiences*) assessment methods.
41. Identify signs of spiritual distress in clients and family (*e.g. pain, anxiety, guilt, loss, anger at God and despair*) and plan to address this distress while being aware of barriers to spiritual care such as lack of time and education.

Table 5.7 Domains and collapsed generic competencies in spiritual care (cont.)

Core competencies in spiritual care Domain 6: Assessment and implementation of spiritual care (Competencies: 39-51)
42. Plan spiritual care while identifying its intersections (*shared elements*) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns.
43. Utilise spiritual care models which integrate client-centred care and a problem-based approach, while focusing on holistic care.
44. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically.
45. Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/religious needs maintaining patience, tact, perseverance and discipline.
46. Provide spiritual care interventions sensitively by promoting clients' positive self-concept (*e.g. positive coping techniques*) monitoring spiritual expression while respecting clients who do not conform with advice on their health.
47. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time.
48. Facilitate family participation in the care of their relative to maintain spiritual habits and rituals and identify alternatives to instil hope.
49. Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team.
50. Recognise the importance of timely referral of clients/their families to chaplains/spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*).
51. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow-up.
Core competencies in spiritual care Domain 7: Informatics and spiritual care (Competencies: 52-55)
52. Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care.
53. Acknowledge the use of information technology as a resource of learning about spiritual care.
54. Acknowledge the use of information technology as a means of a communication network with clients/their families and members of the multi-disciplinary team on spiritual issues and spiritual support.
55. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care.
56. Acknowledge the use of information technology, such as Face book, Twitter, Desk Monitor etc. as a medium for spiritual inspirations.

5.6 PHASE 2: Modified Delphi Study

5.6.1 Introduction

The instrument used in this modified Delphi study consisted of three sections (Appendix 23 - 24) as follows:

Section A: This section focused on the collection of demographic data including the name, age, gender, profession and place of work.

Section B: This section included the 55 competency items retained following the completion of Phase One of the study and included the generation of competency items through the literature and focus group discussion. Each competency item had a 7-point scale ranging from Scale 1 'Not Important At All' to Scale 7 'Extremely Important.' Participants were requested to rate the strength of their opinion on the provided scale. A 'Don't Know' option was provided if the respondent had no opinion.

Section C: This provided space for participants to comment about the questionnaire or to express their views about other issues or competencies which may not have been included.

5.6.2 Pre-test of the modified Delphi questionnaire

The questionnaire was pre-tested to assess the adequacy of the information provided in the participant information sheet, clarity of the instructions and items included, adequacy of the response options and time taken for completion. Three participants were chosen randomly from each of the ten groups of the modified Delphi panel. All (n=30) completed the pre-test. The participants' comments were generally very positive, with a number commenting that items were comprehensive and exhaustive and therefore reflected spiritual care. Items presented addressed the everyday issues they faced. There were also positive comments in terms of the ease in responding to the questionnaire. This pre-test identified problems with six items (Items 2, 7, 27, 52, 53 and 55). These included phrases which participants had difficulty understanding, such as 'life span continuum' in Item 2 and 'established assessment tools/informal assessment tools' in Item 7.

Consequently, explanations of these terms were provided near the items as entries in italics. Two participants did not agree with the items pertaining to information technology as a resource of learning about spiritual care and networking as a means of spiritual support (Items 52, 53 and 55). Two other participants also found some items to be similar. As these items were retained following the focus groups in Phase 1 of the study, it was not deemed appropriate to eliminate them at this stage, on an arbitrary basis. The questionnaire took between 20 and 45 minutes to complete with a median of 30 minutes. Only one participant felt the demand made on the respondents was excessive. A copy of the final version of the modified Delphi questionnaire used in this stage of the study is provided in Appendix 23-24.

5.6.3 Stability of the research instrument

For the majority of items, the Kolmogorov-Smirnov p-values were less than the 0.05 level of significance indicating non-normal distribution of data. This was because the distribution of rating scores for each item were very negatively skewed, implying that a large proportion of the rating scores on a 7-point scale were above 5 and few items scored 4 or less. The Spearman's Rank Order correlation test determined the relationship between Test 1 and 2 responses which demonstrated a very strong to strong correlation. A strong significant correlation was identified in the overall domains and total competency items between test-retest (Table 5.8).

Table 5.8 Spearman's rho correlation of competency domains and items

Competency domains and items	Spearman's rho correlation test	p value (2 tailed)	Strength of correlation
Total of 55 items	0.814**	0.001	correlation is strong
Domain 1	0.949**	0.001	correlation is very strong
Domain 2	0.905**	0.001	correlation is very strong
Domain 3	0.842**	0.001	correlation is strong
Domain 4	0.777**	0.001	correlation is strong
Domain 5	0.947**	0.001	correlation is very strong
Domain 6	0.776**	0.001	correlation is strong
Domain 7	0.983**	0.001	correlation is very strong

****correlation is significant at the 0.001 Level**

Thirteen competency items exceeded 0.9 indicating consistency between Test 1 and 2 (shown as Test a-b due to statistical analysis.) Thirty seven items had correlations between 0.7 and 0.9; four had correlations between 0.5 and 0.7. Item 44 had a border line correlation slightly less than 0.5 but was not rejected (Table 5.9).

Table 5.9 Spearman's rho correlation of competency items between tests

Test a-b ITEMS	Spearman's rho	P Value	Strength of correlation	Test a-b ITEMS	Spearman's rho	P Value	Strength of correlation
1a- 1b	0.797**	0.001	Strong	29a-29b	0.698**	0.001	Moderate
2a –2b	0.955**	0.001	Very strong	30a-30b	0.739**	0.001	Strong
3a- 3b	0.892**	0.001	Strong	31a-31b	0.869**	0.001	Strong
4a-4b	0.914**	0.001	Very strong	32a-32b	0.765**	0.001	Strong
5a-5b	0.856**	0.001	Strong	33a-33b	0.885**	0.001	Strong
6a-6b	0.790**	0.001	Strong	34a-34b	0.818**	0.001	Strong
7a-7b	0.845**	0.001	Strong	35a-35b	0.701**	0.001	Strong
8a-8b	0.728**	0.001	Strong	36a-36b	0.720**	0.001	Strong
9a-9b	0.821**	0.001	Strong	37a-37b	0.910**	0.001	Very strong
10a-10b	0.846**	0.001	Strong	38a-38b	0.958**	0.001	Very strong
11a-11b	0.879**	0.001	Strong	39a-39b	0.890**	0.001	Strong
12a-12b	0.945**	0.001	Very strong	40a-40b	0.796**	0.001	Strong
13a-13b	0.910**	0.001	Very strong	41a-41b	0.506**	0.001	Moderate
14a-14b	0.945**	0.001	Very strong	42a-42b	0.858**	0.001	Strong
15a-15b	0.909**	0.001	Very strong	43a-43b	0.887**	0.001	Strong
16a-16b	0.816**	0.001	Strong	44a-44b	0.478**	0.008	Moderate to low
17a-17b	0.741**	0.001	Strong	45a-45b	0.864**	0.001	Strong
18a-18b	0.877**	0.001	Strong	46a-46b	0.893**	0.001	Strong
19a-19b	0.790**	0.001	Strong	47a-47b	0.790**	0.001	Strong
20a-20b	0.764**	0.001	Strong	48a-48b	0.807**	0.001	Strong
21a-21b	0.783**	0.001	Strong	49a-49b	0.745**	0.001	Strong
22a-22b	0.786**	0.001	Strong	50a-50b	0.769**	0.001	Strong

****Correlation is significant at p=≤ 0.001 (2 tailed)**

Table 5.9 Spearman's rho correlation of competency items between tests (cont.)

Test a-b ITEMS	Spearman's rho	p value	Strength of correlation	Test a-b ITEMS	Spearman's rho	P value	Strength of correlation
23a-23b	0.709**	0.001	Strong	51a-51b	0.839**	0.001	Strong
24a-24b	0.574**	0.001	Moderate	52a-52b	0.839**	0.001	Strong
25a-25b	0.614**	0.001	Moderate	53a-53b	0.981**	0.001	Very strong
26a-26b	0.756**	0.001	Strong	54a-54b	0.913**	0.001	Very strong
27a-27b	0.949**	0.001	Very strong	55a-55b	0.962**	0.001	Very strong
28a-28b	0.927**	0.001	Very Strong				

****Correlation is significant at p=≤ 0.001 (2 tailed)**

5.6.4 Reliability testing of the modified Delphi questionnaire

The internal reliability of the tool was tested by Cronbach alpha coefficient, identifying the extent to which the different constructs deliver consistent scores. In the present study, alpha coefficients ranged from 0.58 to 0.97 as displayed in Table 5.9. According to George and Mallery (2003 pp.231), a score greater than 0.9 is excellent; a score of 0.8 and 0.9 is good; a score ranging from 0.7 to 0.8 is acceptable; a score between 0.6 and 0.7 is questionable; a score ranging from 0.5 to 0.6 is poor and a score less than 0.5 is unacceptable (Table 5.10).

Table 5.10 Interpretation of internal reliability of total items and domains

Test a-b - Domains and total items	Cronbach alpha	Interpretation of internal reliability
Test a (total 55 items)	0.701	Acceptable
Test b	0.967	Excellent
Test a Domain 1	0.924	Excellent
Test b	0.934	Excellent
Test a Domain 2	0.860	Good
Test b	0.831	Good
Test a Domain 3	0.774	Acceptable
Test b	0.725	Acceptable
Test a Domain 4	0.584	Poor
Test b	0.670	Poor
Test a Domain 5	0.901	Excellent
Test b	0.894	Good
Test a Domain 6	0.924	Excellent
Test b	0.908	Excellent
Test a Domain 7	0.890	Good
Test b	0.866	Good

Source: George & Mallery, 2003 pp. 231

The competency items referred to as ‘a’ (Test 1) and ‘b’ (Test 2) were scored on a 7-point scale, ranging from (1 to 7). The reliability of these items in the test-retest was tested by Kappa k coefficient compared to Spearman coefficient of correlation r_s (Table 5.11).

Table 5.11 Test-retest reliability of competency items 1-55

Item	Kappa	Actual standard error	Spearman r	Actual standard error
1	0.62	*0.12*	0.80	*0.09*
2	0.78	*0.09*	0.96	*0.02*
3	0.67	*0.11*	0.89	*0.05*
4	0.84	*0.09*	0.91	*0.05*
5	0.76	*0.10*	0.86	*0.07*
6	0.57	*0.12*	0.79	*0.09*
7	0.63	*0.12*	0.85	*0.07*
8	0.48	*0.15*	0.73	*0.13*
9	0.54	*0.12*	0.82	*0.08*
10	0.50	*0.11*	0.85	*0.07*
11	0.74	*0.11*	0.88	*0.06*
12	0.94	*0.07*	0.95	*0.05*
13	0.89	*0.08*	0.91	*0.07*
14	0.76	*0.09*	0.95	*0.03*
15	0.83	*0.09*	0.91	*0.05*
16	0.64	*0.12*	0.82	*0.09*
17	0.64	*0.13*	0.74	*0.12*
18	0.77	*0.12*	0.88	*0.08*
19	0.64	*0.12*	0.79	*0.10*
20	0.61	*0.13*	0.76	*0.09*
21	0.55	*0.12*	0.78	*0.08*
22	0.64	*0.13*	0.79	*0.10*
23	0.56	*0.13*	0.71	*0.12*
24	0.44	*0.15*	0.57	*0.14*
25	0.44	*0.14*	0.61	*0.11*
26	0.69	*0.14*	0.76	*0.11*
27	0.88	*0.08*	0.95	*0.04*
28	0.85	*0.10*	0.93	*0.06*
29	0.61	*0.15*	0.70	*0.14*
30	0.70	*0.12*	0.74	*0.14*
31	0.62	*0.11*	0.87	*0.07*
32	0.62	*0.12*	0.77	*0.08*
33	0.76	*0.10*	0.89	*0.07*

Table 5.11 Test-retest reliability of competency items 1-55 (cont.)

Item	Kappa	Actual standard error	Spearman r	Actual standard error
34	0.73	*0.11*	0.82.	*0.10*
35	0.62	*0.11*	0.70	*0.14*
36	0.63	*0.11*	0.72	*0.15*
37	0.81	*0.09*	0.91	*0.04*
38	0.81	*0.08*	0.96	*0.03*
39	0.76	*0.10*	0.89	*0.05*
40	0.67	*0.12*	0.80	*0.09*
41	0.65	*0.12*	0.71	*0.14*
42	0.67	*0.11*	0.86	*0.07*
43	0.78	*0.10*	0.89	*0.06*
44	0.60	*0.12*	0.78	*0.08*
45	0.64	*0.11*	0.86	*0.07*
46	0.81	*0.10*	0.89	*0.06*
47	0.64	*0.12*	0.79	*0.08*
48	0.69	*0.12*	0.81	*0.09*
49	0.73	*0.13*	0.75	*0.12*
50	0.61	*0.12*	0.82	*0.09*
51	0.62	*0.11*	0.84	*0.07*
52	0.51	*0.11*	0.81	*0.08*
53	0.83	*0.08*	0.98	*0.01*
54	0.64	*0.10*	0.93	*0.03*
55	0.75	*0.09*	0.96	*0.02*

Overall, the correlation results were regarded to be satisfactory, taking into consideration the 7 point Likert scale (Table 5.9). Ten items have kappa values ranging between 0.81 and 0.94, indicating an almost perfect agreement between test and retest scores. The majority of items (n=36) had kappa values ranging between 0.61-0.81 indicating a substantial agreement while only nine items had smaller kappa values (between 0.44 and 0.57), indicating moderate agreement between test and retest scores (Viera & Garreth, 2005). Spearman correlation coefficients also showed satisfactory values for most items, varying between 0.98 and 0.57. Based on these findings, all items were retained in R1 modified Delphi study. The following is a summary of the kappa values in grouped form with an interpretation of the findings. Based on these findings, all competency items were retained in R1 modified Delphi study (Table 5.12).

Table 5.12 Kappa values of grouped competency items

Kappa range	Competency item number		Interpretation of Kappa [N1]	
			Kappa	Agreement
0.41 – 0.60	6, 8, 9, 10, 21, 23, 24, 25, 52		<0	Less than chance agreement.
0.61 – 0.80	1, 2, 3, 5, 7, 11, 14, 16, 17, 18, 19, 20, 22, 26, 29, 30, 31, 32, 33, 34, 35, 36, 39, 40, 41, 42, 43, 44, 45, 47, 48, 49, 50, 51, 54, 55		0.21-0.40	Fair agreement
			0.41-0.60	Moderate agreement
			0.61-0.80	Substantial agreement
0.81 – 0.99	4, 12, 13, 15, 27, 28, 37, 38, 46, 53		0.81-0.99	Almost perfect agreement

[N1] – Interpretation of Kappa (Viera & Garreth, 2005)

5.6.5 The modified Delphi study - R1

This section presents the characteristics of the panel of experts, the response rate of each subgroup of experts and the level of agreement reached on each item in R1.

5.6.6 Demographic characteristics of the expert panel - R1

Table 5.13 shows the 'legitimate' study sample size and response rates of participating experts in Round 1 and 2 in this modified Delphi study. Appendix 22 provides the participants' coded information on the professional background, gender and age.

Table 5.13 Sample size and response rates of panel of 'experts'

Groups	Participants	Characteristics
Group 1: Qualified nurses	n=1443	Total number of first level nurses - male and females.
	n=369	Received spiritual care study units during training or as CPD. These were invited to participate in the study.
	n=111	Informed consent received from participants and they were asked to answer preliminary questionnaire. (SCCS van Leeuwen *et al.,* 2008).
	n=99	Responded to preliminary questionnaire.
	n=64	Demonstrated required level of competency in spiritual care through the SCCS and were asked to participate in the modified Delphi study.
	n=55	Responded to R1 of the Modified Delphi study.
	n=5	Questionnaires were received late and were excluded from the study.
	n=48	Responded to R2 of the study.
Group 2: Qualified midwives	n=128	Total number of qualified midwives.
	n=31	Received spiritual care study units during training or as CPD.
	n=128	Total population invited to participate.
	n=101	Consented to participate and asked to answer preliminary questionnaire (SCCS van Leeuwen *et al.,* 2008).
	n=75	Responded to preliminary questionnaire.
	n=55	Demonstrated required level of competency in spiritual care through the (SCCS) and were asked to participate in R1 of the modified Delphi study.
	n=39	Responded to R1 of the Modified Delphi study.
	n=2	Questionnaires were received late and were excluded from the study.
	n=31	Responded to R2 of the study.
Group 3: Clinical nurse educators	n=50	Invited to consent to participate in the study by virtue of their pre-registration clinical teaching.
	n=25	Informed consent received from participates who were asked to participate in the study.
	n=25	Responded to R1 of the modified Delphi study.
	n=21	Responded to R2 of the study.
Group 4: Clinical midwife educators	n=14	Educators invited to consent to participate in the study by virtue of their pre-registration clinical teaching.
	n=12	Informed consent received and they were asked to participate in the study.
	n=12	Responded to R1 of the modified Delphi study.
	n=9	Responded to R2 of the study.
Group 5: Faculty nurse educators	n=25	Educators invited to consent to participate in the study by virtue of their teaching to pre-registration nursing students
	n=21	Informed consent received & asked to participate in study.
	n=20	Responded to R1 of the Modified Delphi Study.
	n=17	Responded to R2 of the study.

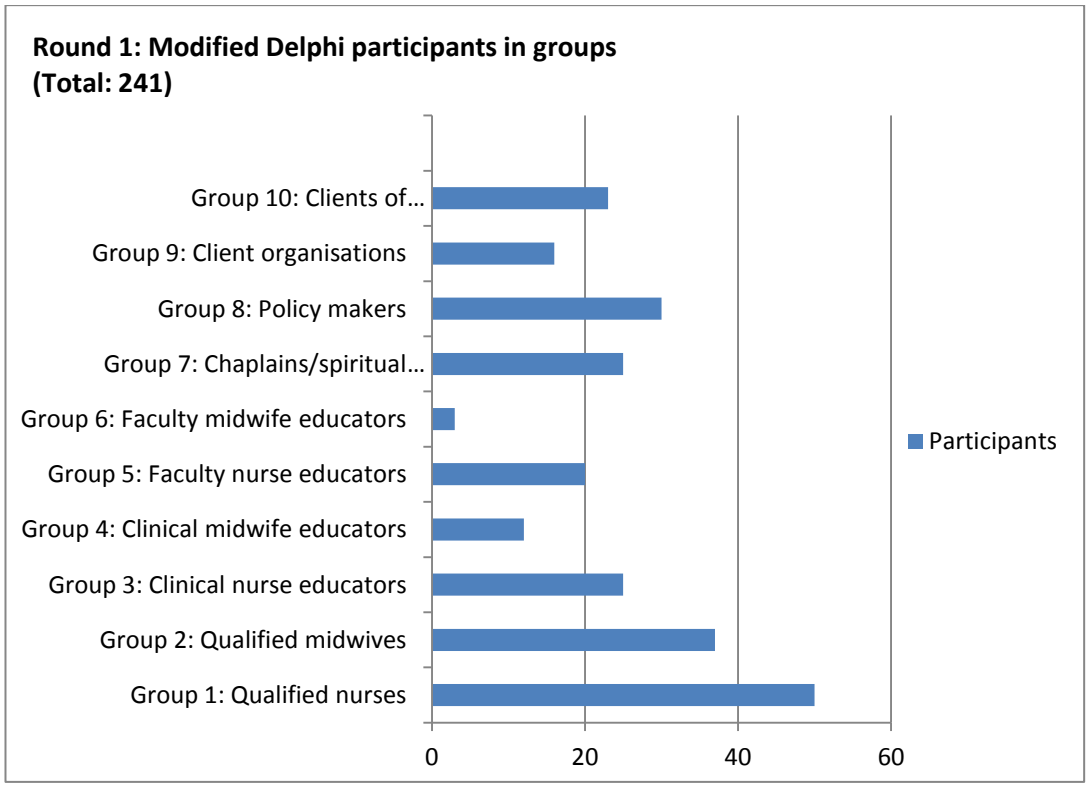
Table 5.13 Sample size and response rates of panel of 'experts' (cont.)

Groups	Participants	Characteristics
Group 6: Faculty midwife educators	n=3	Educators invited to consent to participate in study by virtue teaching to pre-registration midwifery students.
	n=3	Responded to R1 of the Modified Delphi study.
	n=3	Responded to R2 of the study.
Group 7: Chaplains & spiritual leaders	n=40	Invited to consent to participate in the study by virtue of their knowledge and experience in enduring spiritual care.
	n=25	Consented and participated in R1 of the modified Delphi study.
	n=18	Participated in R2 of the study.
Group 8: Policy makers nursing/ midwifery	n=46	Invited to consent to participate in the study due to their role as policy makers involving nurses/midwives.
	n=30	Consented and participated in R1 of the modified Delphi study.
	n=26	Participated in R2 of the study.
Group 9: Representative of clients' organisations	n=35	Participants were invited due to their knowledge & experience of their (personal) or clients' medical, surgical, mental health, oncology and maternity experiences.
	n=20	Consented to participate in the study.
	n=16	Participated in R1 of the study.
	n=15	Participated in R2 study.
Group 10: Clients of nursing/ Midwifery	n=50	Invited to participate in the study due to their personal experience as clients of nursing/midwifery care.
	n=26	Consented to participate in the study.
	n=23	Participated in R1 of the study.
	n=17	Participated in R2 of the study.

A sample of 760 individuals was invited to participate in the study. 384 participants (50.5%) consented to participate. However, nurses/midwives (n=55; 14.3%) were excluded from the study as they did not achieve the appropriate pre-set score level on the Spiritual Care Competency Scale (SCCS) (van Leeuwen *et al.,* 2008). The sample (n=248; 64.6%), confidence interval (6.18) responded to R1 questionnaire of which 7 (2.82%) questionnaires were excluded due to late return of the questionnaire and non-respondents (n=81; 21.09%), yielding a final sample size of 241 (62.76%) participants in R1.

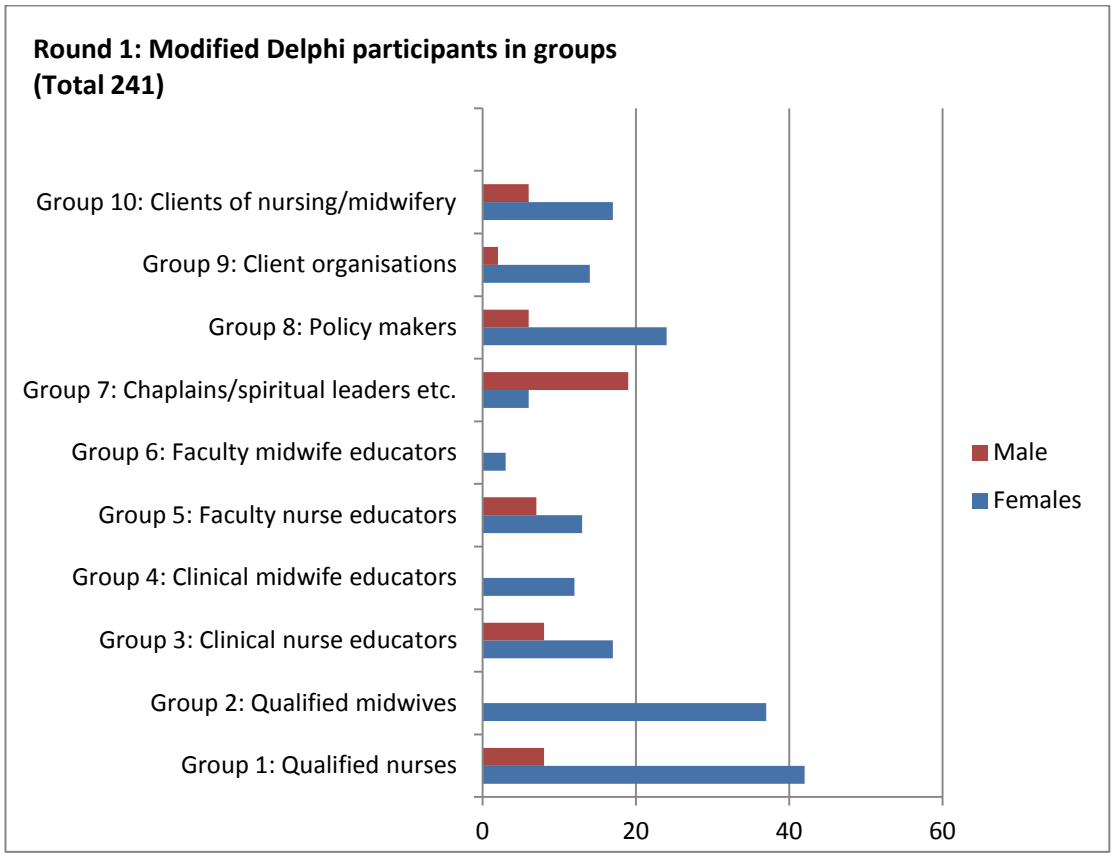
Figure 5.2 summarises the panel of experts' participation rates by group and shows a higher participation rate from faculty midwifery educators (n=3; 100%), clinical midwifery educators (n=12; 80%), faculty nurse educators (n=20; 80%) and qualified nurses (n=50; 76.92%). Thirty seven qualified midwives (n=37; 65.21%) participated in the study. The sample also included thirty policy makers in nursing/midwifery (62.5%), spiritual leaders (n=25) and clinical nurse educators (n=25; 50%). The lowest participation rates were from clients (n=23; 46%) and representatives of patients' organisations (n=16; 45.71%).

Figure 5.2 Participants of R1: Demographic characteristics



Therefore, the heterogenous sample of experts incorporated a broad representation of stakeholders, including the clients with various experiences (Figure 5.2). The overall sample consisted of more females (n=185; 76.76%) than males (n=56; 23.23%) (Figure 5.3). No male participants were part of the midwifery 'experts' group. This is understandable since at the time of writing this study, all midwives in Malta were actually female.

Figure 5.3 R 1: Demographic characteristics of participants by gender



The heterogeneous 'expert' panel with a mean age of 41.3 years contributed towards a wider perspective of experience and knowledge on delivery of spiritual care by nurses/midwives (Keeney, Hasson & McKenna, 2001; Vernon, 2009).

5.6.7 Level of consensus in the modified Delphi study: R1

The mean, standard deviation, 95% confidence interval of the respondents' mean and the percentage of agreement for each competency item demonstrated the level of consensus of each item which was scored on a 7-point Likert scale ranging from 1 (Strongly Disagree) to 7 (Strongly Agree). The cut-off point of agreement was set at 75% or higher; rating the item in the range 5 to 7; as these three categories display moderate to strong agreement (Results of R1 are included in Appendix 25). With the exception of Item 55, all items scored a mean higher than 5 since the lower 95% confidence limit of the overall mean is higher than 5. This implies that the overall experts' mean of these items is more than 1 scale point higher than the middling rating score of 4. Most items scored a high percentage of agreement (Table 5.14).

Table 5.14 Summary of % agreement

Competency item number	No. of items	% Agreement
4; 6; 8; 11; 12; 13; 15; 16; 18; 22-29; 32; 34; 40; 43; 46; 48; 49	24	90% and higher
1; 3; 5; 7; 10; 14; 17; 19-21; 30; 33; 35; 37-39; 44; 45; 47; 50-52	22	80%-89%
2; 31; 36; 41; 42; 53	6	75%-79%
9; 54; 55	3	< 75%

5.6.8 Content analysis of qualitative data derived from R1 questionnaire

Four categories emerged from the open-ended questions in R1 questionnaire. These addressed the importance of spirituality in the education of nurses/midwives whilst considering the barriers inhibiting the provision of spiritual care to clients and their families.

These issues had already been included in the list of competencies presented and therefore no additional competencies were added to the framework which was submitted for R2. Feedback of the content analysis was given to participants in R2 (Table 5.15).

Table 5.15 Feedback from content analysis of R1

Categories	Description
Spirituality as a component of quality holistic care for all clients with diverse religious/spiritual beliefs, practices and culture.	▪ *'Spirituality and support are very important part in holistic care of patients (P32).* ▪ *'Delivering holistic care is very important to both the patients and carers. It provides and generates respect, preserves dignity and enhances self-development' (P127).* ▪ *'Never impose anything that you believe in keep in mind a multi-cultural society and respect their beliefs and customs' (P216).*

Table 5.15 Feedback from content analysis of R1 (cont.)

Categories	Description
Preparation of professionals to provide spiritual care through their own spirituality, reflection, experience and supervision.	▪ *'Most young nurses are of young age and still need their own personal experience to mature and learn' (P210).* ▪ *'Time spent in work experience together with reflection, supervision, training and education will result in more skill growth for the carer' (P76).* ▪ *'I feel that spirituality cannot be taught well by academia or books. .Thus in their training student midwives must be exposed to diverse people and experiences, encouraged to interact and reflect on various situations' (P87).* ▪ *'I think that it is very important for nurses and midwives to have all the necessary knowledge regarding spirituality and diversity to think, accept and react in a professional manner thus communicate effectively without prejudice' (P92).*
Ongoing education of professionals at pre- and post- registration level not as a separate module but integrated across all subject material.	▪ *'Newly qualified nurses also pass from a time of adaptation to the new environment so they may be distressed too, trying to cope with their changing role of being a student to being a nurse with all the responsibility. That is why it is important that all nurses have ongoing spiritual training and support' (P49).* ▪ *'I feel that spiritual care needs to be integrated in the existing subject material and not as a separate module. In this way, it will be more easy [easier] for the student to practise what has been learnt' (P214).*
Addressing barriers to spiritual care such as lack of knowledge, time and staff.	▪ *'It is important that the nurse/midwife has all the support, time, staff and resources to be able to implement such an important issue. Unfortunately, nurses/midwives are too busy with other issues to give the needed time to spiritual care' (P30).*

5.6.9 Modified Delphi study: R2

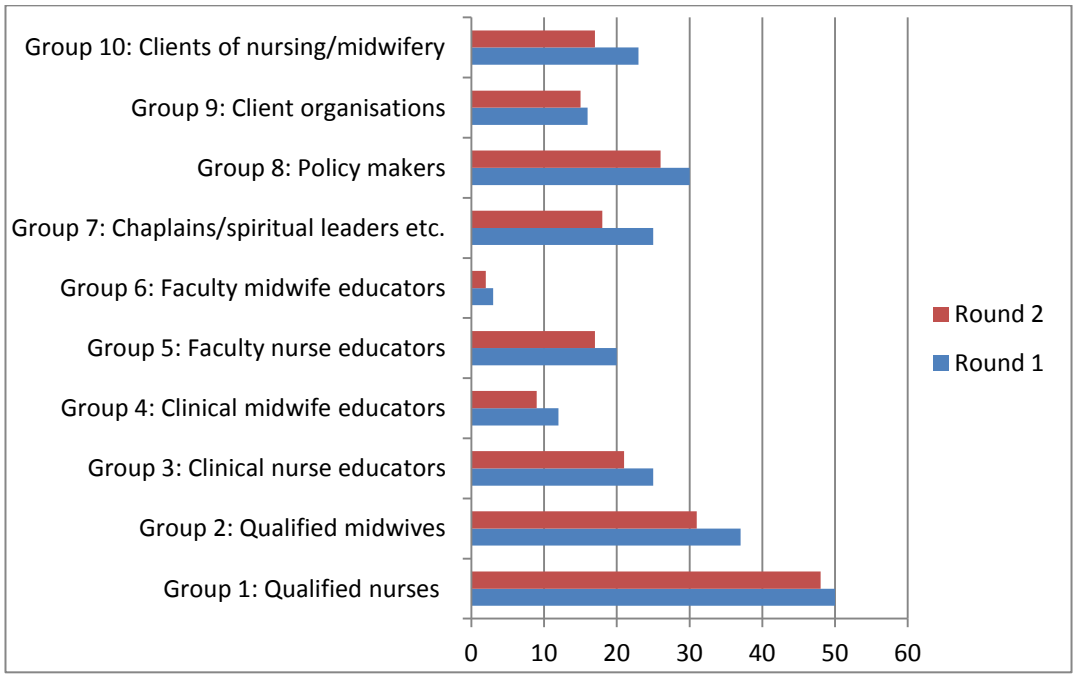
This section reviews the personal characteristics of the expert panel who participated in R2. Due to the well documented attrition rate in Delphi methodology the non-respondents' bias was considered and tested by inferential statistical analysis to identify possible significant differences between respondents and non-respondents.

Following individual feedback to the expert panel on the results of R1, the level of agreement in R2 is presented which showed stability between R1 and R2. Thus, no further rounds were conducted. In R2 the panel of experts (n=241) were asked to reconsider their response for each competency item from Round 1 in the context of feedback provided through the mean score for each item. Participants were also given the option to confirm or change their score if so required (Appendix 26).

5.6.10 Demographic characteristics of the expert panel

The response rate in R2 was 86.06% (n=205) which may demonstrate the participants' interest in the need for the development of the competency framework to guide nursing/midwifery education on spiritual care. While considering the overall good response rate, the low range of response rate was in the clinical midwife educators group (75%), the clients (73.9%) and the spiritual leaders group (72%). A higher participation rate is shown for faculty midwife educators (100%), clinical nurses (96%), representatives of patients' organisations (93.75%), policy makers in nursing/midwifery (86.6%); faculty nurse educators (85%); clinical nurse educators (84%) and clinical midwives (83.78%) (Figure 5.4).

Figure 5.4 Comparison between participants in R1 and R2



Overall, the expert panel (n=205) consisted of a higher percentage of females (n=158; 77.7%) compared to males (n= 43; 20.97%). Similar to R1, the participants' age ranged between 22 and 75 years, with a mean age of 42.5 years. The majority of the participants (n=57; 27.8%) were aged between 42 and 51 years. Fifty three participants, from the next largest age group (n=53; 25.85%) were aged between 22 and 31 years. Forty seven participants (n=47; 22.92%) were between 32 and 41 years. The number of participants in R2 who were in the age group between 62-75 years remained constant (n=13).

5.6.11 Demographic characteristics of non-respondents

As shown in Table 5.16, a total of 36 participants failed to respond in Round 2 of the study. 75% were females (n=27), while 9 (25%) were males. The mean age of all non-respondents in R2 was 40.36 years.

Table 5.16 R2 modified Delphi non-respondents: By group

Group	R1	R2	Response Rate %	Attrition rate %	(n=36)
Group 1: Clinical nurses	50	48	96.0	4.0	2
Group 2: Clinical midwives	37	31	83.78	16.22	6
Group 3: Clinical nurse educators	25	21	84.0	16.0	4
Group 4: Clinical midwife educators	12	9	75.0	25.0	3
Group 5: Faculty nurse educators	20	17	85.0	15.0	3
Group 6: Faculty midwife educators	3	3	100	/	0
Group 7: Chaplains & spiritual leaders, etc.	25	18	72.0	28.0	7
Group 8: Policy makers	30	26	86.6	13.4	4
Group 9 Representatives of client organisations	16	15	93.75	6.25	1
Group 10: Clients of nursing & midwifery	23	17	73.9	25.1	6

The majority of non-respondents were females (75%; n=27), mean age ranging from 32-61 years There were no significant differences in age, gender and group between the respondents between R1 and R2 (Table 5.17). Subgroups containing small numbers of participants were collapsed and included in larger groups. Groups 4, 5

and 6 were included in Group 3 (Educators). Groups 9 and 10 were included in Group 8 (Policy Makers). No significant difference was noted in all three criteria. These contributed towards the reliability of the findings in R2.

Table 5.17 Differences between respondents & non-respondents in R1 and R2

	Modified Delphi Rs & Participants	Chi-Square test	DF	P (p=0.05)
Age group	R1=281	8.357	5	0.138
	R2=205	8.443	5	0.133
Gender	R1=281	0.231	1	0.631
	R2=205	0.019	1	0.890
Groups (collapsed)	R1=281	2.865	4	0.581
	R2=205	1.002	4	0.910

5.6.12 Central tendency, mean, confidence interval and % agreement

Table 5.18 presents the mean, standard deviation, 95% confidence interval of the population mean, percentage of agreement for each competency item together with the percentage increase/decrease for each item over Round 1.

In Round 2, the panel of experts (n=205) were asked to reflect on their response for each competency item while considering the given feedback about the mean score of each item from Round 1. They were asked to confirm or change their score only if they were convinced about it. Similar to Round 1, each item was rated on a 7-point Likert scale, ranging from 1 (Strongly Disagree) to 7 (Strongly Agree).

Consensus was reached if more than 75% of the participants scored in the range 5 to 7 for each item. With the exception of Item 55, all items have a mean rating score significantly higher than 5 since the lower 95% confidence limit of the population mean rating score was above 5. This implies that the population mean rating score of these items is more than 1 scale point higher than the middling rating score 4.

In Round 2, with the exception of Items 54 and 55, the proportion of respondents scoring 5-7 on the Likert scale exceeded the 75% threshold criterion. Overall, there was a 2.46% increase in the mean rating in Round 2 scores (Table 5.18). The items 14, 40, 47, and 52 scored higher than 5% in the mean rating score when compared to Round 1. In contrast, only two items (Numbers 3 & 26) reported a decrease of (1.2% & 0.8%) respectively.

In the majority of items (n=27); Items 4, 6, 8, 11-13, 15-18, 22-30, 32, 34, 40, 43, 46-49 the proportion of respondents scoring in the range 5-7 exceeded 90%. For Items 1-3, 5, 7, 10, 14, 17, 19, 20, 21, 31, 33, 35-39, 41, 42, 44, 45, 50-52 (n=25) this proportion ranged from 80% to 90% and for items 9 and 53 (n=2) this proportion ranged from 75% to 80%.

Percentage agreement for Item 54 increased by 1.7% and achieved a 74.5% agreement, just missing the 75% criterion by a very small margin. The rating score for this item mean 5.24 and SD=1.334 and the 95% confidence interval ranged from 5.06 to 5.42. Since the lower 95% confidence limit (5.06) exceeded 5, this item was also included in the list of agreed items. Therefore, 54 competency items achieved consensus after Round 2. However, Item 55 did not reach the 75% consensus level (57.4%) (Table 5.18).

A diagrammatic representation of the findings in the form of histogram graphs of the frequency distribution of responses are presented in Appendix 31. One notes that all distributions are left skewed; however, some are less skewed than others. For example, if you compare the rating score distributions of Items 49 and 55 presented here as exemplars (Figures 5.5 & 5.6) one notices that the latter is less skewed than the former. This implies that the respondents tended to agree more with Item 49 than Item 55 (Figure 5.7) which consequently did not reach consensus level. The majority of the items showed stability in % agreement as shown by the frequency histograms results of the total sample and the corresponding subgroups which are skewed towards the highest values (5-7) of the Likert scale (Appendix 31).

Table 5.18 R2: Results

Mean, confidence interval and level of agreement reached for each competency item
Percentage increase/decrease over Round 1
Domain 1: Knowledge in spiritual care

ITEM	Mean	SD	95% confidence interval of mean		% of Non-Agreement				% of Agreement			Total [N1]
					7-point Likert Scale							[N2]
			LOWER	UPPER	1	2	3	4	5	6	7	%
1	5.951	1.074	5.80	6.10	/	0.5	1.0	9.8	20.0	29.3	39.5	88.8
												+2.1
2	5.463	1.248	5.29	5.64	1.0	1.5	3.9	12.8	27.1	32.0	21.7	80.8
												+4.2
3	5.810	1.132	5.65	5.97	/	0.5	3.9	8.3	22.0	32.2	33.2	87.4
												-1.2
4	6.063	0.966	5.93	6.20	/	/	1.5	6.2	15.6	37.6	39.0	92.2
												+1.4
5	5.922	1.019	5.78	6.06	/	/	1.5	8.8	20.6	34.3	34.8	89.7
												+4.7
6	6.059	1.003	5.92	6.20	/	0.5	1.5	4.9	19.0	33.2	41.0	93.2
												+0.7
7	5.606	1.240	5.43	5.78	0.5	1.0	4.4	12.3	23.2	30.5	28.1	81.8
												+1.1
8	6.590	0.692	6.50	6.69	/	/	/	1.5	7.3	22.0	69.3	98.6
												+0.2
9	5.368	1.250	5.20	5.54	/	3.9	2.9	15.7	25.5	33.8	18.1	77.4
												+3.1
10	5.632	1.143	5.47	5.79	/	1.5	3.4	9.8	25.5	35.3	24.5	85.3
												+1.6
11	6.098	0.918	5.97	6.22	/	/	0.5	6.3	15.6	38.0	39.5	93.1
												+1.0
12	6.249	1.011	6.11	6.39	/	0.5	1.5	4.9	13.2	25.9	54.1	93.2
												+0.3
13	6.185	0.894	6.06	6.31	/	/	1.0	4.4	13.2	38.0	43.4	94.6
												+1.6
14	5.824	1.033	5.68	5.97	/	0.5	1.0	8.8	26.3	32.2	31.2	89.7
												+6.7

Domain 2: Self-awareness and use of self

ITEM	Mean	SD	95% confidence interval of mean		% of Non-Agreement				% of Agreement			Total [N1]
					7-point Likert Scale							[N2]
			LOWER	UPPER	1	2	3	4	5	6	7	%
15	6.200	0.957	6.07	6.33	/	0.5	0.5	4.9	15.1	30.7	48.3	94.1
												+2.4
16	6.202	0.972	6.07	6.34	/	/	1.5	4.9	15.3	28.6	49.8	93.7
												+3.6
17	6.176	0.901	6.05	6.30	/	/	/	6.8	12.7	36.6	43.9	93.2
												+4.4
18	6.420	0.810	6.31	6.53	/	/	0.5	2.4	10.2	28.2	58.5	96.9
												+1.4
19	5.847	1.135	5.69	6.00	/	1.0	2.5	10.3	17.2	35.0	34.0	86.2
												+1.8

[N1] Total percentage of agreement between panels of experts. [N2] % Increase/decrease over R1

Table 5.18 R2: Results (cont.)

Mean, confidence interval and level of agreement reached for each competency item
Percentage increase/decrease over Round 1

ITEM	Mean	SD	95% confidence interval of mean		% of Non-Agreement				% of Agreement			Total [N1]
					7-point Likert Scale							[N2]
			LOWER	UPPER	1	2	3	4	5	6	7	%
Domain 3: Communication and interpersonal relationships												
20	5.966	1.094	5.81	6.12	0.5	0.5	1.5	7.8	16.7	35.3	37.7	89.7
												+2.4
21	5.510	1.214	5.34	5.68	/	2.5	3.4	11.3	30.9	27.5	24.5	82.9
												+2.3
22	6.293	0.881	6.17	6.41	/	/	1.0	4.4	9.3	35.1	50.2	94.6
												+1.6
23	6.239	0.872	6.12	6.36	/	/	/	5.4	12.7	34.6	47.3	94.6
												+1.6
24	6.210	0.918	6.08	6.34	/	/	/	6.3	14.6	30.7	48.3	93.6
												+1.9
Domain 4: Ethical and legal issues												
25	**6.605**	**0.704**	**6.51**	**6.70**	**/**	**/**	**/**	**1.5**	**8.3**	**18.5**	**71.7**	**98.5**
												+1.4
26	6.500	6.50	6.39	6.61	/	/	/	2.5	9.8	23.0	64.7	97.5
												-0.8
27	6.261	6.26	6.12	6.40	0.5	0.5	1.0	3.4	15.3	23.6	55.7	94.6
												+2.7
28	6.537	0.717	6.44	6.64	/	/	0.5	/	10.2	23.9	65.4	99.5
												+2.0
29	6.590	0.753	6.49	6.69	/	0.5	/	1.5	6.8	20.5	70.7	98.0
												+0.9
30	6.078	1.122	5.92	6.23	1.0	0.5	1.0	5.9	16.1	30.2	45.4	91.7
												+3.9
Domain 5: Quality assurance in spiritual care												
31	5.631	1.142	5.47	5.79	/	1.0	3.9	11.3	22.7	36.9	24.1	83.7
												+4.9
32	6.444	0.750	6.34	6.55	/	/	/	2.4	8.3	31.7	57.6	97.6
												+1.4
33	5.873	1.241	5.70	6.04	2.0	1.0	1.0	6.9	18.1	35.3	35.8	89.2
												+4.4
34	6.195	0.919	6.07	6.32	/	/	0.5	5.9	13.7	33.7	46.3	93.7
												+2.4
35	5.735	1.165	5.57	5.90	1.0	0.5	3.4	5.4	27.9	32.4	29.4	89.7
												+3.9
36	5.512	1.216	5.34	5.68	0.5	1.5	3.9	13.3	24.1	34.5	22.2	80.8
												+4.9

[N1] Total percentage of agreement between panels of experts. [N2] % Increase/decrease over R1

Table 5.18 R2: Results (cont.)

Mean, confidence interval and level of agreement reached for each competency item Percentage increase/decrease over Round 1 Domain 5: Quality assurance in spiritual care												
37	5.583	1.122	5.43	5.74	/	1.5	2.0	11.8	30.4	30.4	24.0	84.8 +2.4
38	5.54	1.159	5.38	5.71	0.5	1.5	4.0	7.4	31.7	33.7	21.3	86.7 +4.4
Domain 6: Assessment and implementation of spiritual care												
ITEM	**Mean**	**SD**	**95% confidence interval of mean**		**% of Non-Agreement**				**% of Agreement**			**Total [N1] [N2]**
					7-point Likert Scale							
			LOWER	**UPPER**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**%**
39	5.632	1.095	5.48	5.78	/	1.5	0.5	14.2	24.5	35.8	23.5	83.8 +2.7
40	6.176	0.851	6.06	6.29	/	/	1.0	2.4	15.6	40.0	41.0	96.6 +5.4
41	5.578	1.096	5.43	5.73	/	0.5	2.0	15.7	26.0	32.8	23.0	81.8 +3.3
42	5.468	1.195	5.30	5.63	0.5	1.5	3.9	11.3	32.0	29.1	21.7	82.8 +3.7
43	5.956	1.028	5.81	6.10	/	1.0	0.5	6.9	21.6	33.8	36.3	91.7 +1.7
44	5.709	1.057	5.56	5.86	/	1.0	1.0	9.9	29.1	32.5	26.6	88.2 +2.2
45	5.776	1.009	5.64	5.91	/	/	1.0	11.2	24.9	35.1	27.8	87.8 +1.6
46	6.137	0.852	6.02	6.25	/	/	0.5	3.4	17.1	40.0	39.0	96.1 +4.4
47	6.063	0.935	5.93	6.19	/	/	1.5	4.9	17.1	39.0	37.6	93.7 +5.3
48	6.185	0.997	6.05	6.32	/	1.0	0.5	5.4	13.2	32.2	47.8	93.2 +0.6
49	6.307	0.879	6.19	6.43	/	/	0.5	5.4	8.8	33.7	51.7	94.2 +0.4
50	5.711	1.170	5.55	5.87	0.5	1.5	2.9	8.8	20.6	39.2	26.5	86.3 +2.2
51	5.663	1.141	5.51	5.82	/	1.0	3.4	11.2	23.4	34.6	26.3	84.3 +3.6
Domain 7: Informatics in spiritual care												
ITEM	**Mean**	**SD**	**95% confidence interval of mean**		**% of Non-Agreement**				**% of Agreement**			**Total [N1] [N2]**
					7-point Likert Scale							
			LOWER	**UPPER**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**%**
52	5.652	1.051	5.51	5.80	/	1.0	2.5	8.8	27.5	38.7	21.6	87.8 +5.0
53	5.368	1.297	5.19	5.55	1.5	2.5	3.4	14.2	25.5	34.8	18.1	78.4 +2.3
54	5.240	1.334	5.06	5.42	1.0	2.9	5.9	15.7	28.9	27.0	18.6	74.5 +1.7
55	4.609	1.552	4.39	4.82	5.0	4.5	13.4	19.8	27.7	18.8	10.9	57.4 +2.0

[N1] Total percentage of agreement between panels of experts. [N2] % Increase/decrease over R1

Figure 5.5 Exemplar: Item 49 - Frequency distribution of respondents

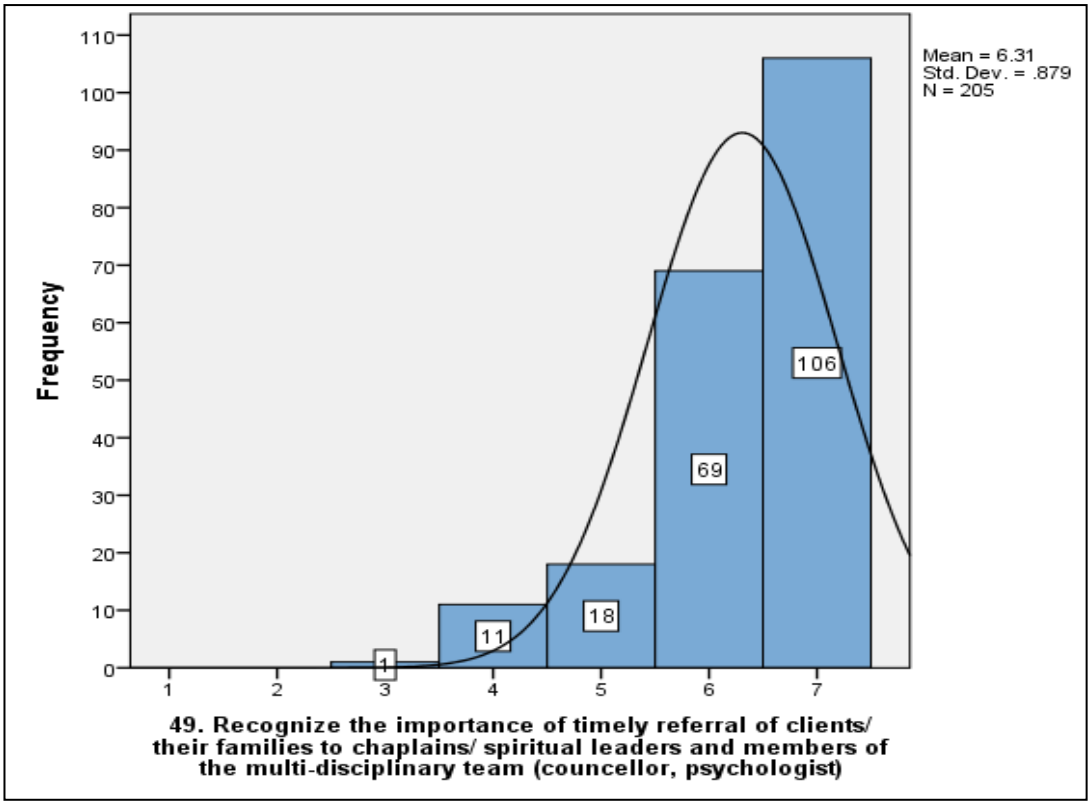


Figure 5.6 Exemplar: Item 55 - Frequency distribution of respondents.

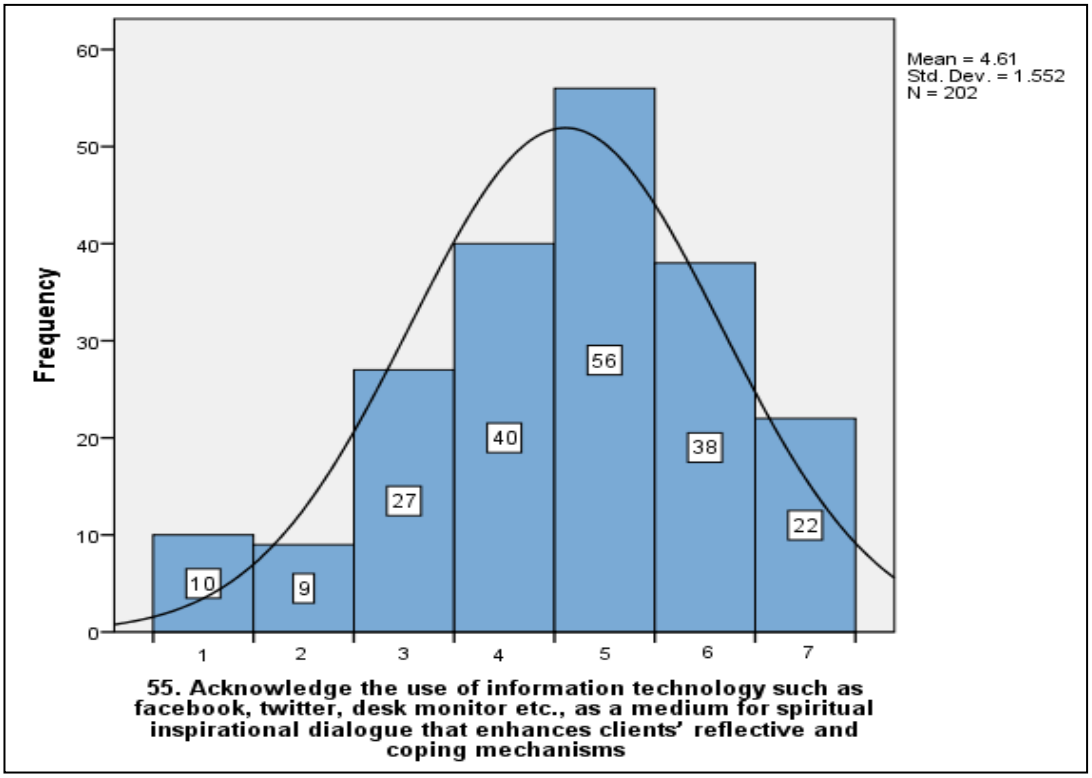


Figure 5.7 Exemplar: Item 49 - Frequency distribution of group respondents

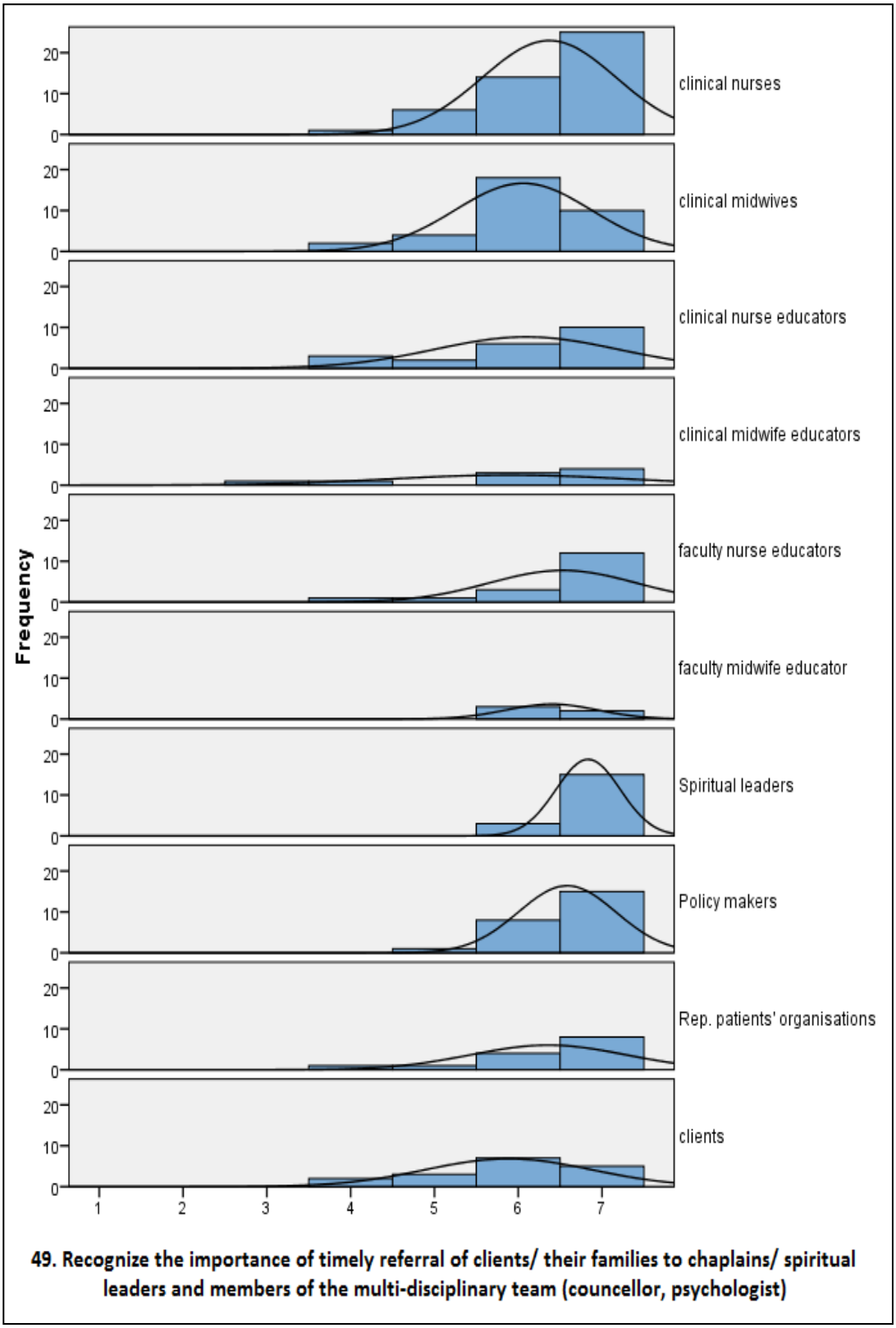
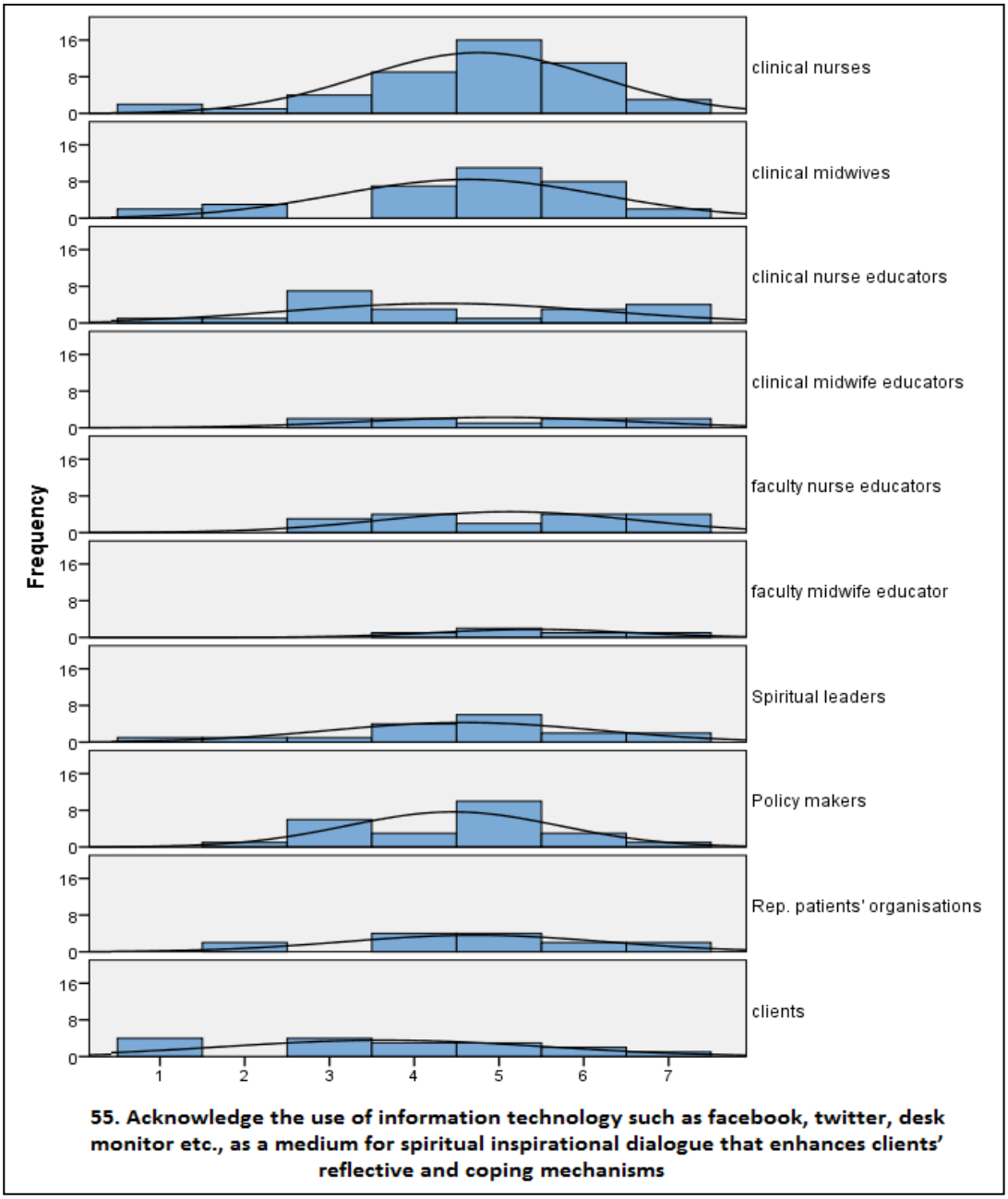


Figure 5.8 Exemplar: Item 55 - Frequency distribution of group respondents



5.6.13 Internal consistency coefficients of competency domains and items

Overall, the competency framework in R1 and R2 obtained a high Cronbach α (R1-R2:0.97). Similarly, that of individual domains ranged between 0.79 to 0.93, indicating a good to excellent homogeneity of the framework (Table 5.19).

Table 5.19 Reliability coefficients of competency domains and items in R1 and R2

DOMAINS & ITEMS	[N] items	[N] R1 participants	R1 [N] Valid Responses	R1 Alpha	R1 Standard Item Alpha	[N] R2 participants	R2 [N] Valid responses	R2 Alpha	R2 Standard Item Alpha
Total Domains (1-55)	**55**	**281**	**189**	**0.971**	**0.972**	**205**	**181**	**0.970**	**0.972**
Domain 1 (1-14)	14	281	225	0.909	0.911	205	198	0.913	0.914
Domain 2 (15-19)	5	281	231	0.816	0.821	205	201	0.808	0.813
Domain 3 (20-24)	5	281	231	0.807	0.815	205	203	0.796	0.807
Domain 4 (25-30)	6	281	234	0.811	0.826	205	202	0.794	0.813
Domain 5 (31-38)	8	281	227	0.880	0.838	205	198	0.887	0.890
Domain 6 (39-51)	13	281	224	0.938	0.938	205	199	0.931	0.933
Domain 7 (52-55)	4	281	229	0.845	0.854	205	200	0.853	0.860

5.6.14 Stability of competency domains and items (R1 & R2)

The Spearman correlation coefficients demonstrated a significant relationship between R1 & R2 rating scores. This implies that participants who scored high in Round 1 tended to yield high scores in Round 2. For 23 items, the correlation coefficients ranged from 0.9 to 1 while for 31 items the correlation coefficients ranged from 0.7 to 0.89, indicating a very strong positive relationship between the scores in Round 1 and 2. The lowest coefficient was obtained in Item 35 (r_s= 0.554) which denotes a weaker relationship (Table 5.20).

Table 5.20 Stability of competency domains and items in R1 and R2

DOMAIN	Item No.	No. of R1 (a) responses	No. of R2 (b) responses	Spearman's rho (r)	P (value)
Domain 1: Body of knowledge in spiritual care	1a-1b	240	197	0.923**	0.001
	2a-2b	235	194	0.920**	0.001
	3a-3b	235	195	0.905**	0.001
	4a-4b	241	197	0.907**	0.001
	5a-5b	239	196	0.890**	0.001
	6a-6b	240	196	0.889**	0.001
	7a-7b	238	196	0.853**	0.001
	8a-8b	241	197	0.867**	0.001
	9a-9b	241	197	0.876**	0.001
	10a-10b	239	196	0.874**	0.001
	11a-11b	240	196	0.893**	0.001
	12a-12b	241	197	0.959**	0.001
	13a-13b	240	197	0.898**	0.001
	14a-14b	241	197	0.862**	0.001
Domain 2: Self-awareness and the use of self in spiritual care	15a-15b	241	197	0.910**	0.001
	16a-16b	238	194	0.964**	0.001
	17a-17b	239	196	0.928**	0.001
	18a-18b	240	196	0.924**	0.001
	19a-19b	236	192	0.926**	0.001
Domain 3: Communication and interpersonal relationship in spiritual care	20a-20b	237	195	0.896**	0.001
	21a-21b	237	194	0.888**	0.001
	22a-22b	241	197	0.893**	0.001
	23a-23b	241	197	0.905**	0.001
	24a-24b	238	195	0.973**	0.001
Domain 4: Ethical and legal issues in spiritual care	25a-25b	241	197	0.865**	0.001
	26a-26b	240	196	0.909**	0.001
	27a-27b	238	194	0.874**	0.001
	28a-28b	240	197	0.936**	0.001
	29a-29b	241	197	0.864**	0.001
	30a-30b	238	195	0.914**	0.001
Domain 5: Quality Assurance in spiritual care	31a-31b	236	192	0.924**	0.001
	32a-32b	241	197	0.901**	0.001
	33a-33b	237	193	0.879**	0.001
	34a-34b	240	196	0.929**	0.001
	35a-35b	239	196	0.554**	0.001
	36a-36b	237	194	0.941**	0.001
	37a-37b	238	195	0.882**	0.001
	38a-38b	237	193	0.901**	0.001

****Correlation is significant at p=≤0.01(2 tailed)**

Table 5.20 Stability of competency domains and items in R1 and R2 (cont.)

DOMAIN	Item No.	No. of R1 (a) responses	No. of R2 (b) responses	Spearman's rho (r)	P (value)
Domain 6: Assessment and Implementation of spiritual care	39a-39b	238	194	0.877**	0.001
	40a-40b	241	197	0.852**	0.001
	41a-41b	238	195	0.887**	0.001
	42a-42b	234	192	0.860**	0.001
	43a-43b	239	195	0.922**	0.001
	44a-44b	235	193	0.938**	0.001
	45a-45b	239	195	0.926**	0.001
	46a-46b	241	197	0.901**	0.001
	47a-47b	241	197	0.870**	0.001
	48a-48b	241	197	0.940**	0.001
	49a-49b	241	197	0.963**	0.001
	50a-50b	238	194	0.898**	0.001
	51a-51b	238	194	0.883**	0.001
Domain 7: Informatics in spiritual care	52a-52b	239	195	0.887**	0.001
	53a-53b	238	194	0.884**	0.001
	54a-54b	236	192	0.944**	0.001
	55a-55b	231	187	0.906**	0.001

****Correlation is significant at p=≤0.01(2 tailed)**

5.6.15 The refined competency framework

Item 55 was deleted from the framework as explained in (Section 5.6.12). The refined competency framework consisting of 7 domains and 54 competency items following the two rounds of the modified Delphi study is presented (Table 5.21).

Table 5.21 The refined competency framework in spiritual care

Generic core competencies in spiritual care Domain 1: Knowledge in spiritual care
1. Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* view of care, attentive to the body-mind-spirit in all healthcare settings.
2. Identify the influence of the world's major faiths/religions (*e.g. Christianity, Islam, Judaism, Hindu and Buddhism*) cultural beliefs and practices in the appropriate clinical context and along the lifespan continuum (*from conception to death*).
3. Demonstrate knowledge of the basic spiritual needs of individuals which include: • A meaningful philosophy of life (*values and moral sense*). • A sense of the transcendent (*outside of self, view of deity/higher power and something beyond the immediate life, having hope*). • Belief and faith in self, others and for some a belief in a deity/higher power. • A relatedness to nature and people (*friendship*). • Experiencing love and forgiveness (*a sense of life meaning*).

Table 5.21 The refined competency framework in spiritual care (cont.)

Generic core competencies in spiritual care **Domain 1: Knowledge in spiritual care**
4. Recognise the importance of the spiritual dimension (*with or without religion*) that sustains physical and mental well-being.
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/her behaviour in dealing with spiritual needs.
7. Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA, RESPECT and HOPE tools*) and informal methods (e.g. *listening to clients' stories*).
8. Demonstrate knowledge and understanding of the grieving process (*denial, anger, bargaining, depression and acceptance*).
9. Demonstrate knowledge and understanding of spiritual/religious development of individuals and assist spiritual/religious growth.
10. Demonstrate knowledge of complex theories of spirituality, such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations.
11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (*e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?*)
12. Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care.
13. Demonstrate knowledge of resources, support systems/agencies that inform nurses/midwives to access spiritual care for clients, their families and staff in all healthcare settings (*e.g. place for worship, Church and support groups*).
14. Demonstrate knowledge on assisting clients in healthcare according to the clients' religious/spiritual, cultural beliefs, such as the use of complimentary/alternative therapies, diets, nutritional supplements and prayer.
Domain 2: Self-awareness and the use of self
15. Be aware of own spirituality and use of self (*e.g. own strengths, limitations, values, beliefs*) as a resource for spiritual care.
16. Recognise the possible impact of the nurse's/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care.
17. Acknowledge and respect the influence of clients' diverse cultural world views, beliefs and practices in the expression of their spirituality in healthcare.
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (*e.g. psychologists, chaplains, counsellors, spiritual leaders*) as deemed necessary.
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care.

Table 5.21 The refined competency framework in spiritual care (cont.)

Generic core competencies in spiritual care Domain 3: Communication and interpersonal skills
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/families in their spiritual needs and sufferings.
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/religious readings and prayer as a means of encouragement and hope.
22. Assess barriers to effective communication in providing spiritual care (*e.g. language, beliefs, culture, anxiety, fear and anger*) and adapt accordingly by active listening, empathy and/or referral to other members of the multi-disciplinary team.
23. Understand and apply the principles of a therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey.
24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/midwife-client relationship (abiding by the professional ethical/legal codes of conduct).
Domain 4: Ethical and legal issues
25. Appreciate the uniqueness of each person and their right to decline spiritual care.
26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/spiritual beliefs, values, practices and lifestyles (*e.g. diet, sexual orientation*).
27. Demonstrate sensitivity, support and respect for the client's autonomous and diverse healthcare decisions/choices influenced by religious/spiritual beliefs and practices (*e.g. blood transfusion, childbirth practices, chemotherapy, immunisation*).
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (*self-esteem and self-respect*) and integrity (*adherence to moral and ethical principles*).
29. Acknowledge and respect the clients' right for information and informed consent to empower the m and facilitate decision-making regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices.
30. Disclose clients' spiritual/religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team, while maintaining confidentiality to safeguard clients' welfare.
Domain 5: Quality assurance in spiritual care
31. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/midwife.
32. Implement professional caring behaviour demonstrating altruism (*a sense of giving*), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues.
33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on.
34. Recognise the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care.
35. Take initiative to participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilise the evidence to bring about practice improvement.

Table 5.21 The refined competency framework in spiritual care (cont.)

Generic core competencies in spiritual care **Domain 5: Quality assurance in spiritual care**
36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity, such as creative art (*e.g. painting*).
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual well-being of clients, their families and health carers and modify accordingly.
38. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all healthcare system.
Domain 6: Assessment and implementation of spiritual care
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) and informal (*listening to the clients' experiences*) assessment methods.
40. Identify signs of spiritual distress in clients and family (*e.g. pain, anxiety, guilt, loss, anger at God and despair*) and plan to address this distress while being aware of barriers to spiritual care, such as lack of time and education.
41. Plan spiritual care while identifying its intersections (*shared elements*) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns.
42. Utilise spiritual care models which integrate client-centred care and a problem–based approach while focusing on holistic care.
43. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically.
44. Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/religious needs maintaining patience, tact, perseverance and discipline.
45. Provide spiritual care interventions sensitively by promoting clients' positive self-concept (*e.g. positive coping techniques*) monitoring spiritual expression while respecting clients who do not conform to advice given on their health.
46. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time.
47. Facilitate family participation in the care of the irrelative to maintain spiritual habits and rituals and identify alternatives to instil hope.
48. Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team.
49. Recognise the importance of timely referral of clients/their families to chaplains and spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*).
50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow-up.
51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care.

Table 5.21 The refined competency framework in spiritual care (cont.)

Generic core competencies in spiritual care Domain 7: Informatics in spiritual care
52. Acknowledge the use of information technology as a resource of learning about spiritual care.
53. Acknowledge the use of information technology as a means of a communication network with clients/their families and members of the multi-disciplinary team on spiritual issues and spiritual support.
54. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care.

5.6.16 Exploratory Factor Analysis of the framework of competencies

Following consensus by the modified Delphi approach, the framework of competencies consists of seven domains and 54 competency items (Table 5.22).

Table 5.22 Domains and competency items of the competency framework

No.	Domain	Item Nos.
1.	Body of knowledge in spiritual care.	1-14
2.	Self-awareness and the use of self in spiritual care.	15-19
3.	Communication and interpersonal relationship in spiritual care	20-24
4.	Ethical and legal issues in spiritual care.	25-30
5.	Quality assurance in spiritual care.	31-38
6.	Assessment and implementation of spiritual care	39-51
7.	Informatics and spiritual care	52-54

The framework of competencies underwent factor analysis on data derived from participants in R1 (n=241) and R2 (n=205). Round 1 loadings of the 'agreed' items following the modified Delphi study (54 items) were sorted in descending order within a factor, whilst loadings less than 0.4 were replaced by blanks to avoid clutter. The factor analyses on the modified Delphi file was satisfactory as most items loaded solely on one factor. The factor structure was consistent between Round 1 (Qa) (Appendix 25) and Round 2 (Qb) (Appendix 30) and confirmed to some extent the predicted structure of the scale of competences.

5.6.17 Interpretation and naming of the factors

Originally, the framework of competencies consisted of seven domains. However, exploratory factor analysis identified six factors of which five were named accordingly to the domains identified and include: assessment, implementation and evaluation of spiritual care; quality assurance; ethical and legal issues; body of knowledge in spiritual care; and informatics. A new factor which was identified was named 'Chaplaincy in healthcare.'

Factor 1: 'Assessment, implementation and evaluation of spiritual care' (Table 5.23). Nine out of 13 items which loaded on this factor had originally been identified by the researcher as indicators of the assessment, implementation and evaluation of spiritual care domain.

Table: 5.23 Factor 1: Assessment, implementation, evaluation of spiritual care

Competency items in R1 and R2 loading on Factor 1	**FACTOR 1** *Rotated factor loading scores*	**Variance: 9.2% Eigenvalue=22.03**
		Factor 1: Assessment, implementation and evaluation of spiritual care
44. Understand the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/religious needs maintaining patience, tact, perseverance and discipline.	0.78	Assessment, implementation and evaluation of spiritual care
45. Provide spiritual care interventions sensitively by promoting clients' positive self-concept (*e.g. positive coping techniques*) monitoring spiritual expression while respecting clients who do not conform to advice on their health.	0.70	Assessment, implementation and evaluation of spiritual care
46. Respond to clients' spiritual needs promptly, demonstrating unhurried actions and good quality time.	0.65	Assessment, implementation and evaluation of spiritual care
41. Plan spiritual care while identifying its intersections (*shared elements*) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns.	0.60	Assessment, implementation and evaluation of spiritual care

Table: 5.23 Factor 1: Assessment, implementation, evaluation of spiritual care (cont.)

Competency items in R1 and R2 loading on Factor 1	FACTOR 1 *Rotated factor loading scores*	Variance: 9.2% Eigenvalue=22.03 Factor 1: Assessment, implementation and evaluation of spiritual care
51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care.	0.58	Assessment, implementation and evaluation of spiritual care
43. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically.	0.55	Assessment, implementation and evaluation of spiritual care
40. Identify signs of spiritual distress in clients and family (*e.g. pain, anxiety, guilt, loss, anger at God and despair*) and plans to address this distress while being aware of barriers to spiritual care, such as lack of time and education.	0.50	Assessment, implementation and evaluation of spiritual care
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) and informal (*listening to the clients' experiences*) assessment methods.	0.48	Assessment, implementation and evaluation of spiritual care
15. Be aware of own spirituality and use of self (*e.g. own strengths, limitations, values, beliefs*) as a resource for spiritual care.	0.49	Self-awareness and use of self
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) and informal (*listening to the clients' experiences*) assessment methods.	0.48	Assessment, implementation and evaluation of spiritual care
50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow up.	0.47	Assessment, implementation and evaluation of spiritual care
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/families in their spiritual needs and sufferings.	0.47	Communication and interpersonal skills
16. Recognise the possible impact of the nurse's/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care.	0.43	Self-awareness and use of self
Cronbach's Alpha*: 0.93 *(12 items)		

Factor 2: 'Quality assurance in spiritual care'. The first five with the highest loadings were originally identified as indicators of quality assurance (Table 5.24). Overall, seven of the 10 items which loaded on this factor had originally been identified as indicators of quality assurance in spiritual care which originally consisted of 8 items.

Table 5.24 Factor 2: Quality assurance in spiritual care

Competency items in R1 and R2 loading on Factor 2	**FACTOR 2** *Rotated factor loading scores*	**Variance: 7.9% Eigenvalue=3.60**
		Factor 2: Quality assurance in spiritual care
33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage to move on.	0.82	Quality Assurance in spiritual care
36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity such as creative art.	0.60	Quality Assurance in spiritual care
31. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/midwife.	0.56	Quality Assurance in spiritual care
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual well-being of clients, their families and health carers and modify accordingly.	0.55	Quality Assurance in spiritual care
42. Utilise spiritual care models which integrate client-centred care and a problem–based approach whilst focusing on holistic care.	0.5	Assessment and implementation of spiritual care
35. Take initiative to participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilise the evidence to bring about practice improvement.	0.53	Quality assurance in spiritual care
32. Implement professional caring behaviour demonstrating altruism (*a sense of giving*), wisdom discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients and their families.	0.48	Quality Assurance in spiritual care
30. Disclose clients' spiritual/religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team while maintaining confidentiality.	0.43	Ethical and legal issues in spiritual care
2. Identify the influence of the world's major faiths/religions (*e.g. Christianity, Islam, Buddhism*) cultural beliefs and practices in the appropriate clinical context and from conception to death.	0.40	Body of knowledge in Spiritual care
Cronbach's Alpha: 0.90 (10 items)		

Factor 3: 'Ethical and legal issues in spiritual care' (Table 5.25). The first five items with the highest loadings were originally identified by the researcher as pertaining to ethical and legal issues in spiritual care domain which originally consisted of six items.

Table 5.25 Factor 3: Ethical and legal issues in spiritual care

Competency items in R1 and R2 loading on Factor 3	**FACTOR 3** *Rotated factor loading scores*	**Variance: 7.7% Eigenvalue=2.15**
		Factor 3: Ethical and legal issues
25. Appreciate the uniqueness of each person and their right to decline spiritual care	0.82	Ethical and legal issues
26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/spiritual beliefs, values, practices and lifestyles (*e.g. diet, sexual orientation*).	0.70	Ethical and legal issues
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (*self-esteem*) and integrity (*adherence to ethical principles*).	0.63	Ethical and legal issues
27. Demonstrate sensitivity, support and respect for the client's autonomous and diverse health care decisions/choices influenced by religious/spiritual beliefs and practices (*e.g. blood transfusion, childbirth practices, chemotherapy)*	0.58	Ethical and legal issues
29. Acknowledge and respect the clients' right for information and informed consent to empower them and facilitate decision-making regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices.	0.56	Ethical and legal issues
23. Understand and apply the principles of a therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope to accompany them on their journey.	0.51	Communication and interpersonal skills
22. Assess barriers to effective communication in providing spiritual care (*e.g. language, beliefs, culture, anxiety, fear and anger*) and adapt accordingly by active listening, empathy and/or referral to members of the multi-disciplinary team.	0.47	Communication and interpersonal skills
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (*e.g. chaplains, counsellors, spiritual leaders*) as deemed necessary.	0.45	Self-awareness and the use of self
8. Demonstrate knowledge and understanding of the grieving process (*denial, anger, bargaining, depression and acceptance*).	0.47	Body of Knowledge in spiritual care
Cronbach's Alpha: 0.89 (10 items)		

Table 5.25 Factor 3: Ethical and legal issues in spiritual care (cont.)

Competency items in R1 and R2 loading on Factor 3	FACTOR 3 *Rotated factor loading scores*	Variance: 7.7% Eigenvalue=2.15
		Factor 3: Ethical and legal issues
24. Assess the impact of self on the effectiveness of communication in spiritual care whilst maintaining boundaries between the nurse/midwife-client relationship (abiding by the professional ethical/legal codes of conduct).	0.44	Communication and interpersonal skills
Cronbach's Alpha: 0.89 (10 items)		

Factor 4: 'Body of knowledge in spiritual care' (Table 5.26). Nine items were originally identified as indicators of knowledge in spiritual care domain. Nine out of the 14 items originally identified by the researcher in this domain loaded on this factor.

Table 5.26 Factor 4: Body of knowledge in spiritual care

Competency items in R1 and R2 loading on Factor 4	FACTOR 4 *Rotated factor loading scores*	Variance: 6.7% Eigenvalue=1.97
		Factor 4: Body of knowledge in spiritual care
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/her behaviour in dealing with spiritual needs.	0.67	Body of knowledge in spiritual care
10. Demonstrate knowledge of complex theories of spirituality such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis.	0.64	Body of knowledge in spiritual care
7. Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA*) and informal methods (e.g. *listening to clients' stories*).	0.58	Body of knowledge in spiritual care
3. Demonstrate knowledge of the basic spiritual needs of individuals which include: ▪ A meaningful philosophy of life (*values and moral sense*) ▪ A sense of the transcendent (*outside of self, view of deity/higher power and something beyond the immediate life, having hope*). ▪ A belief and faith in self, others and for some, a belief in a diety/higher power. ▪ A relatedness to nature and people. ▪ Love and forgiveness (*life meaning*).	0.57	Body of knowledge in spiritual care
Cronbach's Alpha: 0.89 (9 items)		

Table 5.26 Factor 4: Body of knowledge in spiritual care (cont.)

Competency items in R1 and R2 loading on Factor 4	FACTOR 4 *Rotated factor loading scores*	Variance: 6.7% Eigenvalue=1.97
		Factor 4: Body of knowledge in spiritual care
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.	0.46	Body of knowledge in spiritual care
9. Demonstrate knowledge and understanding of spiritual/religious development of individuals and assist spiritual/religious growth.	0.43	Body of knowledge in spiritual care
1. Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* view of care, attentive to the body-mind-spirit in all healthcare settings.	0.48	Body of knowledge in spiritual care
4. Recognise the importance of the spiritual dimension (*with or without religion*) that sustains physical and mental well-being.	0.47	Body of knowledge in spiritual care
11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (*e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?*).	0.40	Body of Knowledge in spiritual care
Cronbach's Alpha: 0.89 (9 items)		

Factor 5 was named 'Informatics in spiritual care' (Table 5.27). All three items loading on this factor had been previously identified as indicators of this domain.

Table 5.27 Factor 5: Informatics and spiritual care

Competency items in R1 and R2 loading on Factor 5	FACTOR 5 *Rotated factor loading scores*	Variance: 6.5% Eigenvalue=1.84
		Factor 5: Informatics and spiritual care
53. Acknowledge the use of information technology as a means of a communication network with clients/their families and members of the multi-disciplinary team on spiritual issues.	0.84	Informatics and spiritual care
54. Acknowledge the use of information technology as a means of documenting spiritual care and maintain consistency with holistic care.	0.82	Informatics and spiritual care
52. Acknowledge the use of information technology as a learning resource of spiritual care.	0.64	Informatics and spiritual care
Cronbach's Alpha: 0.86 (3 items)		

The five factors identified by EFA explicitly addressed the original domains, namely:

- Domain 1: Body of knowledge in spiritual care.
- Domain 4: Ethical and legal issues in spiritual care.
- Domain 5: Quality assurance in spiritual care.
- Domain 6: Assessment, Implementation and evaluation of spiritual care.
- Domain 7: Informatics and spiritual care.

However, two domains: Domain 2*:* Self- awareness and the use of self *(Items 15-19)* and Domain 3: Communication and interpersonal relationship in spiritual care (*Items 20-24*) were integrated with other factors. Consequently, Factor 6 was labelled 'Undefined'. Items from various domains which address 'chaplaincy in healthcare' were loaded on this factor (Table 5.28). Since the achieved loading factor scores of the items stand well above the cut-off score of 0.4, this factor merits consideration. In contrast, no common items were identified in Factor 7 (Table 5.29) of which most items loading factor scores were well below the cut-off score of 0.4.

Table: 5.28 Factor 6: Undefined

Competency items in R1 and R2 loading on Factor 6	**FACTOR 6** *Rotated factor loading scores*	**Variance: 5.7% Eigenvalue=1.68** **Factor 6:** Chaplaincy in healthcare
12. Acknowledge the role of chaplains, spiritual leaders as part of the team in providing spiritual care.	0.74	Body of knowledge in spiritual care
48. Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the team.	0.72	Assessment, implementation and evaluation of spiritual care
13. Demonstrate knowledge of resources, support systems/agencies that inform nurses/midwives to access spiritual care for clients, their families and staff (*e.g. place for worship, support groups*).	0.58	Body of knowledge in spiritual care
49. Recognise the importance of timely referral of clients/their families to chaplains/spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*).	0.53	Assessment, implementation and evaluation of spiritual care
Cronbach's Alpha: 0.86 (4 items)		

Table 5.29 Factor 7: No common items

Competency items in R1 and R2 loading on Factor 7	FACTOR 7 *Rotated factor loading scores*	Variance: ≤3.3% Eigenvalue=1.25
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/religious readings and prayer as a means of encouragement and hope.	0.44	Communication and interpersonal skills
14. Demonstrate knowledge on assisting clients in healthcare according to the clients' religious/spiritual, cultural beliefs, such as the use of complimentary/alternative therapies, diets, nutritional supplements and prayer.	< 0.4	Body of knowledge in spiritual care
47. Facilitate family participation in the care of their relative to maintain spiritual habits and rituals and identify alternatives to instil hope.	< 0.4	Assessment Implementation and evaluation of spiritual care
17. Acknowledge and respect the influence of clients' diverse cultural worldviews, beliefs and practices in the expression of their spirituality in healthcare.	< 0.4	Self-awareness and the use of self
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care.	< 0.4	Self-awareness and the use of self
34. Recognise the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care.	< 0.4	Quality assurance in spiritual care

The correlation matrix demonstrates consistent significant relationships (>0.3) between Factor 1 and the other seven factors, denoting that assessment, implementation and evaluation of spiritual care is the common denominator of spiritual care (Table 5.30).

Table 5.30 Factor correlation matrix

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Factor 1	1.000						
Factor 2	0.447	1.000					
Factor 3	0.407	0.268	1.000				
Factor 4	0.430	0.320	0.326	1.000			
Factor 5	0.346	0.333	0.170	0.216	1.000		
Factor 6	0.342	0.210	0.315	0.282	0.154	1.000	
Factor 7	0.146	0.180	0.091	0.186	0.195	0.045	1.000

KEY:
Factor 1: Assessment implementation and evaluation of spiritual care.
Factor 2: Quality assurance in spiritual care.
Factor 3: Ethical and legal issues in spiritual care.
Factor 4: Body of knowledge in spiritual care.
Factor 5: Informatics in spiritual care.
Factor 6: Chaplaincy in healthcare.
Factor 7: No common items.

5.7 PHASE 3: Consultation with experts

5.7.1 Introduction

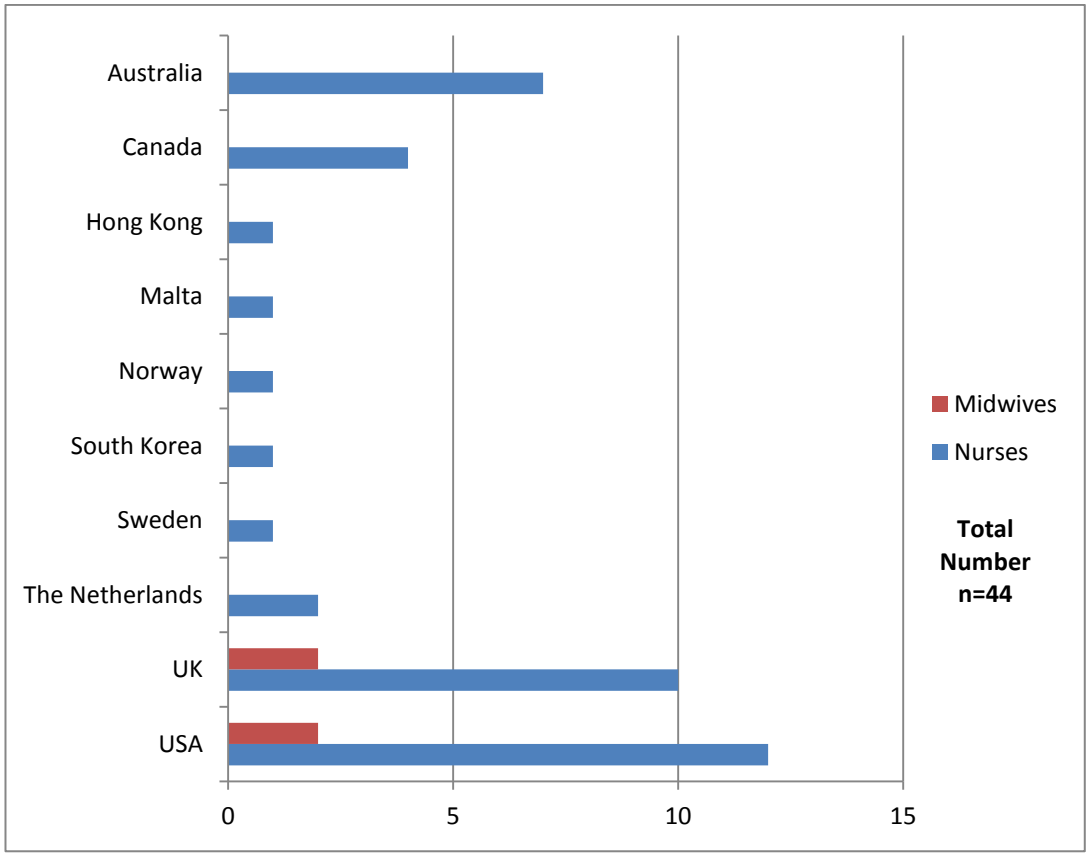
This section presents the results of the consultation process which took place with international researchers in spiritual care and with modified Delphi experts who have a background in education. The seven domain PRE-REGISTRATION competency framework in spiritual care is analysed in this section. The 'fitness' of the competencies with the existing regulatory requirements and the four domain POST-REGISTRATION competency framework in spiritual care for nurses/midwives was also developed at this stage in the study.

Quantitative data were analysed by using frequency distribution and presented in contingency. The researcher referred to the 'thematic content analysis framework' (Braun & Clarke, 2006) when determining the themes and categories to be derived from the qualitative data.

5.7.2 Demographic characteristics of participants

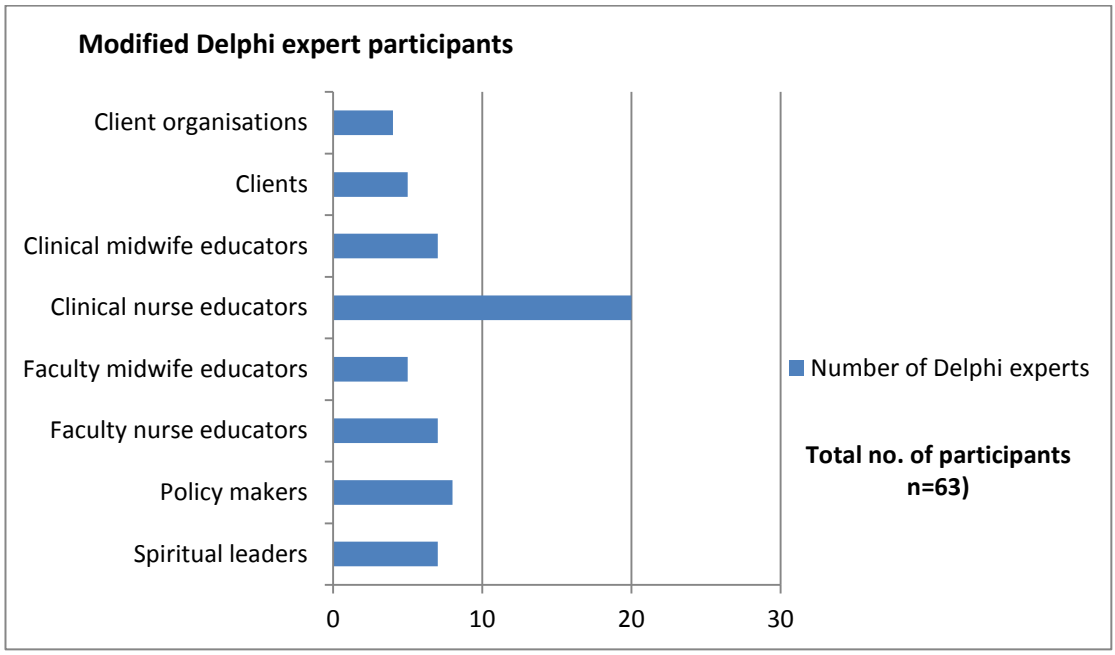
The response rate of participants who responded to the web survey or postal questionnaire was 37.54% (n=107), of whom 23.5% (n=44) were international nurse/midwife researchers in spiritual care (Figure 5.9) and 64.28% (n=63) who were experts sampled from modified Delphi participants and who were educators. It is well documented that web surveys and postal questionnaires response rates tend to be low (Fielding, Lee & Blank, 2008; Cook, O'Dickinson & Eccles 2009). The participants' countries of origin across continents was varied with the highest number from the United States (n=12) and United Kingdom (n= 10) as shown in Figure 5.9.

Figure 5.9 International nurse/midwife researchers and country of origin



The modified Delphi panel who participated in this consultation phase are represented in Figure 5.10. All participants had a relevant background education and were therefore recruited to participate in the consultation phase of the study.

Figure 5.10 Modified Delphi expert participants by group



5.7.3 Quantitative data analysis of responses

The results of responses in the two groups of participants (the international researchers and educators) are presented in Table 5.31 as frequencies and percentages. Participants in this phase of the study were asked to identify which competencies in spiritual care should essentially be acquired by a nursing/midwifery student at **PRE-registration level** (i.e. at point of registration) and which competencies should essentially be obtained at **POST-registration level** (i.e. as part of Continuous Professional Development (CPD).

The third category which was included was 'Not Essential at either level' which showed minimal frequencies. Thirty eight competency items (Table 5.31) were chosen by participants in this consultation process as should 'Essentially be acquired by a student at pre-registration nursing/midwifery education.' Fifteen competency items were scored as 'Essential at post–registration nursing/midwifery education level' and only one competency was scored at both levels. No items were rejected.

5.7.4 Frequencies and differences between 'experts' and researchers

Three options were offered at pre-registration nursing/midwifery level, post-registration nursing/midwifery level or not essential at either level. Table 5.31 presents the perceived educational level of each competency item between the 'researchers' and 'educators' groups and identified significant differences between the perceptions of the researchers and educators using SPSS version 21, the Chi-squared test.

Table 5.31 Frequencies and differences in responses of participants

Competency items in spiritual care	Essential at pre-registration *R=Researchers D=Delphi Experts*	Essential at post-registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
1. Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* view of care, attentive to the body-mind-spirit in all health care settings.	*R=(n=40)* *D (n=48)* Total 82.2% (n=88)	*R=(n=3)* *D=(n=12)* Total 14% (n=15)	*R=(n=1)* *D=(n=3)* Total 3.7% (n=4)
	Differences between R&D (χ 2=3.876; p=0.144)		
2. Identify the influence of the world's major faiths/religions (*e.g. Christianity, Islam, Judaism, Hindu and Buddhism*) cultural beliefs and practices in the appropriate clinical context and along the life span continuum (*from birth to death*).	*R=(n=32)* *D-(n=35)* Total 62.6% (n=67)	*R=(n=9)* *D=(n=26)* Total 32.7% (n=35)	*R=(n=3)* *D=(n=2)* Total 4.7% (n=5)
	Differences between R&D (χ 2=5.388; p=0.068)		
3. Demonstrate knowledge of the basic spiritual needs of individuals: ▪ A meaningful philosophy of life (*values and moral sense*). ▪ A sense of the transcendent (*outside of self, deity / higher power and having hope*). ▪ Belief and faith in self, others and for some a belief in a deity/ higher power. ▪ A relatedness to nature and people (*friendship*). ▪ Experiencing love and forgiveness (*a sense of life meaning*).	R=(n=37) *D=(n=51)* Total 82.2% (n=88)	*R=(n=7)* *D=(n=8)* Total 14% (n=15)	*R=0* *D=(n=4)* Total 3.7% (n=4)
	Differences between R&D (χ 2=3.015;p=0.221)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at pre-registration *R=Researchers D=Delphi Experts*	Essential at post-registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
4. Recognise the importance of the spiritual dimension (*with or without religion*) that sustains physical and mental well-being.	R=(n=39) *D=(n=55)* Total 87.9% (n=94)	R=(n=4) *D=(n=7)* Total 10.3% (n=11)	*R=2.2%(n=1)* *D=(n=1)* Total 1.9% (n=2)
	Differences between R&D (χ 2=0.173; p=0.917		
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.	R=(n=37) *D=(n=32)* Total 64.5% (n=69)	R=(n=7) *D=(n=26)* Total 30.8% (n=33)	R=0 *D=(n=5)* Total (R&D) =4.7%(n=5)
	Differences between R&D (χ 2=13.394; p=0.001*)		
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/ her behaviour in dealing with spiritual needs.	R=(n=32) *D=(n=36)* Total 63.6% (n=68)	R=(n=11) *D=(n=24)* Total 32.7% (n=35)	R=(n=1) *D=(n=3)* Total 3.7% (n=4)
	Differences between R&D (χ 2=2.778; 0.249)		
7. Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA, RESPECT and HOPE tools*) and informal methods (e.g. *listening to clients' stories*).	R=(n=25) *D=(n=23)* Total 44.9% (n=48)	R=(n=16) *D=(n=32)* Total 44.9% (n=48)	R=(n=3) *D=(n=8)* Total 10.3% (n=11)
	Differences between R&D (χ 2=4.456; p=0.108)		
8. Demonstrate knowledge and understanding of the grieving process (*denial, anger, bargaining, depression, acceptance*).	R=(n=39) *D=(n=48)* Total 81.3% (n=87)	R=(n=3) *D=(n=13)* Total 15% (n=16)	R=(n=2) *D=(n=2)* Total 3.7% (n=4)
	Differences between R&D (χ 2=3.931; p=0.140)		
9. Demonstrate knowledge and understanding of spiritual / religious development of individuals and assist spiritual / religious growth.	R=(n=17) *D=(n=16)* Total 30.8% (n=33)	R=(n=17) *D=(n=40)* Total 53.3% (n=57)	R=(n=10) *D=(n=7)* Total 15.9% (n=17)
	Differences between R&D (χ 2=6.677;p= 0.035*)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at pre-registration *R=Researchers D=Delphi Experts*	Essential at post-registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
10. Demonstrate knowledge of complex theories of spirituality such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations.	R=(n=10) *D=(n=18)* Total 26.2% (n=28)	R=(n=23) *D=(n=37)* Total 56.1% (n=60)	R=(n=11) *D=(n=8)* Total 17.8% (n=19)
	Differences between R&D (χ 2=2.739; p= 0.254)		
11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (*e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?*)	R=(n=26) *D=(n=29)* Total 51.4% (n=55)	R=(n=17) *D=(n=31)* Total 44.9% (n=48)	R=(n=1) *D=(n=3)* Total 3.7% (n=4)
	Differences between R&D (χ 2=1.934; p=0.380)		
12. Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care.	R=(n=42) *D=(n=50)* Total 86.0% (n=92)	R=(n=2) *D=(n=11)* Total 12.1% (n=13)	R=0 *D=(n=2)* Total 1.9% (n=2)
	Differences between R&D (χ 2=5.733; p=0.057)		
13. Demonstrate knowledge of resources, support systems / agencies that inform nurses/midwives to access spiritual care for clients, their families and staff in all health care settings (*e.g. place for worship)*	R=(n=33) *D=(n=42)* Total 70.1% (n=75)	R=(n=9) *D=(n=20)* Total 27.1% (n=29)	R=(n=2) *D=(n=1)* Total 2.8% (n=3)
	Differences between R&D (χ 2=2.284;p=0.319)		
14. Demonstrate knowledge on assisting clients in health care according to the clients' religious/spiritual, cultural beliefs such as the use of complimentary/alternative therapies, diets, nutritional supplements and prayer.	R=(n=27) *D=(n=27)* Total 50.5% (n=54)	R=(n=14) *D=(n=35)* Total 45.8% (n=49)	R=(n=3) *D=(n=1)* Total 3.7% (n=4)
	Differences between R&D (χ 2=6.842;p=0.033*)		
15. Be aware of own spirituality and use of self (*e.g. own strengths, limitations, values, beliefs*) as a resource for spiritual care.	R=(n=38) *D=(n=45)* Total 77.6% (n=83)	R=(n=5) *D=(n=14)* Total 17.8% (n=19)	R=(n=1) *D=(n=4)* Total 4.7% (n=5)
	Differences between R&D (χ 2=3.386;p=0.184)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at Pre-Registration *R=Researchers D=Delphi Experts*	Essential at Post-Registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
16. Recognise the possible impact of the nurse/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care.	R=(n=38) *D=(n=42)* Total 74.8% (n=80)	R=(n=6) *D=(n=18)* Total 22.4% (n=24)	R=0 *D=(n=3)* Total 2.8% (n=3)
	Differences between R&D (χ 2=6.016;p=0.049*)		
17. Acknowledge and respect the influence of clients' diverse cultural worldviews, beliefs and practices in the expression of their spirituality in healthcare.	R=(n=38) *D=(n=42)* Total 74.8% (n=80)	R=(n=6) *D=(n=20)* Total 23.3% (n=26)	R=0 *D=(n=1)* Total 0.9% (n=1)
	Differences between R&D (χ 2=5.539;p= 0.063)		
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (*e.g. psychologists, chaplains, counsellor, spiritual leaders*) as deemed necessary.	R=(n=40) *D=(n=45)* Total 79.4% (n=85)	R=(n=4) *D=(n=17)* Total 19.6% (n=21)	R=0 *D=(n=1)* Total 0.9% (n=1)
	Differences between R&D (χ 2=6.162;p=0.045)		
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care.	R=(n=37) *D=(n=30)* Total 62.6% (n=67)	R=(n=0) *D=(n=29)* Total 27.1% (n=29)	R=(n=7) *D=(n=4)* Total 10.3% (n=11)
	Differences between R&D (χ 2=28.060; 0.000*)		
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/ families in their spiritual needs and sufferings.	R=(n=31) *D=(n=28)* Total 55.1% (n=59)	R=(n=9) *D=(n=30)* Total 36.4% (n=39)	R=(n=4) *D=(n=5)* Total 8.4% (n=9)
	Differences between R&D (χ 2=8.464; p=0.015*)		
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/religious readings and prayer as a means of encouragement and hope.	R=(n=21) *D=(n=17)* Total 40.2% (n=43)	R=(n=22) *D=(n=37)* Total 50.5% (n=54)	R=(n=6) *D=(n=4)* Total (9.3% (n=10)
	Differences between R&D (χ 2=4.602; p=0.100)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at Pre-Registration *R=Researchers D=Delphi Experts*	Essential at Post-Registration *R=Researchers D=Delphi Experts*	Not Essential At either level. *R=Researchers D=Delphi Experts*
22. Assess barriers to effective communication in providing spiritual care (*e.g. language, beliefs, culture, anxiety, fear and anger*) and adapt accordingly by active listening, empathy and/or referral to other members of the multi-disciplinary team.	R=(n=32) *D=(n=40)* Total 67.3% (n=72)	R=(n=12) *D=(n=21)* Total 30.8% (n=33)	R=0 *D=(n=2)* Total 1.9% (n=2)
	Differences between R&D (χ 2=2.034;p=0.362)		
23. Understand and apply the principles of a therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey.	R=(n=26) *D=(n=33)* Total 55.1% (n=59)	R=(n=18) *D=(n=29)* Total 43.9% (n=47)	R=0 *D=(n=1)* Total 0.9% (n=1)
	Differences between R&D (χ 2=1.065;p=0.587)		
24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/midwife-client relationship (*abiding by the professional ethical/legal codes of conduct*).	R=(n=32) *D=(n=37)* Total 64.5% (n=69)	R=(n=11) *D=(n=25)* Total 33.5% (n=36)	R=(n=1) *D=(n=1)* Total 1.9% (n=2)
	Differences between R&D (χ 2=2.512;p= 0.285)		
25. Appreciate the uniqueness of each person and their right to decline spiritual care.	R=(n=43) *D=(n=54)* Total 90.7% (n=97)	R=(n=1) *D=(n=7)* Total 7.5% (n=8)	R=0 *D=(n=2)* Total 1.9% (n=2)
	Differences between R&D (χ 2=4.516;p=0.105)		
26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/spiritual beliefs, values, practices and lifestyles (*e.g. sexual orientation*).	R=(n=41) *D=(n=50)* Total 85.0% (n=91)	R=(n=3) *D=(n=11)* Total 13.1% (n=14)	R=0 *D=(n=2)* Total 1.9% (n=2)
	Differences between R&D (χ 2=4.221; p=0.121)		
27. Demonstrate sensitivity, support and respect for the client's autonomous and diverse health care decisions/choices influenced by religious/spiritual beliefs and practices (*e.g. blood transfusion, childbirth practices, chemotherapy*).	R=(n=39) *D=(n=47)* Total 80.4% (n=86)	R=(n=5) *D=(n=15)* Total 18.7% (n=20)	R=0 *D=(n=1)* Total 0.9% (n=1)
	Differences between R&D (χ 2=3.480; p=0.176)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at Pre-Registration *R=Researchers D=Delphi Experts*	Essential at Post-Registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (self-esteem and self-respect) and integrity (adherence to moral and ethical principles).	R=(n=41) *D=(n=50)* Total 85.0 (n=91)	R=6.8%(n=3) *D=(n=13)* Total 15% (n=16)	R=0 *D=(n=0)* Total 0
	Differences between R&D (χ 2=3.889; p=0.041*)		
29. Acknowledge and respect the clients' right for information and informed consent to empower them and facilitate decision making regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices.	R=(n=42) *D=(n=44)* Total 80.0% (n=86)	R=(n=2) *D=(n=18)* Total 18.7% (n=20)	R=0 *D=(n=1)* Total 0.9 (n=1)
	Differences between R&D (χ 2=10.814; p=0.004*)		
30. Disclose clients' spiritual/religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team while maintaining confidentiality to safeguard clients' welfare.	R=(n=36) *D=(n=31)* Total 63.2 (n=67)	R=(n=7) *D=(n=28)* Total 33.0% (n=35)	R=2.2%(n=1) *D=(n=3)* Total 3.8% (n=4)
	Differences between R&D (χ 2=11.241; p=0.004*)		
31. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/midwife.	R=(n=19) *D=(n=35)* Total 50.5% (n=54)	R=(n=19) *D=(n=21)* Total 37.4% (n=40)	R=(n=6) *D=(n=7)* Total 12.1% (n=13)
	Differences between R&D (χ 2=1.594; p=0.451)		
32. Implement professional caring behaviour demonstrating altruism (*a sense of giving*), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues.	R=(n=28) *D=(n=32)* Total 56.1% (n=60)	R=(n=14) *D=(n=29)* Total 40.2% (n=43)	R=(n=2) *D=(n=2)* Total 3.7% (n=4)
	Differences between R&D (χ 2=2.195; p=0.334)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at Pre-Registration *R=Researchers D=Delphi Experts*	Essential at Post-Registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on.	R=(n=2) *D=(n=11)* Total 12.1% (n=13)	R=(n=38) *D=(n=52)* Total 84.1% (n=90)	R=(n=4) *D=(n=0)* Total 3.7% (n=4)
	Differences between R&D (χ 2=9.329: p=0.009*)		
34. Recognise the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care.	R=(n=12) *D=(n=17)* Total 27.1% (n=29)	R=(n=29) *D=(n=44)* Total 68.2% (n=73)	R=(n=3) *D=(n=2)* Total 4.7% (n=5)
	Differences between R&D (χ 2=0.796; p=0.672)		
35. Take initiative to participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilise the evidence to bring about practice improvement.	R=(n=4) *D=(n=15)* Total 17.8% (n=19)	R=(n=31) *D=(n=40)* Total 66.4% (n=71)	R=(n=9) *D=(n=8)* Total 15.9% (n=17)
	Differences between R&D (χ 2=4.331; p=0.115)		
36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity such as creative art (*e.g. painting*).	R=(n=7) *D=(n=13)* Total 18.7% (n=20)	R=(n=29) *D=(n=42)* Total 66.4% (n=71)	R=(n=8) *D=(n=8)* Total 15.0% (n=16)
	Differences between R&D (χ 2=0.833; p=0.659)		
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual wellbeing of clients, their families and health carers and modify accordingly.	R=(n=13) *D=(n=20)* Total 30.8% (n=33)	R=(n=30) *D=(n=38)* Total 63.6% (n=68)	R=(n=1) *D=(n=5)* Total 5.6% (n=6)
	Differences between R&D (χ 2=1.775; p=0412)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at Pre-Registration *R=Researchers D=Delphi Experts*	Essential at Post-Registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
38. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all health care system.	R=(n=6) *D=(n=18)* Total 22.4% (n=24)	R=(n=36) *D=(n=41)* Total 72.0% (n=77)	R=(n=2) *D=(n=4)* Total 5.6% (n=6)
	Differences between R&D (χ 2=3.735; p=0.154)		
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) and informal (*listening to the clients' experiences*) assessment methods.	R=(n=28) *D=(n=17)* Total 42.1% (n=45)	R=(n=14) *D=(n=41)* Total 51.4% (n=55)	R=(n=2) *D=(n=5)* Total 6.5% (n=7)
	Differences between R&D (χ 2=14.306; p=0.001*)		
40. Identify signs of spiritual distress in clients and family (e.g. pain, anxiety, guilt, loss, anger at God and despair) and plan to address this distress while being aware of barriers to spiritual care such as lack of time and education.	R=(n=35) *D=(n=29)* Total 59.8% (n=64)	R=(n=9) *D=(n=32)* Total 38.3% (n=41)	R=0 *D=(n=2)* Total 1.9% (n=2)
	Differences between R&D (χ 2=12.485; p=0.002*)		
41. Plan spiritual care while identifying its intersections (*shared elements*) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns.	R=(n=18) *D=(n=14)* Total (n=32)	R=(n+23) *D=(n=46)* Total 64.5% (n=69)	R=(n=3) *D=(n=3)* Total 5.6% (n=6)
	Differences between R&D (χ 2=4.949; p=0.084)		
42. Utilise spiritual care models which integrate client-centred care and a problem–based approach while focusing on holistic care.	R=(n=21) *D=(n=23)* Total 41.1% (n=44)	R=(n=20) *D=(n=35)* Total 51.4% (n=55)	R=(n=3) *D=(n=5)* Total 7.5% (n=8)
	Differences between R&D (χ 2=1.351; p=0.509)		
43. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically.	R=(n=25) *D=(n=31)* Total 52.3% (n=56)	R=(n=17) *D=(n=31)* Total 44.9% (n=48)	R=(n=2) *D=(n=1)* Total 2.8% (n=3)
	Differences between R&D (χ 2=1.741; p=0.419)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at Pre-Registration *R=Researchers D=Delphi Experts*	Essential at Post-Registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
44. Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/ religious needs maintaining patience, tact, perseverance and discipline.	R=(n=19) *D=(n=18)* Total 34.6% (n=37)	R=(n=21) *D=(n=42)* Total 58.9% (n=63)	R=(n=4) *D=(n=3)* Total 6.5% (n=7)
	Differences between R&D (χ 2=3.920; p=0.141)		
45. Provide spiritual care interventions sensitively by promoting clients' positive self-concept (*e.g. positive coping techniques*) monitoring spiritual expression while respecting clients who do not conform to advice on their health.	R=(n=17) *D=(n=17)* Total 31.8% (n=34)	R=(n=23) *D=(n=45)* Total 63.6% (n=68)	R=9.0%(n=4) *D=(n=1)* Total 4.7% (n=5)
	Differences between R&D (χ 2=5.724; p=0.057)		
46. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time.	R=(n=34) *D=(n=42)* Total 71.0% (n=76)	R=(n=9) *D=(n=21)* Total 28.0% (n=30)	R=(n=1) *D=(n=0)* Total 0.9% (n=1)
	Differences between R&D (χ 2=3.375; p=0.185)		
47. Facilitate family participation in the care of their relative to maintain spiritual habits and rituals and identify alternatives to instil hope.	R=7(n=31) *D=(n=35)* Total 61.7% (n=66)	R=(n=12) *D=(n=26)* Total 35.5% (n=38)	R=(n=1) *D=(n=2)* Total 2.8% (n=3)
	Differences between R&D (χ 2=2.437; p=0.296)		
48. Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team.	R=(n=38) *D=(n=49)* Total 81.3% (n=87)	R=(n=6) *D=(n=14)* Total 18.7% (n=20)	R=0 *D=(n=0)* Total =0
	Differences between R&D (χ 2=1.257; p=0.193)		

Table 5.31 Frequencies and differences in responses of participants (cont.)

Competency items in spiritual care	Essential at Pre-Registration *R=Researchers D=Delphi Experts*	Essential at Post-Registration *R=Researchers D=Delphi Experts*	Not Essential At Either Level. *R=Researchers D=Delphi Experts*
49. Recognise the importance of timely referral of clients/ their families to chaplains/ spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*).	R=(n=37) *D=(n=42)* Total 73.8% (n=79)	R=(n=7) *D=(n=21)* Total 26.2% (n=28)	R=0 *D=(n=0)* Total 0
	Differences between R&D (χ 2=4.071; p=0.035)		
50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow up.	R=(n=30) *D=(n=29)* Total 55.1% (n=59)	R=(n=12) *D=(n=31)* Total 40.2% (n=43)	R=(n=2) *D=(n=3)* Total 4.7% (n=5)
	Differences between R&D (χ 2=5.409; p=0.067)		
51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care.	R=(n=22) *D=(n=8)* Total 28.0% (n=30)	R=(n=17) *D=(n=53)* Total 65.4% (n=70)	R=(n=5) *D=(n=2)* Total 6.5% (n=7)
	Differences between R&D (χ 2=23.707; p=0.003*)		
52. Acknowledge the use of information technology as a resource of learning about spiritual care.	R=(n=28) *D=(n=45)* Total 68.2% (n=73)	R=(n=7) *D=(n=13)* Total 18.7% (n=20)	R=(n=9) *D=(n=5)* Total 13.1% (n=14)
	Differences between R&D (χ 2=3.643; p=0.162)		
53. Acknowledge the use of information technology as a means of a communication network with clients/ their families and members of the multi-disciplinary team on spiritual issues and spiritual support.	R=(n=23) *D=(n=34)* Total 53.3% (n=57)	R=(n=7) *D=(n=23)* Total 28.0% (n=30)	R=(n=14) *D=(n=6)* Total 18.7% (n=20)
	Differences between R&D (χ 2=10.824; p=0.004*)		
54. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care.	R=(n=32) *D=(n=32)* Total 59.8% (n=64)	R=(n=3) *D=(n=22)* Total 23.4% (n=25)	R=(n=9) *D=(n=9)* Total 16.8% (n=18)
	Differences between R&D (χ 2=11.426; p=0.003*)		

5.7.5 Outcome of consultation: Competency frameworks

Following the analyses of the data a seven domain pre-registration and a four domain post–registration competency frameworks in spiritual care were developed (Table 5.32 - 5.33)

Table 5.32 The 7 domain pre-registration competency framework

Domain 1: Body of knowledge in spiritual care At point of registration nurses/midwives should be able to:	
1	Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* view of care, attentive to the body-mind-spirit in all health care setting.
2	Identify the influence of the world's major faiths/religions (*e.g. Christianity, Islam, Judaism, Hindu and Buddhism*) cultural beliefs and practices in the appropriate clinical context and along the life span continuum (*from conception to death*).
3	Demonstrate knowledge of the basic spiritual needs of individuals which include: ▪ A meaningful philosophy of life (*values and moral sense*) ▪ A sense of the transcendent (*outside of self, view of deity/ higher power and something beyond the immediate life, having hope*) ▪ Belief and faith in self, others and for some a belief in a deity/ higher power ▪ A relatedness to nature and people (*friendship*) ▪ Experiencing love and forgiveness (*a sense of life meaning*)
4	Recognise the importance of the spiritual dimension (*with or without religion*) that sustains physical and mental well being
5	Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.
6	Demonstrate knowledge and understanding of the client's condition in order to understand his/her behaviour in dealing with spiritual needs
7*	Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA, RESPECT and HOPE tools*) and informal methods (e.g. *listening to clients' stories*).
8	Demonstrate knowledge and understanding of the grieving process (*denial, anger, bargaining, depression and acceptance*).
9	Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (*e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?*)
10	Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care
11	Demonstrate knowledge of resources, support systems/agencies that inform nurses/midwives to access spiritual care for clients, their families and staff in all health care settings (*e.g. place for worship, Church and support groups*).
12	Demonstrate knowledge in assisting clients in health care according to the clients' religious/spiritual, cultural beliefs, such as the use of complimentary/alternative therapies, diets, nutritional supplements and prayer.

Table 5.32 The 7 domain pre-registration competency framework (cont.)

Domain 2: Self-awareness and use of self in spiritual care At point of registration nurses/midwives should be able to:	
13	Be aware of own spirituality and use of self (*e.g. own strengths, limitations, values, beliefs*) as a resource for spiritual care.
14	Recognise the possible impact of the nurse/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care
15	Acknowledge and respect the influence of clients' diverse cultural worldviews, beliefs and practices in the expression of their spirituality in healthcare.
16	Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (*e.g. psychologists)* as deemed necessary.
17	Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care.
Domain 3: Communication and interpersonal relationship in spiritual care	
18	Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/families in their spiritual needs and sufferings.
19	Assess barriers to effective communication in providing spiritual care (*e.g. language, beliefs, culture, anxiety, fear and anger*) and adapt accordingly by active listening, empathy and/or referral to other members of the multi-disciplinary team.
20	Understand and apply the principles of a therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey.
21	Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/ midwife-client relationship (*abiding by the professional ethical/ legal codes of conduct*)
Domain 4: Ethical and legal issues in spiritual care	
22	Appreciate the uniqueness of each person and their right to decline spiritual care
23	Demonstrate sensitivity and respect for diversity in clients' and their families' religious/ spiritual beliefs, values, practices and lifestyles (*e.g. diet)*
24	Demonstrate sensitivity, support and respect for the client's autonomous and diverse health care decisions/ choices influenced by religious/ spiritual beliefs.
25	Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (self-esteem and self-respect) and integrity (adherence to moral and ethical principles)
26	Acknowledge and respect the clients' right for information and informed consent to empower them and facilitate decision making regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices.
27	Disclose clients' spiritual/religious information verbally or by documenting in a sensitive manner to the multi-disciplinary team while maintaining confidentiality

Table 5.32 The 7 domain pre-registration competency framework (cont.)

Domain 5: Quality Assurance in spiritual care At point of registration nurses/midwives should be able to:	
28	Identify the contribution of spirituality towards self-professional growth based on the vocational calling as nurse/midwife.
29	Implement professional caring behaviour demonstrating altruism (*a sense of giving*), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues.
Domain 6: Assessment implementation and evaluation of spiritual car	
30	Identify signs of spiritual distress in clients and family (*e.g. pain, anxiety, guilt, anger at God and despair)* and plan to address this distress while being aware of barriers to spiritual care, such as lack of time and education.
31	Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically.
32	Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time.
33	Facilitate family participation in the care of their relative to maintain spiritual habits and rituals and identify alternatives to instil hope.
34	Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team.
35	Recognise the importance of timely referral of clients/their families to chaplains/spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*).
36	Provide spiritual care feedback to clients and the relevant members of the team ensuring follow up.
Domain 7: Informatics in spiritual care	
37	Acknowledge the use of information technology as a resource of learning about spiritual care
38	Acknowledge the use of information technology as a means of a communication network with clients/ their families and members of the multi-disciplinary team on spiritual issues and spiritual support
39	39. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care

Table 5.33 The 4 domain post-registration competency framework

Domain 1: Body of Knowledge in spiritual care Post registration nurses/midwives should be able to:	
1	Demonstrate knowledge, understanding of spiritual/religious development of individuals and spiritual/religious growth.
2	Demonstrate knowledge of complex theories of spirituality, such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations.
3*	Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA, RESPECT and HOPE tools* and informal methods (e.g. *listening to clients' stories*). ***Item 3 is achievable at both pre and post registration levels.**
Domain 2: Communication and interpersonal relationship in spiritual care	
4	Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/religious readings and prayer, as a means of encouragement and hope.
Domain 3: Quality Assurance in spiritual care	
5	Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on.
6	Recognise the need for continuing education with supervision, self-reflection, role models, conferences and other learning resources to improve spiritual care.
7	Take initiative to participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilise the evidence to bring about practice improvement.
8	Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity such as creative art (*e.g. painting*).
9	Acknowledge the importance of evaluating the environment to determine the extent of spiritual well-being of clients, their families and health carers accordingly.
10	Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all health care system.
Domain 4: Assessment and Implementation of spiritual care	
11	Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) and informal (*listening to the clients' experiences*) methods.
12	Plan spiritual care while identifying its intersections (*shared elements*) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns.
13	Utilise spiritual care models which integrate client-centred care and a problem-based approach focusing on holistic care.
14	Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/religious needs maintaining patience, tact, perseverance and discipline.

Table 5.33 The 4 domain post-registration competency framework (cont.)

Domain 4: Assessment and Implementation of spiritual care Post registration nurses/midwives should be able to:	
15	Provide spiritual care interventions sensitively by promoting clients' positive self-concept (*e.g. positive coping techniques*) monitoring spiritual expression while respecting clients who do not conform to advice on their health.
16	Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions, and provide solutions to enhance delivery of spiritual care.

5.7.6 'Fitness' of competencies with NMC (UK) requirements

The 7 domain pre-registration framework was cross referenced with NMC Standards for pre-registration education in nursing (2010) and in midwifery (2009) supported by the Essential skills Clusters for (2008) to explore its 'fitness' with the existing regulatory requirements (Table 5.34). The majority of competencies embraced the pre-registration statutory requirements.

Table 5.34 Fitness of pre-registration competencies

The 'fitness' of the pre-registration competency framework in spiritual care CROSS-REFERENCED with pre-registration nursing/midwifery (NMC, 2009; 2010). Abridged competency items	NMC (2010) Pre-registration Nursing	NMC (2009) Pre-registration midwifery
DOMAIN 1: Body of knowledge in spiritual care		
1. Understanding concept of spirituality.		
2. Identify influence of world's major religions and culture.		1.6
3. Knowledge of basic spiritual needs.		
4. Recognise importance of spiritual dimension of care.		
5. Identify distinctions between religiosity/spirituality.	1.2	1.6
6. Demonstrate understanding of the client's condition.	3.1	
7. Knowledge of spiritual assessment established tools.	3.3	
8. Demonstrate knowledge and of the grieving process.	3.4	2.1
9. Dealing with clients' existential questions.		
10. Acknowledge the role of chaplains, spiritual leaders.	1.8	1.8
11. Demonstrate knowledge of support systems/agencies.		
12. Assisting clients according to religious/spiritual, beliefs.		1.6

Table 5.34 Fitness of pre-registration competencies (cont.)

The 'fitness' of the pre-registration competency framework in spiritual care CROSS-REFERENCED with pre-registration nursing/midwifery (NMC, 2009; 2010). Abridged competency items	NMC (2010) Pre-registration Nursing	NMC (2009) Pre-registration midwifery
DOMAIN 2: Self-awareness and the use of self		
13. Be aware of own spirituality and use of self.	2.3	
14. Avoid imposing nurse/midwife's own spirituality.	4.4	
15. Respect the influence of clients' diverse cultural views.	1.2	1.5, 1.6
16. Acknowledge personal limitations in providing care.	1.8, 2.4,3.1	1.8
17. Address personal feelings through reflective groups.	2.4	1.7
DOMAIN 3: Communication and interpersonal relationship in spiritual care		
18. Communicate the principles of 'PRESENCE'		1.7
19. Assess barriers to effective communication	2.2, 2.4	1.1, 1.7
20. Apply principles of a therapeutic trustful relationships	2.1, 3.8	1.7
21. maintaining boundaries between nurse/midwife-client	1.1, 2.5	1.1
DOMAIN 4: Ethical and legal issues in spiritual care		
22. Right to decline spiritual care.	1.1	2.1
23. Demonstrate sensitivity and respect for diversity	1.2	2.1,2.2,3.1
24. Respect for the client's diverse health care decisions	1.1, 1.2, 3.8	2.2,3.4
25. Safeguard clients' privacy by ethical code of conduct	1.1, 1.3	5.1
26. Respect the clients' right for informed consent	1.4	3.1, 4.1
27. Maintain confidentiality disclosing clients' information	2.7, 2.8	1.2
DOMAIN 5: Quality Assurance in spiritual care		
28. The vocational calling as a nurse/midwife.		
29. Implement professional caring behaviour	1.2	7.1
DOMAIN 6: Assessment, implementation and evaluation of spiritual care		
30. Identify signs of spiritual distress in clients and family	2.4	1.7
31. Plan spiritual care in the best interest of the client		
32. Respond to clients' spiritual needs promptly	4.3	
33. Facilitate family participation in the care to instil hope	3.8	

Table 5.34 Fitness of pre-registration competencies (cont.)

The 'fitness' of the pre-registration competency framework in spiritual care CROSS-REFERENCED with pre-registration nursing/midwifery (NMC, 2009; 2010). Abridged competency items	NMC (2010) Pre-registration Nursing	NMC (2009) Pre-registration midwifery
DOMAIN 6: Assessment, implementation and evaluation of spiritual care (cont.)		
34. Acknowledge chaplains/spiritual leaders as experts	1.6	
35. Importance of timely referral of clients/ their families	1.8	2.3
36. Provide feedback to clients, team and follow up		
DOMAIN 7: Informatics in spiritual care		
37. Information technology as a resource for spiritual care.		
38. Information technology for spiritual support		2.1
39. information technology for documenting spiritual care	2.7	

5.7.7 Qualitative data analysis of responses

Respondents were asked to give their views on the proposed competency framework in spiritual care and to identify factors that may enhance or hinder its implementation in education, research and/or clinical practice. The themes, categories which emerged from the thematic analysis of the three questions which were asked to both the international researchers and the modified Delphi educators are presented in the next section. These are supported by codes and exemplars to enhance the credibility of results (Graneheim and Lundman, 2004).

5.7.8 Views of researchers and educators on the proposed framework

A purposive sample of international researchers in the area of spirituality (n=44) and educators selected from the modified Delphi experts (n=63) participated in this phase of the study. Forty international researchers had a nursing background (n=40), while four researchers were midwives (n=4). The majority of the modified Delphi educators (n=58) had a nursing/midwifery or medical background, while five (clients and representatives of clients) had a general education background. Tables 5.35-5.40 summarise the participants' responses to the three questions guided by the 'thematic content analysis framework' (Braun & Clarke, 2006) which was discussed in Chapter 4, Section 4.7.3. Question 1 is analysed in Tables 5.35 and 5.36 consists of

five themes namely: *Complexities of spirituality and spiritual care, demand for education in spirituality and spiritual care, positive and negative views of the framework,* proposed *adjustments to framework of competencies in spiritual care and corresponding categories, codes and exemplars.*

Table 5.35 Q1: Qualitative analysis from researchers and modified Delphi experts

Generation of codes, categories and themes from consultation with researchers and modified Delphi educators to: **Question 1: *Views on the proposed framework of competencies in spiritual care***		
Codes	**Categories**	**Themes**
Complex concept, confused with religion/psychological care, may be offensive to clients, requires ongoing education, treading deeply in core of persons, not implemented constantly in care, overlooked, essence of nursing/midwifery, professionals not encouraged to engage in.	▪ Concept under explored and often confused with other areas of care. ▪ Spiritual care as core of nursing/midwifery care. ▪ Requires education at pre and post-registration levels of nursing/midwifery. ▪ Encompassed by various ethical issues. ▪ Rigorous and comprehensive. ▪ Guides education and clinical practice. ▪ Assessment and evaluation of these competencies may be difficult. ▪ Needs adaptation to fit curricula and to use in other clinical settings.	**1. Complexities of spirituality and spiritual care.** **2. Demand for education in spirituality and spiritual care.** **3. Positive views of the competency framework in spiritual care.** **4. Negative aspects of the framework.** **5. Adjustments to the framework to be more global user friendly**
Difficult to capture universality of concept, underexplored, dismissed, essence of nursing/midwifery.		
Wonderful area of study, framework relevant, useful, comprehensive rigorous, contains multiple elements of knowledge, skills and attitudes, guides clinical practice, may be difficult to assess, global user friendly, adapted to various clinical settings, adaptation of language, avoidance of religious terms.		
Comprehensive, highly relevant, useful, holistic client-centred, satisfies multi-culture society, developed from a rigorous study, guides education and clinical practice, renders positive learning experience, promotes personal growth, concise to fit curricula.		

Table 5.36 Q1: Themes, categories and exemplars generated from consultation

Generation of themes, categories and exemplars generated from consultation with researchers and modified Delphi educators to: **Question 1: *Views on the proposed framework of competencies in spiritual care***
Theme 1 Complexities of spirituality and spiritual care
Category: Concept under explored and often confused with other areas of care
Exemplars: *"For most practitioners spiritual care is a complex phenomena and concept" (Rn12).* *"There is often the debate between spiritual care vs. good care or psychosocial care" (Rn9).* *"[The] framework caters for an unexplored understudied concept of care" (CNE1).*
Category: Spiritual care as core of nursing/midwifery care
Exemplars: *"It's a wonderful concept the core of nurses' practice" (Rn30).* *"Nurses need to remember that spiritually is the essence of nursing and therefore so important to achieve competency in "(Rn7).* *"Unfortunately most of the time spiritual care* [is] *overlooked, only given if requested" (Rn4).* *"Spiritual care is a realistic concept and core to compassionate and competent nursing" (Rn16).* *"Concept is integral to the art of midwifery which is depicted in competencies" (CME2).* *"The framework captures the essence of nursing care on a day to day basis" (CNE4).*
Theme 2: Demand for education in spirituality and spiritual care
Category: Requires education at pre and post-registration levels of nursing/midwifery
Exemplars: "*Nurses should be taught awareness of spiritual care in undergraduate studies then consolidated at post-graduate level" (Rn24).* *"Framework provides an overview of what should be taught and delivered in spiritual care" (CNE10).*
Category: Encompassed by various ethical issues
Exemplars: *"There are times when spiritual care may be offensive to nurses and midwives and not encouraged to engage in" (Rm1).* *"There is the assumption that a nurse can safely tread deeply towards the core of a person with spiritual distress. This is likely to be dangerous for patient and /or the nurse potentially" (Rn24).*

Table 5.36 Q1: Themes, categories and exemplars generated from consultation (cont.)

Generation of themes, categories and exemplars generated from consultation with researchers and modified Delphi educators to: **Question 1: *Views on the proposed framework of competencies in spiritual care***
Theme 3: Positive views of the competency framework in spiritual care
Category: Rigorous and comprehensive
Exemplars: *" … Comprehensive and well thought out addresses spiritual care very thoroughly and comprehensively. It is complete, rigorous and relevant" (Rn28)* *" … Comprehensive, inclusive, client-centred and gives an overview of all necessary competencies" (Rm3).* *"Framework is comprehensive embracing multiple elements of spiritual knowledge, skills and attitudes" (Rn30).* *"A thorough vital framework developed from a rigorous study" (SL2).*
Category: Guides education and clinical practice
Exemplars: *"Framework addresses all area of spiritual care and is useful to nurses, midwives and all health care professionals" (CNE6).* *"'The framework is relevant as it address cultural diversity which is a new perspectives as Malta shifts more and more to a multi-cultural society" (CNE8).* *"It provides a holistic client-centred approach to care" (CME2).* *"Renders a positive learning experience for clients, staff and students with a sense of building up and growth in personally" (FME1).* *"This is a helpful framework to direct nursing students ... detailed, complete framework and challenges to connect to levels of professional responsibility" (Rn36).* *"This framework is useful to both the clinician, patient and family" (Rn16)*
Theme 4: Negative aspects of the framework
Category: Assessment and evaluation of these competencies may be difficult
Exemplars: *"The framework may be difficult to evaluate when issues in the framework are combined." (Rn24).* *"I am unsure whether assessment and evaluation of competencies is at a theoretical level of clinical level. Multiple issues addressed may make it difficult to assess at which level of practitioners they should apply" (Rn30).* *"In my opinion there are too many competencies to integrate in the shortened nursing programme. It would need to be concise to fit curriculum" (FNE6).*
Theme 5: Adjustments to the framework to be more global user friendly
Category: Needs adaptation to fit curricula and to use in other clinical settings
Exemplars: *"The framework should be adapted to various clinical settings. For example some language in the framework may not entirely appropriate for midwifery" (Rm4).* *"The language used within some of the competencies could be interpreted as religious for example use of the word ministry. This may be off putting to a global audience" (Rn36).*

5.7.9 Factors that may enhance implementation of the framework

Table 5.37 summarises the six themes emerging from Question 2 which may enhance implementation of the framework in education, research and/or clinical practice.

- *Knowledge, information and attitudes in spiritual care;*
- *Organisation and management of spiritual care in practice;*
- *Organisational and management of spiritual care in education;*
- *Bridging the theory practice gap;*
- *Research in spirituality and spiritual care;*
- *Professional legislation and policy issues.*

The themes, categories and exemplars generated from Q2 are analysed in Table 5.38.

Table 5.37 Q2: Generation of codes, categories and themes from consultation

Generation of codes, categories and themes from consultation with researchers and modified Delphi educators to Question 2: *Factors that may enhance implementation of the framework in education, research and/or clinical practice*		
Codes	**Categories**	**Themes**
Education, own spirituality changing attitudes. Use of public media, respect to diverse cultures.	▪ Changing attitudes towards spiritual care through education ▪ Implementation of client-centred care. ▪ Team leaders to foster an atmosphere for spiritual care. ▪ Commitment and preparedness of faculty to integrate spiritual care in nursing/midwifery ▪ Endorsement of competencies in spiritual care within curricula. ▪ Early exposure of students to spiritual care. ▪ Education of academics and clinical mentors. ▪ Educational and clinical commitment. ▪ Use of creative teaching ▪ Identified link mentors. ▪ Targeting research resources by demonstrating enhanced clients' outcomes. ▪ Dissemination of research ▪ Collaborative research strategies. ▪ Competence in spiritual care as a requisite for nursing/midwifery. registration.	**1. Knowledge, information and attitudes in spiritual care.** **2. Organisation and management of spiritual care in practice.** **3.Organisational and management of spiritual care in education.** **4. Bridging the theory practice gap.** **5. Research in spirituality and spiritual care.** **6. Professional legislation and policy issues.**
Client-centred care, adapting framework to suit various situations, provide support to staff, facilitation of personal spiritual growth.		
Replace task allocation, implement client-centred care, good team leaders, spiritual atmosphere on wards.		
Faculty preparedness and commitment, integrating spiritual care in curricula, early exposure in undergraduate nursing/midwifery programmes, preparedness of educators.		
Early exposure of undergraduate students, voluntary work, reflection, self-awareness, multi-disciplinary approach to teaching, endorsement of competencies in curricula, training of clinical mentors.		
Educational and clinical commitment, teaching approaches that integrate theory to practice.		
Targeting resources, demonstrate enhanced outcomes, snowballing interest through dissemination of research findings.		
Facilitate projects, participation of clients and multi-disciplinary team, qualitative research.		
Competencies as requisites for registration, involvement of key stakeholders in planning and implementation of the framework.		
Gain practical will from stakeholders, professional organisation, policy makers, top management, service providers and clients.		

Table 5.38 Q2: Themes, categories & exemplars generated from consultation

Themes, categories and exemplars generated from consultation of Q2 with researchers and modified Delphi educators to Question 2: *Factors that may enhance implementation of the framework in education, research and/or clinical practice*
Theme 1: Knowledge, information and attitudes in spiritual care
Category: Changing attitudes towards spiritual care through education and information
Exemplars: **"***The main issue to implementing the framework is a clearer understanding of the meaning and definition of spirituality and to distinguish spirituality from religion as issues may be confusing for novices" (Rn28).* *"Nurses need to keep an open mind not to impose their own religiosity /spirituality on individuals. The insistence that religious and spiritual 'zealots' do not impose on patients who do not welcome them or intrude into people's thoughts and beliefs unless invited" (Rn26).* *"More knowledge and information on spiritual care given via the public media e.g. television, radio, magazines, bill boards and posters will capture the public's interest in this aspect of care as well as generate respect for diverse cultures, religion and beliefs" (CNE18).*
Theme 2: Organisation and management of spiritual care in practice
Category: Implementation of client-centred care
Exemplars: *"… Demonstrate the importance of client-centred care through attending to the spiritual care needs of individuals -Identify spiritual needs and care from patients and family" (Rn20).* *"Awareness for the clients' need through client-centred care is essential to integrate competencies for spiritual care" (Rn16).* *"Involvement of chaplains, counsellors and spiritual leaders together with client-centred approach to care instead of task allocation can assist implementation of the framework as professionals can really focus on the client's holistic needs"(CNE8).*
Category: Good team leaders to foster an atmosphere for spiritual care
Exemplar: *"Recourses for nurses' personal reflection to cope and grow from difficult clinical situations need adequate supervision of practitioners to facilitate spiritual grow that the same time challenged not to become complacent to stretch themselves to new limits" (Rn6).* *"Providing support to students and clinical nurses and midwives is essential. Personal therapy of trainees to deal with their own losses and counter - transferential issues is also an issue" (Rn28).* *"I think that if members of the multi-disciplinary such as chaplains, counsellors, and psychologists are involved in the teaching of spiritual care at faculty and clinical practice, implementation of the framework would be more feasible" (SL3).*

Table 5.38 Q2: Themes, categories & exemplars generated from consultation (cont.)

Themes, categories and exemplars generated from consultation of Q2 with researchers and modified Delphi educators to Question 2: *Factors that may enhance implementation of the framework in education, research and/or clinical practice*
Theme 3: Organisational and management of spiritual care in education
Category: Commitment and preparedness of faculty to integrate spiritual care in nursing/midwifery
Exemplars: "*Faculty preparedness and commitment to teach spirituality/spiritual care and facilitation of personal spiritual growth as you cannot give what you don't have" (Rn26).* *"Faculty must assess self, prior to implementation of the framework in nursing/midwifery education" (Rn26).* *"Identify and address barriers to the teaching of spirituality/spiritual care in academics of nursing/midwifery" (Rm40).* *"Committed personnel within the institution to steer up interest in the need for implementation of the framework across universities" (Rn32).*
Category: Endorsement of competencies in spiritual care within curricula
Exemplars: *"Implementation of this framework in education would be better to make spirituality the backbone of every study unit taught in both nursing and midwifery rather than have a specific unit focusing on spirituality" (FME5).* *"Competencies in spiritual care should be Integrated within other material taught in the curriculum and establish spirituality into mainstream nursing/midwifery knowledge" (Rn29).* *"Competencies in spiritual care should be presented as essential skills, not optional extras and should be integrated in all curriculum not as a special course" (Rn27).* *"There should be outcomes based philosophy programs of education. Competencies presented as evidence-based, clearly defined, achievable and demonstrable at pre-registration and post-registration" (Rn28).* *"Birth is a time of heightened spirituality, a sacred time in which the veil between visible and invisible worlds becomes thinner. The framework needs to be incorporated as an essential component in the curriculum and training of every student midwife. Maybe the framework may need to be slightly adapted e.g. Appropriate language and examples to suit various settings e.g. in midwifery" (Rm3).*
Category: Early exposure of students to spiritual care
Exemplars: *"Early recognition and awareness of spirituality in undergraduate nurse education" (Rn28).* *"Early recognition of the term spirituality into nursing/midwifery language" (Rm4).* *"Basic input to students at an early stage of training of different belief systems" (Rn27).*

Table 5.38 Q2: Themes, categories & exemplars generated from consultation (cont.)

Themes, categories and exemplars generated from consultation of Q2 with researchers and modified Delphi educators to Question 2: *Factors that may enhance implementation of the framework in education, research and/or clinical practice*
Theme 3: Organisational and management of spiritual care in education
Category: Education of academics and clinical mentors
Exemplars: *"I would start with education but also acceptance of necessity by policy bodies. It would need education of clinical mentors in understanding spirituality and spiritual care before they can assess it effectively" (Rm2).* *" … Educators need to become better trained in teaching this dimension of practice, not confusing it with religious teachings or learnings" (Rn28).* *"Education of clinical mentors in understanding spiritual care before assessing it" (Rn37).* *"Better trained educators in teaching this dimension of practice" (Rn32)* *" ... one has to ensure that students are exposed to clinical practice with mentors that are updated in line with the evidence" (CNE12).*
Theme 4: Bridging the theory practice gap
Category: Educational and clinical commitment
Exemplars: *"...hence, commitment and support at both clinical and educational level to minimise theory practice divide is essential to implement competencies in spiritual care" (Rn28).* *"Ensure adequate time for instruction and implementation as some competencies are only achievable after much clinical experience and personal growth" (Rn19).* *Continuing professional development in spiritual care through staff participation in group discussions, in service courses projects, seminars and conferences will enhance the implementation of these competencies and minimise the theory-practice gap" (CNE15).* *'Teaching competencies in spiritual care at pre and post education level in theory and practice would enhance implementation of spiritual care" (Rn29).* *"I think that if members of the multi-disciplinary such as chaplains, counsellors, and psychologists are involved in the teaching of spiritual care implementation of the framework would be more feasible" (SL3).*
Category: Use of creative teaching methods
Exemplars: *"The pedagogy is critical. Information is presented in didactic courses and initially applied in case study assignments. However the real learning happens when applied to real life situations when students experience spiritual care in the clinical setting" (Rn16).* *"I am very glad to see the inclusion of experiential education/spiritual practice, ongoing peer supervision and reflective groups. These are key elements in assisting caregivers to address their own and others spiritual needs" (Rn25).* *"Use of case based- scenarios that can be simulated in simulator labs in order to enhance the understanding of pre-registration students" (Rn16).* *"Reflection on practice and journaling will enhance the benefits to the student" (Rn39).*

Table 5.38 Q2: Themes, categories & exemplars generated from consultation (cont.)

Themes, categories and exemplars generated from consultation of Q2 with researchers and modified Delphi educators to Question 2: *Factors that may enhance implementation of the framework in education, research and/or clinical practice*
Theme 4: Bridging the theory practice gap
Category: Identified knowledgeable link mentors
Exemplar: *"Identifying link nurses/midwives as mentors to co-ordinate the implementation of the framework of competencies in spiritual care is important to ensure good role models in exhibiting appropriate care to patients and appropriate teaching to students" (CME10).*
Theme 5: Research in spirituality and spiritual care
Category: Targeting research resources by demonstrating enhanced clients' outcomes
Exemplars: *"Targeting research funding is important and can be done by using creative research methodology to develop further knowledge in spirituality/spiritual care" (Rn10).* *"Funding can be achieved by conducting research studies that demonstrate the enhanced outcomes of a cognizant framework for mothers and babies and involvement in research projects at post-registration level to evaluate outcomes in view of the literature and research" (Rm25).* *"The interest in terms of local research in this field is a positive factor that may provide the necessary data for higher authorities to finance resources for research in this field" (CNE12).*
Category: Dissemination of research in spirituality and spiritual care
Exemplars: *"Present findings of this modified Delphi study at conferences to educate midwives and other medical professionals about the need for this spirituality intelligent framework"(Rn17)* *"Publicising the framework and findings in public media (TV), online, social media" (Rn24).* *"Publishing the findings of such research studies in peer reviewed journals, midwifery journals and in popular data bases" (Rn36).*
Theme 6: Professional legislation and policy issues
Category: Competence in spiritual care as a requisite for registration as nurse/midwife
Exemplars: *"It is important to think of effective marketing to gain practical goodwill from stakeholders (professional organisations, policy makers, top management, service givers and clients) to ensure recognition of the importance of competence in spiritual care" (CNE13).* *"Involving stakeholders in the planning and implementation process of framework of competencies may enhance implementation of spiritual care" (Rn27).* *"Professional committees that govern registration of midwives endorse and recognise spiritual competencies as a requirement for registration" (Rn38).* *"Policy directives recognised as key outcomes in NMC approved programmes and acceptance of necessity of the framework by policy bodies recognise its importance in the provision of holistic care" (Rn36).*

5.7.10 Factors that may hinder implementation of the framework

Question 3 is analysed in Tables 5.39 and 5.40 which summarise the factors that may hinder implementation of the framework.

Table 5.39 Q3: Factors that may hinder implementation of the framework

Generation of codes, categories and themes from consultation with researchers and modified Delphi educators to Question 3: *Factors that may hinder implementation of the framework in education, research and/or clinical practice.*		
Codes	**Categories**	**Themes**
Negative attitudes to concept, confusion, restricted, vague aims, too rigid definition.	▪ Poorly defined concepts of spirituality and spiritual care. ▪ Concepts not adequately recognised as core aspect of care. ▪ Unaware of own spirituality ▪ Imposing own spirituality. ▪ Lack of education at pre and post-registration levels ▪ Biomedical model of care. ▪ Nurses'/midwives' role in the provision spiritual care. ▪ Reluctance to provide spiritual care. ▪ Resistance to change. ▪ Lack of interest in research in the field. ▪ Lack of funding.	**1. Attitudes to spirituality and spiritual care.** **2. Personal spirituality.** **3. Lack of educational preparedness in spirituality and spiritual care.** **4. Barriers to spiritual care and clinical practice.** **5. Research in spirituality and spiritual care.**
Abstract, intangible, not recognised, prejudice, insensitive to diverse cultures, religions and beliefs, lack of maturity and motivation, general negative views.		
Unaware of own spirituality, view of self, supernatural, imposing own spirituality.		
Lack of awareness of own spirituality, lack of maturity		
Lack of education, funding, integration of spiritual care in curricula, theory not applied to practice, spiritual assessment, inappropriate role modelling and distress.		
Focus on tacit knowledge, busy curricula to fit spirituality, double standards, lack of CPD.		
Reluctance to provide spiritual care, ethical issues, medical model, resistance to change, lack of recognition, lack of time, motivation, nurses too busy.		
Biomedical model, fragmentation of care, task allocation, lack of resources, role models, time, increased documentation, spiritual assessment.		
Lack of funding, resources, dominance of RCTs, lack of recognition.		
Lack of interest, funding, resources.		

Table 5.40 Q3: Themes, categories and exemplars from consultation

Themes, Categories and exemplars generated from consultation with researchers and modified Delphi educators to Question 3: *Factors that may hinder implementation of the framework in education, research and/or clinical practice*
Theme 1: Attitudes to spirituality and spiritual care
Category: Poorly defined concepts of spirituality and spiritual care
Exemplars: *'Negative attitudes that prevails around the concept of spirituality and spiritual care' (Rn16).* *'Not making a distinction between spirituality and religion' (Rn2). 'Restricted view of spirituality' (Rn24).* *'Vague aims and too rigid definitions of concept' (Rn27).* *'I think that spirituality is poorly understood by most nurses and midwives. The problem I think is that it is poorly defined with huge variety of definitions leaving them confused at what actually is spirituality and what spiritual care consists of' (CME6).*
Category: Concepts not adequately recognised as core aspect of care
Exemplars: ***'****Unfortunately generally spirituality and spiritual care is not recognised by management, policy makers and educators as one of the core aspects of care' (PM4).* *'Resistance to viewing spirituality as an essential dimension of healing' (Rn31).* *'Birth professionals who indicate a disregard for or an awareness of the spiritual dimension of life' (R4).* *'Birth regarded as a process to get the baby out and midwives who disregard what is essentially a sacred process' (Rm3).* *'Spiritual care which is a way of being and is experiential is not universally understood and integrated' (Rn37).*
Theme 2: Personal spirituality
Category: Unaware of own spirituality
Exemplars: *'Students unaware of their nascent spirituality and unaware of the value of their own spirituality' (Rn25).* *'Students unable to nurture their own spirituality through silence and stillness in their own busy lives' (Rn18).* *'I feel that knowledge regarding spiritual care can be guided by a framework BUT deep personal spiritual awareness cannot be captured within the framework. The latter process may not be experienced by a person. This growth depends on a multitude of variables' (FNE7).* *'Insistence on embroidering our spiritual life with elaborate supernatural paraphernalia' (Rn3).*
Category: Imposing own spirituality
Exemplars: *'Imposing one's own religious beliefs upon the meaning and /or coping mechanism in each client/family's illness experience' (Rn31).* *' ... there is also lack of understanding and sensitivity at times when it comes to different religious beliefs which is existent as a result of our island's mentality and culture' (CNE6).*

Table 5.40 Q3: Themes, categories and exemplars from consultation (cont.)

Themes, Categories and exemplars generated from consultation with researchers and modified Delphi educators to Question 3: *Factors that may hinder implementation of the framework in education, research and/or clinical practice*
Theme 3: Lack of educational preparedness in spirituality and spiritual care
Category: Lack of education in spiritual care at pre- and post- registration level
Exemplars: *'Lack of education of current nurses and midwives' (Rn32).* *'Lack of commitment of funding and time to implementing the framework in undergraduate courses' (Rn28). 'Not encouraging spiritual practices among trainees' (Rn36)* *'Competencies not integrated into existing teaching' (Rn16).* *'Not integrating spiritual care in theory/didactic learning or clinical /applied courses' (Rn31).* *'Theory not applied to practical relevance by the use of case scenarios' (Rn38).* *'Inappropriate role modelling, behaviour and bullying' (Rn15).* *'Clinical instructors not understanding spiritual care and clinical instructors that foster spiritual distress in students' (Rn34).* *'Nurses in clinical practice not taught to conduct spiritual assessment' (Rn23).* *'Most nurses and midwives have had no education in this aspect of care. It was all gained through personal experience' (FNE8).* *'Nursing programmes are now 3 years. This is too short to include competencies in spiritual care. To make matters worse what students learn in faculty is not practised on the wards' (CNE10).* *'Assessment of competencies may be logistically difficult to carry out' (Rn26).*
Theme 4: Barriers to spiritual care in clinical practice
Category: Biomedical model of care
Exemplars: *'Medical view of our bodies as machines' (Rn4).* *'Lack of individualisation of the person' (Rn21).* *'On the wards the focus is the biomedical model of care. Care is fragmented focused on physical needs and task allocation' (CNE12).* *'Lack of resources, time, political will and medicalisation of care all hinder spiritual care' (Rn9).*
Category: Nurses'/midwives' role in the provision spiritual care
Exemplars: *'Some chaplains do not approve of nurses as providers of spiritual care. This may lead nurses to neglect the delivery of this aspect of care 'Old teaching' - Spiritual care not within the scope of nursing practice and so there is [a] reluctance to provide spiritual care due to ethical issues' (Rn30).* *'Lack of agreement within nursing teams and wards unfortunately, may leave nurses confused about their role in the provision of spiritual care. Sometimes, departmental leaders may be key persons to hinder the implementation the competency framework' (Rn5).*

Table 5.40 Q3: Themes, categories and exemplars from consultation (cont.)

Themes, Categories and exemplars generated from consultation with researchers and modified Delphi educators to Question 3: *Factors that may hinder implementation of the framework in education, research and/or clinical practice*
Theme 4: Barriers to spiritual care in clinical practice
Category: Reluctance to provide spiritual care
Exemplars: *'Time, time and time. Hospital ward environments are far too clinical and spirituality takes a back seat' (Rn6)* *'Lack of understanding and motivation of clinical and education professionals, Lack of time and interest from student/clinician' (Rn11).* *'Nurses are too busy with paper work rather than communicating with patients' (Rn38)* *'Spiritual care needs time with the patient but nurses are busy over worked and short of staff' (CNE18).* *'The introduction of formal spiritual assessment tools adds more documentation, is time consuming and defeats the purpose of spiritual care" (CME6).*
Category: Resistance to change
Exemplars: *'Negative attitudes into an established system to change' (Rn10).* *'Lack of consistent and adequate approach to managing innovation' (Rn17).*
Theme 5: Research in spirituality and spiritual care
Category: Lack of interest in research in the field
Exemplars: *'Funding bodies not recognising that spiritual competence is a requirement not a luxury' (Rn13).* *'The dominance of RCTs as a perceived gold standard in medical research' (Rn30)* *'There seems to be lack of interest in spiritual care as an area of study. Very few students take up this topic to be researched' (FME3).*
Category: Lack of funding
Exemplar: *'Lack of funding and resources for research programs will hinder the implementation of spiritual care as a vital aspect of clients' care' (Rn9).*

5.8 Summary of the findings

Phase 1 identified seven domains and 116 competency items were generated through the literature review. 231 competency items were generated from the five focus groups of which 117 items were similar to competencies elicited through the literature review. Hence, 54 'new' items were added to the list of competencies identified through the literature review which totalled 170 competencies. These were collapsed to 55 competency items which formed the modified Delphi questionnaire.

Phase 2 consisted of a two phase modified Delphi rounds (R1: n=241; R2: n= 205) which sought to reach consensus on 55 competency items. 54 competency items achieved the pre-determined 75% level of consensus by the end of Round 2. The majority of items (n=27) scored above 90% and 25 items scored higher than 80% level of agreement.

The Cronbach's Alpha indicated the homogeneity of the framework. The total competency domains and competency items obtained a Cronbach α of 0.97. The individual 7 domains and the respective competency items had Cronbach α coefficients of (0.79 to 0.93) indicating good to strong internal consistency. The Spearman's test indicated very high correlations (0.9 to 1) for 23 items and high correlations (0.7 - 0.89) for 31 competency items. Only one item had a moderate correlation coefficient (0.5 - 0.69) (Item 35: r*s* = 0.554).

Results for the exploratory factor analysis showed a good fit of five factor model. Items in the domain 'self-awareness and the use of self' and the items in the communication and interpersonal skills domain were not defined as these loaded on various other factors. Items relating to referral to chaplains and spiritual leaders loaded as a separate factor indicating the religious culture in Malta. Only two items (No. 8 and No. 24) cross loaded on another factor while five competency items scored <04 on the rotated factor loading.

In **Phase 3,** the consultation with the international researchers and modified Delphi educators brought about the categorising of the competencies in spiritual care which may essentially be acquired at pre-registration level nursing/midwifery education; post–registration level; and as not essential at either level. A 51% consensus threshold was pre-determined at this phase of the study. Most competencies (n=38) were scored to be essential at pre-registration level while some competencies (n=15) were classified as appropriate at post-registration level. One competency item was scored as appropriate at both levels. No competencies were rejected as being not appropriate at either level. Significant differences were found in 16 competency items between the international researchers and the modified Delphi educators.

A seven domain pre-registration competency framework and a four domain post-registration competency framework in spiritual care emerged from the consultation phase. The pre-registration framework was cross referenced with NMC Standards for pre-registration education in nursing (2010); in midwifery (2009) and The Essential Skills Cluster (2008) which projected a good fit in the majority of the items.

The consultation process identified themes and categories on the participants' views on the proposed framework and factors that may facilitate or hinder its integration in education, research and/or clinical practice. These findings were compared and contrasted with the existing research in Chapter 2 which contributed towards the external validity of the study.

CHAPTER 6: DISCUSSION

6.1 Introduction

There is increasing evidence of the positive influence of the spiritual aspect of life on physical and mental health as well as quality of life (Puchalski *et al.,* 2009; Balboni *et al.,* 2010; Koenig *et al.,* 2012). The importance of nurses/midwives addressing the spiritual dimension is reflected in healthcare guidelines at national and international levels, (e.g. World Health Organisation (WHO) 2014; Joint Commission on the Accreditation of Healthcare Organisation (JCAHO) 2008).

Spirituality is also central to nursing/midwifery codes of ethics, such as International Council of Nurses (ICN) (2012) International Confederation of Midwives (ICM) (2007) and educational guidelines on standards for pre-registration nursing, Nursing and Midwifery Council (NMC) (2014); Standards for pre-registration midwifery NMC (2009); and Quality Assurance Agency for Higher Education (QAA) (2001). Hence, healthcare providers have an ethical obligation to attend to all dimensions of the person (body, mind and spirit) and provide holistic care (Cohen & Rozin, 2001; Pesut & Sawatzky, 2006).

Despite existent guidelines and growing research, there are still inconsistencies in the nature of the spiritual care component within nursing/midwifery education programmes. This is because no competencies exist on spiritual care in nursing/midwifery at point of registration. Hence, the commitment of this study is to develop and establish a framework of competencies in spiritual care (FCSC) for nurses/midwives at point of registration. Seven domains and fifty five competency items in spiritual care were deduced from:

- A literature review on spirituality, spiritual care in nursing/midwifery and spiritual care nursing/midwifery education. This was supported by qualitative data which was generated through focus groups with the clients, policy makers and service providers (Phase 1).

- A validation process by 'experts' using a modified Delphi approach to achieve consensus (Phase 2).
- Classification of the items in competencies achievable at pre-registration and post-registration levels, through quantitative and qualitative data from international and local experts (Phase 3).

This approach generated:

- The development of competencies needed by nurses/midwives at pre- and post-registration levels;
- The validation of the framework of competencies in spiritual care by a modified Delphi method which identified six factors, following Exploratory factor analysis (EFA);
- The identification of enhancers and inhibitors in the implementation of the Framework of Competency in Spiritual Care (FCSC) in education, research and/or clinical practice.

The findings are compared and contrasted with the existing and wider research e.g. NMC guidelines (2010), within the context of a conceptual framework derived from the 'Theory of skill acquisition: From novice to expert' (Benner, 1984) and 'Taxonomy of educational objectives: Cognitive and affective domains' (Bloom, 1956).

The competency domains and items were then classified during the consultation process (Phase 3), which differentiated the achievement levels of these competency items that is, at pre-registration or post-registration levels. Hence, two competency frameworks were developed (Tables 5.32 & 5.33). No psychometric testing to the frameworks was carried out at this stage, but is being recommended. Some significant differences in responses were identified between the researchers and the educators in the consultation phase (Table 5.31). These differences may be due to sample comparability, the low response rate to the web survey, differences in demographic, cultural and professional characteristics of international researchers

and local modified Delphi educators. International researchers may have also had broader and deeper insights into issues concerning spiritual care and spiritual care education whilst the local educators may have been more oriented towards new current issues which are locally influencing the education of nurses/midwives such as; the influx of immigrants to Malta from diverse cultures, religions and with different healthcare needs as claimed by one of the participants.

> *The framework is relevant as it address [addresses] cultural diversity, which is a new perspectives as Malta shifts more and more to [into] a multi-cultural society (En8).*

An overall discussion of the study findings, discussion of specific items, factors enhancing/inhibiting implementation of framework and a critique of the research methodology is outlined in this chapter. The discussion is supported by direct quotations from the qualitative data derived from the focus groups with service providers and service users of spiritual care and the participants who were involved in the consultation phase (researchers and modified Delphi educators). This process was adopted so as to enhance trustworthiness of the findings. Direct quotations from participants are coded to maintain confidentiality (Table 6.1).

Table 6.1 Codes used for study participants

CODE	TERMS
P	Focus group participant
Rn	International researcher in nursing
En	Local modified Delphi educator in nursing
Rm	International researcher in midwifery
Em	Local modified Delphi educator in midwifery
Esl	Local modified Delphi educator spiritual leader
Ec	Local modified Delphi educator client/patient
Epr	Local modified Delphi educator patients' representative

6.2 Overall discussion of the study findings

The 55 generic competency items generated in Phase 1 of the study (literature review and focus groups) were grouped in seven domains. The quantitative findings in Phase 2 (the modified Delphi study) revealed that the competencies were consistent with research and all competency items except one (Item 54) reached the pre-determined consensus of 75% by Round 2, with a mean score ranging between 5.240 - 6.605 on a 7 point Likert form scale (Table 5.18).

The good 'fit' of the six factor model, which was identified through the Exploratory Factor Analysis (EFA), (Section 5.6.17), paralleled five of the domains which were identified in Phase 1 and include the following:

- Assessment, implementation and evaluation of spiritual care;
- Quality assurance in spiritual care;
- Ethical and legal issues;
- Body of knowledge in spiritual care;
- Informatics and spiritual care.

The two domains, namely 'self-awareness and use of self' and 'interpersonal and communication skills', were found to merge with these five domains.

6.2.1 The two merged domains

The merging of these domains into the other five domains implies that self-awareness and use of self and interpersonal communications skills support the spiritual care literature and permeate in the delivery of spiritual care (for example van Leeuwen & Crusveller 2004, van Leeuwen *et al*., 2006; van Leeuwen *et al*., 2009). Thus, the importance of self-awareness and use of self, as well as interpersonal and communication skills, pertain to all aspects of spiritual care irrespective of the religious and cultural backgrounds of individuals.

The competencies in the domains (self-awareness and use of self and interpersonal communications skills) are recognised as core nursing/midwifery requirements and transfer across the fields of care. Consequently, all items in these two domains cross referenced with the NMC Standards for pre-registration education in nursing (2010) and in midwifery (2009) supported by The Essential Skills Clusters for (2008) (Table 5.34).

Emphasis is placed on the attitudinal and communication aspects of spiritual care, regarded as the core of nursing (Ross, 1994; van Leeuwen & Crusveller, 2004, Baldacchino, 2006; Puchalski *et al.,* 2009; Pesut & Reimer-Kirkham, 2010) and midwifery (Huber & Sandal, 2006; England & Morgan, 2012). Similarly, the concept of self-awareness and use of self is considered as a means of therapy to clients and a core area of nursing/midwifery care (Narayanasamy & Narayanasamy, 2012; Mitchell & Hall 2007). This is supported by research whereby healthcare givers' personal spirituality and active presence may contribute towards effective care (Baldacchino, 2010; Hodnett *et al.,* 2012; Clarke, 2013; Attard, Baldacchino & Camilleri, 2014). Consequently, these concepts are integrated throughout nursing/midwifery curricula to address holistic care (Meyer, 2003; Mooney & Timmins, 2007; Hall & Mitchell, 2008; Attard & Baldacchino, 2014).

6.2.2 Module/study unit vs. threaded through curricula

The findings derived from the international researchers and Delphi educators (Phase 3) demonstrate the importance of the concepts 'self-awareness and use of self' and 'communication and interpersonal skills' in spiritual care. However, as most nursing/midwifery pre-registration course programmes are of a three year duration, the feasibility of the number of competencies presented in the competency framework is questioned, despite participants' positive comments on the newly developed framework (FCSC).

> *The framework is comprehensive and well thought out, [it] addresses spiritual care very thoroughly and comprehensively. It is complete, rigorous and relevant. However, in my opinion a three year nursing programme may be too short to integrate these competencies. It would need to be concise to fit [the] curriculum (Rn28).*

Therefore, when teaching specific aspects of spiritual dimension of care, for example communication/interpersonal skills and self-awareness may complement the concepts taught in the core study units across the course programme and eventually the framework (FCSC) will become more feasible in nursing/midwifery curricula.

> *Implementation of this framework in education would be better to make spirituality the backbone of every study unit taught in both nursing and midwifery, rather than have a specific unit focusing on spirituality (Em5).*
>
> *Competencies in spiritual care should be integrated within other material taught in the curriculum and establish spirituality into mainstream nursing/midwifery knowledge (Rn29).*
>
> *Competencies in spiritual care should be presented as essential skills, not optional extras and should be integrated in all curriculum, not as a special course (Rn27).*

An essential condition for adequate spiritual care reported by the study participants seems to lie in the nurses' self-awareness and therapeutic use of self. Developing the right attitude in spiritual care needs to be aimed explicitly at handling the nurse's/midwife's own spirituality in relation to the client's spirituality. Personal spirituality may not relate directly to one's skills of communication with the client but it also depends on a client's beliefs (van Leeuwen & Cusveller 2004).

The effectiveness of nurse education on spiritual care was demonstrated by a heightened spiritual awareness and communication throughout the entire curriculum (Pesut, 2002; Meyer, 2003; van Leeuwen *et al.,* 2008). Also, students reported increased learning about spirituality during their progression through the three year nursing education programme, rather than by one module dealing specifically in spiritual care (Lemmer, 2002; Baldacchino, 2008, 2011; van Leeuwen *et al.,* 2008). Education of spiritual care was found to be supported by the 'reflective education' model. Reflection enables nurses/midwives to consider and critically review one's own conduct, emotional responses and thoughts with the purpose of learning from these experiences and integrating them consciously in practice (van Leeuwen & Cusveller, 2004).

The revisiting of concepts by students throughout the programme may also reinforce their learning through theory and practice (Attard, Baldacchino & Camilleri, 2014) while evolving through the stages from novice to competent (Benner, 1984) (Table 3.1) and from the simplest cognitive (knowledge, comprehension and application) and affective behaviour (receiving, responding and valuing) to the most complex cognitive and affective aspects of spiritual care (Bloom, 1956) (Table 3.2 and 3.3). This enables students to learn according to their stage of spiritual development across time, as nursing/midwifery students gain new knowledge and clinical experience in their professional life (EU Tuning, 2014). However, one single study unit on spiritual care was identified as a predictor for increased competency in spiritual care in nurses/midwives in a study which was conducted in Malta (Attard, Baldacchino & Camilleri, 2014).

Such findings may be due to differences in research methodology. For example, a quantitative research method was adopted in Malta with 212 nurses/midwives as participants. This resulted in a high response rate (82%; n=174). Also, the Maltese culture, which is oriented towards Christianity and 95% of the population is Roman Catholic (Gouder, 2013) might have influenced the result of the teaching and therefore brought about different results to other identified studies, (van Leeuwen *et al.,* 2008; Baldacchino, 2008; O'Shea *et al.*, 2011). Hence, the findings showing acquisition of competency in spiritual care as a result of teaching throughout the curriculum requires further research and which is beyond the parameters of this study. Whilst considering this debate, competencies pertaining to 'self-awareness and use of self' as well as 'interpersonal and communication skills' have been retained in the newly identified competency frameworks in spiritual care (Tables 5.32 and 5.33). Their inclusion in the frameworks may accentuate their importance further when dealing with the spiritual dimension of clients' care. Self-awareness of personal spirituality is needed because the spirituality of the nurse/midwife may influence their comprehension and provision of spiritual care (Cooper, *et al.,* 2013). Spiritual awareness encourages nursing/midwifery students to reflect on their perspectives of spirituality and/or religion and consider how these perspectives may influence communication and interactions with their clients.

6.2.3 Usefulness of the developed frameworks

The responses of nurses/midwives involved in the focus groups of this study, have revealed that they received inadequate and inconsistent education to prepare them to provide spiritual care. This is consistent with existing research (Ross, 1994; Attard, Baldacchino & Camilleri, 2014), hence the emergence of the two competency frameworks consisting of competencies appropriate at pre-registration (Table 5.32) and post-registration levels (Table 5.33). These frameworks may guide the learning of students and qualified staff and facilitate delivery of spiritual care.

The emergence of two competency frameworks may also contribute towards feasibility in executing the pre-registration programme in spiritual care by providing a shorter more focused programme. This will be followed up by continuing professional education in spiritual care, acquiring proficiency and expertise (Benner, 1984) (Table 3.1), through more analysis, synthesis and evaluation of cognitive and affective behaviour of spiritual care (Bloom, 1956) (Tables 3.2 and 3.3), as well as through clinical practice and experience.

6.3 Specific competency domains and items

This section discusses the individual factors as they emerged through Exploratory Factor Analysis (EFA), while comparing them with existing research which is supported by the conceptual frameworks of 'From novice to expert' (Benner, 1984) and 'Taxonomy of educational objectives: Cognitive and affective domains' (Bloom, 1956) as well as the NMC standards in nursing education (2010) and midwifery education (2009).

6.3.1 FACTOR 1: Assessment, implementation, evaluation of spiritual care

There is general agreement in the literature that identifying and responding to spiritual needs of clients and their family is the focus of spiritual care and is the responsibility of every healthcare worker in particular nurses/midwives. Consequently, competency items pertaining to identifying and addressing spiritual distress, planning for spiritual care using a multi-disciplinary team approach, conveying quality time, family participation, timely referral to spiritual leaders and

ensuring follow up care were identified by researchers and Delphi educators as appropriate at the pre-registration nursing/midwifery level.

Research tends to assign ongoing spiritual assessment, planning, implementing and evaluating spiritual care in clinical practice to nurses/midwives (McSherry & Ross 2010; Hall, 2010; Lyndon-Lam 2012; Draper, 2012). In this study, formal and informal methods of spiritual assessment, ethical, legal, cultural spiritual/religious issues influencing spiritual care, models of spiritual care, respecting clients who do not conform to advice on their health, finding meaning in suffering, and evaluation of the effectiveness of spiritual care given appeared to demand higher levels of knowledge and application (Bloom, 1956; Benner, 1984) and consequently were identified as being appropriate at post-registration level. This may imply that pre-registration nursing/midwifery students are not taught to conduct assessment, monitoring and evaluation of spiritual care at this level of training with respondents claiming that:

> *Nurses in clinical practice are not taught to conduct spiritual assessment (Rn23).*
>
> *Most nurses and midwives have had no education in assessment of spiritual care. It was all gained through personal experience (En8).*

These findings are consistent with research which indicates that while nurses believed that spiritual care enhanced the quality of nursing care, they reported that they did not receive sufficient education and training on spirituality and spiritual care issues, feeling inadequately prepared to deal with clients' spiritual needs (RCN, 2010; McSherry & Jamieson, 2011). Thus, efforts might need to be focused on approaches to maximise engagement with this competency framework and translation into professional practice.

Active presence of nurses/midwives to relieve suffering of clients and their family also loaded on this factor and is identified as an important key aspect of spiritual care interventions (Clarke, 2013; Kimble & Bamford-Wade, 2013). This may be since

presence may foster openness and acceptance of the illness through communication whilst instilling hope (Clarke, 2013). Active presence was emphasised in the focus groups, one participant recalling:

> *When you are on the ward the place you look for is the prayer area. I mean we weren't alone. Other parents were there. We found a nun who was Irish, as soon [as] she knew we were Christians we felt more comfortable because we were in the minority. She used to come and talk to us. When my son was discharged from hospital and even when we were back in Malta she used to call to ask about us. It was a relief to hear her voice and encouraging words* (Focus Group 5: P38).

The way nurses/midwives intervene after spiritual assessment may be influenced by the nurses'/midwives' self-awareness of their values and beliefs (McSherry & Ross 2012; Tiew, Creedy & Chan, 2013). Self-awareness' has been singled out by Meyer (2003) as the greatest predictor of students' ability to perform spiritual assessment through active listening (Conner & Eller, 2004; Meyer, 2003) and to provide spiritual care.

Personal spirituality appears to be associated with sensitivity of clients' spiritual needs. Thus, if nurses/midwives do not prioritise their own spirituality in their personal life they are unlikely to be sensitive to the spiritual needs of clients (van Leeuwen *et al.,* 2009). Personal spirituality and use of self as a resource for spiritual care and the impact of the nurse/midwife's own spirituality on clients and colleagues also loaded on Factor 1. However, it might be pertinent to explore emotional intelligence and the impact this has on personal spirituality on clients. The qualitative data which was derived from the focus groups and consultation phase emphasise the need for more education on self-awareness and use of self and interpersonal and communication skills to help nurses/midwives bridge the theory-practice gap:

> *I think we need to have the students to be coached in a way that's not just a thing too academic, academic ok that's important but with a human element to it like being able to communicate well* (Focus Group 1: P5).

The medical model of care, with less attention on compassionate care was indicated by respondents, as having a negative influence on the 'art' of nursing/midwifery which seeks to address all dimensions of the person, holistically.

> *On the wards the focus is the biomedical model of care. Care is fragmented [and] focused on physical needs and task allocation* (En12).

These findings are supported by research whereby nursing/midwifery programmes may offer importance to the clients' disease and condition, while other factors such as 'self-awareness' and 'use of self', may influence the clients' behaviour and may eventually lessen the outcome on clients' health (Tiew & Creedy, 2012; Aiken, Rafferty & Sermeus, 2014a; Aiken *et al.,* 2014b). Conversely, clients' positive self-concept, good quality time to respond to clients' spiritual needs and identifying spiritual distress are consistent with research, whereby spiritual care aims to help clients to find meaning in their suffering through compassionate care (Benner, 1998; Greenstreet, 2006; Puchalski *et al.,* 2009). Hence, this is confirmed by Item 44 which achieved the highest factor loading score (0.78).

> *Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/religious needs maintaining patience, tact, perseverance and discipline* (Item 44).

Awareness about delivery of spiritual care is inconsistent in research. Some studies suggest the nurses'/midwives' competence in spiritual assessment and implementation of spiritual interventions are under-developed because of poor education in this area (McSherry & Ross, 2010; van Leeuwen *et al.,* 2006; RCN, 2010). Others claim that nurses/midwives tend to assess spiritual needs and deliver spiritual care without realising that they are actually providing spiritual care (Biro, 2012; Clarke, 2013).

In the focus groups where the participants' background was nursing/midwifery, they explicitly acknowledged the need and responsibility of the nurse/midwife to assess and implement spiritual care interventions and recommended relevant

training to enhance the quality of spiritual care. They were able to articulate the different perspectives of spiritual care assessment and implementation of spiritual care interventions but appeared less able to specify the use of assessment methods and tools. This implies lack of knowledge in the use of formal assessment tools in this group of participants which is consistent with the existing research on the subject (Taylor, 2006; Hall, 2010; Lyndon-Lam, 2012; Draper 2012).

Collecting spiritual assessment information is a fundamental role of nurses/midwives in this area as it promotes standardisation in approaches to care. The use of the assessment, planning, implementation and evaluation approach (Ross, 1997; Baldacchino, 2011) appears beneficial as it facilitates the use of formal assessment tools, such as FICA (Faith, Importance, Community, Address) (Puchalski & Romer, 2000; Puchalski, 2006) and HOPE (Sources of Hope, Organised religion, Personal spirituality, Effect of medical care) (Anandarajah & Hight, 2001). However, participants found them overly complicated and time-consuming which supports the existing research on the topic (McSherry & Ross, 2010).

Consequently, participants stated that spiritual care assessment and implementation of interventions were 'picked up' through their exposure to the clinical experience, rather than through the use of formal assessment tools. Thus, it appears that formal assessment tools were considered inappropriate to assess the complexity of spiritual needs (McSherry & Ross, 2002). Accordingly, participants were sceptic about their use claiming that:

> *The introduction of formal spiritual assessment tools adds more documentation, is time consuming and defeats the purpose of spiritual care* (Em 6).

This is comparable with research whereby problems were encountered by nurses to assess spiritual needs by formal methods, such as lack of time and inadequate training (McSherry & Ross, 2002; Taylor, 2006; Draper, 2012). Informal spiritual assessment methods involving listening to the patients' narratives about their lives and problems, questioning and observing for cues indicative of a spiritual need

appeared to be more practical to nurses/midwives. However, these studies were conducted on qualified staff who had years' of clinical experience which may have contributed towards their proficiency and expertise in care (Benner, 1984).

In contrast, pre-registration students and newly qualified nurses are still limited in knowledge and clinical experience and so, formal assessment may guide them to assess clients' spiritual needs. Thus, further educational programmes may increase students' awareness of the importance of spirituality in care and increase their competence in spiritual assessment and delivery of spiritual care (Baldacchino, 2006; van Leeuwen *et al.*, 2008; McSherry & Ross, 2010; McSherry & Jamieson, 2011).

The importance of spiritual care to clients and their family when confronting illness or a crisis situation is well documented (Puchalski *et al.*, 2009). However, participants reported that through their experience as clients, nurses/midwives tend to address spiritual needs with great limitations;

> *... till the news is broken you will have support but then because of the workload, midwives are busy and support stops. From a personal experience, I remember that once back at home we were told to contact the bereavement midwife and found out that no support groups were going on. So now what do we do?* (Focus Group 1: P5).

Consistent care in the community is one of the factors which may enhance continuity of spiritual care. Other factors include a functioning multi-disciplinary team approach (Stirling, 2007; Baldacchino, 2009; Lombardo & Eyre, 2011) as well as good ward climate which may alleviate and lessen stress, which ultimately may improve clients' outcomes (Zborowsky & Kreitzer, 2008) with increased quality of spiritual care (Lombardo & Eyre, 2011). Thus, the reported findings by nurses/midwives in this study, indicate the need to bridge the theory-practice gap by post-registration continuing education on spiritual care. This may increase their knowledge in spiritual care and translate it into clinical practice by transforming

their attitudes to meet clients' needs holistically and minimise barriers to the delivery of spiritual care (Balboni *et al.,* 2014).

Research is consistent on the importance of education in spiritual care at pre-registration and post-registration (Cooper *et al.,* 2013). Positive impact has been reported following education programmes by nurses/midwives namely: more spiritual awareness, enhanced relationship with clients and more competence in providing spiritual care (Baldacchino, 2006; Attard, Baldacchino & Camilleri*,* 2014). While considering the various possible influencing variables, further longitudinal research is suggested to explore the process of teaching and learning of spiritual care across time i.e. from novice, advanced beginner to competent, proficient and expert levels in spiritual care (Benner, 1984). The qualitative data from the focus groups and consultation with researchers revealed various methods of teaching spiritual care creatively, based on the experiential and reflective education philosophies, such as journaling, using case-based scenarios and online discussion.

> *Ensure adequate time for instruction and implementation as some competencies are only achievable after much clinical experience and personal growth. Continuing professional development in spiritual care through staff participation in group discussions, in service courses projects, seminars and conferences will enhance the implementation of these competencies and minimise the theory-practice gap* (Rn19).
>
> *The pedagogy is critical. Real learning happens when applied to real life situations when students experience spiritual care in the clinical setting. (Rn16).*
>
> *Creative teaching methods to teach spiritual care e.g. journaling during clinical rotations (Rn33).*
>
> *Using online discussion boards to allow on-going mentoring of students beyond class hours. Use of case-based scenarios that can be simulated in simulator labs in order to enhance the understanding of pre-registration students (Rn16).*
>
> *Reflection on practice and journaling will enhance the benefits to the student (Rn39).*

Thus, experimental research is suggested to identify the impact of creative teaching methods on learning spiritual care to enhance understanding of the complexity of spiritual care. Research demonstrates that teaching spiritual care is mainly originating from the initiative of educators who have researched the concept of spirituality in care and nursing/midwifery education. Thus, networking, publications and materials need to be disseminated through online networks and international conferences to enhance expertise in spiritual care education.

6.3.2 FACTOR 2: Quality assurance in spiritual care

Competency items in this domain pertaining to the vocational aspect of nursing/midwifery, professional caring attributes of staff, the provision of emotional support of professionals and students in order maintain positive attitudes towards the clients and their care. Supportive clinical practice environment, staff development, research and other learning resources were thought to improve the provision of spiritual care. These competency items appeared to demand higher levels of knowledge and experience (Bloom, 1956; Benner, 1984) and therefore considered by the consultation participants in phase 3 of the study as being appropriately achieved at post-registration level.

Following EFA, three Items which loaded of this factor focused on the use of spiritual care models (Sulmasy, 2002; Puchalski *et al.*, 2009), disclosing clients' information to members of the multi-disciplinary team (McSherry & Ross, 2002) and knowledge of worlds' major faiths, religions cultural beliefs and practices (McSherry, 2004; Narayanasamy 2006) (Table 5.24). These competencies are identified in the literature as key areas for improving quality spiritual care (Cockell & McSherry, 2012; Narayanasamy *et al.*, 2012; Clarke, 2013).

In this factor, the highest loading score (0.82) was related to participants' perception that provision of emotional support to students and qualified staff is important in their daily enduring situations of distress caused by clients' sufferings. While sustaining courage and hope to move on and provide quality care to clients

and their families further emphasises the importance of holistic health of students and qualified staff involved in spiritual care enduring clients' spiritual distress.

> *It happened to me before when I was still working. I was taking care of a baby who was doing badly, and its 7pm and I'm supposed to leave and at 9pm I'm still there. I think to myself what am I going to do? Leave? Just when the family has started to bond with me and I'm giving support? Because you feel it. I find a problem sometimes because I get too involved. I think it's good to have some kind of emotional support for nurses because one can vent a little even about the family and such* (Focus Group 4: P33).

Whilst considering the context in which nursing/midwifery students and qualified staff practice, the item about the legal, political and economic implications of incorporating spiritual care in all healthcare systems reinforced the quality of spiritual care as it achieved the second highest factor loading score (0.64). This is further supported by research, whereby quality of spiritual care includes the implementation of professional caring behaviour, such as altruism, patience, courage, understanding, reassurance and trust towards the clients, their families and colleagues (Cockell & McSherry, 2012; Biro, 2012; Clarke 2013).

The concept of *a spiritual healing clinical environment* as a variable in this factor was developed by Florence Nightingale, founder of modern nursing and rooted in research which incorporates the prevention of physiological effects of stress on the individual and the ability to heal (Zborowsky & Kreitzer, 2008). Psychologically supportive environments such as a place of worship and prayer may enable clients and family to cope with distress and illness (Walsh, 2012). This is because a physical setting may have the potential to be therapeutic, as experienced by this participant,

> *Prayer is important. I remember when we were in hospital in UK with my son, they don't really have a church, more a type of prayer room. When you are on the ward the place you look for is the prayer area. It used to give us so much comfort* (Focus Group 5: P38).

> *A patient may find comfort in music or painting. We should encourage this and not complain and maybe the patient is told off because she is making a mess* (Focus Group 1: P7).

These findings suggest that positive distractions, such as interactive arts, music, internet connection to access special video programmes with soothing images of nature accompanied by music, developed specifically for the healthcare setting, may generate feelings of peace, hope, reflection and spiritual connection. This is supported by the new but growing body of nursing research in the area of interactive art interventions to enhance emotional expression, spirituality and psychological well-being (Puig *et al.*, 2006; Hall 2012).

The effectiveness of the practice environment on qualified staff also emerged as a relevant aspect in this factor. Thus, a supportive manager, positive working environments, support groups and clinical supervision are recommended as it allows the nurse/midwife to talk through her emotions and use reflection to work through demanding situations to minimise stress and burnout of students and staff involved in spiritual care (Taylor, 2001; Lombardo & Eyre, 2011).

Reflection in education and practice of nursing/midwifery was emphasised in these findings, as it allows practitioners to see a broader picture of the situation, identify strategies for action and help professionals to articulate and deal with some of the emotional and spiritual conflicts implicit in professional practice (Lipp & Fothergill, 2009). To maintain quality of spiritual care, continuing professional development to guide nurses/midwives in mapping their skills to their role and responsibilities was emphasised by participants. Thus, nurses/midwives are recommended to attend Continuing Professional Development (CPD) programmes, conferences and follow-up support groups, self-awareness training to cope with stress and to nurture the well-being of practitioners (Rogers *et al.*, 2008). This should enable nurses/midwives to have positive attitudes to clients and their care. Healthcare professionals need to reflect on their practice to prevent emotional over-involvement with clients by maintaining professional boundaries. Maintaining boundaries was particularly emphasised by spiritual leaders in this study who narrated episodes of emotional situations witnessed in clinical practice, necessitating professional boundaries between the nurse/midwife and the client.

> *I think that nurses should be cautious not to cross that barrier and get emotionally involved with patients ... I think that young nurses have to understand that they can't go over that barrier and get involved in that emotional situation as such* (Focus Group 2: P17).

Researcher participants in this study viewed spiritual care as a variable that may impinge on the various ethical and legal implications in the delivery of spiritual care as claiming that:

> *... there are times when spiritual care may be offensive to nurses and midwives and not encouraged to engage in (Rm1).*
>
> *... there is the assumption that a nurse can safely tread deeply towards the core of a person with spiritual distress. This is likely to be dangerous for the patient and the nurse potentially (Rn24).*

This may imply that professional staff, especially new recruits to the profession may easily find themselves involved with clients' emotional burdens which may over-stress them. The impact of nurses'/midwives' stress caused by emotional labour brought about by difficult clinical situations when caring for clients through their illnesses and sufferings. This should not be under-estimated or overlooked so as not to undermine the well-being of the caregivers. There is evidence that emotional intelligence abilities which requires that emotions are recognised and surfaced correlate with a wide variety of important workplace outcomes, such as increased job satisfaction and retention, positive conflict styles, team performance, psychological and physiological health (Codier, Muneno & Freitas, 2011). Consequently, personal reflection and supervision were also highlighted by the researchers' in the consultation phase of this study as key resources for professionals to prevent 'compassion fatigue', stress and burnout. These recommendations are similar to those given in existing literature on the subject (Lombardo & Eyre, 2011) and as claimed by the study participants.

> *Resources for nurses' personal reflection to cope and grow from difficult clinical situations need adequate supervision of practitioners to facilitate spiritual growth and at the same time are challenged not to become complacent to stretch themselves to new limits* (Rn6).

... personal therapy of trainees to deal with their own losses and counter-transferential issues is also an issue (Rn28).

For the midwife as well I think she needs support. We do all need support amongst us between colleagues and I think in such cases it is important to be able to meet up as professionals to discuss sensitive issues such as this and be able to move on. This would help not just psychologically the midwife who has gone through such an experience but to help identify potentially better practices to help parents in such cases experience these situations in a better way (P28).

Hence, this growing body of nursing research should be explored further to define and recognise signs of spiritual fatigue in nurses/midwives and to implement resources that promote their personal and professional development. Quality assurance in spiritual care may also be maintained by auditing using quality of care frameworks which incorporate standard statements and policies.

6.3.3 FACTOR 3: Ethical and legal issues

This factor (Table 5.25) is composed of competency items pertaining to the ethical principles grounded in beneficence, non-maleficence, autonomy and justice (Beauchamp & Childress, 2009). Legal issues relating to spiritual care competence, in line with the clients' values, spiritual/religious beliefs and practices while maintaining professional boundary issues also loaded on this factor. All competencies in this factor were identified by participants in the consultation phase as being appropriately achieved at pre-registration level and all items cross-referenced with the statutory requirements in pre-registration nursing/midwifery education (NMC, 2009; 2010), indicating the importance of integrating ethical and legal issues in spiritual care and within general nursing/midwifery education and practice. Significant differences were identified in the responses of researchers and local modified Delphi educators which may indicate their different professional and cultural characteristics. These competency items pertained to: 'safeguarding of clients' dignity and integrity,' 'informed consent,' 'documentation and confidentiality to safeguard clients' welfare.'

Ethical issues impinging on spiritual care are grounded in the four principles of bioethics: beneficence, non-autonomy and justice, (Beauchamp & Childress, 2009), in the holistic perspective of individual persons (Polzer-Casarez & Engebretson, 2012). Thus, omission of spiritual care by healthcare providers is both unethical and in violation of these principles (Pesut, 2006). However, the item pertaining to the uniqueness of each person and their right to decline spiritual care scored the highest factor loading score (Table 5.25). This may imply that participants in this study might have perceived spiritual care to be given on request and consequently, respecting clients' right to decline spiritual care. This is consistent with the literature which asserts that healthcare givers should not assume that all clients have spiritual concerns and/or are comfortable entrusting their innermost thoughts and feelings in newly formed relationships with nurses/midwives (McSherry & Ross, 2002).

While considering the expertise of the study participants on the spiritual dimension of care, the right of the client to accept, refuse or withdraw from any form of care including spiritual care needs to be given attention (Puchalski *et al.*, 2009; Polzer-Casarez & Engebretson, 2012; Sulmasy, 2012). This is demonstrated by the item safeguarding the clients' right to refuse spiritual care which denotes the importance of sound knowledge of ethical issues in spiritual care. Literature debates the process of informed acceptance of spiritual care as it involves various ethical dilemmas, such as imposing own beliefs and practices on clients, confidentiality and documentation spiritual needs and teaching of spirituality and spiritual care to nurses/midwives (McSherry *et al.*, 2008; McSherry & Ross, 2010).

Further trans-cultural research is recommended to explore how ethical and legal issues may be safeguarded in the delivery of spiritual care in different cultures and diverse religious beliefs to help interpret what is happening on a spiritual level during a health crisis for clients and their family. Additionally, exploration of the impact of spiritual and religious beliefs and values of health carers in the provision of spiritual care is also recommended.

Other items scoring high in this factor are the ethical obligation of respect for diverse religious and spiritual beliefs, values, practices and lifestyles of clients. Items concerning the right for information, informed consent to empower and facilitate decision-making regarding the client's illness and autonomy which involves nurses/midwives not to proselytise their own religious beliefs, and support clients' healthcare decisions which may be based on religious/spiritual convictions, are other ethical principles outlined in the factor and cited in the literature (Pesut, 2009; Taylor, Park & Pfeiffer, 2014).

The concept of clients' dignity also emerged as an ethical item which loaded on the factor. The importance of maintaining dignity and integrity is supported in the literature (McSherry & Jamieson, 2011).The need for dignity stems from the client's state of vulnerability who then becomes dependent on nurses/midwives' care. However, maintaining dignity of vulnerable persons by health carers is a moral duty which motivates them to respond adequately and appropriately to the needs of the client (McSherry *et al.,* 2008).

> *One thing I find very important in this type of situation is that you maintain personhood. The person changes and almost becomes someone else but the inner self is still there. The person you knew is still there. So her personhood and her dignity is very important. Nurses need to remember this. This is where the vocation of the nurse comes into play* (Focus Group 4: P37).

Three competency items pertaining to the key elements of spiritual care such as respect, active listening, empathy, being sensitive to barriers in communication, such as beliefs and culture, clients' anxieties and fears loaded on this factor and cited in the literature (van Leeuwen *et al.*, 2008; Puchalski *et al.*, 2009; McSherry &. Jamieson, 2011; Clarke, 2013). Consequently ethical implications may stem from the omission of communication, as clients may not voice their spiritual needs and concerns. Central to the communication in spiritual care is applying the principles of a therapeutic trustful nurse/midwife-client relationship, providing hope while maintaining boundaries as stipulated in the ethical and legal codes of professional conduct (McSherry & Jamieson, 2013).

Consequently, the items exhibiting the concepts of a therapeutic trustful nurse/midwife-client relationship, providing hope, empathy and active listening, while maintaining boundaries loaded on this factor (Table 5.25).

Concern of commission in ethics (Polzer-Casarez & Engebretson, 2012) refers to the inappropriate application of spiritual care in the nurse/midwife-client relationship. Major concerns identified are coercion because of the social power of the health carer over the vulnerability of the client; overstepping one's competence in offering and providing spiritual care, based on inadequate preparation of nurses/midwives on spiritual care issues. Consequently, items pertaining to the need for nurses/midwives to be knowledgeable in spiritual care issues, such as grieving and to acknowledge limitations when lacking competence in spiritual care loaded on this factor. In this situation, referral to the appropriate other members of the multi-disciplinary team is deemed necessary which also loaded on this factor. Discussions relevant to the ethical and legal obligations of spiritual care issues involve the right for information and respect for spiritual/religious and cultural issues, influencing the decisions and choices in healthcare (Puchalski, 2001; Hayes 2004).

When clients refuse treatment due to their religious beliefs e.g. A Jehovah's witness who refuses a blood transfusion, nurses/midwives and other members of the multi-disciplinary team need to respect clients' beliefs, while giving appropriate care:

> *… these are very deep held beliefs. We believe that blood is sacred and God's commandment is to abstain from blood. So, in this case, someone trying to force a transfusion onto this woman is like trying to rape her* (Focus Group 2: P18).

The obligation to acknowledge limitations in the provision of spiritual care and to refer to other members of the multi-disciplinary team is seen as honouring the principle of beneficence in respecting clients' spiritual beliefs:

> *... because it was a deep conviction that you don't need a doctor's knife to give birth. It was like a curse. She wouldn't let them touch her, in fact she spit [spat] at the policeman. All I had to do is call the Imam. He came and*

spoke with her for a few minutes and she had the baby by caesarean section (Focus Group 2: P10).

Legal and ethical implications in nurse/midwife education in spiritual care, such as the difficulties related to the influence of religion on care, teaching of spiritual care interventions e.g. prayer, display of religious symbols and the use of religious literature (Lantz, 2007), were not identified in this study findings. This may be due to the religious cultural orientation in Malta, which is still facilitating religious practices in hospitals/institutions. However, spiritual care was perceived as a sensitive issue for both the client and the nurse/midwife which may impinge on various ethical and legal implications in the delivery of spiritual care as claimed by the international researchers:

... there are times when spiritual care may be offensive to nurses and midwives and not encouraged to engage in (Rm1).

... there is the assumption that a nurse can safely tread deeply towards the core of a person with spiritual distress. This is likely to be dangerous for the patient and the nurse potentially (Rn24).

Hence, the importance of abiding by the ethical and legal codes of care was reinforced in this study's findings which support research. Policies and guidelines need to be developed to guide education and implementation of spiritual care in practice in the local scenario and abroad.

6.3.4 FACTOR 4: Body of knowledge in spiritual care

Competency items pertaining to knowledge of complex theories in spiritual care, development and growth of spirituality in students loaded on this factor however were considered by respondents as being appropriate to post-registration level. This may be so, as these competency items seem to require more analysis, synthesis and evaluation (Bloom, 1956) and requiring a degree of clinical experience (Benner, 1984) particularly when applied in the clinical setting.

The item pertaining to the knowledge of spiritual assessment methods was identified as appropriate at both pre- and post-registration levels, implying the importance of spiritual assessment in the provision of spiritual care and consequently, should be taught at pre-registration level and revisited in more depth at post-registration level (Joyce, 2012).

The competencies which loaded on this factor address the spiritual dimension of care, as a component of holistic care, knowledge on the distinctions and relationship between spirituality/religiosity, understanding clients' illness/condition in relation to spiritual needs, development of spiritual growth, knowledge of the various world religions and cultural beliefs that may influence care, knowledge of spiritual assessment tools as well as theories of spirituality and bereavement.

The focus group qualitative data similar to the research findings (Ross, 2006; Puchalski *et al.*, 2009; Clarke, 2013), reinforced the concept of spirituality as an established component within holistic care. Participants were found knowledgeable about the dimension of spiritual care, which is integrated in the philosophy of holistic care.

> *It is important that professionals offer spiritual care within holistic care because it is self-enriching, this means that you will be helping them a lot if they are finding comfort in spirituality, here when we are mentioning spirituality, we cannot not include religion. It is not all spirituality, but it's a major part of it* (Focus Group 1: P7).

However, focus groups revealed that the spiritual dimension of care within the clinical practice setting did not always match up with this philosophy. For example, nurses/midwives, spiritual leaders and clients perceived the impact of the medical model of care as a barrier to providing holistic care as it often delivers fragmented care adopting task allocation system of care with minimal client-centred care demonstrated by lack of personalised attention. This is similar to what is to be found in literature on this subject (Puchalski *et al.*, 2009; Biro, 2012; Dahlberg & Aune, 2013).

> *Care is so medicalised, we learn about client-centred care but in the clinical setting we provide task allocation which takes you away from the concept of personhood* (Focus Group 1: P8*).*
>
> *The assumption is, the holistic approach is so important. A patient is coming in as a complete person – carrying a religion etc. but many times the patient becomes only the illness or the problem* (Focus Group 2: P10).
>
> *In every case of illness you have to treat the patient holistically. Not just the disease. Diabetes does not make the person – the person has diabetes but there's a lot more to them. They have bio (physiological), psycho (mental), spiritual and social needs to add to that too. And the nurse has to be aware of all of these* (Focus Group 5: P34).

The dominance of the medical model of care in nursing /midwifery hinders consistently holistic care (Ross, 1997; Baldacchino, Bonello & Debattista, 2014). Additionally, the clients' group of participants claimed that nurses/midwives do not regularly incorporate spiritual care into their daily routine and identified lack of time as an obstacle to explore clients' spiritual needs. These findings are consistent with research, whereby the nurses/midwives and the culture of their clinical environment tend not to prioritise spiritual care stating that work overload lessens the allocation of enough time for one to one encounters (Hubbell *et al.* 2006; Baldoni *et al.* 2014). Time constraints appear to show nurses'/midwives' lack of motivation to prioritise care (Swinton, 2001), spiritual care perceived as 'optional' (Ross, 1997) and 'extra' (Walter, 2002); rather than an integral part of care (Clarke, 2013). Lack of time to provide spiritual care has been related to lack of spiritual care preparation in the nursing/midwifery programmes (McSherry & Ross, 2012).

Qualitative data from the service providers (focus groups: nurses/midwives, spiritual leaders and nursing/midwifery educators) emphasised the importance of including the spiritual dimension of care in nursing/midwifery curricula. Service users (focus group: clients and informal carers) demanded that nurses/midwives should meet their spiritual needs. This infers that the spiritual dimension of care within holistic care is an important component in the education of nurses /midwives in preparation for their future roles.

Thus, spiritual care should be 'taught' (Baldacchino, 2008; Ross *et al.,* 2013; Attard, Baldacchino & Camilleri, 2014) and not only 'caught' from role models in the clinical environment (Bradshaw, 1997; Giske & Cone, 2012). It is argued that if students' clinical role models do not demonstrate spiritual care giving due to lack of time or other barriers, students may misinterpret it as not forming part of their role.

> *I worry about the manners too … Is there something in their training they're learning and are not putting in practice? ... For me this profession [nursing] has nothing to do with letters [qualifications] but how capable you are to be there for the sick and you make a difference … not that you just give the medication but that the patient feels comforted and supported* (Focus Group 5: P40).

In contrast, when role models in the clinical environments demonstrate quality spiritual care, students may understand their role to include spiritual care in the care (Giske, 2012).

> *There was a nun, she was sister in charge, but she was like a mummy to everyone on the ward, she used to be a counsellor, a nurse - a real role model of a nurse* (Focus Group 5: P41).

Data from focus group service providers reported that spiritual and religious development and the delivery of spiritual care may be influenced by the students' personal life experiences (Hoffert, Henshaw & Mvududu, 2007). Tiew, Creedy & Chan (2013) perceive spirituality to be an innate characteristic that can be enriched throughout life and not as a result of experience. However, life experiences may trigger young nurses/midwives to find meaning and purpose in life (Bowman & Small, 2010). Participants in the present study reported that spiritual and religious development and growth may be the result of nurses'/midwives' life experiences and their clinical experience. However, institutional religious affiliation may influence both the personal religious development and the delivery of spiritual care (Bowman & Small, 2010).

> *… I think they should know the stages of religious development because not all people are at the same level … I think nurses should know about this. It doesn't take much, in two hours you can teach them the aspect and development of religion On the other hand, real life experiences will also bring about this development* (Focus Group 2: P12).

While research suggests a relationship between life experiences and spiritual development, further research is recommended to define and specify the type of experiences that might influence spiritual development. For example, whether negative or positive, short or long term experiences. A number of educational strategies thought to promote spiritual and religious development and growth in nursing/midwifery students were suggested in this study, such as, the use of stories, narratives, case studies. These may allow students to reflect on their own experiences, within a safe environment to help explore and express their feelings, reflect on their practice which fosters self-awareness and spiritual growth.

Engaging students in intellectual and affective activities that lead to new understanding, is a good resource of learning complex issues in spiritual care which is brought about by the different cultures of clients and care givers. The research findings explore culture and spirituality (Narayanasamy & Narayanasamy, 2012; Chambers, Thompson & Narayanasamy, 2013) and its inclusivity in nursing/midwifery education enhances cultural competence (Pesut & Reimer-Kirkham, 2010) which is important when it comes to addressing the increasing diversity in religions and culture as is being experienced in many countries. Similarly, in the focus groups the qualified nurses/midwives, chaplains and spiritual leaders recognised the need to augment the students' knowledge with information about the various world religions and cultures. According to the participants, this should be mandatory in order to provide competent and spiritually sensitive care. This is due to the fact that some health practices or restrictions may have a religious and/or cultural basis which may dictate diverse care giving. This is applicable to Malta and various international counties which are faced with a multi-cultural transition as a result of immigrants and asylum seekers from North Africa and emigration from Eastern Europe.

> *I would like to speak about knowledge of different religions. There are situations within the Maltese nation that have different religions. I came across a case where I told her we will baptise the baby and this one answered that I don't believe in baptism. I continued to think of her. Afterwards, I knew the reason behind it. She belonged to evangelistic faith. I know nothing about them, but it's good to respect the different needs* (Focus Group 1: P3).

Thus, nurses/midwives in this study pointed out that responding to the diverse religious and cultural issues in their clinical practice may have significant implications for healthcare delivery.

6.3.5 FACTOR 5: Informatics and spiritual care

These competencies address information technology as a resource for teaching and learning about spiritual care, a medium for spiritual inspiration, a means to maintain consistency when documenting spiritual care and a means to provide spiritual support to clients and their families through a communication network.

The loading of all three competencies on this factor (Table 5.27) is consistent with the current trend of rapid technological advancement. This may be to accommodate the teaching and learning of nursing/midwifery students and provide spiritual support as a therapeutic cognitive-behavioural intervention to prevent and/or treat stress and complicated grief conditions in clients (Wagner & Maercher, 2007). Communication networks in the form of web-based spiritual support services scored the highest factor loading score (0.84). This is in parallel with research which has shown that web-based mental health services including informative websites, online help groups, virtual counselling services and automated therapy programmes have recently emerged as useful and popular options for persons experiencing grief (Kersting *et al.,* 2011).

Although it is assumed that such resources may provide a sense of emotional support, further research is recommended to identify the beneficial effects of spiritual care utilising informatics on clients' spiritual well-being. Qualitative data gathered from focus groups revealed that participants perceived information

technology in the field of spiritual care as a social network and a medium for spiritual inspiration. However, some participants were unsure about utilisation of information technology as a resource for emotional therapy, documentation of care and teaching and learning about spiritual care issues:

> *... let me tell you. Speaking on my behalf, at ward level, I don't think the nurse has the time to stay on the computer doing literature search. Yes we do have the internet to make good use of it* (Focus Group 1: P4).

> *That monitor screen in front of them can be a means. For example, in the morning, three times a day, there is a spiritual message that goes on throughout the day. For example, some commotion [e.g. the client received some bad news] that happened that day and you pass them on a small encouraging message* (Focus Group 1: P1).

Information technology has advanced swiftly in the last two decades. However, apprehension to its use and demand at ward level might be related to the lack of importance given to it by healthcare professionals in the context of spiritual care delivery and hence inhibits its use (Moule, Ward & Lockyer, 2010). The limited available resources in the clinical environment, such as internet access and few computers may also inhibit its use, which may also yield frustration as expressed by the nurses/midwives in this study.

> *We don't even have internet on the ward* (Focus Group 1: Ps, 4, 7 & 9).
> *Let me make myself understood. If they're going to make good use of it to research aspects in spiritual care, I will provide computers and internet access to them* (Focus Group 1: P3).

Conversely, the educators in Focus Group 3 were enthusiastic about the use of information technology as a resource of learning about spiritual care:

> *... but the way the discussions were through video conferencing. I believe it was much more effective than classroom teaching, in that discussions developed and broadened the topic. It was totally online, it was this top up and as I said, we were dealing with mostly existential questions, about dealing with and caring for the dying, the moral distress associated with it etc* (Focus Group 3: P23).

These findings on e-learning is supported by the literature especially the use of video-conferencing, video clips depicting clinical skills and scenarios which were the most useful feature of e-learning as images may exert a more powerful influence on recall of information (Bloomfield, 2013). However, the same focus group participants considered face to face teaching and learning as invaluable, irrespective of their positive views of e-learning. Additionally, a change is frequently accompanied by reluctance and resistance. While participants recalled their personal experiences, they were reluctant to relinquish conventional teaching methods:

> *... because there are post-registration students, they have experience and they can translate. In the case of newer students, to assimilate that information they have to learn concepts and theories, maybe to discuss ... but to assimilate information and turn it into behaviour and develop the appropriate attitude and translate it into a behaviour to work with the patient and each other, I think it has to be face to face* (Focus Group 3: P30).

Finally, participants agreed to a combination of face to face teaching methods and e-teaching strategy approach.

6.3.6 FACTOR 6: Healthcare chaplaincy

This factor (Table 5.28) consists of four competency items and emerged as a new factor following Exploratory Factor Analysis and identified as Factor 6. Since the **four** competency items were oriented towards the role of chaplaincy in the spiritual/religious care of clients, this factor was named 'healthcare chaplaincy.'

The emergence of these four items as a separate factor, appears to reinforce the importance of chaplains and spiritual leaders to cater for the spiritual/religious needs of clients and staff of all faiths and none (Tiew & Creedy, 2011; King; 2012; Koenig, 2012). This is in line with the recent and evolving developments in the establishment of Healthcare Chaplaincy in Europe and the US. Thus, the importance of a multidisciplinary team approach may indicate the need to address the

religious/spiritual needs of clients and staff to help them find meaning and purpose in their illness and life by referral to chaplains and spiritual leaders.

The role of the chaplains in hospital and community care was frequently associated with meeting clients' religious needs, as spirituality was synonymously defined as religiosity (Ross, 1994; Mowat & Swinton, 2005, 2007; Fitchett 2011; King 2012; Koenig, 2012; Nolan & Holloway 2014). Similarly, research shows that referral to chaplains by nurses/midwives indicated the exclusion of religious care from nursing/midwifery care (Ross, 1994; Galek *et al.,* 2007). Thus, this study's findings highlight the role of the chaplain and spiritual leaders, in liaison with the multi-disciplinary team.

> *Considering what the nurse needs to know, I think first of all the nurse has to know that there exists a multi-disciplinary team made up of chaplains, psychologists, social worker etc.* (Focus Group 2: P14).

> *Nurses need to feel that they can call on ministers and chaplains as fellow professionals and have a sensible conversation about how to exercise this care in the best interest of the patient* (Focus Group 2: P11).

As the concept of spiritual care is complex, hospital chaplains need to be qualified for this role and be supported by CPD programmes in competencies in spiritual care.

While considering the current debate as to whether nurses should concern themselves with spiritual and religious aspects in people's lives (Paley, 2009), research shares many views regarding referral of clients with spiritual/religious issues to hospital chaplains, spiritual leaders and members of the multi-disciplinary team. Research has identified reasons why nurses/midwives refer clients to chaplains, such as perceived incompetence to provide spiritual care due to lack of preparedness to address clients spiritual needs thinking that religious/spiritual care is not part of their role as well as the lack of self-awareness about one's own spirituality which limits the delivery of spiritual care (McSherry, 1996; Taylor, 2008; Baldacchino, 2008).

The qualitative data showed that the chaplains and spiritual leaders identified nurses/midwives as being in the fore-front to provide spiritual care to clients, as it is within their vocational realm of their profession.

> *... It may well be in the first days of him being in hospital the nurse is in the best position to decide about the patient's spiritual/religious needs than anyone else. Because a nurse deals with the person rather than the symptom and is with the patient all the time* (Focus Group 2: P11).

Chaplains claimed that since they are the experts in spiritual care, nurses/midwives are requested to refer clients to them. It is argued that hospital chaplains who are resident workers in hospitals tend to be recruited as qualified chaplains following pastoral care training. However, the diversity of religions generates the need to call pastors/spiritual leaders who might not be qualified in spiritual care in illness. In the local scenario, nurses/midwives usually refer to the list of spiritual leaders from various religious affiliations available on the wards to request their assistance, with regards to the clients' spiritual/religious needs. These might not be qualified in the spiritual dimension of illness. Thus, the importance of education of spiritual leaders to address spiritual/religious needs is emphasised (Speck, 2005; Baldacchino, 2008). Moreover, the findings of Galek *et al.* (2007) indicated that nurses, doctors and social workers referred clients to chaplains for end of life issues. However, they were found not make referrals related to unresolved grief, anxiety and anger manifested in physical symptoms and spiritual issues. Thus, these findings may indicate lack of knowledge in nurses/midwives in understanding the manifestations of physical symptoms, due to spiritual distress.

Galek *et al.* (2007) pointed out that religiously affiliated hospitals were more likely to believe in the importance of referring clients to chaplains and multi-disciplinary teams to address the holistic needs of clients. Additionally, the culture of the institution may influence the attitudes of nurses/midwives about spiritual interventions and referrals to members of the multi-disciplinary team (Galek *et al.,* 2007). Consequently, the influence of a strong religious culture in Malta may have

contributed to the aggregation of the **four** competency items into one factor - Healthcare Chaplaincy.

Since in this study, the majority of the experts were Christians, the comparison with other religions and atheists was not possible and hence the results may be due to the lack of sample comparability in religious affiliations. This is in line with existing research on the subject (Waltz, Strickland & Lenz, 2005). However, the contribution of international research and education experts in spiritual care in the consultation phase and comparison of these competencies with the regulatory guidelines in nursing/midwifery (NMC, 2010; 2009) enabled the framework to 'fit' within the existing regulatory requirements.

Thus, it appears that irrespective of the type of religious affiliation, the assistance to clients given to address their spiritual needs is seen by research as an important contribution in spiritual care (Ross, 1994; Baldacchino, 2008; Mowat & Swinton, 2005, 2007; Fitchett 2011; King 2012; Koenig, 2012; Nolan & Holloway 2014). However, it is noted that much of the research was oriented towards spiritual care during end of life. Therefore, further trans-cultural comparative research is recommended on clients with acute and chronic illness to explore further the chaplains' role in holistic care of clients, in liaison with the multi-disciplinary team. Research to explore how the framework fits cross-culturally and be used by educators of different cultural background is also recommended in order to confirm the two frameworks of competencies identified at pre- and post-registration nursing/midwifery education.

6.3.7 Factors enhancing/inhibiting implementation of the framework

The final aim of the study was to adopt a pragmatic view of the proposed framework of competencies in spiritual care as a potential tool in nursing/midwifery curricula. In view of this, a consultation process was established with international researchers and Delphi experts with a background in education who had participated in the modified Delphi study. The participants who had been recruited, were asked to give their views on the proposed framework and to identify the

factors that may enhance or hinder implementation of the framework in research, education, and/or clinical practice.

The response rate of the international researchers in spiritual care to the web survey was n=44. The response rate of the modified Delphi educators was n=63. Thus, the overall n=107 participants (43.84%) is a modest response rate from a 'specialist' population (Couper *et al.*, 2007). Compounding to the impersonal method used to recruit international researchers by e-mail, the researchers' busy schedules and the large number of requests to participate in research may have significantly affected the response rate. Reminders sent did not stimulate a better response rate. On a positive note, researchers were recruited from ten different geographic locations across continents, which gave a broader view of the findings in the nursing/midwifery education arena and enriched the findings of this study.

Although generalisation of the findings derived from the consultation phase is limited, due to sample size of participants, these were consistent with the existing research relating to the complexity. The lack of integration of spirituality and spiritual care in education, practice and research were related to the broad and diverse definitions and complexity of the concepts of spirituality and spiritual care and hence, the views of the proposed competency framework which circled around the concept and definitions of spirituality and spiritual care.

> *Spirituality and spiritual care are complex concepts with vague aims, various definitions and very often confused with religiosity* (Rn2).

The controversies in the definitions and meaning of spirituality and spiritual care have contributed to a lack of understanding and poor application in practice (Ross, 1994; McSherry & Cash 2004; Narayanasamy, 2004; Clarke, 2009). Most barriers were attributed to nurses'/midwives' negative attitudes to spirituality and spiritual care in the clinical area which included issues of qualified staff being unaware of their nascent spirituality (Narayanasamy, 2004), imposing their own spiritual or religious beliefs on their clients and/or families (Hubbell *et al.,* 2006), a lack of role modelling behaviour (Baldacchino, 2008) as well as the issue that nurses/midwives

were at times, unable to assess clients' spiritual needs (McSherry & Ross, 2010). The findings from the focus groups, revealed participants' reluctance to provide spiritual care due to the biomedical model of care in practice, task-orientation, resistance to change, lack of time and ethical issues linked to nurses/midwives being unsure of their role. These findings are in line with current literature on the subject (Edwards *et al.,* 2010; Baldacchino, 2011; Tiew & Creedy, 2012; Balboni *et al.,* 2014). These issues or barriers hinder the integration of the framework into clinical practice.

Therefore, the barriers identified in this study namely, inappropriate attitudes to spirituality and spiritual care, personal spirituality, lack of educational preparedness, the theory-practice divide and the lack of research funding in areas of spirituality and spiritual care threaten the effective implementation of spiritual care in education and practice. As mentioned above, this is frequently cited in the literature and these findings are therefore consistent with those relating to the need to bring about change in other areas of nursing/midwifery, such as the implementation of research findings which in turn will affect evidence-based practice and healthcare policy (Fitchett, 2011; Kalish, 2012).

> *Competencies in spiritual care should be presented as essential skills, not optional extras and should be integrated in all curriculum [curricula] not as a special course (Rn27).*
>
> *There should be outcomes-based philosophy programmes of education. Competencies presented as evidence-based, clearly defined, achievable and demonstrable at pre-registration and post-registration (Rn28).*
>
> *Policy directives recognised as key outcomes in NMC approved programmes and acceptance of necessity of the framework by policy bodies recognise its importance in the provision of holistic care (Rn36).*

At a time when effective interventions may be withheld or minimised because of lack of funding, the difficult process to access research funding in the area of spiritual care is another possible reason for the existence of these barriers which may be due to the lack of awareness of the funding bodies on the requirement of competences in spiritual care at National and International policy level (ICN, 2012; JCAHO, 2010 WHO, 2012; NMC, 2012).

Most research in the area of spiritual care features in the lower hierarchy of the evidence as it is mostly conducted by qualitative approach and randomised controlled trials are rarely used. Given the dominance of randomised controlled trials perceived as the gold standard in medical research, spiritual care research should move in this direction to better access research funds. The lack of critical debate in relation to the ill-defined concept of spirituality, which must be challenged, may be another reason for lack of research funding in spiritual care.

> *Funding bodies not recognising that spiritual competence is a requirement not a luxury (Rn13).*
>
> *The dominance of RCTs as a perceived gold standard in medical research over research in spiritual care is a problem (Rn30).*
>
> *There seems to be lack of interest in spiritual care as an area of study. Very few students take up this topic to be researched (Em3).*

Consequently, integration of spiritual care in clinical practice needs collaboration from the various stakeholders.

> *Effective marketing strategies to gain practical goodwill from stakeholders: professional organisations, policy makers, top management, service providers and service users* (Em7).

This response proposes a concerted tripartite approach involving the commitment and collaboration of clinical nursing/midwifery professionals across the hierarchy in education, clinical practice and research. Numerous educational, clinical and research strategies have called upon stakeholders, service providers and service users to integrate spiritual care into clinical practice (Cockell & Mcsherry, 2012; Draper, 2012; Ross *et al.,* 2013). These strategies recommend early exposure of pre-registration students to spiritual care by threading the concept of spirituality in client care across the course programme, facilitating self-growth through their involvement in community voluntary work, using creative teaching methodology to incite reflection and self-awareness. This is thought to foster and enhance spiritual perspectives in students (Hall & Mitchell, 2007; Baldacchino, 2008; Tiew, Creedy & Chan, 2013) involving a multi-disciplinary approach.

The findings of this study proposed faculty educators and clinical mentors in the teaching of spiritual care and providing opportunities for continuing professional education in the area of spiritual care.

> *Most nurses and midwives have had no education in this aspect of care. It was all gained through personal experience (En8).*
>
> *I would start with education but also acceptance of necessity by policy bodies. It would need education of clinical mentors in understanding spirituality and spiritual care before they can assess it effectively … Educators need to become better trained in teaching this dimension of practice, not confusing it with religious teachings or learnings (Rn28).*
>
> *One has to ensure that students are exposed to clinical practice with mentors that are updated in line with the evidence (En12).*

While these strategies are consistent with research, there is little evidence to confirm the usefulness of one single teaching and learning approach. (Lovanio & Wallace 2007; Hall & Mitchell 2007; Mooney & Timmins 2007; O'Shea et al., 2011; Vlasblom *et al*; 2011; Baldacchino, 2008; 2010; 2011; Ross *et al.* 2013). The findings from this study support the observation that there is lack of clarity about the teaching content and strategies used to enhance competence of nurses/midwives to address clients' needs. Thus, participation in international network is of great importance to share and learn from each other about innovative ways of teaching spiritual care (Baldacchino, 2008; Ross *et al.*, 2013).

The findings also identified the commitment and support of educators and clinicians, the implementation of a multi-disciplinary client-centred model of care and the facilitation of multi-disciplinary research in spiritual care. This is supported in literature which suggests possible ways of facilitating spiritual care. However, the researcher observed that the literature is limited when it comes to providing direction on how to provide spiritual care. Thus, generic and specific competencies need to be developed to guide students' learning.

> *Spiritual care is a realistic concept and core to compassionate care and competent nursing/midwifery. The concept is integral to the art of midwifery which is depicted in competencies (Em2).*

The framework captures the essence of nursing care on a day to day basis and can offer ways to provide spiritual care (En4).

The national and international regulatory bodies are consistent with the provision and education of spiritual care (QAA, 2001; ICM, 2014; NMC, 2009; 2010; JCAHO 2008; WHO, 2012; ICN, 2012; NMC 2012). The specific competence of nurses/midwives' to satisfy their role in providing spiritual care remains unclear (NMC, 2012) in spite of the abundance of literature on spirituality and spiritual care (Timmins & Neill, 2013). Thus, clear guidance from the nursing/midwifery professions is recommended on the curricular content and consistent teaching approaches to enhance the outcomes of the teaching of spiritual care to achieve and maintain standards of performance in spiritual care. Thus, these competency frameworks to be achieved at pre-registration and/or post-registration will guide the education and practice of nurses/midwives in the delivery of spiritual care.

The main themes that emerged from the consultation phase regarding the proposed framework include the negative and positive aspects of the framework and highlight areas for improving the framework (Tables 5.35 - 5.36). The proposed competency framework was evaluated positively because of the rigour of the research process adopted and its usefulness in education and clinical practice. Respondents recommended a global user-friendly approach, regarding the use of language to suit the various clinical settings and persons with diverse or no religious beliefs. This is in line with research which proposes an approach to spirituality based on universal perspectives, rather than solely religiosity.

The ambiguity between spirituality and religiosity given the present secular age supports the adoption of a broader definition of spirituality which may or may not consist of religiosity (Tanyi, 2002; McSherry & Cash, 2004; Ross, 2006). While addressing the spiritual needs in a pluralistic society in countries where populations are predominately of the same religious affiliation, for example Christianity, Islam and Judaism, the teaching and learning in spiritual care would be appropriately formulated according to that specific religious framework (Timmins & Neill, 2013).

6.4 Methodological limitations

This study utilised a mixed method approach to address the research questions of this study. A solely qualitative approach of phenomenology to explore the experiences and perceptions of nurses'/midwives' experiences of competencies in spiritual care, or a quantitative approach, such as a survey would not have captured the whole data required for the development of the competency framework. Triangulation of theories and data investigations generated data building from one phase of the study to another. The overall research objectives, which were best addressed with three study phases enhanced rigour across the study with the outcome of developing a reliable and valid competency framework for the delivery of spiritual care.

6.4.1 Phase 1: Literature review and focus groups

This phase identified the competency items and domains from the existing research studies in spirituality/spiritual care and spiritual care education in nursing/midwifery. The focus group method was considered the most adequate to generate discussion from service users and providers of spiritual care to enhance further identification of competency items.

The principal advantage is that it is relatively easy to set up, run and satisfy certain social needs, such as power, status, recognition and affiliation (Landeta, Barrutia & Lertxundi, 2011) and tends to have high subjective validity. However, focus groups have some important limitations. The analysis and presentation of data were complex, due to group interaction. For example, participants may become distracted or inhibited, due to their own personality, the influence of others such as, pressure to conform, status incongruence, dominant personalities and fear of social marginalisation (Gibbs, 1997; Krueger & Casey, 2009).

The use of case scenarios in this study facilitated the analysis of spiritual care, development of competencies in spiritual care as it enabled each participant to share her/his views and experiences within the group in a safe and trustful environment. This approach is in line with the literature on this subject (Krueger &

Casey, 2009). However, some limitations that may have impaired the validity of results, such as sample selection bias of participants who were willing to participate because they were explicitly interested in the theme of spiritual care.

The purposive sample technique of experts in the field of spiritual care composed of clients, nurses/midwives, educators, spiritual leaders, policy makers, parents and informal carers provided a heterogeneous sample which provided a broader picture of the data as outlined in the literature (Polit & Beck, 2014). The majority of participants were Christians and were therefore affiliated with the Roman Catholic religion (Gouder, 2013). Although an attempt was made to include various religions by including spiritual leaders from other religions, the majority of participants in Phase 1 were Christian. Due to the increasing number of Islamic refugees and displaced persons in Malta, diversity of religions within the group was vital. Consequently, Islamic representation was achieved in Phase 2 and 3 of the study.

To overcome the expected attrition of participants, additional participants were recruited to enhance the full potential of the focus group. A total of forty six respondents participated in five focus groups to form groups of about 7-11 participants. Precautious were taken by the researcher to minimise bias in the focus groups and to enhance trustworthiness of the data (Chapter 4, Section 4.9.10).

6.4.2 Phase 2: Modified Delphi study

A nominal group technique with a group of experts, who physically coincide in terms of place and time, may have been an appropriate approach for capturing, aggregating opinions and clarify emerging meaning (Kadam, Jordon & Croft, 2006). This was impossible for many pragmatic reasons, such as distances, expense and availability of participants.

The researcher considered that this also applied to this study and therefore selected the modified Delphi method due to its flexibility and simplicity which in turn, allows the successful application with a group of geographically dispersed participants. This method was considered appropriate due to the thematic contexts of the participants. It also prevents social-psychological problems that may limit the range

of options which may be generated and the frankness with which participants may demonstrate in their judgements of the options. However, identifying and gauging Delphi rigour remains elusive due to ongoing epistemological debate, continual modifications to the approach and an artificial divergence in responses, which may possibly give a false consensus (Hassan & Keeney, 2011).

Other additional limitations which have been outlined in relevant literature include the difficulty with verifying the precision of the research method. Consensus is used as a means of approaching the truth and a 'real expert' is difficult to identify (Landeta, Barrutia & Lertxundi, 2011). The lack of a clear definition of the research method described above, threatens reliability and validity. Furthermore, the methodology consists of some uncertainties such as, the meaning of consensus, criteria for defining an expert, multiple types of Delphi methods available and the scant studies that explore Delphi rigour which makes the method open to criticism (Hasson & Keeney, 2011). In spite of these shortcomings, a modified Delphi approach to the study was considered appropriate as the opinions and judgments of experts and practitioners in the field of spirituality and spiritual care were necessary for the development of this competency framework. The use of a focused meaning of consensus and selection criteria of the 'expert' panel enhanced the reliability of the competency framework.

The use of a conventional or exploratory Delphi study with the use of an open-ended question in the opening round of the Delphi study could have been utilised to identify competencies in spiritual care from participants' knowledge and experience. However, after consultation with experts in the field, a modified Delphi approach was adopted. The primary advantages of this modification to the Delphi is that it typically improves the initial round response rate, especially when topics are ambiguous and there is no guarantee that forecasts produced from the first round open-ended question, would identify a range of competencies in spiritual care (Hardy *et al.*, 2004). Consequently, this led the researcher to lose confidence in the ability of the participants to provide an in-depth interpretation of these complex concepts of spirituality and spiritual care.

As a result of this, pre-selected competency items which were drawn from related competency profiles (MCCC, 2003; van Leeuwen & Cusveller, 2004; Baldacchino, 2006), as well as the review of relevant literature and the outcome of the focus groups, the researcher felt confident that this provided a good resource for data collection. This in fact, resulted in a satisfactory response rate for Round 1 (n=241; 85.76%). A high response rate was actually achieved for both modified Delphi rounds (R1: n=241; 85.76%, R2: n=205; 85.06%). The sample size achieved for this phase of the study appeared satisfactory and also exceeded the minimum sample size required for EFA (100-200 participants) (MacCallum *et al.,* 1999).

The high response rate in both rounds may indicate some influences, such as the fact that the researcher is a nurse midwife and a faculty lecturer who the participants know quite well. Thus, participants might have given socially desirable responses which may threaten reliability of the findings. The likelihood of the latter is minimised as most participants were subjected to Spiritual Care Competency Scale (SCCS); (van Leeuwen *et al.*, 2008), to determine their knowledge and experience in spiritual care, were recognised 'experts' in the field. Some participants had leadership and managerial posts within healthcare and are known to be accountable and responsible individuals.

Attrition of participants is expected in rounds of Delphi studies which may bring about bias in the results (Kristman, Manno & Cote, 2005). However, no significant differences were identified between the characteristics of the respondents and non-respondents (Section 5.6.11, Table 5.17). Non-respondents may possibly restrict the representativeness of the results in view of the population of 'experts' in spiritual care which contributes towards generalisation of the findings.

The modified Delphi questionnaire had satisfactory test-retest correlations and high Cronbach α results which showed an internal consistency of the tool. Various competency items included in the questionnaire contained several elements on spiritual care, due to the complexity of the concept. Thus, participants were requested to answer each competency item as a whole which might have

threatened the reliability of the findings. The long questionnaire with 55 items might have discouraged the experts to complete the questionnaire, rigorously. However, their personal interest in the topic and commitment to the study may have outweighed this limitation.

The use of a pencil and paper questionnaire over the use of e-mail surveys has been documented to enhance response rates. Additionally, both e-mail and postal questionnaire were used but might have influenced consistency in the responses.

The good fit of the five factor model was identified through the EFA, namely:

- Assessment, implementation and evaluation;
- Quality assurance;
- Ethical and legal issues;
- Body of knowledge
- Informatics in spiritual care.

This worked in parallel with the domains and the competency items which had originally been determined from the literature review and focus groups. Two domains out of the original seven domains overlapped and were merged within the five factor model following EFA. Only **five** competency items out of the original 54 items were considered as less important and factor loaded less than 0.4. An additional factor, Factor 6 was identified and given the name 'Healthcare chaplaincy.'

The intention of this was to address the cultural orientation of the study population since the majority of participants were Christians and were affiliated to the Roman Catholic religion. Since the items of the framework were quite broad and addressed both the Judeo Christian religions and non-theistic world views, the researcher was not too concerned about the effect that this would have on the results but concluded that such an approach would avoid any possible bias due to this cultural orientation of the participants.

The framework of competencies underwent classification of the items during the consultation phase. The items were categorised as achievable at pre-registration level as well as post-registration level and **two** items were reported to have been achieved at both levels. Thus, the two new frameworks need to undergo further psychometric testing to explore and confirm their construct validity and the respective reliability coefficients of each factor, as well as the overall frameworks as a whole to enhance reliability and validity of the frameworks (Henson & Roberts, 2006).

6.4.3 Phase 3: The consultation process

The response rate in the consultation phase was twofold: The modified Delphi educators 64.28% (n=63) and international researchers 23.5% (n=44). The impersonal method used to recruit researchers by e-mail of whom only few knew the author through networking in conferences might have inhibited their initiative to complete the questionnaires. Reminders might have also been caught up in the spam system. However, the response rate is acceptable given the expected low response rate from postal and web surveys and the characteristics of participants. Being experts in the field of research and education in spiritual care, the commitment to this study superceded the experts' busy schedules. Once again, two different modes of data collection were used in the consultation phase namely, a postal questionnaire and web survey. The use of a web survey was preferred, particularly in view of the practical difficulties involved in the administration of postal survey. Postal questionnaires were mostly used for the local participants.

The use of a web survey provided an acceptable solution to the geographical distances and resulted in a group of participants who hailed from ten different countries at minimal cost. However, the researcher is aware of the fact that by utilising two different modes in the consultation phase, this might have affected the reliability of the findings. Thus, further research is recommended with the use of only one method. For example, either a web survey or postal questionnaire.

The pre-planned 51% value of agreement (simple majority) in this phase of the study contributed towards a rigorous classification of items as essential at pre-registration level, essential at post-registration or Not essential at either levels (Mckenna 1994).

6.5 Conclusion

The competency framework in spiritual care was developed using the process of an eclectic Competency Framework Model which was designed for this study (Figure 4.1). This involved the following:

PHASE 1: An in-depth literature review and five focus groups;
PHASE 2: A modified Delphi study
PHASE 3: An exploratory survey using a consultation process.

This approach enabled the development of two competency frameworks in spiritual care at pre- and post-registration levels (Tables 5.32 & 5.33). The items were confirmed to 'fit' with the regulatory bodies' requirements. Factors that may enhance or hinder integration of the framework in education and clinical practice were also identified.

The participation of the stakeholders, service users and service providers in the study generated rich data which may have prevented assumptions being made about the individuals' spiritual needs. Few research studies have collected the opinions of the general public on their understanding and expectations of spiritual care (McSherry, 2007).

It is intended that these competency frameworks will be disseminated through local and international meetings and conferences to guide nurses/midwives when they are required to address the spiritual needs of clients and their families across the life span continuum.

The theoretical framework which was adopted for this study was composed using elements from the 'Theory of skill acquisition: From novice to expert' (Benner,

1984) and 'Taxonomy of educational objectives: Cognitive and affective domains' (Bloom, 1956), both of which offered a guide for the design of the framework. The choice of these two theories is appropriate as they indicate the barriers that may be encountered in the translation of these competencies to clinical practice. Both theories categorise the learning needs of students in both theoretical and clinical practice levels. Depending on the desired outcome, the theoretical and practical learning objectives are set to the student's appropriate level. Then, by using the appropriate teaching approaches that correspond to the level of the student's learning needs the desired level of competency in spiritual care is achieved.

The competency frameworks whether as a 'stand alone' module or 'threaded' across the curriculum may provide guidance for the educational content in pre-registration and post-registration nursing/midwifery programmes. The use of a competency-based approach addresses the educational mission of integrating the concepts of spirituality and spiritual care in education and practice. In clinical practice, the framework may foster a culture for spiritual care, instigating commitment and guidance to improve spiritual care standards, not only in the care provided to clients but also to colleagues by embracing a multi-disciplinary team spirit and continuing professional development. The competencies will be achieved over the span of an educational programme at pre-or post-registration level, over a variety of settings in the areas of nursing/midwifery.

In view of the existent inconsistencies surrounding the educational preparation of nurses/midwives on spiritual care issues, the competency domains and items identified in the course of this study are the 'fabric' of everyday client care which connect students and qualified staff to the lives of their clients with hope and compassion.

Nursing/midwifery claim ownership in the biological, psychosocial, cultural and spiritual realms of clients' care. This requires a tripartite approach, involving nursing/midwifery leaders, educators and policy makers to improve or set up spiritual care standards in practice and education, by including the spiritual

dimension of care as a core competency. This facilitates the explicit integration through a holistic nursing/midwifery care delivery model. In order to achieve competence in care, the researcher recognises that educators need to embrace these concepts as central to their education philosophy and mission statement.

During this era of inter-professional learning, this framework of competencies in spiritual care may enhance comprehension of spiritual care and team-work within the healthcare setting. Therefore, this study illustrates that if nurses/midwives are more effectively equipped with knowledge, skills and attitudes, they are likely to become more competent in responding to clients' spiritual needs. The implementation of the study's competency frameworks would provide an insight into the complexity of spiritual care and would guide the educational and clinical practice of nurses/midwives in such a way that clients will eventually experience a better quality of care which is more holistic and addresses their deepest concerns and needs.

CHAPTER 7: CONCLUSION

7.1 Introduction

Spiritual care is identified by nursing/midwifery educational and professional bodies and research as an area that merits competence at the point of registration. It is unclear the extent to which pre-registration education prepares students for their role in delivering spiritual care and how competency in spiritual care might be assessed and integrated with nursing/midwifery education and clinical practice.

The discrepancy between the teaching of spiritual care and its delivery in clinical practice is a well-recognised fact by practitioners in this field. The need for the development of a framework of competencies in spiritual care in order to better equip nursing/midwifery students in meeting clients' spiritual needs has long been felt.

In the absence of rigorous and validated competencies in spiritual care to guide the education of nurses/midwives, this study sought to address this key research gap in the literature in a number of phases and by utilising a mixed methodological approach which included:

I. The design and development of a framework of competencies in spiritual care for nurses/midwives which was guided by the theoretical frameworks, the 'Theory of skill acquisition: Novice to expert' (Benner, 1984) and 'Taxonomy of educational objectives: Cognitive and affective domains' (Bloom, 1956).

II. **Phase 1** of the study involved the competency item generation which resulted from an in-depth literature review and focus groups with stakeholders, service providers and service users, followed by data analysis using the qualitative data analysis technique (Krueger & Casey, 2009)**.**

III. A validation process of the identified domains and competency items using the modified Delphi approach and the emergence of a generic framework of competencies in spiritual care was then undertaken in **Phase** 2 of the study. Quantitative data was analysed using SPSS v21 and qualitative data were analysed using thematic content analysis (Braun & Clarke, 2006).

IV. The researcher then obtained a pragmatic view on the identified framework of competencies in spiritual care by consulting with experts in the field in order:

1. To identify which competencies should be acquired at pre- or post-registration level and which competencies are not essential at either level.
2. To identify which factors may enhance and/or hinder implementation of the framework in education, research and/or clinical practice (**Phase 3)**. SPSS v21 was used to analyse the quantitative data while the qualitative data was analysed using thematic content analysis (Braun & Clarke, 2006).

7.2 The key findings of the study

As a result of the above mentioned process which was undertaken in this study, the key findings or outputs from this study include:

- The identification of a reliable, valid and psychometrically rigorous generic framework of competencies for spiritual care from an extensive literature review as well as focus groups with stakeholders, service-users and service providers.
- The development of a conceptual framework for spiritual care based on the 'Theory of skill acquisition: Novice to expert' (Benner, 1984) and 'Taxonomy of educational objectives: Cognitive and affective domains' (Bloom, 1956).
- The formulation of a seven domain spiritual care competency framework for pre-registration level and a four domain competency

framework at post-registration level in nursing/midwifery. These competencies were cross-referenced with the regulatory bodies requirements (NMC 2009; 2010) and were endorsed by the local experts and international researchers who were involved in the study.

- The identification of factors which may enhance and/or hinder the implementation of the framework in education, clinical practice and healthcare policy by consultation with international researchers and local modified Delphi educators.

7.3 The contribution of the study to the body of knowledge

Evidence indicates that spiritual needs are not adequately met when clients are hospitalised. Although, clients do not expect nurses/midwives to deliver spiritual care as these are seen to be busy dealing with the physical part of care, spiritual care is still recognised as being an integral part of nurses'/midwives' role and when offered it is valued. Nurses/midwives are often hesitant to provide spiritual care, which is attributed to the lack of educational preparation in spiritual care issues. This innovative study has made an important step forward in the development of knowledge of competencies in spiritual care to inform curricular contents in nursing/midwifery at pre-and post-registration educational levels. Furthermore, the study has provided knowledge of the factors which may enhance and/or hinder the integration of these competencies in education and clinical practice.

The study also contributes to knowledge of the difficulties impinging on research in the field of spiritual care. The major focus area of competency in spiritual care is on oncology or palliative care. While such work is invaluable, spiritual care appears to be the focus of death and dying, which may add an element of bias to the research field. Since spirituality is a broad and useful concept, this study has contributed towards knowledge of spiritual care competencies that should ideally be achieved by all health caregivers in particular nurses/midwives who are constantly with clients, other than those nearing end of life.

The participation of clients in research methodologies enhances the relevance of the subsequent actions that need to be implemented, as these are not assumed but grounded on clients' actual needs. Clients' participation in research therefore prevents the development of professional discourse which may be meaningless to them. Consequently, this is the first known study to have attempted to identify and develop a reliable, valid and psychometrically rigorous competency framework through the Integration of a theory-based, process-oriented approach, involving client participation, local and international experts in the area of spiritual care in nursing/midwifery.

In addressing European educational strategies, a competency-based approach was adopted. This is the first known study in spiritual care adopting this approach in preparing nursing/midwifery students to integrate spiritual care in their developing practice. Following further testing of the framework, its generic philosophy and the core elements can be adapted and adopted to address the spiritual needs of clients of other cultures and beliefs in a variety of nursing/midwifery healthcare settings.

The development of these competencies through a competency-based approach can provide a benchmark against which shared expectations around performance can be measured (Kerry, 2001). The identified framework of competencies may therefore, be used in setting up standards in spiritual care and contribute in staff appraisal as part of continuing professional development and to elicit further learning needs. Whether a 'stand alone' module or 'threaded' in the curriculum, the framework will provide guidance for the educational preparedness of nurses/midwives and clinical practice of spiritual care. Hopefully, the developed competency framework in spiritual care and the publication of research, for example, Attard, Baldacchino and Camilleri (2014); Attard and Baldacchino (2014) (Appendix 32) will be useful to clinicians, nurse/midwife educators and students as they strive to incorporate spiritual care within their practice and instigate further research in the field. In turn, clients and their families should benefit from care which is more holistic and addresses their deepest concerns and needs.

7.4 Recommendations

As a conclusion to this research and discussion, the researcher proposes a number of recommendations with the intention of contributing towards increasing awareness on the subject of spiritual care in nursing/midwifery, increasing the quality of education of this subject and ultimately improving client care. The researcher has outlined a number of recommendations which are relevant to:

- Spiritual care policy.
- Nursing/midwifery education.
- Clinical practice.
- Future studies.

7.4.1 Recommendations relevant to spiritual care policy

On the basis of the findings from the research, the following recommendations relevant to spiritual care policy are proposed.

- **Greater attention to be given to the spiritual dimension of care**

Due to lack of attention to the spiritual dimension of care, policy directives and educational strategies should promote competence when providing spiritual care concurrently with other aspects of care, such as the physical, psychological and social dimensions of care, as lack in one aspect may impact on the other aspects.

- **The inclusion of a written policy on spiritual care**

Healthcare organisations, such as hospitals, clinics and hospices should have a written policy on spiritual care. This could also occur at a national level for the inclusion of spiritual care in healthcare practice. The policy should contain statements about spiritual care, some clarification of the concepts and a check list for assessing and implementing of spiritual care competence. The goal is to include spiritual care in mainstream healthcare practice through the dissemination of these research findings in conferences, peer-reviewed

journals and further research involving the stakeholders, to ensure that research is relevant to and useful for the decision makers.

Stakeholder involvement also increases transparency in the research process, which is critical for maintaining the scientific integrity and credibility. Consequently, it is hoped that stakeholders who are involved in the process are more likely to actively use, disseminate and develop policies with the information that they helped produce.

7.4.2 Recommendations for nursing/midwifery education

One of the focal points of this study has been nursing/midwifery education. A number of recommendations in relation to this are suggested in the hope of enhancing the achievement spiritual care competence at point of registration and formally integrate spiritual care competencies and assessment of these competencies, as recommended by research.

- **Review of pre- and post-registration curricula**

Nursing/midwifery pre-and post-registration curricula should be examined to identify elements which are necessary to achieve spiritual care competence. This involves consultation with lecturers, key education stakeholders and students to explore the organisational culture of both education and practice, their perceptions of spiritual care and its location in the curriculum and practice.

This is then followed by an integration plan involving revision of curricula and teaching, learning and assessment strategies in order to address spiritual care competence at the point of registration followed up at post-registration to ensure that nurses/midwives keep their skills and knowledge up to date and maintain their attitude in addressing clients' spiritual needs.

- **Integration of the identified frameworks in nursing/midwifery curricula**

Integration of the frameworks of competencies in spiritual care within nursing/midwifery curricula is suggested and should incorporate a global user-

friendly approach to endorse addressing the spiritual needs of clients in the various contexts of nursing/midwifery. This would involve adapting the language, terms and statements used in this generic framework to suit the global audience within the nursing/midwifery professions.

- **Involvement of the multi-disciplinary team in spiritual care**

The contribution and involvement of hospital chaplains and spiritual leaders of other religious denominations or other healthcare professionals should be considered as important to spiritual care education. However, these need to be qualified for this complex role and be supported by Continuing Professional Development (CPD) programmes.

- **Spiritual care education for nursing/midwifery educators**

Further education for both faculty and clinical nursing/midwifery educators in the teaching and assessment of spiritual care competencies is essential to ensure consistency and conformity in this matter. More effort and determination is necessary to encourage nursing/midwifery educators to enhance the process of providing students with competencies in spiritual care. This should not just take place at point of registration but should also be followed up with CPD programmes in nursing/midwifery and by meeting the post-registration education and practice (PREP) standards set by their regulatory body, for example, the NMC.

- **More effort to minimise barriers hindering spiritual care**

Understanding the concepts of spirituality and spiritual care does not equate with transfer of these concepts into clinical practice. Attention needs to be given to minimise barriers to spiritual care in practice by constant collaboration between clinical mentors and faculty educators. Clinical mentorship is not only pivotal to students' clinical experiences and instrumental in preparing them for their role as confident and competent practitioners, but also improves bridging of theory practice divide. Hence, faculty educators, together with the clinicians should develop partnerships to support students to deliver and monitor learning in practice. Partnerships should also involve the provision for adequate preparation,

support and the implementation of national standards to clarify the roles and responsibilities of the mentor in the practice settings, in particular when confronted by complex spiritual care issues.

- **Utilisation of technology in spiritual care**

The development of new virtual and e-based pedagogical methods, including the use of social and digital media should be promoted as these educational strategies encourage active student participation and may provide opportunities for students to explore in-depth spiritual care which, for many is interpreted as religiosity**.**

7.4.3 Recommendations for clinical practice

The recommendations presented by the researcher also extend to clinical practice.

- **Ongoing assessment of clients' spiritual/religious needs**

Nurses/midwives should conduct ongoing spiritual assessment on clients using formal and informal assessment approaches to assess clients' spiritual/religious needs and implement spiritual/religious care interventions to enhance the quality of compassionate holistic care.

- **More recognition of the role of healthcare chaplaincy**

Healthcare chaplaincy should be more formally recognised as a professional discipline and established to promote a multi-disciplinary team approach to spiritual care operating as a multi-faith referral service to chaplains and members of the multidisciplinary team. This will enable addressing the religious needs of clients and help them to find meaning and purpose in their illness and life.

- **Promotion of emotional Intelligence to prevent 'burnout'**

Emotional labour is important in establishing therapeutic nurse/midwife-client relationships when providing spiritual care but carries the risk of 'burnout' if prolonged or intense. Consequently, nurses/midwives should be able to define and recognise compassion fatigue, stress and burnout, brought about by difficult clinical situations impinging on their emotions.

Emotional intelligence requires that emotions are recognised and surfaced. Hence, this concept needs to be incorporated into educational programmes to foster skills, in particular self-awareness, self-regulation and social skills that enable nurses/midwives to seek resources provided by the workplace that help them promote their personal well-being and professional development.

7.4.4 Recommendations for further research

The last recommendations focus on possible future studies and touch on areas which were beyond the parameters of this particular study.

- **Further longitudinal research**

This is recommended to test the competency framework by confirmatory factor analysis to enhance construct validity and confirm the factor structure identified through exploratory factor analysis.

- **Further collaborative exploratory research**

This is suggested to investigate the impact of this competency framework for nursing/midwifery education with other educational guidance, such as the NMC, QAA. This will explore whether this new competency framework which was presented in this study, effectively represents the characteristics of the overall spiritual care competencies or is unique to a specific cohort.

- **Further experimental research**

Such research would offer the opportunity to explore the educational methodology that would facilitate the development of competence at pre- and post-registration levels, as defined by this competency framework is being suggested. In particular, this should be conducted utilising student-centred creative teaching and learning methods and educational strategies, such as reflection and reflective practice, which may enhance the understanding of the complexity of spiritual care.

- **More cross-cultural projects**

As nations become increasingly diversified, nurses/midwives must be able to

translate and test this knowledge into education and practice in new cultural contexts through a process of piloting, evaluation and implementation of the framework locally and internationally. Cross-cultural projects through collaboration are proposed to broaden the perspective of the dimension of spiritual care of various cultures. This may enable the facilitation and strengthening of funding in this field to improve the quality, effectiveness, accessibility and cost effectiveness of health care.

- **Further trans-cultural research**

This is to explore how ethical and legal issues may be safeguarded in the delivery of spiritual care in different cultures and when dealing with diversity in religious beliefs. Additionally, further exploration of the impact of spiritual and religious beliefs and values of health carers in the provision of spiritual care is recommended.

7.5 Personal reflections on my PhD journey

My PhD journey extended from 2009 to 2014. I acknowledge that each person's experience is unique, my PhD has taught me more about reserach, critique, contributing to knowledge and consequently, to make a difference in education and clinical practice. Hence, it cannot be taken half-heartedly as this is such a large piece of work that can have a toll on health and relationships.

During the journey, I found that I needed to accommodate my work and family responsability to maintain my commitment and my sanity over the long period of study. I was overwhelmed at the intensive large-scale study. Many times, I doubted my commitment and ability to stay on the course of the journey. Consequently, I found myself using metaphors to conceptualise the task which I continued to use throughout the whole, and sometimes lonely PhD journey.

Metaphors helped me to reframe the PhD in a positive way. There are two metaphors that I used at different stages of the journey. The first was during the initiation and over the data analysis stage and the second metaphor I used during the writing stage of the dissertation.

I constructed these metaphors and wrote in my journal:

> *The paths that I take in my life can take me to many places.I may choose to take a broad road that has been well travelled, or I may take a road out of my territory that only some have dared to travel. Often, the hardest part of reaching the goals is not the work involved, but rather the choices and decisions I must make to reach those goals. A traveller in the forest may know the particular place she needs to reach at the other side of the forest; but which path should she take? The paths themselves may twist, may be scary when darkness falls.*
>
> *The traveller cannot see down the whole trail because the trees are in the way. I found that it is helpful when travelling down the path to have a guide along with me. Someone who may not know where each and every trail leads, but who knows the lay of the land and who might see a dead end before I do. Someone who can point out the nearly-hidden path that I would have missed.*

The forest in this methaphor is the intensive task to be undertaken. The trees and vegetation represent my well-being with progress in the PhD stages. The trees blocking the view in the path represent the obstacles and challenges that need to be undertaken along the journey. Darkness represents the periods of uncertainty experienced during the journey and the guide in the methaphor stands for the supervisory team who inspire hope, give support and strength to keep going.

The second mataphor is my experience of labour as a mother and midwife which accompanied me throughout writing my thesis and helped me to focus on the final product after sustained commitment and hard work. I recorded in my journal the following reflection.

> *I was pushing as far as I could, only to find out those weren't the real limits and I could set my goals further ahead. I discovered I had to believe, I could keep setting ahead of my previous threshold of what I felt, I could do and what I could handle. Believing in the leap of faith, it became real - I could push still harder.*
>
> *I just had to concentrate everything on that total effort and keep pushing. Sometimes, I had to override the temptation to interpret that powerful push as pain instead of force. Finally, a huge surge of adrenaline followed by a euphoric sigh of relief and satisfaction.*

The experience of birth refers to the thesis writing which stretched me intellectually as I learnt the process of critique and story building. Like birth, I had instances of self-doubt, anxiety, confusion and pain but had to maintain courage and a positive attitude.

I found out that over the twelve months of writing the thesis I had to persevere and keep going. I came to understand that my thesis had to develop at its own pace and could not be rushed. I also realised, now that the jouney is complete, that the future of my thesis is not determined by its birth, it needs to be nurtured to grow through unwaving commitment .

Returning to the initial aims of the study and on the basis of the author's work, the pre-registration midwifery curriculum within the University of Malta was reviewed to promote the development of competency in spiritual care. Nursing curricula had already been reviewed and as a result, study-units in spiritual care were already running (Attard *et al.* 2014).

During the course of my PhD study, a study unit focusing on competencies in spiritual care in midwifery, led and taught by the researcher was piloted in 2010/2011 with a cohort of fifteen midwifery students. The end of the study unit evaluation feedback from students was very positive which yielded its integration as a core study unit in the pre-registration midwifery programme.

This study unit in spiritual care (MID 3118) includes some lecture presentations supported mostly by discussion of case scenarios or students' stories and reflections divulged by the students through their own reflective journals.

Experience has shown that the framework of competencies in spiritual care is a useful teaching/learning resource. It has structured my teaching on spiritual care and offered guidelines of what should be taught in addressing this important dimension within holistic care. The framework has also provided students, nurses/midwives and educators with an opportunity to discuss various potentially

difficult healthcare issues. For example, academics have long written about the impact of press reporting on asylum issues and the effect of labelling on refugees and asylum seekers. The way negative labels are predominantly reported and entrenched have a detrimental consequence on the understanding of asylum issues, perceive asylum seekers and provide healthcare.

Beyond technical distinctions over terms and language, directed by the developed competency framework, students are made aware of a lack of personalisation of the human side of asylum seekers, refugees and immigrants. Students are asked to reflect and share stories of why people decide to leave their homes. It is only through reflection will students better understand the healthcare needs of these people.

This study unit has been important as it stimulated discussions in areas not frequently talked about. The developed framework of competencies in spiritual care may build confidence in nurses/midwives in providing quality spiritual care while satisfying the demands made by the nursing/midwifery accreditation bodies and healthcare policy to ameliorate holistic care.

7.6 Concluding thought

This journey, this adventure, this tale I wrote for myself, is not a means to an end; it is an expression of who I am. As I stand before a mirror, in looking at the choices and decisions I have made, and the reasons behind them, I see reflected the change I wish to see in preparing nursing/midwifery students and nurses/midwives properly for what awaits them in clinical practice.

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APPENDICES

THE DESIGN AND VALIDATION OF A FRAMEWORK OF COMPETENCIES IN SPIRITUAL CARE FOR NURSES AND MIDWIVES: A MODIFIED DELPHI STUDY

By
JOSEPHINE ATTARD

APPENDIX 1 THE DATA EXTRACTION SHEET

Name of Article: _____

Country: _____

First Author: _____

Other Authors: Yes____ No____

Year of Publication: _____

Research Design: _____

Clear research Question/s: Defined _____ Not Defined _____

Clear aims and objectives: Defined _____ Not Defined _____

VALIDITY:

Content:	One Type Low	(>0.5)	_____
Predictive:	One Type Modest	(0.5-0.75)	_____
Concurrent:	One Type High	(<0.75)	_____
Construct:	Two Types or more High		_____

RELIABILITY:

Internal Consistency	One Type Low	(>0.5)	_____
Stability/Equilance	One Type Modest	(0.5-0.75)	_____
	One Type High	(<0.75)	
	Two Types High		_____

RIGOUR:

Credibility: _____	One Type	(Low)	_____
Dependability: _____	Two Types	(Modest)	_____
Transferability: _____	Three Types	(High)	_____
Confirmability: _____	Four Types	(High)	_____

RECOMMENDATIONS: Practical: _____ Not Practical: _____

Peer-Reviewed: _____ National Peer-reviewed _____

International Peer-reviewed _____ Not Peer-reviewed _____

Publication:

Not published in scientific journal Published in scientific journal _____

TOTAL POINTS: _____

APPENDIX 2 LETTERS OF APPROVAL FROM THE UNIVERSITY OF MALTA

- Letter of approval from the Ethics Committee, University of Malta for Phase 1
- Letter of approval from the Ethics Committee, University of Malta for Phase 2
- Letter of approval from the Ethics Committee, University of Malta for Phase 3

APPENDIX 3 LETTERS OF APPROVAL - FORMER THE UNIVERSITY OF GLAMORGAN

- Letter of approval from the former University of Glamorgan for the study
- Email from the former University of Glamorgan approving the slight change in the research tool.

Note:

The former University of Glamorgan is now called the University of South Wales

APPENDIX 4 FOCUS GROUP DISCUSSIONS - PARTICIPANTS' INFORMATION SHEET

Title of the Study:
Framework of competencies in spiritual care for nurses and midwives:
A modified Delphi study

Dear Participant,
I am Josephine Attard lecturer in midwifery at the Faculty of Health and Sciences University of Malta and PhD student. I would like to invite you to participate in this postgraduate research project being conducted at the University of Glamorgan Wales U.K. and the University of Malta under the supervision of Dr. Donia Baldacchino as local supervisor and a team of supervisors at Glamorgan University. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation would involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

The goal of this study is to develop a list of competencies that will inform nurses and midwives with regards to what they need to know, be able to do and think, in order to provide high quality spiritual (holistic) care to clients at point of registration.

In order to develop this list your participation is essential. Participation would involve taking part in a discussion group (Focus Group). The group will consist of 8-10 individuals. After the presentation of a case scenario, you will be asked for your views regarding the educational preparedness of students in meeting the spiritual needs of the client in the case scenario. The discussions will take approximately 1 ½ hrs, be tape recorded in order to allow time for the researcher to develop the list of competencies. Confidentiality with regards to the discussions in progress will be emphasized to all members in the group.

The date for the focus group is ……at ……
Venue:…….

If you do decide to take part you will be asked to sign a consent form, but you are still free to withdraw at any time and without giving any reason. The information you submit may be published as a report. Please note that confidentiality will be maintained and it will not be possible to identify you from any publications. Once the study is completed, a copy of the final report of the study will be made available in the School library. For any further information, please contact: Josephine Attard at: josephine.attard@um.edu.mt or telephone number 2340 1825 or 79340682.

Thank you for your help.

Josephine Attard.

APPENDIX 5 PARTICIPANTS' CONSENT FORM USED IN PHASE 1 AND PHASE 2

Please complete this form after you have read the information sheet and /or listened to an explanation about the research project.

Title of the study: Framework of competencies in spiritual care for nurses and midwives: A Modified Delphi Study

Thank you for accepting to participate in this research study. If you have any questions arising from the information sheet or explanation already given to you, please ask the researcher before you decide to join in.

Participant's statement:
I (Full name) _____
agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study.

I understand that:
My participation is voluntary.
I consent to the processing of my personal information for the purposes of this research study and that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data protection Act 1998 and Privacy and Electronic Communications (EC Directive) Regulations (2003).
I have the right to withdraw at any time without consequence.
I will be asked to give opinions on issues related to the research and that these opinions will not result in any judgment of me. I will be kept informed of the results at the end of study.

Confidentiality of all data gathered will be maintained during the analysis of the research.

Signed _____ Date: _____

Investigator's statement:
I _____
confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research volunteer.

Signed _____Date: _____
(Investigator)

Signed _____Date: _____
(Research supervisor)

APPENDIX 6 FOCUS GROUP DISCUSSIONS: DEFINITIONS AND CASE SCENARIOS

Definition for spirituality:

'Spirituality is about hope and strength, trust, meaning and purpose, forgiveness, belief and faith in self, others, and for some this includes a belief in a deity/higher power, peoples' values, love and relationships, morality, creativity and self-expression (RCN 2011).

Definition for spiritual care:

For the purposes of this study, spiritual care refers to: 'that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires' (NHS Education for Scotland 2009, p6).

Case studies

Scenario 1

Eric Jenkins is a 34 year old male with a past medical history of depression. He has had some treatment for his depression and prescribed medicine which he is currently not taking. He presents to the Emergency Department with the complaint of wanting to jump off a cliff and kill himself.

''What am I living for? I went from being an 'A' student to a loser. There is nothing more for me'' he whispers softly between tears. He tells his nurse that he has been drinking gin. He stopped a by passer who brought him to hospital before he acted on impulse.

Eric is an only son and has been the sole caregiver of his elderly mother and father for about 10 years. He tells his nurse that taking care of his parents has been 'his life'. His father died about 4 years ago. He continued taking care of his mother after his father died but was devastated 6 months ago when his mother died. He is now saying 'I have no purpose to my life." He looks very sad and continues to gaze downward. When he looks at you his eyes clearly show that he is asking for help. Eric believes in God, reads the Bible regularly, thinks that if you ''live a good life according to the Bible then things will go well for you''. He belongs to a non-denominational Christian church, use to go to church regularly, not so much lately.

Questions:

What are the spiritual needs of Eric in this story?

What does the nurse need to know, be able to do, or think, in order to meet these needs?

Scenario 2

One afternoon when I had about seven weeks left of my pregnancy, I suddenly realised that my baby hadn't moved all day. I had a job at the time that kept me very busy and I hadn't been paying that much attention to my pregnancy except that I had an exceptionally active baby; she seemed to wiggle all the time. So when I didn't feel her move for a whole day, got a sort of sick, scared feeling in my stomach. I called my midwife and she told me to come over to hospital. When I reached hospital Claire the midwife explained that she knew of

cases when the mum did not feel movements and the baby was still alive. She quickly took me to the ultrasound department. Everyone encouraged me not to give up hope so I tried to think that way, but it felt really heavy. Michael my husband managed to it together somehow that day even though I cried and cried. I felt an anguish and pain I'd never felt before. I tried to keep up hope that the baby was alive. As soon as I got in the room I felt a clear aura of Truth. In the room there were 2 persons wearing white coats looking at the screen as the scan proceeded. Claire looked at the screen and then we looked at each other long and strong. We both knew my baby had died.

Questions:
What are the spiritual needs of this client and her husband?
What do carers need to know, be able to do, or think in order to meet these needs?

Scenario 3
The woman had conceived this, her much-wanted, eighth child, whilst visiting Mecca to pray for last chance at motherhood. This conception was a 'blessing from Allah'. During a routine ultrasound scan, it was revealed to this woman that her unborn child has congenital heart problems. The effect of this news upon this woman was devastating, 'her world fell apart' and she was feeling that the health service, its personnel and God had failed her.
When the child was born he was diagnosed with severe heart defect and was transferred to intensive care. The mother did not want to visit or learn of the child's problem: all she asked was whether a child with this condition had ever lived.

Questions:
What are the spiritual needs of this client?
What do nurses and midwives need to know, be able to do, or think, in order to meet this client's needs?

Scenario 4
Christina is a 54 year old married woman, mother of four children. The oldest daughter is 29 years old, married and has 1 child and the youngest daughter is 14 years. Christina has been diagnosed with brain tumour after experiencing severe headaches with vomiting.
Christina's main thoughts are; 'What have I done to deserve this'? and 'Why me"? Christina a devoted Catholic feels angry at God and as a result she finds it hard to pray and meditate, although she still attends mass regularly. She also feels incredibly helpless which is making her more and more frustrated.Apart from this Christina also feels a strange guilt regarding her illness which she attributes to her diet, her work and her life style. She feels depressed and isolated from her loved ones. She feels afraid of the pain she is likely to go through, of losing her hair due to chemotherapy and death which she claims to be at her doorstep.

Members of the church community have also come to visit her at her home. They have encouraged Christina to come to their meetings which include a talk, prayers and meditation. Family members encourage her to attend and promise to accompany her to these gatherings.
Questions:

What are the spiritual needs of Christina, her cares and family members?
What do nurses and other care givers need to know, be able to do, or think, in order to meet these needs?

Scenario 5

Jane is the mother of 10 year old John and 6 year old Mark. Jane is a qualified nurse. John her eldest son, has been diagnosed with acute Lymphoblastic Leukaemia and is currently receiving chemotherapy. Although Jane is a Roman Catholic, she perceived herself more as a spiritual person rather than a religious one. She attends church every Sunday and prays only when faced with a problem. She is also very well supported by her husband, family and friends. Like other parents, when Jane was faced with her child's devastating illness, many times asks herself 'why did this happen to me and why to my child'. Jane felt punished for her wrong doings, felt lost and unable to pray. Her life transformed into anger, frustration and irritability.

Questions:

What are the spiritual needs of Jane and her family?
What do health carers need to know, be able to do, or think, in order to meet these needs?

Source: McSherry (2007)

Scenario 6

Daniella's first birth experience had ended in a long two- hour second stage and a bad perineal tear, which she remembers two doctors taking two hours or more to suture. She recalls not being able to walk for three weeks, and could not resume sexual intercourse for a year and a half. She felt brutalised, with her sexual identity in tatters. Daniella felt so traumatised by the memory of that second stage that she considered opting for an elective caesarean section for this birth, but decided in the end to have a vaginal birth. The first stage went easily and quickly, and needed no analgesia; then the second stage began, she panicked and it all started to go horribly wrong:

The midwife told Daniella to 'go with her body', which left Daniella confused over whether or not she should push. Yet when she did get an urge to push and tried, the midwife told her not to, which undermined what little confidence she had. Midwives were coming in and out of the room, and Daniella felt that everything was slipping out of control. The midwife was taking charge, Daniella did not feel in control and, importantly, her body was obviously not being trusted. Daniella did not know what to do, whether to push or breathe, and then there was the continuing, excruciating pain. But then came her 'angel'. A second midwife came in after this had been going on for an hour and a half, 'took charge' and assisted Daniella to give birth vaginally by giving clear precise directions. Daniella recalls:

'This midwife came in and took charge, almost like military precision, and you just felt confident with her. She just looked at me and took my arm and she was an angel sent from heaven. I suddenly had a surge of energy. It brings tears to my eyes, because she really did.'

Questions:

What are the spiritual needs of this client in this story?
What does the midwife need to know, be able to do, or think, in order to meet those needs?

Source: Gaskin (2002)

APPENDIX 7: PRE-TEST QUESTIONNAIRE USED IN FOCUS GROUP PILOT STUDY

Dear participant,

I would like to ask you some questions regarding the focus group discussion you have just experienced. Your response will help me improve other focus group discussions which are underway.
Please tick the appropriate box for each question and include any comments.

1. Did you feel welcomed as a participant in the focus group discussion?

   Yes ☐ No ☐ Unsure ☐

Comments

2. Do you feel you were given enough information about the study?

   Yes ☐ No ☐ Unsure ☐

Comments

3. Where the ground rules during the discussions outlined in the beginning of the meeting?

   Yes ☐ No ☐ Unsure ☐

Comments

4. Where the instructions provided at the beginning of the meeting easily understandable?

   Yes ☐ No ☐ Unsure ☐

Comments

5. Do you think the focus group was well planned and well organised?

   Yes ☐ No ☐ Unsure ☐

Comments

6. Do you think that the choice of case scenarios was a relevant method to address the topic discussed?

Yes ☐ No ☐ Unsure ☐

Comments

7. Do you think that the group size and selection of participants was appropriate to generate discussion?

Yes ☐ No ☐ Unsure ☐

Comments

8. Do you think the duration of the focus group was sufficient to collect all the views of the participants?

Yes ☐ No ☐ Unsure ☐

Comments

9. Do you think the facilitator of the discussion demonstrated;

(Please tick ONE box)

- A pleasing disposition towards group participants.

  Yes ☐ No ☐ Unsure ☐

- Was a good listener and was responsive.

  Yes ☐ No ☐ Unsure ☐

- Allows for group interaction.

  Yes ☐ No ☐ Unsure ☐

- Let discussion flow with a minimum of intervention.

  Yes ☐ No ☐ Unsure ☐

- Is non-judgmental to ideas and non-authoritarian.

  Yes ☐ No ☐ Unsure ☐

10. Please give your overall comments on the focus group session and include any suggestions.

Thank you for your contribution

APPENDIX 8 ANALYSIS - FOCUS GROUP 1: NURSES AND MIDWIVES

Elements of spiritual care in nursing and midwifery:
Focus Group 1: Nurses and midwives - Sheet A
Theme: Nurses'/midwives' attitudes to spiritual care
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	Categories:	Competencies	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Spiritual herself, use of self, respect for diverse religions, beliefs and practices.	**Own spirituality**		
'*I think that on the midwife's side, there was the need for her personally. The midwife used herself just to be with the mother even if this practically meant doing and saying nothing.' (P1)*		Recognise importance of own spirituality and use of self in providing spiritual care.	47
'I mean we respect them as our own religion. When the Moslem's priest came to pray on them, I feel we can be involved with them and be present. (P3).		Show respect for clients' diverse religion, beliefs and practices.	49
Understanding, wise, caring, warm, knowledgeable, standing up for the client, responsible, respectful, trustful, resourceful, reflective, client focused, empowering, has a holistic and individualised view of care, cheerful, non-judgmental, creative, reassuring, supportive.	**Personal attributes**	Demonstrate attributes of wisdom, reassurance, warmth, joy, trust, respect, responsibility, support, understanding, and caring for clients.	96
'*I think that there was already a trustful relationship Between her and the midwife. She surely needed a lot of support when she came to face the truth and in her (the midwife), she found someone who would face it with her. She reassured her that she is going to journey with her whatever the situation. She had a lot of security. (P1).*		Demonstrate a reflective, holistic and individualised view of care.	92
'If we are taking care of the patient its no what the N.O. says, we need to be empowered and as I, the nurse taking care of the patient, I am talking to my patient, I am listening to him, I know what he's thinking' (P3).		**Stand up for the client, empowering clients to reach decisions in their own care.**	new
		Demonstrate non-judgmental behaviour towards clients' diversity.	38
'We have ward policies, Sometimes we have mother that cry out to you to allow their mother to visit them in labour. I allow her in. As she sees her mother she hugs her (emotional), she is so relieved, I allow it.' (P4).		Demonstrate creativity in purposeful activity such as keeping with clients' traditions, beliefs, work and routines.	88

I remember a case were a mother was holding her still born baby, she was really distressed. All of a sudden her husband started shouting and told her 'we have to end this, put it away, now we will do another one.' I said to myself, what is he saying? It wasn't a normal reaction. But perhaps he was so hurt' (P4). **Emotionally mature, feeling responsible, guilt feelings, emotionally moved, empathic, expressing feelings of fear, breaking bad news, tending to negative/strange reactions.** '*I think in these circumstances (a stillborn baby), you need a lot of emotional maturity. Sometimes when I do not hear the foetal heart I already have visions of the mother's distress. When I am confronted by a mother who tells me that she is not feeling the baby moving, I tell her to come with me immediately and together we check if the foetal heart is present hoping that all is well.' (P1).* '*I think you need to empathise. This means to feel the same thing that they would feel in the same situation. The midwife needs spiritual help because since the midwife got attached to the mother she would feel responsible that perhaps she should have done something to change the situation. Perhaps tell her to come before (to hospital), you will start having these question marks. Could I have done something else? (P2).*	**Personal emotions**	***Be emotionally mature by having the capacity to witness and endure distress while sustaining an attitude of hope.*** Demonstrate empathy, support and responsibility when dealing with complex life issues. ***Be able to give without feeling drained, request help and support to grieve appropriately***	new 33 new

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery:
Focus Group 1 Nurses and midwives - Sheet B
Theme: Client's and family spiritual/religious needs.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Trusting relationship, being with, presence, connection, silence, touch, reassuring, lost for words, tactful with words, active listening, journey with client, questioning, responding, intuition, story-telling, praying with clients.	**Commun-ication needs**	Understand the importance of verbal and non-verbal communication.	16, 17,18
		Able to develop trusting relationships with clients and family in order to journey the illness with them.	19, 20
Support, company, guilt, anger, isolated, finding meaning and purpose, body image, comfort, Coping with spiritual distress, access to spiritual practices/routines.	E**motional needs**	Able to listen actively, connect and maintain presence with the client.	16, 30
		Acknowledge the importance of clients narrating their sufferings and pray with the client if he/she requests	17, 66
Truth vs hope, withholding information to 'protect' patient vs right for information, decisions to withhold treatment, last wishes, questions surrounding resuscitation, acceptance of treatment, 'ethical' group to decide, decline spiritual care.	N**eed for information**	Able to recognise and respond appropriately to emotions of anger, isolation and conflict in clients and families.	23, 27
		Able to discern and address complex spiritual needs in situations of spiritual distress.	27
		Assist clients and families to make sense of and derive meaning from experiences, including illness.	73
		Demonstrate an awareness of spiritual resources and how these can be accessed.	45
		Respect clients' right for information in reaching decisions regarding their illness, care and treatment.	67, 85

.		***Offer support, comfort and realistic hope to clients and families***.	new
		Respect right to decline spiritual care.	63
		Able to recognise complex ethical issues and refer appropriately.	58

Elements of spiritual care in nursing and midwifery:
Focus Group 1: Nurses and midwives - Sheet C
Theme: Nurses'/midwives' spiritual needs
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Meaning of spirituality, knowledge of worlds' main religions, knowledge of religious/ spiritual movements.	**Knowledge**		
'It is important that professionals offer spiritual care because it is self-enriching, this means that you will be helping them a lot if they are finding comfort in spirituality, here when we are mentioning spirituality, we cannot not include religion. It is not all spirituality but it's a major part of it '(P7).		Demonstrate a broad understanding of spirituality integral to holistic care.	1
'Lately we got to know that spiritual care is part of holistic care, we didn't know it before' (P2).			
'Nurses are capable of addressing the physical needs but are not competent at addressing psychological and spiritual needs' (P9).		Able to recognise spiritual, religious, psychological and ethical issues.	5
'In the Malta we are having people of different religions. I came across a case where I asked the mother to baptize the baby (normal practice when baby is in critical condition). She replied that she does not belief in baptism. I kept thinking about her reply. I found out that she belonged to the evangelist church. I don't know anything of this religion. You need to respect the different needs '(P3)		Demonstrate knowledge and understanding of the main world faiths in particular around birth, illness and death.	7, 40
Access for support from colleagues, spiritual director and counsellor.	**Emotional support**		

'They [members of the multi-disciplinary team] have to be reachable because they are available .I have no idea how to reach a psychologist' (P7). *'If you are at peace its good because you will know how to cope. But we need help from the chaplain or psychologist, we need continuous, I mean therapy. I feel we cannot do it by ourselves' (P3).*	**Emotional support (cont.)**	Articulate their spiritual and religious needs and identify resources to address them. Recognise own limitations and access assistance from the appropriate members of the multi-disciplinary team.	34 53
'We need continuous supervision. Spirituality is not easy and some levels of spirituality you do not reach easily' (P3). *'Just as students today have mentors, perhaps we qualified staff, will have better access of a spiritual director, counsellor because we can speak with them' (P3).* **Experiential learning, multi-disciplinary participation in support groups and multi-disciplinary discussions, CPD in spiritual issues, how to access spiritual support, reflective practice, keeping of reflective diaries, inclusion of spirituality in training, spiritual development of students, quality vs quantity training of students, self-awareness sessions, clinical supervision, participating in voluntary work, access and use of internet by the younger generation, no access of internet on the wards**. *'When you are on the wards you will immediately find yourself in these situations whether you're a qualified staff or student. So you cannot wait to address spiritual needs through experience. We need to review our training, we need lessons on spirituality. If you are alone you have to face the situation, you are not going to be accompanied by someone with experience' (P2).* *'I think we need to have the students to be coached in a way that's not just academic, academic OK, that's important but the human element of it? They need to be more sensitive to people……I think spirituality needs to be integrated'.(P5)* *'We need something like a reflective dairy not so academic, in the sense we have to do an assignment with the references. But perhaps a reflective dairy can share more their personal experience because otherwise you're going the loose the spiritual touch. We also need to get them out and perhaps do voluntary work like the experience we had in Lourdes. (P4).* '	**Education**	***Assist in the provision and supervision of members in the team engaged in spiritual care.*** Identify personal education, training and development needs in spiritual care and identify resources to access them. ***Acknowledge reflective diaries as a source to reflect on spiritual care.***	New 104, 93 New

I am weary about all these new ways of learning (internet moodle). Sometimes the way you write we're not sure how one is expressing himself especially translating in Maltese and writing in English' (P5). *'I don't feel comfortable sharing knowledge through the internet as I need to have the eye contact, but I think for the younger generation it's an important source of information'.(P4).* *'I think at ward level I don't think the nurse is going to search literature on the internet' (P3).* *'We don't have access to internet on the wards' (Ps 4, 7 and 9).*		Identify the importance of information technology to enhance knowledge on spiritual care.	107, 109
'I think there is this sort of thing, lets refer to the bereavement midwife and she will come into the picture. First of all I think we need to be more exposed, have a bit of more training if she is dealing with these couples with loss. The only way we are sort of guided what to do, and what to say is by sitting in as well in the support groups. That is the only way. When trauma happens within the maternity ward, delivery suite the couple is there for a short time. The problem starts in the community in the everyday life. So for us I think to really know and be trained how to be able to face the future, you know scenarios and what not, it is that we need to listen what these couples have to say in these support groups. For us to sit in with them and see what they felt. (P5).		Participate in group discussion and experiential exercises to enhance spiritual awareness.	56, 97
'*They need continuous supervision. We, as mature adults have life experience, but these youngsters as new beginners in nursing, the way they look at spirituality is surely different'.(P3).* *'I have been working as a qualified nurse for 4 years. When I was a student you kind of don't care about spirituality. Now that I'm qualified you realize now its importance'(P8)*		***Assist in the spiritual development and growth of students.***	New

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery:
Focus Group 1: Nurses and midwives - Sheet D
Theme: Provision of spiritual care
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Holistic care, individualised care vs task allocation, continuity of care, privacy, identify spiritual/religious/psychological/ ethical needs, diagnose spiritual distress, referral to other members of multi - disciplinary team, providing care, enriching people, reflective practice, dignity of patients, helping get through difficult times, referral to spiritual/religious advisor, lack of time.	**Organisation of spiritual care**		
'*I like to leave the couple alone to give them privacy and time together to come to terms with the situation (P3).*		***Allow clients for a time, place and privacy if they so wish.***	new
'Not all clients want to be alone. The couple I had did not want to stay alone. They had the baby (stillborn), and when they came to have their second baby they wanted me as the midwife. I thought that they would want to avoid me, not to bring memories of their previous experience. But it wasn't like that (P6).			
'The problem is that till the news is broken you will find support but then because of the workload, midwives are busy support stops. From a personal experience I remember that ones back at home we were told to contact the bereavement midwife and found out that no support groups were going on. So now what do we do?' (P5).		Able to provide holistic care ensuring its continuity in the community.	9
'I think that it would be useful if at least at the end of the training students are given the opportunity to care for the patient and journey with him. They admit the patient, very often they provide him with basic care follow him closely, they would know what happened to him, what he left behind at home and what he would be returning to when he is discharged, he would get to know the patient's hopes, plan and provide him with care when he is discharged.'(P4).		***Ensure that clients feel valued, safe and secure; being treated with respect and dignity.***	new
'I think that the place of work is spiritual in itself. It's made up of human beings and every individual is spiritual, caring, helping and			

comforting people with respect and dignity, this is spirituality too'(P7).			
'Unfortunately because of the workload nurses and midwives are busy, we are missing the spiritual aspect of care. Perhaps if we give students something like a reflective dairy where they share more of their (clients') experience, their journey, what they have been through, listening to him. This will give them more of a realistic touch to a caring profession.' (P5).		***Allow clients to spend time with carers who seem sympathetic and unhurried.***	new
Giving hope, team spirit, calm, access to counsellors, chaplains, bible praying, acceptance, music, painting, scenery, praying, At peace with yourself, maintaining religious and non-religious practices, positive ward culture, close team.	**Spiritual environment**		
'*I suggest that there should be reflective groups in the hospital and in the wards where they would be able to discuss and be able to refer actual cases to different members of a multi-disciplinary team, like the chaplain, spiritual advisors, psychologist and bereavement midwife.' On the wards team spirit is also very important to work in harmony with all members of the multi-disciplinary team (P4).*		Refer appropriately and effectively to members of the multi-disciplinary.	78, 86
'*The patient has a monitor in front of him. I think that we can also help him if for example a message of hope and solidarity is screened on this monitor' (P1).*	**Spiritual environment**	Identify and develop resources that facilitate and create an environment for quiet reflection and purposeful activity such as creative art.	74,75,10
'A patient may find comfort in music or painting. We should encourage this and not complain and maybe the patient is told off because she is making a mess' (P7).			
'Patients in hospital seek a lot the radio. You see them early in the morning at half five listening to the radio station Radio Maria because it broadcasts religious/spiritual programs which patients find comforting' (P7).			
'We should also see that a bible or other holy book like the Koran is available to the patient because you don't find any on the ward' (P2).			

Note 1: Reference number to competencies elicited from literature review.

APPENDIX 9 ANALYSIS - FOCUS GROUP 2: CHAPLAINS AND SPIRITUAL LEADERS

Elements of spiritual care in nursing and midwifery.
Focus Group 2: Chaplains and spiritual leaders - Sheet A
Theme: Nurses'/midwives' role in spiritual/religious care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	Categories:	Competencies	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
To reaffirm or not to reaffirm client's beliefs, nurse's role, deals with persons, humanity, holistic care vs medical model, find right person to do it, part of the process, reluctance, multidisciplinary team, spiritual assessment, responding to spiritual needs of patients and relatives, access to spiritual care, referral, healing	**Awareness of clients' spiritual/ religious needs.**		
The nurse would need to know that this man (in the scenario) actually has a belief in God and who this God is, and to affirm that. (P10)		Appreciate that all individuals have a spiritual dimension and some have a religious element to their spirituality**.**	8, 11
I don't think it's the nurse's place to say that. But I think the nurse has to know where she can find that kind of support and the right person to be doing this with Eric It may well be in the first days of him being in hospital the nurse is in the best position to decide about the patient's spiritual/religious needs than anyone else. Because a nurse deals with the person rather than the symptom and is with the patient all the time' (P11).		Appreciate the role of chaplains and spiritual leaders in providing spiritual care.	21
'Because we [chaplains] feel the responsibility to be immediately on the spot. But the nurses seem reluctant to tell you whether the person has a religion- not in the resuscitation room, when he is already about 2or 3days in the ward.(P15)		Refer clients to the appropriate provider of spiritual/religious care.	54, 78, 86, 34
		Identify and plan care to meet the spiritual/ religious needs.	81, 83
'I find that, I have been seven years, giving psychological support and even in my area the nurses leave it to the last moment when doctors have given up with the patient and then it's like let's call the psychotherapist. It's like that….not everywhere. We can't generalize but yes I do find problems .It's after 7 years ITU are calling me alongside the chaplain. (P12)		Recognise the role and responsibility of nurses and midwives in the provision of spiritual care.	10
'[Eric's] spiritual needs are to have his humanity fully recognised in hospital and so to have holistic care including if necessary psychiatrist or a psychologist with him……The nurse should be prepared to maintain these		Refer to other providers of spiritual care appropriately and in a timely manner.	54

conversations with Eric through the normal nursing routines, whether or not the minister or chaplain is present'.(P11)			
'The assumption is, the holistic approach is so important- that a patient is coming in as a complete person – carrying a religion etc.'(P10)	**Providing humane holistic care.**	***Demonstrate care that fully recognises humanity.***	new
'Yes' [referring to nurse assessing the person for religious denomination], but when I suggested it one nurse told me-'but what about data protection'? (Very angry) 'Where is the confidentiality - am I tampering with some personal thing? Put it on the admission ticket, and there is a place for that. They (the nurses) always say first the patient, first the patient, like I'm not there to look after the patient too. We need to understand that religion is something important' (P15)		Integrate spiritual care to holistic care.	2, 3,15
		Monitor spiritual expression during normal nursing routines.	87
		Demonstrate complete care attentive to the spiritual/religious element.	15
'I wonder if in your dissertation [referring to the write up of thesis] you would include a section that in it you try to jot down questions, universal questions that would help the nurse discern a pastoral diagnosis. By these general questions, they'll help the nurse to assess the spiritual needs of the person involved irrespective of their religion. That way the nurse will tap into the spiritual resources of the place' (P14)	**Spiritual assessment of clients and their family.**	Value the importance of the spiritual/religious elements of individuals in their care and well-being.	80
		Demonstrate correct knowledge of ethical issues pertaining to spiritual/religious care.	68
		Demonstrate ability in assessing spiritual/religious needs.	81
		Demonstrate knowledge in formal and informal methods of spiritual assessment.	69
'…it is no longer the case that anybody can assume that a patient coming in has or has no religion. They [the patients] must be asked …….anyone coming in must be asked. And so the nurses are on the front line of this process' (P17)		***Elicit a spiritual history on admission to hospital to discern spiritual needs***.	new
'……so even to say, can I call your pastor, your friend, or who do you know in the church?… [reaffirms again] – I am not abandoned. I think nurses should look at these issues and I think that the nurse is able to bring these fundamentals to staff……. they [nurses] need to be aware of opportunities within the hospital for appropriate meditation or worship and encourage (Eric) to take part in that, even to only just sit in the hospital chapel for a while, perhaps with someone sitting beside him. Just to know that they(nurses) are part of the process'.(P11)	**Implementing spiritual care to clients and family**	Appreciate the role and responsibility of other members of the care team in the provision of spiritual/religious care.	78
		Collaborate with members of the health care team in providing spiritual/religious care.	3

'The patient should be encouraged to tap into his spiritual resource. So if he was a Christian, introduce him to his sacred book'(P13)		***Encourage colleagues and members of the team to provide compassionate care.***	new
		Provide for facilities within the hospital to access spiritual care such as a place for worship or meditation.	75
		Demonstrate support and presence in being with the client	16
'… because there is a difference between religious and being spiritual and I know for a fact that the spiritual climate in Wales in Glamorgan is entirely different to what it is here in Malta….When I came to Malta my understanding of spirituality had to change somewhat because although within Anglican tradition there is still anointing of the sick and last rights it is never used in the Anglican church or hardly ever…..here its entirely different because when I came here first I couldn't understand how many times I was asked to give the last rights because the person I was administering to wasn't an Anglican they were Roman Catholic married to an Anglican and only knew one way of doing things'(P17)	**Responding to cultural diversity issues**	Comply with the client's spiritual/ religious beliefs and provide resources that suit his beliefs.	66
		Identify distinctions between spirituality and religiosity.	70
		Acknowledge geographical differences in the practice of spiritual/religious practices.	new
		Demonstrate sensitivity and respect for diversity in care choices and health beliefs.	5
'We know we have a lot of African migrants….I have been called many times and the baby is breech and she says 'I'm not going to have a caesarean because my grandma had a baby at home and I don't want to go under the knife because the Maltese want to operate me and then close my womb not to have children….I'd rather die than do this. Because it was a deep conviction that you don't need a doctor's knife to give birth. It was a curse. She wouldn't let them touch her, in fact she spit at the policeman. All I had to do is call the Imam. He came and he spoke to her for a few minutes and she had the baby(by CS) (P10)		Acknowledge and respect the influence of cultural beliefs and practices in decision making about their care.	51
		Assess barriers to effective communication such as language, culture and religion and make appropriate adaptations.	27
'About the multi-disciplinary team….I think there is a multi-disciplinary team but without the chaplain' (P16)	**Providing a multi-disciplinary approach to care**		
'Considering what the nurse needs to know, I think first of all the nurse has to know that there exists a multi-disciplinary team made up of chaplains, psychologists, social worker etc.' (P14)		Recognise the role of chaplains, psychologists, social workers and other members of the multidisciplinary team in the provision of spiritual /religious care.	10, 78

'Nurses need to feel that they can call on ministers and chaplains as fellow professionals and have a sensible conversation about how to exercise this care in the best interest of the patient'(P11)		Identify the need to call on ministers, chaplains and spiritual leaders.	86
'….attend, be close at the viewing of the body. I think that makes a lot of sense, when the nurse stands by relatives. I saw it happening here, just offering support that would heal the sense of loss.'(P14)	**The nurse as healer**	***Discuss with members of the multidisciplinary team how to exercise spiritual/religious care in the best interest of the client.***	new
'….I think to find a way to explain to him (patient) that sickness is a result of being human, the fall of man, disease and selfishness. But again that God is a healer. I would emphasise that with stories in the bible' (P10)		***Exercise support and therapeutic presence with relatives who are experiencing loss.***	new
The nurse needs to know that they [nurses] can call on Christian chaplaincy or spiritual assistance for cases like Eric's and how to do it' (P11)	**Referral to chaplaincy, spiritual leaders and available resources.**	***Provide courage and hope in scriptures relevant to the client's spiritual/ religious beliefs.***	new
'Sometimes when I meet a foreigner-Roman Catholic, Protestant, Muslim, whoever, I ask him personally whether he'd like to see his pastor. And we have the addresses of all pastors with the phone numbers and we (chaplains) call them ourselves. But the nurse tells you with reluctance. It makes me sick.' (P15)		Identify resources and support systems available to assist clients with spiritual/religious assistance.	45
		Respect the role of clergy and spiritual leaders in providing spiritual care.	21
'We need to know or the patient needs to know who he can contact. On each card there are 2 signatures and 2 phone numbers (referring to Jehovah witness) and addresses where people can be contacted and we found it very helpful because in an emergency that may be the only way they can get to the hospital liaison committee or one of the elders to go straight to them.'(P19)		Recognise the role and responsibility of the nurse to assist clients to request spiritual/religious attention.	77
'I'm [spiritual leader], very happy to have them (patients) being comforted by a member of the chaplaincy here (hospital, of different religious denomination), as long as the patient is happy with that. I have no problem with one of the chaplaincy teams sitting with them and reading the bible or whatever……As Jeff [name has been changed for confidentiality reasons] was saying there's one of him and one of me. If I'm out or off the island and people call me they'll get a message with someone else's name and number. Quite often that's where it stops. People in the rush of things think didn't get him – too bad. That number and name are for a reason. It may well be an elder or minister and he will come. It's important that they persist and use the number and name –you will get a response' (P11)		Avail of resources to make the necessary contacts and arrangements in providing spiritual/religious care.	54

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 2: Chaplains and spiritual leaders - Sheet B
Theme: Nurses' and idwives attributes in providing spiritual care
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Spiritual calling, generations difference regarding spirituality, conflict with own spirituality, grieving process, religious development, difference between spirituality and religiosity, spiritual/religious resources, being with the patient, religious development, database access, listening, compassion, respect, companionship, empathize, guilt, prayer, bible reading, choices in care, respect, maintaining personal barriers, making time for spiritual care.	**Professional Issues**		
"I would also suggest that nurses should be trained to see their profession as a way of spiritual care as well. So how a nurse is changed through her profession. The calling because it makes a whole difference. As Fr……..was saying, there is a huge difference between a nurse who is spiritually oriented to God and one who does his or her work simply for stipend' (P14)		***Recognise nursing and midwifery as a way of spiritual calling.***	new
"The problem does arise though when things are hectic in hospitals and I've seen things hectic and things have to be done. Then frustration sets in when the nurse tries to do what she needs to do and your mother in saying NO NO NO for different reasons and poor nurse doesn't understand. I think one of the things they have to do is to have this understanding where there are an awful lot of ways of looking at things and the way people are. That's the crux of it."(P17)		***Appreciate the uniqueness of each person.***	new
'It seems that the older generation of nurses have a different view than the younger generation who are more open minded. An older nurse sticks to her own beliefs and may decide to impose and restrict the patient, which I think is unfair because if you believe in something maybe it will help you get better faster than medicine" (P19).			
"They should be open to work with such a Christian person, whether or not it conflicts with the nurse's own belief or faith or lack of it. Because this is about Eric [patient in the scenario], not the nurse" (P11).	**Nurse's/ midwife's own spirituality and beliefs**	Recognise that their own beliefs may impact in the care of the client.	46,47

"When a person goes through such a change they have to go through a process a lot of emotions and could come to acceptance. Something which is interesting, when a person goes through this process- denial, anger, bargaining. They start asking a lot of existential questions….I think that she (the patient) needs help in the grieving process……I think that first of all the nurse needs to know and understand the process that she [(the patient] is going through…….. I think they should know the suffering involved. As well as that I think they should know the stages of religious development because not all people are at the same level (P12). *"Because there is a difference between religious and being spiritual……..To be able to know to push your or our direction. To help without actually doing the work yourself .To knowing where the agencies are which she (The nurse) can pass them along to."(P17)* *".....The second purpose of the Hospital Liaison Committee is education….It's a question of speaking to them (nurses and midwives) what resources we have and help. We have to help them deal with patients who refuse blood. That's something that the nurse and the midwife need to know"(P18)* *"And even, nurses are trained to do most of the time- give an injection etc…that is the difference. I had to learn between becoming a nurse and a psychotherapist from doing things for the patient to being there for the patient"(P12)* *"....I think they should know the stages of religious development because not all people are at the same level….I think nurses should know a little bit. It doesn't take much, in two hours you can teach them the aspect and development of religion. On the other hand real life experiences will also bring about this development"(P12)* *'.....the third function [of nurses and midwives]) is as a resource. So the world's offices hold a database of thousands of different medical articles about how we can be helped in this case [blood alternatives] and even access to other medical specialists that are willing to help the consultancy in this case" (P18).*	**Knowledge and education in spiritual/ religious care and access to it.**	Demonstrate the ability not to impose own beliefs in the client's care. Respect clients' beliefs and decisions in their care. ***Demonstrate knowledge and understanding of the process of grieving.*** ***Demonstrate knowledge in the stages of religious development*** Demonstrate knowledge in responding to existential questions the client might pose. Identify distinctions between spiritual and religious needs. Identify agencies that can provide spiritual/religious assistance. Demonstrate knowledge of different beliefs and practices ***Demonstrate ability in being there for the client.*** ***Understand the stages of religious development of individuals.*** Use information technology to inform carers about alternative therapies in providing care.	52 62,49,51,57 new new 73 5, 70 45 7, 40, 41 New New 14,107,83, 79
'she [the nurse] needs to listen to the family including the husband a lot. Because the husband is going through a similar process, he is losing his real wife because this person who has dementia is not the same person he	**Communic-ation and interpersonal skills**		

knew…….We [carers] need to give time to this client. We need to listen, empathize and be patient. (P12).		Collaborate with other health care professionals in the provision of care.	78
'The first thing I would have felt a great sense of guilt [putting himself in the scenario]. That is the first need –so I need someone to be beside me to let me vent my feelings … secondly, after listening and offering companionship, compassion and empathy. I would have liked the chaplain to invite me in prayer, or read a biblical text or hear my confession so that I can ease the pain or sense of guilt …I would have liked the chaplain to do is, for instance the sense of touch, done in a very discerning way, that also means that God is beside me' (P14).		Listen to clients and their family, empathise and demonstrate presence	16, 30
		Recognise the role of the chaplain in the provision of spiritual care.	21
		Recognise the role of prayer, bible reading, touch and other interventions as a means of support.	43
We believe that blood is sacred and God's commandment is to abstain from blood. So in this case someone trying to force a transfusion onto this woman is like someone trying to rape her. That's the equivalent in her mind at that stage' (P18)	**Respect spiritual/ religious beliefs and choices in care.**	Understands therapeutic nurse/patient relationship.	19, 20, 18
'… those areas where it comes to minor blood derivatives and antilogous procedures, it's a case of patient's choice. So the patient has to choose for themselves what to do. It's good in this case that the nurses' or midwives know what the choices that the patient has are. Would she (the patient) be ready to accept a cell saver, or cryo-precipitates?' (P18)		Demonstrate sensitivity and respect for the client's diverse health care choices influenced by religious/spiritual beliefs and practices.	57, 62, 85
		Plans and provides care to meet the client's needs and beliefs	83, 84
		Recognise complex ethical and legal issues and deal with them appropriately.	68
'Another thing that the nurses could know is that Jehovah Witness carry a blood card with them and on this blood card there are these choices written down so they can see what particular choices the patient has made'(P18)		Demonstrate sensitivity and respect to client's decisions in their care free from manipulation and coercion.	65, 67
…..I think you need to know if the husband is a Jehovah Witness or not. He may be another denomination……You know you can have a Muslim married to a Catholic, a Catholic to a Pentecostal. So background of patient and family needs to be known and respected too' (P19)		Seek resources that will inform nurses and midwives regarding health care options in line with the client's religious/spiritual beliefs and practices.	83, 84, 85
		Demonstrate knowledge of spiritual/ religious beliefs and practices in issues pertaining specifically to the client's health problem.	new
		Seek available information regarding the clients' health beliefs and practices that may influence their care.	new

'……I think that it is applicable to the nurses because without getting involved in emotional situations with patients- they have to have that barrier where you look at it and understand but you don't cross it and get involved emotionally in it and I've been there as well the same as probably all of us have where we crossed that barrier. I think that young nurses have to understand they can't go over that barrier and get involved in that emotional situation as such' (P17) *'I think one of the biggest things they (nurses) have to do is have this understanding where there are an awful lot of ways of looking at things and the way people are. That's the crux of it' (P17)*	**Maintaining boundaries**	***Acknowledge and respect diversity in religious/ spiritual beliefs and practices of close family members.***	new
		Demonstrate an ability to maintain appropriate professional boundaries	59
		Appreciate that all individuals are unique and have their own dimensions at going about with their lives.	new

APPENDIX 10 ANALYSIS - FOCUS GROUP 3: EDUCATORS OF NURSING/MIDWIFERY

Elements of spiritual care in nursing and midwifery.
Focus Group 3: Educators of nursing/midwifery - Sheet A
Theme: Education in spiritual care for nurses/midwives
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Knowledge of illnesses, psychological aspects, empowering, response to illness, normal and abnormal reactions, individuality, different religions, importance of religion, coping, grieving process.	**Knowledge in spiritual care**		
' … The question of knowledge. Basic knowledge will tell us that anorexia [condition in the scenario] has to be linked to psychological aspect also. It can be linked to psychological pressures. So by giving students the knowledge that these aspects are present, you empower them'.(P20)		***Realise the importance of knowing the client's medical condition when dealing with spiritual needs***.	new
'…..knowledge about the illness so they can help her [the patient in scenario] with this. But also for them [the students] a knowledge of the varied responses that people can give. Every individual has a reaction to life threatening diseases. Also for them to realise whether this is a normal or abnormal form of response and for them to be able to refer should they see this response as abnormal' (P23).		***Respect individuals' different responses to life threatening conditions.***	new
		Recognise need to refer to other members of the multi-disciplinary team.	24, 34, 54.
'With regards to the nurses they need to learn about the importance of religion to various people not just to patients. The importance of religion and the kind of religion they are participating in. Again, they need to know backgrounds of various types of religions so they get an idea of what is actually going on … Some psychological aspect is needed where we [lecturers] can focus on stages these patients pass through and their relatives. Sometimes even we as nurses pass through them when handling cases. We should teach them how to handle these situations' (P24).		Recognise that for some individuals spirituality will have a religious element.	11
		Demonstrate knowledge of the world's major faiths and religions.	7, 40
'The grieving process would apply here (in the scenario, and part of the knowledge students need to be acquainted with (P28).		***Demonstrate knowledge in the process of how individuals grief.***	new
'….I am going to emphasise all helping skills.			

And they need to know who to refer the cases to if need be….We need to know the support systems that exist' (P25).		Demonstrate knowledge in helping skills.	6
		Be aware of the available support systems and agencies.	45
		Value the importance of integrating a psycho-social approach to care.	1, 2, 3, 15, 80
'I think something like spirituality should be taught across the curriculum, in the sense that it's not spirituality. Of course you start, but it needs to be taught. So if I'm doing palliative care, the spiritual aspect should come in. If you're doing cardiac care it should come in. Because of the abstractness of the concept- Ok I say it but what do I mean by it? How do you teach it? What do I teach? When I'm talking about the psycho-social approach in a way I'm teaching it. But what is that extra? Where, what is it? (P23)		***Value experience as an important element in dealing with clients' existential questions.***	new
'How do you facilitate it? That's the problem - to get it out because it's within us. How to get it out of the individual' (P26).			
'Experience places a big difference in these sort of situations. So it's not only the teaching but the experience. New recruits- How do you do it if they do not have the life experience' (P23).			
'You just can't pin it down because you're dealing with the existential' (P26).			

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 3: Educators of nursing/midwifery - Sheet B
Theme: Education in spiritual care for nurses/midwives
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Awareness of own values, own beliefs, knowing oneself, non-judgmental, not impose own beliefs, being sensitive, own perceptions, own experiences, reflect, reflective activities, inner search.	**Self-awareness**		
'….Again I think one of the important things when it comes to teaching this subject is first of all to make sure the students are aware of themselves, their values and beliefs. What do they understand by death, what is death for them? This is crucial because knowing oneself will help them to communicate and listen. But first they have to know themselves'(P31)		Demonstrate personal awareness of one's own values and beliefs.	52
'*…Studies have found that nurses dealing with existential questions can be one of the most difficult things when they are dealing with people with a life threatening illness. They need to have an awareness of their own beliefs and being non-judgmental. They need to realize that their beliefs may lead to bias in how they answer these questions. They need to rise above their own beliefs because unless they do that this will infringe on the care' (P23)*		Demonstrate ability in dealing with existential questions. Demonstrate non-judgmental attitudes to diverse spiritual beliefs. Recognise that their own spirituality may affect how they interact with clients.	73 49,50 46
'I think its sensitising into being sensitive –that awareness' (P26)		Demonstrate sensitivity to clients.	16,18
'And your ability to know what is needed and to assess the situation. You cannot, even if you learn that you need these skills. You can't apply them so stringently to each situation' (P20) *You just can't pin it down because you're dealing with the existential' (P26).*		Demonstrate ability in assessing clients' individual spiritual needs.	69,70,84
'….I think again, very important for the student, for them to become aware of their own perceptions of things. They might have a previous experience, or someone close to them. They need to be helped to reflect on their experiences and helped to move on. But yet again not to go through other experiences with the idea that each one is similar. It's good to have the experience but that should help them identify that each one is different' (P28).		Appreciate the value of own experiences without imposing such experiences on others.	56

'It was a resuscitation that they had on one of the wards ……it was a whole question of resuscitation, euthanasia, and she (the student), was very upset because it was the first time she had seen such things. I mean between us we have thousands of experiences, but for someone, it still upsets me, let alone someone who's new. So I agree, I think these reflective activities help spiritual care, in being in touch with yourself, which is really difficult. And that does not mean writing a reflective account. That means going through self-inner search' (P26).		Appreciate the importance of seeking reflective activities in meeting one's inner feelings in order to move on.	92

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 3: Educators of nursing/midwifery - Sheet C
Theme: Education in spiritual care for nurses/midwives
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	Categories:	Competencies	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Active listening, feelings, thoughts, attention, understanding, support, encouragement, trust, communication skills, narratives, person's life history, fears, empathy, trusting relationship, good questioning techniques, boundaries, reflecting, verbal and non-verbal, touch, language	**Communi-cation and interpersonal skills**		
'I think the first thing would be just to listen to Eric (client in the scenario)and what he's feeling, growing through and what his thoughts are' (P20)		Understand the importance of active listening to the clients' narratives.	16, 30
'Basically here the spiritual need of listening to her (client in the scenario) and problem deeper than that. Patients are aware that our ears are open but we're jumping about doing 100 things and they are there needing our attention. The need for understanding, support, encouragement. As soon as she found that nurse willing to listen, things began coming out. As soon as the episode was closed she asked her (the nurse) not to tell anyone. Someone you can trust. I think Pamela and her partner [couple in scenario], had another need. The need to be able to communicate those inner repressed thoughts that are haunting her. They are at the back of her mind and she (the nurse) needs to help them surface and come out. The key points in us professionals is sometimes we don't realise that what we see in reality and what our perceptions are, are not those of our patients and sometimes our student nurses do not realise that……students need to realize the need to listen to patients' narratives……It will help the communication process between us both'(P21).		Recognise the need to understand, support, trust and encourage clients. Demonstrate effective therapeutic nurse/midwife-client relationship.	17 19, 20
'Sometimes we don't do that enough—giving importance to a person's life history. He [client in scenario] is recalling his past experiences. Sometimes as a nurse and student we don't think that people have a history , a memory, and an identity……I think nurses should know and be able to appreciate and understand and be more aware about the person's life history" (P31)		***Demonstrate interest and ability to reflect on the client's life story and experiences.***	new

'…….I think carers need to get a clear idea of Jane's [client in scenario], feelings and fears and they can only do this through active listening and empathy to help her to open up. They need to build a trusting relationship because by listening you can help people and build boundaries in the relationship, and they need good communication skills……they need good questioning techniques' (P22)		Adapt barriers to effective communication (such as fear) by demonstrating active listening and empathy. Demonstrate ability in building trustful relationships with clients and their family.	27 29,39.
'…….communication skills are key but communication is a word that we play around with and sometimes I don't think we understand what it really is because it goes at many levels'.(P26)		Demonstrate good communication skills such as good questioning techniques to elicit clients' life story. .	31, 32,
'It's hard not to say it because I think we've all said it. Somehow somewhere in our career if you reflect back and the minute it comes out you realise, it was the wrong word, the wrong pause, the wrong tone of voice, maybe even the wrong touch'(P26).		Understand the importance of reflection on own practice in relation to meeting spiritual needs	92
'Language is very important. It's not just a question of going with your body (in scenario). What does that mean? It's very important for a student to understand that what we read in the literature is not something we're going to apply in practice. We need to look into the mother's [client in scenario] need' (P27).		Communicate with clients in language and terms they can understand ***Appreciate that theory should inform practice in relation to meeting the individual needs of the client.***	25 new

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 3: Educators of nursing/midwifery - Sheet D
Theme: Education in spiritual care for nurses/midwives
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Confidentiality, non-judgmental, right to decide, duty to save lives, court order, going against client's wishes, dignity, resuscitation, refusing treatment,	**Ethical and legal issues**		
'……I want to emphasise confidentiality. They need to know where we stand with regards to confidentiality. Some things that patients tell us we share them with others and the patient has to know that we are going to share this information …..' (P25).		Acknowledge and respect confidentiality issues in addressing clients' spiritual health care needs.	62
'…. As nurses we need to know where we stand regarding confidentiality issues. Some things that patients tell us we share with others and the patient has to know that we are going to share this information. That's why we need to know about confidentiality' (P26).		Acknowledge and respect clients' confidentiality when disclosing personal information to members of the healthcare team.	64
'And being safe practitioners as well. In certain scenarios it's all about not being judgmental at all- not saying the wrong word' (P25).			
'…. With regards with the care giver, Jane [client in the scenario] might have days where she feels down and depressed and the carers should not have a judgmental attitude and always be there for support and encouragement' (P29).		Demonstrate non-judgmental attitudes towards clients' needs.	49, 50
'....The patient has a right to decide and if he dies he dies. I had the opportunity to think about situations like this. But yes we tend to focus on ethical issues more than what we think. What influences the patient is more important than what influences the nurse. Over here [in the scenario] it was what is important to the nurse … But not only religion. I had a similar case with blood [refusing blood transfusion] when a relative of a woman of someone after having blood had an anaphylactic shock and died. So in this case it was not because of his religious beliefs but because someone had died. It's not just the religious beliefs' (P30).			

'We used to talk to the parents [parents who refuse to transfuse blood to their newborn] a lot. Our chief [Paediatrician] used to give them blood just the same and then go to court for it. Because he used to say our aim is to save lives so he used to go against the wishes of the parents … yes in the case of a child, a court order is issued' (P25).		Respect diversity in clients' decisions in their care based on religion, values and beliefs.	51, 67
'…..there was a case last year, the parents did not want to give Vitamin K to the baby [this is the protocol and therefore compulsory to all newborn babies], and it was given under court order' (P20).		Demonstrate sensitivity and responsiveness to clients' spiritual and health needs free from manipulation and coercion.	65
' As far as adults go, even though we're saying we should be able to take our own decisions, as the law stands it's not that clear at the moment….They can do that [refuse treatment], but let's say that I'm sick and I do not want to be resuscitated- that does not have legal bearing at the moment' (P23)		Identify intersections of legal, ethical, religious /spiritual concerns and beliefs and seek advice.	58
'That's why you have all these inverted commas resuscitations that are done so that something is done. At the end the patient's dignity is not taken into consideration' (P26).		***Ensure clients' dignity in addressing clients' holistic health care needs.***	new

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 3: Educators of nursing/midwifery - Sheet E
Theme: Education in spiritual care for nurses/midwives
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Reflect on past experiences, environment, values, morals, mature, character, information, discussions with colleagues, support for care provider and students, multi-disciplinary team, continuing education, role models, reflective practice, implement projects, curriculum, experiential learning, psycho-social approach, existential, small groups	**Quality assurance**		
'But mostly I would try, maybe even through my example and non-verbals try to make the student more mature and build his character and values and moral understanding of life' (P31).		Demonstrate personal growth, high moral values and lives directed to spiritual principles.	96
'*It's hard not to say it because I think we've all said it. Somehow, somewhere, in our career if you reflect back and the minute it comes out you realise it was the wrong word, the wrong pause , the wrong tone, maybe even the wrong touch' (P26).*		Understand the importance of reflection on own practice and make changes as required.	92
'….There is no control of the environment. The mother [in the scenario], felt like a showcase – people walking in and out of the room. It was a very intimate moment for the mother …'(P27)		***Respect clients' right for integrity, dignity and privacy.***	new
'…….And the mother is now faced with the (dead) baby…..And she needs someone to explain to her how this could all come about….' (P28).		Demonstrate sensitivity with clients'.	65
		Understand the importance of providing explanations to clients' stressful situations.	33
'…..obviously it is important that information is given to this lady .However, one has to take into consideration that she may already be knowledgeable because she is a nurse. We shouldn't take anything for granted. Even though she may be qualified to know about the situation. If the situation is happening to us, we might become blocked and therefore the way we communicate, we have to be more sensitive to the particular needs of the person' (P29)		***Provide information to clients consistently.***	new
'For the midwife as well I think she needs support. We do all need support amongst us between colleagues and I think in such cases it is important to be able to meet up as professionals to discuss sensitive issues such as		***Value the importance of seeking spiritual support from colleagues and members of the multi-disciplinary team.***	new

this and be able to move on. This would help not just psychologically the midwife who has gone through such an experience but to help identify potentially better practices to help parents in such cases experience these situations in a better way. This not something that is a happy ending but we could help the parents go through it better, not just moving on as if this is just another mother who's baby didn't make it' (P28).			
'We tend to focus on spiritual care as caring for the patient. It's not the patient; these nurse need the spiritual care. We tend to focus on the patient. We are in an environment of immediacy. We do something because we know it has to be done. But after a situation like this, these will come up weeks after. You had a patient who died 2 weeks before, but in the meantime you had 4 patients who died but you still feel the sense of this patient. Because we fail to take into consideration the spiritual care of the care provider' (P30).		Diagnose spiritual distress in clients and their care givers.	81
'…….It's important how you teach this spiritual aspect. You need a smaller group. You come across situations where the students themselves have passed through spiritual distress which stresses the student and the rest of the class and will be quite difficult to deal with. I know because I passed through these in a different scenario. We have to be careful because students can be hurt themselves' (P29).			
'What I think about spiritual care now, through my own research is one of the physios who was very influential in the unit was very reflexive. So it is true, the care she delivered and also she influenced the others who were giving that care. So in that little space there was a holistic physiotherapist I'm talking about. But because of that one person, since she was in a senior position she tried to make them aware of that, so that is really important' (P26).		***Identify role models who promote holistic reflective care.***	new
'When we're asking, we sort of come to a point, how do we apply spiritual care in our therapies? And to myself I was saying, where I teach- public health, it shouldn't apply to me. But then I started to realize there were common issues threading along case studies(in focus group), we were constantly suggesting that spiritual care is looking at his beliefs and concerns as opposed to what my beliefs and concerns are and to what extent even in public health. When we come to decide about services and prioritisation of where we spend resources. We look at what communities believe in.' (P22)		***Apply spiritual care principles in primary health care settings.***	new

Elements of spiritual care in nursing and midwifery.
Focus Group 3: Educators of nursing/midwifery - Sheet F
Theme: Education in spiritual care for nurses/midwives
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Exploring purpose in life, identity, hope, conflict, beliefs and religion influence decisions, involving family members, unique person, pain, support, being alone, client's needs, midwife's needs, understood, humane approach, dealing with shattered hopes, expectations, inner feelings, reassuring, truth, understand actual characteristics, constructs.	**Assessing and implementing spiritual care**		
'….So first of all I think he [client in scenario] needs to explore his purpose in his life and explore his self-identity. Who is he? Is he the person who was his mum's and dad's care giver? I don't think he is just that .There must be other aspects which he needs to explore and hopefully from then he can start planning what to do with the rest of his life…..I mean the last sentence says he beliefs in God and reads the bible regularly and that might help him in the long run, but it may create conflict because he beliefs that if you live a good life according to the bible then you feel better, but it may make you feel worse ……. As a student nurse I might help to guide him explore other alternatives…..a ray of hope' (P20).		Assist clients and their family in identifying their spiritual needs.	69, 70, 71
		Assist clients and their family to identify alternatives to instil hope.	new
'……And the partner. Sometimes we forget the patient's partner and we look at the patient as though they are functioning in a vacuum where as they are not. They function together' (P21).			
'…..here we're talking about religion. For some people it helps and some don't mention it because they don't see it as something that could help. It's a double edged sword it can either help or hinder in cases of spirituality….' (P26).		Recognise that for some individuals religion is an important element in their care.	72
'Basically we need to understand that people have different beliefs, which eventually will influence their decision and people will look at the same situation we are looking at from a different perspective. We tend to look at it from a clinical perspective, other people might have different ones- in this case a religious issue'(P30)		***Recognise that for some individuals religion is not an important element in their care.***	new

'…….If we have nurses and midwives appreciate that every person is unique, that word in itself tells you the way you're going to deal with that person will vary. That's where sensitivity comes in. there's no magic formula' (P23).		Recognise that people are unique beings who have beliefs that may influence their decisions in their care.	85
'……the mother (in the scenario) seemed to fight against the pain without having that support. She seemed alone .I think that the mother needs to be understood ….. and for the midwife, she needs to know herself more , her own needs of being understood to deal humanely with people'(P27).		Provides caring interventions to meet clients' needs in a humane way.	84
' … then again we have to realise the expectations of a healthy baby at the end of a pregnancy by both parents and this is suddenly shattered. And the mother is now faced with the baby (dead). She needs someone to help her deal with her inner feelings. These things will all come out - these guilt feelings or whatever, whether she has been keeping herself well in pregnancy and all that … .and her partner, very often we focus on the mother but we have to remember that this baby is the partner's as well. Again sometimes there's a dilemma between reassuring and helping her to keep up hope but you have to realistic help her face the truth. It is a process which the midwife must help the couple go through' (P28).		To journey with the clients and family their sufferings whilst keeping up realistic hope.	8, 18
'Being able to think about what the patient is thinking and what is the source? Not what is the result and you move backwards but what is the original source and you move forwards. To understand the original characteristic not what you think the characteristics are. The actual constructs not what I think' (P30).		Acknowledge and respect the clients' individual characteristics in their way of thinking.	19, 20

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 3: Educators of nursing/midwifery - Sheet G
Theme: Education in spiritual care for nurses/midwives
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Online, existential questions, moral distress, depth, learning tool, discussions, medium, post registration, new students, face to face.	**Information Technology**		
'I saw a student. At the beginning I thought…..online how is this going to talk? But the way the discussions etc were. I believe it was much more effective than classroom teaching, in that discussions developed and broadened the topic. It was totally online, it was this top up and as I said we were dealing with mostly existential questions, about dealing with and caring for the dying, the moral distress associated with it etc. But originally I thought online it's too clinical for a topic like this. I think it worked very very well, much more than I expected. And the way the discussions were developed and the depth were incredible. So in this aspect I would say yes it can be used as a learning tool because of this capacity to create these discussions….This was solely VLE…..I found it as a medium as opposed to what I thought' (P23).		Acknowledge the use of information technology as a valuable learning tool when dealing with spiritual care issues.	108,109
'In that situation because they are post-reg students, they have experience they can translate. In the case of newer students, to assimilate that information, they have to learn the concepts and theories. Maybe to discuss but to assimilate information and turn it into behaviour, to develop the appropriate attitude, and translate it into a behaviour to work with the patient and each other, I think it has to be face to face. (P28)		Use information technology to enhance own continuing knowledge in spiritual care.	107

Note 1: Reference number to competencies elicited from literature review.

APPENDIX 11 ANALYSIS - FOCUS GROUP 4: CLIENTS OF NURSING/MIDWIFERY

Elements of spiritual care in nursing and midwifery.
Focus Group 4: Clients of nursing/midwifery - Sheet A
Theme: Nurses'/midwives' role in the provision of spiritual care
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	Categories:	Competencies	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do, and think the following:	
Confident, respect, intuitive, trustful, understanding, empathic, calm, to give courage, hope, kind, sweet, patient, vocational, attentive, empowering, caring compassionate, knowledgeable, sense of humour, positive attitude, genuine, loving, self-awareness, acknowledge limitations, efficient.	**Nurses'/ midwives' attributes to spiritual care**		
'….and this person [the nurse] understood and said 'don't worry we'll take good care of you and we'll be here when you wake up', and she gave me reassurance, and she gave me a lot of hope. The second I opened my eyes I thought about her and she was there and she really made me feel better.'(P33)		Demonstrate attributes of understanding, caring, courage, reassurance and empowerment with clients.	89
'…..Then there's the nurse, she gave him [the patient] some courage and calmed him down because the situation happened too quickly. He needed time to process it. It's one thing when something happens to you in the blink of the eye and another when you're expecting this situation to happen'(P37)			
'*…..every patient needs empowerment. You need to make her understand that just because she has this it does not mean that the world has stopped. You need to show her how to take care of herself and what she needs to do…..'*(P34)			
'*….It's the fact that the nurse or the person giving the service needs to be conscious of what is happening inside him personally. As a nurse or midwife, what is happening inside me? There needs to be self-awareness…'* (P36).		Identify self- awareness as a resource to understand clients' inner feelings.	30, 48

'*…..I always found some kind of respite, even the way they [the nurses] speak. There are ways and ways of saying things even to the family. For me the nurse is the best way to give you courage and take away some of the pain and sickness you're feeling. Nurses need to be sweet with their patients…..It's not about money or because I want to leave[referring to the nurse] you need to have time for each patient- good time.'* (P37).		***Demonstrate good quality time with clients***. Demonstrate compassion with clients who do not conform with advice on their health.	new 57
'*….the nurse needs to be non-judgmental. Even if the patient has been eating anything under the sun [referring to diabetic patient in scenario].She [the nurse] needs to be caring. It could be a coping mechanism for the patient, plus compassion. The nurse needs to be knowledgeable about diet and patient education….'* (P34).		Demonstrate a positive attitude with clients through being genuine.	89
'*….and they [the nurses] must have said we know you inside out now as they were washing me- there was a sense of humour. Every question you ask out of fear she [the nurse] had a positive answer and she was genuine. When she didn't know, she asked and she always came back with a positive response. When I was in pain she didn't just pass and say I'll bring you something and my pain remained increasing. I was attended to promptly'* (P34).		***Identify humour as a resource to meet spiritual needs.***	new
'*I think that they [midwives] need to put themselves in the patient's shoes at the end of the day because the patient isn't in their environment they're in hospital. They're going through something birth, an operation whatever, you're always on edge, you don't know what's going to happen so obviously there needs to be that little bit of patience because even the patient can lose his temper. They need to communicate and understand. Sometimes treating the patient as a baby- spoiling to a certain extent-you know giving them that care and love' (*(P38)		Respond to clients' needs promptly Demonstrate empathy, patience, attention and love with clients undergoing stressful life situations.	54 33, 77

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 4: Clients of nursing/midwifery - Sheet B
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Religious element in care, referral, on admission, attention, holistic needs,	Assessment of spiritual care		
'*I made it very clear. I mean my parents are separated and I was scared I would die. I wanted to write my last will and testament so that my parents wouldn't have to worry that much. I wasn't worried about last rites or anything but the problems I may leave to someone else should I go. And no one paid attention to me' (P33).*		Assess, plan and provide interventions that meet clients' spiritual needs.	71, 81, 83, 84
'….from my experience, I passed through a lot of things. Your quality of life needs the presence of God and I feel it helping me' (P37).			
'I don't know how it works .I had two of my siblings die in hospital. And I saw a priest going round giving the last rites. And because they weren't responsive they couldn't ask for them. So I went up to the priest and asked him and he [the priest] said but do they want? I said well they can't talk but I would like them to have the last rites. And for my other sister as well. In hospital the patient has to ask or does the nurse have to see who needs the most?' (P35).		Recognise that religion may be a significant element in the clients' life.	11
		Recognise and respond to religious/ spiritual requests of all clients and their family.	23
A lot of the time they [the nurses] ask on admission. There's a form and they ask if you want last rites and they tick the box' (P33).		Perform spiritual/ religious assessment and provide spiritual/ religious interventions to all clients at the appropriate time.	81, 83, 84,
'In every case of illness you have to treat the patient holistically. Not just the disease. Diabetes does not make the person – the person has diabetes but there's a lot more to them. They have bio (physiological), psycho (mental), spiritual and social needs to add to that too. And the nurse has to be aware of all of these' (P34).		Recognise their role in providing spiritual care integral to holistic care.	9, 10
'You'll be so lost when you go to hospital, and I'm one of those persons who thinks about what I've left behind not what is happening to me. I know I've left the kids and they're going to come home from school and not find me there. My mind wasn't working on what the doctor told me' (P37).		Recognise barriers to effective spiritual care such as anxiety and make appropriate adaptations.	27

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 4: Clients of nursing/midwifery - Sheet C
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Existential questions, trustful relationship, being with the patient, family's support, valuing patient's feelings, active listening, breaking bad news, explaining, touch, face expressions, barriers, language, support, connection, feel important, express fears, continue routines, being positive.	**Communi-cation**		
'*… 24 hours after the operation you start to ask yourself. What is going to happen to me? The family and partners also ask these questions .What is going to become of my loved one?'*(P32).		Demonstrate effective therapeutic nurse/ midwife- client relationship when dealing with clients' existential questions.	20,73
'*I think that a nurse should know the person and what kind of individual she is dealing with, how he would react to a situation and to the knowledge of things'* (P34).		Recognise the importance of a trustful relationship with clients to assess clients' inner thoughts and feelings.	37
'…the nurse needs to find that moment to talk to the patient. The doctor comes in and spends ten minutes whereas the nurse can create that relationship. The nurse can find a little time to explain' (P32).		Demonstrate attention, interest and time to dialogue with clients.	28,29
'*…You feel more comfortable with one person than another because you feel this one gives you more attention than the other. She makes you feel important' (P33).*			
The doctor doesn't even give you the satisfaction of letting you know what's going on. It's good to have that ray of light of information. But I'd like them [the nurses] to be positive with me. If they're negative you can take it badly especially if I know about the illness and things like that' (P35).		***Demonstrate sensitivity when providing infor-mation about clients' health issues.***	new
'Sometimes that happens. The consultant was explaining everything to me on a spoon and I still didn't get it….he [the consultant] wrote CABG on a piece of paper. And then it hit me. I said you're going to do a bypass? Yes that's what I've been talking to you about. Did you not understand word I said?' (P33).		***Ensure clear understanding of information to clients' in stressful situations.***	new

'….It's important that they [the patients] understand as different things mean different to different people. It's important for us that we understand' (P36).		Communicate with clients in language and terms they can understand.	25
'….they tell me something and I don't understand. In fact I take my nephews and nieces. Isn't there a solution for these people, so that the nurse can go down to the level of the patient and explain better?'(P35)			
'…..I used to look at the nurses' faces, their tone of voice and the way they used to look. I used to say this one isn't like that one. She's much sweeter - her face can express what's in her heart'(P37)		***Appreciate the importance of non-verbal communication when interacting with clients.***	New
'….then the next midwife came and she was very patient she explained everything, she broke my waters and told me what she was going to do. Then she said when you feel that you have to push she said to call her. She told me in Maltese and I didn't understand. When the pain started I told my husband to call her. What I mean by supportive she told me I can do it. She gave me that moral help to go on' (P38).			28, 29, 30, 38, 39
'…Just the fact that she came [the midwife] and asked how I am and the problems I had told her. Even the problems I had with breast feeding I opened up to her about it and she made me feel so much better that time. That bit of connection helped' (P38).		Recognise the importance to understand, support and connect with clients in dealing with their spiritual needs.	

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 4: Clients of nursing/midwifery - Sheet D
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Prayer, empowerment, faith, religious momentum, last rites, referral to spiritual leaders, meeting objectives, routines. *'I confessed before the operation and I felt very good. And we (the nurses) prayed before it. I belief a lot in these things. For me these are sources of empowerment. I carry a memento of the Miraculous Mary- that helps me'(P34)* *'Before my operation I had the last rites 3 times. You should receive the last rites ones every 6 months but the priest was a friend and he gave them to me as per hospital regulations. Then the second time the priest came and asked 'Didn't I already administered the last rites? And I said yes but give me the last rites because I feel I'm going to die- the good thing is that nurses called him and he came'(P33)* *'…..and the next day I went home. I had a target even though I had to sit down and take it easy. But for me the fact that I kept on going as normal really helped' (33)*	**Spiritual/ religious interventions**	Comply with clients' request for prayer and other religious mementoes significant to the client. Identify the need to consult the chaplain or spiritual leader as often as the client requests. Assist clients' to continue with their spiritual habits and routines.	66 86 88

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 4: Clients of nursing/midwifery - Sheet E
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Professional barriers, support for professionals, involved, support for clients and family.	**Quality assurance**		
'It happened to me before when I was still working. I'll have a baby that's doing badly, and its 7pm and I'm supposed to leave and at 9pm I'm still there. I think to myself what am I going to do? Leave? Just when the family has started to bond with me and I'm giving support? Because you feel it. I find a problem sometimes because I get too involved' (P33).		Maintain professional boundaries in the sphere of spiritual care.	61
'I think it's good to have some kind of emotional support for nurses because one can vent a little even about the family and such'(P33)		Participate in activities that provide emotional support for members of the team.	56
'….But there don't seem to be any jobs [for professional support].Why isn't there a call for applications on these? Because the nurses don't have the voice they should have ?(P34)		***Recognise the need for professionals to deal with spiritual issues of members of the team***	new

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 4: Clients of nursing/midwifery - Sheet F
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Information giving vs withholding information, dignity, respect, non-judgmental, choice, decisions in care,	**Ethical and legal issues**		
'….then they told me that I needed chemo. But I found a lot of help in the society I was a member in and the family. And they started letting me know about everything. But slowly not a shock at once. I think it's a good thing that they tell you what's happening. But as long as they do it slowly so you have time to grasp it' (P35)		Disclose information to clients in a sympathetic tactful way.	60
'I may know your thoughts and feelings as an individual but I don't respect them. If I don't respect his dignity as a person and I am judgmental' (P36)			
'During the delivery was telling them [the midwives] that I was having contractions and I wanted an epidural which the midwives didn't want to give me claiming I had no contractions. At one point I shouted at them and told them if these are not contraction, can someone tell me what they are? (P37).		Maintain respect, dignity and a non-judgmental attitude towards clients' thoughts and feelings.	57, 38, 62

Note 1: Reference number to competencies elicited from literature review.

APPENDIX 12 ANALYSIS - FOCUS GROUP 5: PARENTS AND INFORMAL CARERS

Elements of spiritual care in nursing and midwifery.
Focus Group 5: Parents and informal carers - Sheet A
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	Categories:	Competencies	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Knowledgeable, professional, sensitive, reassuring, patient, giving time, good bedside manners, dedicated, role model, caring, making a difference, supportive, comforting, empathic, communicator, respectful, non-judgmental, good listener, present, understanding, reflecting, altruistic, values.	**Attributes of the nurse/ midwife**		
'I find from a practical point of view that carers need to be informed as to what they have to do, what they need to do. It's not easy to understand it[referring to dementia] but it's important that someone tries to help you understand what is happening … because otherwise you're in conflict with yourself, you're in conflict with the person' (P37).		***Demonstrate knowledge in the clients' medical condition in order to understand clients' behaviour.***	new
		Recognise spiritual conflict and distress in clients and their family.	81,23
		Demonstrate an understanding caring attitude to clients and their family.	18
'And ones, there was an hour where I lost it. But the nurses were so professional that out of the blues I found myself in a room, they gave me something to drink to calm me down…….The thing that used to bother me was a nurse who was particularly loud…….No at that time in that place it is not good to laugh……What they had [referring to the nurses] that was fantastic. They used to explain everything that went on. If he had 10 pipes coming out of him you would know what all the 10 pipes were there for…….You know you are in professional hands. They know what they're doing. Even if they didn't talk to you, you trust them. But the fact that you know that this person [the nurse] is not in a hurry with you makes a difference' (P38).		***Demonstrate an appropriate professional behaviour on the work place.***	new
		Provide consistent information regarding the clients' welfare.	64
		Demonstrate a professional attitude of trust.	30,38
		Demonstrate attention and time with clients and their family.	30
'What I want to say, the nurses' bedside manners are cardinal. It's not about academic achievement, that's important but not enough. Unfortunately the week I spent in hospital [with his son], there was none at all' (P39).		***Recognise the importance of both the art and science of the nursing and midwifery profession.***	new

'I worry about the manners too……Is there something in their training they're learning and are not putting in practice?....For me this profession [nursing] has nothing to do with letters [qualifications] but how capable you are to be there for the sick and you make a difference….not that you just give the medication but that the patient feels comforted and supported' (P40).		Appreciate the vocational elements of the profession in clinical nursing /midwifery basic care.	98
'… There was a nun, she was sister in charge, but she was like a mummy to everyone on the ward, she used to be a counsellor, a nurse- a real role model of a nurse' (P41).		***Identify role models who demonstrate holistic care.***	new
'I think that the nurses and who is looking after the patient , they need to put themselves in the patient's shoes' (P42) *'I feel that it's enough to sit down near a patient take their hand in mine and ask them to try and smile for me and to have courage' (P42)*		Provide empathy, time, courage and therapeutic touch to clients.	16,19, 20,25
'I do voluntary work at the psychiatric ward. You will be surprised at how much patience is needed… they don't want to do anything, they want to stay in bed and not get out. And you have to be sweet to them and tell them let's do this together, let's try it and with that sweetness you 'll be surprised how far you get' (P45)		Demonstrate patience, sweetness, tact and perseverance with depressed clients.	38
'…being a physical presence, being non-judgmental. You need to be an active presence, not necessarily talking because sometimes words hurt. But even an active presence in silence' (P40)		Demonstrate a physical active presence in silence.	28
'Carers and nurses need to understand that the shock of that moment [losing her baby], is unexplainable. They need to be understanding empathic, and non-judgmental. You do crazy things you don't even know what you're doing. You need to be given the liberty to accept what happened to you without hurry. A lot of people came up to me to try and force me to hurry up and accept it' (P43).		Demonstrate a non-judgmental attitude towards clients and their family. Understand clients' situations of shock and allow time for clients to work through it.	38 33
'….when there is a relapse they wouldn't want anyone, they would want to be alone and lock themselves in a box and see no one. You need to respect that if they want to be alone leave them….offer them help and when they are ready and want help, you're there' (P42).		Respect clients' wishes to be alone while offering them help when they need it.	62
'No words will make you feel better. You wanted that baby not another one, no one is going to replace it. I wanted to find the meaning for it and I still do. I feel proud that I completely understand what it now means to go home and have nothing' (P43).		Assist clients' to find meaning and purpose of their grief.	73

'You need to have a sense of altruism and it's not easy. I'm not there because of my pay at the end of the month and I'm not there so that the mother will appreciate me' (P40). *'We can be very charitable-character of the Maltese, we care about people and we show it. We're very much involved and family is important. We have values –Christian values' (P4)*		Demonstrate values of altruism, charity, family and lives directed to spiritual principles.	96

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 5: Parents and informal carers - Sheet B
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	Categories:	Competencies	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Assessment early in the course of disease of client and family members, grieving process, helplessness, hopelessness, existential questions, convictions, prayer, God, crisis, spiritual distress, despair, religious beliefs, rituals, decline of spirituality and religiosity, frustration, anger, unfinished business, holistic approach, environment, referral, barriers, religious denomination.	**Assessment of spiritual/ religious needs**		
'*I belief you have to prepare yourself spiritually when there is a condition like this progressive condition. The spiritual preparation has to begin from the beginning ,not at the end of life but from the beginning…….Another thing is that the family pass through the grieving process and they pass from it from the very beginning of the illness……The denial and anger especially my father you know her spouse for a very long time. The family have to be helped to pass through the grieving process. I think that is very important…..there'll be no peace, there'll be complete chaos in the family. The carers have spiritual needs themselves, they want to support the loved one. They feel helpless and hopeless' (P37)*		Assess spiritual/ religious needs of clients with progressive illnesses in a timely and appropriate way.	70, 81
		Assess family members' feelings of helplessness and hopelessness in coping with stressful life situations.	new
'The spiritual needs at time of crisis you always look upwards. I keep thinking maybe God wants to teach me something .Is there something good going to come of this? He's 13, just a kid. What good could come out of watching him suffer? More than spiritual needs you need a conviction that what you're doing is something good for the child, what is good for your family. You're doing whatever you can so that you can get out of this crisis as soon as possible.....prayer is important' (P38)		***Assess carers and family members' needs for support.***	new
		Recognise that for some people to transcend is an important element in crisis situations.	11
'At that point in time the more you hear that God loves you the angrier you get. I went through it personally. At that point you just get more frustrated because you ask 'why is He giving me this then. I live a good life, I try to be good to people' (P41)		***Discuss with family members issues regarding meaning and purpose in life, illness and suffering.***	new
'At that time I wanted a reason why this happened to me. When you pass through this, I am very spiritual and I believe in God but I had		Recognise prayer as an important influence in coping for some individuals.	43,66

no energy to turn to God, pray or talk. I kept thinking there must be a reason for this'(P43)			
'I met a consultant in hospital who took care of my son for 3 years and when he saw me he said 'What brings you here?' I told him my son has cranioparyngioma and we're going to take him to UK .He told me we had another girl who had that. At that point I exploded. I really spoke to him badly, it's not my nature. I told him you didn't do this test for me. We've been waiting for 3 years to find out what's wrong with him. And he just turned round and left' (P38)		***Assess barriers to spiritual care such anger towards God and frustration.***	new
		Assess and identify spiritual distress and spiritual needs.	81
'When I was in England I remember, the operation was on the 9th February [eve of St Paul's feast], I am very enthusiastic about St Paul and I said 'Paul it's in your hands'…….and on Saturday I went to mass' (P38)			
'….the fact that you've lost your son, it's like someone told you have terminal cancer. Spirituality is the last thing that goes through your head and it takes years and years. It doesn't pass and it takes time. This question of religion –it's better not to talk (P39)		Identify and respect clients' religious beliefs and practices that promote a positive self-concept.	49
'…….If there's something unresolved it's like we don't pay attention to it. I think the nurse has to keep in mind whether he [client in the scenario] had pending issues or worries…….was there any unfinished business- anything he wanted to do with his wife and we didn't notice it? (P41)		Identify and respect decline of spiritual/religious care.	63
		Recognise any unmet spiritual needs.	91
'……we attack the problem at the surface and we don't see the person as a whole. Maybe she left her dog or cat behind her, or a mother who doesn't have anyone to pick up her children. In this case I think the nurse didn't pay attention to see the patient as a whole' (P41)		Elicit a detailed spiritual history and identify clients' individual holistic needs.	81
'…..maybe he's not Catholic, he's of some other religion. Have we ever paid attention to the fact that he may need a spiritual director' (P41)		Recognise the need to consult a chaplain or spiritual leader and see that contact is done.	21,
'…..because nurses aren't catching up with the patients because sometimes they are overworked'(P37)		Identify barriers to spiritual care, such as lack of time.	27,54
'I passed through this not so long ago. Three months ago in fact I remember what my needs were at the time. I don't think it ever occurred to them [nurses /midwives], how painful it was to be put in a room with mothers who had given birth to a live baby when I had just lost mine' (P43)		Evaluate the environment to determine the spiritual well-being of clients and modify as needed.	99,102

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 5: Parents and informal carers - Sheet C
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Listening to clients' narratives ,supportive, caring environment, prayer, pray area, spiritual/religious leaders, support, presence, silence, sweetness, quietness, peace, therapeutic touch, follow up care in the community, resources, coping, referrals, acceptance, finding meaning and purpose, reassured, loved	**Spiritual/ religious interventions**	***Recognise the need to listen to the clients' narratives.***	new
'*You have presented me with a case but I would like to talk of my son. My son to-day is his 10th anniversary since he left us. We took him to hospital, he was 7 years old. He had just done his first holy communion, he was healthy, he didn't need anything. He was lovely……'(P39)*		Participate in the creation of a supportive caring environment for clients and their family.	99
		Organise a place of worship to enhance the spiritual environment in the workplace.	new
'Martha [client in the scenario] need is of supportive caring environment. Martha and her family need to know that there is someone there for you' (P37)		Recognise personnel and support resources available to assist clients and their family seeking spiritual /religious assistance.	45
'Prayer is important I remember when we went to the hospital in UK, because of the how they are they don't really have a church, more a type of a prayer room. When you are on the ward the place you look for is the prayer area. I mean we weren't alone .Other parents were there. We found a nun who was Irish, as soon she knew we were Christians we felt more comfortable because we were in the minority. She used to come and talk to us '(P38)		Participate in the creation of a spiritually healthy workforce and support systems available.	102
'The largest amount of support I found was from my friends at work. You cannot go home in a bad mood or crying, you need to be strong and ready. You go to work, you sit and they bring you some tea. One of them had come up to me, tapped me on the back and said 'you can throw up now'. They are small things that aren't small to you'(P38)		Ensure that clients have the therapeutic presence of family and friends.	38
'Its important that there is presence of someone, people close to you when this happens. The nurse is outside doing her work and you can understand. But I couldn't imagine myself in a room on my own without my husband' (P43)		Foster an environment that determines spiritual well-being through calmness and quietness.	99
		Allow family members to share and participate in the care to their loved ones.	new

'Don't be loud with the patient… he wants sweetness not noise. I belief that if a patient is allowed one relative to stay with him at all times it will help the patient and the nurses since they are over worked. It won't confuse the nurse, we used to hand him things he needed. I think one relative would make sense'(P 45) *' I'm learning how to listen more and not to speak when you should be quiet. At that time and situation no word will make the patient feel better. The presence and I'm praying for you is enough. The fact that you visited me and left is enough. There was no need for talking, just presence in those moments is very important. That person remembered you and is thinking about you is enough'(P43)* *'….and on Saturday I went to mass. I was more there just as a presence I didn't really know what was going on. Someone came up to me and touched my shoulder and said 'Don't worry everything will be OK. And I didn't know this person, but I feel it was the biggest therapeutic thing ever.'(P38)* *' Another thing I wanted to say was about follow up. I only spent one day in hospital but you still need health care professionals…..when I went home I switched my PC and continued with my work. I think when you are in that situation people want to see that you are coping. I don't think that a psychologist can help you if they haven't seen you before. If they were there all along they will help more. I think this is one of the services that should be available….People thought I'll be back to normal physically at least no one expected that mentally. They told me take your time.'(P43)* *'…..My dad had terminal cancer….it's nice to have him home ,spend time with him and we did have some help from hospice nurses but they come twice or three times a week. They are not going to look after him 24hours a day. I think sometimes it doesn't work to leave patients at home. For example my dad needed morphine. When the doctor came he gave him the dose for that time and then we had to really hassle to get his morphine from hospital' (P45)* *'Today it's rare to hear of MMDNA and the care they give at home. There is Pharmacy of your choice. We need to be up to date about these things. Do you have someone to cook for them? There is meals on wheels. These are things that can accommodate people more'(P41)*		Understand the importance of own life experiences in own practice in relation to spiritual care. Appreciate the value of therapeutic presence and non-verbal communication in promoting clients' positive self-concept (hope, courage and support). Provide effective therapeutic communication as appropriate. ***Ensure the physical-psychological- spiritual well-being of clients in hospital and in the community*** ***Provide information about facilities and resources in spiritual care in hospital and the community and how to access them.*** ***Contribute towards the organisation of recourses in spiritual care in the community that can better accommodate clients' needs*** Evaluate the effectiveness of spiritual interventions through monitoring clients' self- concept and acceptance. ***Respond with love in situations that pose internal conflicts and judgment.***	92 89 19,20 new new new 90 new

I never got angry at God, never asked why did you do this to me? I have seen enough suffering to not do that because he gave me a fraction of what I've seen other people go through. And I say he gave me this to teach me how to feel for others' (P43) *'I always feel that he got in the problem because he wanted to, maybe a bit of peer-pressure. But I think because I've been through they need a lot of love these patients because they are patients too. And they need to be reassured that those around them really love them. Not that they are a burden'(P44)*			

Note 1: Reference number to competencies elicited from literature review.

Elements of spiritual care in nursing and midwifery.
Focus Group 5: Parents and informal carers - Sheet D
Theme: Nurses'/midwives' role in the provision of spiritual care.
Competencies elicited from focus groups and similar to competencies elicited from literature.
New competencies in italics and bold

Codes	**Categories:**	**Competencies**	Comp. No (Lit.) [note 1]
		At point of registration nurses and midwives should know, be able to do and think the following:	
Maintain personhood, dignity, continuing education, vocational elements, discipline, information giving, professional hands	**Ethical and professional issues**		
'One thing I find very important in this type of situation is that you maintain personhood. The person changes and almost becomes someone else but the inner self is still there. The person you knew is still there. So her personhood and her dignity is very important'(P37)		Respect person's right for autonomy and dignity.	62
'I've been working with hospital volunteers for these last 4 years and I tell them I'm giving a lecture and they all come. So the need to learn is big' (P41)		Recognise the need to participate in learning events on spiritual care.	56, 97, 10, 4
'For me this profession has nothing to do with letters, but how capable you are to be there for the sick and make a difference' (P40)		Acknowledge the vocational element of the nursing and midwifery professions.	98
'…..when we (Maltese) go abroad to work or study we excel. But then they (British) have someone in the ward who is the ward manager who has executive power- hire and fire no questions asked. There (UK) what they have is that they are extremely disciplined'(P38)		***Acknowledge discipline as an essential element in providing spiritual care.***	new
' I would want to know to be well informed to prepare myself and put myself-you know settled. Settle what I have to do settle my things even spiritually'(P37)		***Acknowledge and respect the clients' right for information regarding their health.***	new
' If there were 10 pipes you would know all the 10 pipes were there for. Otherwise you look at someone with 10 pipes coming out of him and you'll say –he's done. But if you know what they're there for then it's Ok. A day before the operation the consultant spent 2 hours talking us through the process……you feel in professional hands' (P38)			

Note 1: Reference number to competencies elicited from literature review.

APPENDIX 13 FOCUS GROUPS 2 -5

Focus Group 2: Chaplains and spiritual leaders

Focus Group 2: Demographic data

The demographic characteristics of Focus Group 2 involve ten chaplains and spiritual leaders. Most representatives of religious denominations were males (n=9) which can be explained by the dominance of males within religious hierarchy. The majority were Christians with a lot of experience in pastoral care. One spiritual leader was female.

Demographic characteristics of Focus Group 2

Characteristics	**Findings**
Gender	
Males	9
Females	1
Total participants	**10**
Years of pastoral experience	**Mean=15.4** **Range: 10.6- 23.4 years**
Age	**Mean=38.2** **Range: 34-52 years**
Chaplains and spiritual leaders:	
Hospital Roman Catholic chaplains	3
Church of Scotland	1
Church of England	1
Baptist church	1
Coptic orthodox	1
Jehovah witness	2
Hospital counsellor	1

Focus Group 2: Results of thematic analysis

Three themes emerged from Focus Group 2, which involved chaplains and spiritual leaders with the necessary skills required to deliver meaningful spiritual care. These themes identified the role of nurses and midwives as providers of spiritual care, nursing/midwifery as vocational professions and identified the educational preparation necessary to provide spiritual/religious interventions while maintaining professional barriers.

Codes, categories and themes generated from Focus Group 2

Focus Group 2: Chaplains and spiritual leaders Codes	**Categories**	**Themes**
To reaffirm or *not* to reaffirm clients' beliefs, nurse's role, part of the process, reluctance, multi-disciplinary team, spiritual assessment, responding to spiritual needs of patients and relatives, access to spiritual care, referral, nurses as healers. **Deals with persons, humanity, holistic care vs. medical model, find right person to do it, cultural/religious diversity of clients, collaboration of MDT.**	**1.1** Awareness of clients' spiritual/ religious needs.	**1** The role of nurses/midwives in providing spiritual care.
	1.2 Nurses/midwives providers of humane holistic care.	
	1.3 Spiritual assessment of clients and family.	
	1.4 Implementation of spiritual care.	
	1.5 Responding to cultural/religious diversity.	
	1.6 Providing multi-disciplinary approach to spiritual care.	
	1.7 Nurses/midwives as healers.	
	1.8 Referral of clients to spiritual leaders and other resources.	
Spiritual calling, spiritual/religious resources, being with the patient, database access, listening, compassion respect, companionship, empathise, guilt, prayer, bible reading, choices in care, respect, maintaining personal barriers, making time for spiritual care, someone to vent feelings [with],	**2.1** Vocational calling of nurse/midwife.	**2.** Nursing/midwifery vocational professions.
	2.2 Nurses/midwives personal spirituality.	

Codes, categories and themes generated from Focus Group 2 (cont.)

Focus Group 2: Chaplains and spiritual leaders Codes	Categories	Themes
Generation difference regarding spirituality, conflict with own spirituality, knowledge of the grieving process, religious development, difference between spirituality and religiosity, respect for deep-held beliefs, respect for decisions that affect care, getting too emotionally involved.	**3.1** Meaning of spirituality/ religiosity.	**3.** Educational preparation of nurses/midwives in spiritual/ religious issues.
	3.2 Knowledge of spiritual/ religious interventions and access to resources.	
	3.3 Knowledge and respect for diverse beliefs and decisions that affect care.	
	3.4 Maintain professional barriers.	

Themes, categories and exemplars generated from Focus Group 2

Focus Group 2: Chaplains and spiritual leaders
THEME 1: The role of nurses/midwives in providing spiritual care
Category 1.1 Awareness of clients' spiritual/religious needs
Exemplars: "*The nurse would need to know that this man [in the scenario] actually has a belief in God and who this God is and to affirm that" (P10).* *"I don't think it's the nurse's place to say that. But I think the nurse has to know where she can find that kind of support and the right person to be doing this with Eric [patient in case scenario]. It may well be in the first days of him being in hospital, the nurse is in the best position to decide that than anyone else. Because a nurse deals with the person rather than the symptoms" (P11).*
Category 1.2 Nurses/midwives as providers of humane holistic care
Exemplars: "*[Eric's] spiritual needs are to have his humanity fully recognised in hospital and so to have holistic care including, if necessary, [having a] psychiatrist or a psychologist with him … The nurse should be prepared to maintain these conversations with Eric through the normal nursing routines, whether or not the minister or chaplain is present." (P11).* *"The assumption is the holistic approach is so important - that a patient is coming in as a complete person – carrying a religion etc." (P10).*

Themes, categories and exemplars generated from Focus Group 2 (cont.)

Category 1.3 Spiritual assessment of clients and family
Exemplars: *"I wonder if in your dissertation [referring to the write up of thesis] you would include a section that in it you try to jot down questions, universal questions that would help the nurse discern a pastoral diagnosis. By these general questions, they'll help the nurse to assess the spiritual needs of the person involved, irrespective of their religion. That way, the nurse will tap into the spiritual resources of the place" (P14).* *"… it is no longer the case that anybody can assume that a patient coming in has or has no religion. They [the patients] must be asked … anyone coming in must be asked. And so the nurses are on the front line of this process" (P17).*
Category 1.4 Implementation of spiritual care
Exemplar: *" … so even to say, 'Can I call your pastor, your friend, or who do you know in the church?' reaffirms again – 'I am not abandoned.' I think nurses should look at these issues and I think that the nurse is able to bring these fundamentals to staff … they [nurses] need to be aware of opportunities within the hospital for appropriate meditation or worship and encourage Eric to take part in that, even to only just sit in the hospital chapel for a while, perhaps with someone sitting beside him. Just to know that they [nurses] are part of the process" (P11).*
Category 1.5 Responding to cultural/religious diversity
Exemplars: "*... because there is a difference between religious and being spiritual and I know for a fact that the spiritual climate in Wales in Glamorgan is entirely different to what it is here in Malta .... When I came to Malta my understanding of spirituality had to change somewhat because although within [the] Anglican tradition there is still [the] anointing of the sick and [the] last rights, it is never used in the Anglican church or hardly ever .. .here its entirely different because when I came here first, I couldn't understand how many times I was asked to give the last rights because the person I was administering [them] to wasn't an Anglican, they were Roman catholic married to an Anglican and only knew one way of doing things" (P17).* "*We know we have a lot of African migrants ... I have been called many times and the baby is breech and she says 'I'm not going to have a caesarean because my grandma had a baby at home and I don't want to go under the knife because the Maltese want to operate [on] me and then close my womb not to have children ... '.I'd rather die than do this.' Because it was a deep conviction that you don't need a doctor's knife to give birth. It was a curse. She wouldn't let them touch her, in fact she spit [spat] at the policeman. All I had to do is call the Imam. He came and he spoke to her for a few minutes and she had the baby [by caesarean section] (P10).*
Category 1.6 Providing multi-disciplinary approach to spiritual care
Exemplars: "*Considering what the nurse needs to know, I think first of all the nurse has to know that there exists a multi-disciplinary team made up of chaplains, psychologists, social worker etc." (P14).* *"Nurses need to feel that they can call on ministers and chaplains as fellow professionals and have a sensible conversation about how to exercise this care in the best interest of the patient" (P11).*

Themes, categories and exemplars generated from Focus Group 2 (cont.)

Focus Group 2: Chaplains and spiritual leaders
Theme 1: The role of nurses/midwives in providing of spiritual care
Category 1.7 Nurses/midwives as healers
Exemplar: "*... attend, be close at the viewing of the body. I think that makes a lot of sense, when the nurse stands by relatives. I saw it happening here, just offering support that would heal the sense of loss" (P14).*
Category 1.8 Referral of clients to spiritual leaders and other resources
Exemplars: "*The nurse needs to know that they [nurses] can call on Christian chaplaincy or spiritual assistance for cases like Eric's [patient in case scenario] and how to do it" (P11).* *"Sometimes when I meet a foreigner-Roman Catholic, Protestant, Muslim, whoever, I ask him personally whether he'd like to see his pastor. And we have the addresses of all pastors with the phone numbers and we [chaplains] call them, ourselves. But the nurse tells you with reluctance. It makes me sick" (P15).*
Theme 2: Nursing/midwifery as a vocational profession
Category 2.1 Vocational calling of nurse/midwife
Exemplar: *"I would also suggest that nurses should be trained to see their profession as a way of spiritual care, as well. So how a nurse is changed through her profession. The calling because it makes a whole difference. As Fr.....was saying, there is a huge difference between a nurse who is spiritually oriented to God and one who does his or her work simply for [the] stipend" (P14).*
Category 2.2 Nurses'/midwives' personal spirituality
Exemplar: "*It seems that the older generation of nurses have a different view than the younger generation who are more open-minded. An older nurse sticks to her own beliefs and may decide to impose and restrict the patient, which I think is unfair because if you believe in something, maybe it will help you get better faster than medicine' (P19).*
THEME 3: Educational preparation of nurses/midwives in spiritual/religious issues
Category 3.1 Meaning of spirituality/religiosity
Exemplar: *" ... when a person goes through this process - denial, anger, bargaining. They start asking a lot of existential questions ... I think that she [the patient] needs help in the grieving process ... I think that, first of all, the nurse needs to know and understand the process that she [the patient] is going through ... I think they should know the suffering involved. As well as that, I think they should know the stages of religious development because not all people are at the same level" (P12).*
Category 3.2 Knowledge of spiritual/religious interventions and access to resources
Exemplar: "*The first thing I would have felt [is] a great sense of guilt [putting himself in the scenario]. That is the first need – so I need someone to be beside me to let me vent my feelings ... secondly, after listening and offering companionship, compassion and empathy. I would have liked the chaplain to invite me in prayer, or read a biblical text or hear my confession so that I can ease the pain or sense of guilt ...I would have liked the chaplain to do is [this], for instance the sense of touch, done in a very discerning way, that also means that God is beside me" (P14).*

Themes, categories and exemplars generated from Focus Group 2 (cont.)

Focus Group 2: Chaplains and spiritual leaders
THEME 3: Educational preparation of nurses/midwives in spiritual/religious issues
Category 3.3 Knowledge and respect for diverse beliefs and decisions that affect care
Exemplar: "*It's good in this case that the nurses realise we Jehovah's Witnesses see life as a gift from God. So for us life is holy. It's important that the nurses realise that the patient needs to know that she is getting the best treatment possible in line with her beliefs. These are very deep [deeply] held beliefs. We believe that blood is sacred and God's commandment is to abstain from blood. So, in this case, someone trying to force a transfusion onto this woman is like someone trying to rape her" (P18).*
Category 3.4 Maintain professional barriers
Exemplar: " *... I think that it is applicable to the nurses because without getting involved in emotional situations with patients - they have to have that barrier where you look at it and understand but you don't cross it and get involved emotionally in it and I've been there as well the same as probably all of us have where we crossed that barrier. I think that young nurses have to understand they can't go over that barrier and get involved in that emotional situation as such" (P17).*

Focus Group 2: Generated competencies

Sixty one competency items were derived from the second focus group which involved chaplains and spiritual leaders. Fifty items were similar to those identified from the literature review. However, eleven new items (shown with an asterisk [*] and in bold) were identified by the chaplains and spiritual leaders which were then added to the list of competencies.

Competencies in spiritual care derived from Focus Group 2

	Focus Group 2: Chaplains & spiritual leaders
1	Appreciate that all individuals have a spiritual dimension and some have a religious
2	Appreciate the role of chaplains and spiritual leaders in providing spiritual care.
3	Refer clients to the appropriate provider of spiritual/religious care.
4	Identify and plan care to meet the spiritual/religious needs.
5	Recognise the role and responsibility of nurses and midwives in the provision of
6	Refer to other providers of spiritual care appropriately and in a timely manner.
7	Demonstrate care that fully recognises humanity.
8	Integrate spiritual care into holistic care.
9	Monitor spiritual expression during normal nursing routines.
10	Demonstrate complete care which is attentive to the spiritual/religious element.
11	Value the importance of the spiritual/religious elements of individuals in their care
12	***Demonstrate correct knowledge of ethical issues pertaining to spiritual/religious**

Competencies in spiritual care derived from Focus Group 2 (cont.)

Focus Group 2: Chaplains & spiritual leaders	
13	Demonstrate ability in assessing spiritual/religious needs.
14	Demonstrate knowledge in formal and informal methods of spiritual assessment.
15	***Elicit a spiritual history on admission to hospital to discern spiritual needs.**
16	Appreciate the role and responsibility of other members of the care team in the
17	Collaborate with members of the health care team when providing spiritual/religious
18	Encourage colleagues and members of the team to provide compassionate care.
19	Provide for facilities within the hospital to access spiritual care, such as a place for
20	Demonstrate support and presence in being with the client.
21	Comply with the client's spiritual/religious beliefs and provide resources that suit his
22	***Acknowledge geographical differences in the practice of spiritual/religious**
23	Demonstrate sensitivity and respect for diversity in care choices and health beliefs
24	Acknowledge and respect the influence of cultural beliefs and practices in decision
25	Assess barriers to effective communication, such as language, culture and religion
26	Recognise the role of chaplains, psychologists, social workers and other members of
27	Identify the need to call on ministers, chaplains and spiritual leaders.
28	***Discuss with members of the multidisciplinary team how to exercise**
29	Exercise support and therapeutic presence with relatives who are experiencing loss.
30	*** Provide courage and hope in scriptures relevant to the client's spiritual/religious**
31	Identify resources and support systems available to assist clients with
32	Respect the role of clergy and spiritual leaders in providing spiritual care.
33	Recognise the role and responsibility of the nurse to assist clients to request
34	Avail of resources to make the necessary contacts and arrangements in providing
35	***Recognise nursing and midwifery as a way of spiritual calling.**
36	Appreciate the uniqueness of each person.
37	Recognise that their own beliefs may impact on the care of the client.
38	Demonstrate the ability not to impose own beliefs in the client's care.
39	Respect clients' beliefs and decisions in their care.
40	***Demonstrate knowledge and understanding of the process of grieving.**
41	Demonstrate knowledge in responding to existential questions the client might pose.
42	Identify distinctions between spiritual and religious needs.
43	Identify agencies that can provide spiritual/religious assistance.
44	Demonstrate knowledge of different beliefs and practices with particular reference
45	Demonstrate ability in being there for the client.
46	***Understand the stages of religious development of individuals.**
47	Use information technology to inform carers about alternative therapies
48	Collaborate with other health care professionals in the provision of care.
49	Listen to clients and their family, empathise and demonstrate presence.
50	Recognise the role of the chaplain in the provision of spiritual care.
51	Recognise the role of prayer, bible reading and touch as a means of support.
52	Understands therapeutic nurse/patient relationship.
53	Plans and provides care to meet the clients' needs and beliefs.
54	Recognise complex ethical and legal issues and deal with them appropriately.
55	Demonstrate respect client's decisions in their care free from coercion.

Competencies in spiritual care derived from Focus Group 2 (cont.)

Focus Group 2: Chaplains & spiritual leaders	
56	Seek resources to inform nurses/midwives about health care options in line with the client's religious/spiritual beliefs and practices.
57	***Demonstrate knowledge of spiritual/religious beliefs and practices in issues pertaining specifically to the client's health problem**.
58	Seek available information regarding clients' beliefs that may influence their care.
59	***Acknowledge and respect diversity in religious/spiritual beliefs and practices of close family members.**
60	Demonstrate an ability to maintain appropriate professional boundaries.
61	***Appreciate that all individuals are unique and have their own dimensions at going about with their lives.**

Focus Group 3: Pre-registration nursing/midwifery educators

Focus Group 3: Demographic data

The demographic characteristics of Focus Group 3 include pre-registration nursing/midwifery educators.

Demographic characteristics of Focus Group 3

Focus Group 3: Pre-registration nursing/midwifery educators	
Characteristics	**Findings**
Gender	
Males	2
Females	9
Total participants	**11**
Years of teaching experience	Mean=17.4 Range: 6.2 - 16.4 years
Age	Mean=34.2 Range: 28-52 years
Areas of teaching	
General Nursing	7
Mental Health	2
Midwifery	2

The majority of participants were female (n=9) with over six years' teaching experience in areas of general nursing, mental health and midwifery.

Focus Group 3: Results of thematic analysis

Two themes emerged from the educators which describe the essential elements in the preparation of nursing/midwifery students to deliver spiritual care to clients and their family; and the use of information technology as a resource for learning about spiritual care.

The content of education included knowledge of spiritual/religious issues relevant to the clients' illness and aspect of care; communication and interpersonal skills; self-awareness exercises; ethical and legal issues as a guide to clients and staff; professional and educational issues; assessment, implementation and evaluation of spiritual care; and utilisation information technology as a current tool for teaching spiritual care.

Codes, categories and themes generated from Focus Group 3

Focus Group 3: Pre-registration nursing/midwifery educators Codes	**Categories**	**Themes**
Teaching students, spiritual distress, knowledge of illnesses, psychological aspects, empowering, response to illness, normal and abnormal reactions, individuality, different religions, importance of religion, coping, grieving process.	**1.1** Knowledge of spiritual/ religious aspect of care.	**1.** Elements in the educational preparation of nursing/ midwifery.
	1.2 Knowledge of spiritual/ religious issues relevant to clients' illness.	
Active listening, feelings, thoughts, attention, understanding, support, encouragement, trust, communication skills, narratives, person's life history, fears, empathy, trusting relationship, good questioning techniques, boundaries, reflecting, verbal and non-verbal, touch, language.	**1.3** Communication and interpersonal skills.	
Awareness of own values, own beliefs, knowing oneself, non-judgmental, not impose own beliefs, being sensitive, own perceptions, own experiences, reflect, reflective activities, inner search.	**1.4** Teaching self-awareness to students.	

Codes, categories and themes generated from Focus Group 3 (cont.)

Focus Group 3:Pre-registration nursing/midwifery educators Codes	Categories	Themes
Confidentiality, non-judgmental, right to decide, duty to save lives, court order, going against client's wishes, dignity, resuscitation, refusing treatment.	**1.5** Ethical and legal issues that protect clients and staff.	
Reflect on past experiences, environment, values, morals, mature, character, information, discussions with colleagues, support for care provider and students, multi-disciplinary team, continuing education, role models, reflective practice, implement projects, curriculum, experiential learning, psycho-social approach, existential, small groups.	**1.6** Professional and educational issues of staff.	
Exploring purpose in life, identity, hope, conflict, beliefs and religion influence decisions, involving family members, unique person, pain, support, being alone, client's needs, midwife's needs, understood, humane approach, dealing with shattered hopes, expectations, inner feelings, reassuring, truth, understand actual characteristics, constructs.	**1.7** Assessment, implementation and evaluation of spiritual care.	
Online, existential questions, moral distress, depth, learning tool, discussions, medium, post registration, new students, face to face.	**2.1** Use of online video conferencing as a resource for learning about spiritual care.	**2.** Information technology as a teaching and learning tool in spiritual care.

Themes, categories and exemplars generated from Focus Group 3

Focus Group 3: Pre-registration nursing/midwifery educators
THEME 1: Elements in the educational preparation of nursing/midwifery students
Category 1.1 Knowledge of spiritual/religious aspect of care
Exemplars: *" ... It's important how you teach this spiritual aspect. You need a smaller group. You come across situations where the students themselves have passed through spiritual distress which stresses the student and the rest of the class and will be quite difficult to deal with' (P16).* *" ... And the partner. Sometimes we forget the patient's partner and we look at the patient as though they are functioning in a vacuum where as they are not. They function together" (P21).*

Themes, categories and exemplars generated from Focus Group 3 (cont.)

THEME 1: Elements in the educational preparation of nursing/midwifery students
Category 1.2 Knowledge of spiritual/ religious issues relevant to clients' illness
Exemplars: *" ... knowledge about the illness so they can help her [the patient in the scenario] with this. But also for them [the students] knowledge of the varied responses that people can give. Every individual has a reaction to life threatening diseases. Also for them to realise whether this is a normal or abnormal form of response and for them to be able to refer should they see this response as abnormal" (P23).* *"With regards to the nurses they need to learn about the importance of religion to various people not just to patients. The importance of religion and the kind of religion they are participating in" (P24).*
Category 1.3 Communication and interpersonal skills
Exemplars: "*Patients are aware that our ears are open but we're jumping about doing a hundred things and they are there needing our attention. The need for understanding, support, encouragement. As soon as she found that nurse willing to listen, things began coming out ... students need to realise the need to listen to patients' narratives ... it will help the communication process between us both" (P21).* "*Patients need to be able to communicate those inner repressed thoughts that are haunting them. They are there on their minds and she [the nurse] needs to help them surface and come out. The key point in us professionals is sometimes we don't realise that what we see in reality and what our perceptions are, are not those of our patients and sometimes our students do not realise this." (P26).*
Category 1.4 Teaching self-awareness to students
Exemplars: *" ... Again I think one of the important things when it comes to teaching this subject is first of all to make sure the students are aware of themselves, their values and beliefs. What do they understand by death, what is death for them? This is crucial because knowing oneself will help them to communicate and listen. But first they have to know themselves" (P31).*
Category 1.5 Ethical and legal issues that protect clients and staff
Exemplar: *" ... The patient has a right to decide and if he dies he dies. I had the opportunity to think about situations like this. But yes, we tend to focus on ethical issues more than what we think. What influences the patient is more important than what influences the nurse. Over here [in the scenario] it was what is important to the nurse ... But not only religion. I had a similar case with blood (refusing blood transfusion) when a relative of a woman of someone after having blood had an anaphylactic shock and died. So in this case, it was not because of his religious beliefs but because someone had died. It's not just the religious beliefs' (P30).*
Category 1.6 Professional and educational issues of staff
Exemplars: "*But mostly I would try, maybe even through my example and non-verbals [to] try to make the student more mature and build his character and values and moral understanding of life" (P31).* "*It's hard not to say it because I think we've all said it. Somehow, somewhere, in our career if you reflect back and the minute it comes out you realise it was the wrong word, the wrong pause , the wrong tone, maybe even the wrong touch" (P26).*

Themes, categories and exemplars generated from Focus Group 3 (cont.)

Focus Group 3: Pre-registration nursing/midwifery education
THEME 1: Elements in the educational preparation of nursing/midwifery student
Category 1.7 Assessment, implementation and evaluation of spiritual care
Exemplars: " *... So first of all I think he [client in the scenario] needs to explore his purpose in his life and explore his self-identity. There must be other aspects which he needs to explore and hopefully from then he can start planning what to do with the rest of his life" (P30)* "*Again, sometimes there's a dilemma between reassuring and helping her to keep up hope but you have to realistic [realistically] help her face the truth. It is a process which the midwife must help the couple go through" (P28).*
THEME 2: Information technology as a teaching and learning tool in spiritual care
Category 2.1 Use of online video conferencing as a learning resource
Exemplar: "*Online discussion - I believe it was much more effective than classroom teaching, in that discussions developed and broadened the topic. It was totally online and as I said, we were dealing with mostly existential questions, about dealing with and caring for the dying, the moral distress associated with it, etc." (P23).*

Focus Group 3: Generated competencies

Fifty four competency items were derived from the third focus group which involved pre-registration nursing/midwifery educators. Forty two were similar to those identified from the literature review. However, twelve new items (shown with an asterix [*] and in bold) were identified by the educators. These were then added to the list of competencies.

Competencies in spiritual care derived from Focus Group 3

Focus Group 3: Pre-registration nursing/midwifery educators	
1	*** Realise the importance of knowing the client's medical condition when dealing**
2	*** Respect individuals' different responses to life threatening condition.**
3	Recognise need to refer to other members of the multi-disciplinary team.
4	Recognise that for some individuals, spirituality will have a religious element.
5	Demonstrate knowledge of the world's major faiths and religions.
6	***Demonstrate knowledge in the process of how individuals grieve.**
7	Demonstrate knowledge in helping skills.
8	Be aware of the available support systems and agencies.
9	Value the importance of integrating a psycho-social approach to care.
10	*** Value experience as an important element in dealing with clients' existential**
11	Understand the importance of active listening to the clients' narratives.
12	Recognise the need to understand, support, trust and encourage clients.
13	Demonstrate effective therapeutic nurse/midwife-client relationship.

Competencies in spiritual care derived from Focus Group 3 (cont.)

Focus Group 3: Pre-registration nursing/midwifery educators	
14	*** Demonstrate interest and ability to reflect on the client's life story and**
15	Adapt barriers to effective communication (such as fear) by demonstrating active
16	Demonstrate ability in building trustful relationships with clients and their families.
17	Demonstrate good communication skills, such as good questioning techniques to
18	Understand the importance of reflection on own practice in relation to meeting
19	Communicate with clients in language and terms they can understand.
20	*** Appreciate that theory should inform practice in relation to meeting the**
21	Demonstrate personal awareness of one's own values and beliefs.
22	Demonstrate ability in dealing with existential questions.
23	Demonstrate non-judgmental attitudes to diverse spiritual beliefs.
24	Recognise that their own spirituality may affect how they interact with clients.
25	Demonstrate sensitivity to clients.
26	Demonstrate ability in assessing clients' individual spiritual needs.
27	Appreciate the value of own experiences without imposing such experiences on
28	Appreciate the importance of seeking reflective activities in meeting one's inner
29	Acknowledge and respect confidentiality issues in addressing clients' spiritual
30	Acknowledge and respect clients' confidentiality when disclosing personal
31	Demonstrate non-judgmental attitudes towards clients' needs.
32	Respect diversity in clients' decisions in their care, based on religion, values and
33	Demonstrate sensitivity and responsiveness to clients' spiritual and health needs,
34	Identify intersections of legal, ethical, religious/spiritual concerns and beliefs and
35	Ensure clients' dignity in addressing clients' holistic healthcare needs.
36	Demonstrate personal growth, high moral values and lives directed to spiritual
37	Understand the importance of reflection on own practice and make changes as
38	*** Respect clients' right for integrity, dignity and privacy.**
39	Demonstrate sensitivity with clients'.
40	Understand the importance of providing explanations to clients' stressful situations.
41	*** Provide information to clients consistently**.
42	*** Value the importance of seeking spiritual support from colleagues and members**
43	Diagnose spiritual distress in clients and their care givers.
44	*** Identify role models who promote holistic reflective care.**
45	*** Apply spiritual care principles in primary health care settings.**
46	Assist clients and their family in identifying their spiritual needs.
47	*** Assist clients and their families to identify alternatives to instil hope.**
48	Recognise that for some individuals religion is an important element in their care.
49	Recognise that for some individuals religion is not an important element in their
50	Recognise that people are unique beings who have beliefs that may influence their
51	Provide caring interventions to meet clients' needs in a humane way.
52	Journey with the clients and family [during] their sufferings whilst keeping up
53	Acknowledge and respect the clients' individual characteristics in their way of
54	Acknowledge the use of information technology as a valuable learning tool when

Focus Group 4: Clients of nursing/midwifery

Focus Group 4: Demographic data

The demographic characteristics of Focus Group 4 include clients of nursing/midwifery.

Demographic characteristics of Focus Group 4

Focus Group 4: Clients of nursing/midwifery	
Characteristics	**Findings**
Gender	
Males	1
Females	6
Total participants	**7**
Stay in hospital (days)	Mean=9 Range: 7 – 12 days
Age	Mean=39.6 Range: 36.4 - 54.2 years
Illness/condition	
Surgical intervention	1
Medical illness	1
Surgical/medical/mental health conditions	2
Childbirth	2
Oncological conditions	1

The majority of participants were females (n=6). All participants had received hospital based care.

Focus Group 4: Results of thematic analysis

Three themes emerged from this group discussion, which describe the characteristics of nurses/midwives in the provision of a holistic approach to care and the use of spiritual and/or religious interventions including ethical and legal issues that affect the care of clients, their family and healthcare professionals.

Codes, categories and themes generated from Focus Group 4

Focus Group 4:Clients of nursing/midwifery Codes	**Categories**	**Themes**
Confident, respect, intuitive, trustful, understanding, empathic, calm, to give courage, hope, kind, sweet, patient, vocational, attentive, empowering, caring compassionate, knowledgeable, sense of humour, positive attitude, genuine, loving, self-awareness, acknowledge limitations, efficient.	**1.1** Qualities of the nurse/midwife.	**1.** Characteristics of the nurse/midwife in the provision of spiritual care.
Religious element in care, referral, on admission, attention, holistic needs.	**2.1** Assessment of clients' spiritual needs	**2.** Holistic approach to care.
Existential questions, trustful relationship, being with the patient, family's support, valuing patient's feelings, active listening, breaking bad news, explaining, touch, face expressions, barriers, language, support, connection, feel important, express fears, continue routines, being positive.	**3.1** Effective nurse/midwife-client communication.	**3.** Providing spiritual care
Prayer, empowerment, faith, religious momentum, last rites, referral to spiritual leaders, meeting objectives, routines.	**3.2** Provision of spiritual/ religious interventions.	
Professional barriers, support for professionals, Involved, support for clients and family**.**	**3.3** Support for clients their family and professionals.	
Information giving vs. withholding information, dignity, respect, non-judgmental, choice, decisions in care.	**3.4** Legal and ethical issues involved in spiritual care.	

Themes, categories and exemplars generated from Focus Group 4

Focus Group 4: Clients of nursing/midwifery
THEME 1: Characteristics of the nurse/midwife in the provision of spiritual care
Category 1.1 Qualities of the nurse/midwife
Exemplar: " *... and this person [the nurse] understood and said 'don't worry we'll take good care of you and we'll be here when you wake up', and she gave me reassurance, and she gave me a lot of hope. The second I opened my eyes. I thought about her and she was there and she really made me feel better*" (P33).

Themes, categories and exemplars generated from Focus Group 4 (cont.)

Focus Group 4: Clients of nursing/midwifery
THEME 2: Holistic approach to care
Category 2.1 Assessment of clients' spiritual needs
Exemplars: "*I wasn't worried about last rites or anything but the problems I may leave to [for] someone else should I go. And no one paid attention to me" (P33).* "*In every case of illness you have to treat the patient holistically. Not just the disease. Diabetes does not make the person – the person has diabetes but there's a lot more to them. They have bio (physiological), psycho (mental), spiritual and social needs to add to that too. And the nurse has to be aware of all of these" (P34).*
THEME 3: Providing spiritual care
Category 3.1 Effective nurse/midwife-client communication
Exemplar: " *… the nurse needs to find that moment to talk to the patient. The doctor comes in and spends ten minutes, whereas the nurse can create that relationship. The nurse can find a little time to explain"* (P32).
Category 3.2 Provision of spiritual/religious interventions
Exemplar: "*I confessed before the operation and I felt very good. And the nurse prayed for me too. I believe a lot in these things. For me, these are sources of empowerment. I carry a memento of the Miraculous Mary - that helps me" (P34).*
Category 3.3 Support for clients their family and professionals
Exemplar: "*I always found some kind of respite, even the way they (the nurses) speak. There are ways and ways of saying things even to the family. For me the nurse is the best way to give you courage and take away some of the pain and sickness you are feeling." (P37).* *"I think it is good to have some kind of emotional support for nurses too because one can vent a little about the difficult situations they have to face on a daily basis." (P33)*
Category 3.4 Legal and ethical issues involved in spiritual care
Exemplar: " *... then they told me that I needed chemo. But I found a lot of help in the society I was a member in and the family. And they started letting me know about everything. But slowly not a shock at once. I think it's a good thing that they tell you what's happening. But as long as they do it slowly so you have time to grasp it and make a choice whether to have the treatment or not" (P35).* *"I may know your thoughts and feelings as an individual but I don't respect them. In this way I am not respecting the dignity of the person and many a time I may also be judgmental" (P36).*

Focus Group 4: Generated competencies

Thirty one competency items were derived from Focus Group 4 which involves clients of nursing/midwifery. Twenty five were similar to those identified from the literature review. However, six new items (shown with an asterix [*] and marked in bold) were identified by the clients' group and were added to the list of competencies.

Competencies in spiritual care derived from Focus Group 4

Focus Group 4: Clients of nursing/midwifery	
1	Demonstrate attributes of understanding, caring, courage, reassurance and
2	Identify self-awareness as a resource to understand clients' inner feelings.
3	***Demonstrate good quality time with clients.**
4	Demonstrate compassion with clients who do not conform with advice on their
5	Demonstrate a positive attitude with clients through being genuine.
6	*** Identify humour as a resource to meet spiritual needs.**
7	Respond to clients' needs promptly.
8	Demonstrate empathy, patience, attention and love with clients undergoing stressful
9	Assess, plan and provide interventions that meet clients' spiritual needs.
10	Recognise that religion may be a significant element in the clients' life.
11	Recognise and respond to religious/spiritual requests of all clients and their families.
12	Recognise that the medical model of care is focused on the disease not the client.
13	Perform spiritual/religious assessment and provide interventions to all clients at the
14	Recognise their role in providing spiritual care as an integral aspect of holistic care.
15	Recognise barriers to effective spiritual care, such as anxiety and make appropriate
16	Demonstrate effective therapeutic nurse/midwife - client relationship to clients'
17	Recognise the importance of a trustful relationship to assess clients' inner thoughts
18	Demonstrate attention, interest and time to dialogue with clients.
19	*** Demonstrate sensitivity when providing information about clients' health issues.**
20	*** Ensure clear understanding of information to clients' in stressful situations.**
21	Communicate with clients in language and terms they can understand.
22	*** Appreciate the importance of non-verbal communication when interacting with**
23	Recognise the importance to understand and connect with clients in dealing with
24	Comply with clients' request for prayer and other religious mementoes significant to
25	Identify the need to consult the chaplain or spiritual leader as often as the client
26	Assist clients' to continue with their spiritual habits and routines.
27	Maintain professional boundaries in the sphere of spiritual care.
28	Participate in activities that provide emotional support for members of the team.
29	*** Recognise the need for professionals who deal with spiritual issues of members**
30	Disclose information to clients in a sympathetic and tactful way.
31	Maintain respect, dignity and a non-judgmental attitude towards clients' thoughts

Focus Group 5: Parents and informal carers

Focus Group 5: Demographic data

The demographic characteristics derived from Focus Group 5 involve parents and informal carers.

Demographic characteristics of Focus Group 5

Focus Group 5: Parents and informal carers	
Characteristics	**Findings**
Gender	
Males	3
Females	6
Total participants	**9**
Age	Mean=39.6 Range: 34.4 - 48.2 years
Participants' Experiences	
Death of child	1
Terminal illness of child	1
Termination of pregnancy	1
Cared for son with substance misuse	1
Cared for father with terminal illness	1
Cared for mother with dementia	1
Cared for brother with multiple sclerosis	1
Performs voluntary work with oncology patients	2

The majority of participants were female (n=6). All participants had cared for family members or patients with illness, or experienced the loss of a loved one.

Focus Group 5: Results of thematic analysis

Three themes emerged from this group of parents and informal carers. These include the expectations of parents and informal carers of nurses/midwives in the provision of spiritual, as well as the assessment and implementation of spiritual care in hospital, as well as the community. Abiding by ethical and professional codes was the final theme. Fifty four items were generated from this focus group discussion.

Codes, categories and themes generated from Focus Group 5

Focus Group 5:Parents and informal carers Codes	**Categories**	**Themes**
Knowledgeable, professional, sensitive, reassuring, patient, giving time, good bedside manners, dedicated, role model, caring, making a difference, supportive, comforting, empathic, communicator, respectful, non-judgmental, good listener, present, understanding, reflecting, altruistic, values.	**1.1** Qualities of a caring nurse/ midwife.	**1.** Characteristics of nurses/ midwives in the provision of care.
Spiritual assessment of client and family members, grieving process, helplessness, hopelessness, existential questions, convictions, prayer, God, crisis, spiritual distress, despair, religious beliefs, rituals, decline of spirituality and religiosity, frustration, anger, unfinished business, holistic approach, environment, referral, barriers, religious denomination.	**2.1** Assessing spiritual/religi ous needs of clients and family.	**2.** Assessment and implementation of spiritual care in hospital and follow up in the community.
Listening to clients' narratives ,supportive, caring environment, prayer, pray area, spiritual/religious leaders, support, presence, silence, sweetness, quietness, peace, therapeutic touch, follow up care in the community, resources, coping, referrals, acceptance, finding meaning and purpose, reassured, loved.	**2.2** Implementing spiritual/ religious interventions to clients and their family in hospital and community	
Maintain personhood, dignity, continuing education, vocational elements, discipline, information giving, professional hands, confidentiality.	**3.1** Respect for issues pertaining to dignity, confidentially, information and clients' wishes.	**3.** Ethical and professional issues relating to spiritual care.

Themes, categories and exemplars generated from Focus Group 5

Focus Group 5: Parents and informal carers
THEME 1: Characteristics of nurses/midwives in the provision of care
Category 1.1 Qualities of a caring nurse/midwife
Exemplar: "*And once, there was an hour where I lost it. But the nurses were so professional that out of the blues I found myself in a room, they gave me something to drink to calm me down. The thing that used to bother me was a nurse who was particularly loud ... Not at that time in that place it is not good to laugh." (P38).*
THEME 2: Assessment & implementation of spiritual care in hospital and follow up in the community
Category 2.1 Assessing spiritual/religious needs of clients and family
Exemplar: **"*I believe you have to prepare yourself spiritually when there is a condition like this progressive condition. The spiritual preparation has to begin from the beginning, not at the end of life but from the beginning ... Another thing is that the family pass through the grieving process and they pass from it from the very beginning of the illness ... " (P37).***

Themes, categories and exemplars generated from Focus Group 5 (cont.)

Focus Group 5: Parents and informal carers
THEME 2: Assessment & implementation of spiritual care in hospital and follow up in the community
Category 2.2 Implementing spiritual/religious interventions to clients & their family in hospital & community
Exemplar: "*Prayer is important I remember when we went to the hospital in UK, because of how they are they don't really have a church, more a type of a prayer room. When you are on the ward the place you look for is the prayer area. I mean we weren't alone .Other parents were there. We found a nun who was Irish, as soon she knew we were Christians, we felt more comfortable because we were in the minority. She used to come and talk to us. When my son was discharged from hospital and even when we were back in Malta, she used to call to ask about us. It was a relief to hear her voice and encouraging words" (P38).*
THEME 3: Ethical and professional issues relating to spiritual care
Category 3.1 Respect for issues pertaining to confidentially, dignity, information, clients' wishes
Exemplar: "*One thing I find very important in this type of situation is that you maintain personhood. The person changes and almost becomes someone else but the inner self is still there. The person you knew is still there. So her personhood and her dignity is very important. Nurses need to remember this. This is where the vocation of the nurse comes into play" (P37**).***

Focus Group 5: Generated competencies

Fifty four competency items were derived from this focus group. Thirty five were similar to those identified from the literature review. However, nineteen new items (shown with an asterix [*] and marked in bold) were identified by the group and were added to the list of competencies.

Competencies in spiritual care derived from Focus Group 5

Focus Group 5: Parents and informal carers	
1	*** Demonstrate knowledge in the clients' medical condition in order to understand**
2	Recognise spiritual conflict and distress in clients and their family.
3	Demonstrate an understanding, caring attitude to clients and their family.
4	*** Demonstrate an appropriate professional behaviour on the work place.**
5	Provide consistent information regarding the clients' welfare.
6	Demonstrate a professional attitude of trust.
7	Demonstrate attention and time with clients and their family.
8	*** Recognise the importance of both the art and science of the nursing and**
9	Appreciate the vocational elements of the profession in clinical nursing/midwifery

Table 5.21 Competencies in spiritual care derived from Focus Group 5 (cont.)

Focus Group 5: Parents and informal carers	
10	*** Identify role models who demonstrate holistic care.**
11	Provide empathy, time, courage and therapeutic touch to clients.
12	*** Demonstrate patience, sweetness, tact and perseverance with depressed clients.**
13	Demonstrate a physical active presence in silence.
14	Demonstrate a non-judgmental attitude towards clients and their family.
15	*** Understand clients' situations of shock and allow time for clients to work**
16	*** Respect clients' wishes to be alone while offering them help when they need it.**
17	*** Assist clients' to find meaning and purpose of their grief.**
18	Demonstrate values of altruism, charity, family and lives directed to spiritual
19	*** Assess spiritual/religious needs of clients with progressive illnesses in a timely**
20	***Assess family members' feelings of helplessness and hopelessness in coping with**
21	*** Assess carers and family members' needs for support.**
22	Recognise that for some people the transcended is an important element in crisis
23	Discuss with family members issues regarding meaning and purpose in life, illness
24	Recognise prayer as an important influence in coping for some individuals .
25	*** Assess barriers to spiritual care, such as anger towards God and frustration.**
26	Assess and identify spiritual distress and spiritual needs.
27	Identify and respect clients' religious beliefs and practices that promote a positive
28	Identify and respect decline of spiritual/religious care.
29	Recognise any unmet spiritual needs.
30	Elicit a detailed spiritual history and identify clients' individual holistic needs.
31	***Recognise the need to consult a chaplain or spiritual leader and see that contact**
32	Identify barriers to spiritual care, such as lack of time.
33	Evaluate the environment to determine the spiritual well-being of clients and modify
34	Recognise the need to listen to the clients' narratives.
35	Participate in the creation of a supportive caring environment for clients and their
36	Organise a place of worship to enhance the spiritual environment in the workplace.
37	Recognise resources available to assist clients and their family seeking
38	*** Participate in the creation of a spiritually healthy workforce and support systems**
39	Ensure that clients have the therapeutic presence of family and friends.
40	*** Foster an environment that determines spiritual well-being through calmness**
41	*** Allow family members to share and participate in the care to their loved ones.**
42	*** Understand the importance of own life experiences in own practice in relation to**
43	Appreciate the value of therapeutic presence and non-verbal communication.
44	Provide effective therapeutic communication, as appropriate.
45	Ensure the physical/psychological/spiritual well-being of clients in hospital and in the
46	*** Provide information about facilities and resources in spiritual care in hospital and**
47	Contribute towards the organisation of recourses in spiritual care in the community.
48	Evaluate the effectiveness of spiritual interventions through monitoring clients' self-
49	*** Respond with love in situations that pose internal conflicts and judgment.**
50	Respect person's right for autonomy and dignity.
51	Recognise the need to participate in learning events on spiritual care.
52	Acknowledge the vocational element of the nursing and midwifery professions.
53	Acknowledge discipline as an essential element in providing spiritual care.
54	Acknowledge and respect the clients' right for information regarding their health.

APPENDIX 14 : INITIAL GENERATION OF COMPETENCIES - COLLAPSE OF DATA

DOMAIN 1: BODY OF KNOWLEDGE IN SPIRITUAL CARE
At point of registration (i.e. when they finish nursing or midwifery training), nurses and midwives NEED TO KNOW, BE ABLE TO DO, or THINK the following competencies in spiritual care:

Competency 1
Identify spiritual care as integral to holistic care (i.e. care of the whole person body-mind-spirit).

Other competencies which have been integrated into Competency 1:
- Demonstrate a broad understanding of spirituality integral to holistic care.
- Define 'holistic care.'
- Identify the interconnectedness of body-mind-spirit.
- Integrate spiritual care to holistic care.
- Values spiritual care as integral to holistic care.
- Integrate spiritual care to holistic care.

Competency 2
Recognise the role of nurses and midwives in demonstrating an individualised (personalised) view of care, attentive to the body-mind-spirit in hospital and ensuring its continuity in the community.

Other competencies which have been integrated into Competency 2:
- Demonstrate a reflective, holistic and individualised view of care.
- Recognise their role in providing spiritual care integral to holistic care.
- Demonstrate care attentive to the body-mind-spirit (holistically).
- Monitor spiritual expression, while providing physical care.
- Monitor spiritual expression during normal nursing routines.
- Able to provide holistic care ensuring its continuity in the community.
- Demonstrate complete care, attentive to the spiritual/religious elements.

Competency 3
Demonstrate knowledge of the world's major faiths, (e.g. humanism, atheism) religions, (e.g. Christianity, Islam, Judaism, Hindu and Buddhism) cultural beliefs and practices in the appropriate clinical context along the life span continuum (conception, birth, mid-life, old age, death).

Other competencies which have been integrated into Competency 3:
- Define the beliefs and practices of the world's major religions.
- Demonstrate knowledge of the world's major faiths and religions.
- Demonstrate knowledge and understanding of the main world faiths, in particular around birth, illness and death.
- Demonstrate knowledge of the world's faith, humanism and atheism with particular reference to their philosophies, beliefs and practices around birth, during life, illness, dying and death.
- Apply the knowledge of spirituality/religiosity in the appropriate clinical context along the life span continuum (birth-acute-chronic-life threatening illnesses).
- Demonstrate knowledge of spiritual/religious beliefs and practices in issues pertaining specifically to the client's health problem.

Competency 4
Identify the influence of faiths, religion, cultural beliefs and practices around birth, during life, illness and death (e.g. refusal of blood transfusions, organ donations, immunisation, chemotherapy).

Other competencies which have been integrated into Competency 4:

- Define the influences of cultural beliefs and practices in health care.
- Define the influences of cultural beliefs and practices in health care. Demonstrate knowledge of different beliefs and practices with particular reference to their influence during illness.
- Seek available information regarding the clients' health beliefs and practices that may influence their care.

Competency 5
Demonstrate knowledge in the basic spiritual needs of individuals which include:

- **A meaningful philosophy of life (values and moral sense).**
- **A sense of the transcendent (outside of self, view of God and something beyond the immediate life, having hope).**
- **A trusting relationship with God (faith).**
- **A relatedness to nature and people (friendship)**
- **Experiencing love and forgiveness (a sense of life meaning).**

Other competencies which have been integrated into Competency 5:

- Value the importance of the spiritual/religious elements of individuals in their care and well-being.
- Recognise that for some people to transcend is an important element in crisis situations.
- Discuss questions with clients about meaning and purpose in life.

Competency 6
Recognise and appreciate that all individuals have a spiritual dimension that sustains physical and mental well-being and that some people have a religious element to their spirituality.

Other competencies which have been integrated into Competency 6:

- Recognise that for some individuals, spirituality will have a religious element.
- Recognise that some people will have a religious element to their spirituality.
- Appreciate that all individuals have a spiritual dimension in the provision of compassionate care.
- Recognise that religion may be a significant element in the clients' life.
- Value spirituality as a potentially important component of every client's physical and mental well-being.
- Recognise that for some individuals religion is an important element in their care.
- Recognise that for some individuals religion is not an important element in their care.
- Value the importance of the spiritual/religious elements of individuals in their care and well-being.

Competency 7
Identify the distinctions and relationship between spirituality and religiosity and acknowledge geographical differences in meeting spiritual and religious needs in relation to health.

Other competencies which have been integrated into Competency 7:

- Identify the relationship of spirituality/religion to health outcomes and wellness.
- Identify distinctions between spiritual and religious needs.

- Identify between a spiritual and religious need.
- Identify distinctions between spiritual and religious needs.
- Define religion and spirituality and spiritual care.
- Acknowledge geographical differences in the practice of spiritual/religious practices.

Competency 8
Demonstrate knowledge and understanding of the client's life threatening illness or condition (e.g. dementia, cancer, depression, childbirth) in order to understand client's behaviour in dealing with spiritual needs.

Other competencies which have been integrated into Competency 8:
- Realise the importance of knowing the client's medical condition when dealing with spiritual needs.
- Demonstrate knowledge in the clients' medical condition in order to understand clients' behaviour.
- Define the meaning of illness, suffering and healing.
- Understand how spirituality influences the way clients deal with illness, pain and handicap.
- Respect individuals' different responses to life threatening conditions.

Competency 9
Demonstrate knowledge of spiritual assessment through formal (e.g. FICA and HOPE tools) and informal methods (e.g. listening to clients' stories).
Other competencies which have been integrated into Competency 9:

- Demonstrate knowledge of formal and informal methods of spiritual assessment
- Demonstrate knowledge in asking about patients'/clients' spiritual/religious backgrounds, biography, mystical and religious events and experiences, role of habits, rituals, symbols and traditions in daily life.
- Demonstrate knowledge of available spiritual assessment tools.
- Elicit a detailed spiritual history and identify spiritual distress and spiritual needs.

Competency 10
Demonstrate knowledge and understanding of the grieving process (denial, anger, bargaining, depression and acceptance).

Other competencies which have been integrated into Competency 10:
- Demonstrate knowledge and understanding of the process of grieving.
- Demonstrate knowledge and understanding of the process of grieving.
- Understand clients' situations of shock and allow time for clients to work through it.
- Respect clients' wishes to be alone while offering them help when they need it.

Competency 11
Apply the knowledge of helping skills, caring and healing theories in assisting clients to get the strength to face, accept and heal life's crisis.

Other competencies which have been integrated into Competency 11:
- Demonstrate knowledge in helping skills.
- Demonstrate knowledge in caring and healing theories.

Competency 12
Demonstrate knowledge and understanding of the stages of religious development of individuals and assist spiritual growth of students.

Other competencies which have been integrated into Competency 12:

- Assist in the spiritual development and growth of students.
- Demonstrate knowledge in the stages of religious development.
- Understand the stages of religious development of individuals.

Competency 13

Value knowledge and experience as important elements in dealing with the clients' and their family existential questions (e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?)

Other competencies which have been integrated into Competency 13:

- Demonstrate knowledge in responding to existential questions the client might pose.
- Value experience as an important element in dealing with clients' existential questions
- Discuss questions with clients about meaning and purpose in life.
- Assist clients' to find meaning and purpose of their grief.
- Assist clients and families to make sense of and derive meaning from experiences, including illness.
- Discuss with family members issues regarding meaning and purpose in life, illness and suffering.

Competency 14

Acknowledge the role of chaplains, spiritual leaders and other members of the multi-disciplinary team in providing spiritual care.

Other competencies which have been integrated into Competency 14:

- Respect the role of clergy and other spiritual leaders in providing spiritual care.
- Appreciate the role of chaplains and spiritual leaders in providing spiritual care.
- Recognise need to refer to other members of the multi-disciplinary team.
- Seek assistance and refer to the appropriate spiritual/ religious experts.
- Value the collaboration of other health care professionals in providing spiritual care.
- Respect the role of clergy and spiritual leaders in providing spiritual care.

Competency 15

Demonstrate knowledge of resources, support systems and agencies that inform nurses and midwives to access spiritual care for clients, their family and staff in hospital and the community (e.g. place for worship, Church, support groups, Hospice, friends, and employment peers).

Other competencies which have been integrated into Competency 15:

- Be aware of the available support systems and agencies.
- List resources and support systems available to assist patients/clients and health care professionals seeking spiritual assistance.
- Identify agencies that can provide spiritual/religious assistance.
- Avail of resources to make the necessary contacts and arrangements in providing spiritual/religious care.
- Identify resources and support systems available to assist clients with spiritual/religious assistance.

Competency 16
Demonstrate knowledge and assist clients in health care in line with the clients' religious/spiritual, cultural beliefs such as the use of complementary and alternative therapies, diets, nutritional supplements and prayer.

Other competencies which have been integrated into Competency 16:

- Seek resources that will inform nurses and midwives regarding health care options in line with the client's religious/spiritual beliefs and practices.
- Understand the appropriate use of complementary and alternative therapies.
- Respect the clients' choice to use alternative and complimentary therapies (aromatherapy, acupuncture, therapeutic touch, nutritional supplements, diets).

Competency 17
Contribute and provide information towards the organisation of recourses in spiritual care in hospital and the community that can better accommodate clients' spiritual needs.

Other competencies which have been integrated into Competency 17:

- Provide information about facilities for accessing spiritual care in hospital (such as a place of worship) and in the community.
- Comply with the client's spiritual/ religious beliefs and provide resources that suite his beliefs.
- Provide for facilities within the hospital to access spiritual care such as a place for worship or meditation.
- Articulate their spiritual and religious needs and identify resources to address them.
- Provide information about facilities and resources in spiritual care in hospital and the community and how to access them.
- Demonstrate an awareness of spiritual resources and how these can be accessed.
- Recognise personnel and support resources available to assist clients and their family seeking spiritual /religious assistance.

DOMAIN 2: SELF-AWARENESS AND USE OF SELF

Competency 18
Recognise importance of own spirituality, values, beliefs and use of self in providing spiritual care.

Other competencies which have been integrated into Competency 18:

- Recognise that their own spirituality plays a key role in their professional lives.
- Demonstrate personal awareness of one's own values and beliefs.

Competency 19
Recognise that their own spirituality affects how they interact with clients and colleagues.

Other competencies which have been integrated into Competency 19:

- Recognise that their own spirituality may affect how they interact with clients.
- Recognise that their own spirituality affects how they interact with their clients and colleagues.

Competency 20
Demonstrate the ability not to impose OWN values, beliefs, convictions and experiences in providing spiritual care to clients.

Other competencies which have been integrated into Competency 20:

- Appreciate the value of own experiences without imposing such experiences on others.
- Demonstrate sensitivity and responsiveness to clients' spiritual needs free from manipulation or coercion.
- Demonstrate ability in handling own values, convictions and feelings in clients' relationship.
- Demonstrate the ability not to impose own beliefs in the client's care.

Competency 21
Acknowledge and respect the influence of clients' diverse cultural worldviews, beliefs and practices in the expression of spirituality in healthcare and value self- reflection as a means of respecting diversity.

Other competencies which have been integrated into Competency 21:
- Values the role of self-assessment through self- reflection in order to respect diversity.
- Accepts and respects the clients' diverse spiritual and religious beliefs, practices and cultural worldviews.
- Acknowledge and respect the influence of cultural beliefs and practices in the expression of the clients' spirituality.
- Acknowledge and respect the influence of cultural beliefs and practice in their decision making in care.

Competency 22
Identify self-awareness as a resource to understand clients' inner feelings, being comfortable and confident in what you believe, and identifying sources of spiritual strength (e.g. meditation, prayer) in order to help others.
Other competencies which have been integrated into Competency 22:

- Identify self- awareness as a resource to understand clients' thoughts and feelings.
- Ensure confidence in what you belief in order to help others.
- Identify personal sources of spiritual strength e.g. meditation, prayer.

Competency 23
Acknowledge personal limitations in providing spiritual care and access assistance from the appropriate members of the multi-disciplinary team.

Other competencies which have been integrated into Competency 23:
- Recognise own limitations and access assistance from the appropriate members of the multi-disciplinary team.
- Admit to personal limitations and communicate these limitations to patients/clients and team.

Competency 24
Seek assistance in reflective group discussions to discuss and evaluate stressful situations, availing of advice to meet personal inner feelings in order to move on.

Other competencies which have been integrated into Competency 24:
- Appreciate the importance of seeking reflective activities in meeting ones inner feelings in order to move on.
- Be able to give without feeling drained, grieve appropriately and let go.
- To participate in group discussions and experiential exercises to enhance personal awareness of own spiritual needs.

DOMAIN 3: COMMUNICATION AND INTERPERSONAL SKILLS

Competency 25
Understand and communicate the principles of the ministry of 'PRESENCE' (i.e. being fully present and attentive to clients' and their family needs), through active listening, empathy, genuine concern, trust, touch, humility and commitment in all their suffering: physical, emotional and spiritual.

Other competencies which have been integrated into Competency 25:

- Able to listen actively, connect and maintain presence with the client.
- Demonstrate support and presence in being with the client.
- Exercise support and therapeutic presence with relatives who are experiencing loss.
- Demonstrate ability in being there for the client.
- Listen to clients and their family, empathize and demonstrate presence.
- Understand the importance of active listening to the clients' narratives.
- Recognise the need to understand, support, trust and encourage clients.
- Actively listen to clients, demonstrating genuine concern and trust in the expression of spiritual thoughts and feelings.
- Demonstrate attention, interest and time to dialog with clients.
- Appreciate the importance of non-verbal communication when interacting with clients.
- Recognise the importance to understand, support and connect with clients in dealing with their spiritual needs.
- Provide empathy, time, courage and therapeutic touch to clients.
- Demonstrate a physical active presence in silence.
- Recognise the need to listen to the clients' narratives.
- Ensure that clients have the therapeutic presence of family and friends.
- Appreciate the value of therapeutic presence and non-verbal communication in promoting clients' positive self-concept (hope, courage and support).
- Provide effective therapeutic communication as appropriate.
- Offer support, comfort and realistic hope to clients and families.
- Demonstrate empathy, support and responsibility when dealing with complex life issues.
- To journey with the clients and family their sufferings whilst keeping up realistic hope.

Competency 26
Understand and communicate the principles of the 'ministry of WORDS' including: good questioning techniques, discussion of spiritual/religious issues, verbal support, appropriate language and humour, encouragement, the use of scripture or religious literature and prayer.

Other competencies which have been integrated into Competency 26:

- Provide courage and hope in scriptures relevant to the client's spiritual/religious beliefs.
- Acknowledge the importance of clients narrating their sufferings and pray with the client if requested.
- Chooses the right setting, time and appropriate language to initiate conversation.
- Assess the patient's/ client's readiness to communicate.
- Demonstrate effective interviewing techniques.
- Communicate with clients in language and terms they can understand
- Provide opportunity to ask and respond to questions.
- Ensure that clients have the therapeutic presence of family and friends.
- Demonstrate good communication skills such as good questioning techniques to elicit clients' life story.
- Identify humour as a resource to meet spiritual needs.
- Understand the importance of verbal and non-verbal communication

- Communicate with clients in language and terms they can understand.
- Recognise the role of prayer, bible reading, touch and other interventions as a means of support.
- Comply with clients' request for prayer and other religious mementoes significant to the client.
- Recognise prayer as an important influence in coping for some individuals.
- Comply with the patients'/clients' requests including a request for prayer regardless of personal beliefs.

Competency 27
Assess barriers to effective communication (such as language, beliefs, culture, anxiety, fear and anger) and make appropriate adaptations by demonstrating active listening, empathy and access of appropriate members of the multi -disciplinary team.

Other competencies which have been integrated into Competency 27:
- Assess barriers to effective communication such as language, culture and religion and make appropriate adaptations.
- Adapt barriers to effective communication (such as fear) by demonstrating active listening and empathy.
- Assess barriers to effective communication (such as anxiety, fear and anger) and make appropriate adaptations.
- Recognise barriers to effective spiritual care such as anxiety and make appropriate adaptations.

Competency 28
Understand and apply the principles of a therapeutic trustful nurse/midwife - client relationship, respond appropriately with love and realistic hope in order to journey with them their sufferings.

Other competencies which have been integrated into Competency 28:
- Demonstrate effective therapeutic nurse/ midwife- client relationship when dealing with clients' existential questions.
- Demonstrate ability in building trustful relationships with clients and their family.
- Demonstrate effective therapeutic nurse/midwife-client relationship
- Understands therapeutic nurse/patient relationship.
- Able to develop trusting relationships with clients and family in order to journey the illness with them.
- Recognise the importance of a trustful relationship with clients to assess clients' inner thoughts and feelings.
- Seek to build relationships with patients/clients and their families.
- Establish rapport with patients/clients, their families and team.
- Accept the responsibility to provide effective therapeutic communication.
- Understands the principles of therapeutics- nurse/midwife-patient/client relationship.
- To journey with the clients and family their sufferings whilst keeping up realistic hope.

Competency 29
Assess the impact and use of self in effective communications in order to ensure and maintain boundaries of a therapeutic nurse/midwife - client relationship reflected in the professional legal and ethical codes of practice and conduct in the sphere of spiritual care.

Other competencies which have been integrated into Competency 29:
- Assess the impact and use of self in effective communications.
- Identify the ethical issues for the professional regarding appropriate boundaries.

- Identify the professional, legal and ethical code of practice and conduct in the sphere of spiritual care.
- Respect patients'/clients' boundary issues.
- Maintain professional boundaries in the sphere of spiritual care.
- Identify the ethical issues for the professional regarding appropriate boundaries.

DOMAIN 4: ETHICAL AND LEGAL ISSUES

Competency 30
Appreciate that all individuals are unique and have their own dimensions at going about with their lives

Other competencies which have been integrated into Competency 30:
- Appreciate the uniqueness of each person

Competency 31
Demonstrate correct knowledge of ethical issues pertaining to sensitiveness and respect for diversity in religious/spiritual beliefs, values, practices and lifestyles (e.g. dietary differences, sexual orientation) of clients and family.

Other competencies which have been integrated into Competency 31:
- Demonstrate correct knowledge of ethical issues pertaining to spiritual/religious care.
- Show respect for clients' diverse religion, beliefs and practices and lifestyles.

Competency 32
Demonstrate sensitivity, support and respect for the client's diverse health care decisions and choices influenced by religious/spiritual beliefs and practices (e.g. refusal of blood transfusion, childbirth practices, chemotherapy, immunisation) free from manipulation or coercion.

Other competencies which have been integrated into Competency 32:
Demonstrate sensitivity and respect for diversity in care choices and health beliefs.
- Respect clients' beliefs and decisions in their care.
- Demonstrate sensitivity and respect for the client's diverse health care choices influenced by religious/spiritual beliefs and practices.
- Demonstrate sensitivity and respect to client's decisions in their care free from manipulation and coercion.
- Respect diversity in clients' decisions in their care based on religion, values and beliefs.
- Demonstrate sensitivity and responsiveness to clients' spiritual and health needs free from manipulation and coercion.
- Demonstrate sensitive and respect for diversity in choices and health beliefs (eg. sexual orientation, childbirth practices dietary differences, values, beliefs, culture).
- Recognise that people are unique beings who have beliefs that may influence their decisions in their care.
- Support the informed choice of the patient/client in making decisions regarding their care influenced by their religious beliefs (e.g. Right to refuse blood transfusion, organ donation, immunization, chemotherapy).

Competency 33
Ensure that clients feel valued, safe and secure, demonstrating a non-judgmental attitude, integrity (adherence to moral and ethical principles), dignity (self-esteem and self- respect) and privacy, providing holistic care.

Other competencies which have been integrated into Competency 33:

- Ensure clients' dignity in addressing clients' holistic health care needs.
- Respect clients' right for integrity, dignity and privacy
- Maintain respect, dignity and a non-judgmental attitude towards clients' thoughts and feelings.
- Demonstrate integrity, high moral standards and values and have lives directed to spiritual principles.
- Maintain respect, dignity and a non-judgmental attitude towards clients' thoughts and feelings.
- Respond with love in situations that pose internal conflicts and judgment.
- Demonstrate a non-judgmental attitude towards clients and their family.
- Demonstrate non-judgmental attitudes towards clients' needs.
- Demonstrate non-judgmental attitudes to diverse spiritual beliefs.
- Demonstrate non-judgmental behaviour towards clients' diversity.

Competency 34

Be the client's advocate (i.e. standing up for the client) whilst respecting his right for autonomy (i.e. free will of own actions), empowering clients (i.e. developing confidence in their own capacities) to reach decisions in their own care.

Other competencies which have been integrated into Competency 34:

- Stand up for the client, empowering clients to reach decisions in their own care.
- Respect person's right for autonomy and dignity.

Competency 35

Acknowledge and respect the client's right for information in order to reach decisions regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices.

Other competencies which have been integrated into Competency 35:

- Acknowledge and respect the clients' right for information regarding their health.
- Respect clients' right for information in reaching decisions regarding their illness, care and treatment.

Competency 36

Disclose information regarding the clients' illness and treatment in a sympathetic tactful manner, ensuring sensitiveness and constant explanations to ensure understanding about their welfare.

Other competencies which have been integrated into Competency 36:

- Disclose information to clients in a sympathetic tactful way
- Demonstrate sensitivity when providing information about clients' health issues.
- Ensure clear understanding of information to clients' in stressful situations.
- Provide consistent information regarding the clients' welfare.
- Understand the importance of providing explanations to clients' stressful situations.
- Provide information to clients consistently.
- Demonstrate sensitivity with clients.

Competency 37

Acknowledge and respect confidentiality issues in addressing clients' spiritual/ religious healthcare needs, disclosing information to significant members of the multi- disciplinary team, and documenting clients' findings in a retrievable way.

Other competencies which have been integrated into Competency 37:

- Acknowledge and respect confidentiality issues in addressing clients' spiritual health care needs.
- Acknowledge and respect clients' confidentiality when disclosing personal information to members of the healthcare team.
- Respect confidentiality and security of written and verbal information.
- Acknowledge and respect patients'/clients' confidentiality, autonomy, right of choice and decision making in addressing their spiritual and health needs.
- Disclose information about individuals to significant others of the team. .
- Respect appropriate disclosure of patients'/clients' personal information to members of the team.
- Document and communicates findings and interventions in a retrievable way.
- Value confidentiality and protects spiritual/religious information of clients.

Competency 38
Respect clients' individual characteristics in their way of thinking to decline spiritual/religious care.

Other competencies which have been integrated into Competency 38:

- Acknowledge and respect the clients' individual characteristics in their way of thinking.
- Respect right to decline spiritual care.
- Identify and respect decline of spiritual/religious care.
- Recognise patients'/clients' right to decline spiritual care.

DOMAIN 5: QUALITY ASSURANCE IN SPIRITUAL CARE

Competency 39
Demonstrate an understanding of spirituality and how it can be nurtured as part of professional growth as the basis of the vocational calling as nurse or midwife, demonstrating high moral values and have lives directed to spiritual principles.

Other competencies which have been integrated into Competency 39:

- Recognise nursing and midwifery as a way of spiritual calling.
- Value their own spirituality, nurture it as part of their professional growth and their well-being on the basis of their calling as a nurse or midwife.
- Demonstrate personal growth, high moral values and lives directed to spiritual principles.
- Demonstrate integrity, high moral standards and values and have lives directed to spiritual principles.
- Appreciate the vocational elements of the profession in clinical nursing /midwifery basic care.
- Acknowledge the vocational element of the nursing and midwifery professions. Demonstrate values of altruism, charity, family and lives directed to spiritual principles.
- Recognise the importance of both the art and science of the nursing and midwifery profession.

Competency 40
Ensure an appropriate professional behaviour demonstrating personal attributes (characteristics) of altruism (a sense of giving), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their family and colleagues undergoing stressful life situations.

Other competencies which have been integrated into Competency 40:

- Demonstrate attributes of understanding, caring, courage, reassurance and empowerment with clients.
- Demonstrate a positive attitude with clients through being genuine.
- Demonstrate an appropriate professional behaviour on the work place.
- Demonstrate a professional attitude of trust.
- Demonstrate values of altruism, charity, family and lives directed to spiritual principles.
- Demonstrate attributes of wisdom, reassurance, warmth, joy, responsibility, trust, respect, support, understanding, and caring for clients.
- Demonstrate empathy, patience, attention and love with clients undergoing stressful life situations.

Competency 41

Assist in the need for supervision and provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining hope and move on.

Other competencies which have been integrated into Competency 41:

- Be emotionally mature by having the capacity to witness and endure distress while sustaining an attitude of hope.
- Value the importance of seeking spiritual support from colleagues and members of the multi-disciplinary team.
- Assist in the provision and supervision of members in the team engaged in spiritual care.
- Recognise the need for professionals and students to deal with spiritual issues of members of the team**.**
- Participate in activities that provide emotional support for members of the team.

Competency 42

Recognise the need for continuing educational interest in spiritual care through reflection on own experience, in and on own practice, identification of role models, attending conferences and other learning events in order to improve spiritual care.

Other competencies which have been integrated into Competency 42:

- Understand the importance to further their academic and professional interests in spiritual care in order to improve patients'/ clients' care.
- Understand the importance of reflection on own practice and make changes as required.
- Identify role models who promote holistic reflective care.
- Identify role models who demonstrate holistic care.
- Understand the importance of own life experiences in own practice in relation to spiritual care.
- Recognise the need to participate in learning events on spiritual care.
- Understand the importance of reflection on own practice in relation to meeting spiritual needs and make changes as a result.
- Recognise the need to attend to conferences, presentations and other learning events on spiritual care.
- Is able to identify personal continuing educational needs and developments in spiritual care.

Competency 43

Contribute to scholarly research on the impact of spirituality and spiritual care on health and wellbeing in order to utilise the evidence in the improvement and provision of spiritual care.

Other competencies which have been integrated into Competency 43:

- Value research data on the impact of spirituality on health and on health outcomes.
- Uses evidence in providing spiritual care to patients/ clients.
- Contribute to scholarly research on the roles of spirituality and health.

Competency 44

Recognise the need to integrate spiritual care into management by developing and evaluating guidelines and policies on spiritual care and creating alliances with supervisors, administrators and policy makers.

Other competencies which have been integrated into Competency 44:

- Implement projects for the improvement of spiritual care for clients within the unit and team.
- Contribute to the development and evaluation of guidelines and policies on spiritual care.
- Values the need to integrate spirituality into management.
- Recognise the need to make policy recommendations about spiritual care to supervisors and administrators.

Competency 45

Create, foster and enhance a spiritual environment in the work place through a supportive, caring, calm environment nurtured by a spiritual healthy workforce, support system and purposeful activity such as creative art (e.g. painting).

Other competencies which have been integrated into Competency 45:

- Organise a place of worship to enhance the spiritual environment in the workplace.
- Participate in the creation of a spiritually healthy workforce and support systems available.
- Foster an environment that determines spiritual well-being through calmness and quietness.
- Participate in the creation of a spiritual healthy environment workforce.
- Participate in the creation of a supportive caring environment for clients and their family.
- Identify and develop resources that facilitate and create an environment for quiet reflection and purposeful activity such as creative art.
- Demonstrate creativity in purposeful activity such as keeping with clients' traditions, beliefs, work and routines.

Competency 46

Audit (evaluate) the environment to determine spiritual wellbeing for clients, their family and health carers and modify as needed.

Other competencies which have been integrated into Competency 46:

- Evaluate and audit the environment to determine spiritual well-being and modify environment as needed.
- Evaluate the environment to determine the spiritual well-being of clients and modify as needed.

Competency 47

Evaluate spiritual care resources in the primary health sector (community) to ensure follow up and continuity while discussing the legal, political and economic factors of incorporating spiritual care in all health care system.

Other competencies which have been integrated into Competency 47:

- Ensure follow up and continuity of spiritual care in the primary sector.
- Describe importance of incorporating spirituality into a healthcare system.
- Describe and evaluate spiritual resources in the community.
- Discuss legal, political and economic factors of healthcare that influence spiritual care.
- Apply spiritual care principles in primary health care settings.

DOMAIN 6:
ASSESSING, PLANNING, IMPLEMENTING AND EVALUATING SPIRITUAL CARE.

ASSESSING CARE
Competency 48
Provide opportunities for clients' on admission to hospital to express thoughts and feelings about spirituality in order to elicit a spiritual history, to assess and discern spiritual/religious needs utilizing formal (using an established tool) and informal (listening to the clients' experiences) assessment methods.

Other competencies which have been integrated into Competency 48:

- Demonstrate ability in assessing spiritual/religious needs.
- Elicit a spiritual history on admission to hospital to discern spiritual needs.
- Demonstrate ability in assessing clients' individual spiritual needs.
- Elicit a detailed spiritual history and identify clients' individual holistic needs.
- Value the opportunity of patients/ clients to express thoughts and feelings about spirituality.
- Assess spiritual/ religious needs of clients with progressive illnesses in a timely and appropriate way.
- Value clients 'request for spiritual attention

Competency 49
Recognise and address barriers to spiritual care in situations of spiritual distress manifested by emotions of anger towards God, frustration, isolation, conflict, helplessness and hopelessness in clients and their family.

Other competencies which have been integrated into Competency 49:

- Able to recognise and respond appropriately to emotions of anger, isolation and conflict in clients and families.
- Able to discern and address complex spiritual needs in situations of spiritual distress
- Recognise spiritual conflict and distress in clients and their family.
- Assess and identify spiritual distress.
- Is able to recognise and respond appropriately to spiritual conflict in clients and their families
- Assess family members' feelings of helplessness and hopelessness in coping with stressful life situations.
- Assess barriers to spiritual care such as anger towards God and frustration.
- Assess carers and family members' needs for support.

PLANNING CARE

Competency 50
Identify the intersections (shared elements) of ethical, legal, psychological, cultural, spiritual, religious issues and health concerns when planning care.

Other competencies which have been integrated into Competency 50:

- Recognise complex ethical and legal issues and deal with them appropriately.
- Able to recognise complex ethical issues and refer appropriately.
- Able to recognise spiritual, religious, psychological and ethical issues.
- Identify the intersections of legal and ethical issues, medical concerns and religious beliefs.

Competency 51

Recognise that spiritual care should be based on spiritual care models which integrate client - centred care and problem–based approach whilst the medical model of care focuses on the disease not the client.

Other competencies which have been integrated into Competency 51:

- Able to use a problem – based approach to plan care and meet identified spiritual needs.
- Recognise that the medical model of care is focused on the disease not the client.

Competency 52

Discuss with the client and team members how spiritual care is planned will be provided and reported ensuring that planned interventions are made in the light of identified spiritual needs and in the best interest of the client.

Other competencies which have been integrated into Competency 52:

- Ensures that medical treatment decisions are made in the light of identified spiritual needs.
- Plans and provides care to meet the client's needs and belief.
- Plans and provides caring interventions to meet the patients'/clients' spiritual needs.
- Discuss with the client and team members how spiritual care is planned, provided and reported.
- Discuss with members of the multidisciplinary team how to exercise spiritual/religious care in the best interest of the client.

IMPLEMENTING CARE

Competency 53

Understands the 'Ministry of ACTION' in conveying compassionate care i.e. helping clients find meaning in their suffering and addressing their spirituality while maintaining patience, tact, perseverance and discipline.

Other competencies which have been integrated into Competency 53:

- Understands the 'ministry' of action in conveying compassionate care.
- Acknowledge discipline as an essential element in providing spiritual care.
- Demonstrate patience, sweetness, tact and perseverance with depressed clients.

Competency 54

Demonstrate sensitivity when providing spiritual care interventions such as promoting clients' positive self- concept (e.g. promoting positive coping techniques), monitoring spiritual expression while promoting physical care and compassion with clients who do not conform with advice on their health.

Other competencies which have been integrated into Competency 54:

- Demonstrate sensitivity to clients.
- Provides caring interventions to meet clients' needs in a humane way.
- Promote the patient/client positive self-concept (eg. supporting cultural and spiritual preferences promoting coping techniques, hope, support and courage).
- Monitor spiritual expression while providing physical care.
- Demonstrate compassion with clients who do not conform with advice on their health.

Competency 55

Respond to clients' needs promptly demonstrating unhurried actions and good quality time.

Other competencies which have been integrated into Competency 55:

- Respond to clients' needs promptly
- Demonstrate good quality time with clients.
- Allow clients to spend time with carers who seem sympathetic and unhurried.

Competency 56

Allow family members to share and participate in the care to their loved ones assisting clients and their family to continue their spiritual habits and rituals, identify alternatives to instil hope.

Other competencies which have been integrated into Competency 56:

- Assist clients and their family to identify alternatives to instil hope.
- Assist clients to continue their spiritual habits and rituals.
- Allow family members to share and participate in the care to their loved ones.

Competency 57

Recognise and acknowledge the role of chaplains, ministers and spiritual leaders as experts of spiritual care and collaborate with clients, family, and other members of the multi-disciplinary team in providing spiritual care for clients, their family and healthcare professionals.

Other competencies which have been integrated into Competency 57:

- Respect the role of clergy and other spiritual leaders in providing spiritual care.
- Appreciate the role of chaplains and spiritual leaders in providing spiritual care.
- Recognise need to refer to other members of the multi-disciplinary team.
- Seek assistance and refer to the appropriate spiritual/ religious experts.
- Value the collaboration of other health care professionals in providing spiritual care.
- Respect the role of clergy and spiritual leaders in providing spiritual care.
- Collaborate with staff, family, pastoral care and other members of the healthcare team.

Competency 58

Recognise the role and responsibility of the nurse/ midwife to IDENTIFY the need to REFER clients, family members and other healthcare workers to chaplains, ministers, spiritual leaders, and members of the team (counsellor, psychologist) appropriately and in a timely manner and as often is requested.

Other competencies which have been integrated into Competency 58:

- Refer appropriately and effectively to members of the multi-disciplinary.
- Refer clients to the appropriate provider of spiritual/religious care.
- Refer to other providers of spiritual care appropriately and in a timely manner.

- Identify the need to call on ministers, chaplains and spiritual leaders.
- Recognise the role and responsibility of the nurse to assist clients to request spiritual/religious attention.
- Recognise and respond to religious/spiritual requests of all clients and their family.
- Identify the need to consult the chaplain or spiritual leader as often as the client requests.
- Perform spiritual/religious assessment and provide spiritual/ religious interventions to all clients at the appropriate time.
- Recognise the need to consult a chaplain or spiritual leader and see that contact is done.
- To refer to another provider of spiritual care in a timely and appropriate way.

Competency 59
Following referral provide feedback to clients and the relevant members of the team ensuring follow up.

Other competencies which have been integrated into Competency 59:
- Provides feedback to clients and team members following referral.
- Ensure follow up care of referrals

EVALUATION

Competency 60
Evaluate effectiveness of spiritual interventions through monitoring clients' self- concept (e.g. acceptance) and identify unmet spiritual needs.

Other competencies which have been integrated into Competency 60:
- Recognise any unmet spiritual needs.
- Able to evaluate the effectiveness of spiritual interventions through monitoring patients'/clients' self-concept, acceptance and spiritual integrity.

Competency 61
Identify barriers to the provision of spiritual care such as nurses and midwives lack of time, fatigue and burn out and seek alternatives.

Other competencies which have been integrated into Competency 61:
- Identify barriers to spiritual care such as lack of time, fatigue and burnout

DOMAIN 7: INFORMATICS

Competency 62
Acknowledge the use of information technology to communicate and manage knowledge in terms of enhancing own continuing knowledge in spiritual care, plans and documents clients' data and communicate with people through the network as a means of spiritual support (e.g. Facebook, Twitter).

Other competencies which have been integrated into Competency 62:
- Identify the importance of information technology to enhance knowledge on spiritual care.
- Use information technology to inform carers about alternative therapies in providing care.
- Acknowledge the use of information technology as a valuable learning tool when dealing with spiritual care issues.

- Use information technology to enhance own continuing knowledge in spiritual care.
- Explain the reason why information technology skills are essential in providing spiritual care.
- Is able to document and plans clients' spiritual care in an electronic health data base.
- Uses research based information and technology to communicate, manage knowledge and mitigate errors to improve and support spiritual care.
- Communicate with people through the network as a means of spiritual support.

[7 domains& 55 final collapsed competencies]

-----Original Message-----
From: Leeuwen, R van [mailto:rleeuwen@gh.nl]
Sent: Tuesday, January 24, 2012 3:01 PM
To: JOSEPHINE ATTARD
Subject: RE: SCCS

Hello Josephine,

I understand the changes you want to apply in the SCCS. I can agree with that and, of course, I give you my permission to use that modified tool.
Good to hear that you are going to use the SCCS as a whole. I am looking forward to your results.
Is your study going well?

Success and best wishes, also for Donia,

René

Postbus 10030
8000 GA Zwolle

Grasdorpstraat 2
8012 EN Zwolle

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F 038 - 423 07 85

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APPENDIX 16 SELECTION OF EXPERTS
NURSES AND MIDWIVES: PARTICIPANTS' INFORMATION SHEET

Title of the study:
Framework of competencies in spiritual care for nurses and midwives:
A modified Delphi study

Dear Participant,
I am Josephine Attard undergoing my PhD studies at the University of Glamorgan, Wales U.K. and the University of Malta under the supervision of Dr. Linda Ross and a team of supervisors. Dr. Donia Baldacchino is my local supervisor.

The goal of this Modified Delphi study is to gain consensus nationally from nursing and midwifery practitioners, educators, policy makers, spiritual leaders, hospital psychologists and counsellors and clients on competencies (knowledge, skills and attitudes) in spiritual care that will guide nurses and midwives at point of registration. The potential benefit of the study is to better the professional preparation of nurses and midwives to provide holistic care to clients.

As you are aware the area of study in spiritual care was only recently introduced in nursing and midwifery curricula. Consequently the researcher needs to gauge your opinion on competencies in spiritual care in a preliminary questionnaire based on van Leeuwen *et al.* (2008) Spiritual care competency scale.

The processing of responses and any personal information will be for the purposes of this research study and such information will be treated as strictly confidential and handled in accordance with the provisions of the Data protection Act.
If you agree to participate in the study, please sign the consent form and fill in questionnaire enclosed and return it in the self- addressed envelope provided.
If you have any questions about the study or about participating in the study, please feel free to contact me on mobile No 79340682 or e-mail josephine.attard@um.edu.mt. or my supervisors:

Dr. Linda Ross: lross@glam.ac.uk,
Dr. Donia Baldacchino:donia.baldacchino@um.edu.mt

The University of Glamorgan Wales and the University of Malta Ethics Committee have approved the study and procedures.

You can also find the questionnaire online by following this link:
http://tinyurl.com/84h7jj2

Kind regards,

Josephine Attard

APPENDIX 17 SCCS QUESTIONNAIRE FOR NURSES (van Leuween *et al.,* 2008)

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR NURSES (Based on SCCS, van Leeuwen *et al.,* 2008) (cont.)

Thank you for consenting to participate in this phase of the study. Please complete the questionnaire and submit in the stamped self-addressed envelope enclosed. Please respond by 24th February 2012.

Section A **CODE NUMBER:**

1. **Did you ever undertake any education on 'SPIRITUALITY/'SPIRITUAL CARE'? (Please tick ✓appropriate box)**

   Yes ☐ **No** ☐

2. **If your response to question 1 is Yes when did you take this education? (Please tick ✓appropriate box/es)**

   During your pre-registration nursing program? ☐

   During continuing professional education (CPD)? ☐

   Other ☐

Please specify_____

Section B

Please circle ◯ the extent to which you agree/disagree with the following competencies in spiritual care

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR NURSES (Based on SCCS, van Leeuwen *et al.,* 2008) (cont.)

Please circle ◯ the extent to which you agree/disagree with the following competencies in spiritual care.

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR NURSES (BASED ON SCCS VAN LEEUWEN *et al.,* 2008) (cont.)

Please circle ◯ the extent to which you agree/disagree with the following competencies in spiritual care.

9. I can tailor care to a patient's spiritual needs/problems through multi-disciplinary consultation.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR NURSES (Based on SCCS van Leeuwen *et al.,* 2008) (cont.)

Please circle ◯ the extent to which you agree/disagree with the following competencies in spiritual care.

16. I can provide a patient with spiritual care.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR NURSES (Based on SCCS van Leeuwen *et al.,* 2008) (cont.)

Please circle ◯ the extent to which you agree/disagree with the following competencies in spiritual care.

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

24. Within the department, I can identify problems relating to spiritual care in peer discussion sessions.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

THANK YOU FOR YOUR CONTRIBUTION

APPENDIX 18 SCCS QUESTIONNAIRE FOR MIDWIVES (van Leeuwen *et al.,* 2008)

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR MIDWIVES (Based on SCCS, van Leeuwen *et al.,* 2008).

Thank you for consenting to participate in this phase of the study. Please complete the questionnaire and submit in the stamped self-addressed envelope enclosed. Please respond by 24th February 2012.

Section A

CODE NUMBER:

1. **Did you ever undertake any education on 'SPIRITUALITY'/'SPIRITUAL CARE'? (Please tick ✓appropriate box)**
   Yes ☐ **No** ☐
2. **If your response to question 1 is Yes when did you take this education? (Please tick ✓appropriate box/es)**

During your pre-registration midwifery program? ☐

During continuing professional education (CPD)? ☐

Other ☐ **Please specify**_____

Section B

Please circle ◯ the extent to which you agree/disagree with the following competencies in spiritual care PROVIDING SPIRITUAL CARE TO WOMEN AND THEIR FAMILIES IMPLIES THAT:

1. I show unprejudiced respect for the client's spiritual/religious beliefs regardless of her spiritual/religious background.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR MIDWIVES (Based on SCCS, van Leeuwen *et al.,* 2008).

Please circle ◯the extent to which you agree/disagree with the following competencies in spiritual care

.

2. I am open to the client's spiritual/religious beliefs, even if they differ from my own.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

3. I do not try to impose my own spiritual/ religious beliefs on the client.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

5. I can listen actively to the client's 'life story' in relation to her condition.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

7. I can report orally and / or in writing on the client's spiritual needs.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

8. I can tailor care to the client's spiritual needs/ problems in consultation with the client.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

9. I can tailor care to the client's spiritual needs/problems through multidisciplinary consultation.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

10. I can record the midwifery component of the client's spiritual care in the midwifery care plan.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

11. I can report in writing the client's spiritual functioning.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

12. I can report orally on the client's spiritual functioning.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

13. I can effectively assign care for the client's spiritual needs to another care provider/care discipline.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

15. I know when I should consult a spiritual advisor concerning the client's spiritual care.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

16. I can provide the client with spiritual care.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

18. I can give the client information about spiritual facilities within the care institution (including spiritual care, meditation centre, religious services).

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

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

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

25. I can coach other care workers in the area of spiritual care delivery to clients.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

26. I can make policy recommendations on aspects of spiritual care to the management of the midwifery department

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

27. I can implement a spiritual-care improvement project in the midwifery department.

1	2	3	4	5
Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree

THANK YOU FOR YOUR CONTRIBUTION

APPENDIX 19 SCCS QUESTIONNAIRE FOR NURSES:
EXEMPLAR: EMAIL AND WEB (van Leeuwen, *et al.,* 2008)

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR NURSES (BASED ON SCCS VAN LEEUWEN *et al.,* 2008)

Thank you for consenting to participate in this phase of the study. Please complete the questionnaire and submit by 24th February 2012.

* Required Name & Surname *

Did you undertake any 'SPIRITUALITY' 'SPIRITUAL CARE' study/ education? *

- YES
- NO

If your response is Yes when did you take the 'Spirituality' 'Spiritual care' education? *

- During your pre-registration course?
- During continuing professional education (CPD)?
- Other:

- Please indicate the extent to which you agree/ disagree with the following:

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

	1	2	3	4	5	
Completely Disagree						Fully Agree

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

	1	2	3	4	5	
Completely Disagree						Fully Agree

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

	1	2	3	4	5	
Completely Disagree						Fully Agree

APPENDIX 20 SCCS QUESTIONNAIRE FOR MIDWIVES: EXEMPLAR: EMAIL AND WEB (van Leeuwen *et al.,* 2008)

PRELIMINARY QUESTIONNAIRE TO GAUGE YOUR VIEWS ON COMPETENCIES IN SPIRITUAL CARE FOR MIDWIVES (Based on SCCS van Leeuwen *et al.,* 2008).
Thank you for consenting to participate in this phase of the study. Please complete the questionnaire and submit by 24th February 2012.

* Required Name & Surname *

Did you undertake any 'SPIRITUALITY' 'SPIRITUAL CARE' study/ education? *

- YES
- NO

If your response is Yes when did you take the 'Spirituality' 'Spiritual care' education? *

- During your pre-registration course?
- During continuing professional education (CPD)?
- Other:

- Please indicate the extent to which you agree/ disagree with the following:

1. I show unprejudiced respect for the client's spiritual/ religious beliefs regardless of his or her spiritual/ religious background

	1	2	3	4	5	
Completely Disagree						Fully Agree

2. I am open to the client's spiritual/ religious beliefs, even if they differ from my own

	1	2	3	4	5	
Completely Disagree						Fully Agree

3. I do not try to impose my own spiritual/religious beliefs on the client

	1	2	3	4	5	
Completely Disagree						Fully Agree

APPENDIX 21 MODIFIED DELPHI STUDY: PARTICIPANT INFORMATION SHEET

Title of the Study:
Framework of competencies in spiritual care for nurses and midwives:
A modified Delphi study

Dear Participant,

I am Josephine Attard undergoing my PhD studies at the University of Glamorgan, Wales U.K. and the University of Malta under the supervision of Dr. Linda Ross and a team of supervisors. Dr. Donia Baldacchino is my local supervisor.

You have been identified as an 'expert 'to participate in this modified Delphi study as your knowledge and experience can contribute in validating a set of competencies in spiritual care for nurses and midwives.

The goal of this Modified Delphi study is to gain consensus nationally from nursing and midwifery practitioners, educators, policy makers, spiritual leaders, hospital psychologists and counsellors and clients on competencies (knowledge, skills and attitudes) in spiritual care that will guide nurses and midwives at point of registration. The potential benefit of the study is to better the professional preparation of nurses and midwives to provide holistic care to clients.

This modified Delphi study consists of two rounds of questionnaires and your participation involves filling in a questionnaire for each round. It is important to emphasize that commitment to participate involves participating in the two rounds

- The first round questionnaire which will occur in May 2012, asks you to grade the strength of your opinion to a list of competencies in spiritual care based on your personal/professional judgment and to identify any other additional competencies.
- The second round questionnaire will ask you to **reconsider your response indicated** in the context of feedback derived from participants provided through the average (mean) score. This round of questionnaires will be distributed in July 2012.

There will be a process of iteration and controlled feedback. You will be issued with a code number to ensure anonymity amongst the panel of expert members and the opinions of the panel will remain confidential. Your participation, commitment and expertise will be greatly appreciated. **If you agree to participate in the study, please sign the consent form and fill in questionnaire enclosed and return it in the self- addressed envelope provided.**

If you have any questions about the study or about participating in the study, please feel free to contact me on mobile No 79340682 or e-mail josephine.attard@um.edu.mt or my supervisors:

Dr. Linda Ross: lross@glam.ac.uk,

Dr. Donia Baldacchino: donia.baldacchino@um.edu.mt

The University of Glamorgan Wales and the **University of Malta Ethics Commitee have approved the study and procedures.**

Kind regards,

Josephine Attard

APPENDIX 22 THE MODIFIED DELPHI STUDY: LIST OF EXPERTS

Key: (F/M): Male (M), Female (F)

No	INDEX	AGE	F/M	PROFESSION	GRP	R1	R2	COMMENTS
1	*4	48	M	Nurse(CICU)	1	✓	✓	
2	*9	43	F	Nurse(Medical)	1	✓	✓	
3	*11	24	F	Nurse(theatre)	1	✓		
4	*12	40	F	Nurse(stoma care)	1	✓	✓	
5	*14	48	F	Nurse(Urology)	1	✓	✓	
6	*15	44	F	Nurse(Medical)	1	✓	✓	
7	*17	27	F	Nurse(Obstetrics)	1	✓	✓	
8	*18	28	F	Nurse(Ophthalmic)	1	✓	✓	
9	*22	36	M	Nurse(ITU)	1	✓	✓	
10	*23	29	F	Nurse(Surgical)	1	✓	✓	
11	*24	30	F	Nurse(Phlebotomy)	1	✓	✓	
12	*25	28	F	Nurse(Tissue viability)	1	✓	✓	
13	*26	48	F	Nurse(Geriatrics)	1	✓	✓	
14	*27	31	F	Nurse(Paediatrics)	1	✓	✓	
15	*29	28	F	Nurse (Surgical)	1	✓	✓	
16	*30	47	F	Nurse (Paediatrics)	1	✓	✓	
17	*32	28	F	Nurse (Theatre)	1	✓	✓	
18	*33	29	F	Nurse (ophthalmic)	1	✓	✓	
19	*34	26	F	Nurse (Palliative care)	1	✓	✓	
20	*37	28	F	Nurse(Gynaecology)	1	✓	✓	
21	*40	27	F	Nurse(Urology)	1	✓	✓	
22	*43	34	F	Nurse (Hospice)	1	✓	✓	
23	*44	24	F	Nurse(Geriatric)	1	✓	✓	
24	*45	29	F	Nurse (Hospice)	1	✓		
25	*47	28	F	Nurse(Orthopaedics)	1	✓	✓	
26	*48	45	F	Nurse(Tissue viability)	1	✓	✓	
27	*52	31	F	Nurse (ITU)	1	✓	✓	
28	*54	27	F	Nurse (Surgical)	1	✓	✓	
29	*63	30	F	Nurse (Theatre)	1	✓	✓	
30	*65	57	F	Mental health Nurse	1	✓	✓	Crisis management team
31	*67	25	F	Nurse (Oncology)	1	✓	✓	
32	*68	48	F	Nurse (Hlth centre)	1	✓	✓	
33	*71	25	F	Nurse (A&E)	1	✓	✓	
34	*75	36	F	Nurse (Pediatrics)	1	✓	✓	
35	*77	31	F	Nurse (Pediatrics)	1	✓	✓	
36	*84	25	F	Nurse (Mental Hlth)	1	✓	✓	
37	*87	26	M	Nurse (Med/ Surg)	1	✓	✓	
38	*91	35	F	Nurse (Mental Hlth)	1	✓	✓	Crisis management
39	*92	33	M	Nurse (Mental Hlth)	1	✓	✓	Atheist
40	*93	28	M	Nurse (A&E)	1	✓	✓	
41	*96	40	F	Nurse (Theatre)	1	✓	✓	
42	*98	34	M	Nurse (Mental Hlth)	1	✓	✓	Crisis management
43	*99	43	M	Nurse (Theatre)	1	✓	✓	
44	*101	25	F	Nurse (Hlth centre)	1	✓	✓	
45	*102	44	F	Nurse (E&A)	1	✓	✓	
46	*103	24	F	Nurse(Gast.enterology)	1	✓	✓	
47	*104	30	M	Nurse (Phlebotomy)	1	✓	✓	

No	INDEX	AGE	F/M	PROFESSION	GRP	R1	R2	COMMENTS
48	*105	27	F	Nurse (Mental Hlth)	1	✓	✓	Outreach Team
49	*110	38	F	Nurse (Theatre)	1	✓	✓	
50	*201	27	F	Nurse (Oncology)	1	✓	✓	
51	*112	39	F	Midwife(B/F clinic)	2	✓	✓	
52	*113	47	F	Midwife (B/F clinic)	2	✓	✓	
53	*114	48	F	Midwife (B/F clinic)	2	✓	✓	
54	*115	22	F	Midwife(Obstetrics)	2	✓		
55	*117	49	F	Midwife (P/Craft edu.)	2	✓	✓	
56	*120	36	F	Midwife (Obstetrics)	2	✓		
57	*123	42	F	Midwife (P'craft edu.)	2	✓	✓	
58	*124	53	F	Midwife (Obstetrics)	2	✓	✓	
59	*125	22	F	Midwife (NPICU)	2	✓		
60	*128	23	F	Midwife (Obstetrics)	2	✓		
61	*129	27	F	Midwife (Obstetrics)	2	✓	✓	
62	*134	45	F	Midwife (P'Craft edu.)	2	✓		
63	*135	24	F	Midwife (Obstetrics)	2	✓	✓	
64	*139	38	F	Midwife (Obstetrics)	2	✓	✓	
65	*142	26	F	Midwife (Obstetrics)	2	✓		
66	*143	48	F	Midwife (Obstetrics)	2	✓	✓	
67	*145	33	F	Midwife (Obstetrics)	2	✓	✓	
68	*146	59	F	Midwife(Delivery suite)	2	✓	✓	
69	*150	24	F	Midwife (Obstetrics)	2	✓	✓	
70	*151	45	F	Midwife (Obstetrics)	2	✓	✓	
71	*154	29	F	Midwife (NPICU)	2	✓	✓	
72	*156	23	F	Midwife (Obstetrics)	2	✓	✓	
73	*157	48	F	Midwife (Delivery suite)	2	✓	✓	
74	*160	55	F	Midwife(Ultra sound)	2	✓	✓	
75	*164	34	F	Midwife (Obstetrics)	2	✓	✓	
76	*171	36	F	Midwife (obstetrics)	2	✓	✓	
77	*172	39	F	Midwife (P'Craft Edu.)	2	✓	✓	
78	*174	51	F	Midwife (Obstetrics)	2	✓	✓	
79	*175	39	F	Midwife(Delivery suite)	2	✓	✓	
80	*176	24	F	Midwife (Obstetrics)	2	✓	✓	
81	*177	56	F	Midwife (Obstetrics)	2	✓	✓	
82	*179	53	F	Midwife (Obstetrics)	2	✓	✓	
83	*180	36	F	Midwife (Obstetrics)	2	✓	✓	
84	*181	53	F	Midwife (Obstetrics)	2	✓	✓	
85	*183	50	F	Midwife (Obstetrics)	2	✓	✓	
86	*185	33	F	Midwife (Obstetrics)	2	✓	✓	
87	*188	51	F	Midwife (Delivery Suite)	2	✓	✓	
88	*1	45	M	Clin. Nurse Edu. (Theatre)	3	✓	✓	
89	*2	26	F	Clin. Nurse Edu. (NPICU)	3	✓		
90	*3	56	M	Clin. Nurse Educator	3	✓	✓	Geriatrics
91	*6	25	F	Clin. Nurse Educator	3	✓	✓	Geriatrics
92	*7	42	F	Clin. Nurse Edu.	3	✓	✓	Mental Hlth.
93	*10	26	F	Clin. Nurse Edu. (A&E)	3	✓	✓	
94	*13	53	F	Clin. Nurse Edu.	3	✓	✓	Mental Hlth.
95	*16	33	F	Clin. Nurse Edu.	3	✓	✓	Mental Hlth.
96	*21	36	F	Clin. Nurse Edu. (A&E)	3	✓	✓	
97	*28	62	F	Clin. Nurse Edu.(Medical)	3	✓	✓	
98	*31	29	M	Clin. Nurse Edu. (Surgical)	3	✓	✓	
99	*35	40	F	Clin. Nurse Edu.	3	✓	✓	Primary care
100	*36	34	F	Clin. Nurse Edu.	3	✓	✓	Obstetrics
101	*158	31	F	Clin. Nurse Edu.	3	✓		Mental Hlth.

No	INDEX	AGE	F/M	PROFESSION	GRP	R1	R2	COMMENTS
102	*162	44	M	Clin. Nurse Edu.	3	✓	✓	Mental Hlth.
103	*167	46	F	Clin. Nurse Edu.	3	✓	✓	Mental Hlth.
104	*169	48	M	Clin. Nurse Edu.(Medical)	3	✓	✓	
105	*195	33	M	Clin. Nurse Edu.(Medical)	3	✓		
106	*196	25	F	Clin. Nurse Edu.(Medical)	3	✓	✓	
107	*209	32	F	Clin. Nurse Edu.	3	✓	✓	Coronary care
108	*211	46	M	Clin. Nurse Edu. (ENT)	3	✓	✓	
109	*213	26	F	Clin. Nurse Edu.	3	✓		Mental Hlth
110	*214	29	M	Clin. Nurse Edu. (Surgical)	3	✓	✓	
111	*215	26	F	Clin. Nurse Edu. (Surgical)	3	✓	✓	
112	*218	28	F	Clin. Nurse Edu.	3	✓	✓	Geriatrics
113	*61	50	F	Clin. Midwife Edu	4	✓		Obstetrics
114	*66	38	F	Clin. Midwife Edu	4	✓	✓	Rotation
115	*70	50	F	Clin. Midwife Edu	4	✓	✓	Delivery
116	*73	50	F	Clin. Midwife Edu	4	✓		Obstetric
117	*78	37	F	Clin. Midwife Edu	4	✓		Delivery
118	*121	29	F	Clin. Midwife Edu (NPICU)	4	✓	✓	
119	*122	49	F	Clin. Midwife Edu	4	✓	✓	Delivery
120	*130	46	F	Clin. Midwife Edu	4	✓	✓	Obstetrics
121	*147	53	F	Clin. Midwife Edu	4	✓	✓	Delivery
122	*197	27	F	Clin. Midwife Edu	4	✓	✓	Delivery
123	*210	27	F	Clin. Midwife Edu	4	✓	✓	Obstetric
124	*273	48	F	Clin. Midwife Edu	4	✓	✓	Obstetric
125	*83	51	F	Nurse Faculty Lecturer	5	✓	✓	
126	*85	38	F	Nurse Faculty Lecturer	5	✓	✓	
127	*88	53	F	Nurse Faculty lecturer	5	✓	✓	
128	*89	39	F	Nurse faculty Lecturer	5	✓	✓	
129	*94	29	F	Nurse Faculty Lecturer	5	✓	✓	
130	*95	52	F	Nurse Faculty Lecturer	5	✓	✓	
131	*97	32	M	Nurse Faculty Lecturer	5	✓	✓	
132	*106	50	F	Nurse Faculty Lecturer	5	✓	✓	
133	*107	49	F	Nurse Faculty Lecturer	5	✓	✓	
134	*108	33	M	Nurse Faculty Lecturer	5	✓	✓	
135	*131	52	M	Nurse Faculty Lecturer	5	✓	✓	
136	*132	61	M	Nurse Faculty lecturer	5	✓	✓	
137	*133	46	F	Medical doctor	5	✓		Faculty lecturer
138	*138	44	M	Psychologist	5	✓	✓	Faculty Lecturer
139	*140	38	M	Nurse Faculty lecturer	5	✓	✓	
140	*202	51	F	Nurse Faculty Lecturer	5	✓	✓	
141	*199	58	F	Nurse Faculty Lecturer	5	✓	✓	
142	*250	52	F	Nurse Faculty lecturer	5	✓		
143	*254	59	F	Nurse Faculty lecturer	5	✓	✓	
144	*266	35	M	Nurse Faculty Lecturer	5	✓		
145	*82	61	F	Midwife Faculty lecturer	6	✓	✓	
146	*255	27	F	Midwife Faculty Lecturer	6	✓	✓	
147	*141	26	F	Midwife Faculty Lecturer	6	✓	✓	
148	*50	53	M	Priest(RC)/Counsellor	7	✓	✓	Hospital chaplain
149	*39	56	M	Priest(RC)/Lecturer	7	✓	✓	
150	*170	39	M	Priest (RC)	7	✓	✓	Hospital chaplain
151	*189	50	M	Priest (RC)/Lecturer	7	✓	✓	
152	*191	35	M	Priest (RC)/Lecturer	7	✓	✓	
153	*193	58	M	Priest (RC)/Lecturer	7	✓	✓	Clinical Psychologist
154	*203	45	M	Priest (RC)	7	✓	✓	Hospital chaplain
155	*224	52	F	Counsellor	7	✓	✓	
156	*228	61	M	Imam	7	✓	✓	Imam
157	*232	59	M	Priest Church of England	7	✓	✓	Anglican chaplain_Malta
158	*237	48	F	Nurse/Psychotherapist	7	✓	✓	Psychotherapist for qualified staff DH

No	INDEX	AGE	F/M	PROFESSION	GRP	R1	R2	COMMENTS
159	*240	40	M	Psychologist	7	✓		Clinical psychologist DH
160	*241	55	F	Psychologist	7	✓	✓	Clinical psychologist DH
161	*244	40	M	Pastor (Theologian)	7	✓		Nations for Christ/River of love
162	*245	42	F	Psychologist	7	✓		Clinical Psychologist DH
163	*246	55	M	Priest (RC)	7	✓		Hospital chaplain
164	*247	62	M	Church minister	7	✓	✓	St Andrew's Church of Scotland in Malta
165	*249	47	F	Psychologist/Nurse	7	✓		Clinical psychologist DH
166	*253	40	M	Psychiatrist	7	✓	✓	Head of CRISIS team DH
167	*263	48	F	Midwife Counsellor	7	✓	✓	Bereavement midwife
168	*267	36	M	Spiritual director	7	✓		Spiritual Director for youths
169	*271	38	M	Engineer	7	✓	✓	Chairman. Jehovah's Witness
170	*278	72	M	Hospital Chaplain (RC)	7	✓	✓	Hospital chaplain
171	*279	63	M	Hospital Chaplain (RC)	7	✓	✓	Hospital chaplain
172	*281	40	M	Lawyer/Pastor	7	✓		Director of open centre for refugees in Malta
173	*38	60	F	Midwife(Obstetrics)	8	✓	✓	Midwifery Manager DH
174	*41	54	F	Nurse (Hospice)	8	✓	✓	Gen. Manager Hospice
175	*42	48	F	Nurse (Hospice)	8	✓	✓	Care Service manager Hospice
176	*51	60	F	Nurse (Oncology)	8	✓	✓	Departmental Nursing Manager (General)
177	*53	47	M	Nurse(Geriatrics)	8	✓	✓	Departmental. Nursing Manager MUMN Hon. Pres. ICN Vice President
178	*57	58	F	Midwife(Obstetrics)	8	✓	✓	Manager Midwifery Services
179	*60	49	F	Midwife (Obstetrics)	8	✓	✓	Departmental Midwifery Manager
180	*81	58	F	Midwife (Faculty lecturer)	8	✓	✓	Head of Department Midwifery Studies. Member N&M council
181	*111	38	F	Nurse (Wound Care)	8	✓	✓	Departmental Nurse Manager (General)
182	*116	41	M	Nurse Clinical Nutritionist	8	✓	✓	Member of the N&M council
183	*118	69	F	Nurse (Primary care)	8	✓	✓	Chairperson M M D N A
184	*178	59	F	Nurse (Management)	8	✓		Manager Nursing Services
185	*186	42	M	Nurse (Management)	8	✓		General Manager. Private Sector
186	*204	28	M	Nurse (Medical)	8	✓	✓	Council Member MNMN
187	*205	49	F	Midwife (B/F Clinic)	8	✓	✓	Council member MNMN
188	*206	51	F	Nurse (management)	8	✓	✓	Nurse Manager Community
189	*212	41	F	Nurse (Faculty Lecturer)	8	✓		Head of Department Nursing Studies
190	*217	53	F	Nurse (Mental Health)	8	✓	✓	Manager. Dementia Unit U.K.
191	*219	56	F	Nurse (Oncology)	8	✓	✓	Manager Nursing Services (Oncology hospital) DH
192	*220	38	F	Medical Dr. (Lecturer)	8	✓	✓	Chief Medical Officer DH
193	*221	40	F	Nurse (Lecturer)	8	✓	✓	Policy co-coordinator DH
194	*223	40	F	Nurse (management)	8	✓		Director of Nursing and Midwifery DH

No	INDEX	AGE	F/M	PROFESSION	GRP	R1	R2	COMMENTS
195	*248	32	M	Nurse (Medical)	8	✓	✓	Council Member on the Nursing and Midwifery Council DH
196	*252	52	M	Nurse (Mental Health)	8	✓	✓	Manager Nursing Services (Psychiatric Hospital DH)
197	*257	54	F	Midwife	8	✓	✓	Midwifery Manager MMDNA (Community)
198	*269	58	F	Nurse	8	✓	✓	Manager of M.M.D.N.A
199	*274	65	F	Director of Continuing Adult Education	8	✓	✓	Chairperson of the Board Elderly Homes
200	*275	75	F	Nurse/Midwife	8	✓	✓	Nursing and Midwifery Consultant to the MMDNA (Community)
201	*277	48	F	Nurse	8	✓	✓	Manager of Antenatal Care DH
202	*280	49	F	Midwife	8	✓		Planning manager. Nursing and Midwifery
203	*46		F	Teacher	9	✓	✓	President : Malta Diabetes Association
204	*49	47	F	Nurse Manager Diabetic Clinic	9	✓	✓	Council Member Malta Diabetes Association
205	*55	39	F	Nurse (Hospice)	9	✓	✓	Member of Hospice Movement (Malta)
206	*58	41	F	Nurse (Hospice)	9	✓	✓	Member of Hospice Movement (Malta)
207	*59	43	F	Nurse (Hospice)	9	✓		Member of Hospice Movement (Malta)
208	*198	36	F	Nurse (Hospice)	9	✓	✓	Member of Hospice Movement (Malta)
209	*207	45	F	Nurse (Hospice)	9	✓	✓	Member of Hospice Movement (Malta)
210	*238	56	M	Family doctor	9	✓	✓	President: Mental Health Association.
211	*229	66	F	Housewife	9	✓	✓	President: Breast Cancer Support
212	*231	69	F	Housewife	9	✓	✓	Chairperson Coeliac Association Malta
213	*234	48	F	Housewife	9	✓	✓	Member of the Multiple Sclerosis Association Malta
214	*242		F	Nursing aid	9	✓	✓	Member to the Action for Breast Cancer Foundation
215	*243	60	F	Nurse	9	✓	✓	Member to the Action for Breast Cancer Foundation
216	*264	47	M	Manager/Radiographer	9	✓	✓	President: Malta Asthmatic Society
217	*230	55	F	Teacher	9	✓	✓	Member: Coeliac Association, Malta
218	*64	44	F	Midwife(clinical practice)	9	✓	✓	President of the Malta Midwives Association
219	*137	47	F	Medical doctor	10	✓		Experienced: Surgical operation, childbirth and Loss of a loved one.
220	*148	43	F	Client (surgical)	10	✓	✓	Experienced: Cancer, surgical operation and childbirth.
221	*149	39	M	Client(Medical/ surgical)	10	✓	✓	Suffers from Diabetes and had coronary by-pass.
222	*216	37	F	Paramedic	10	✓	✓	Suffers from asthma

No	INDEX	AGE	F/M	PROFESSION	GRP	R1	R2	COMMENTS
223	*222	28	F	Housewife	10	✓	✓	Experienced a surgical op., childbirth and loss of loved one.
224	*225	29	F	Teacher	10	✓	✓	Experienced a surgical operation and childbirth.
225	*226	58	F	Teacher	10	✓		Experienced cancer chemotherapy, surgical op. and childbirth.
226	*227	22	M	student	10	✓	✓	Suffers from diabetes
227	*233	37	M	Security Manager	10	✓	✓	Suffers from a mental health condition
228	*235	30	F	Nurse	10	✓	✓	Experienced miscarriage and childbirth
229	*236	39	F	Senior clerk	10	✓		Suffers from diabetes
230	*251	33	F	Clerk	10	✓	✓	Suffers from mental health condition
231	*256	67	F	Religious	10	✓	✓	Experienced a surgical operation and chemotherapy
232	*258	29	F	Nurse	10	✓	✓	Experienced childbirth
233	*259	56	M	Gerontologist Social work	10	✓		Suffers from medical conditions and had surgical operations
234	*260	47	F	Teacher	10	✓	✓	Had a surgical operation and had loss of a loved one
235	*261	65	M	General surgeon	10	✓	✓	Had a surgical operation and lossof a loved one
236	*262	60	F	College Principal	10	✓		Had a surgical operation
237	*265	48	F	Public health doctor	10	✓	✓	Had a surgical operation and experienced childbirth.
238	*268	64	M	Senior citizen	10	✓	✓	Suffers from a medical condition and had a Surgical operation
239	*270	32	F	Learning support Ass.	10	✓	✓	Had a surgical operation and experienced childbirth
240	*272	46	F	General Practitioner	10	✓	✓	Had a surgical operation, experienced childbirth and loss of a loved one
241	*276	42	F	Teacher	10	✓		Had a surgical operation

APPENDIX 23 ROUND 1 OF THE MODIFIED DELPHI STUDY: THE QUESTIONNAIRE

TITLE OF THE STUDY:
FRAMEWORK OF COMPETENCIES IN SPIRITUAL CARE FOR NURSES AND MIDWIVES: A MODIFIED DELPHI STUDY.

INSTRUCTIONS TO PARTICIPANTS.

Thank you for assisting me with this research study.

The aim of this Modified Delphi study is to gain consensus nationally from nursing and midwifery practitioners, educators, policy makers, spiritual leaders, hospital psychologists and counsellors and clients on competencies (knowledge, skills and attitudes) in spiritual care that will guide nurses and midwives at point of registration. The potential benefit of the study is to better the professional preparation of nurses and midwives to provide holistic care to clients.

The questionnaire consists of 3 sections. As a member of the panel of 'experts' please complete your personal details in section A of the questionnaire.

Read **all** competencies in **Section B** and **CIRCLE the strength of your opinion** on the scale provided for each competency. **Many of the competency items presented in the questionnaire contain several elements due to the complexity of the concept of spiritual care. You are requested to answer each competency item as a WHOLE.** A **Don't Know** option is also provided if you do not have an opinion. Please enter any comments or additional competencies where necessary in **Section C** at the end of the questionnaire.

SECTION A: DEMOGRAPHIC INFORMATION OF RESPONDENT

(Please complete)

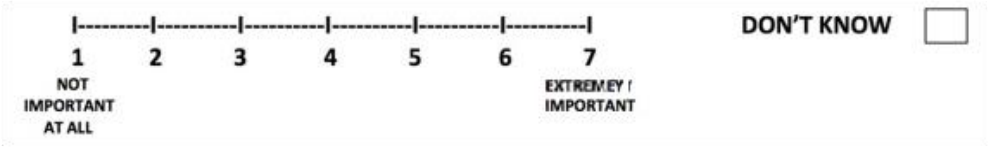
NAME	
GENDER	
AGE	
PROFESSION/ OCCUPATION	
PLACE OF WORK	

SECTION B: LIST OF COMPETENCIES IN SPIRITUAL CARE.
You are requested to answer each competency item as a WHOLE.

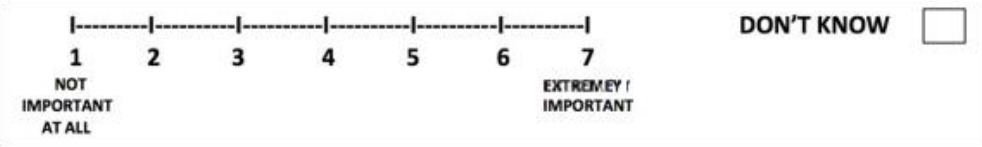
BY THE END OF THEIR EDUCATIONAL PROGRAMME NURSES AND MIDWIVES SHOULD: KNOW and/or BE ABLE TO DO and/or THINK the following:

TO WHAT EXTENT DO YOU THINK THAT NEWLY QUALIFIED NURSES AND MIDWIVES SHOULD DEMONSTRATE THESE COMPETENCIES (KNOWLEDGE, SKILLS AND ATTITUDES)? Please circle the strength of your opinion.

1. Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* **view of care, attentive to the body-mind-spirit in all health care settings.**

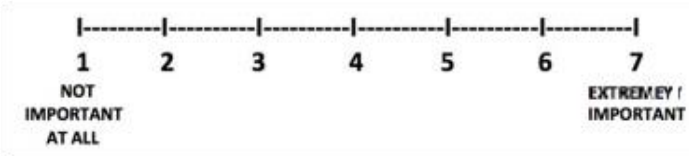


2. Identify the influence of the world's major faiths/religions (*e.g. Christianity, Islam, Judaism, Hindu and Buddhism*) **cultural beliefs and practices in the appropriate clinical context and along the life span continuum** (*from conception to death*).



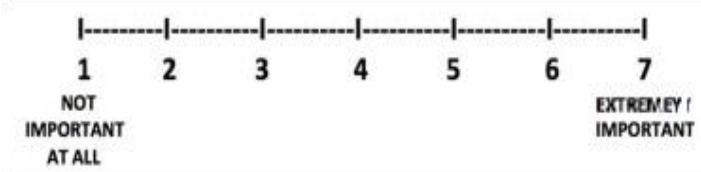
3. Demonstrate knowledge of the basic spiritual needs of individuals which include:

- **A meaningful philosophy of life** (*values and moral sense*).
- **A sense of the transcendent** (*outside of self, view of deity/ higher power and something beyond the immediate life, having hope*).
- **Belief and faith in self, others and for some a belief in a deity/ higher power.**
- **A relatedness to nature and people** (*friendship*).
- **Experiencing love and forgiveness** (*a sense of life meaning*).



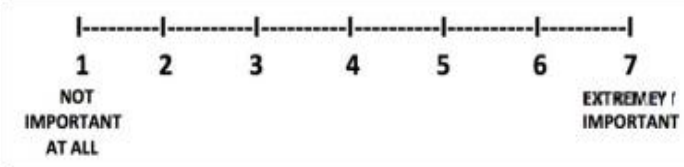
DON'T KNOW ☐

4. Recognise the importance of the spiritual dimension (*with or without religion*) **that sustains physical and mental well-being.**



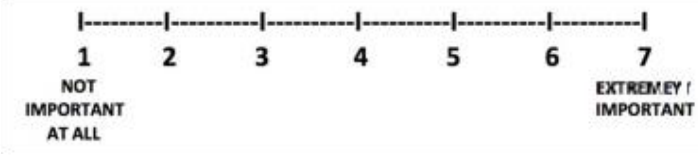
DON'T KNOW ☐

5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.



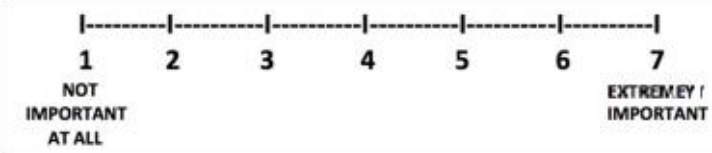
DON'T KNOW ☐

6. Demonstrate knowledge and understanding of the client's condition in order to understand his/her behaviour in dealing with spiritual needs.



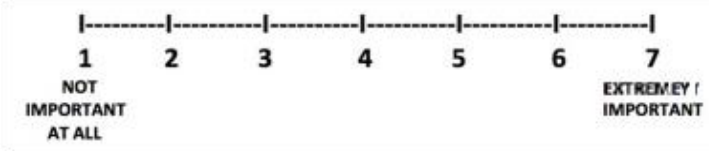
DON'T KNOW ☐

7. **Demonstrate knowledge of spiritual assessment through established tools** (*e.g. FICA, RESPECT and HOPE tools*) **and informal methods** (e.g. *listening to clients' stories*).



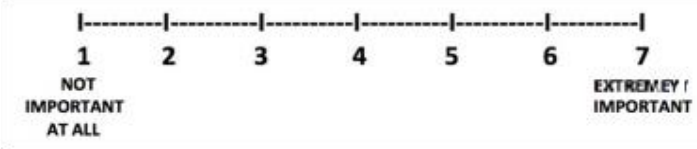
DON'T KNOW ☐

8. **Demonstrate knowledge and understanding of the grieving process** (*denial, anger, bargaining, depression, acceptance*).



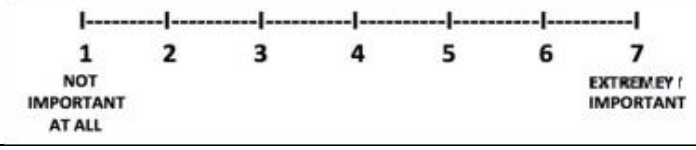
DON'T KNOW ☐

9. **Demonstrate knowledge and understanding of spiritual/religious development of individuals and assist spiritual/religious growth.**



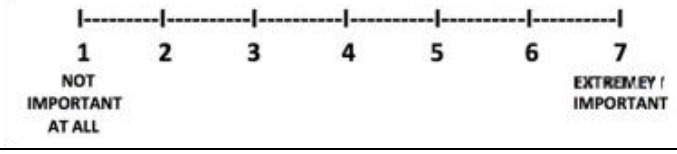
DON'T KNOW ☐

10. **Demonstrate knowledge of complex theories of spirituality such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations.**



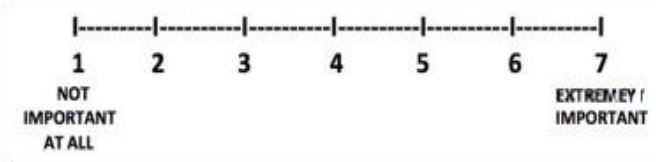
DON'T KNOW ☐

11. **Value knowledge and experience as important elements in dealing with the clients' and their family existential questions** (*e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?*)



DON'T KNOW ☐

12. **Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care.**

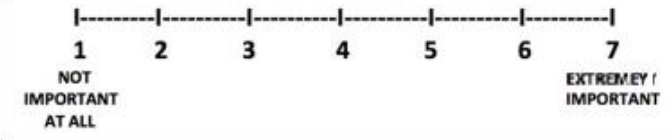


DON'T KNOW ☐

13. **Demonstrate knowledge of resources, support systems/ agencies that inform nurses/midwives to access spiritual care for clients, their families and staff in all healthcare settings** (*e.g. place for worship, Church and support groups*).

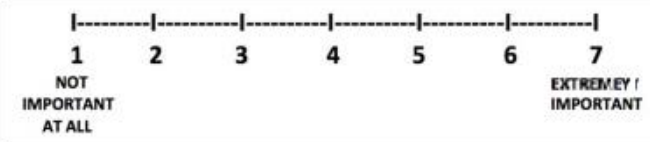
DON'T KNOW ☐

14. **Demonstrate knowledge on assisting clients in health care according to the clients' religious/spiritual, cultural beliefs such as the use of complimentary/ alternative therapies, diets, nutritional supplements and prayer.**



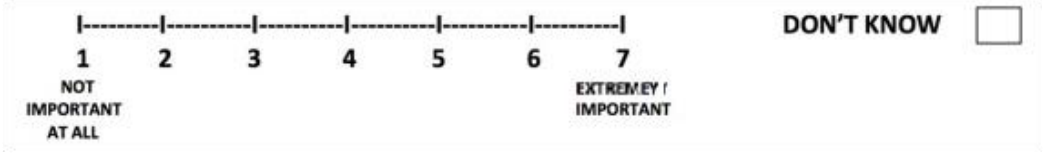
DON'T KNOW ☐

15. **Be aware of own spirituality and use of self** (*e.g. own strengths, limitations, values, beliefs*) **as a resource for spiritual care.**

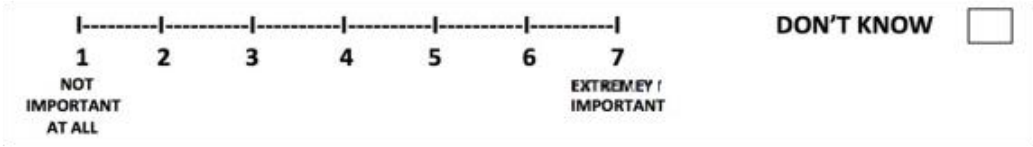


DON'T KNOW ☐

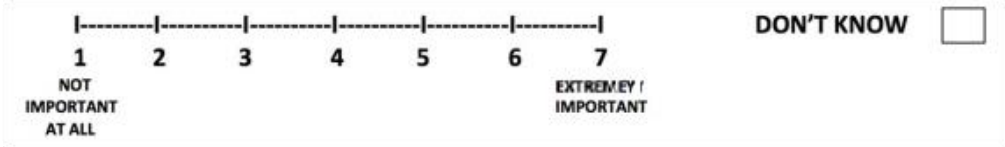
16. **Recognise the possible impact of the nurse/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care.**



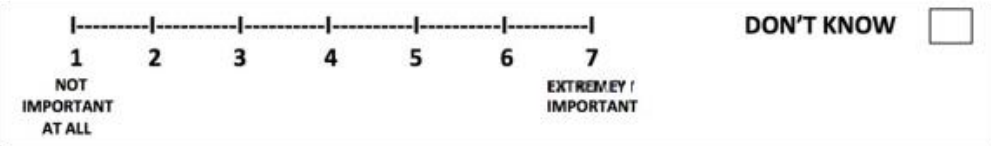
17. **Acknowledge and respect the influence of clients' diverse cultural worldviews, beliefs and practices in the expression of their spirituality in healthcare.**



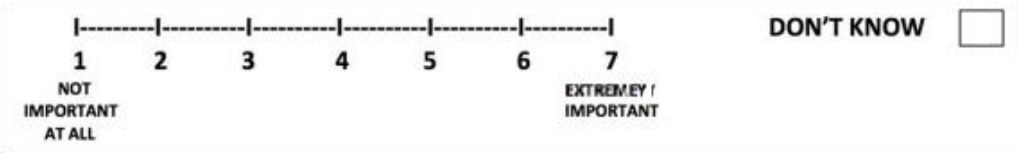
18. **Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team** (*e.g. psychologists, chaplains, counsellors, spiritual leaders*) **as deemed necessary:**



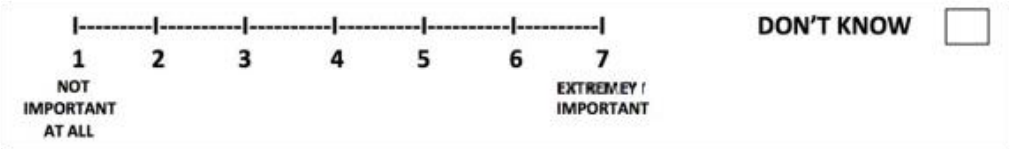
19. **Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self- awareness on the quality of spiritual care.**



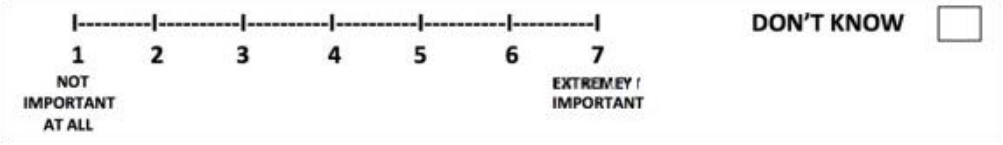
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/ families in their spiritual needs and sufferings.



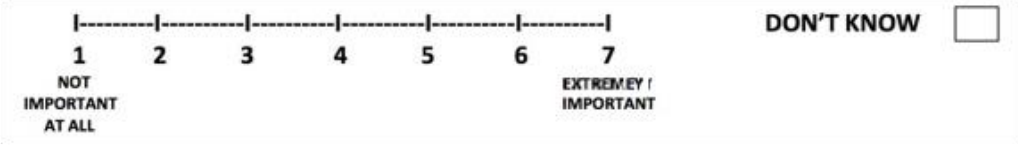
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/ religious readings and prayer as a means of encouragement and hope.



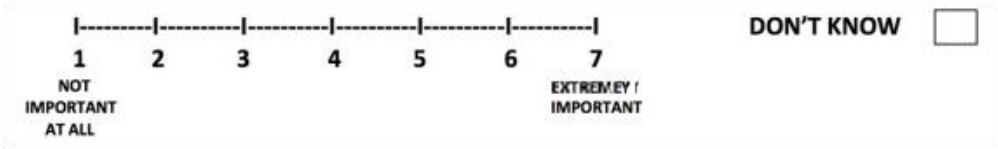
22. Assess barriers to effective communication in providing spiritual care (*e.g. language, beliefs, culture, anxiety, fear and anger*) **and adapt accordingly by active listening, empathy and/ or referral to other members of the multi-disciplinary team.**



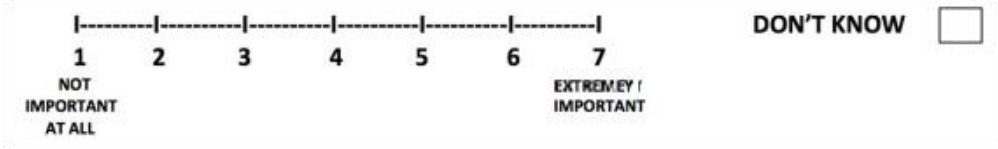
23. Understand and apply the principles of a therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey.



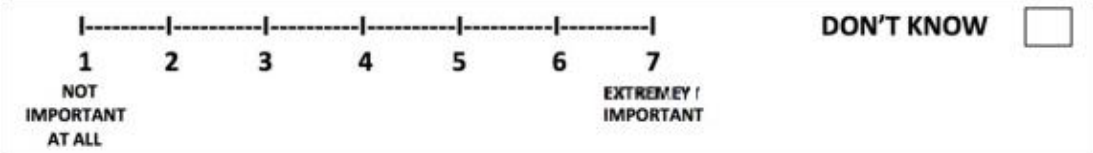
24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/ midwife-client relationship (abiding by the professional ethical/ legal codes of conduct).



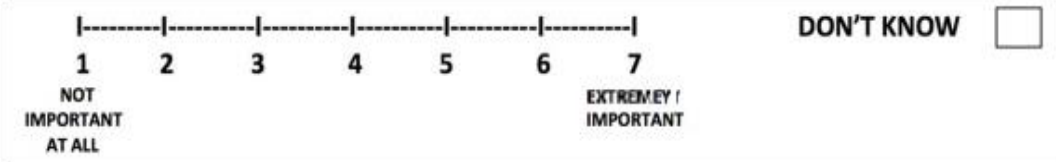
25. Appreciate the uniqueness of each person and their right to decline spiritual care.



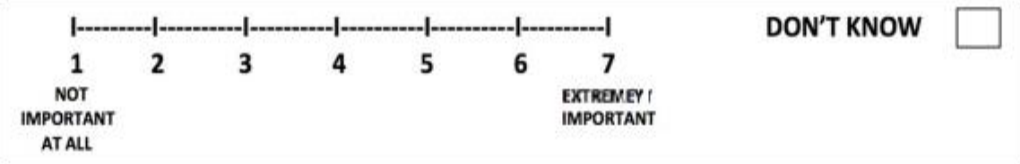
26. **Demonstrate sensitivity and respect for diversity in clients' and their families' religious/spiritual beliefs, values, practices and lifestyles** (*e.g. diet, sexual orientation*).



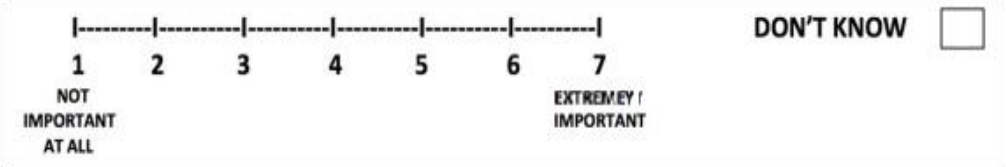
27. Demonstrate sensitivity, support and respect for the client's autonomous and diverse health care decisions/ choices influenced by religious/spiritual beliefs and practices (*e.g. blood transfusion, childbirth practices, chemotherapy, immunisation*).



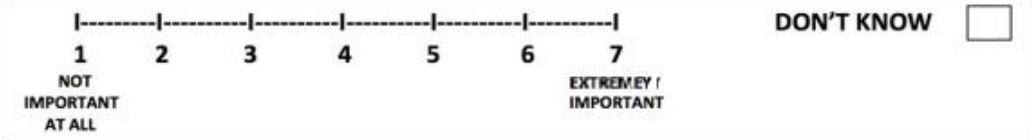
28. **Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity** (*self-esteem and self-respect*) **and integrity** (*adherence to moral and ethical principles*).



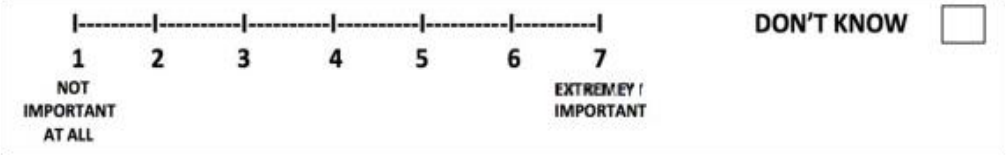
29. **Acknowledge and respect the clients' right for information and informed consent to empower them and facilitate decision making regarding their illness, care and treatment in line with their values, spiritual/ religious beliefs and practices.**



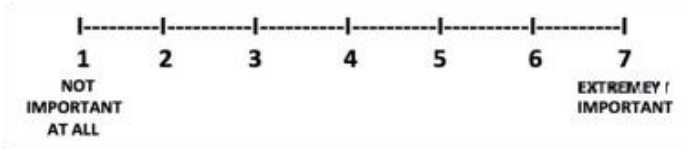
30. **Disclose clients' spiritual/religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team while maintaining confidentiality to safeguard clients' welfare.**



31. **Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/ midwife.**



32. Implement professional caring behaviour demonstrating altruism (*a sense of giving*)**, wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues.**

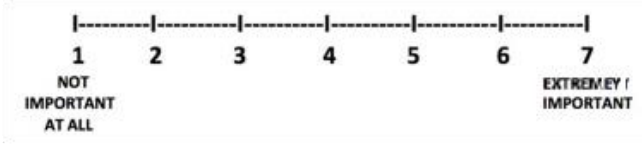


DON'T KNOW ☐

33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on.

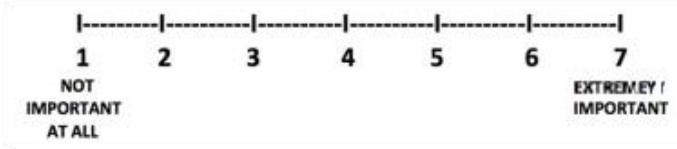
DON'T KNOW ☐

34. Recognise the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care.



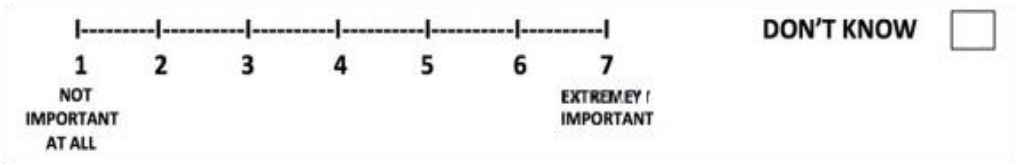
DON'T KNOW ☐

35. Take initiative to participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilise the evidence to bring about practice improvement.

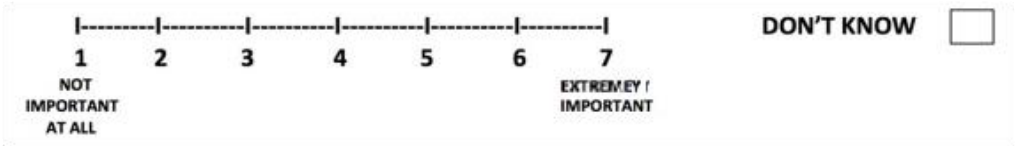


DON'T KNOW ☐

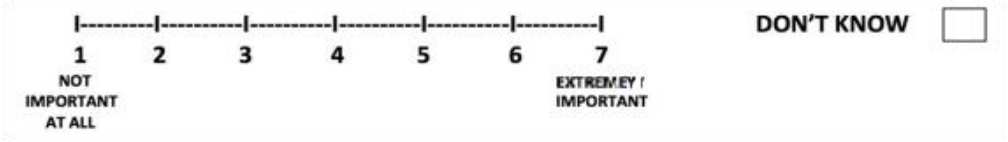
36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity such as creative art (*e.g. painting*).



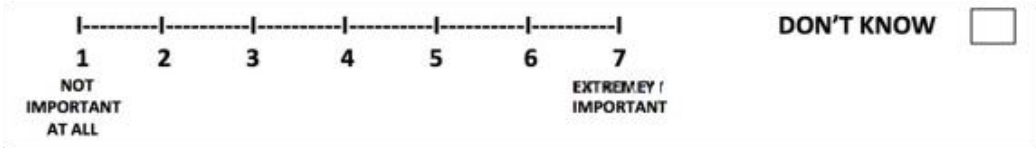
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual wellbeing of clients, their families and health carers and modify accordingly.



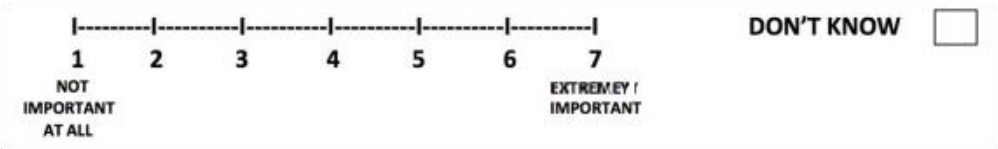
38. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all health care system.



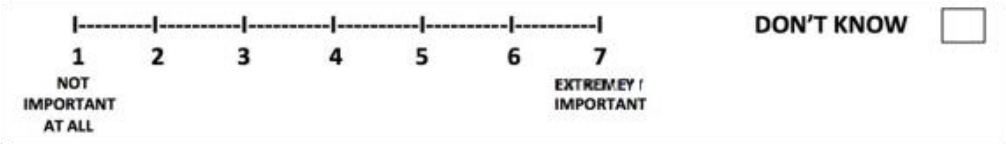
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) **and informal** (*listening to the clients' experiences*) **assessment methods.**



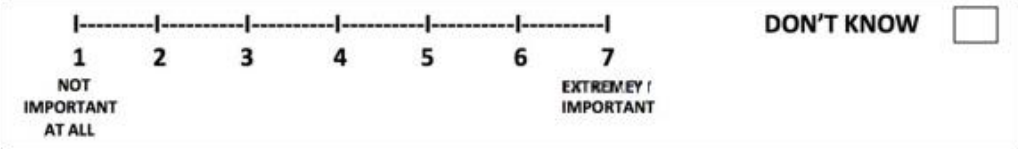
40. Identify signs of spiritual distress in clients and family (*e.g. pain, anxiety, guilt, loss, anger at God and despair*) **and plan to address this distress while being aware of barriers to spiritual care such as lack of time and education.**



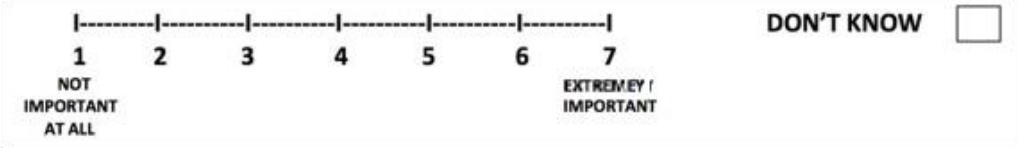
41. Plan spiritual care while identifying its intersections (*shared elements*) **with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns.**



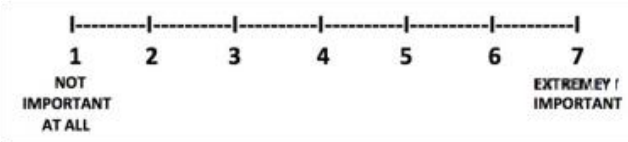
42. Utilise spiritual care models which integrate client-centred care and a problem–based approach while focusing on holistic care.



43. Plan spiritual care in the best interest of the client by including the client and the multi- disciplinary team in order to meet the clients' spiritual needs holistically.

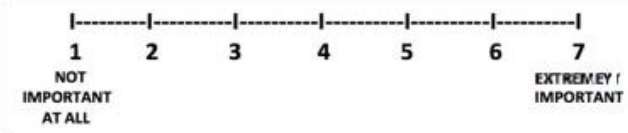


44. Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/ religious needs maintaining patience, tact, perseverance and discipline.



DON'T KNOW ☐

45. Provide spiritual care interventions sensitively by promoting clients' positive self-concept (*e.g. positive coping techniques*) **monitoring spiritual expression while respecting clients who do not conform with advice on their health.**

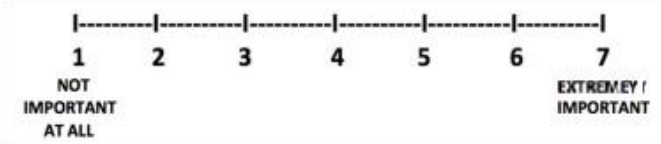


DON'T KNOW ☐

46. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time.

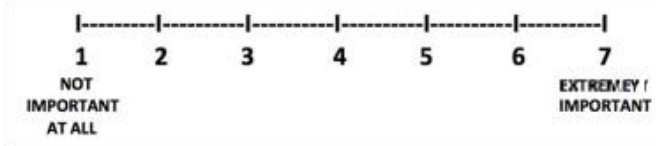
DON'T KNOW ☐

47. Facilitate family participation in the care of their relative to maintain spiritual habits and rituals and identify alternatives to instil hope.



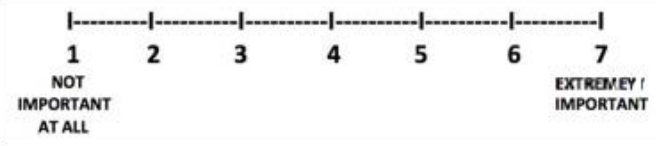
DON'T KNOW ☐

48. Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team.



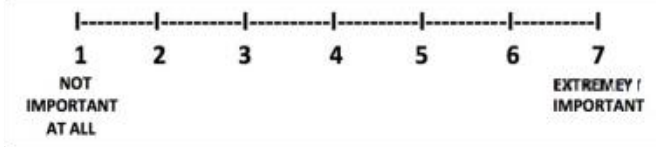
DON'T KNOW ☐

49. Recognise the importance of timely referral of clients/ their families to chaplains/spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*).



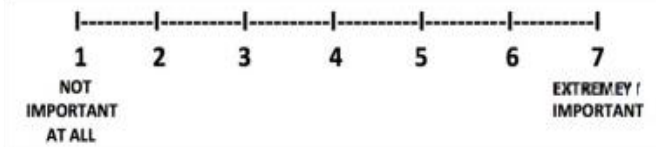
DON'T KNOW ☐

50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow up.



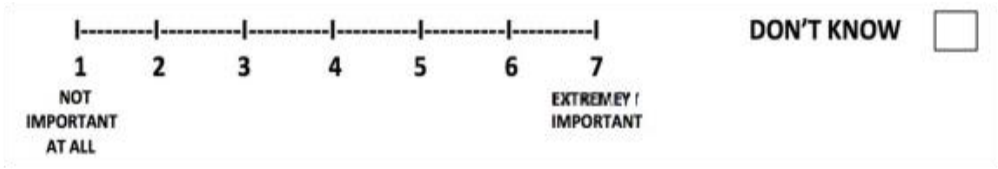
DON'T KNOW ☐

51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care

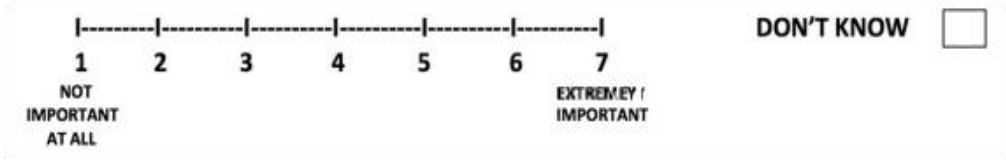


DON'T KNOW ☐

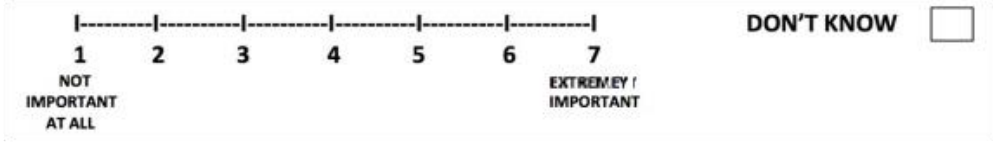
52. Acknowledge the use of information technology as a resource of learning about spiritual care.



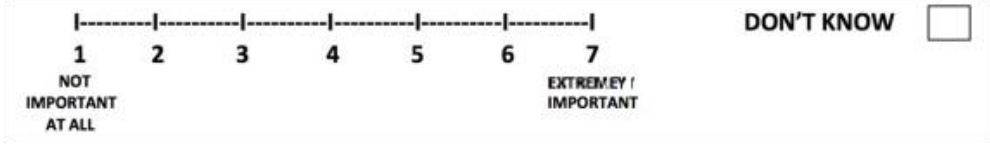
53. Acknowledge the use of information technology as a means of a communication network with clients/their families and members of the multi-disciplinary team on spiritual issues and spiritual support.



54. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care.



55. Acknowledge the use of information technology, such as Facebook, Twitter, Desk monitor etc., as a medium for spiritual inspirations.



SECTION C:

Please include any additional comments and/or competencies in the space below:

THANK YOU FOR YOUR PARTICIPATION

Please send the filled in questionnaire in the stamped and self-addressed envelope provided.

APPENDIX 24 ROUND 1 OF MODIFIED DELPHI STUDY: EXEMPLAR: E-MAIL/WEB QUESTIONNAIRE

FRAMEWORK OF COMPETENCIES IN SPIRITUAL CARE: A MODIFIED DELPHI STUDY FOR NURSES AND MIDWIVES

SECTION A: Demographic information

Name & Surname *

- Male
- Female

Age *

Profession / Occupation *

Place of work *

SECTION B: LIST OF COMPETENCIES

Thank you for assisting me with this research study. As a member of the panel of 'experts' please read all competencies in Section B and indicate the STRENGTH OF YOUR OPINION on the scale 1-7 OR check box DON'T KNOW if you have no opinion. You are requested to answer each competency item as a WHOLE. Please enter any comments or additional competencies where necessary in Section C at the end of the questionnaire.

By the end of their educational program nurses/midwives should: KNOW and/or BE ABLE TO DO and/or THINK the following. TO WHAT EXTENT DO YOU THINK THAT NEWLY QUALIFIED NURSES AND MIDWIVES SHOULD DEMONSTRATE THESE COMPETENCIES (KNOWLEDGE, SKILLS AND ATTITUDES)?

Please circle the strength of your opinion.

Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualized (personalized) view of care, attentive to the body-mind-spirit in all health care settings

- 1 - Not important at all
- 2
- 3
- 4
- 5
- 6
- 7 - Very important
- DON'T KNOW

APPENDIX 25 ROUND 1 OF MODIFIED DELPHI STUDY: RESULTS

Mean, confidence interval and level of agreement reached for each competency item Domain 1: Knowledge in spiritual care												
ITEM	Mean	SD	95% confidence interval of mean		% of Non-Agreement				% of Agreement			Total
					7-point Likert Scale							[N1]
			LOWER	UPPER	1	2	3	4	5	6	7	%
1	5.888	1.124	5.74	6.03	/	0.8	1.3	11.3	19.6	29.2	37.9	86.7
2	5.336	1.337	5.16	5.51	1.7	1.7	5.1	14.9	26.4	29.8	20.4	76.6
3	5.824	1.124	5.68	5.97	/	0.8	3.3	7.1	23.3	31.8	33.5	88.6
4	5.979	1.047	5.85	6.11	/	0.4	2.5	6.2	17.8	35.7	37.3	90.8
5	5.795	1.147	5.65	5.94	/	0.4	3.3	11.3	19.7	31.8	33.5	85.0
6	5.979	1.029	5.85	6.11	/	0.8	1.3	5.4	21.7	33.3	37.5	92.5
7	5.521	1.197	5.37	5.67	0.4	0.8	4.2	13.9	25.2	32.4	23.1	80.7
8	6.477	0.748	6.38	6.57	/	/	/	1.7	10.4	26.6	61.4	98.4
9	5.278	1.292	5.11	5.44	0.4	3.7	4.1	17.4	24.5	33.2	16.6	74.3
10	5.548	1.262	5.39	5.71	0.4	3.3	2.5	10.0	27.2	31.4	25.1	83.7
11	6.017	1.043	5.88	6.15	0.4	/	2.1	5.4	18.3	34.6	39.2	92.1
12	6.220	1.040	6.09	6.35	/	0.4	2.5	4.1	13.7	26.1	53.1	92.9
13	6.108	0.979	5.98	6.23	/	0.4	1.7	5.0	13.8	37.9	41.3	93.0
14	5.656	1.173	5.51	5.80	/	0.8	3.3	12.9	24.9	28.6	29.5	83.0
Domain 2: Self-awareness and use of self												
15	6.054	1.126	5.91	6.20	0.8	0.8	0.8	5.8	17.4	29.9	44.4	91.7
16	6.109	1.097	5.97	6.25	0.4	0.4	1.7	6.3	15.5	27.7	47.9	90.1
17	6.092	1.012	5.96	6.22	/	/	1.7	7.5	14.2	31.1	43.5	88.8
18	6.358	0.936	6.24	6.48	0.4	/	1.3	2.9	9.6	28.8	57.1	95.5
19	5.720	1.240	5.56	5.88	0.4	1.3	4.2	9.7	20.8	31.4	32.2	84.4
Domain 3: Communication and interpersonal relationships												
20	5.882	1.162	5.73	6.03	0.8	/	2.5	9.3	18.1	32.5	36.7	87.3
21	5.464	1.297	5.30	5.63	0.4	3.0	4.6	11.4	27.0	29.5	24.1	80.6
22	6.191	0.960	6.07	6.31	/	/	2.1	5.0	10.8	36.1	46.1	93.0
23	6.129	0.942	6.01	6.25	/	/	0.4	6.6	16.2	33.2	43.6	93.0
24	6.097	1.037	5.96	6.23	/	0.4	1.7	6.3	16.0	30.7	45.0	91.7
Domain 4: Ethical and Legal issues												
25	6.539	0.806	6.44	6.64	/	0.4	0.4	2.1	7.1	22.0	68.0	97.1
26	6.429	0.794	6.39	6.61	/	/	0.4	1.3	12.9	25.8	59.6	98.3
27	6.130	1.104	6.12	6.40	0.4	0.8	0.8	5.9	17.6	23.9	50.4	91.9
28	6.446	0.852	6.44	6.64	/	0.4	0.8	1.3	10.8	24.6	62.1	97.5
29	6.490	0.822	6.49	6.69	/	0.4	0.4	2.1	8.3	24.5	64.3	97.1
30	6.013	1.231	5.92	6.23	0.8	0.8	2.9	7.6	13.4	28.2	46.2	87.8
Domain 5: Quality Assurance												
31	5.492	1.310	5.47	5.79	0.8	0.8	8.1	11.4	19.9	35.2	23.7	78.8
32	6.365	0.801	6.34	6.55	/	/	/	3.7	9.1	34.0	53.1	96.2
33	5.764	1.397	5.70	6.04	2.5	2.1	2.1	8.4	14.8	34.6	35.4	84.8

[N1] Total percentage of agreement between panels of experts.

R1 of modified Delphi study: Results (cont.)

Mean, confidence interval and level of agreement reached for each competency item Domain 5: Quality assurance in spiritual care (cont.)												
ITEM	Mean	SD	95% confidence interval of mean		% of Non-Agreement				% of Agreement			Total
					7-point Likert Scale							**[N1]**
			LOWER	**UPPER**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**%**
34	6.063	1.090	6.07	6.32	/	1.7	1.3	5.8	14.6	33.8	42.9	91.3
35	5.611	1.235	5.57	5.90	1.3	0.4	5.0	7.5	27.2	32.2	26.4	85.8
36	5.439	1.256	5.34	5.68	0.8	0.8	5.5	14.8	24.1	32.5	21.5	78.1
37	5.534	1.168	5.43	5.74	/	1.2	3.4	13.0	30.3	27.3	24.8	82.4
38	5.443	1.286	5.38	5.71	1.3	1.3	6.8	8.4	28.3	32.9	21.1	82.3
Domain 6: Assessment and implementation of spiritual care												
39	5.571	1.209	5.48	5.78	/	2.5	2.9	13.4	20.2	37.8	23.1	81.1
40	6.025	1.008	6.06	6.29	/	0.4	0.8	7.5	17.8	34.0	39.4	91.2
41	5.513	1.221	5.43	5.73	0.4	0.8	4.6	15.5	21.4	34.0	23.1	78.5
42	5.380	1.367	5.30	5.63	1.7	1.3	7.3	10.7	29.1	26.1	23.9	79.1
43	5.895	1.149	5.81	6.10	0.4	1.3	1.7	6.7	22.6	29.7	37.7	90.0
44	5.626	1.189	5.56	5.86	0.4	1.7	3.0	8.9	28.1	31.5	26.4	86.0
45	5.707	1.118	5.64	5.91	/	1.3	2.1	10.5	24.7	33.9	27.6	86.2
46	6.017	1.049	6.02	6.25	0.4	0.4	1.7	5.8	16.2	37.3	38.2	91.7
47	5.946	1.049	5.93	6.19	/	/	2.1	9.5	16.6	35.3	36.5	88.4
48	6.120	1.040	6.05	6.32	/	0.8	1.2	5.4	16.6	29.5	46.5	92.6
49	6.257	0.927	6.19	6.43	/	/	1.2	5.0	10.8	32.8	50.2	93.8
50	5.618	1.303	5.55	5.87	0.4	3.4	5.0	7.1	19.3	38.7	26.1	84.1
51	5.513	1.337	5.51	5.82	1.3	2.1	5.0	10.9	22.3	33.2	25.2	80.7
Domain 7: Informatics in spiritual care												
52	5.531	1.259	5.51	5.80	0.8	2.1	4.2	10.0	24.7	35.1	23.0	82.8
53	5.273	1.383	5.19	5.55	1.7	2.9	6.7	12.6	25.2	32.8	18.1	76.1
54	5.242	1.345	5.06	5.42	0.8	2.1	8.5	15.7	25.0	29.2	18.6	72.8
55	4.515	1.691	4.39	4.82	6.9	6.5	13.0	18.2	25.5	16.9	13.0	55.4

[N1] Total percentage of agreement between panels of experts.

Round 1: Modified Delphi factor analysis

Cases with complete data: [194] Variables: Q1a to Q54a ALPHA FOR ALL VARIABLES=0.9724 FACTOR EIGEN CUMULATIVE PROPORTION OF VARIANCE CARMINES VALUE IN DATA SPACE IN FACTOR SPACE – THETA				
1.	22.4837	0.4088	0.6448	0.9732
2.	3.3927	0.4705	0.7421	
3.	2.1347	0.5093	0.8034	
4.	2.0670	0.5469	0.8626	
5.	1.7970	0.5795	0.9142	
6.	1.5696	0.6081	0.9592	
7.	1.4229	0.6340	1.0000	
8.	1.3438	0.6584		
9.	1.1793	0.6798		
10.	1.1253	0.7003		
11.	0.9790	0.7181		
12.	0.9043	0.7345		
13.	0.7958	0.7490		
	The first 7 factors explain 63% of the total variance.			

Round 1: Factor correlations for rotated factors

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Factor 1	1.000						
Factor 2	0.335	1.000					
Factor 3	0.330	0.309	1.000				
Factor 4	0.335	0.295	0.316	1.000			
Factor 5	0.266	0.198	0.284	0.372	1.000		
Factor 6	0.329	0.378	0.319	0.198	0.239	1.000	
Factor 7	0.306	0.260	0.270	0.211	0.127	0.278	1.000

Round 1: Sorted rotated factor loadings (pattern)

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Q46a	0.711						
Q44a	0.619						
Q45a	0.590						
Q43a	0.553						
Q41a	0.540						
Q51a	0.520						
Q40a	0.513						
Q50a	0.456						
Q47a	0.441						

Round 1: Sorted rotated factor loadings (pattern) (cont.)

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Q26a		0.750					
Q25a		0.703					
Q28a		0.692					
Q27a		0.667					
Q29a		0.625					
Q17a		0.571					
Q24a		0.412					
Q30a		0.443					
Q3a			0.627				
Q5a			0.597				
Q1a			0.594				
Q4a			0.593				
Q7a			0.570				
Q10a			0.563				
Q2a			0.549				
Q6a			0.453				
Q14a			0.404				
Q33a				0.843			
Q34a				0.616			
Q35a				0.552			
Q32a				0.504			
Q36a				0.461			
Q42a				0.433			
Q37a				0.470			
Q38a				0.479			
Q53a					0.822		
Q54a					0.777		
Q52a					0.516		
Q19a					0.433		
Q48a						0.814	
Q12a						0.812	
Q13a						0.754	
Q49a						0.604	
Q8a							0.540
Q23a							0.510
Q20a							0.504
Q18a							0.492
Q15a							0.411
Q11a							
Q22a							
Q16a							
Q21a							
Q39a							
Q31a							
Q9a							
%Variance explained							
	7.5	**7.3**	**7.0**	**6.9**	**6.8**	**6.0**	**4.8**

APPENDIX 26 ROUND 2 OF MODIFIED DELPHI STUDY:
EXEMPLAR PARTICIPANTS' INFORMATION SHEET & QUESTIONNAIRE

Title of the Study:
Framework of competencies in spiritual care for nurses and midwives:
A modified Delphi study

Dear Participant,

Thank you for your commitment in completing the 1st round questionnaire of this modified Delphi study and for your invaluable comments which focused on:

- Spirituality as a concept and component of quality holistic care to help all clients irrespective of their religious/spiritual beliefs, practices and culture.
- Preparation of professionals to provide spiritual care through their own spirituality, reflection, experience and referral when necessary.
- Ongoing preparation of professionals at pre and post registration level not as a separate module but integrated across all subject material.
- Addressing barriers to spiritual care such as lack of knowledge, time and staff.

You will find enclosed the second round modified Delphi questionnaire. The aim of this round is to try and generate consensus amongst the expert panel of which you are a member through feedback from the whole group. **This feedback is provided through the average score calculated for each competency item. In the 2nd round of this modified Delphi study you are asked to consider your score from round 1 and confirm or change your opinion in the light of the group's feedback.**

Please read the instructions carefully and complete the questionnaire. Remember it is your opinion which is important to me. Return the questionnaire in the stamped self-addressed envelope by 7th August 2012. If you wish to discuss any aspect of the questionnaire further please contact me on: mobile No 79340682 office No 2340 1825 or e-mail josephine.attard@um.edu.mt or my supervisors:

Dr.Linda Ross: lross@glam.ac.uk,
Dr. Donia Baldacchino:donia.baldacchino@um.edu.mt
Thank you for your continued participation in the study.
Kind regards,

Josephine Attard

ROUND 2 QUESTIONNAIRE

Many of the competency items presented in the questionnaire contain several elements due to the complexity of the concept of spiritual care. You are requested to answer each competency item as a WHOLE.

INSTRUCTIONS TO PANEL OF EXPERTS: ROUND 2 OF MODIFIED DELPHI QUESTIONNAIRE.

❶ Please **reconsider your response indicated on the scale as X in the middle column of the questionnaire** in the context of feedback derived from participants provided through the average (mean) score shown in the last column of the questionnaire.

❷ Please **respond to each competency item in the first column of the questionnaire by placing a** ✓ next to your previous 1st round questionnaire response indicated with an **X** (example 1). **The absence of a ✓ would indicate that you have not responded to the competency item.**

❸ **If you wish to change your score** from your previous 1st round questionnaire please **circle O** your new score on the 1-7'likert' scale in the middle column of the questionnaire(example 2).

E.g.1: Confirming your response from 1st round questionnaire. Tick (✓) ONLY IF CONVINCED YOU SHOULD DO SO.

COMPETENCIES	**Confirm your RESPONSE** from 1st round questionnaire **by placing a ✓next to your score marked with X. OR place a circle (O) round a new score** ONLY IF CONVINCED YOU SHOULD DO SO. **YOU ARE NOT OBLIGED TO CHANGE YOUR SCORE.**	**Overall Group Response On a 1-7 scale (Average)**	
1. Recognise the role of nurses/ midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* **view of care, attentive to the body-mind-spirit in all health care settings.**	**Your response from round 1 questionnaire** 1----------2----------3---------4--------5----------6----------7 **X✓ Confirmed response** NOT AT ALL IMPORTANT — EXTREMELY IMPORTANT	DON'T KNOW	5.86

E.g.2: Changing score from 1st round modified Delphi questionnaire. ONLY IF CONVINCED YOU SHOULD DO SO

COMPETENCIES	**Confirm your RESPONSE** from 1st round questionnaire **by placing a ✓next to your score marked with X. OR place a circle (O) round a new score** ONLY IF CONVINCED YOU SHOULD DO SO. **YOU ARE NOT OBLIGED TO CHANGE YOUR SCORE.**	**Overall Group Response On a 1-7 scale (Average)**	
1. Recognise the role of nurses/ midwives in demonstrating an understanding of the concept of spirituality through an individualized *(personalized)* **view of care, attentive to the body-mind-spirit in all health care settings.**	**Your response from round 1 questionnaire** **1----------2----------3-------4----------5----------6------⑦** **X** **Changed response** NOT AT ALL IMPORTANT — EXTREMELY IMPORTANT	DON'T KNOW	5.86

APPENDIX 27 PHASE 3: LETTER TO THE PARTICIPANTS

'INVITATION TO CONTRIBUTE TO THE DEVELOPMENT OF SPIRITUAL CARE COMPETENCIES IN SPIRITUAL CARE FOR NURSES AND MIDWIVES'

Dear Participant,

I am Josephine Attard undergoing my PhD studies at the University of Glamorgan, Wales U.K. and the University of Malta under the supervision of Dr Linda Ross and a team of supervisors. Dr Donia Baldacchino is my local supervisor.

Following your participation in the modified Delphi study and an expert recognised locally for your contribution in the field of spiritual care and education I would like to invite you to participate in the 'consultation phase' of this PhD study entitled: 'Framework of competencies in spiritual care: A modified Delphi study for nurses and midwives.'

Your opinion in the development of this framework of competencies in spiritual care is vital and therefore your participation and contribution to the study is highly valued.

The goal of this modified Delphi study is to gain consensus on competencies (knowledge, skills and attitudes) in spiritual care that will guide nurses and midwives at point of registration. The potential benefit of the study is to enhance the professional preparation of nurses and midwives to provide holistic care to clients.

What's next?

After reaching consensus on 54 competencies in spiritual care, I am focusing my exploration around a small - scale consultation process with 'experts' in spiritual care.

The aim of this consultation process is to ask you to:

- **Identify which competencies in spiritual care should *essentially* be acquired by a student at pre-registration nursing/midwifery education and which competencies should be left at post–registration level**
- **Identify factors that FACILITATE or HINDER the integration of the proposed framework.**

You will be issued with a code number to ensure anonymity amongst the consultation panel members and the opinions of the panel will remain confidential. **Please find enclosed the consultation questionnaire. Read the study's background information and instructions carefully and complete the questionnaire. Return the questionnaire in the stamped self-addressed envelope by 24th January 2013. Responding to the questionnaire signifies consent.**

The questionnaire is also available on web should you prefer to respond in this way;

- **Please press CTRL and click to follow link:**

  https://docs.google.com/spreadsheet/viewform?formkey=dGpfYzg3UFFEbjNtbWhHbTU5dGNTOXc6MA
- **Read the study's background information**
- **Fill in the questionnaire**
- **Submit by pressing the submit button at the end of questionnaire**

It takes approximately 15mins to answer the questionnaire and responding to the questionnaire signifies consent. You will be issued with a code number to ensure anonymity amongst participating researchers and all information given will be treated as confidential and handled in accordance with the data Protection Act 1998. Data will be Password protected and used solely for the purpose of this study and be destroyed when I have written the report.

If you have any questions about the study or about participating in the study, please feel free to contact me on mobile No (+356) 79340682 or e-mail josephine.attard@um.edu.mt or my supervisors:

Dr Linda Ross: lross@glam.ac.uk,

Dr Donia Baldacchino: donia.baldacchino@um.edu.mt

The Faculty Ethics Committee of HESAS and the University **of Malta Ethics Committee have approved the study and procedures.**

Thanks

Ms Josephine Attard

(Researcher)

APPENDIX 28 PHASE 3 QUESTIONNAIRE

BACKGROUND INFORMATION

Framework of competencies in spiritual care for nurses and midwives: A modified Delphi study

Aims of the study

- **Develop a Competency Framework model in spiritual care for nurses and midwives,**
- **Provide guidelines on spiritual care for clinical practice in nursing and midwifery,**
- **Inform nursing and midwifery education to ensure that new recruits to the profession will be equipped to meet clients' holistic needs at point of registration.**

Identification and Formulation of the competencies in spiritual care

- Constituents of competencies namely knowledge, skills and attitudes in spiritual care were identified through an in depth review of the literature and 5 focus group discussions with key stakeholders.
- 7 domains and 321 competencies were identified and collapsed into 55 competency items. Consensus on these competencies utilising a modified Delphi research approach was sought in order to formulate the competency framework.
- 241 participants (N=281) participated in Round 1 and 205 (N=241) participated in round 2. Consensus was assumed if competency items were rated 5, 6, or 7 on a 7 point Likert scale and if agreement was greater than the 75%.

Reaching Consensus

In round 1 of this modified Delphi study participants were asked to validate each competency item on a 7 point 'Likert' scale on ***THE EXTENT TO WHICH NEWLY QUALIFIED NURSES AND MIDWIVES SHOULD DEMONSTRATE THESE COMPETENCIES (Knowledge, skills and attitudes) IN THEIR PROFESSIONAL PRACTICE***. Participants were requested to answer each competency item as a WHOLE. "A Don't Know" option was also provided if they had no opinion. Participants were also asked for additional comments or competencies. **Round 2** aimed to generate consensus amongst participants by calculating the average scores for each competency item. ***PARTICIPANTS IN ROUND 2 WERE ASKED TO CONSIDER THEIR SCORE FROM ROUND 1 AND CONFIRM OR CHANGE THEIR SCORE IN THE LIGHT OF THE GROUP'S MEAN RESULT FOR EACH ITEM.*** **All competency items except one** achieved consensus during the 2nd round. In view of results achieved and to avoid participants' fatigue, the author decided to stop at round 2. These competencies would be achieved over the duration of undergraduate or post-graduate nursing and midwifery programmes and relate to level 3 descriptors as defined by the European Qualifications Framework (2008).

The aim of this consultation process is to ask you to:

- Identify which competencies in spiritual care should essentially be acquired by a student at pre-registration nursing/midwifery education and which competencies should be left at post–registration level;

-Identify factors that FACILITATE or HINDER the integration of the proposed framework.

Many of the competency items presented in the questionnaire contain several elements due to the complexity of the concept of spiritual care. You are requested to respond to each competency item as a WHOLE.

In this study 54 competency items in spiritual care have reached consensus in the 2nd round of the modified Delphi study.

GLOSSARY

Pre-registration level i.e. students undertaking a nursing or midwifery program in a higher education institution leading to an academic award and registration as a nurse or midwife.

Post-registration level i.e. qualified registered nurses or midwives who are undertaking either an educational program in a higher education institution leading to an additional academic and /or professional award or an in–house program of professional development (Quinn 2001).

Section A: ***Please respond to ALL 3 sections and submit your response by_____***

DEMOGRAPHIC DATA
NAME:
PROFESSIONAL OCCUPATION
AREA OF EXPERTISE
E-MAIL ADDRESS

SECTION B: COMPETENCIES IN SPIRITUAL CARE: LEVEL OF IMPORTANCE PRE- OR POST-REGISTRATION			
PLEASE IDENTIFY WHICH COMPETENCIES IN SPIRITUAL CARE SHOULD ESSENTIALLY BE ACQUIRED BY A STUDENT AT PRE-REGISTRATION NURSING/ MIDWIFERY EDUCATION AND WHICH COMPETENCIES SHOULD BE LEFT TO POST-REGISTRATION LEVEL. ***"A Not Essential At Either Level" option is provided if your opinion reflects this.***			
PLEASE INDICATE ONE OPTION FOR EACH COMPETENCY ITEM			
Competency items	**ESSENTIAL AT PRE-REGISTRATION**	**ESSENTIAL AT POST-REGISTRATION**	**NOT ESSENTIAL At EITHER LEVEL**
1. Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* **view of care, attentive to the body-mind-spirit in all health care settings.**			
2. Identify the influence of the world's major faiths/religions (*e.g. Christianity, Islam, Judaism, Hindu and Buddhism*) **cultural beliefs and practices in the appropriate clinical context and along the life span continuum** (*from conception to death*).			
3. Demonstrate knowledge of the basic spiritual needs of individuals which include: • **a meaningful philosophy of life** (*values and moral sense*) • **a sense of the transcendent** (*outside of self, view of deity/ higher power and something beyond the immediate life, having hope*) • **belief and faith in self, others and for some a belief in a deity/ higher power** • **a relatedness to nature and people** (*friendship*) • **experiencing love and forgiveness** (*a sense of life meaning*).			
4. Recognise the importance of the spiritual dimension (*with or without religion*) **that sustains physical and mental well-being.**			
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.			
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/ her behaviour in dealing with spiritual need.			
7. Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA, RESPECT and HOPE tools*) **and informal methods** (e.g. *listening to clients' stories*).			

Competency items	ESSENTIAL AT PRE-REGISTRATION	ESSENTIAL AT POST-REGISTRATION	NOT ESSENTIAL At EITHER LEVEL
8. Demonstrate knowledge and understanding of the grieving process (*denial, anger, bargaining, depression, acceptance*).			
9. Demonstrate knowledge and understanding of spiritual/religious development of individuals and assist spiritual/ religious growth.			
10. Demonstrate knowledge of complex theories of spirituality such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations.			
11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (*e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?*).			
12. Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care.			
13. Demonstrate knowledge of resources, support systems/agencies that inform nurses/ midwives to access spiritual care for clients, their families and staff in all health care settings (*e.g. place for worship, Church and support groups*).			
14. Demonstrate knowledge on assisting clients in health care according to the clients' religious/ spiritual, cultural beliefs such as the use of complimentary/ alternative therapies, diets, nutritional supplements and prayer.			
15. Be aware of own spirituality and use of self (*e.g. own strengths, limitations, values, beliefs*) **as a resource for spiritual care.**			
16. Recognise the possible impact of the nurse/ midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care.			
17. Acknowledge and respect the influence of clients' diverse cultural worldviews, beliefs and practices in the expression of their spirituality in healthcare.			
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (*e.g. psychologists, chaplains, counsellors, spiritual leaders*) **as deemed necessary.**			

Competency items	ESSENTIAL AT PRE-REGISTRATION	ESSENTIAL AT POST-REGISTRATION	NOT ESSENTIAL At EITHER LEVEL
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care.			
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/ families in their spiritual needs and sufferings			
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/ religious readings and prayer as a means of encouragement and hope.			
22. Assess barriers to effective communication in providing spiritual care (e.g. language, beliefs, culture, anxiety, fear and anger) and adapt accordingly by active listening, empathy and/ or referral to other members of the multi-disciplinary team.			
23. Understand and apply the principles of a therapeutic trustful nurse/ midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey.			
24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/ midwife-client relationship (abiding by the professional ethical/legal codes of conduct).			
25. Appreciate the uniqueness of each person and their right to decline spiritual care.			
26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/ spiritual beliefs, values, practices and lifestyles (*e.g. diet, sexual orientation*).			
27. Demonstrate sensitivity, support and respect for the client's autonomous and diverse health care decisions/ choices influenced by religious/ spiritual beliefs and practices (*e.g. blood transfusion, childbirth practices, chemo)*			
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (*self-esteem and self-respect*) **and integrity** (*adherence moral and ethical principles.*			
29. Acknowledge and respect the clients' right for information and informed consent to empower and facilitate decision making regarding their illness and treatment in line with their values, spiritual/religious beliefs			

Competency items	ESSENTIAL AT PRE-REGISTRATION	ESSENTIAL AT POST-REGISTRATION	NOT ESSENTIAL At EITHER LEVEL
30. Disclose clients' spiritual/ religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team while maintaining confidentiality to safeguard clients' welfare			
31. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/ midwife			
32. Implement professional caring behaviour demonstrating altruism (*a sense of giving*)**, wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues**			
33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on			
34. Recognise the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care			
35. Take initiative to participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilize the evidence to bring about practice improvement			
36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity such as creative art (e.g. painting)			
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual wellbeing of clients, their families and health carers and modify accordingly			
38. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all health care system			
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) **and informal** (*listening to the clients' experiences*) **assessment methods**			

Competency items	ESSENTIAL AT PRE-REGISTRATION	ESSENTIAL AT POST-REGISTRATION	NOT ESSENTIAL At EITHER LEVEL
40. Identify signs of spiritual distress in clients and family (*e.g. pain, anxiety, guilt, loss, anger at God and despair*) **and plan to address this distress while being aware of barriers to spiritual care such as lack of time and education**			
41. Plan spiritual care while identifying its intersections (*shared elements*) **with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns**			
42. Utilise spiritual care models which integrate client-centered care and a problem–based approach while focusing on holistic care			
43. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the client's spiritual needs holistically			
44. Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/ religious needs maintaining patience, tact and discipline			
45. Provide spiritual care interventions sensitively by promoting clients' positive self-concept (*e.g. coping techniques*) **monitoring spiritual expression respecting clients who do not conform with advice on their health**			
46. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time			
47. Facilitate family participation in the care of their relative to maintain spiritual habits and rituals and identify alternatives to instil hope			
48. Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team			
49. Recognise the importance of timely referral of clients/ their families to chaplains/ spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*)			
50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow up			

Competency items	ESSENTIAL AT PRE-REGISTRATION	ESSENTIAL AT POST-REGISTRATION	NOT ESSENTIAL At EITHER LEVEL
51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions and provide possible solutions to enhance delivery of spiritual care			
52. Acknowledge the use of information technology as a resource of learning about spiritual care			
53. Acknowledge the use of information technology as a means of a communication network with clients/ their families and members of the multi-disciplinary team on spiritual issues and spiritual support			
54. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care			

SECTION C: INTEGRATION OF THE FRAMEWORK IN EDUCATION AND CLINICAL PRACTICE

Please answer the following questions:

1. Please give your views on the proposed Framework of competency items.

2. Please identify factors that may ENHANCE implementation of this framework in education and/or clinical practice

3. Please identify factors that may HINDER the implementation of this framework in education and/or clinical practice?

4. Any other comments?

THANK YOU FOR YOUR PARTICIPATION

APPENDIX 29 PHASE 3: INTERNATIONAL RESEARCHERS: INFORMATION TO PARTICIPANTS AND EXEMPLAR WEB SURVEY

'INVITATION TO CONTRIBUTE TO THE DEVELOPMENT OF SPIRITUAL CARE COMPETENCIES IN SPIRITUAL CARE FOR NURSES AND MIDWIVES'

Dear Researcher,

I am Josephine Attard undergoing my PhD studies at the University of Glamorgan, Wales U.K. and the University of Malta under the supervision of Dr Linda Ross and a team of supervisors. Dr Donia Baldacchino is my local supervisor.

As an expert recognised internationally for your contribution in the field of spiritual care I would like to invite you to participate in the 'consultation phase' of my PhD study entitled: **'Framework of competencies in spiritual care: A modified Delphi study for nurses and midwives.'**

Your opinion in the development of this framework of competencies in spiritual care is vital and therefore your participation and contribution to the study is highly valued.

The goal of this modified Delphi study is to gain consensus on competencies (knowledge, skills and attitudes) in spiritual care that will guide nurses and midwives at point of registration. The potential benefit of the study is to enhance the professional preparation of nurses and midwives to provide holistic care to clients.

What's next?

After reaching consensus on 54 competencies in spiritual care, I am focusing my exploration around a small - scale consultation process with international researchers in spiritual care.

The aim of this consultation process is to ask you to:

- **Identify which competencies in spiritual care should *essentially* be acquired by a student at pre-registration nursing/midwifery education and which competencies should be left at post–registration level**
- **Identify factors that FACILITATE or HINDER the integration of the proposed framework.**

You will be issued with a code number to ensure anonymity amongst the consultation panel members and the opinions of the panel will remain confidential.

- **Please press CTRL and click to follow link:**

https://docs.google.com/spreadsheet/viewform?formkey=dGpfYzg3UFFEbjNtbWhHbTU5dGNTOXc6MA

- **Read the study's background information**
- **Fill in the questionnaire**
- **Submit by pressing the submit button at the end of questionnaire**

It takes approximately 15mins to answer the questionnaire and responding to the questionnaire signifies consent. You will be issued with a code number to ensure anonymity amongst participating researchers and all information given will be treated as confidential and handled in accordance with the data Protection Act 1998. Data will be Password protected and used solely for the purpose of this study and be destroyed when I have written the report.

Please submit responses by: 24th January 2013. If you have any questions about the study or about participating in the study, please feel free to contact me on mobile No (+356) 79340682 or e-mail josephine.attard@um.edu.mt or my supervisors:

Dr Linda Ross: lross@glam.ac.uk,

Dr Donia Baldacchino: donia.baldacchino@um.edu.mt

The Faculty Ethics Committee of HESAS and the **University of Malta Ethics Committee have approved the study and procedures.**

Thanks

Ms Josephine Attard

(Researcher)

Web survey for international researchers Exemplar

Framework of competencies in spiritual care for nurses and midwives: A modified Delphi study.

BACKGROUND INFORMATION

Aims of the study

• Develop a Competency Framework model in spiritual care for nurses and midwives;
• Provide guidelines on spiritual care for clinical practice in nursing and midwifery,
• Inform nursing and midwifery education to ensure that new recruits to the profession will be equipped to meet clients' holistic needs at point of registration.

Identification and formulation of the competencies in spiritual care

• Constituents of competencies namely knowledge, skills and attitudes in spiritual care were identified through an in depth review of the literature and 5 focus group discussions with key stakeholders.

• 7 domains and 321 competencies were identified and collapsed into 55 competency items. Consensus on these competencies utilising a modified Delphi research approach was sought in order to formulate the competency framework.
• 241 (N=281) participated in Round 1 and 205 (N=241) participated in round 2. Consensus was defined as Competency items that have rated within the highest region of the scale on a 7-point Likert scale 5, 6, or 7 and equated to be greater than the 75% threshold agreement. Reaching Consensus In round 1 of this modified Delphi study participants were asked to validate each competency item on a 7 point Likert scale on THE EXTENT TO WHICH NEWLY QUALIFIED NURSES AND MIDWIVES SHOULD DEMONSTRATE THESE COMPETENCIES (Knowledge, skills and attitudes) IN THEIR PROFESSIONAL PRACTICE.

Participants were requested to answer each competency item as a WHOLE. A Don't Know option was also provided if they had no opinion. Participants were also asked for additional comments or competencies. Round 2 aimed to generate consensus amongst the participants by calculating the average scores for each competency item. PARTICIPANTS IN ROUND 2 WERE ASKED TO CONSIDER THEIR SCORE FROM ROUND 1 AND CONFIRM OR CHANGE THEIR SCORE IN THE LIGHT OF THE GROUP'S MEAN RESULT FOR EACH ITEM. All competency items except one achieved consensus during the 2nd round. These competencies would be achieved over the duration of undergraduate or post-graduate nursing and midwifery programs and relate to level 3 descriptors as defined by the European Qualifications Framework (2008).

RESEARCHERS' CONSULTATION QUESTIONNAIRE

Identify which competences in spiritual care should essentially be acquired by a student at pre-registration nursing/midwifery education and which competences should be left to post –registration level

Identify factors that FACILITATE or HINDER the integration of the proposed framework.

Many of the competency items presented in the questionnaire contain several elements due to the complexity of the concept of spiritual care. You are requested to respond to each competency item as a WHOLE.
In this study 54 competency items in spiritual care have reached consensus in the 2nd round of the modified Delphi study.

GLOSSARY:

Pre-registration level i.e. students undertaking a nursing or midwifery program in a higher education institution leading to an academic award and registration as a nurse or midwife.
Post-registration level i.e. qualified registered nurses or midwives who are undertaking either an educational program in a higher education institution leading to an additional academic and/or professional award or an in–house programme of professional development (Quinn 2001).

Please respond to ALL 3 sections and submit your response by: 24th January 2013

SECTION A: PERSONAL DATA

NAME AND SURNAME *

PROFESSIONAL OCCUPATION: *

COUNTRY: *

E-mail: *

AREA OF RESEARCH SPECIALISATION: *

SECTION B:

PLEASE IDENTIFY WHICH COMPETENCES IN SPIRITUAL CARE SHOULD ESSENTIALLY BE ACQUIRED BY A STUDENT AT PRE-REGISTRATION NURSING/MIDWIFERY EDUCATION AND WHICH COMPETENCES SHOULD BE LEFT TO POST-REGISTRATION LEVEL.

'A Not Essential At Either Level' option is provided if your opinion reflects this.

1. Recognise the role of nurses/ midwives in demonstrating an understanding of the concept of spirituality through an individualised (personalised) view of care, attentive to the body-mind-spirit in all health care settings. *

- ESSENTIAL AT PRE-REGISTRATION
- ESSENTIAL AT POST-REGISTRATION
- NOT ESSENTIAL AT EITHER LEVEL

2. Identify the influence of the world's major faiths/ religions (e.g. Christianity, Islam, Judaism, Hindu and Buddhism) cultural beliefs and practices in the appropriate clinical context and along the life span continuum (from conception to death). *

- ESSENTIAL AT PRE-REGISTRATION
- ESSENTIAL AT POST-REGISTRATION
- NOT ESSENTIAL AT EITHER LEVEL

3. Demonstrate knowledge of the basic spiritual needs of individuals which include; • a meaningful philosophy of life (values and moral sense) • a sense of the transcendent (outside of self, view of deity/ higher power and something beyond the immediate life, having hope) • belief and faith in self, others and for some a belief in a deity/ higher power • a relatedness to nature and people (friendship) • experiencing love and forgiveness (a sense of life meaning). *

- ESSENTIAL AT PRE-REGISTRATION
- ESSENTIAL AT POST-REGISTRATION
- NOT ESSENTIAL AT EITHER LEVEL

4. Recognise the importance of the spiritual dimension (with or without religion) that sustains physical and mental well-being. *

- ESSENTIAL AT PRE-REGISTRATION
- ESSENTIAL AT POST-REGISTRATION
- NOT ESSENTIAL AT EITHER LEVEL

SECTION C: INTEGRATION OF THE FRAMEWORK IN EDUCATION AND CLINICAL PRACTICE

Please answer the following questions.

1. Please give your views on the proposed Framework of competency items.

*

2. Please identify factors that may ENHANCE implementation of this framework in education, research and/or clinical practice?

*

3. Please identify factors that may HINDER the implementation of this Framework in education, research and/or clinical practice?

*

4. Any other comments?

THANK YOU FOR YOUR PARTICIPATION

Submit

APPENDIX 30 R 2: RESULTS

Factor analysis

Cases with complete data: [181] Variables: Q1b to Q54b ALPHA FOR ALL VARIABLES=0.9715 FACTOR VARIANCE - CUMULATIVE PROPORTION OF VARIANCE CARMINES EXPLAINED IN DATA SPACE IN FACTOR SPACE – THETA				
1.	22.0344	0.4006	0.6378	0.9723
2.	3.6029	0.4661	0.7421	
3.	2.1504	0.5052	0.8044	
4.	1.9705	0.5411	0.8614	
5.	1.8455	0.5746	0.9149	
6.	1.6865	0.6053	0.9637	
7.	1.2548	0.6281	1.0000	
8.	1.1965	0.6498		
9.	1.1808	0.6713		
10.	0.9914	0.6893		
11.	0.9809	0.7072		
12.	0.9107	0.7237		
	The first 7 factors explain 63% of the total variance.			

Round 2: Factor correlations for rotated factors

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Factor 1	1.000						
Factor 2	0.447	1.000					
Factor 3	0.407	0.268	1.000				
Factor 4	0.430	0.320	0.326	1.000			
Factor 5	0.346	0.333	0.170	0.216	1.000		
Factor 6	0.342	0.210	0.315	0.282	0.154	1.000	
Factor 7	0.146	0.180	0.091	0.186	0.195	0.045	1.000

Round 2: Sorted factor loading (pattern)

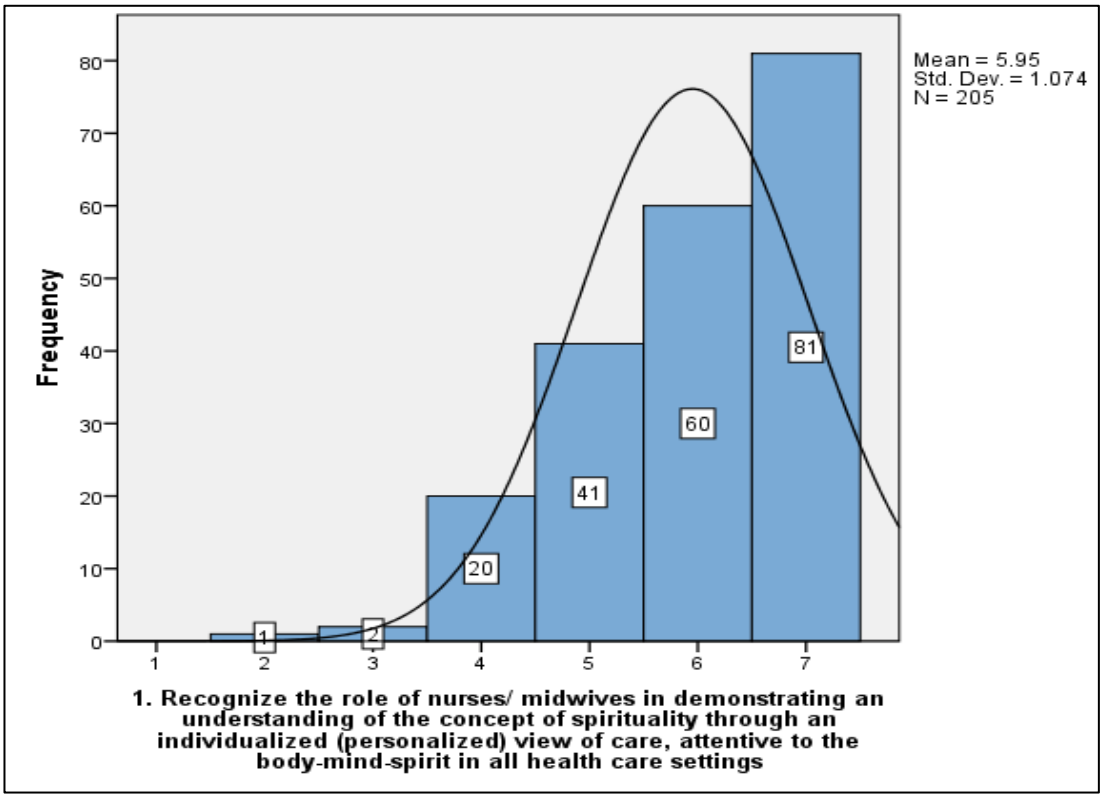
	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Q44b	0.784						
Q45b	0.703						
Q46b	0.655						
Q41b	0.606						
Q51b	0.587						
Q43b	0.553						
Q40b	0.503						
Q15b	0.491						
Q39b	0.487						
Q50b	0.479						

Round 2: Sorted factor loading (pattern) (cont.)

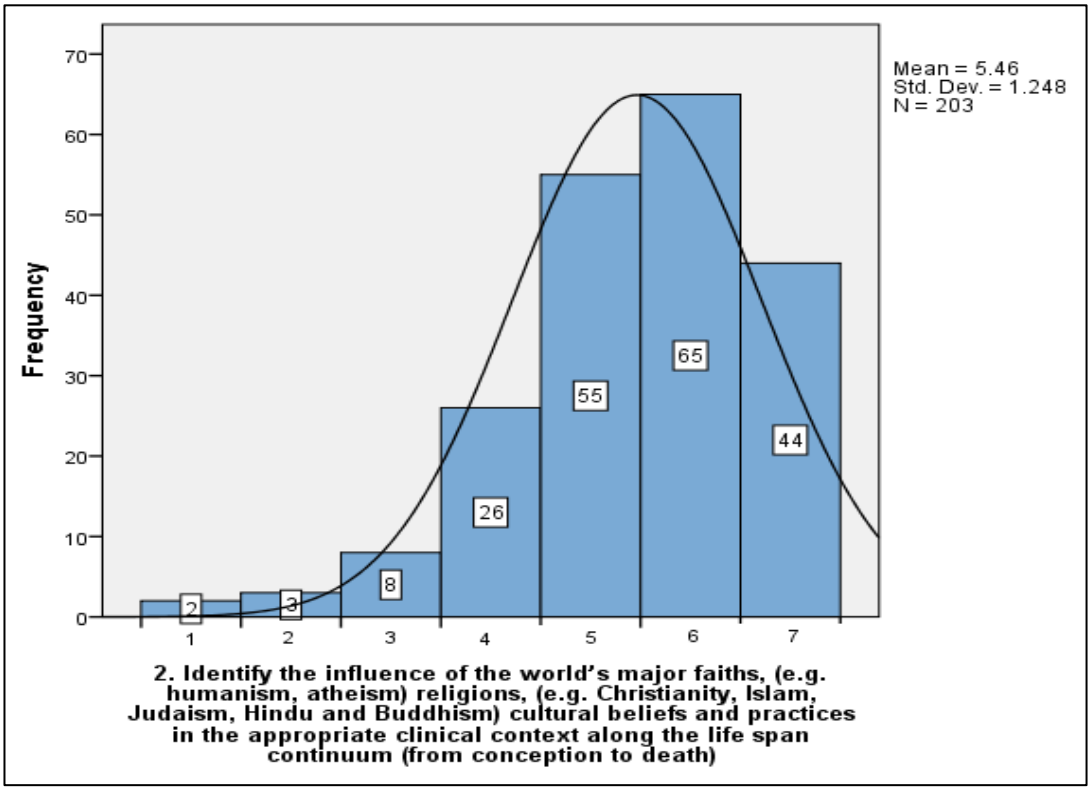
	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Q20b	0.476						
Q16b	0.439						
Q33b		0.823					
Q38b		0.645					
Q36b		0.608					
Q31b		0.568					
Q37b		0.557					
Q42b		0.536					
Q35b		0.532					
Q32b		0.483					
Q30b		0.431					
Q2b		0.407					
Q25b			0.822				
Q26b			0.703				
Q28b			0.639				
Q27b			0.587				
Q29b			0.565				
Q23b			0.512				
Q22b			0.478				
Q18b			0.451				
Q8b			0.479	0.466			
Q24b	0.422		0.446				
Q6b				0.672			
Q10b				0.642			
Q7b				0.584			
Q3b				0.575			
Q5b				0.465			
Q9b				0.431			
Q1b				0.485			
Q4b				0.475			
Q11b				0.406			
Q53b					0.849		
Q54b					0.821		
Q52b					0.644		
Q12b						0.740	
Q48b						0.726	
Q13b						0.588	
Q49b						0.535	
Q21b							0.442
% Variance explained							
	9.2	**7.9**	**7.7**	**6.7**	**6.5**	**5.7**	**3.3**

The above factor loading matrix has been rearranged so that the columns appear in decreasing order of variance explained by factors. The rows have been rearranged so that for each successive factor, loading greater than 0.5000 appear first. Loading less than 0.4000 are replaced by zero.

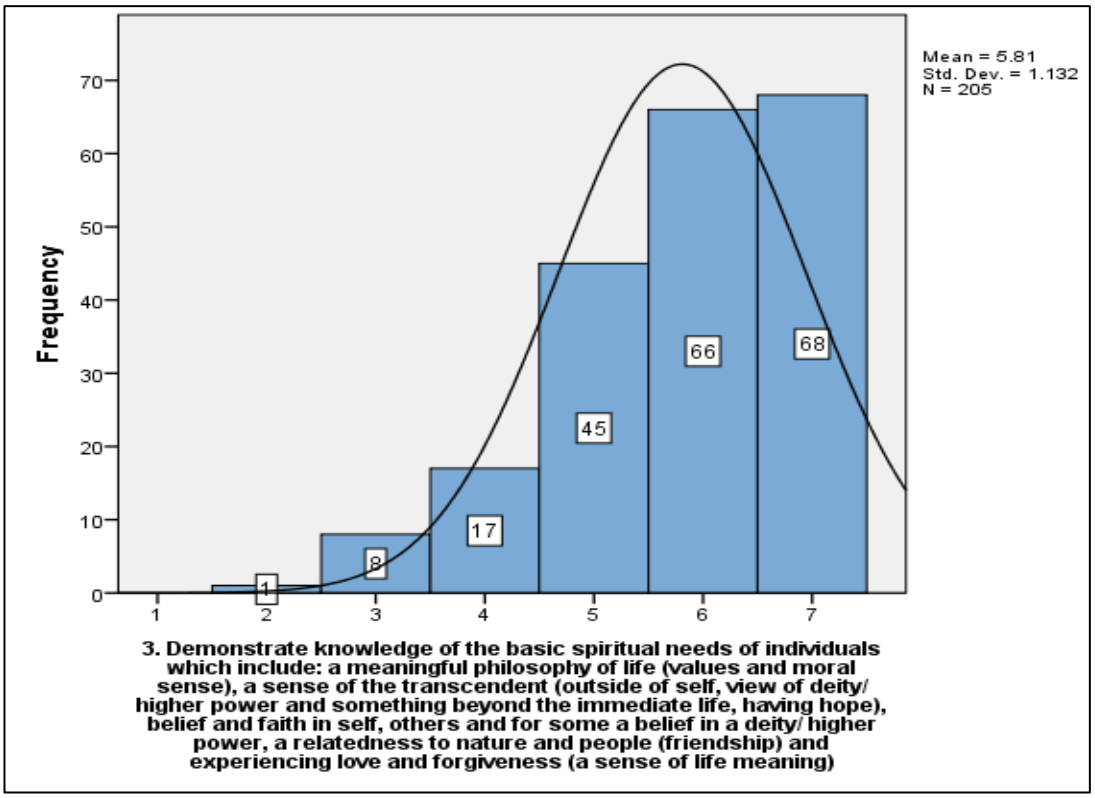
APPENDIX 31 PHASE 2 OF MODIFIED DELPHI STUDY: RESPONDENTS' FREQUENCY DISTRIBUTION

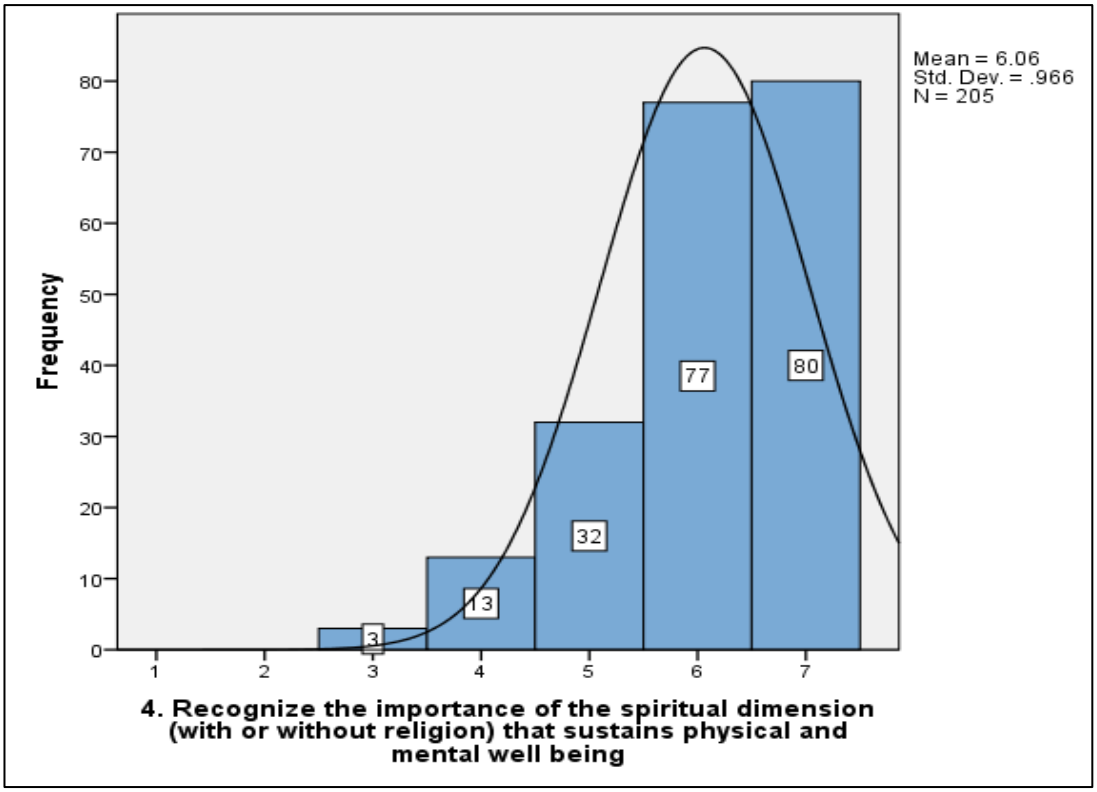


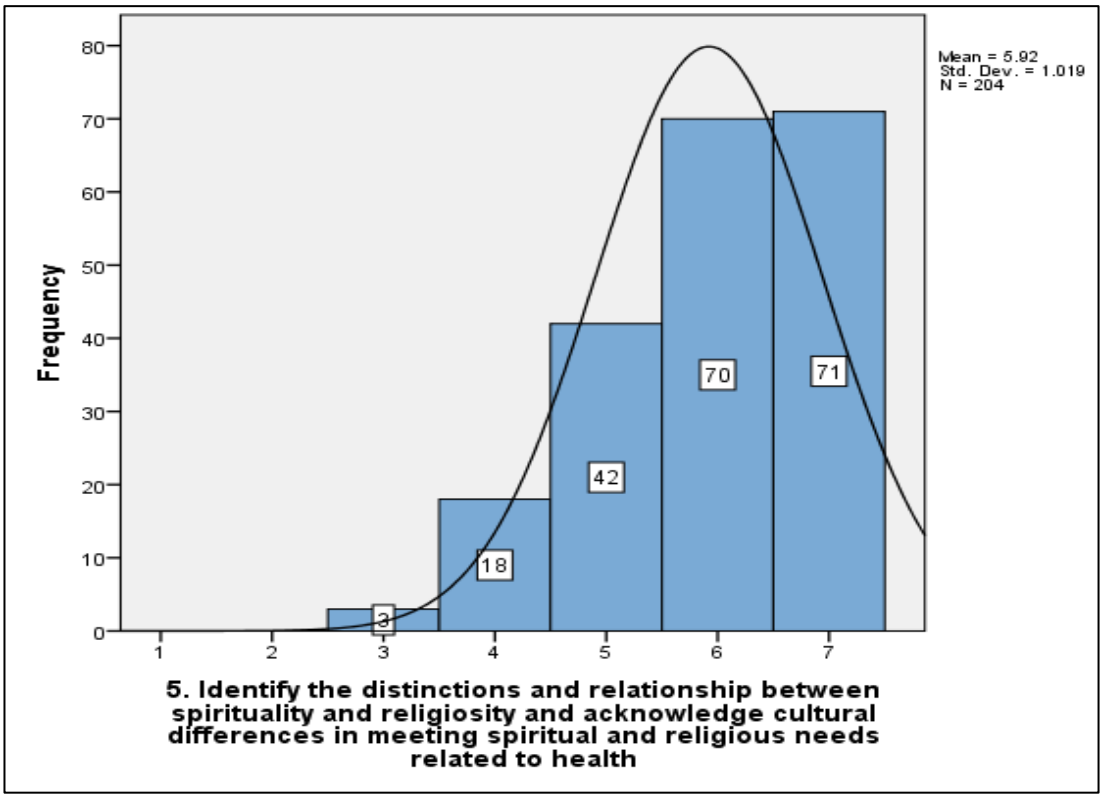
1. Recognize the role of nurses/ midwives in demonstrating an understanding of the concept of spirituality through an individualized (personalized) view of care, attentive to the body-mind-spirit in all health care settings



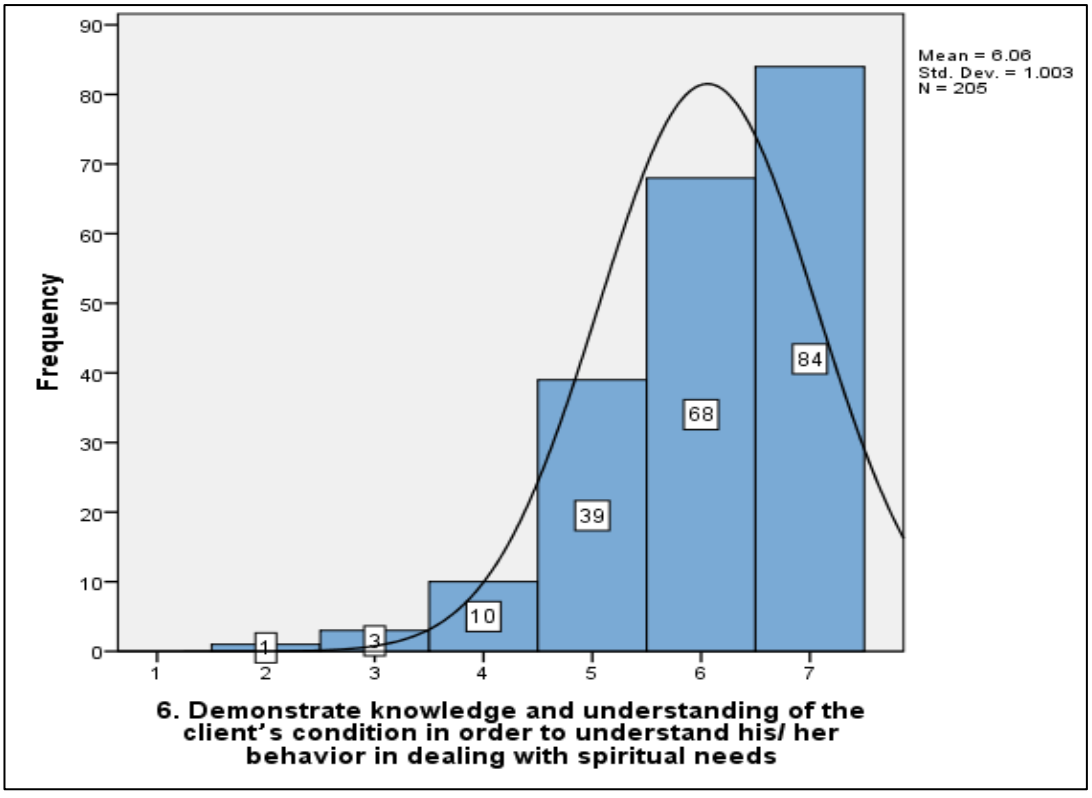
2. Identify the influence of the world's major faiths, (e.g. humanism, atheism) religions, (e.g. Christianity, Islam, Judaism, Hindu and Buddhism) cultural beliefs and practices in the appropriate clinical context along the life span continuum (from conception to death)


Mean = 5.81
Std. Dev. = 1.132
N = 205
Frequency
70
60
50
40
30
20
10
0
1
2
3
4
5
6
7
1
8
17
45
66
68
3. Demonstrate knowledge of the basic spiritual needs of individuals which include: a meaningful philosophy of life (values and moral sense), a sense of the transcendent (outside of self, view of deity/ higher power and something beyond the immediate life, having hope), belief and faith in self, others and for some a belief in a deity/ higher power, a relatedness to nature and people (friendship) and experiencing love and forgiveness (a sense of life meaning)

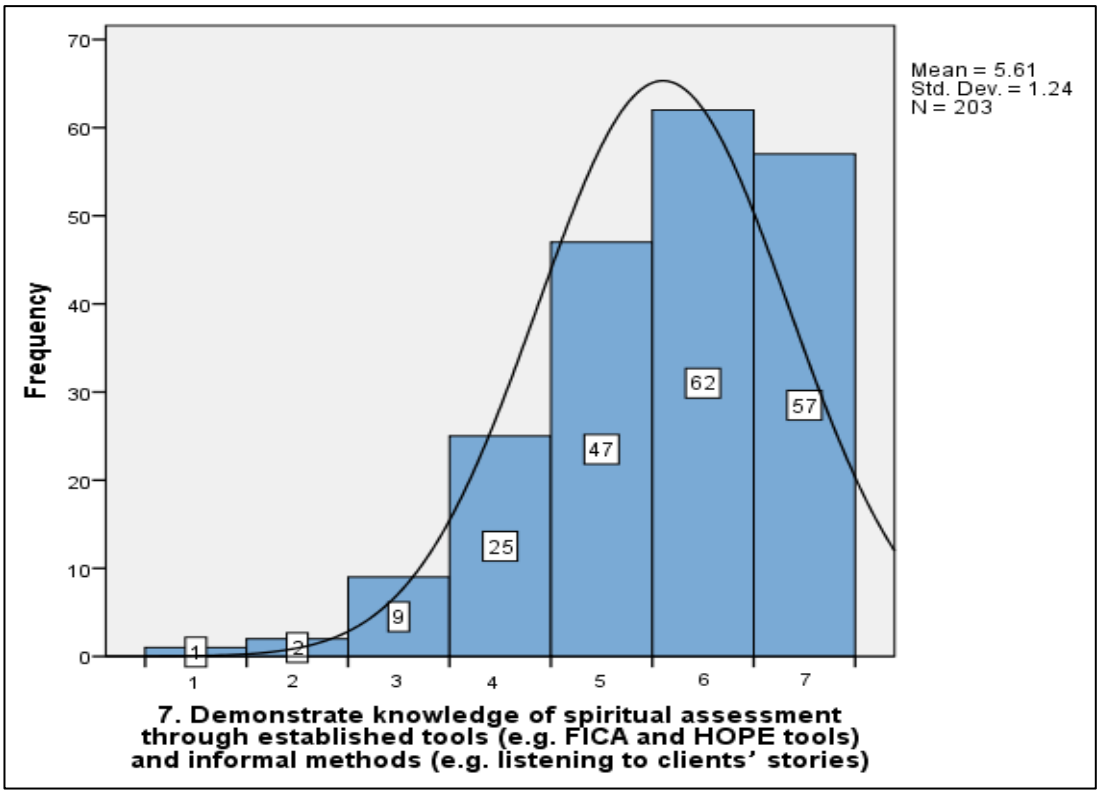

Mean = 6.06
Std. Dev. = .966
N = 205
Frequency
80
70
60
50
40
30
20
10
0
1
2
3
4
5
6
7
3
13
32
77
80
4. Recognize the importance of the spiritual dimension (with or without religion) that sustains physical and mental well being



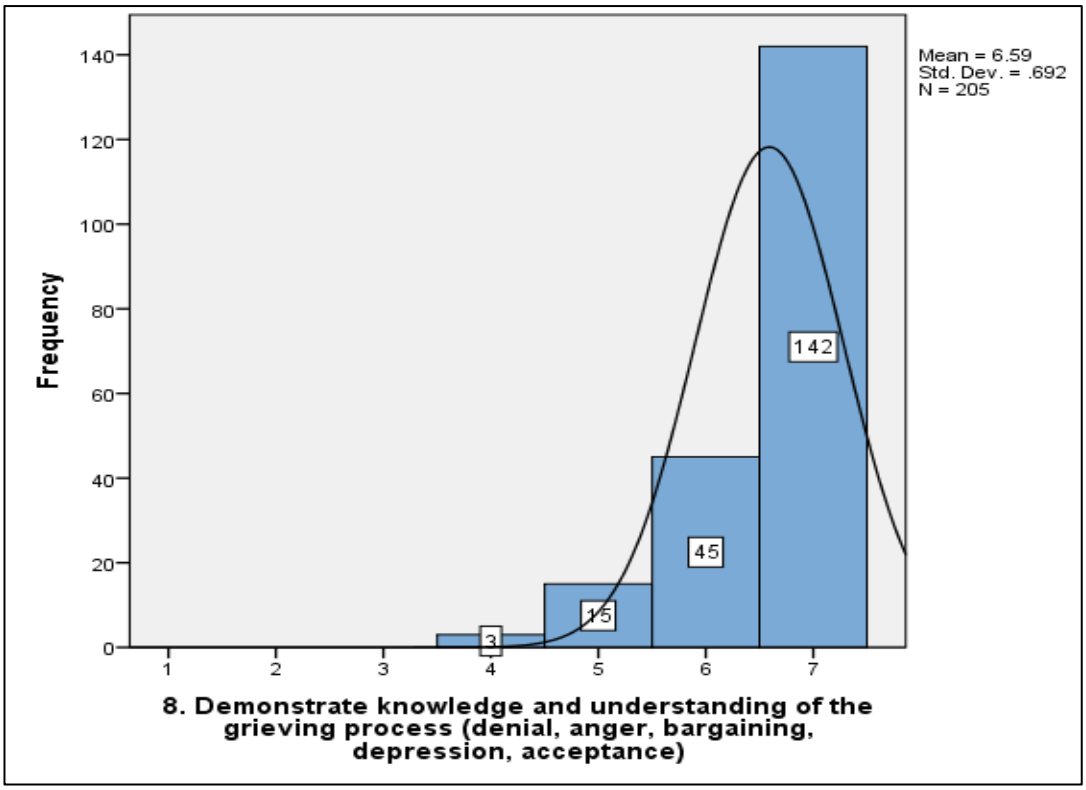
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health



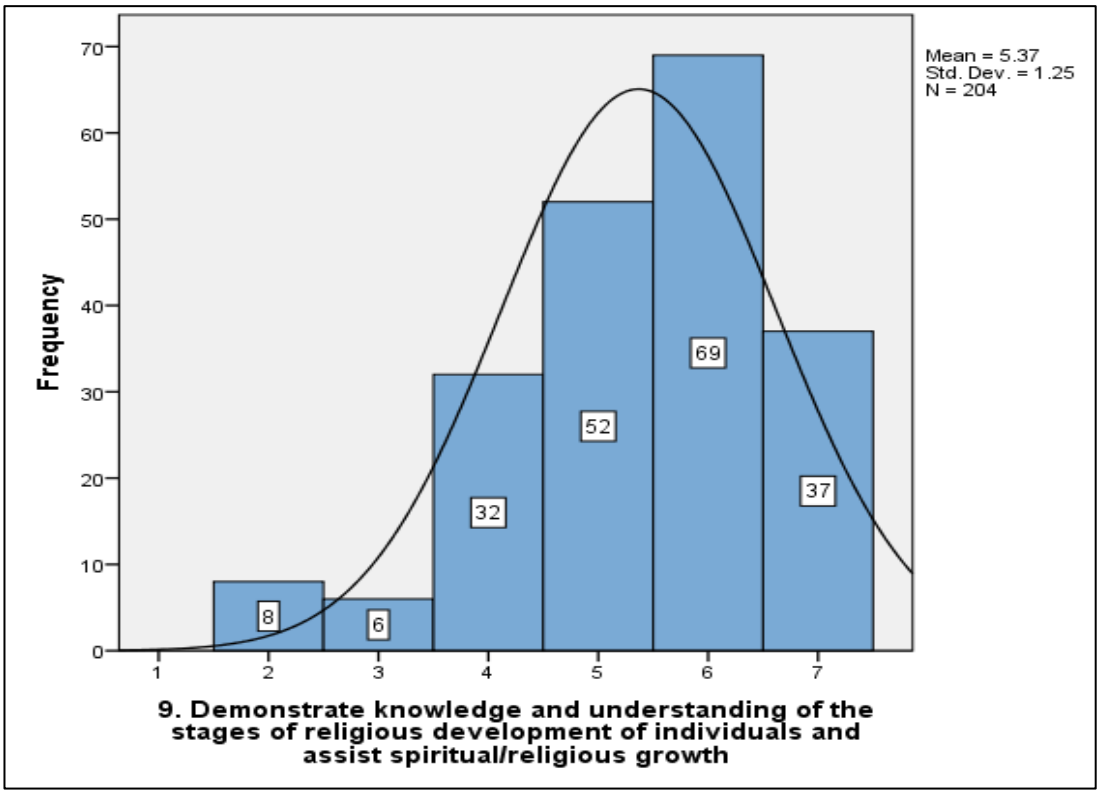
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/ her behavior in dealing with spiritual needs



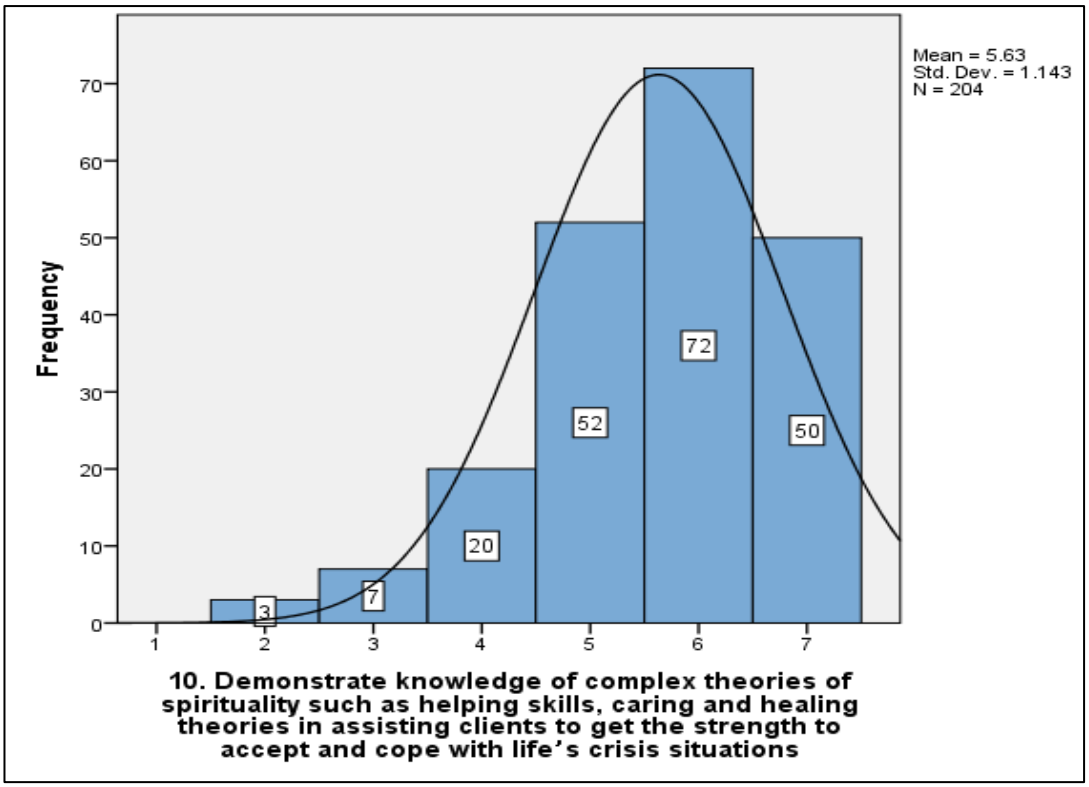
7. Demonstrate knowledge of spiritual assessment through established tools (e.g. FICA and HOPE tools) and informal methods (e.g. listening to clients' stories)



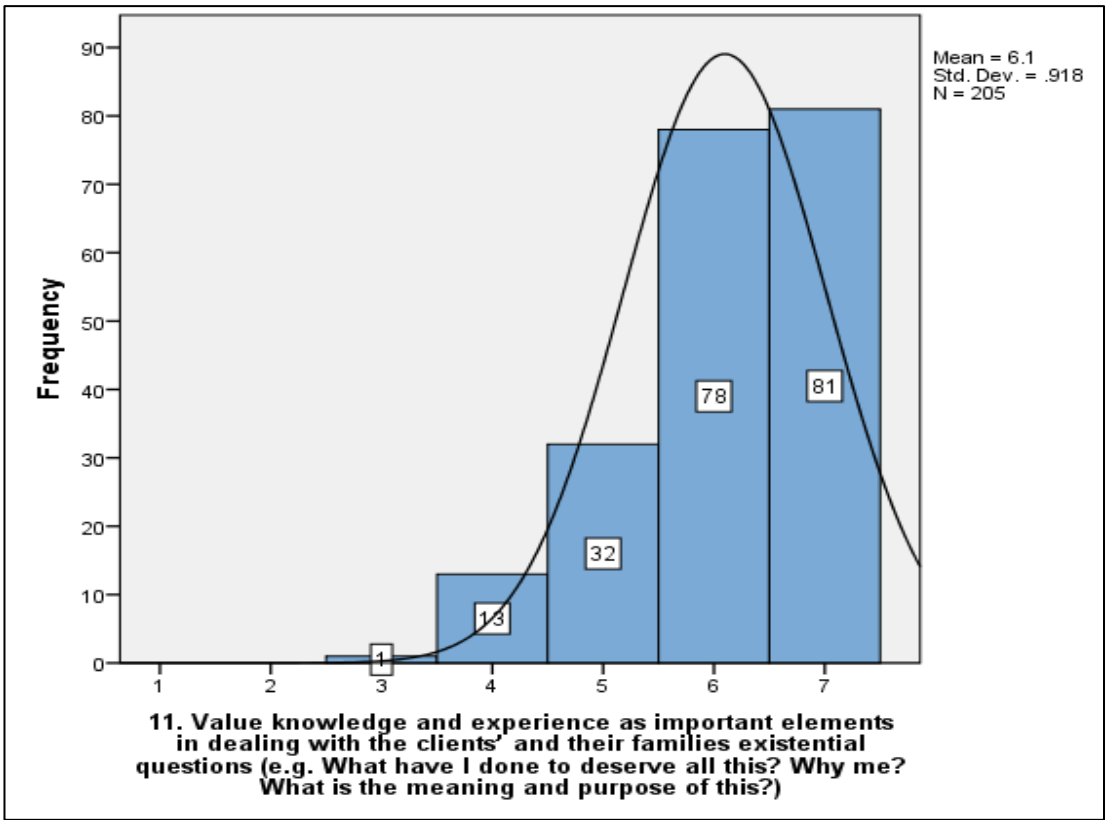
8. Demonstrate knowledge and understanding of the grieving process (denial, anger, bargaining, depression, acceptance)



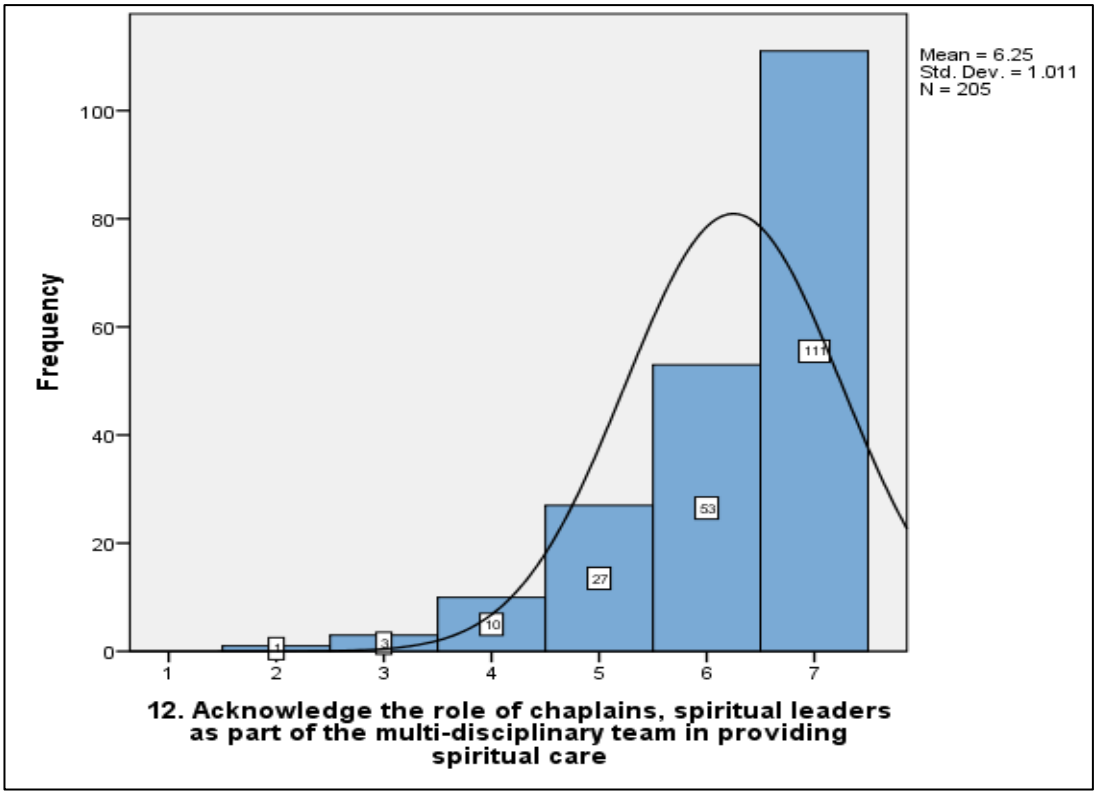
9. Demonstrate knowledge and understanding of the stages of religious development of individuals and assist spiritual/religious growth



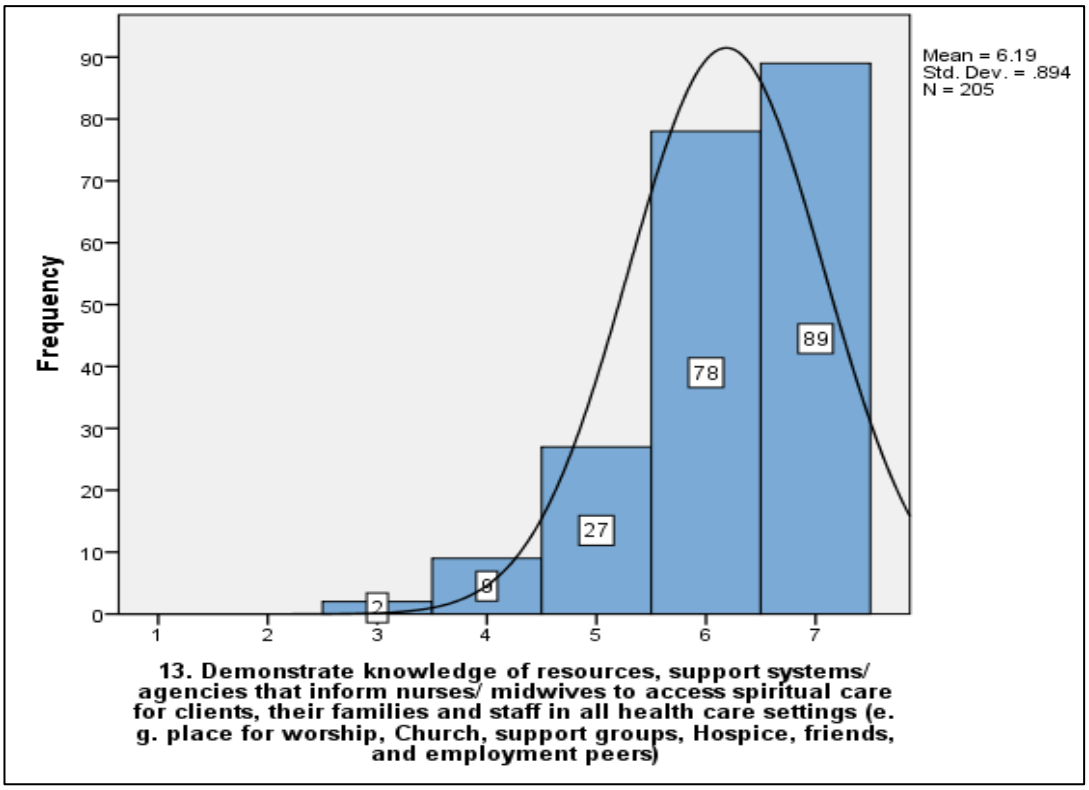
10. Demonstrate knowledge of complex theories of spirituality such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations



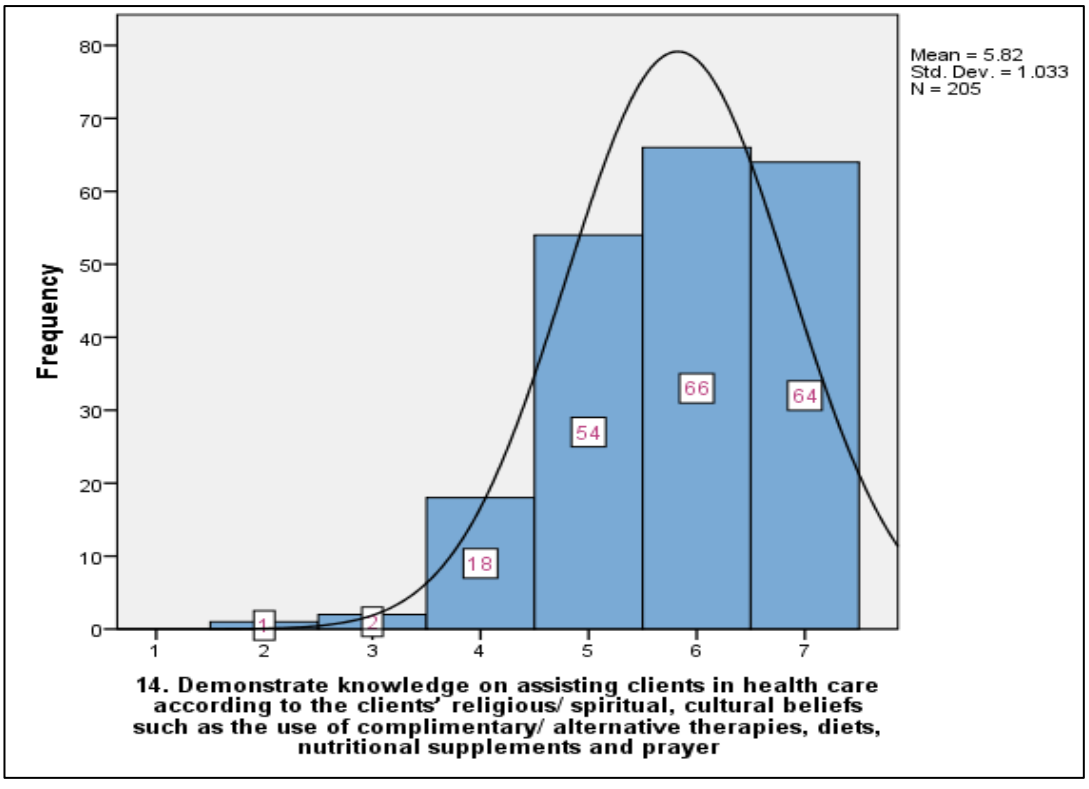
11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?)



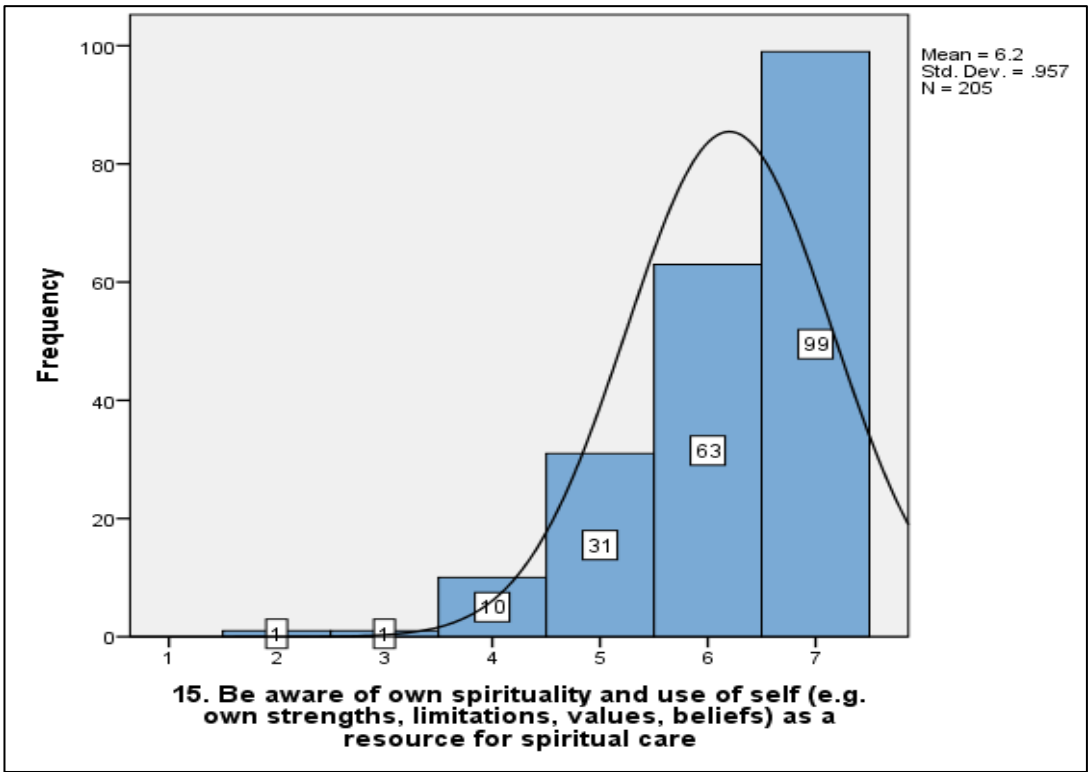
12. Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care



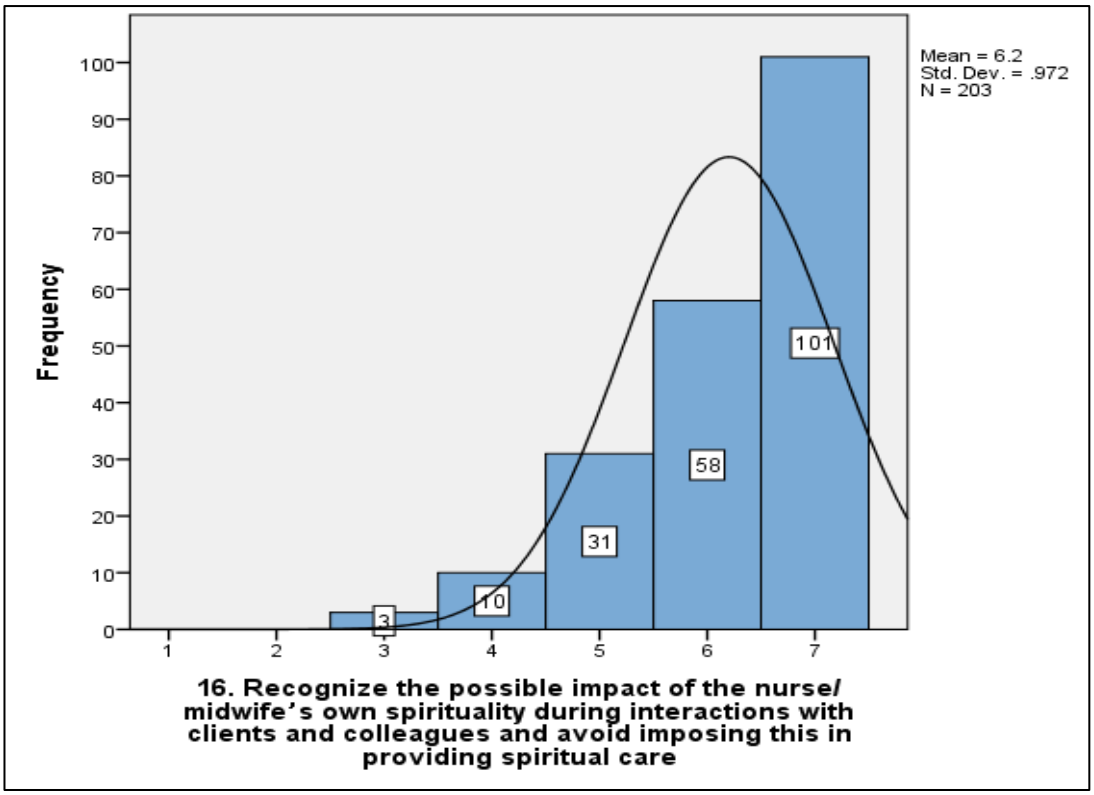
13. Demonstrate knowledge of resources, support systems/ agencies that inform nurses/ midwives to access spiritual care for clients, their families and staff in all health care settings (e. g. place for worship, Church, support groups, Hospice, friends, and employment peers)



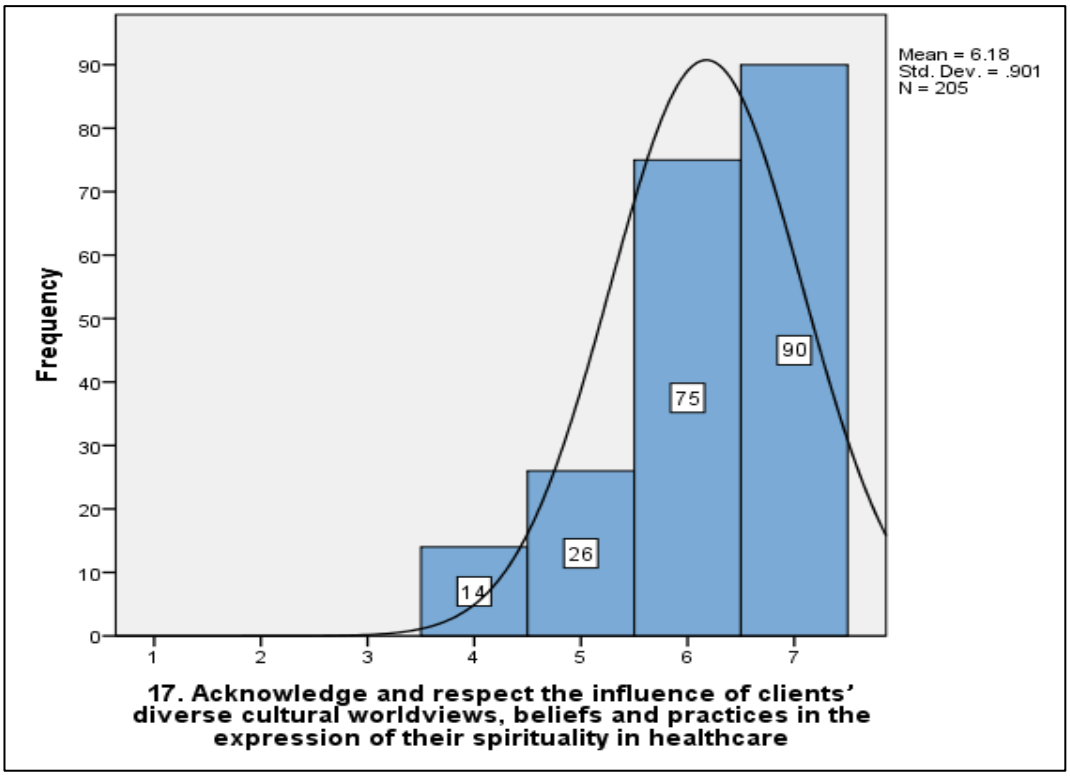
14. Demonstrate knowledge on assisting clients in health care according to the clients' religious/ spiritual, cultural beliefs such as the use of complimentary/ alternative therapies, diets, nutritional supplements and prayer



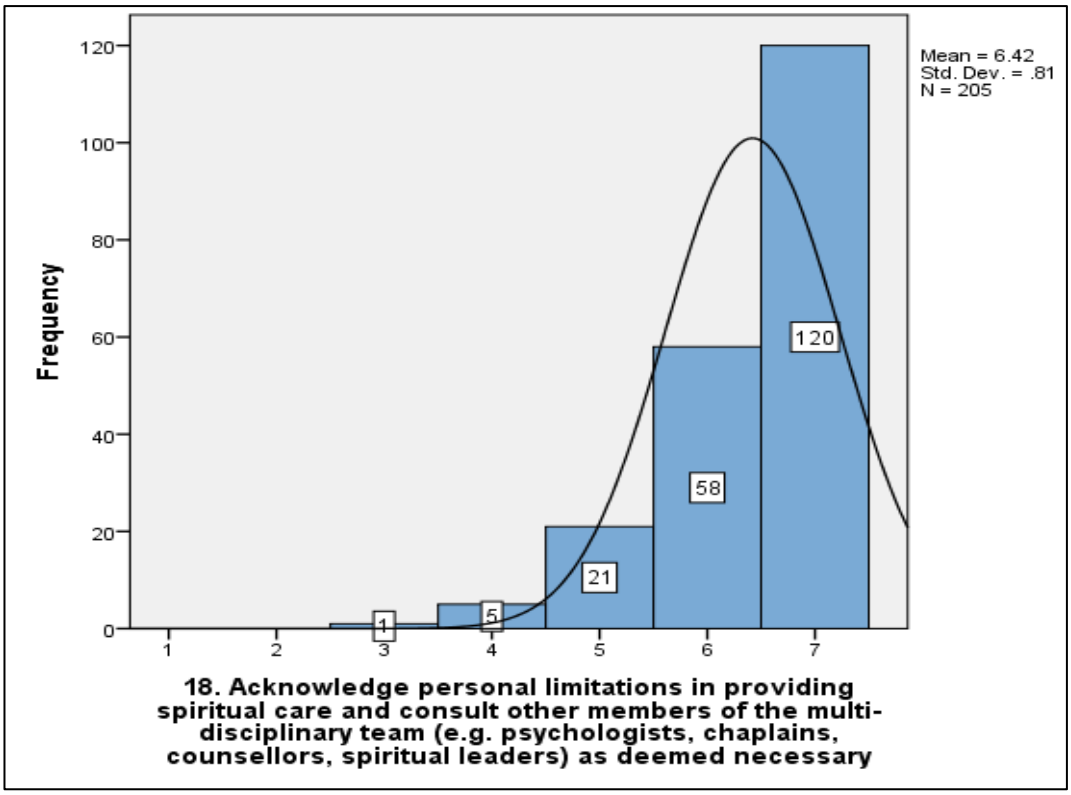
15. Be aware of own spirituality and use of self (e.g. own strengths, limitations, values, beliefs) as a resource for spiritual care



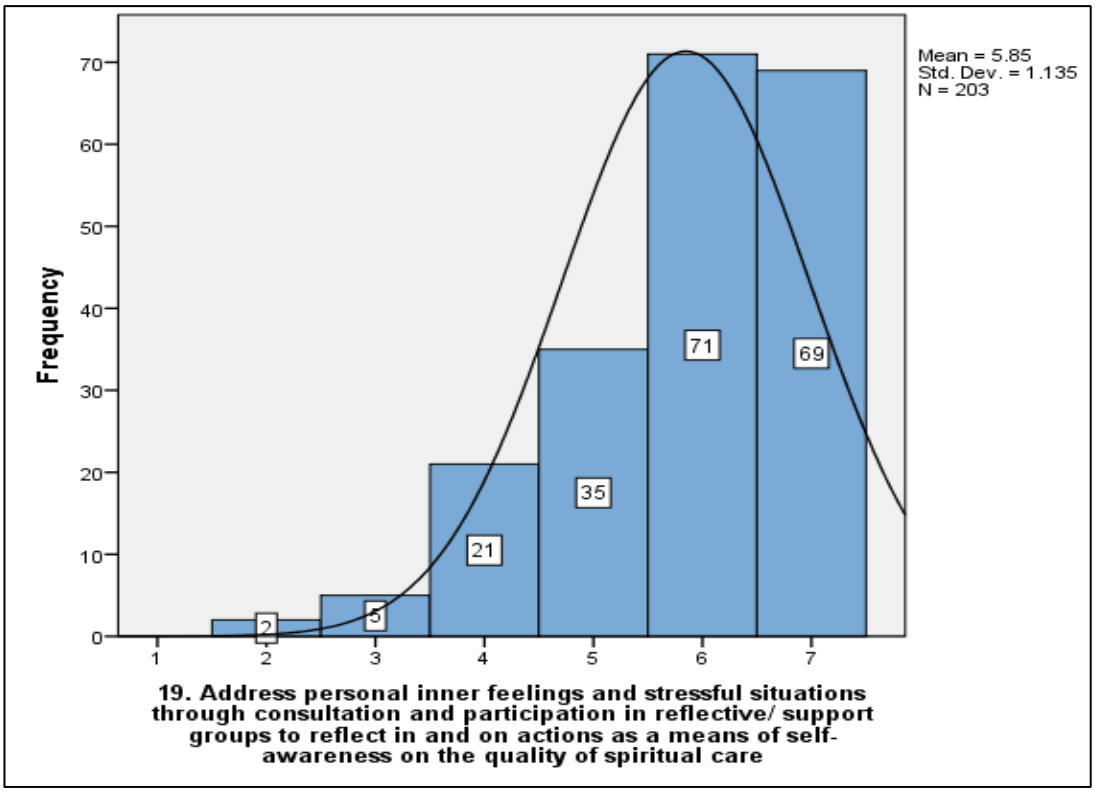
16. Recognize the possible impact of the nurse/ midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care



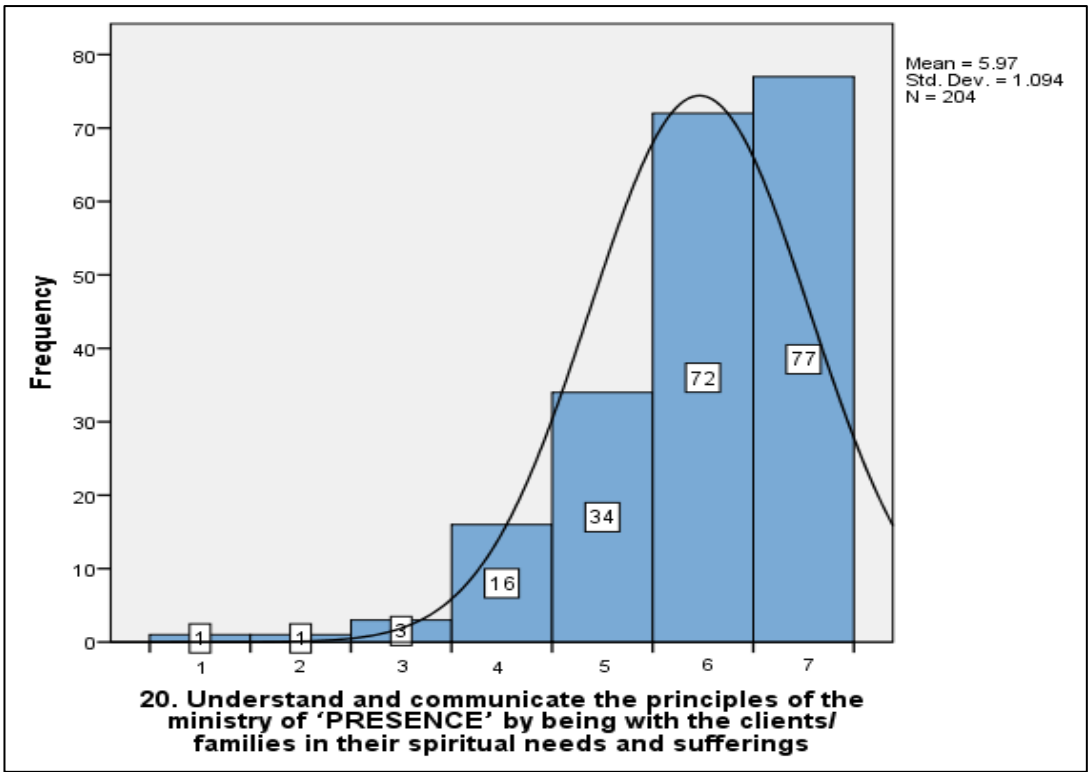
17. Acknowledge and respect the influence of clients' diverse cultural worldviews, beliefs and practices in the expression of their spirituality in healthcare



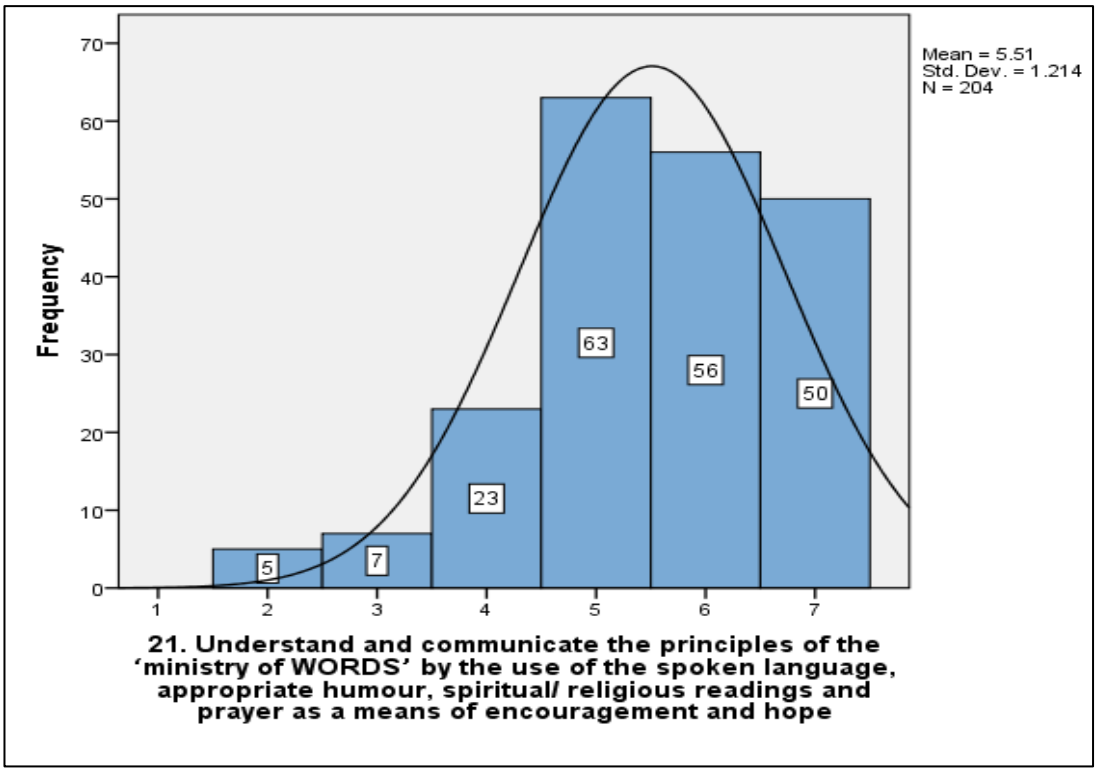
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (e.g. psychologists, chaplains, counsellors, spiritual leaders) as deemed necessary



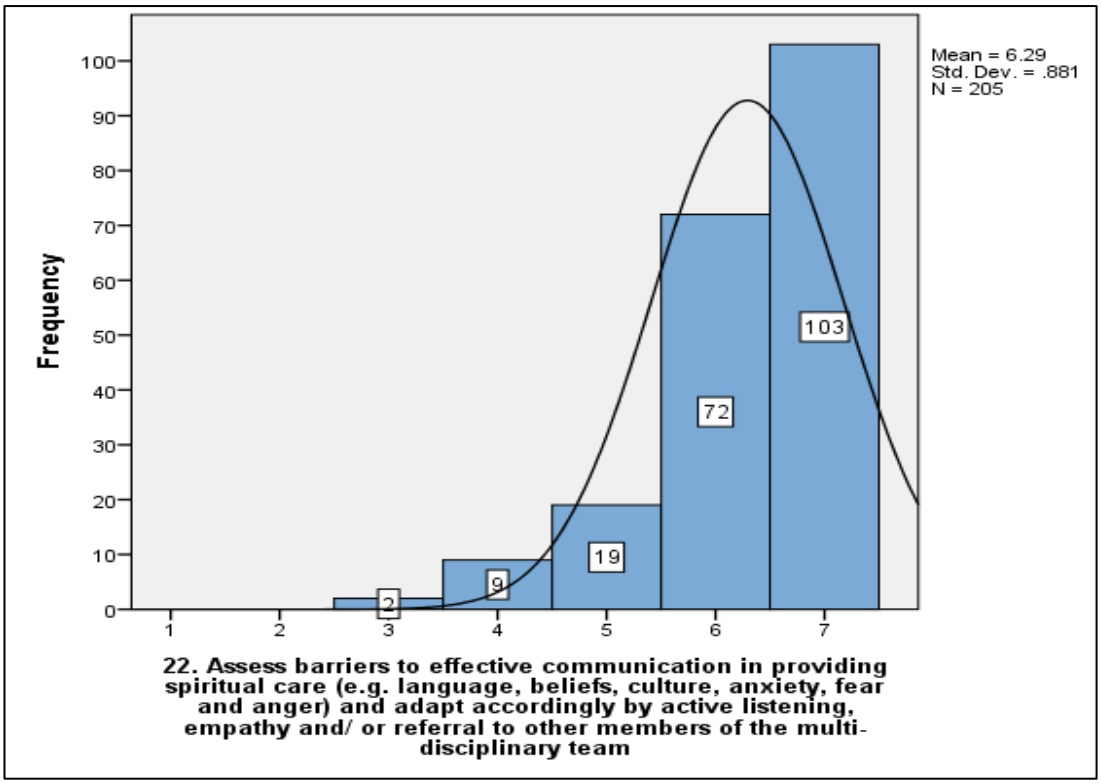
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/ support groups to reflect in and on actions as a means of self-awareness on the quality of spiritual care



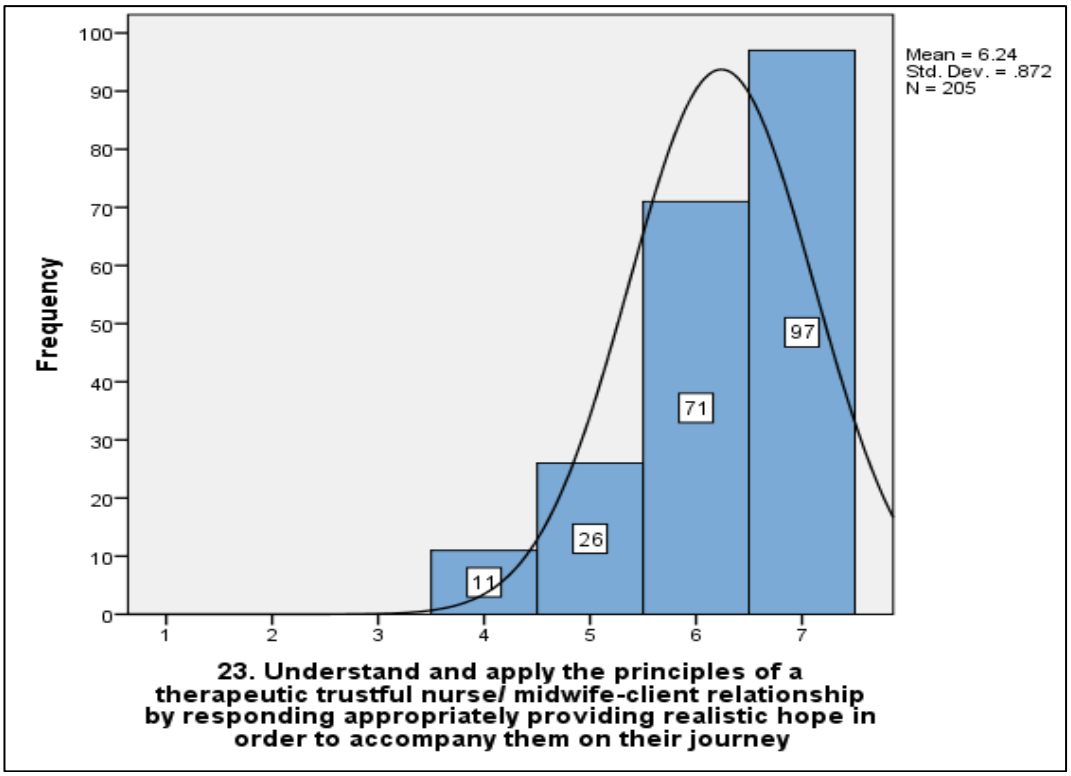
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/ families in their spiritual needs and sufferings



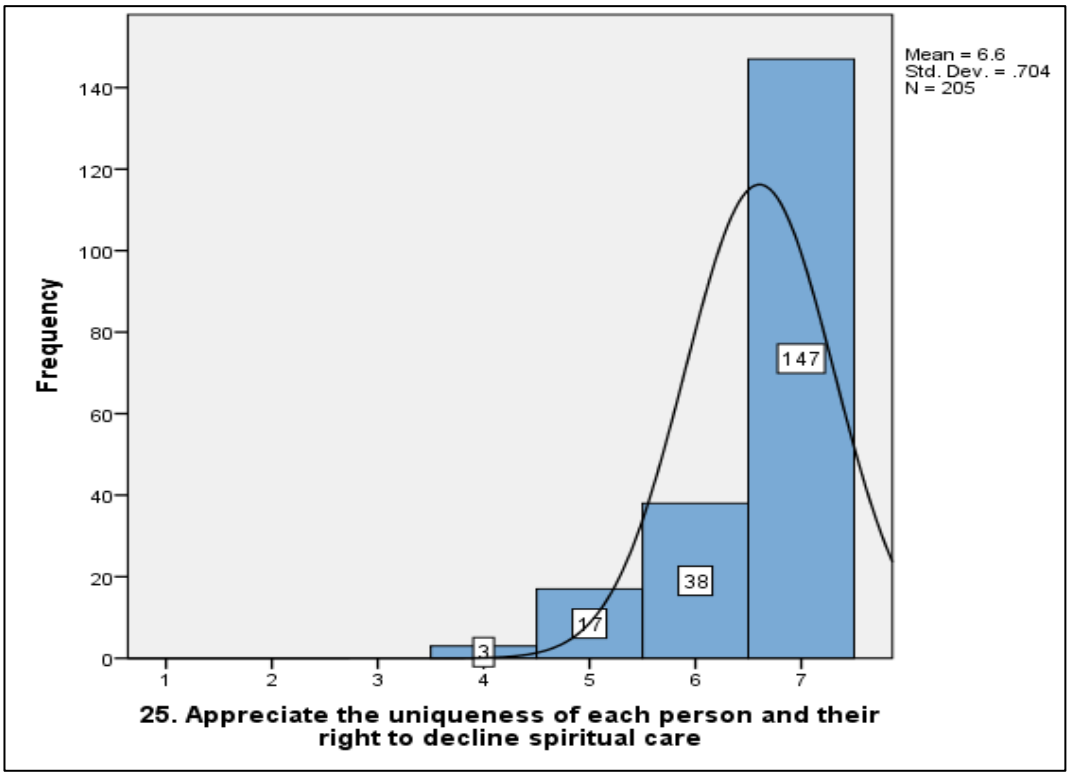
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/ religious readings and prayer as a means of encouragement and hope

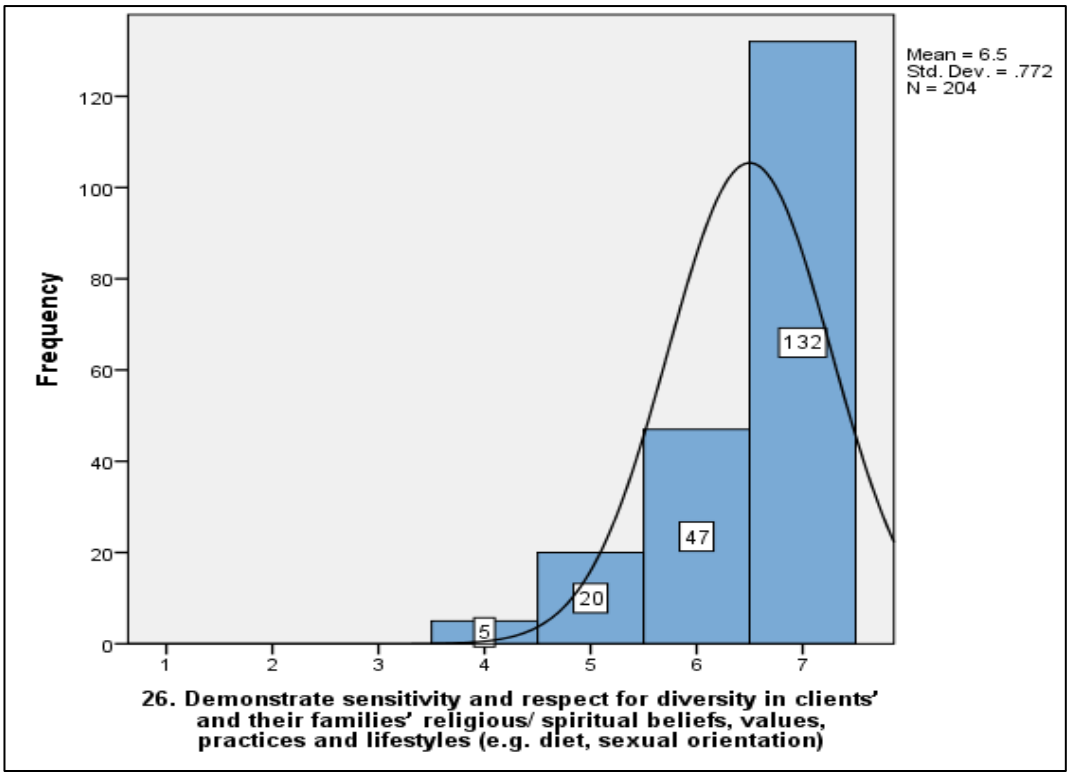


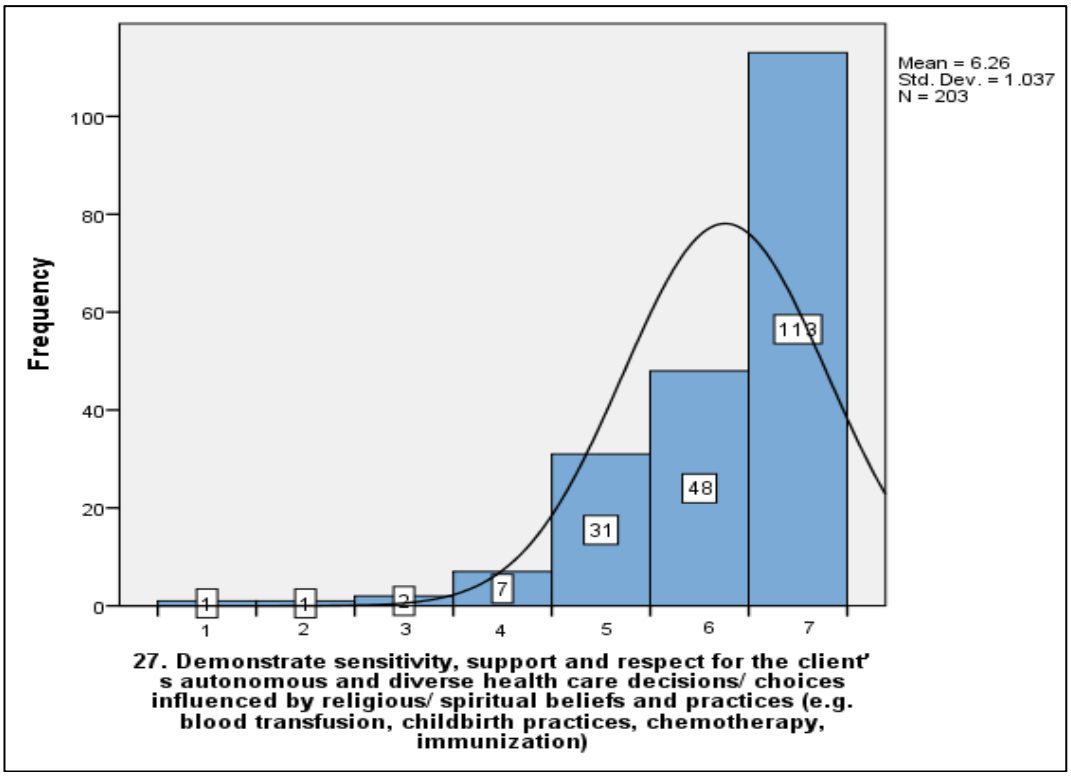
22. Assess barriers to effective communication in providing spiritual care (e.g. language, beliefs, culture, anxiety, fear and anger) and adapt accordingly by active listening, empathy and/ or referral to other members of the multi-disciplinary team


Mean = 6.24
Std. Dev. = .872
N = 205
Frequency
11
26
71
97
23. Understand and apply the principles of a therapeutic trustful nurse/ midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey

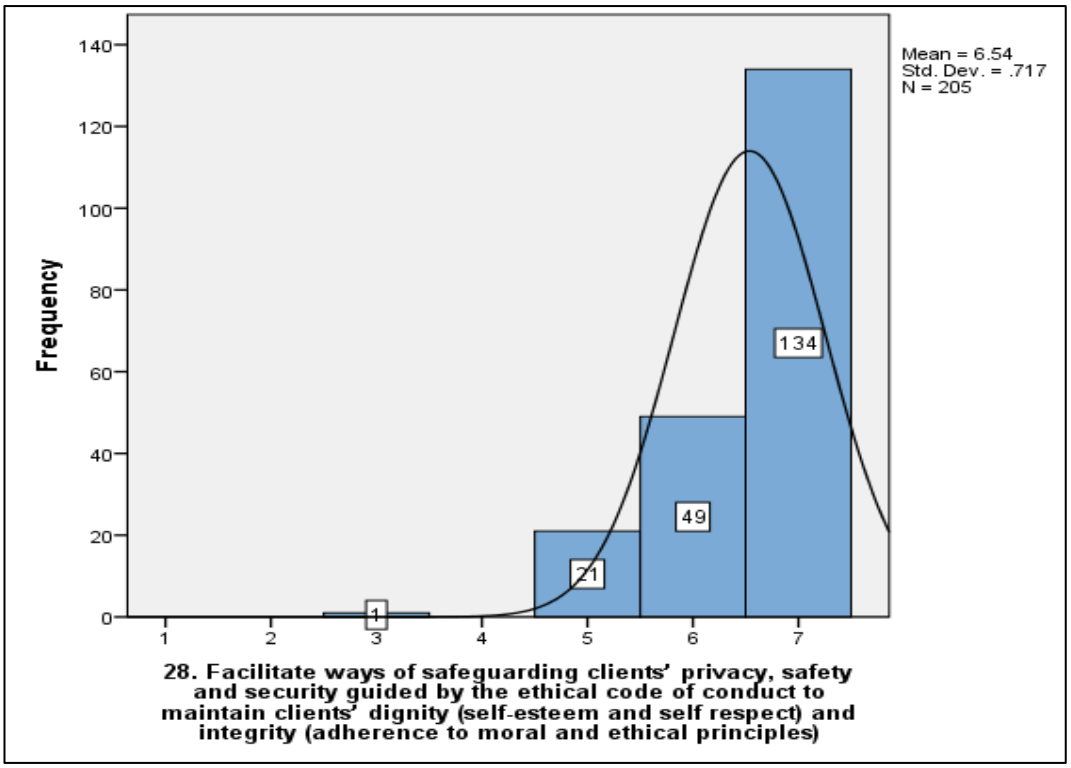

Mean = 6.21
Std. Dev. = .918
N = 205
Frequency
13
30
63
99
24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/ midwife-client relationship; (abiding by the professional ethical/ legal codes of conduct)


Mean = 6.6
Std. Dev. = .704
N = 205
Frequency
140
120
100
80
60
40
20
0
1
2
3
4
5
6
7
147
38
17
3
25. Appreciate the uniqueness of each person and their right to decline spiritual care

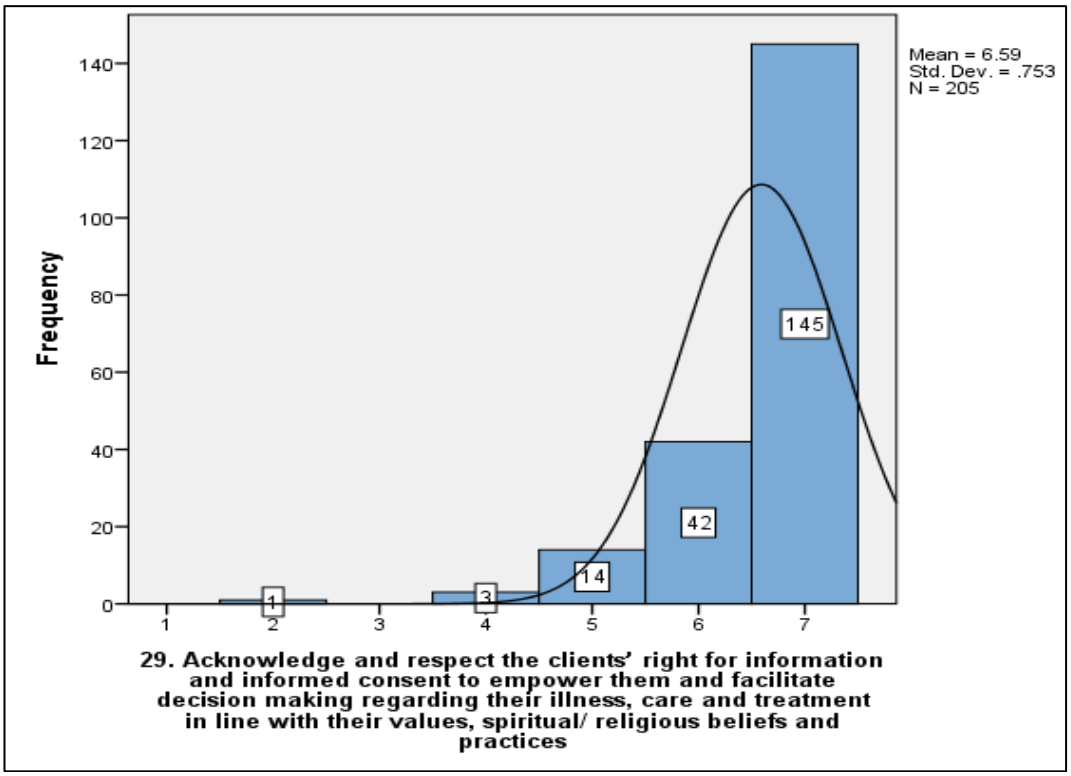

Mean = 6.5
Std. Dev. = .772
N = 204
Frequency
120
100
80
60
40
20
0
1
2
3
4
5
6
7
132
47
20
5
26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/ spiritual beliefs, values, practices and lifestyles (e.g. diet, sexual orientation)



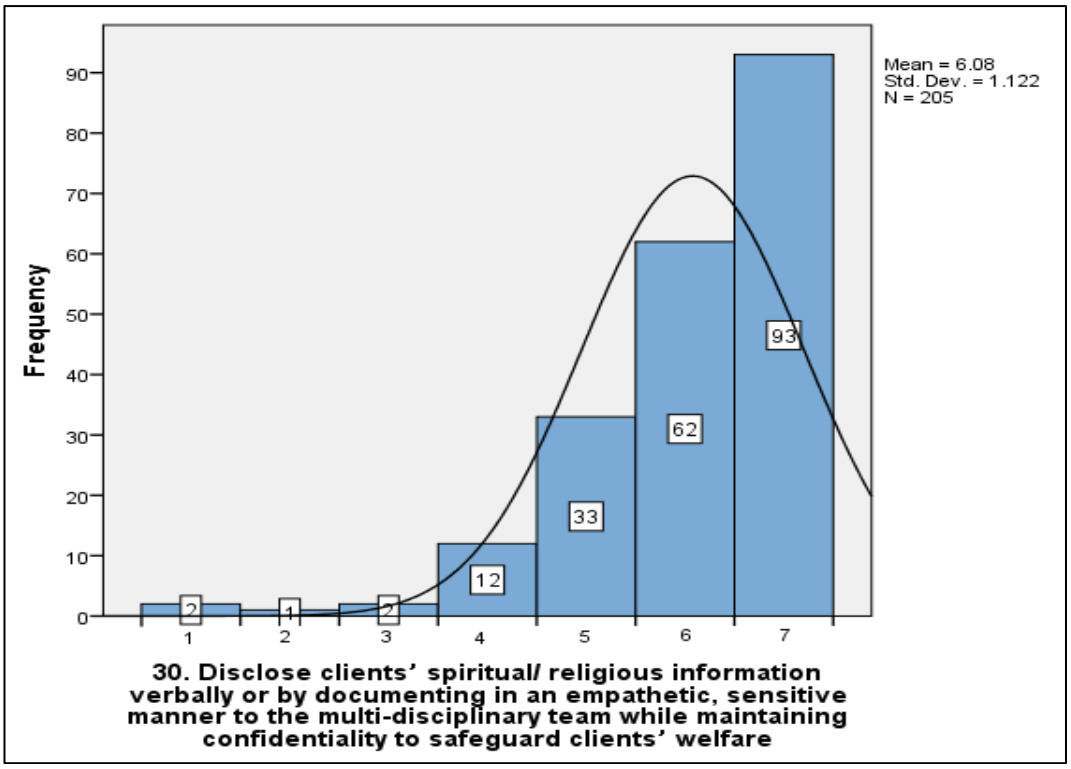
27. Demonstrate sensitivity, support and respect for the client' s autonomous and diverse health care decisions/ choices influenced by religious/ spiritual beliefs and practices (e.g. blood transfusion, childbirth practices, chemotherapy, immunization)



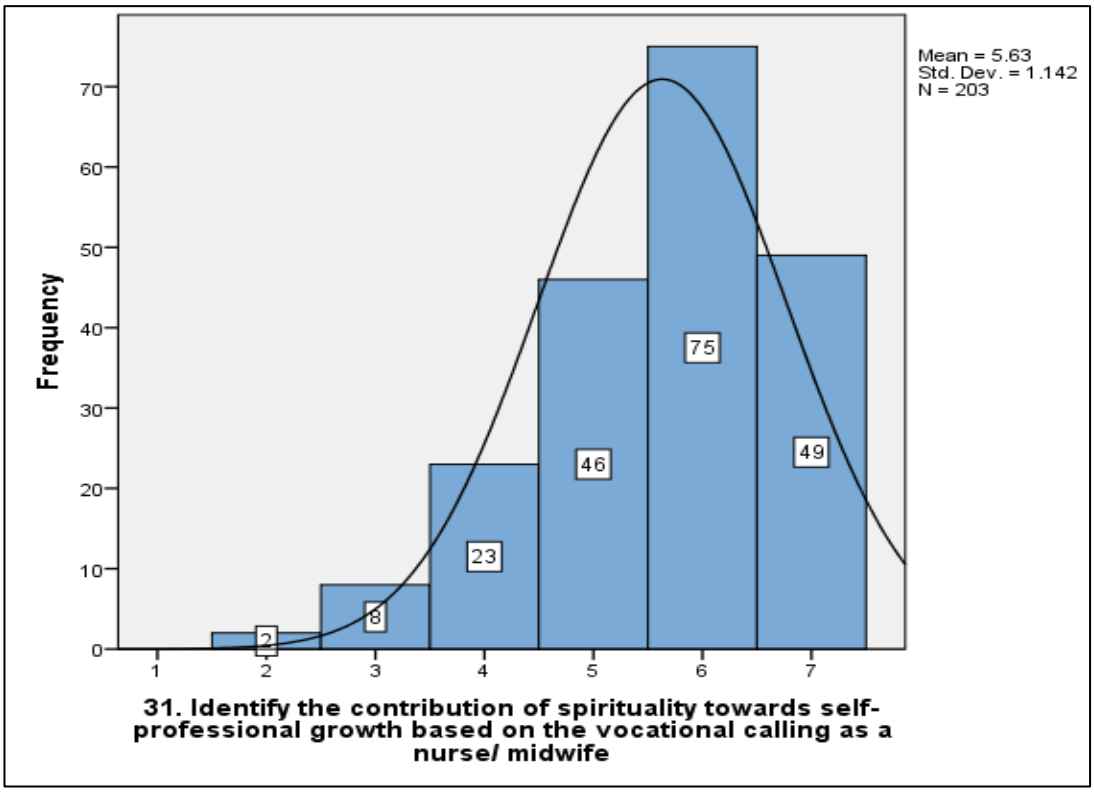
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (self-esteem and self respect) and integrity (adherence to moral and ethical principles)



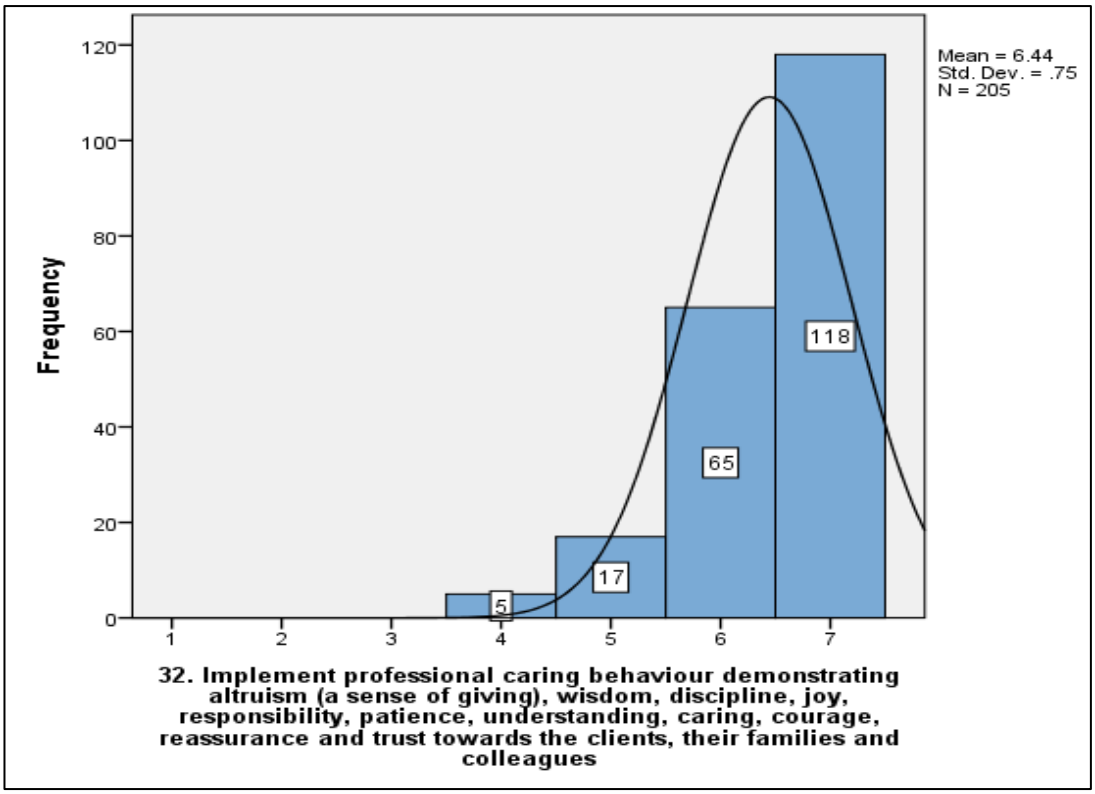
29. Acknowledge and respect the clients' right for information and informed consent to empower them and facilitate decision making regarding their illness, care and treatment in line with their values, spiritual/ religious beliefs and practices



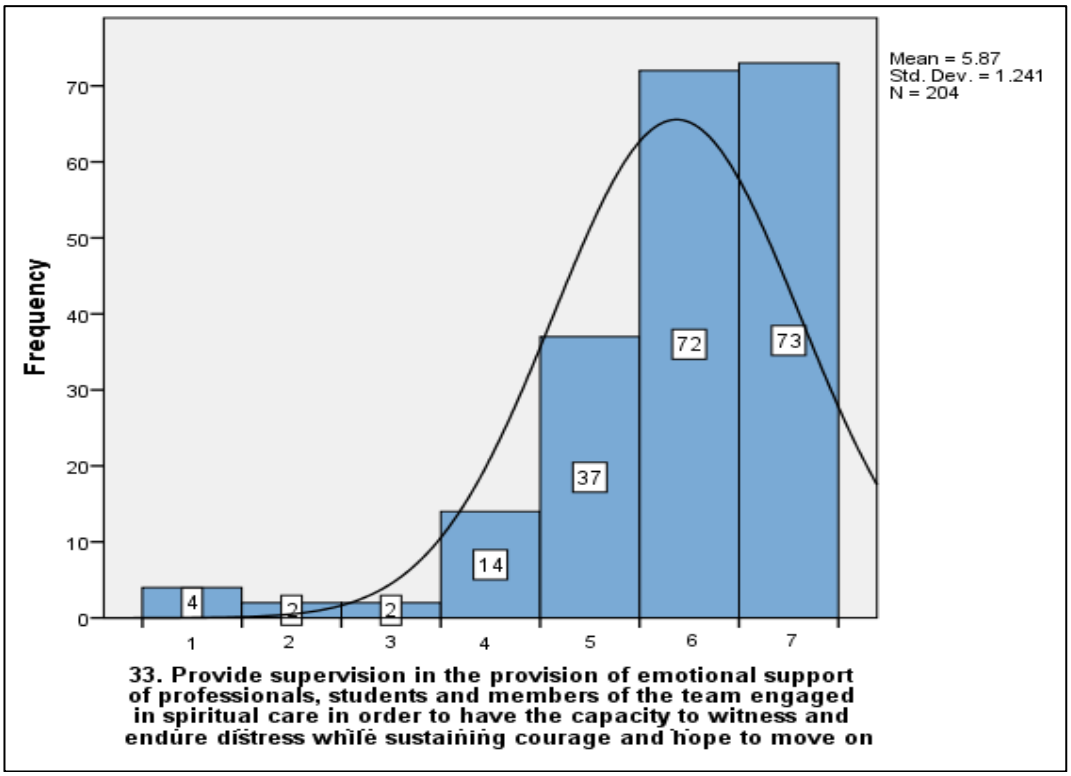
30. Disclose clients' spiritual/ religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team while maintaining confidentiality to safeguard clients' welfare



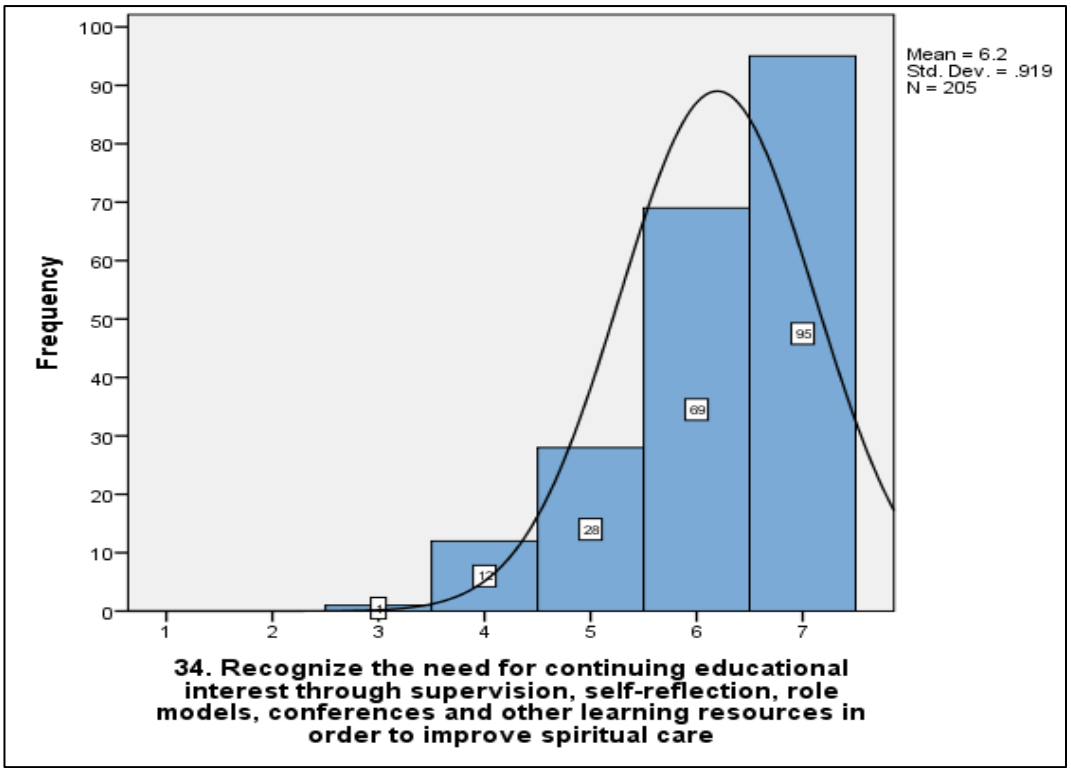
31. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/ midwife



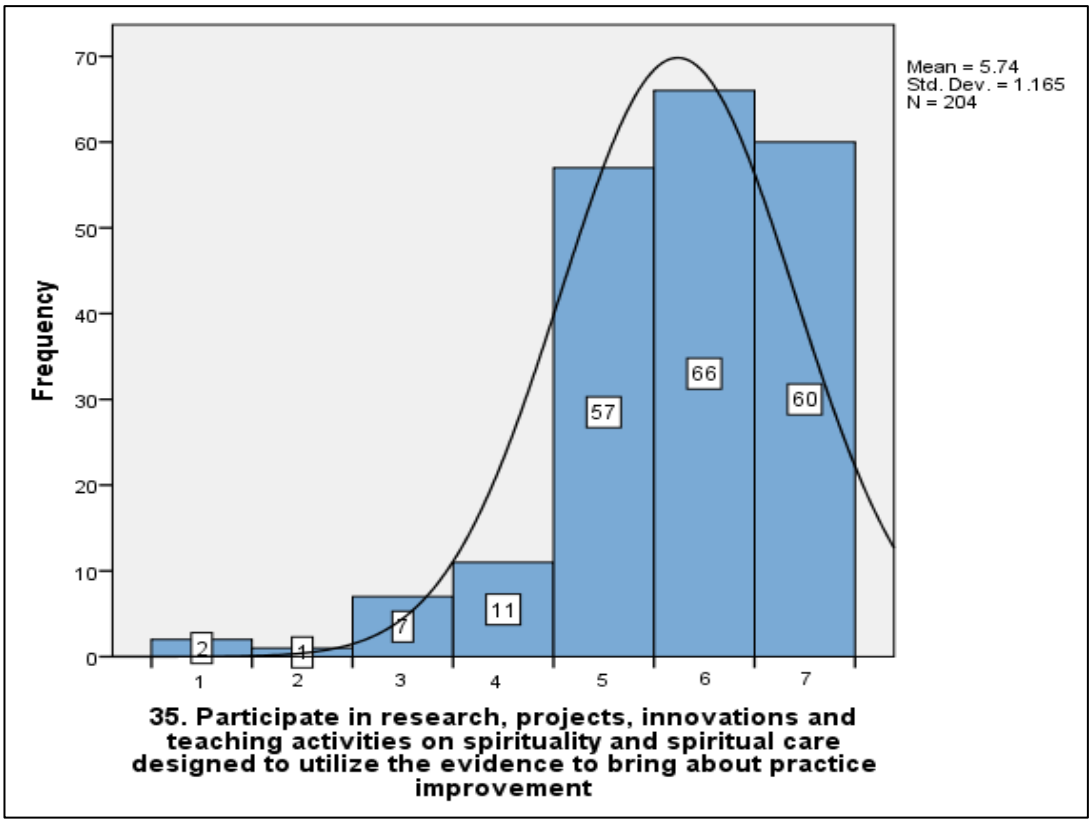
32. Implement professional caring behaviour demonstrating altruism (a sense of giving), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues

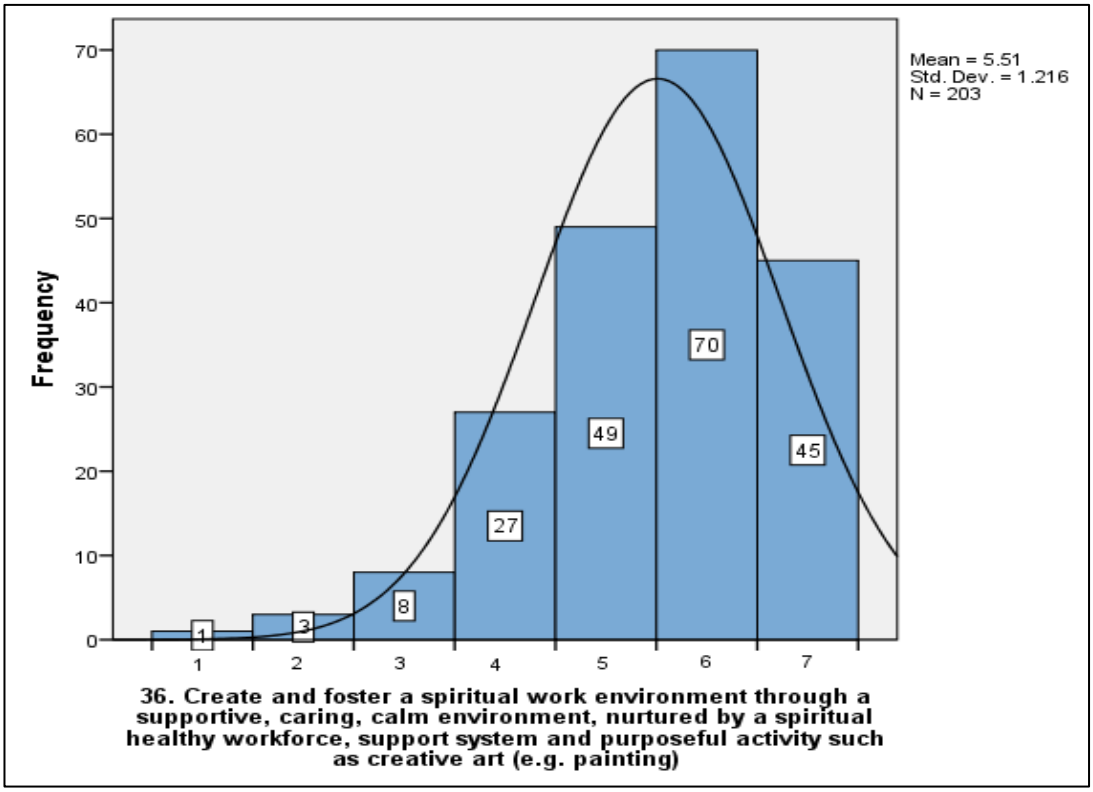


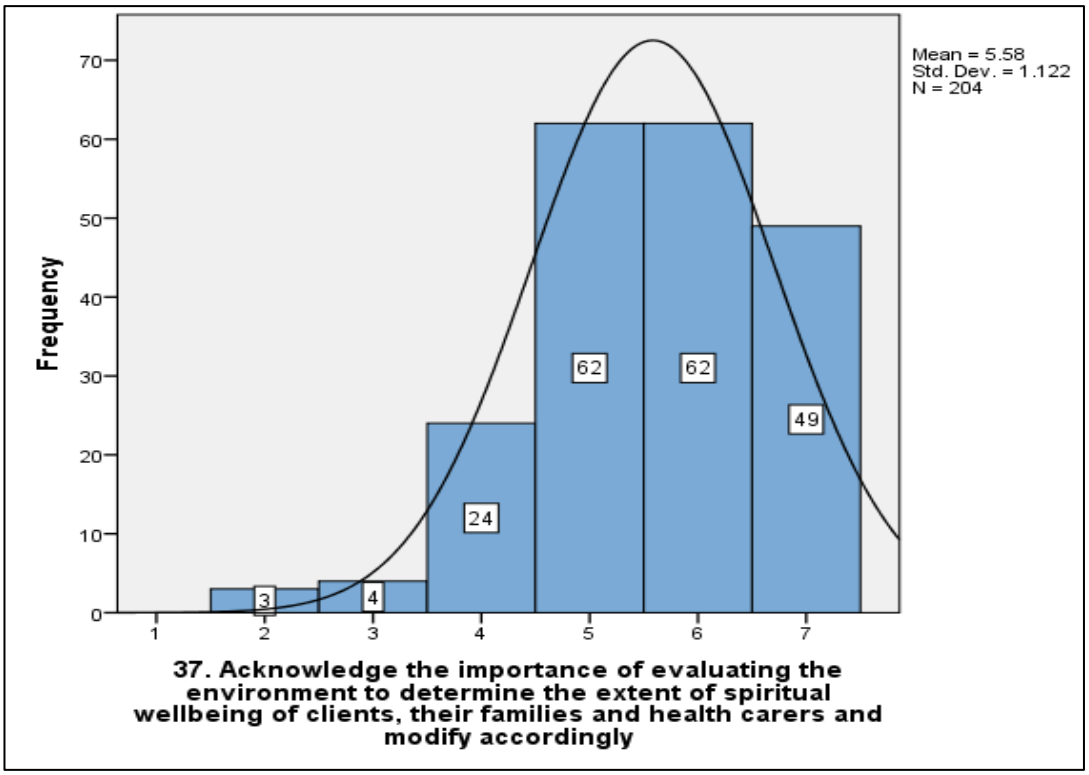
33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on



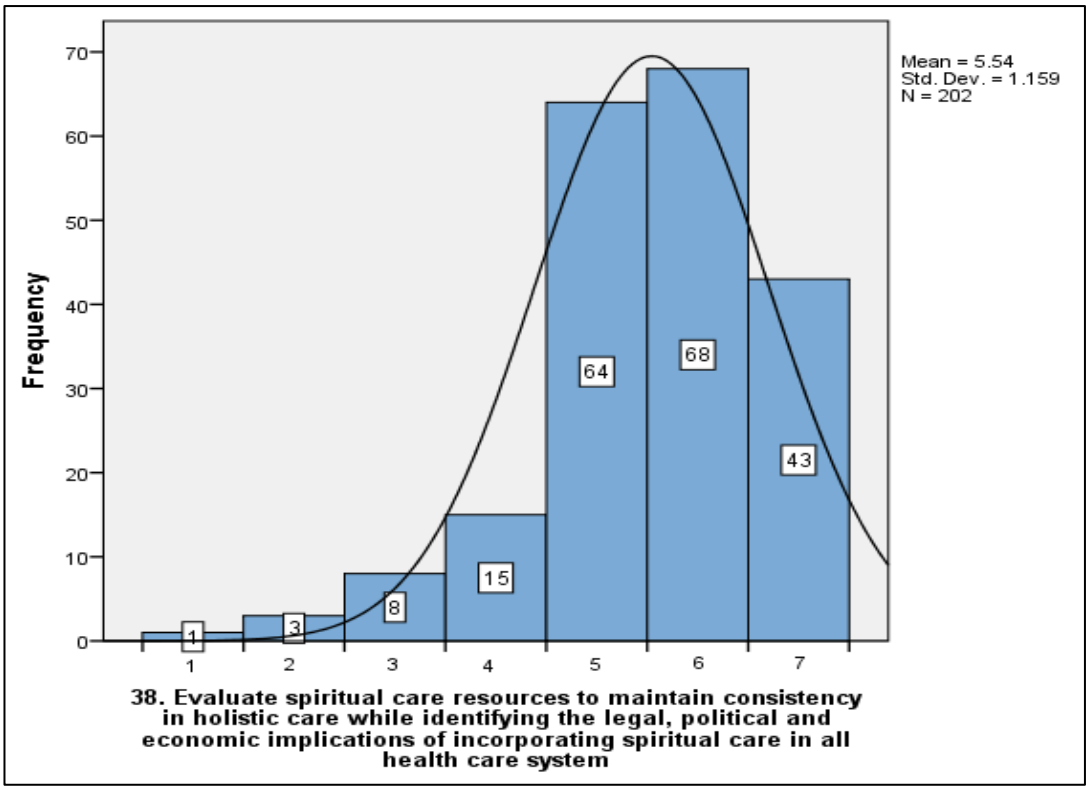
34. Recognize the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care


Mean = 5.74
Std. Dev. = 1.165
N = 204
Frequency
70
60
50
40
30
20
10
0
2
1
7
11
57
66
60
1
2
3
4
5
6
7
35. Participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilize the evidence to bring about practice improvement

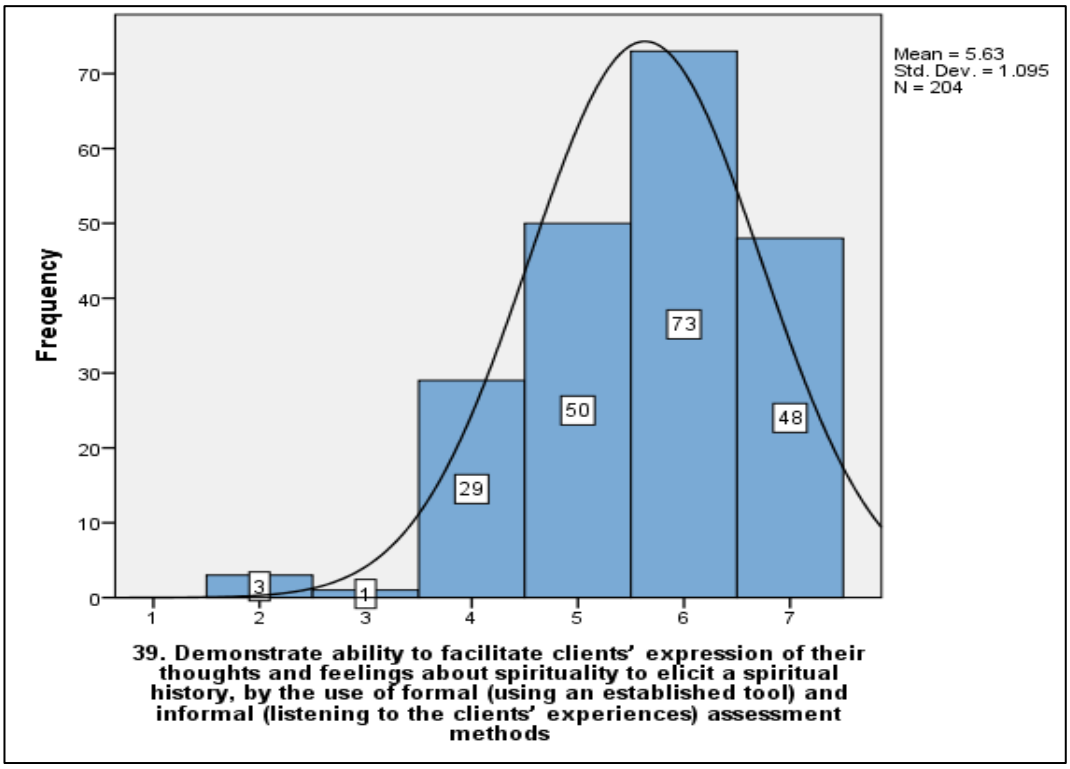

Mean = 5.51
Std. Dev. = 1.216
N = 203
Frequency
70
60
50
40
30
20
10
0
1
3
8
27
49
70
45
1
2
3
4
5
6
7
36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity such as creative art (e.g. painting)



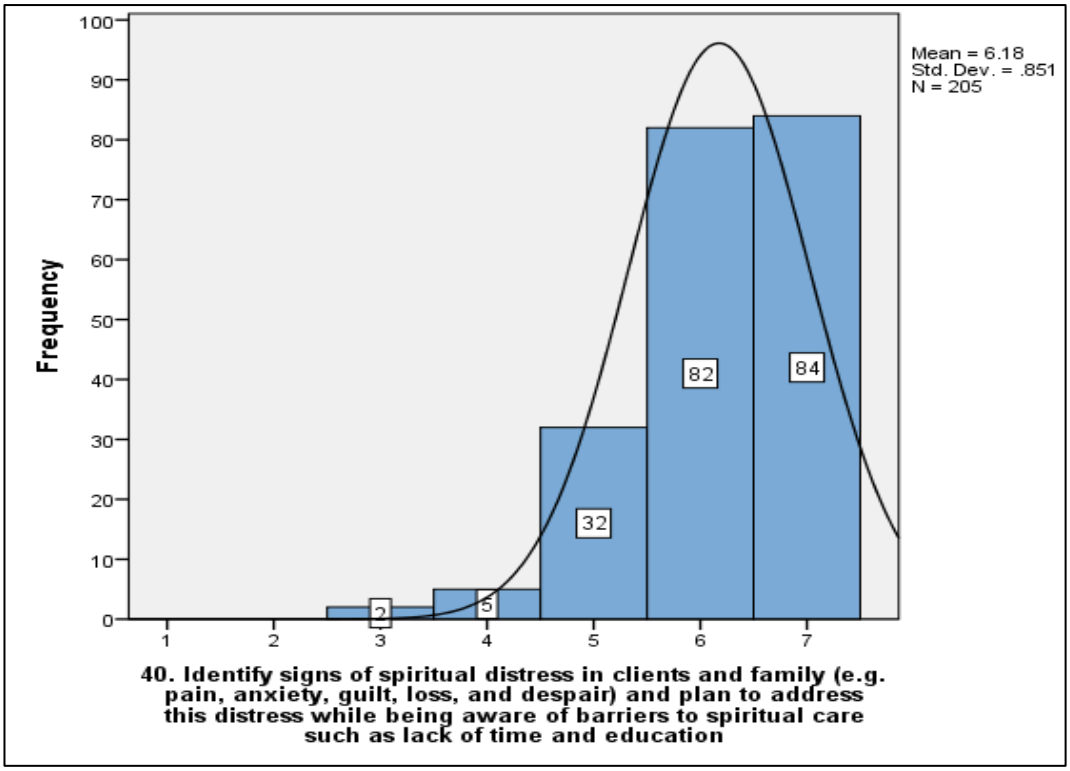
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual wellbeing of clients, their families and health carers and modify accordingly



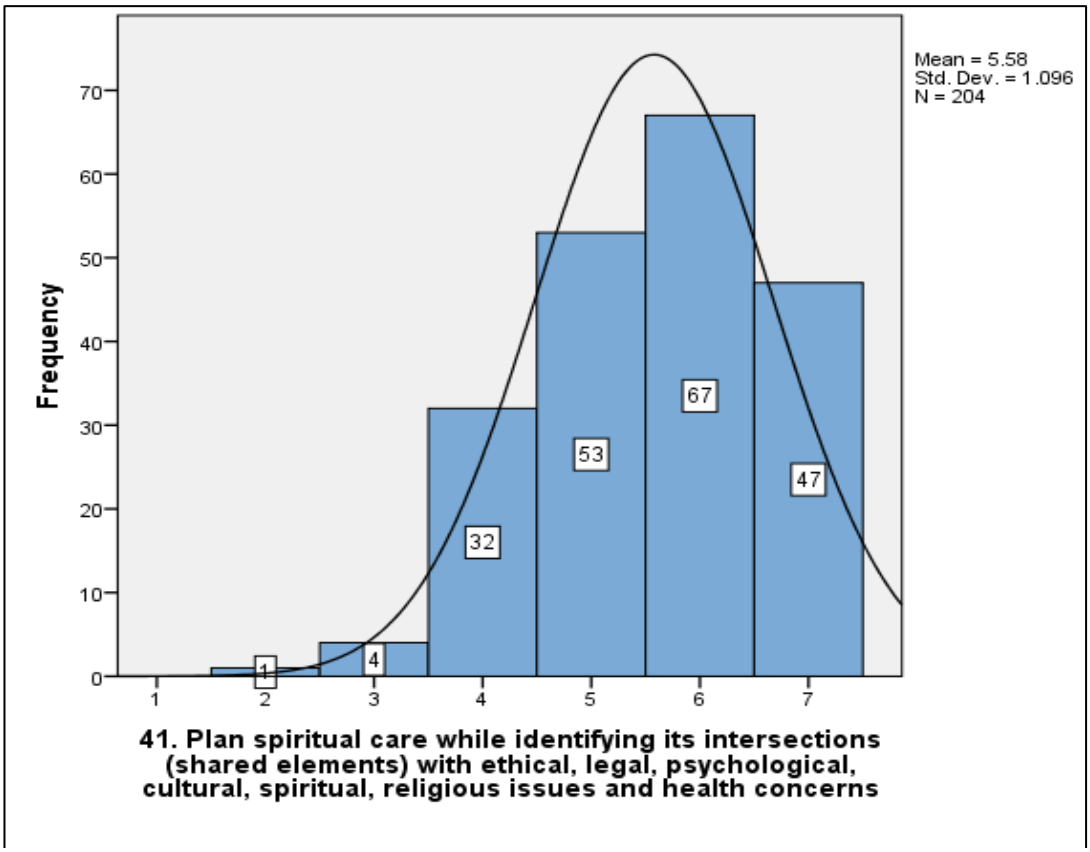
38. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all health care system



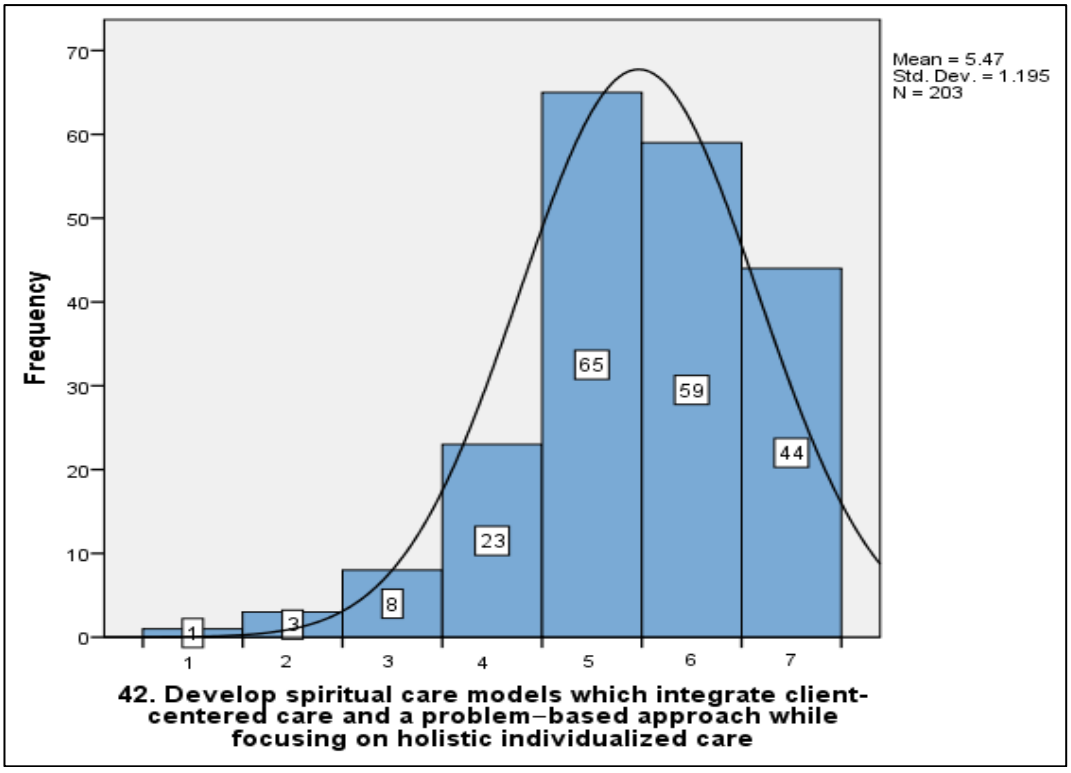
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (using an established tool) and informal (listening to the clients' experiences) assessment methods



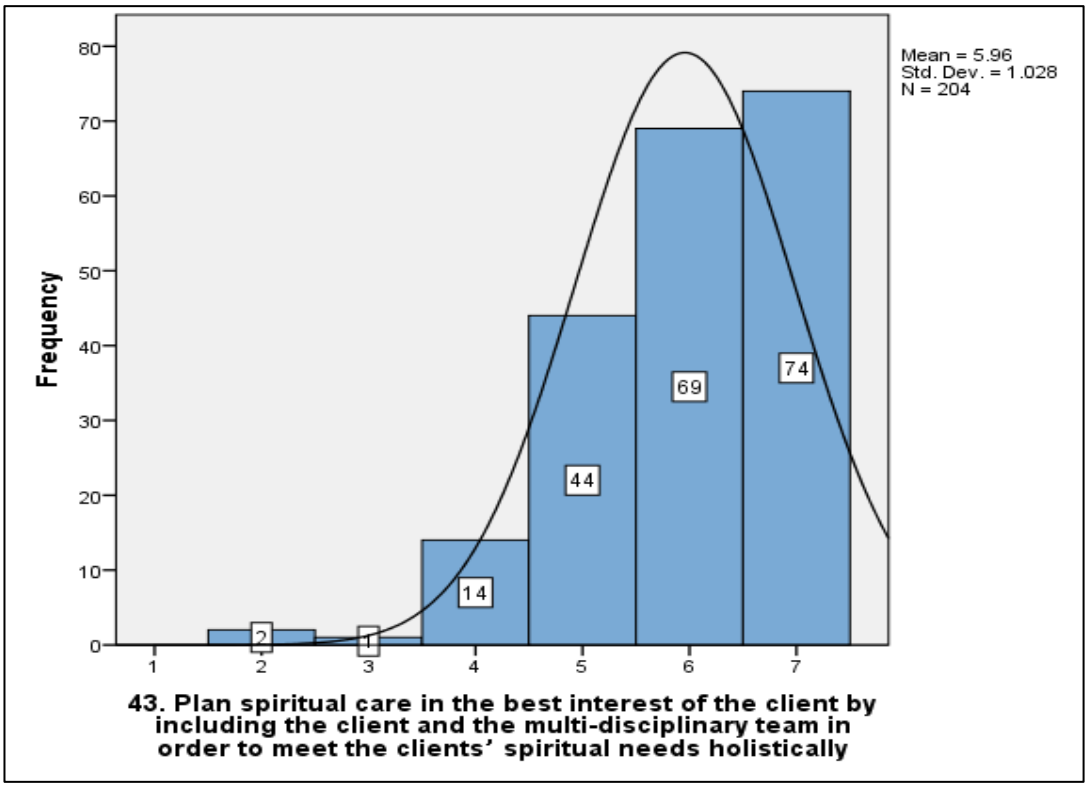
40. Identify signs of spiritual distress in clients and family (e.g. pain, anxiety, guilt, loss, and despair) and plan to address this distress while being aware of barriers to spiritual care such as lack of time and education



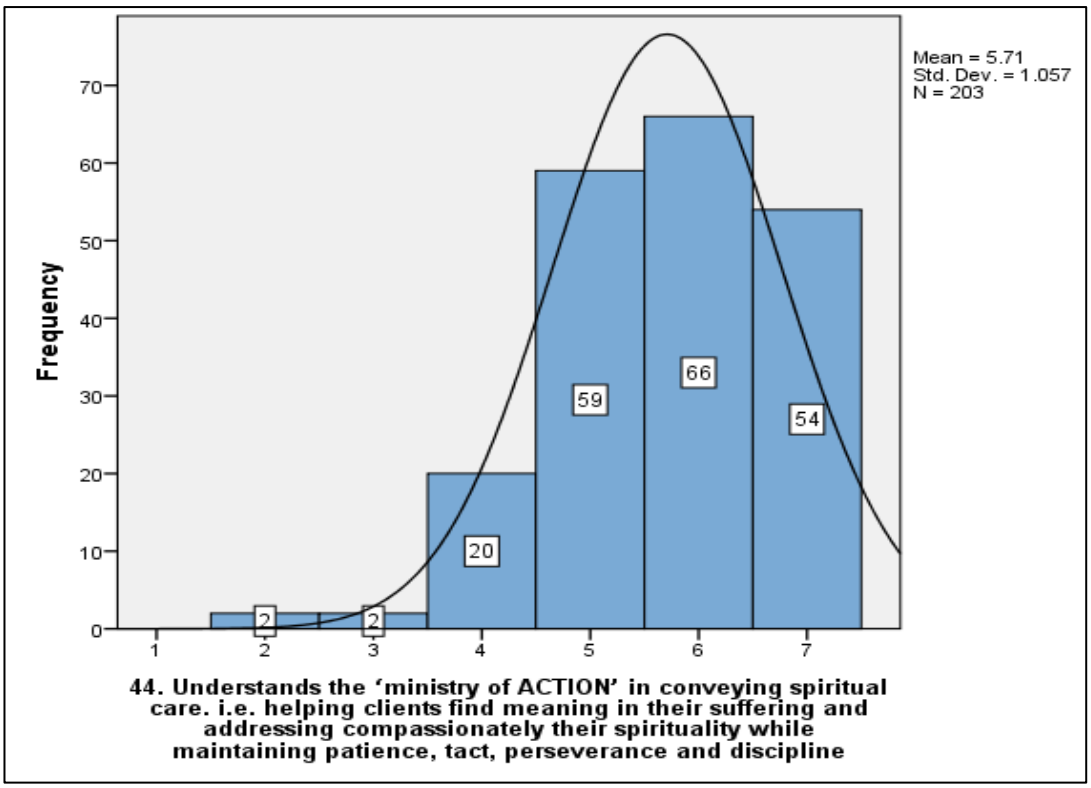
41. Plan spiritual care while identifying its intersections (shared elements) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns



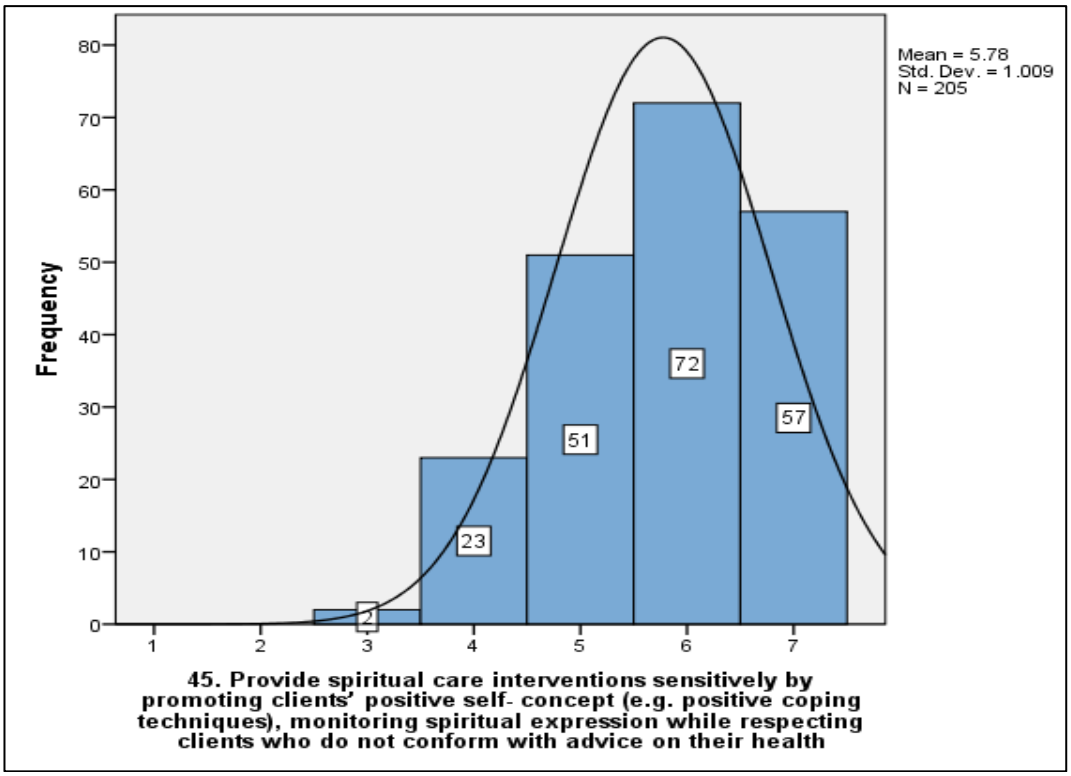
42. Develop spiritual care models which integrate client-centered care and a problem–based approach while focusing on holistic individualized care

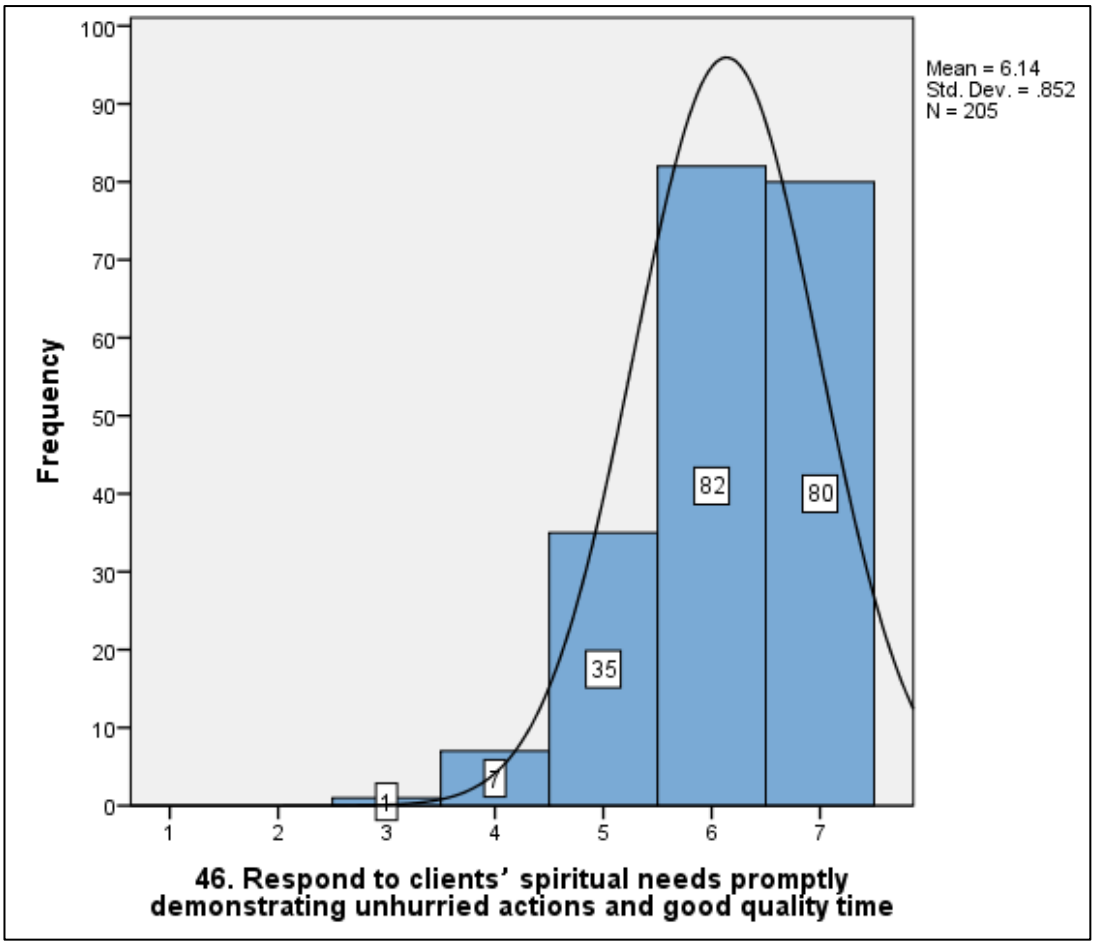


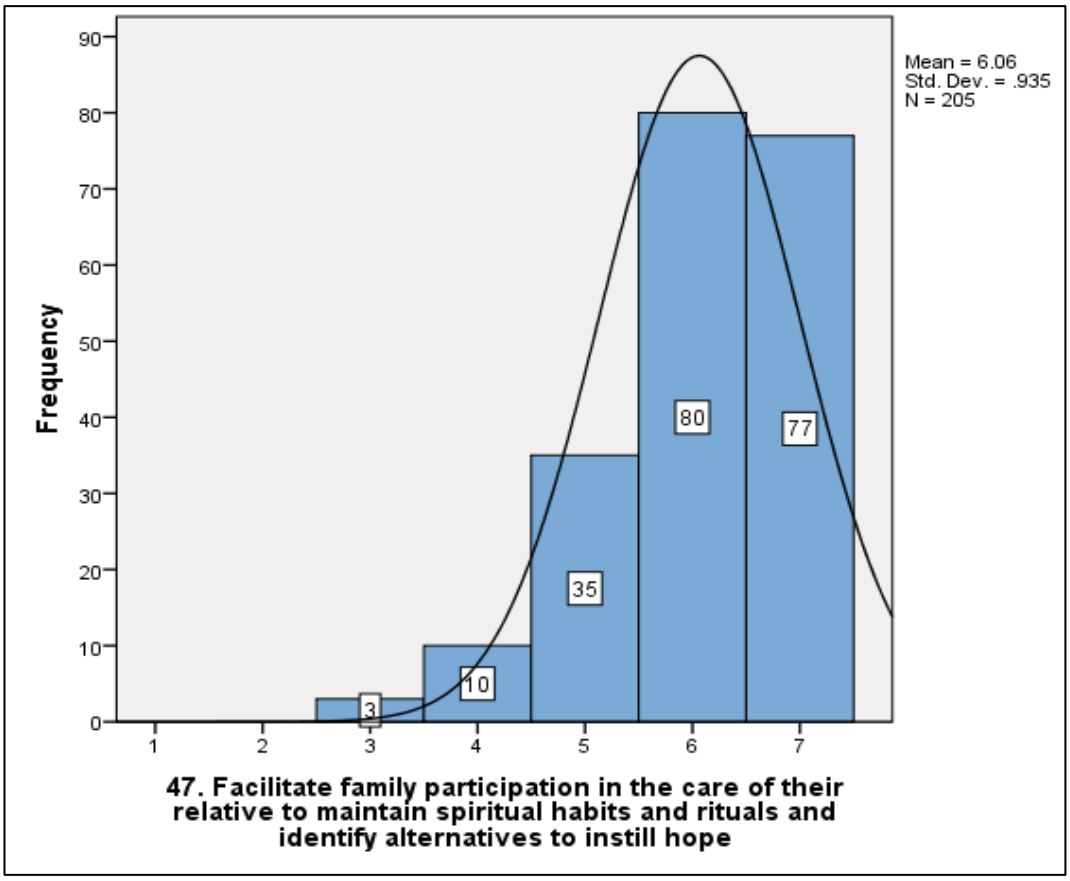
43. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically

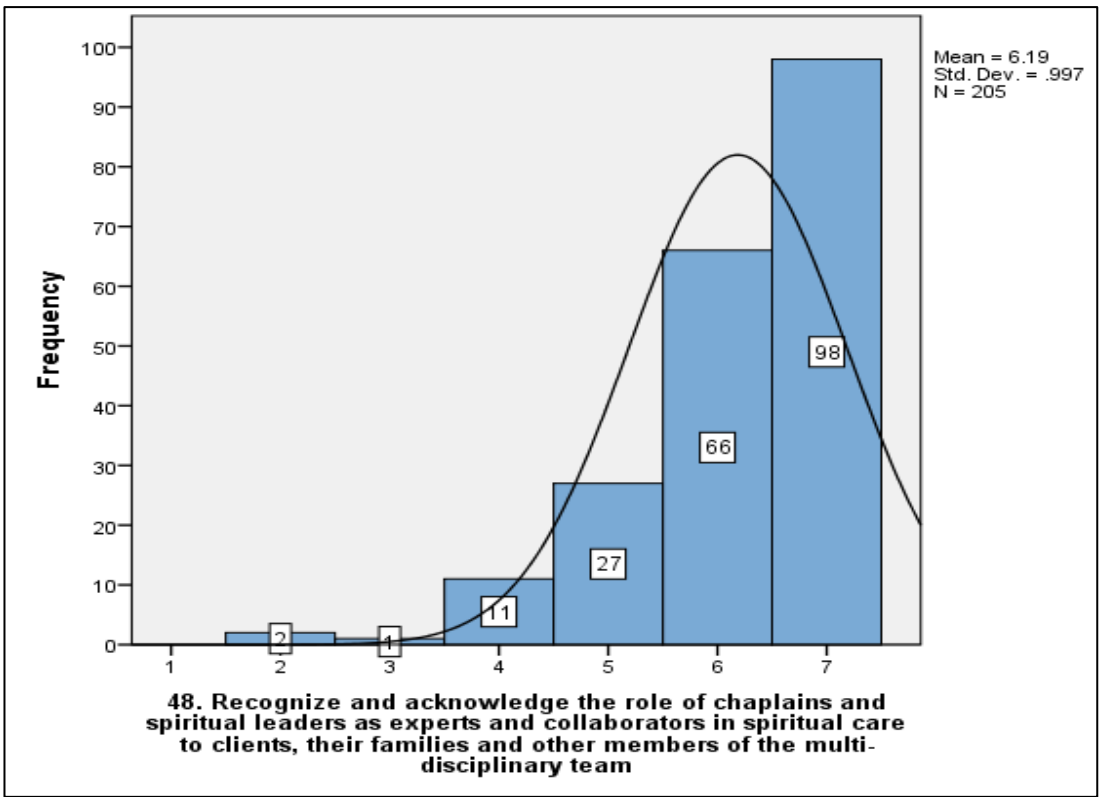


44. Understands the 'ministry of ACTION' in conveying spiritual care. i.e. helping clients find meaning in their suffering and addressing compassionately their spirituality while maintaining patience, tact, perseverance and discipline


Mean = 5.78
Std. Dev. = 1.009
N = 205
Frequency
2
23
51
72
57
45. Provide spiritual care interventions sensitively by promoting clients' positive self- concept (e.g. positive coping techniques), monitoring spiritual expression while respecting clients who do not conform with advice on their health


Mean = 6.14
Std. Dev. = .852
N = 205
Frequency
1
7
35
82
80
46. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time


Mean = 6.06
Std. Dev. = .935
N = 205
Frequency
90
80
70
60
50
40
30
20
10
0
1
2
3
4
5
6
7
3
10
35
80
77
47. Facilitate family participation in the care of their relative to maintain spiritual habits and rituals and identify alternatives to instill hope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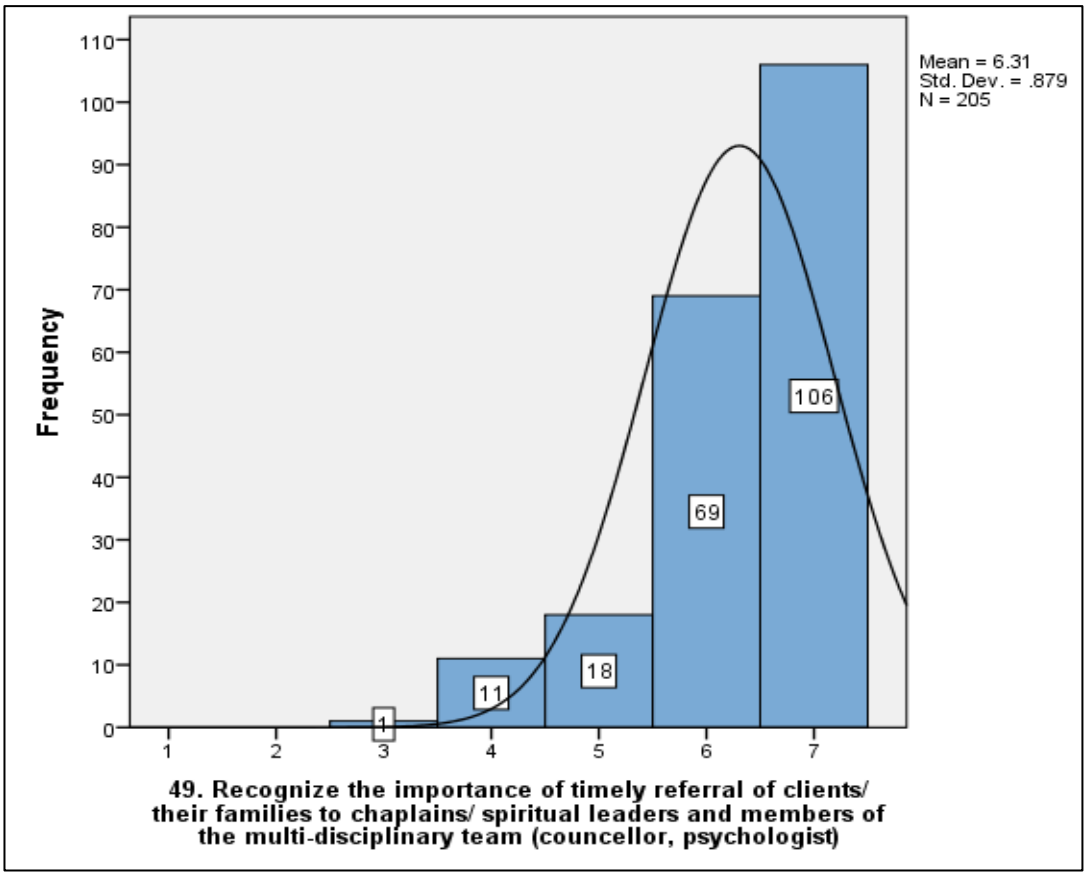
70
60
50
40
30
20
10
0
1
2
3
4
5
6
7
2
1
11
27
66
98
48. Recognize and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team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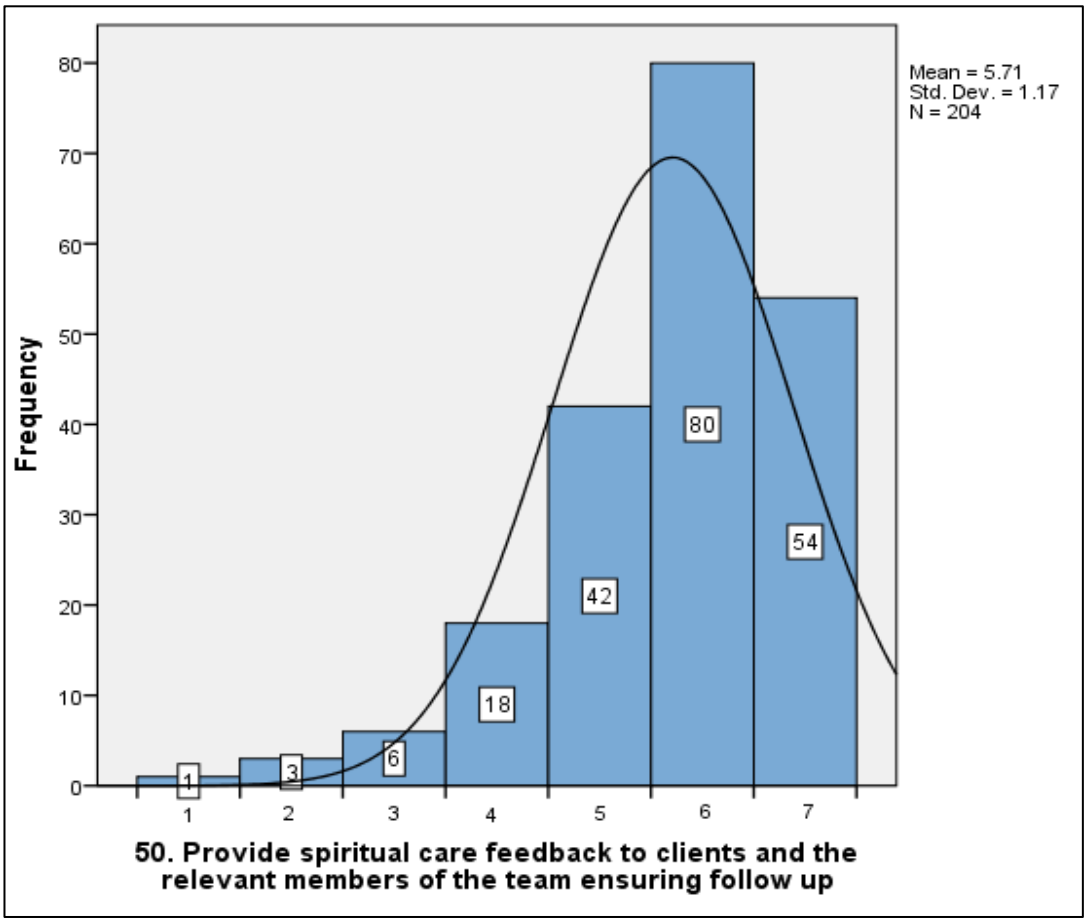
80
70
60
50
40
30
20
10
0
1
2
3
4
5
6
7
1
11
18
69
106
49. Recognize the importance of timely referral of clients/ their families to chaplains/ spiritual leaders and members of the multi-disciplinary team (councellor, psychologist)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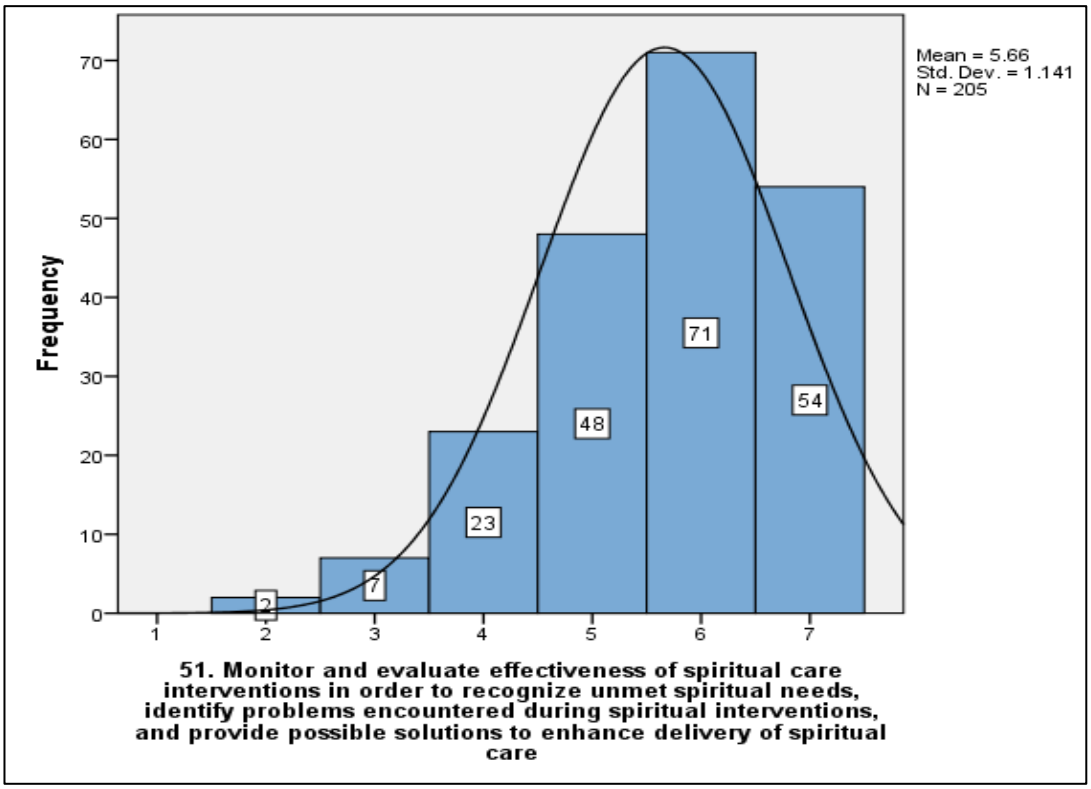
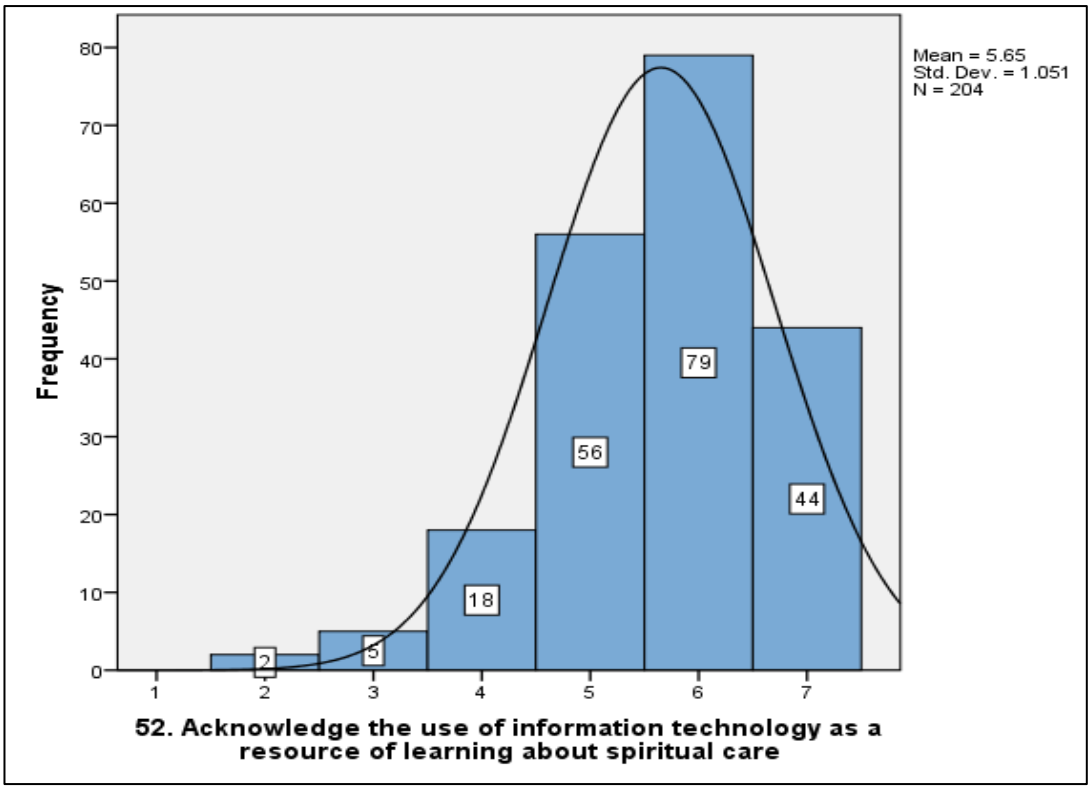
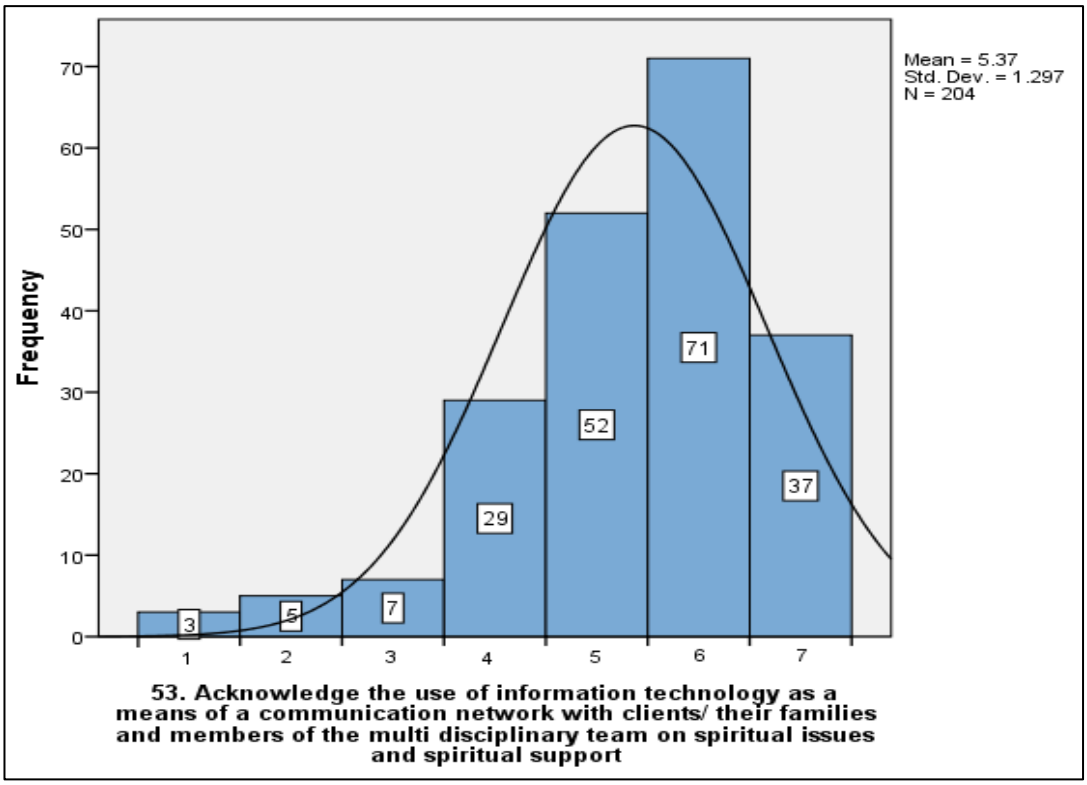
60
50
40
30
20
10
0
1
2
3
4
5
6
7
1
3
6
18
42
80
54
50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow up



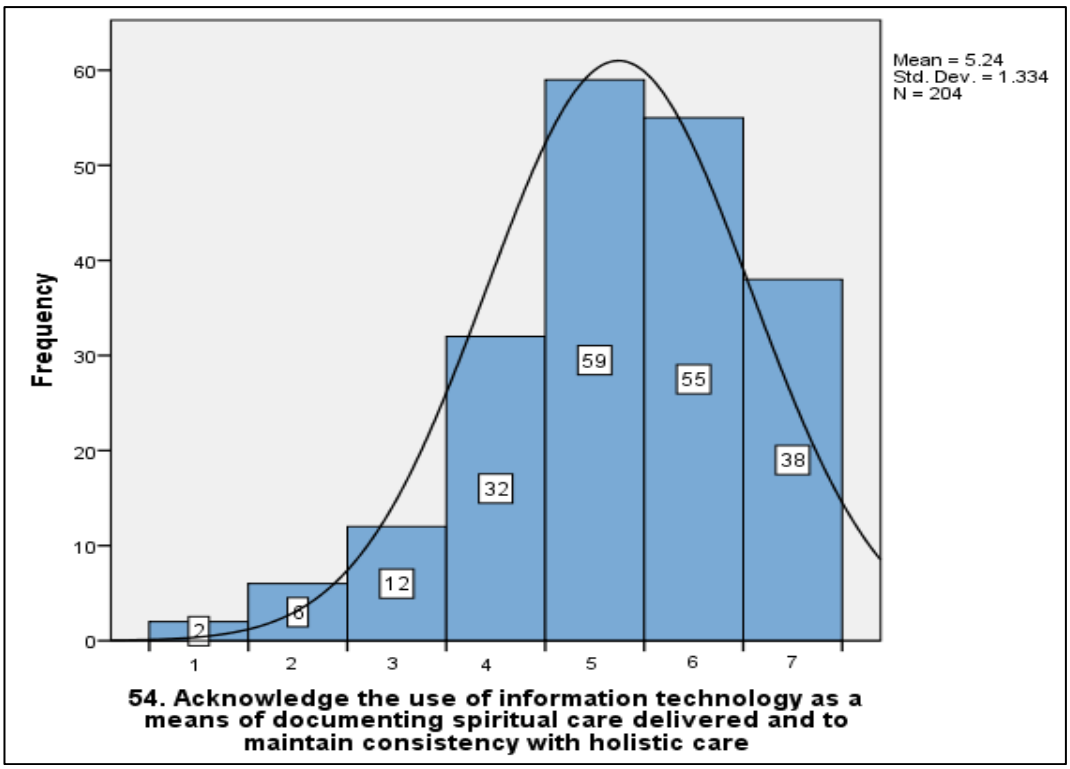
51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognize unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care



52. Acknowledge the use of information technology as a resource of learning about spiritual care

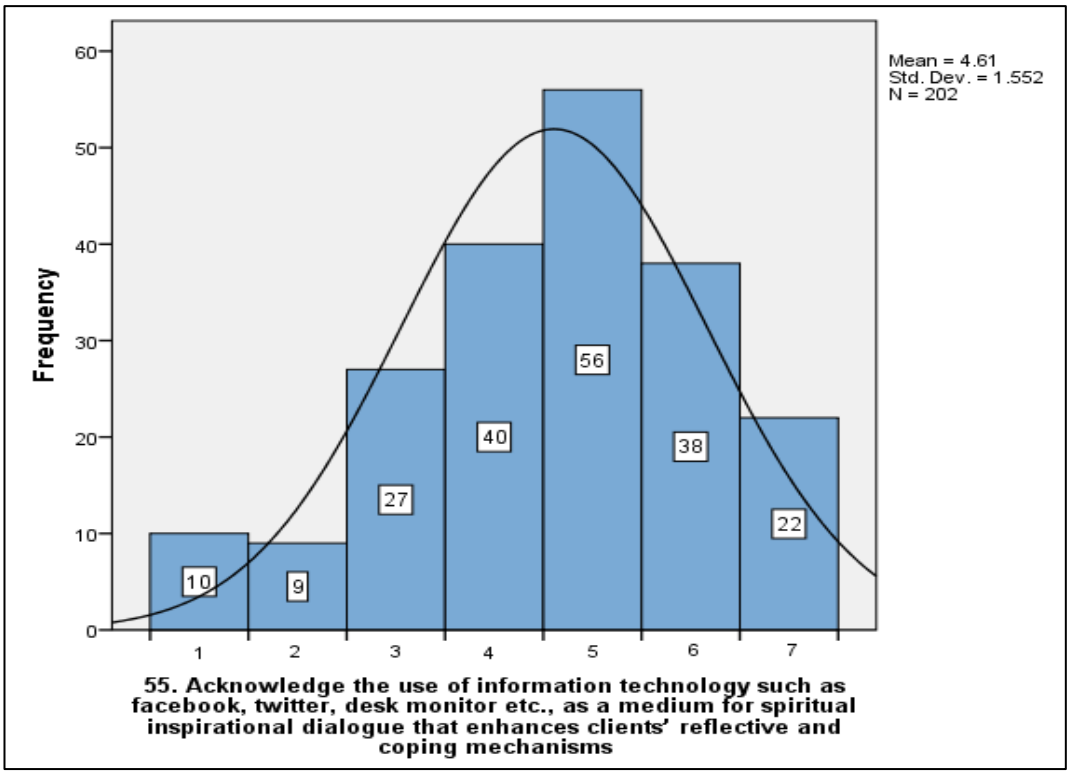


53. Acknowledge the use of information technology as a means of a communication network with clients/ their families and members of the multi disciplinary team on spiritual issues and spiritual support



54. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care

12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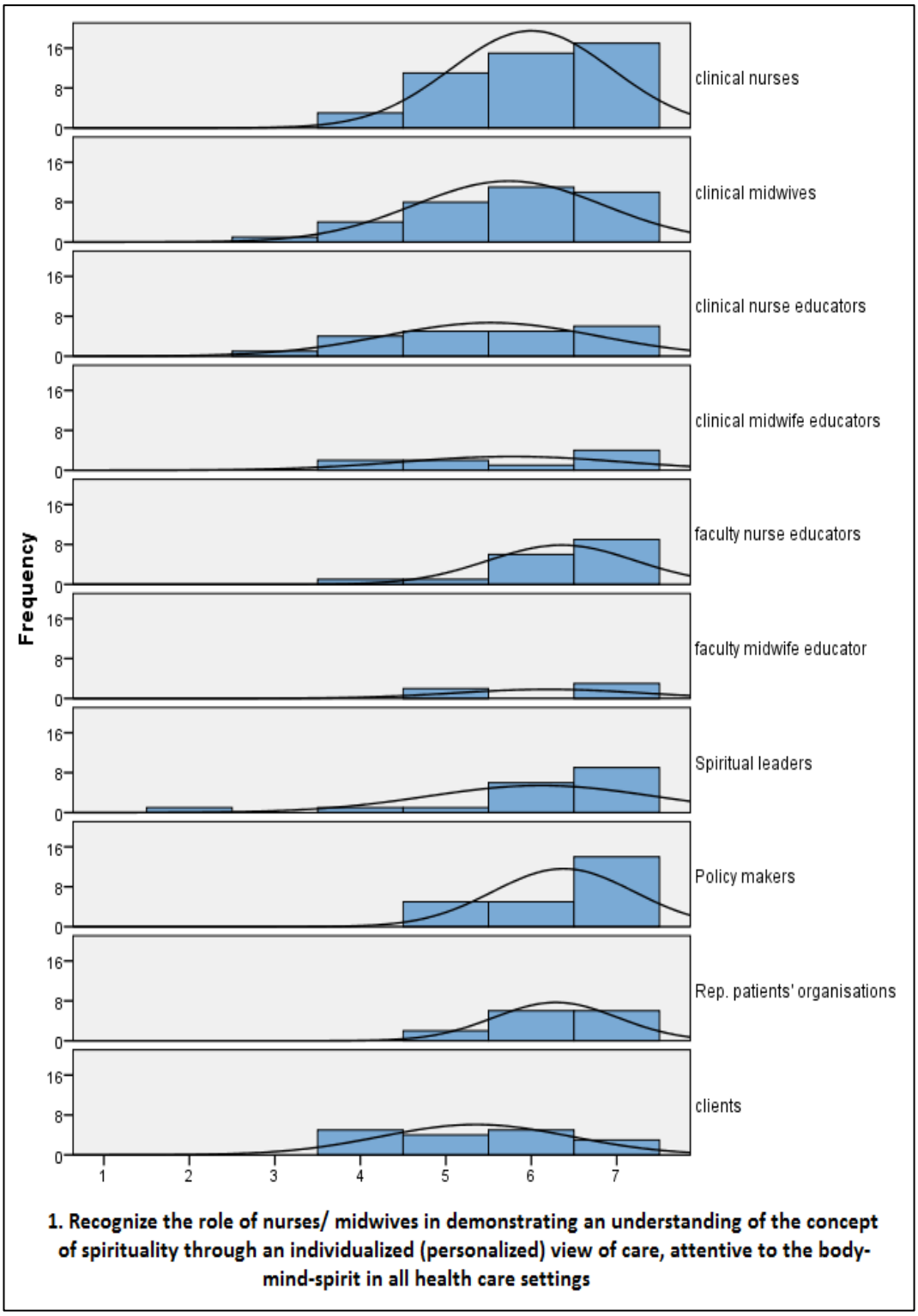
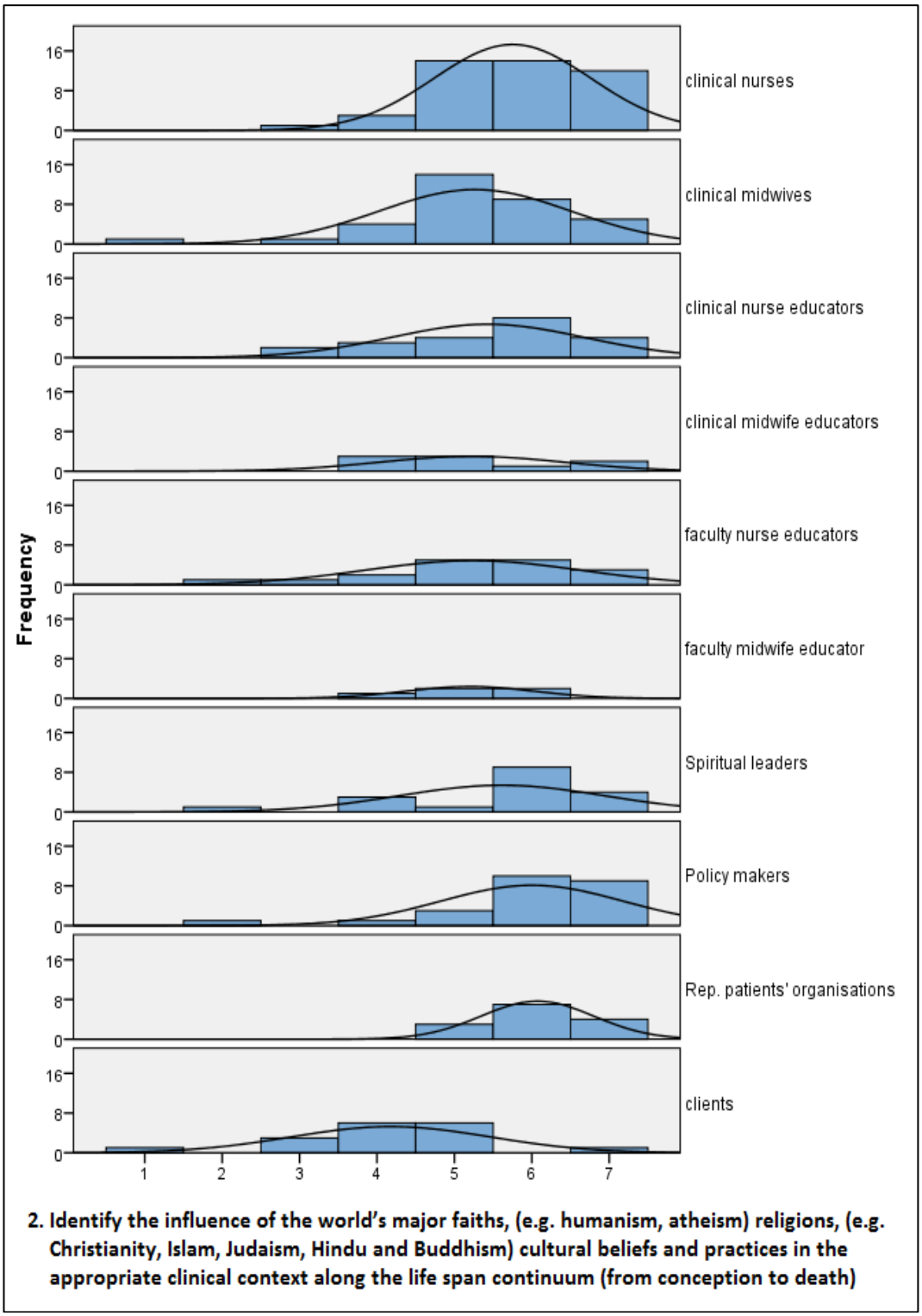
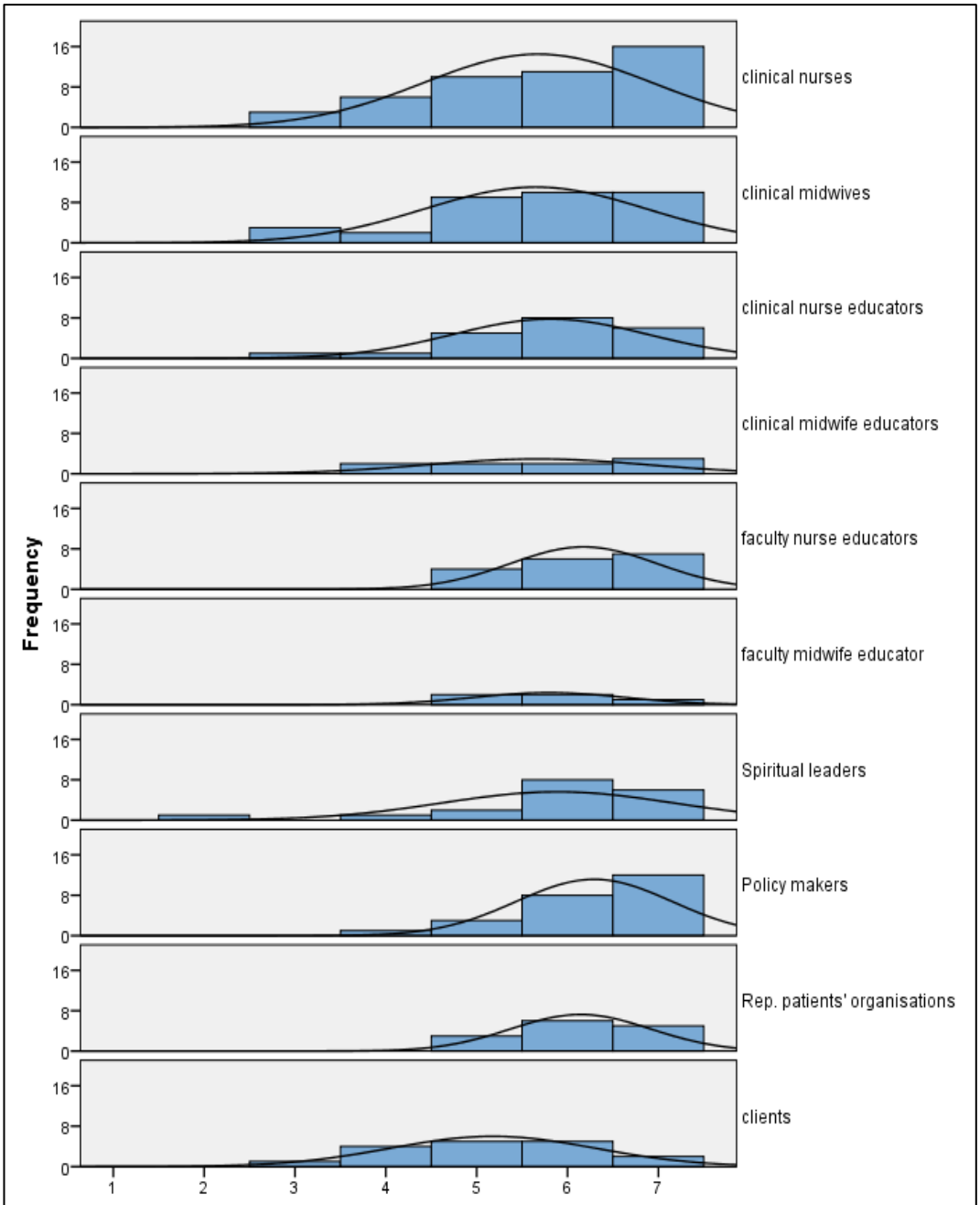
50
40
30
20
10
0
10
9
27
40
56
38
22
1
2
3
4
5
6
7
55. Acknowledge the use of information technology such as facebook, twitter, desk monitor etc., as a medium for spiritual inspirational dialogue that enhances clients' reflective and coping mechanisms



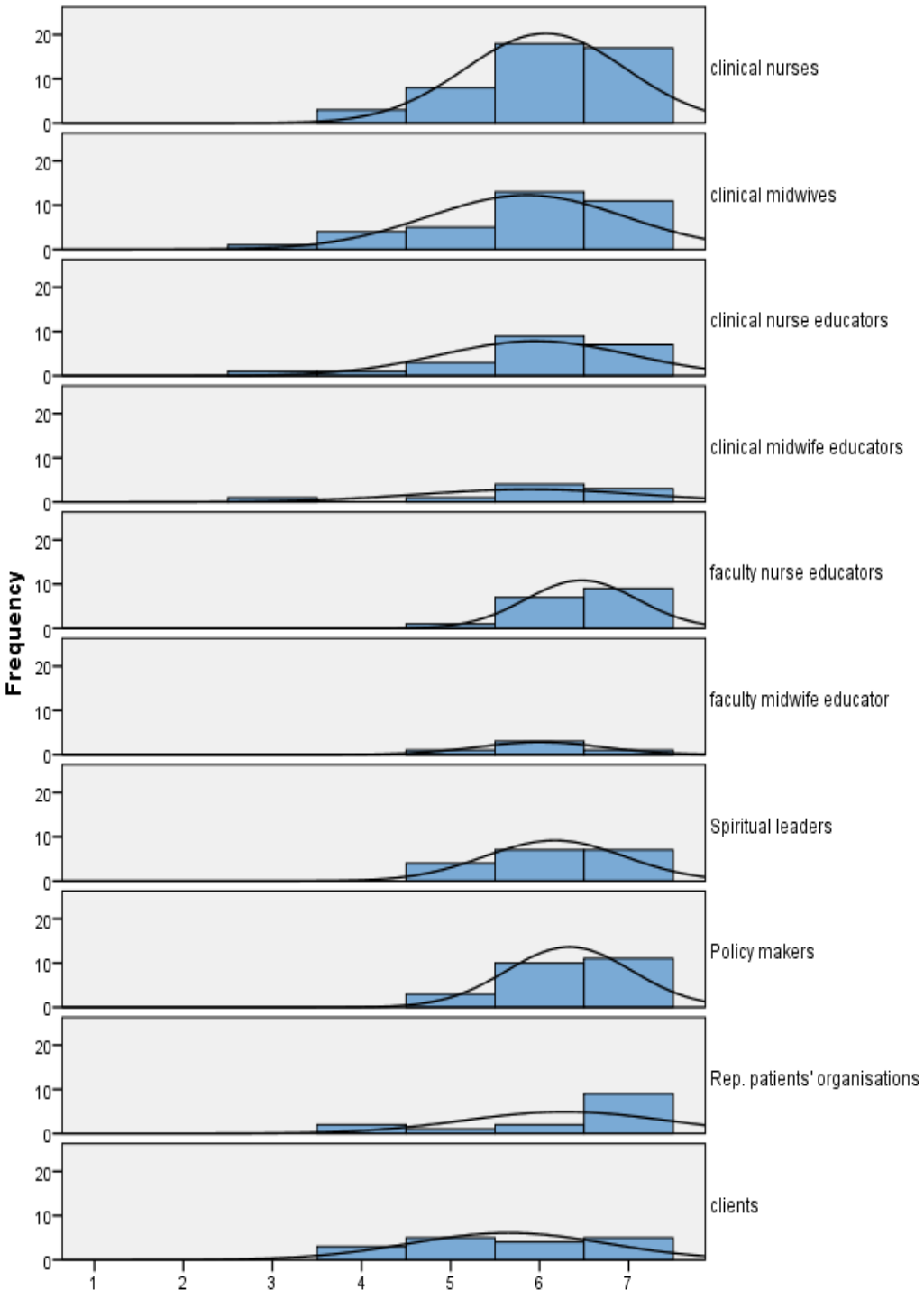
1. Recognize the role of nurses/ midwives in demonstrating an understanding of the concept of spirituality through an individualized (personalized) view of care, attentive to the body-mind-spirit in all health care settings



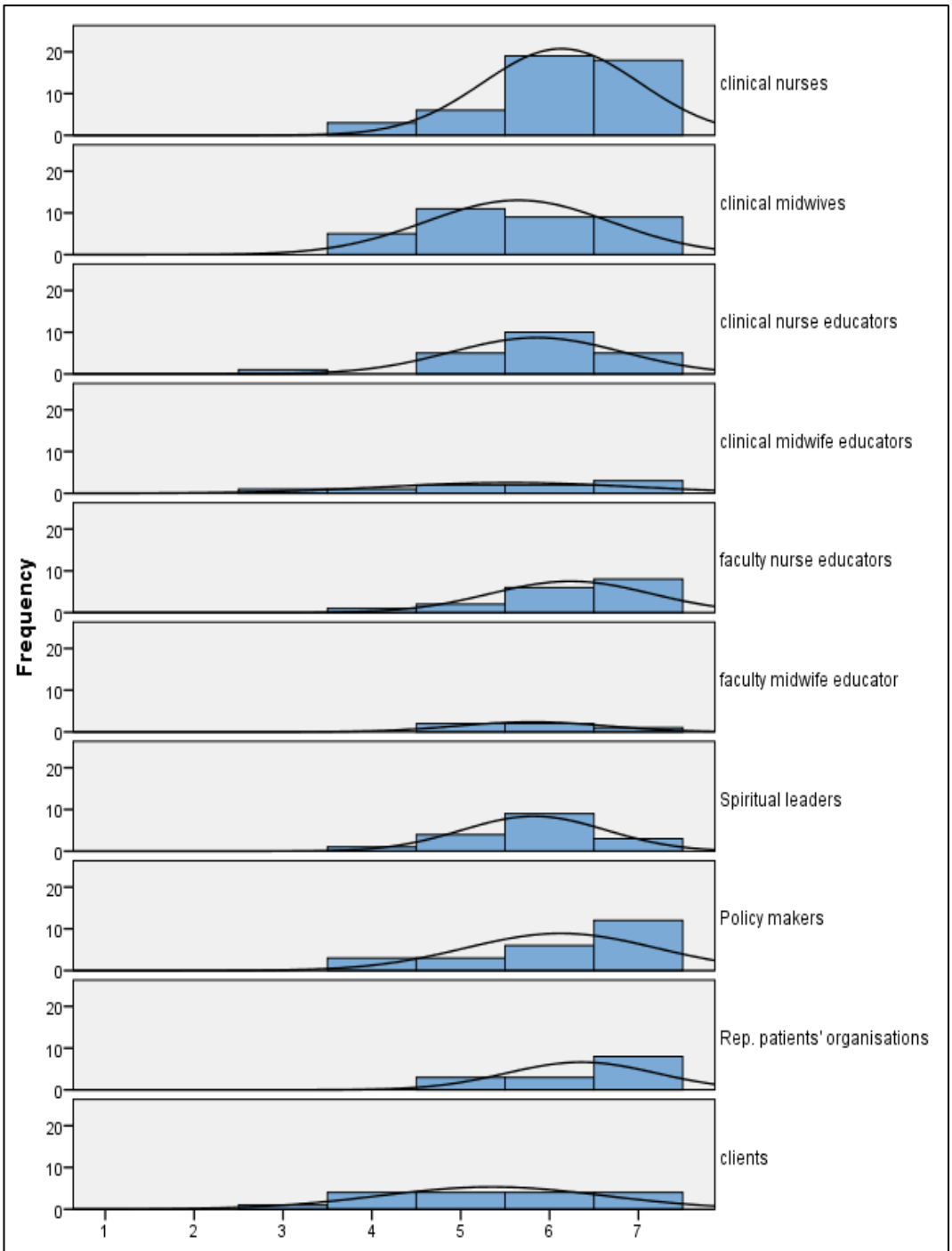
2. Identify the influence of the world's major faiths, (e.g. humanism, atheism) religions, (e.g. Christianity, Islam, Judaism, Hindu and Buddhism) cultural beliefs and practices in the appropriate clinical context along the life span continuum (from conception to death)



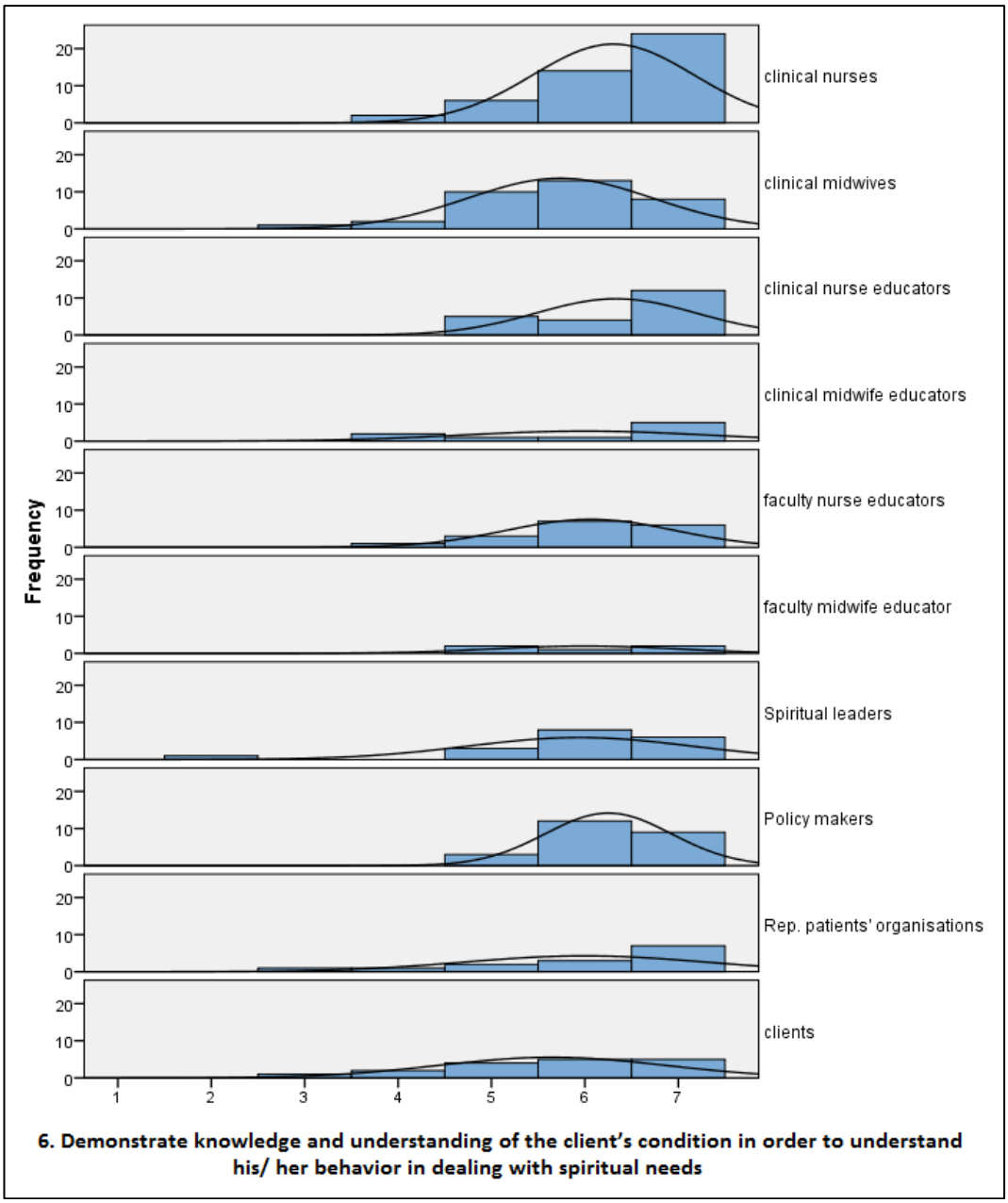
3. Demonstrate knowledge of the basic spiritual needs of individuals which include: a meaningful philosophy of life (values and moral sense), a sense of the transcendent (outside of self, view of deity/ higher power and something beyond the immediate life, having hope), belief and faith in self, others and for some a belief in a deity/ higher power, a relatedness to nature and people (friendship) and experiencing love and forgiveness (a sense of life meaning)



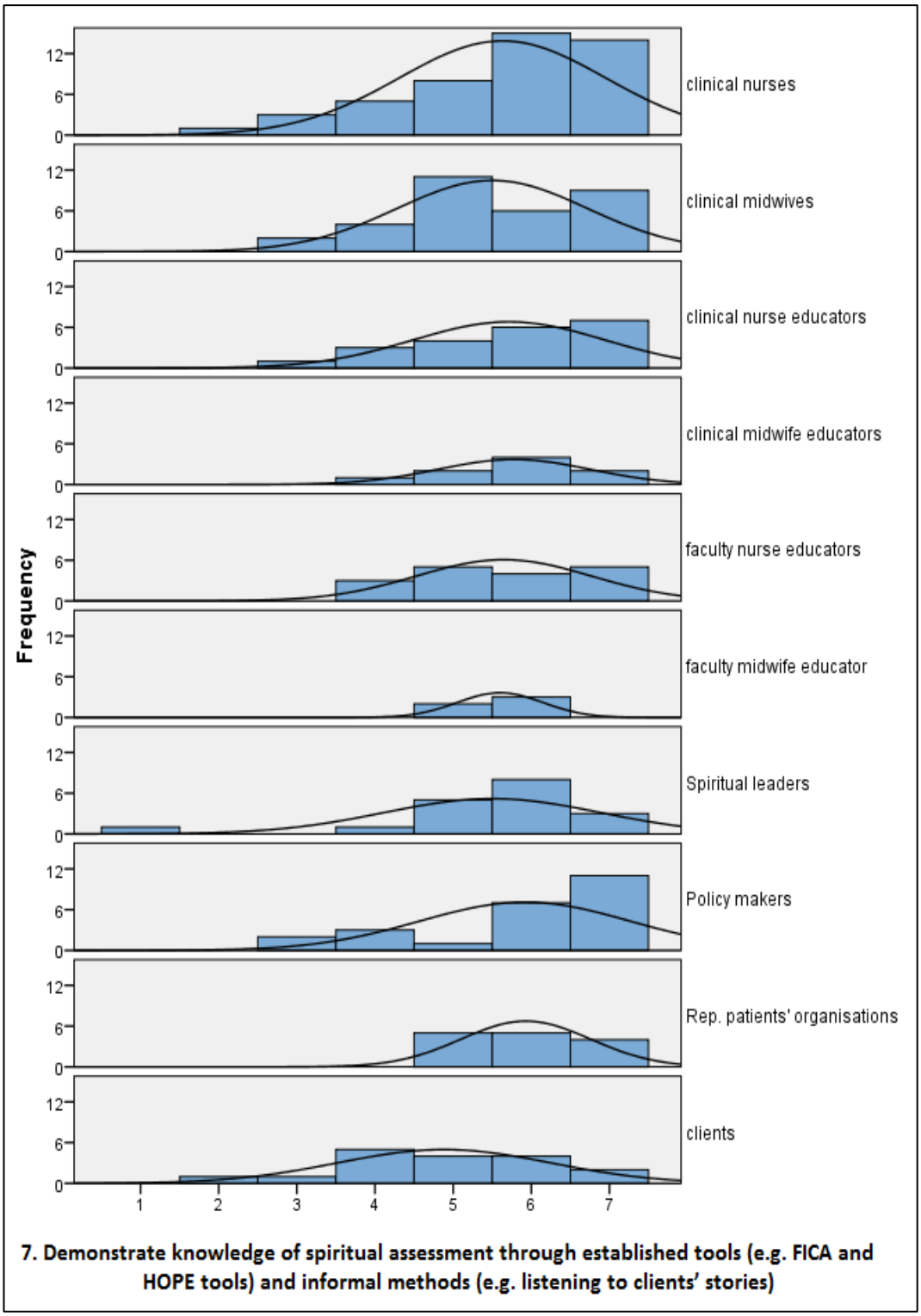
4. Recognize the importance of the spiritual dimension (with or without religion) that sustains physical and mental well being



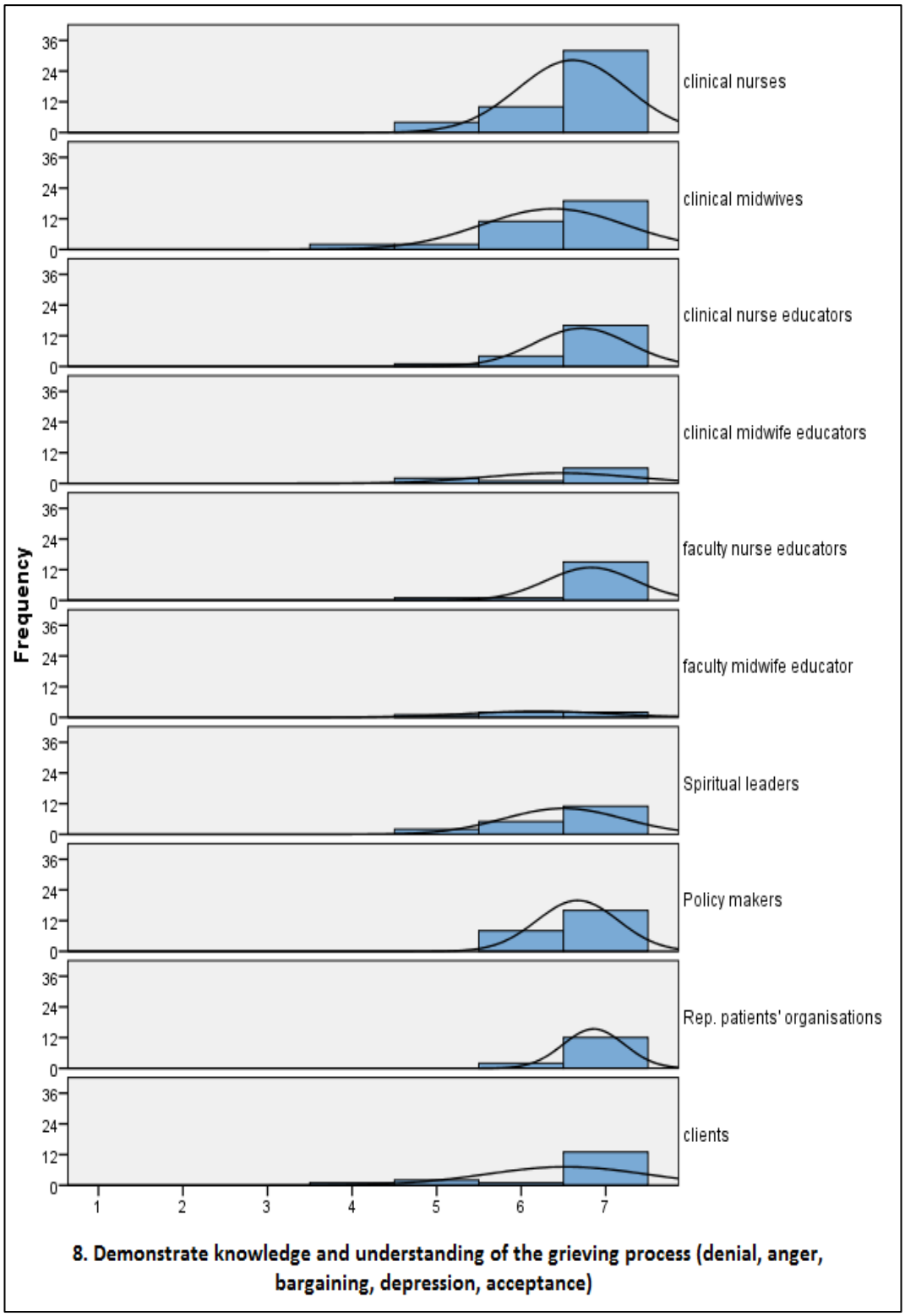
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health



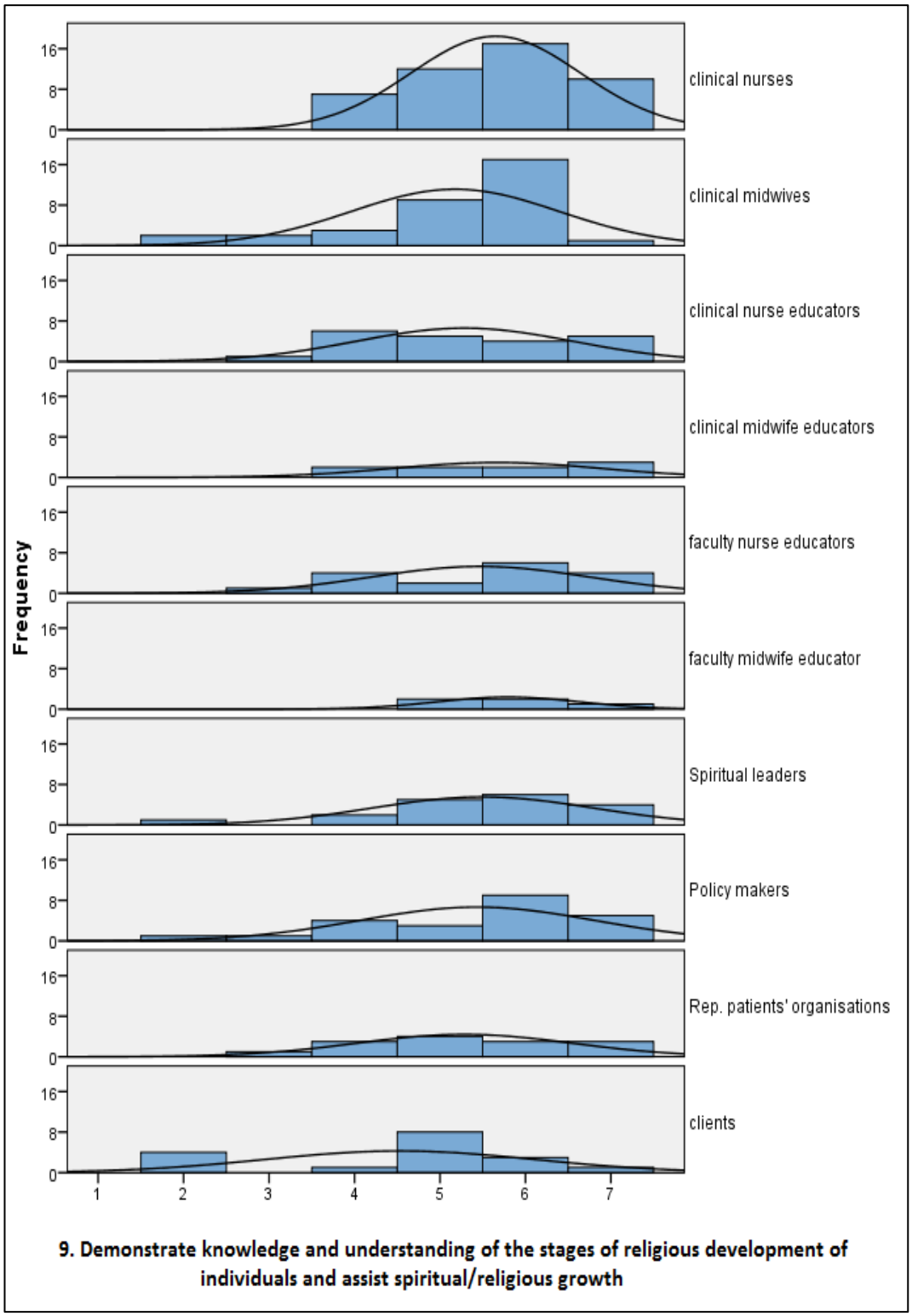
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/ her behavior in dealing with spiritual needs



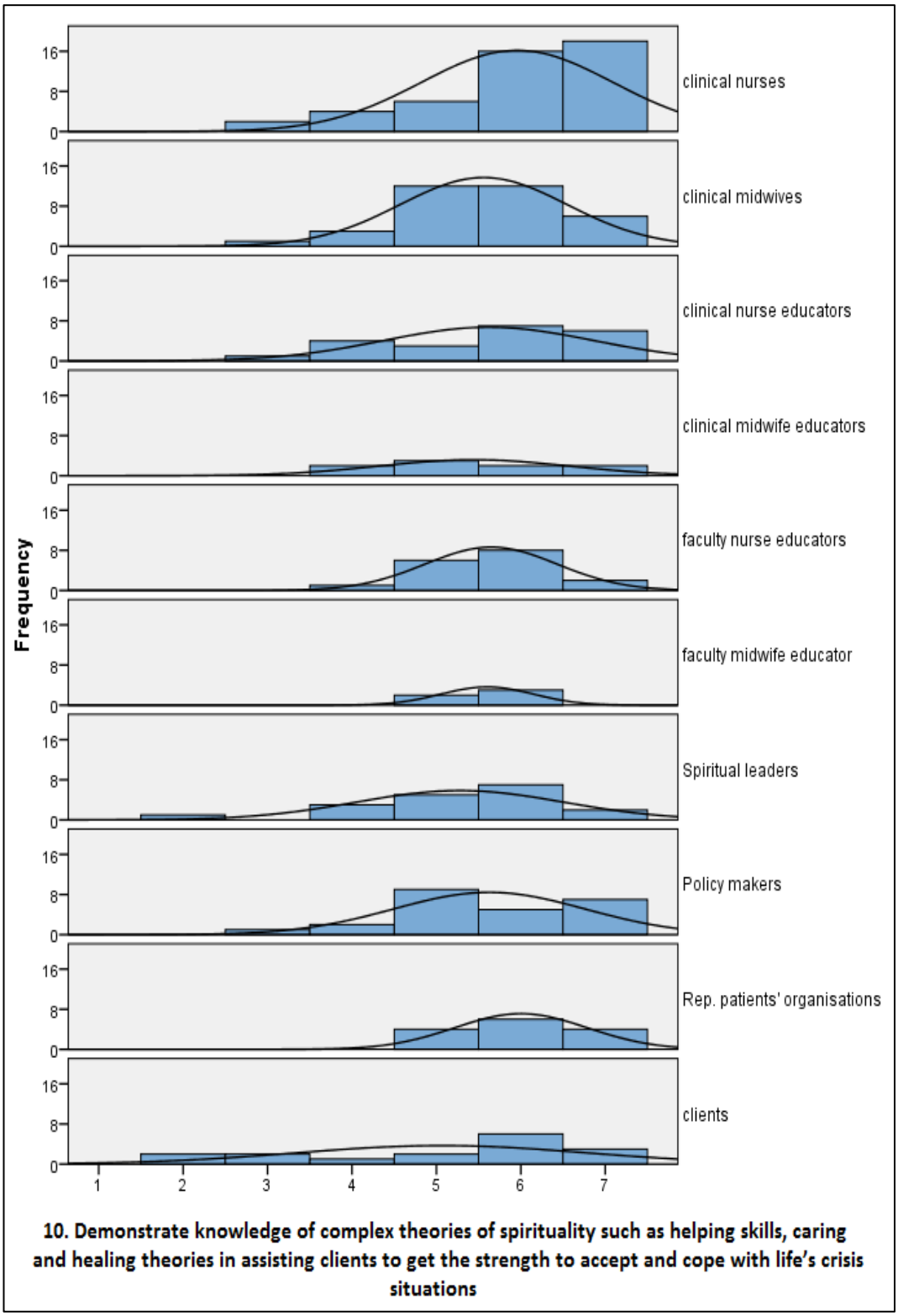
7. Demonstrate knowledge of spiritual assessment through established tools (e.g. FICA and HOPE tools) and informal methods (e.g. listening to clients' stories)



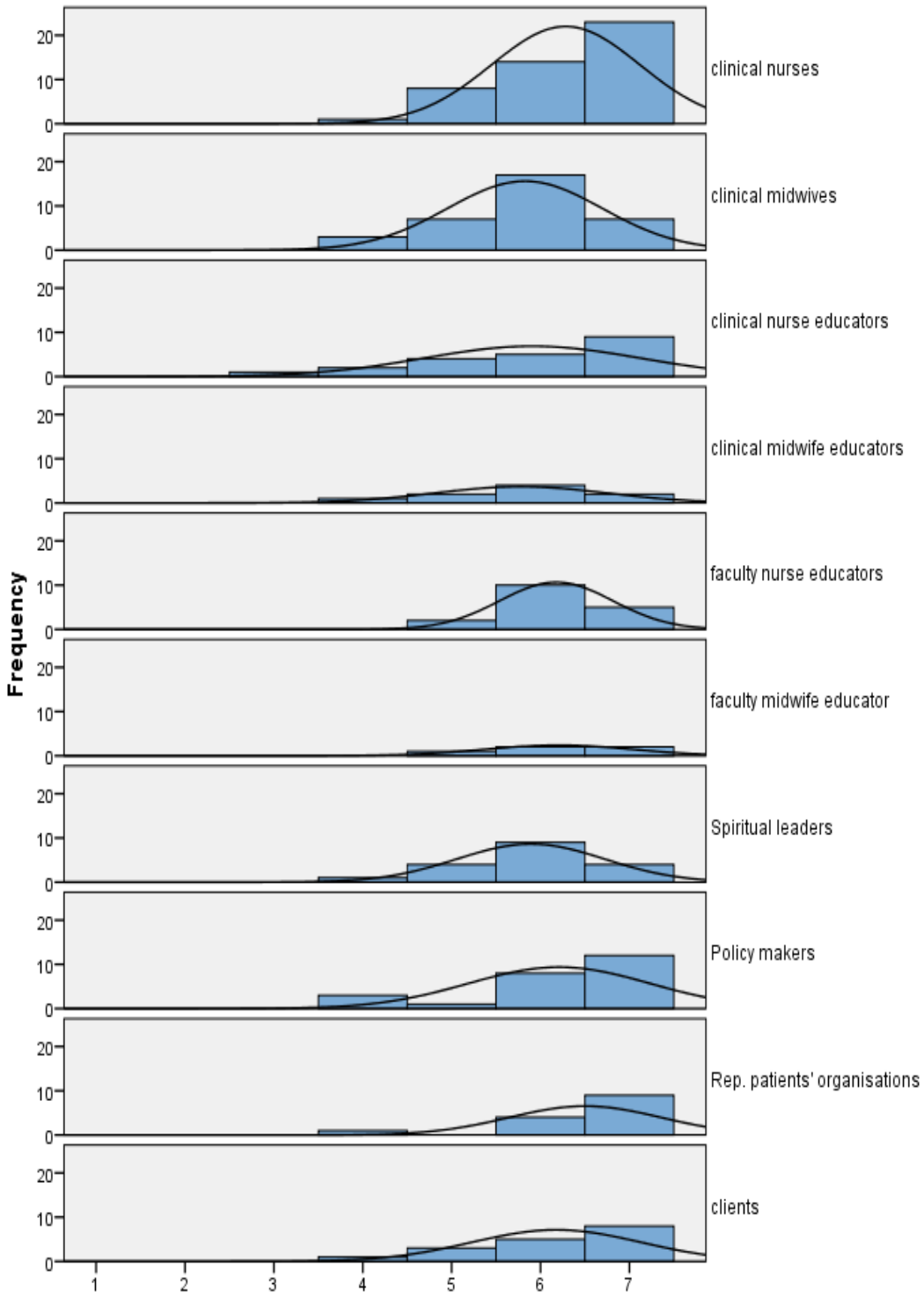
8. Demonstrate knowledge and understanding of the grieving process (denial, anger, bargaining, depression, acceptance)



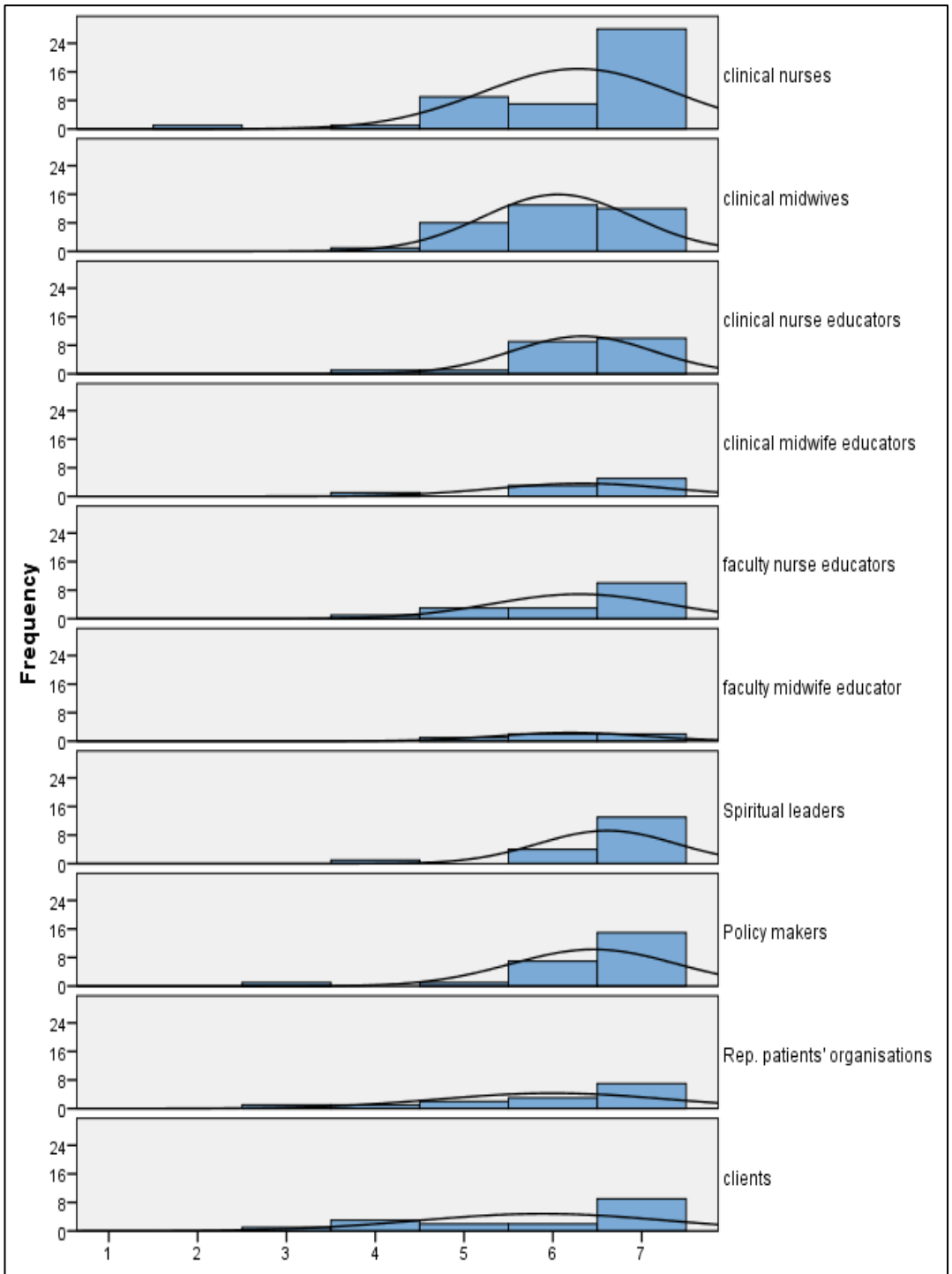
9. Demonstrate knowledge and understanding of the stages of religious development of individuals and assist spiritual/religious growth



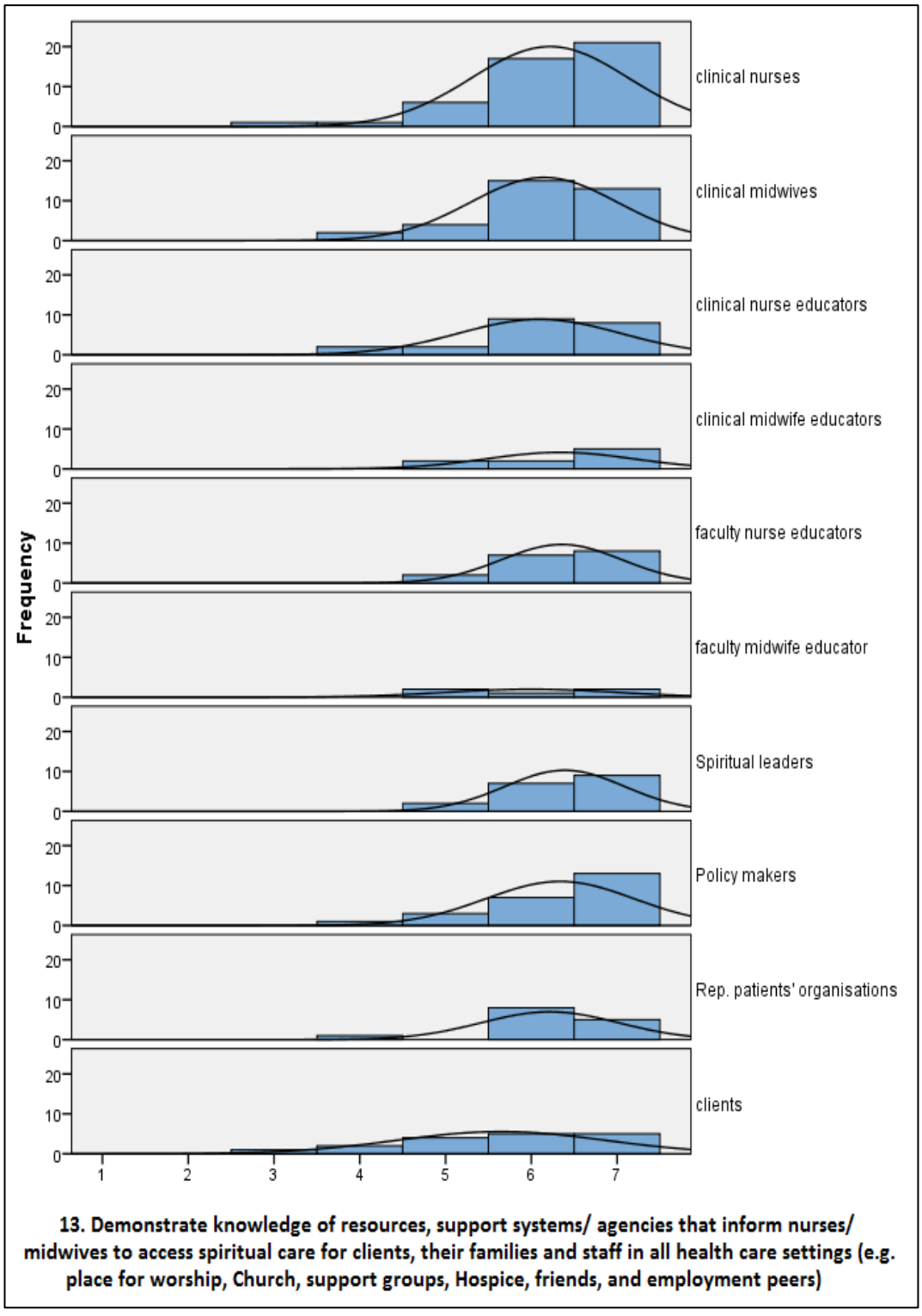
10. Demonstrate knowledge of complex theories of spirituality such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations



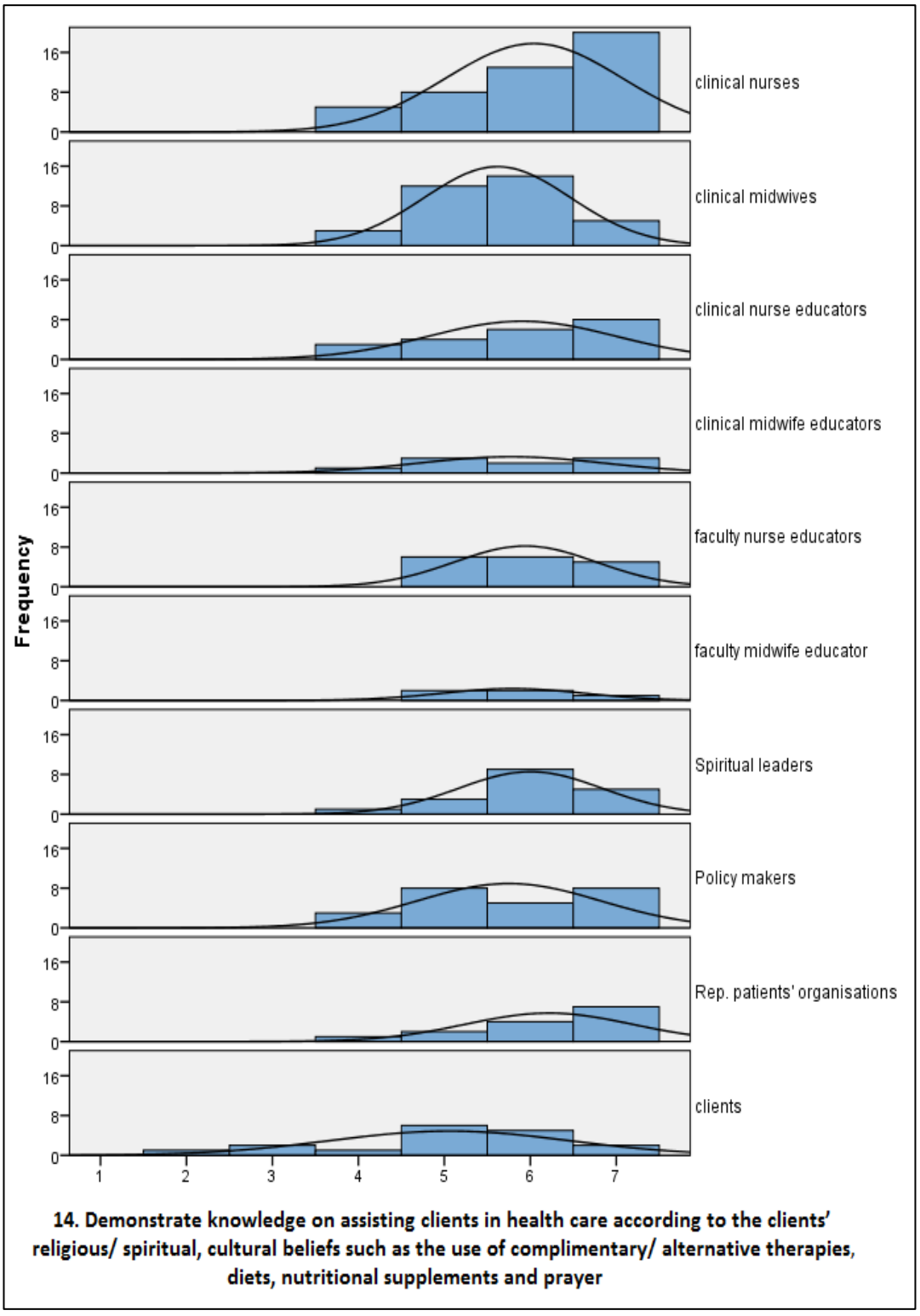
11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?)



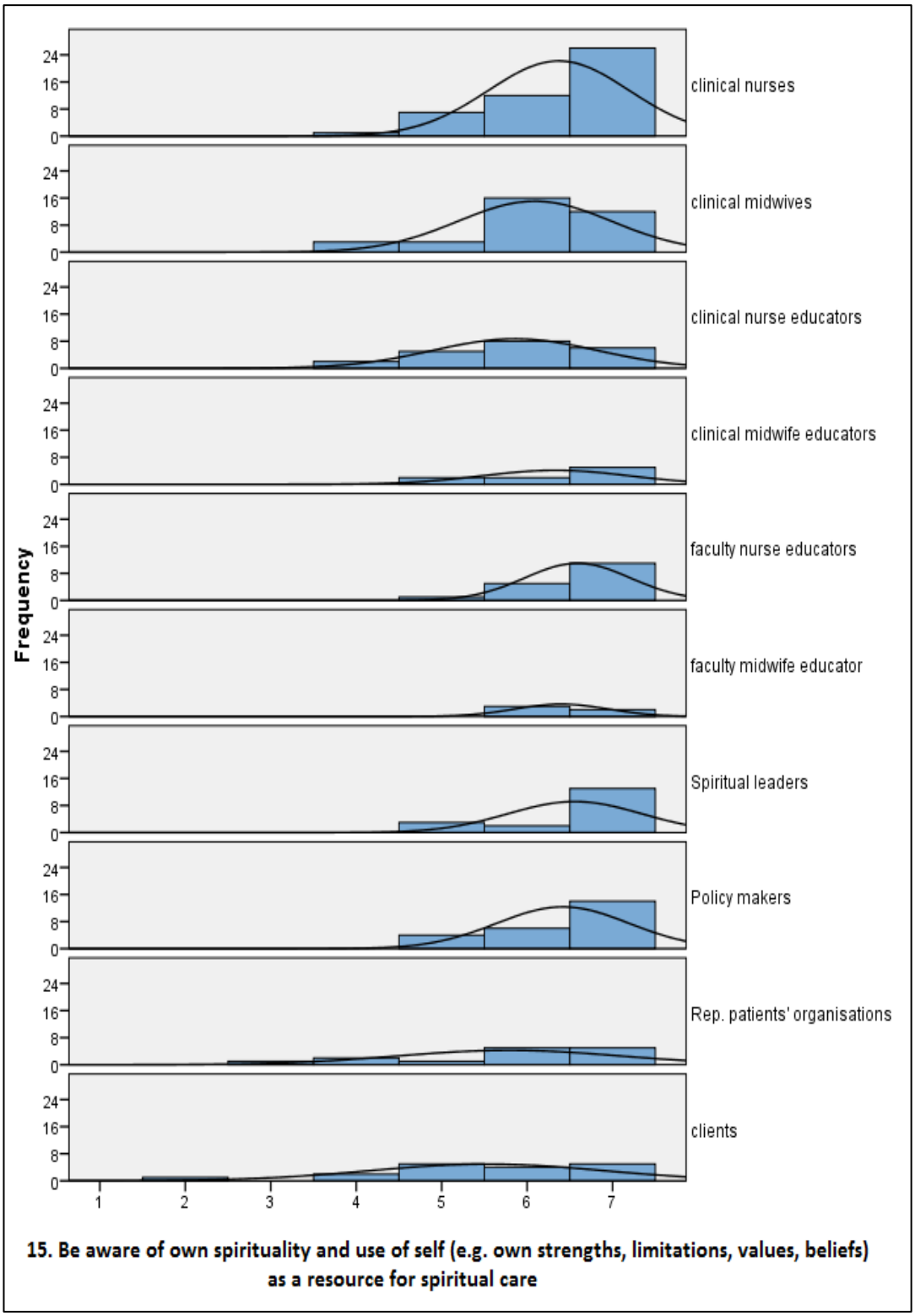
12. Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care



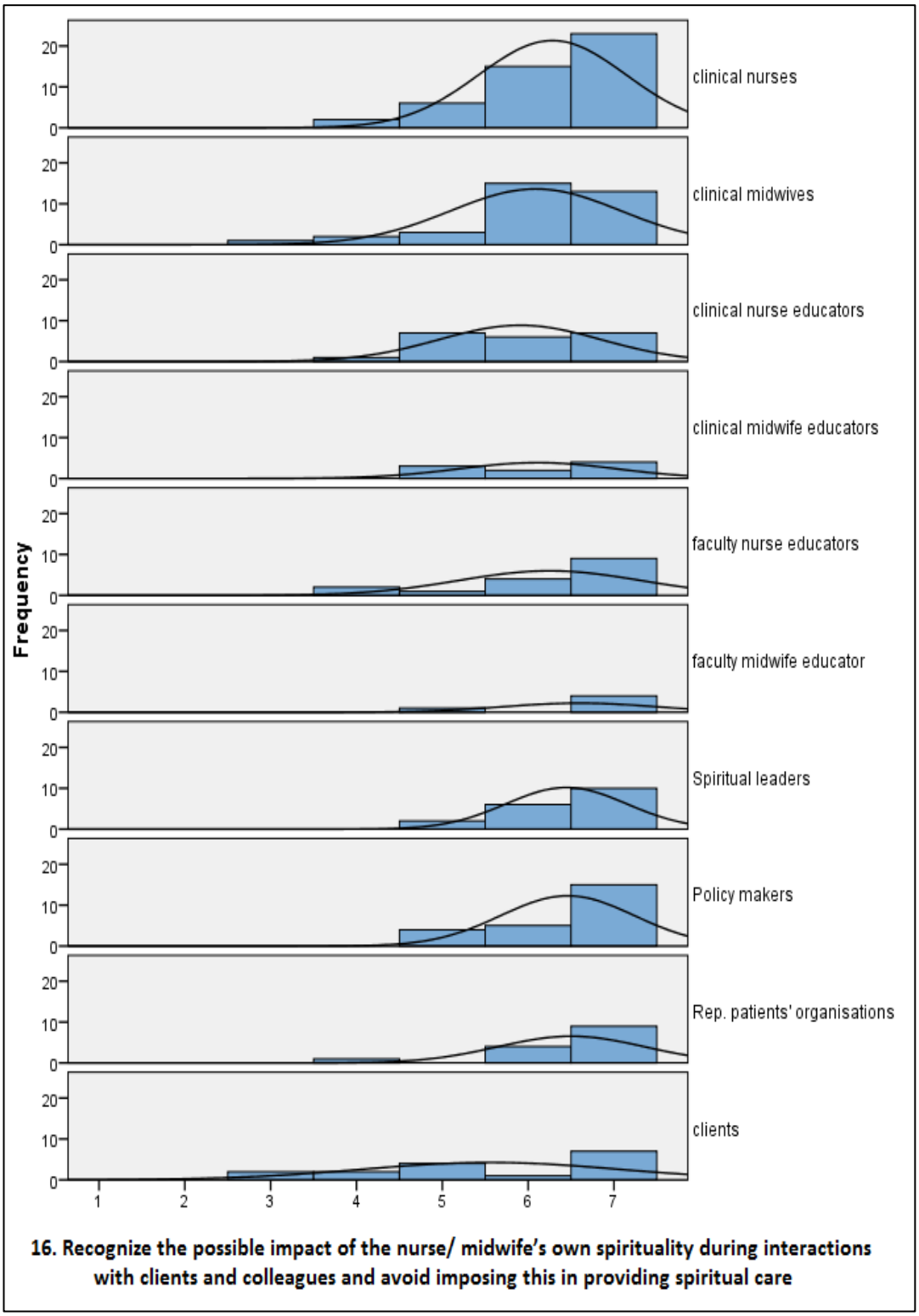
13. Demonstrate knowledge of resources, support systems/ agencies that inform nurses/ midwives to access spiritual care for clients, their families and staff in all health care settings (e.g. place for worship, Church, support groups, Hospice, friends, and employment peers)



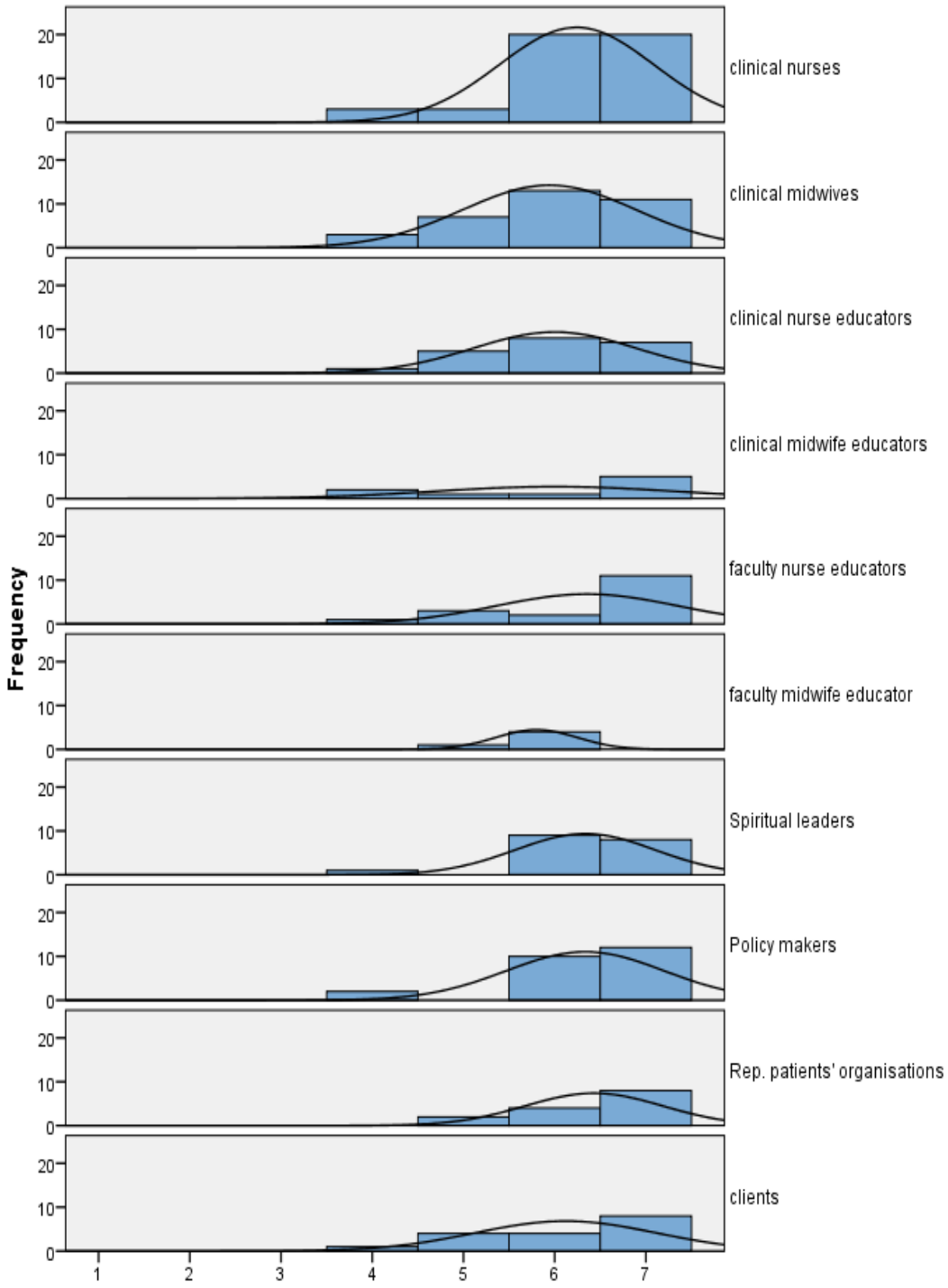
14. Demonstrate knowledge on assisting clients in health care according to the clients' religious/ spiritual, cultural beliefs such as the use of complimentary/ alternative therapies, diets, nutritional supplements and prayer



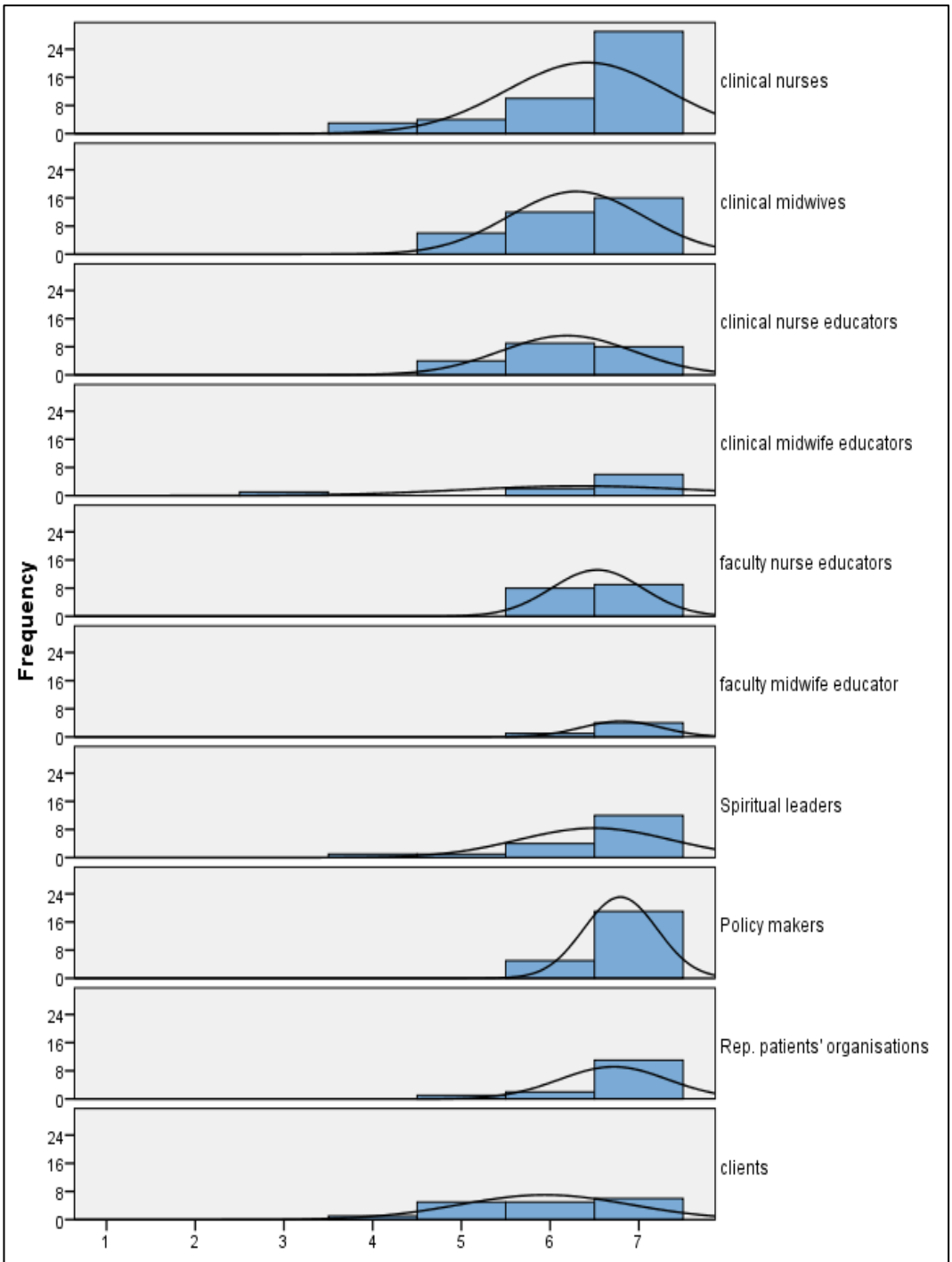
15. Be aware of own spirituality and use of self (e.g. own strengths, limitations, values, beliefs) as a resource for spiritual care



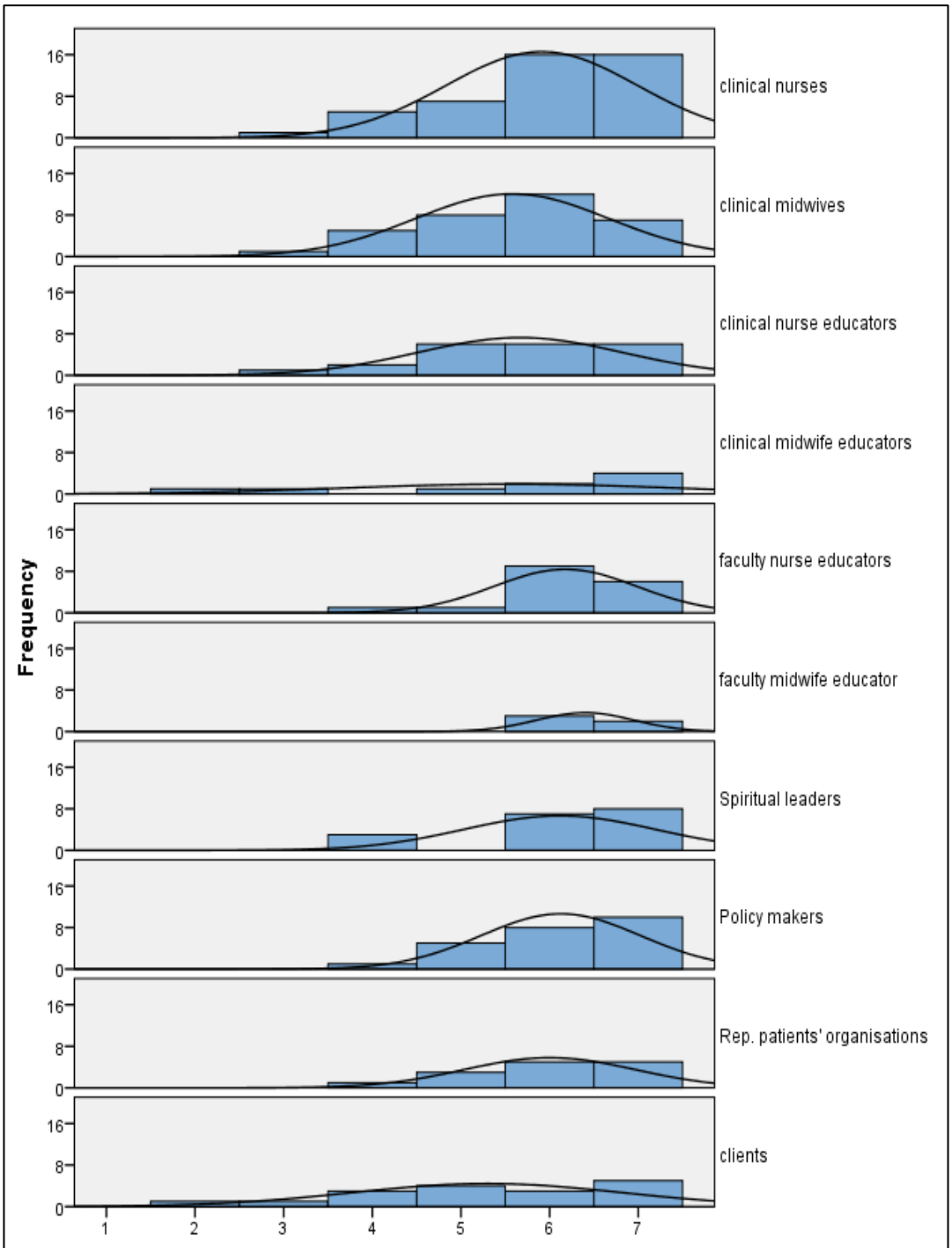
16. Recognize the possible impact of the nurse/ midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care



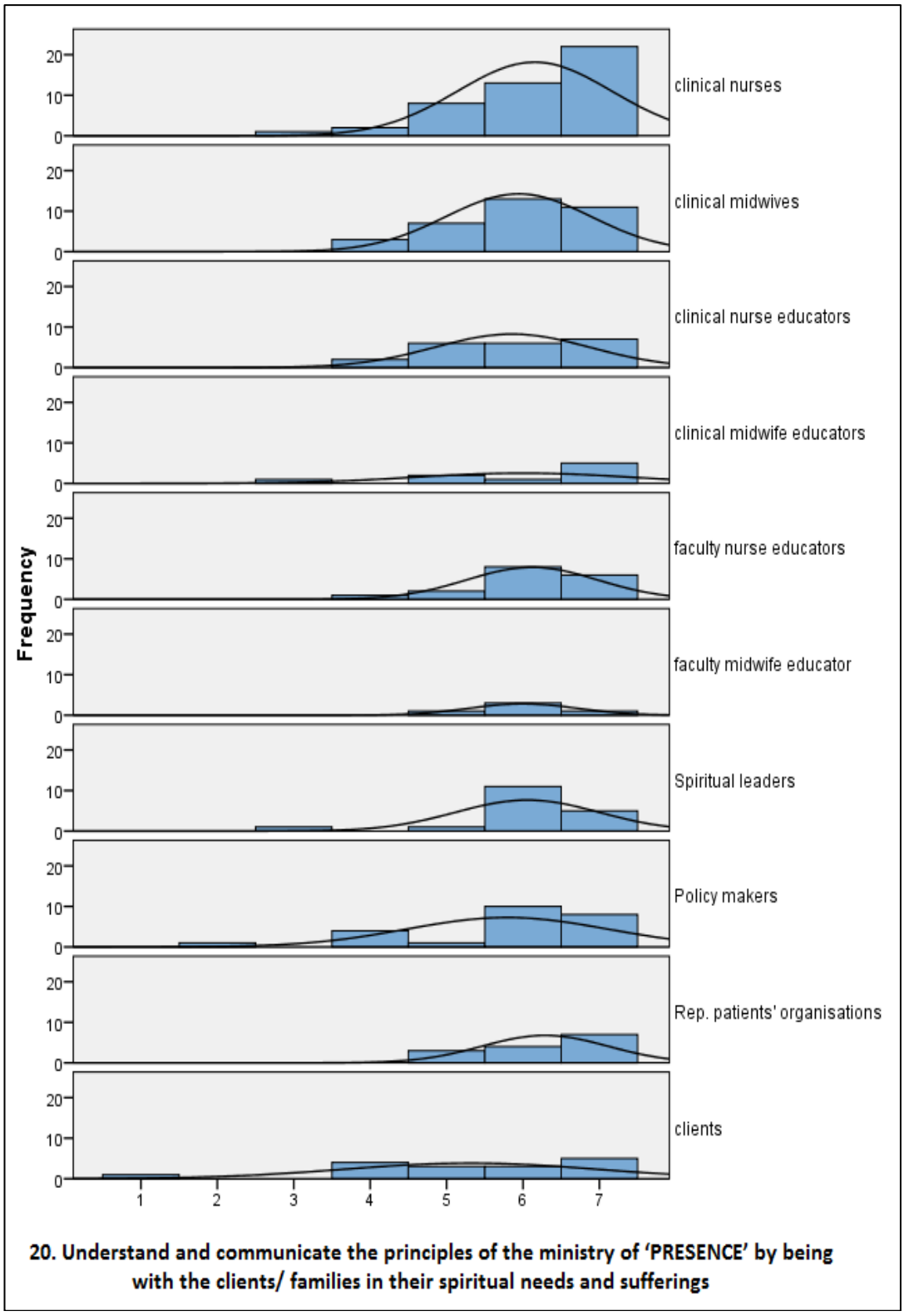
17. Acknowledge and respect the influence of clients' diverse cultural worldviews, beliefs and practices in the expression of their spirituality in healthcare



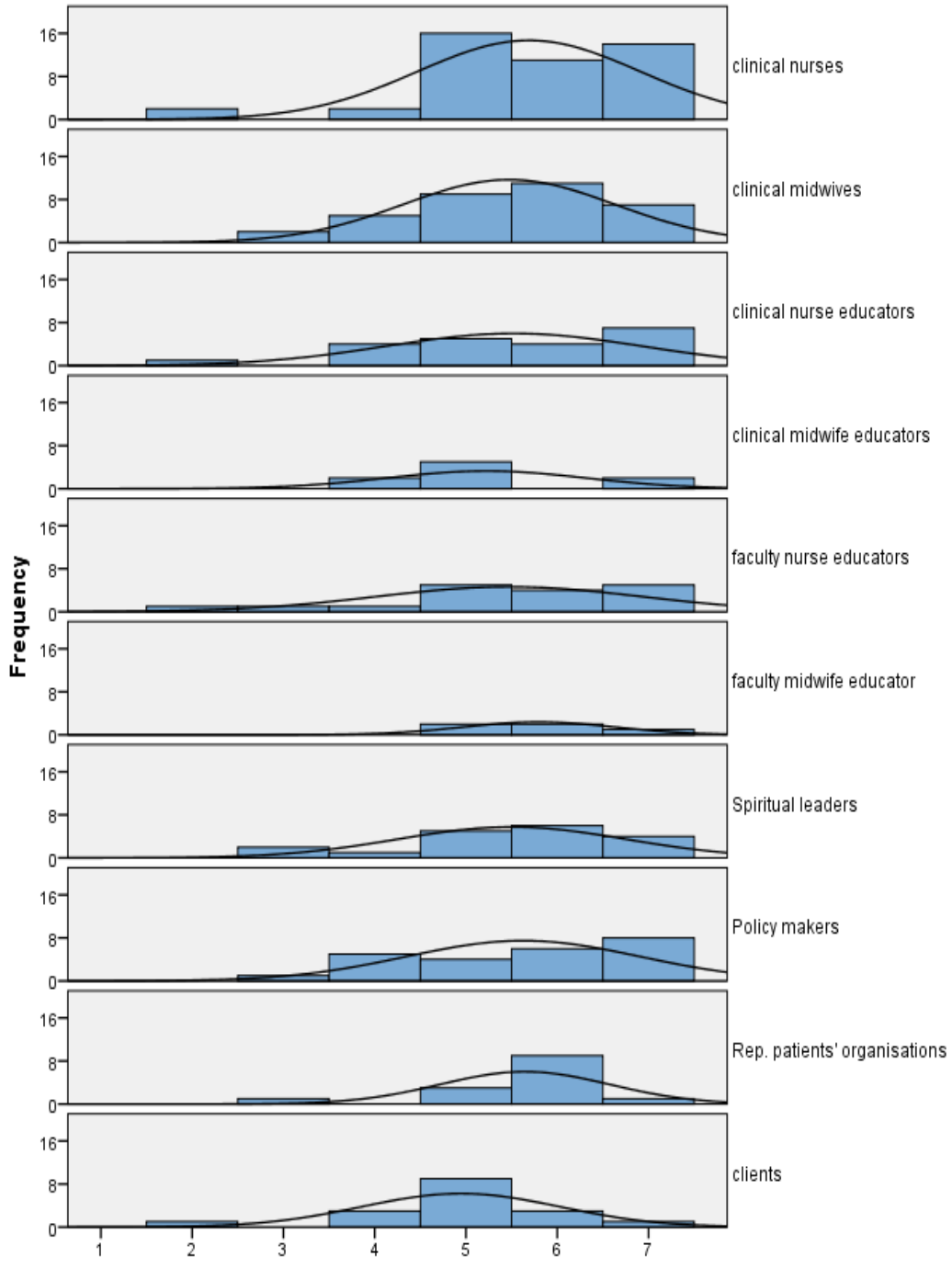
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (e.g. psychologists, chaplains, counsellors, spiritual leaders) as deemed necessary



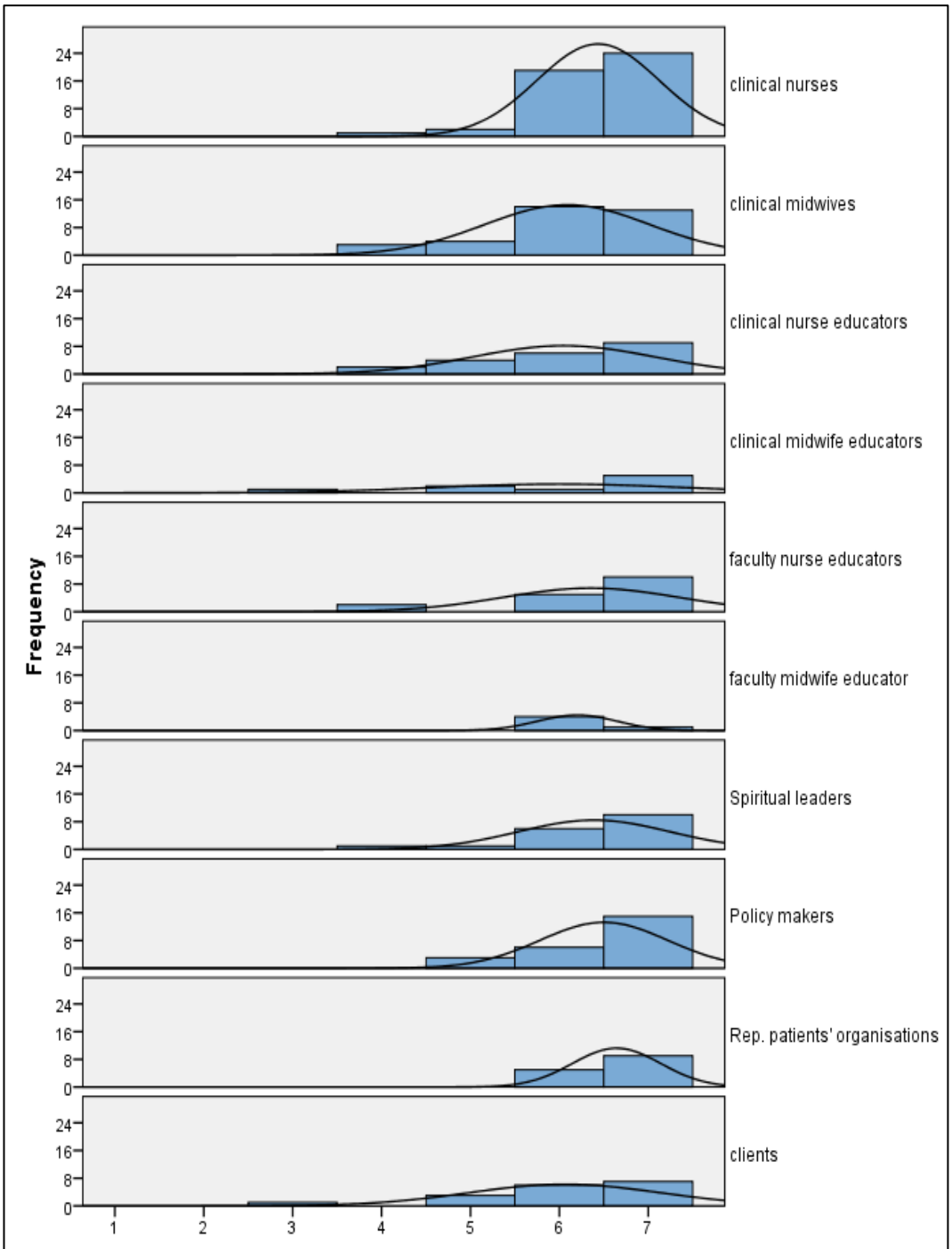
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/ support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care



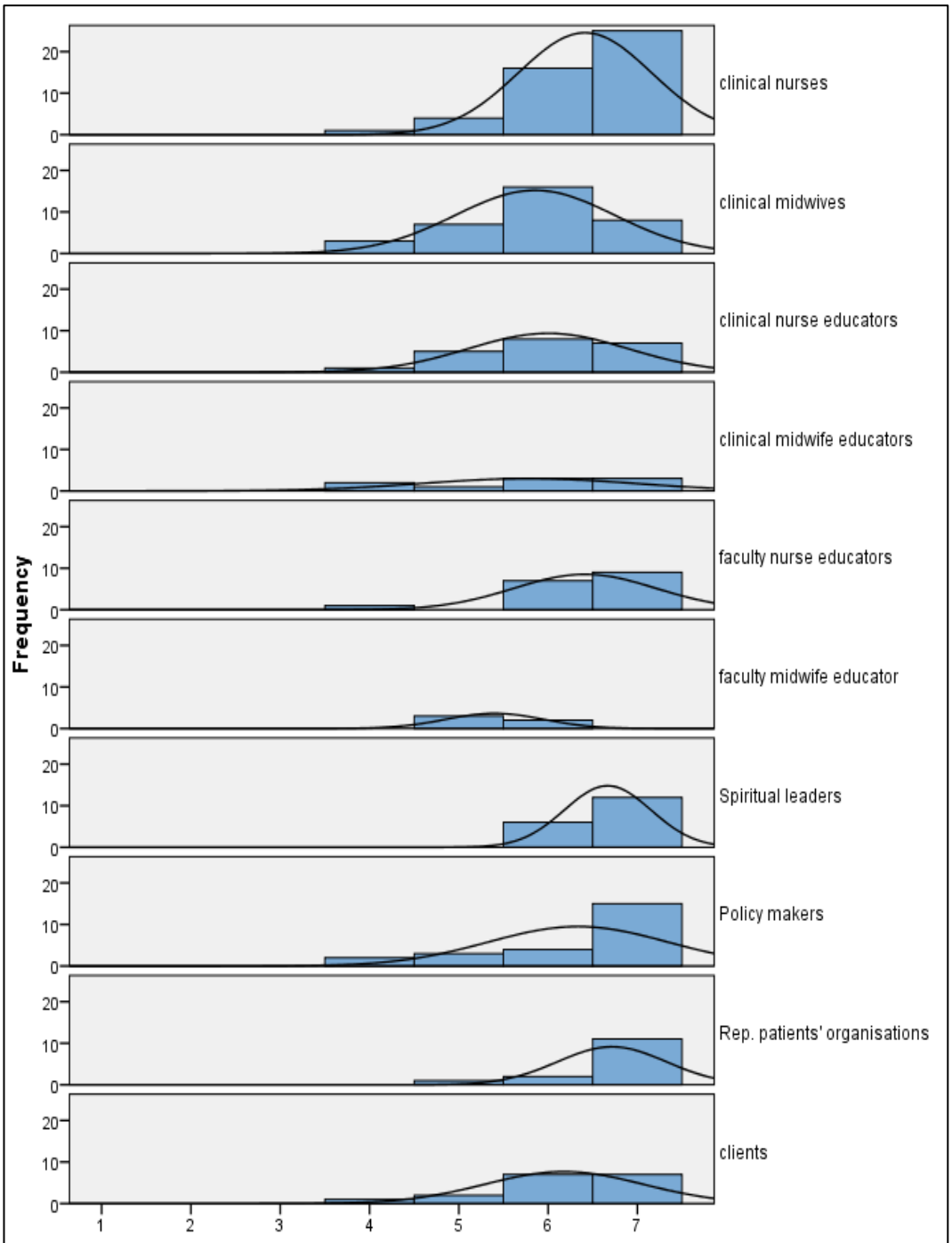
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/ families in their spiritual needs and sufferings



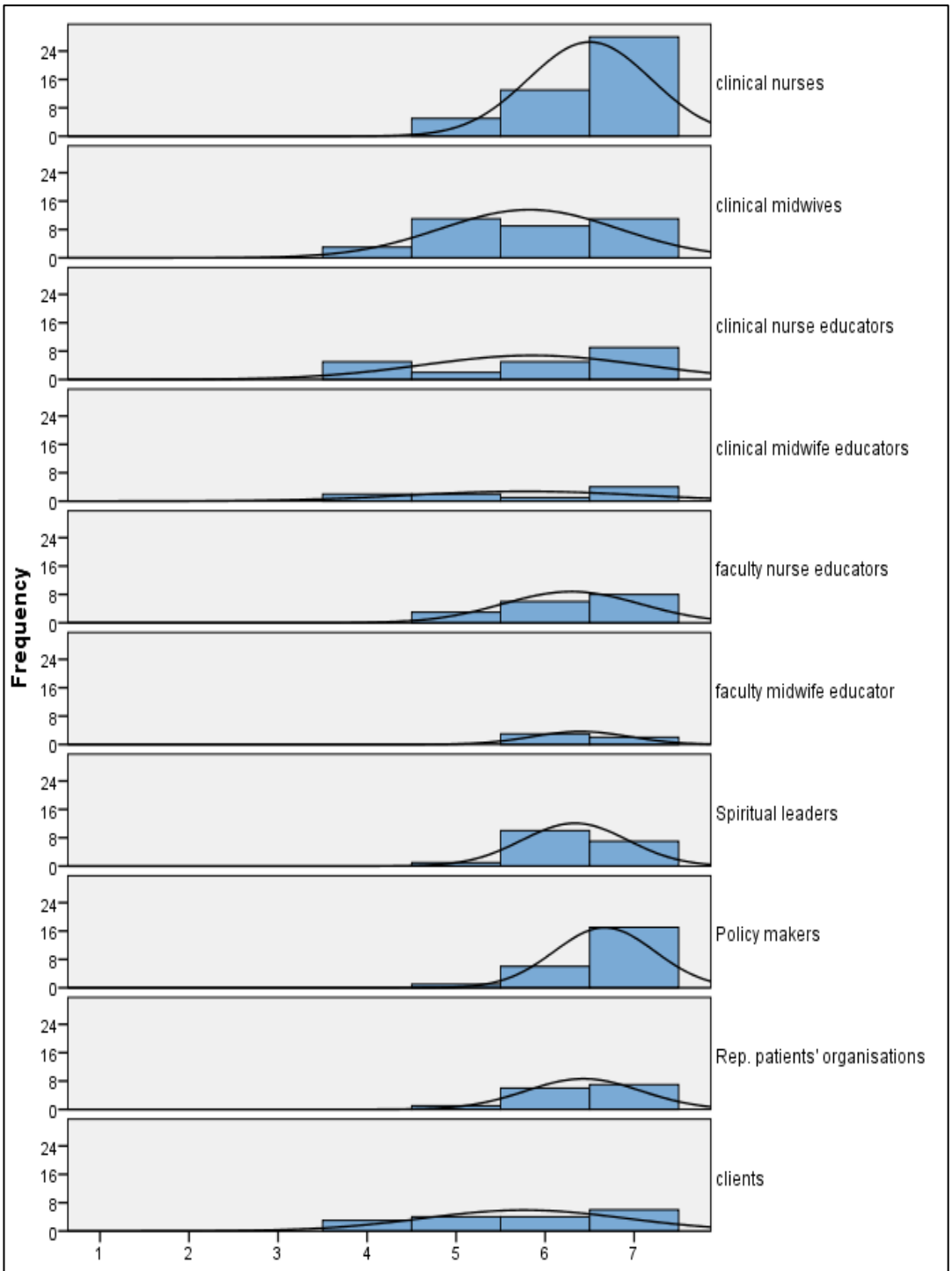
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/ religious readings and prayer as a means of encouragement and hope



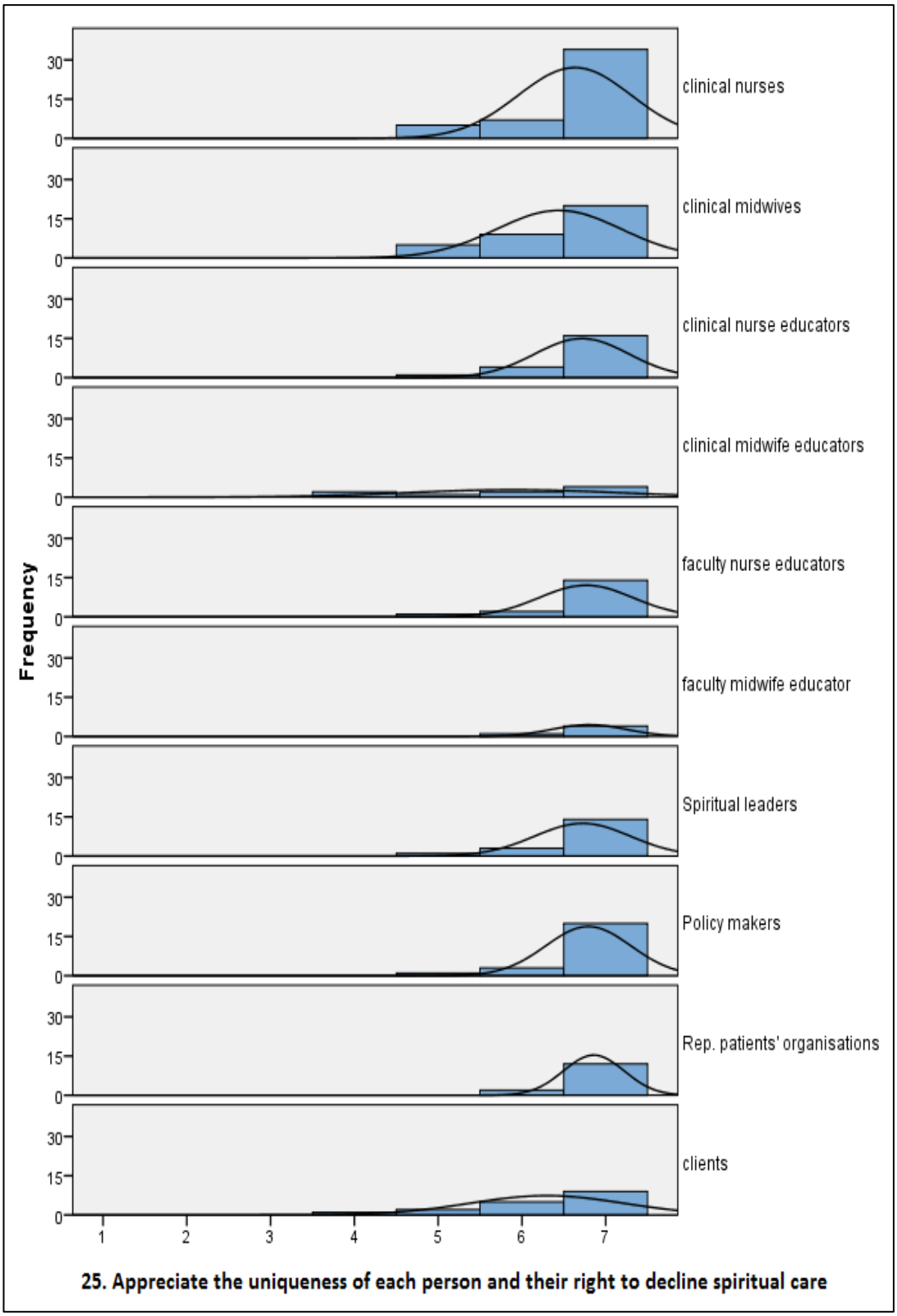
22. Assess barriers to effective communication in providing spiritual care (e.g. language, beliefs, culture, anxiety, fear and anger) and adapt accordingly by active listening, empathy and/ or referral to other members of the multi-disciplinary team

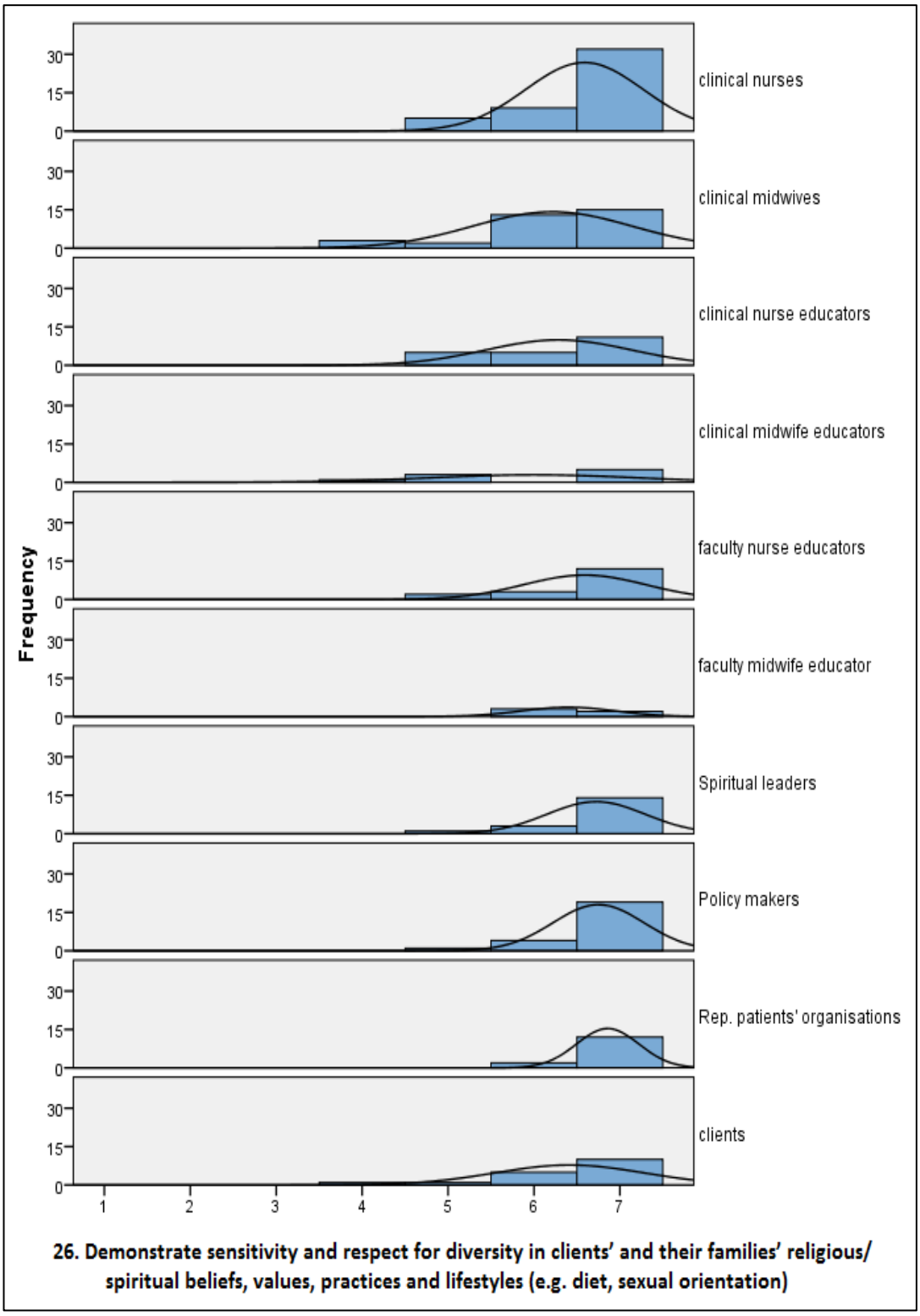


23. Understand and apply the principles of a therapeutic trustful nurse/ midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey

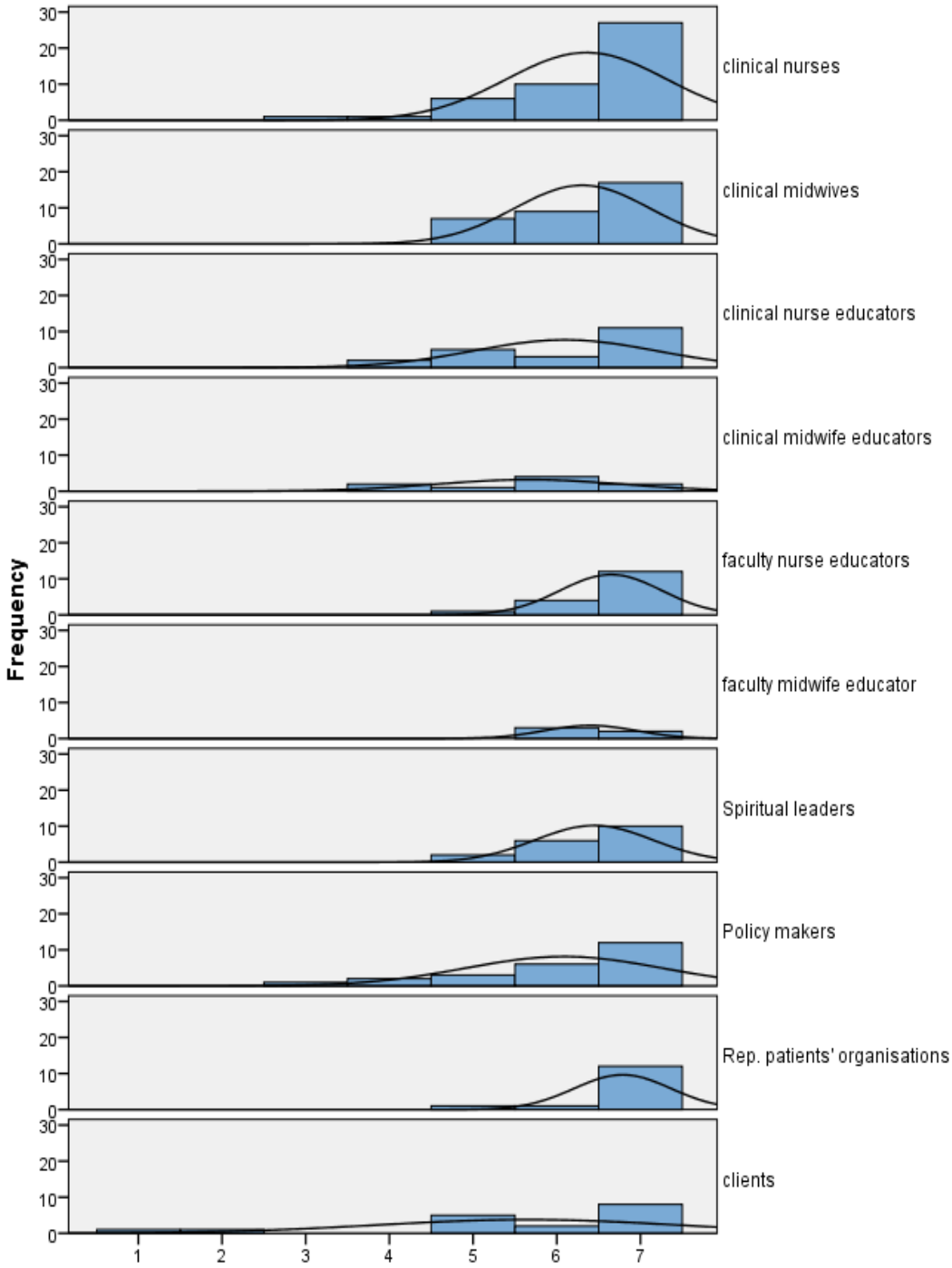


24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/ midwife-client relationship; (abiding by the professional ethical/ legal codes of conduct)

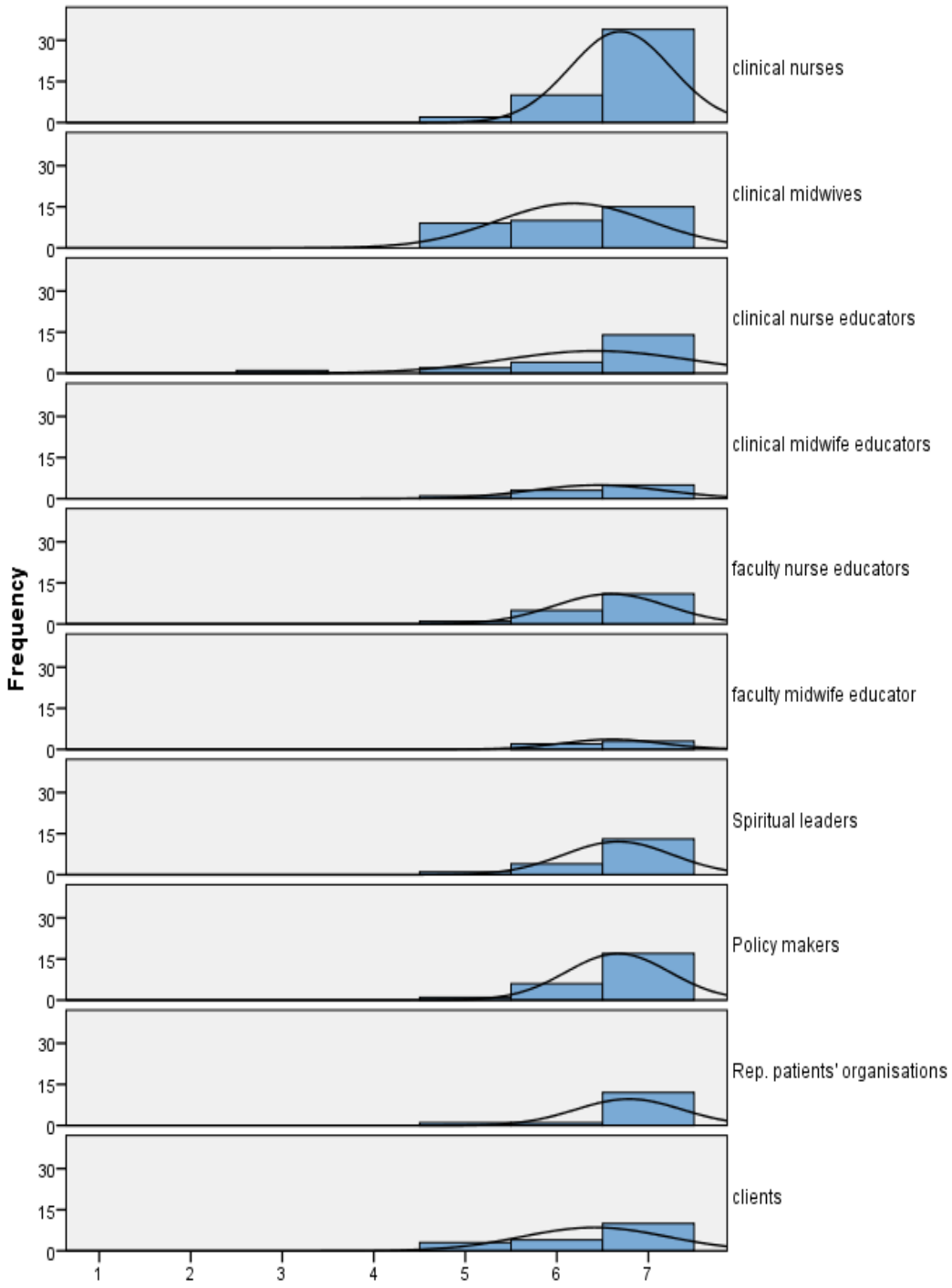

Frequency
clinical nurses
clinical midwives
clinical nurse educators
clinical midwife educators
faculty nurse educators
faculty midwife educator
Spiritual leaders
Policy makers
Rep. patients' organisations
clients
30
15
0
1
2
3
4
5
6
7
25. Appreciate the uniqueness of each person and their right to decline spiritual care



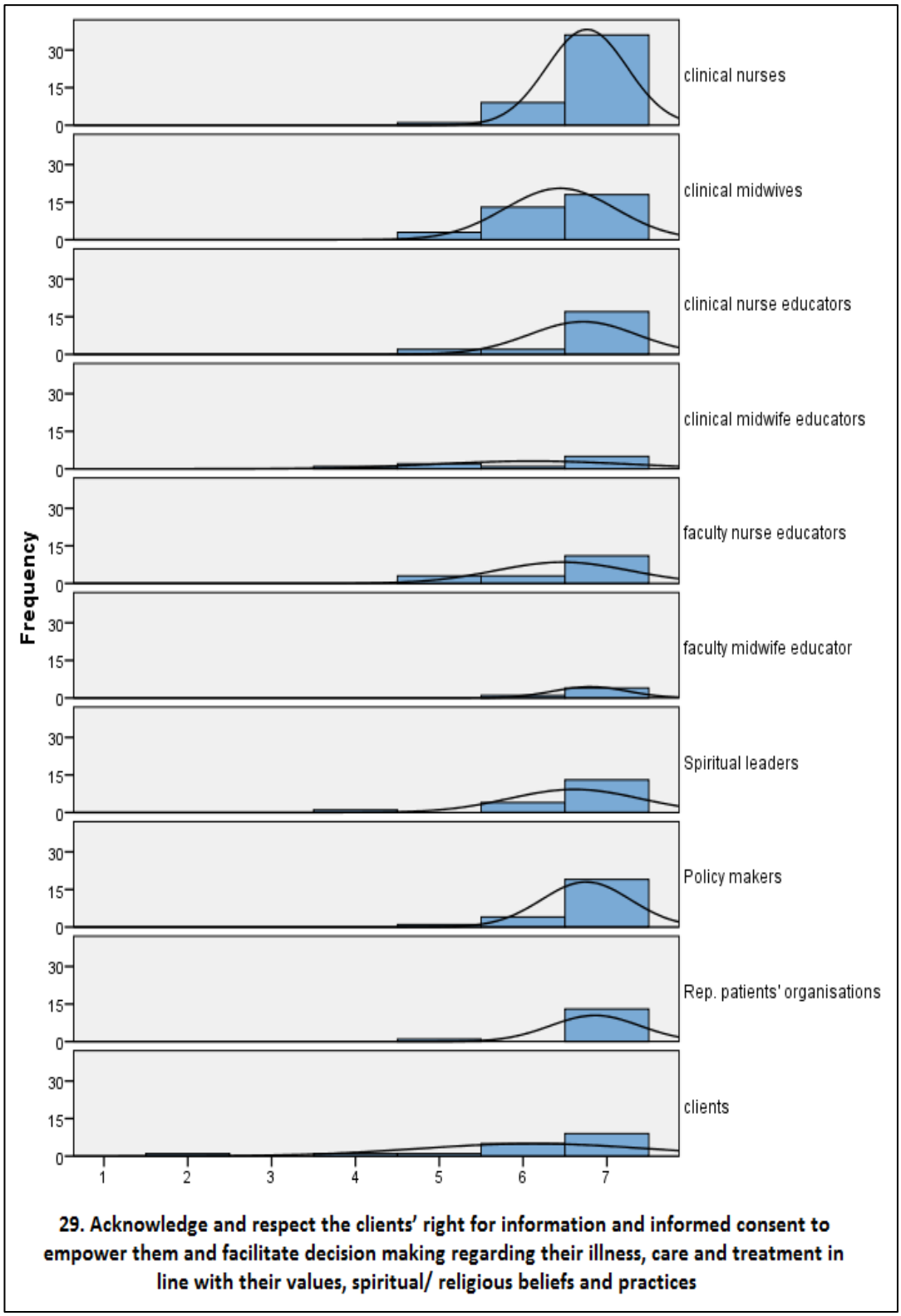
26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/ spiritual beliefs, values, practices and lifestyles (e.g. diet, sexual orientation)



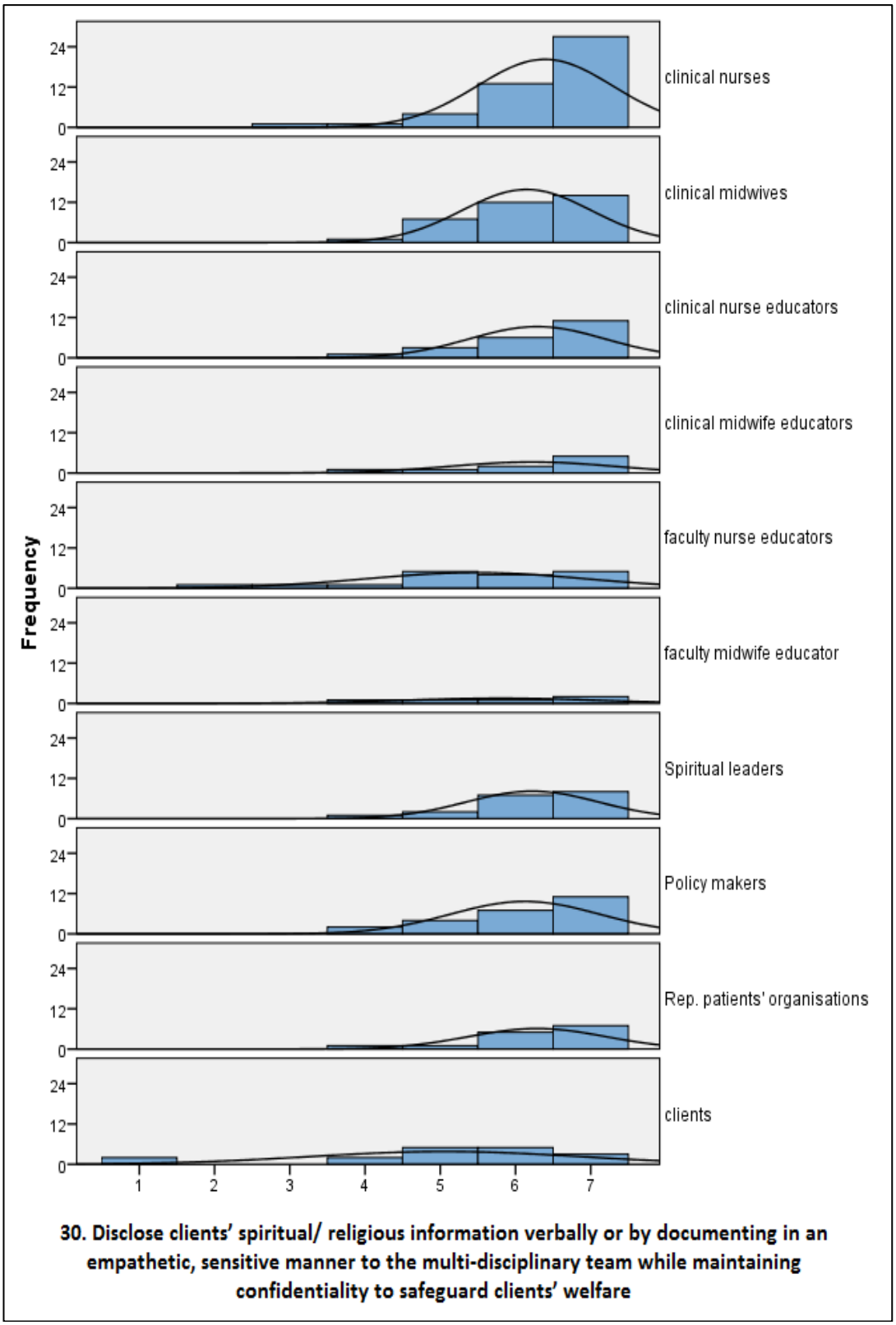
27. Demonstrate sensitivity, support and respect for the client's autonomous and diverse health care decisions/ choices influenced by religious/ spiritual beliefs and practices (e.g. blood transfusion, childbirth practices, chemotherapy, immunization)



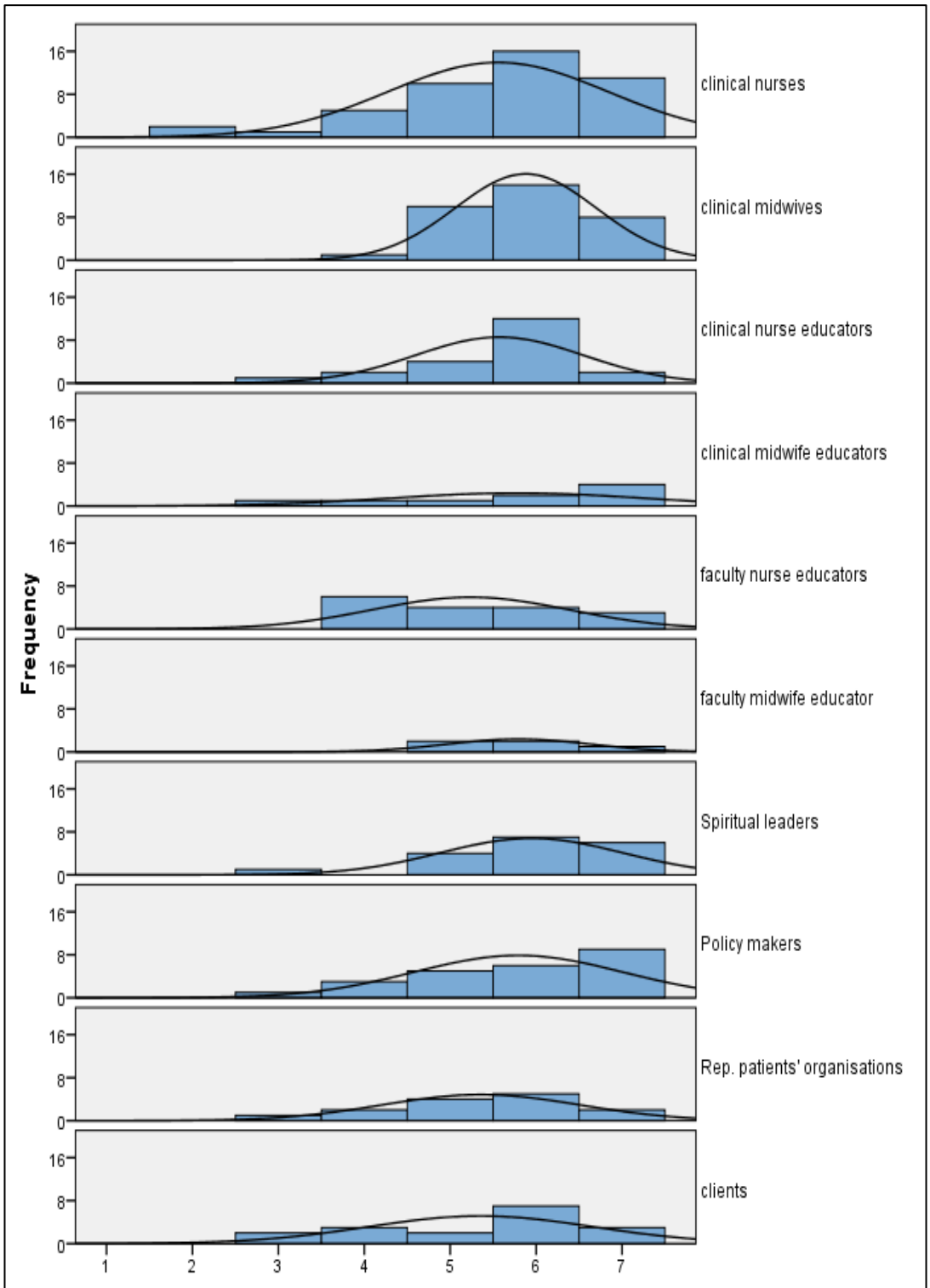
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (self-esteem and self respect) and integrity (adherence to moral and ethical principles)



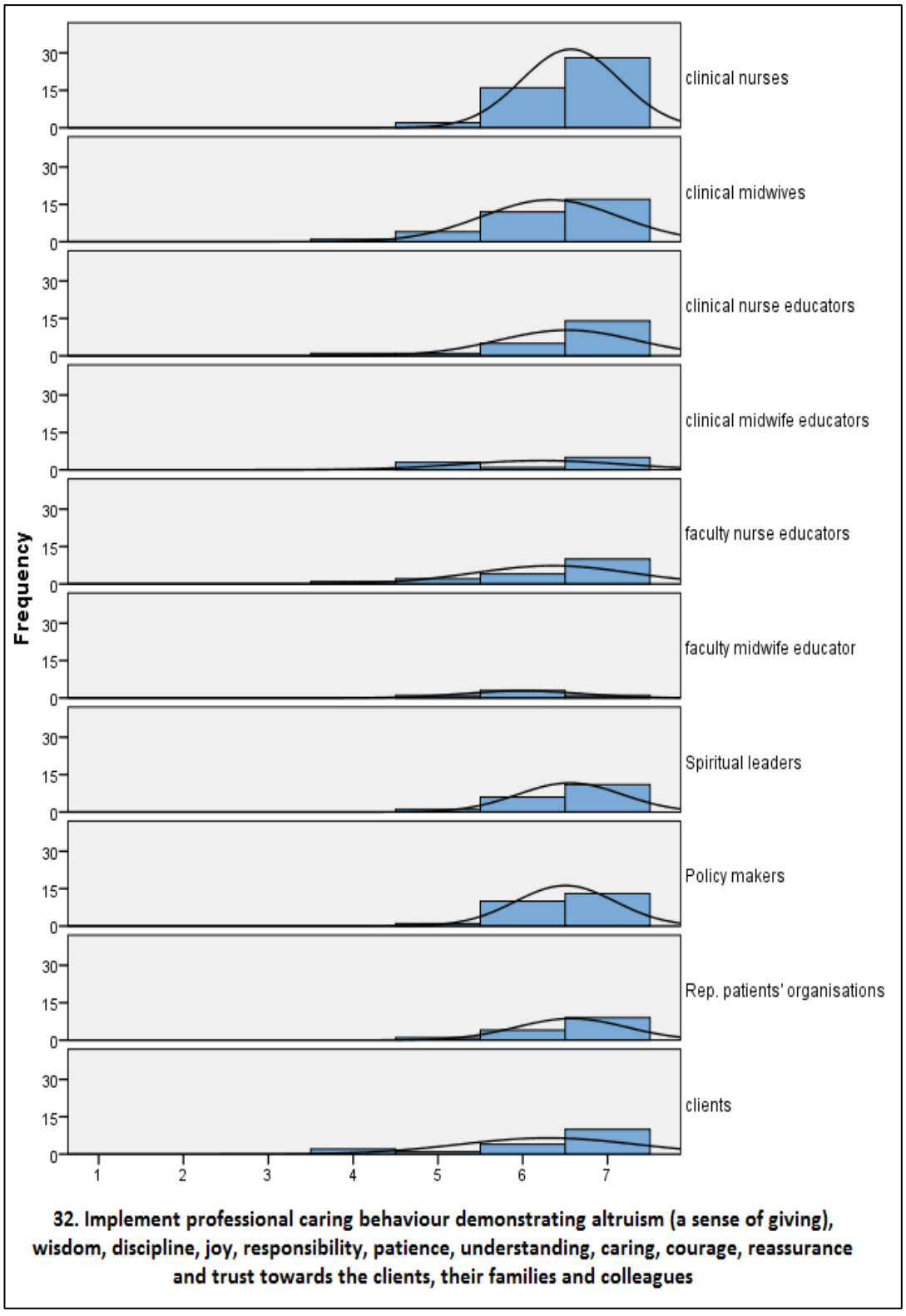
29. Acknowledge and respect the clients' right for information and informed consent to empower them and facilitate decision making regarding their illness, care and treatment in line with their values, spiritual/ religious beliefs and practices



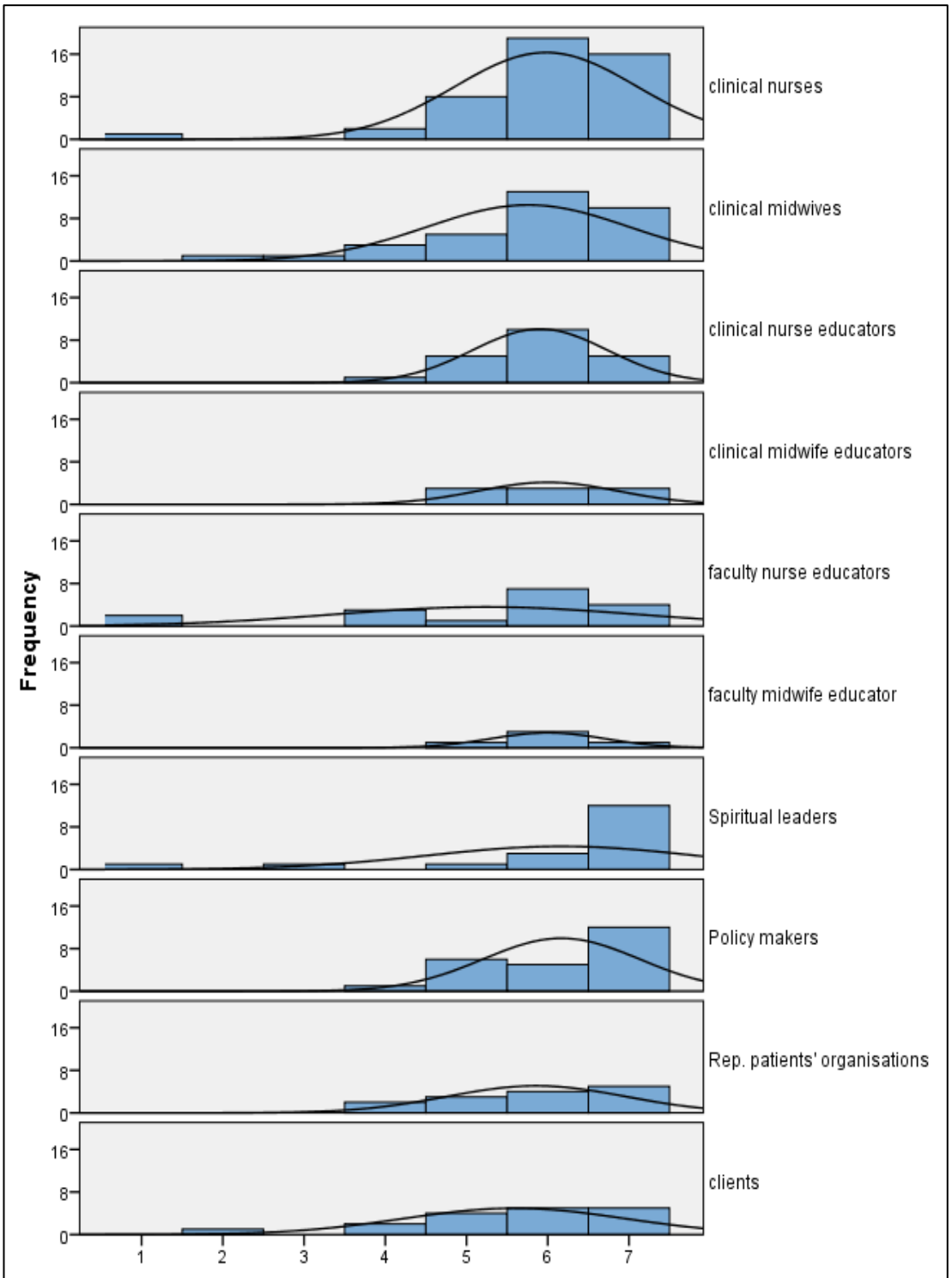
30. Disclose clients' spiritual/ religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team while maintaining confidentiality to safeguard clients' welfare



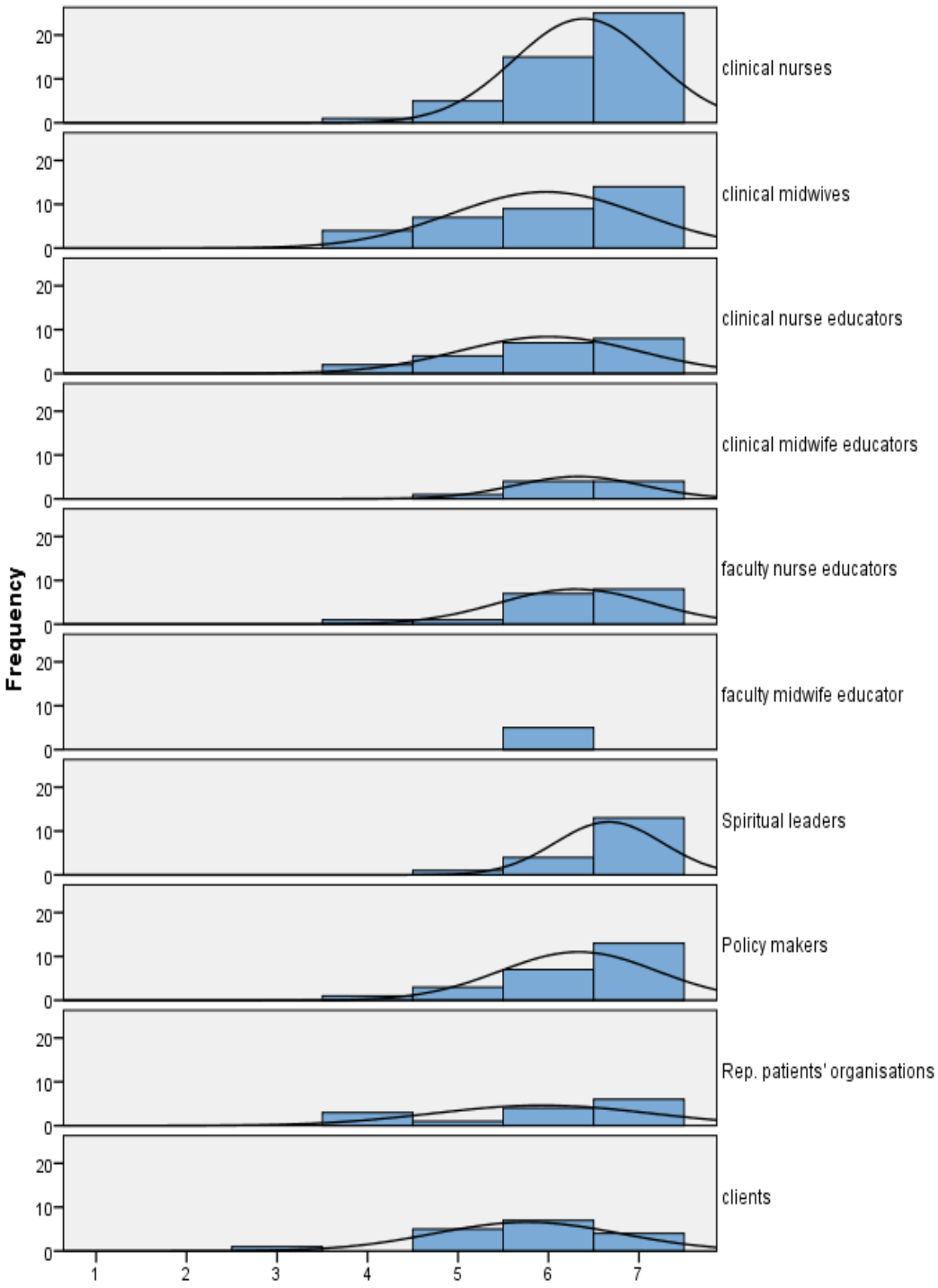
31. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/ midwife



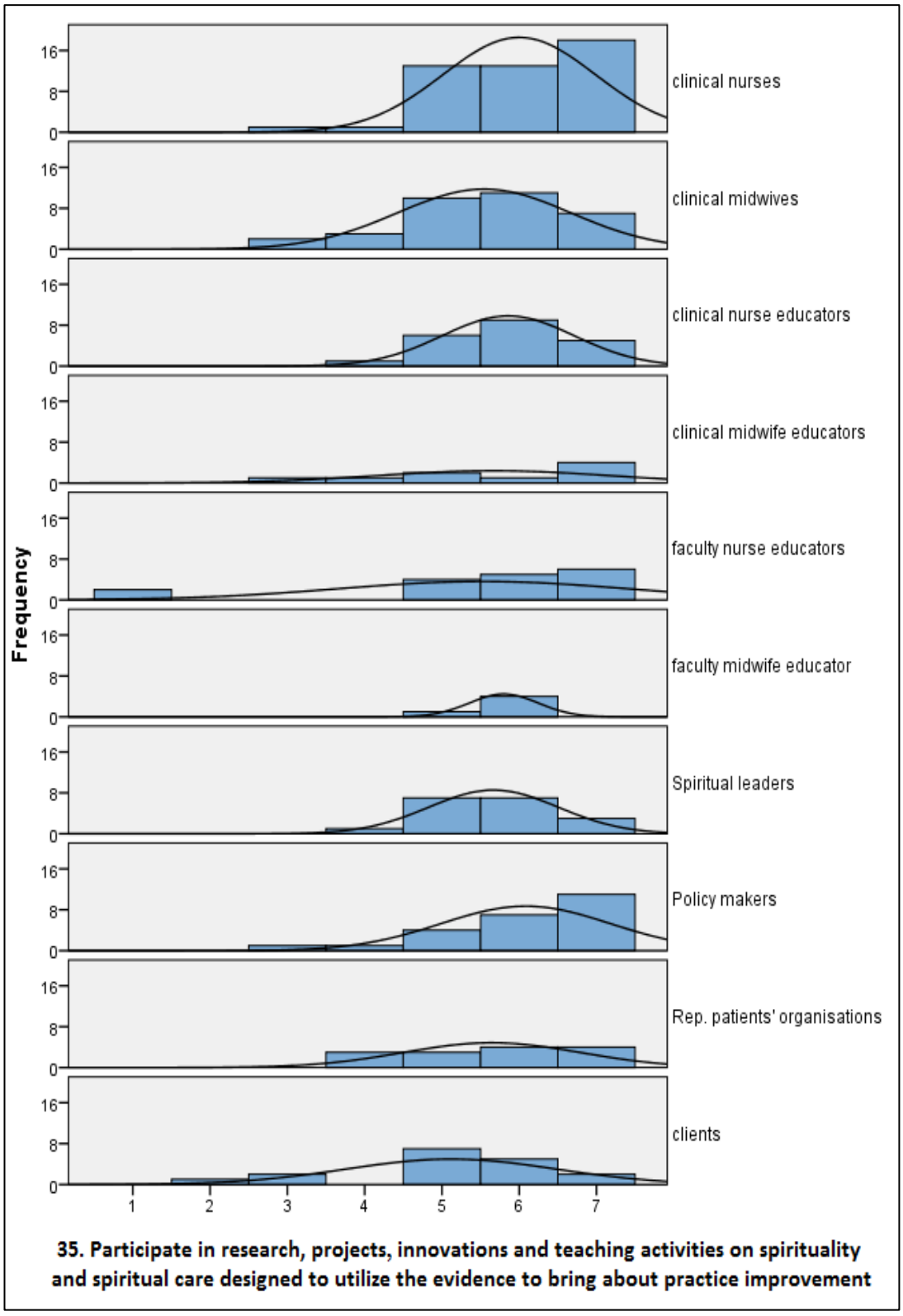
32. Implement professional caring behaviour demonstrating altruism (a sense of giving), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues



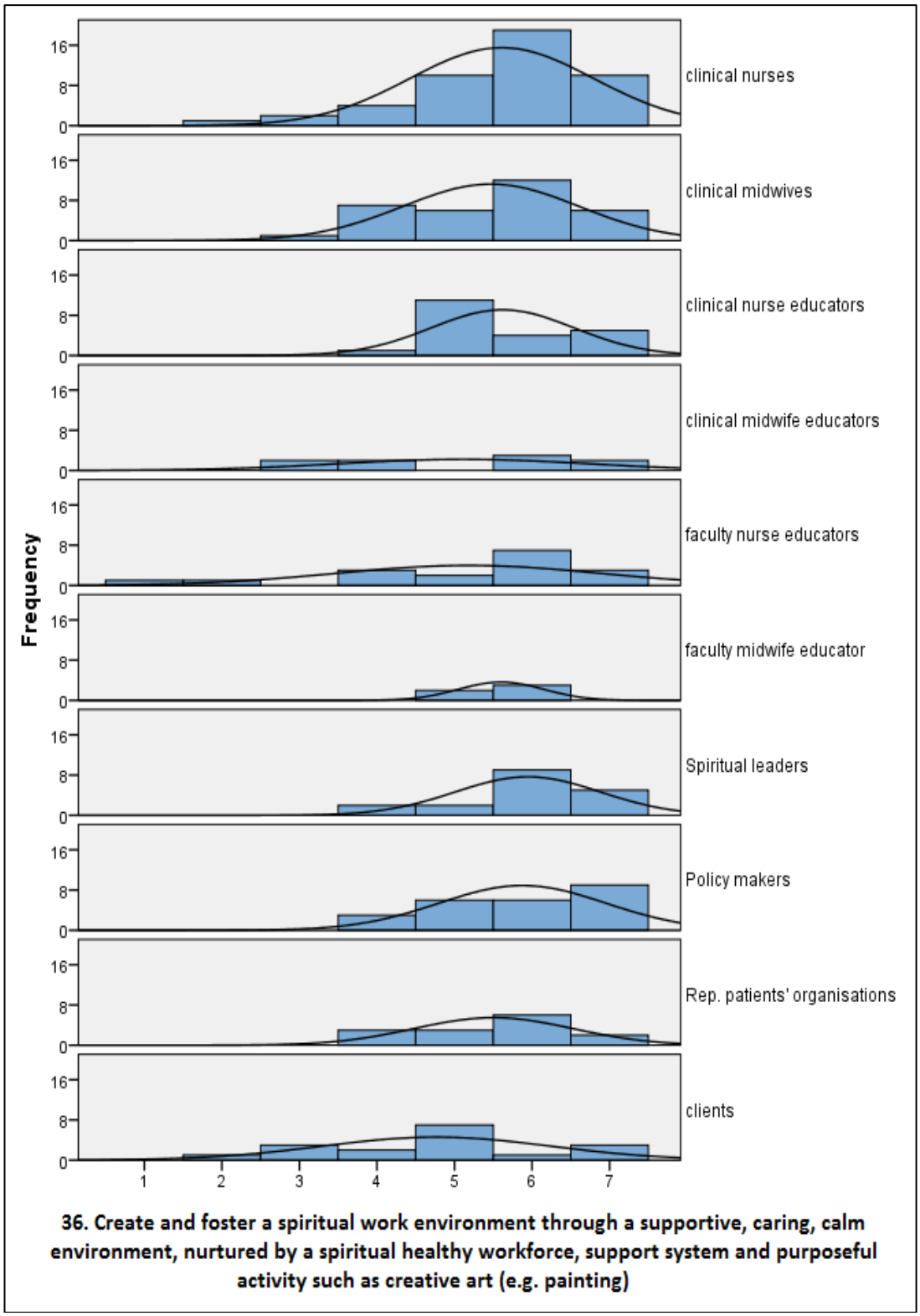
33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on



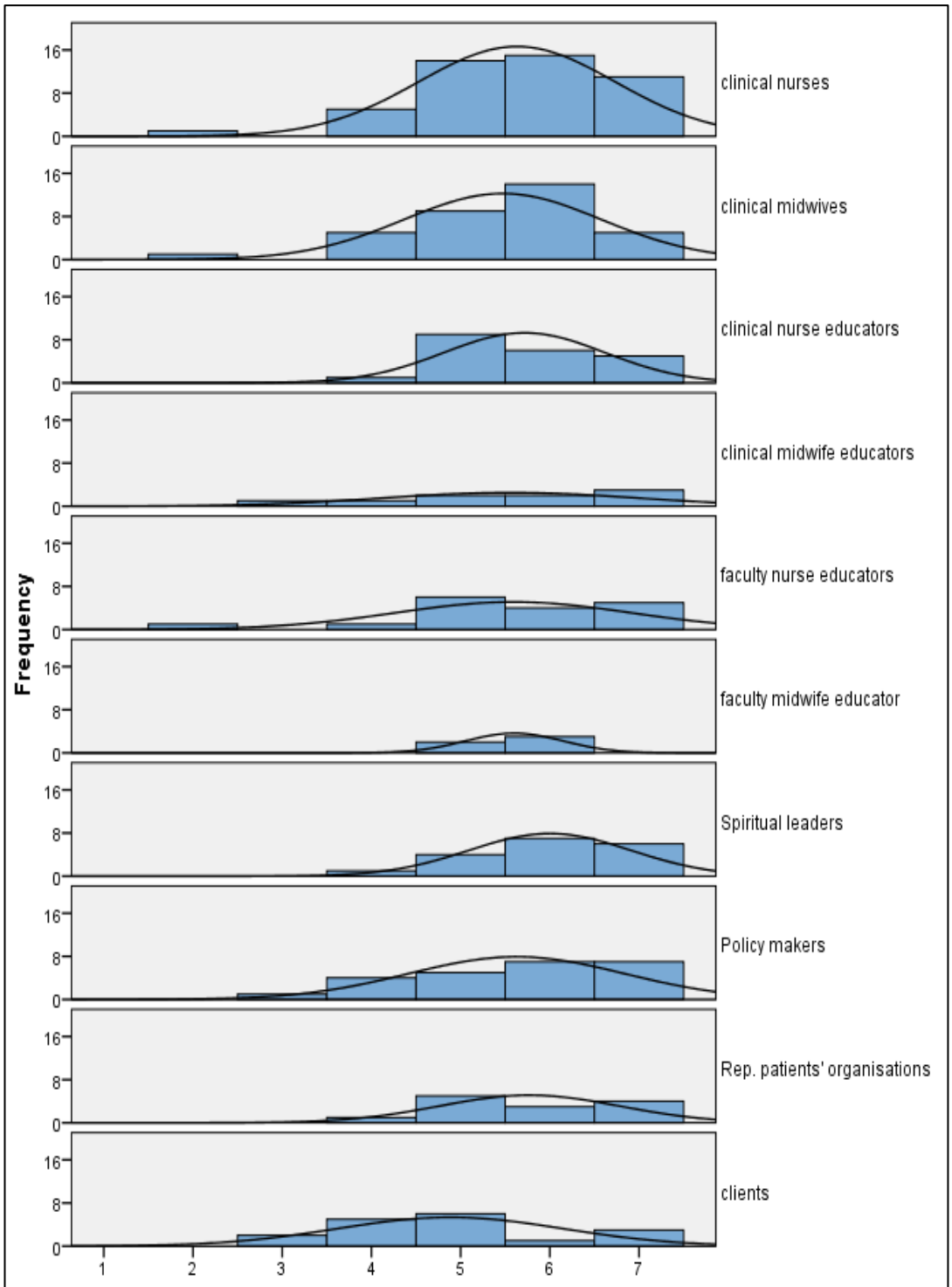
34. Recognize the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care



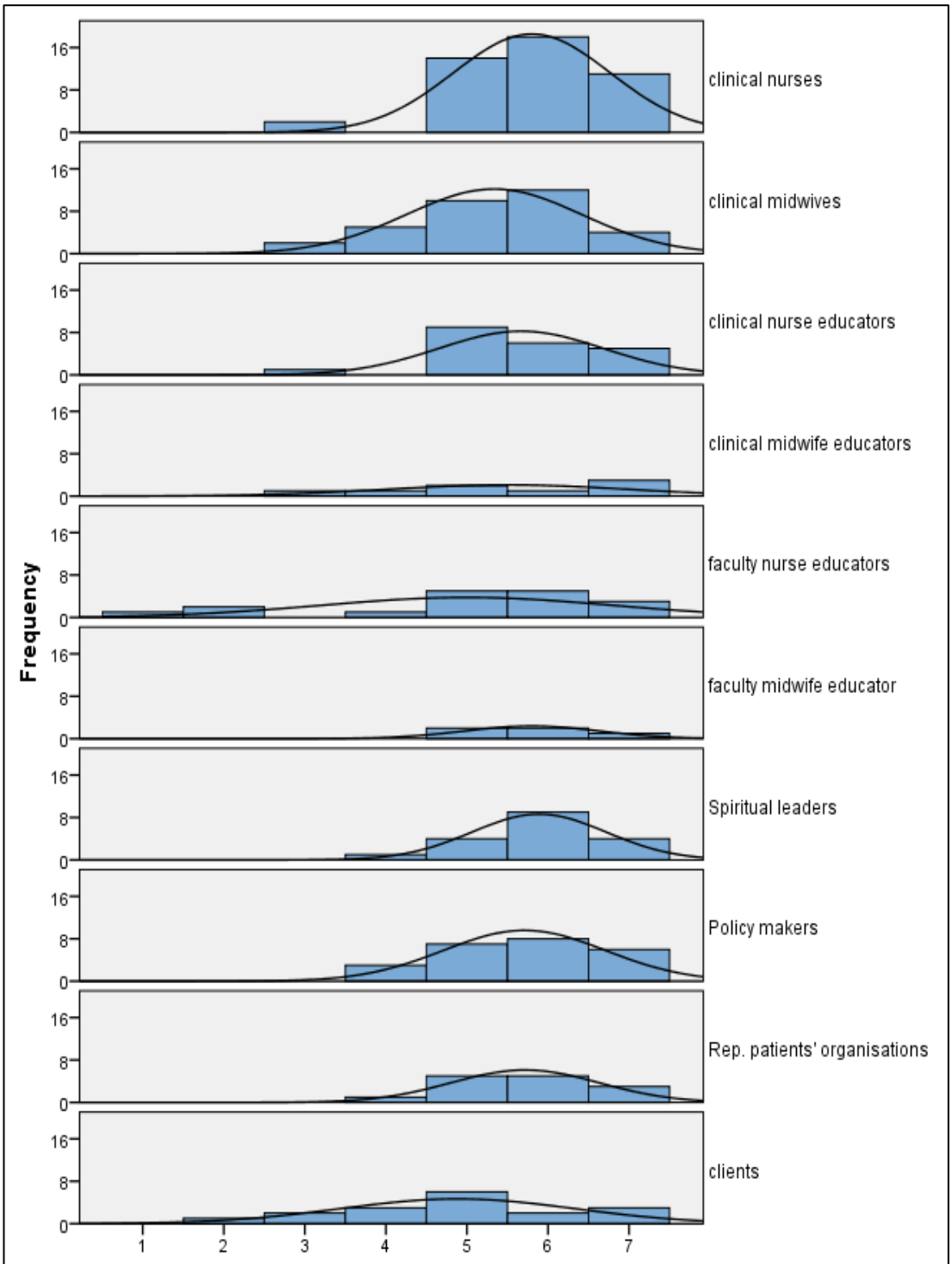
35. Participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilize the evidence to bring about practice improvement



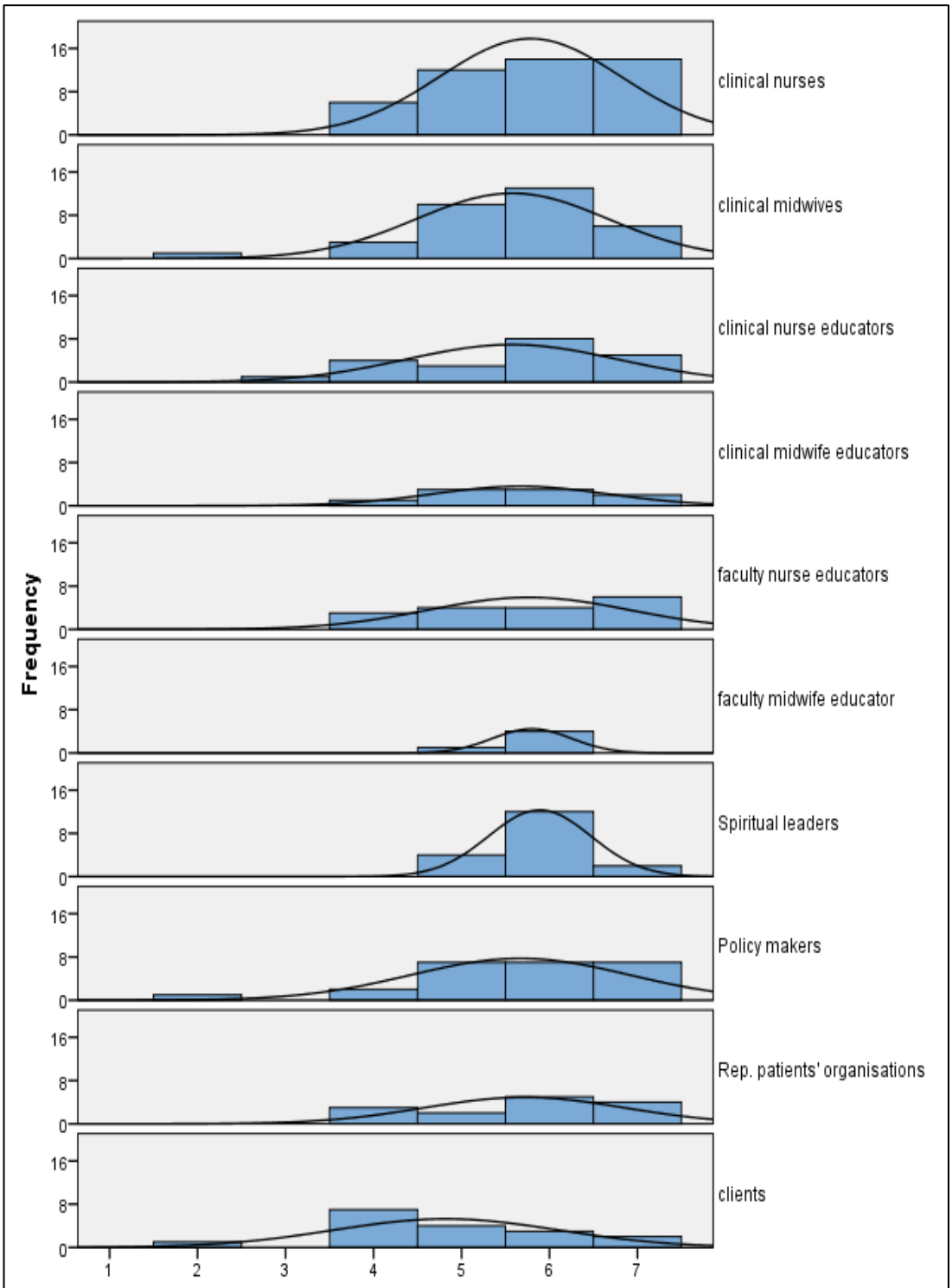
36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity such as creative art (e.g. painting)



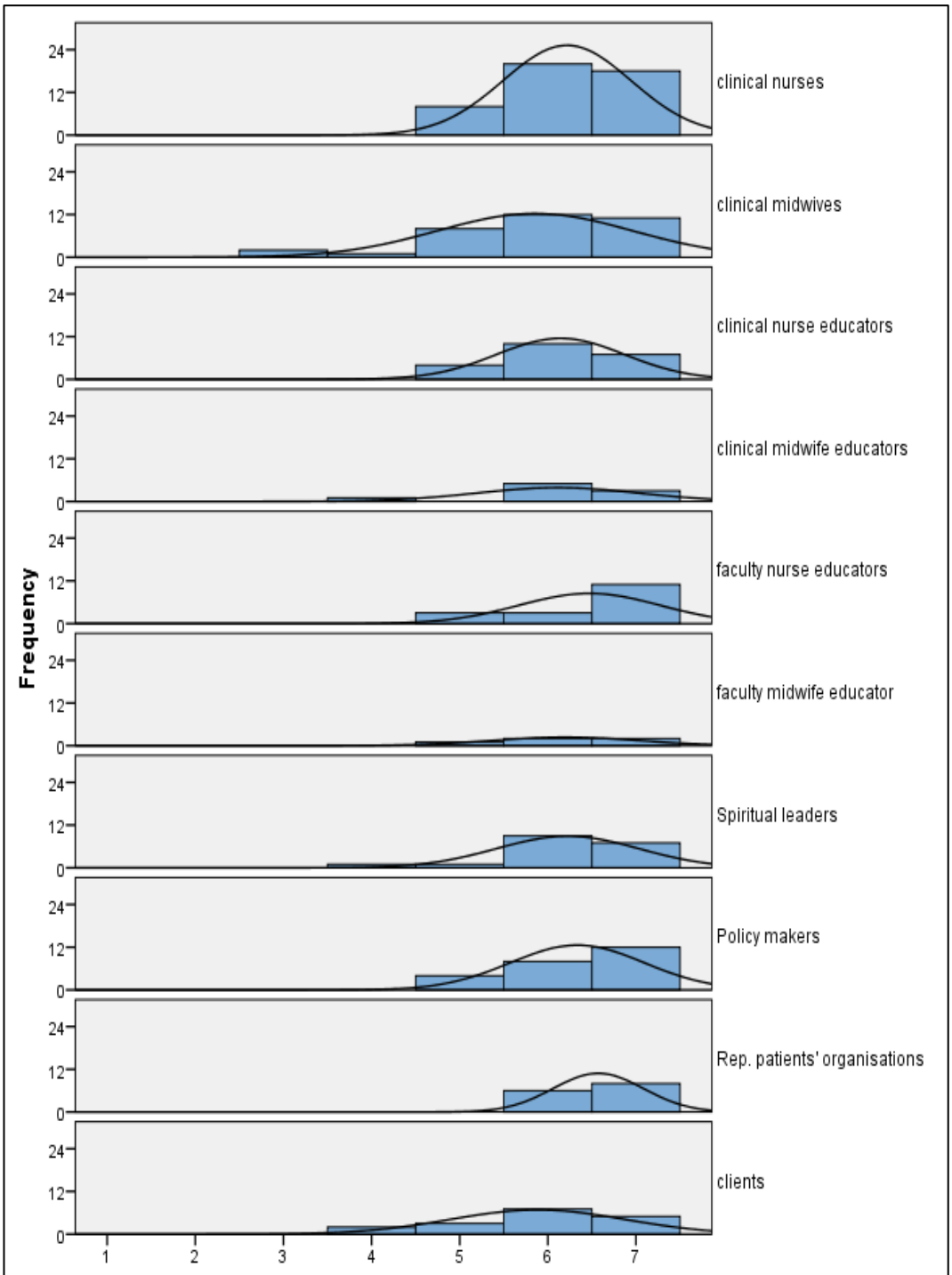
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual wellbeing of clients, their families and health carers and modify accordingly



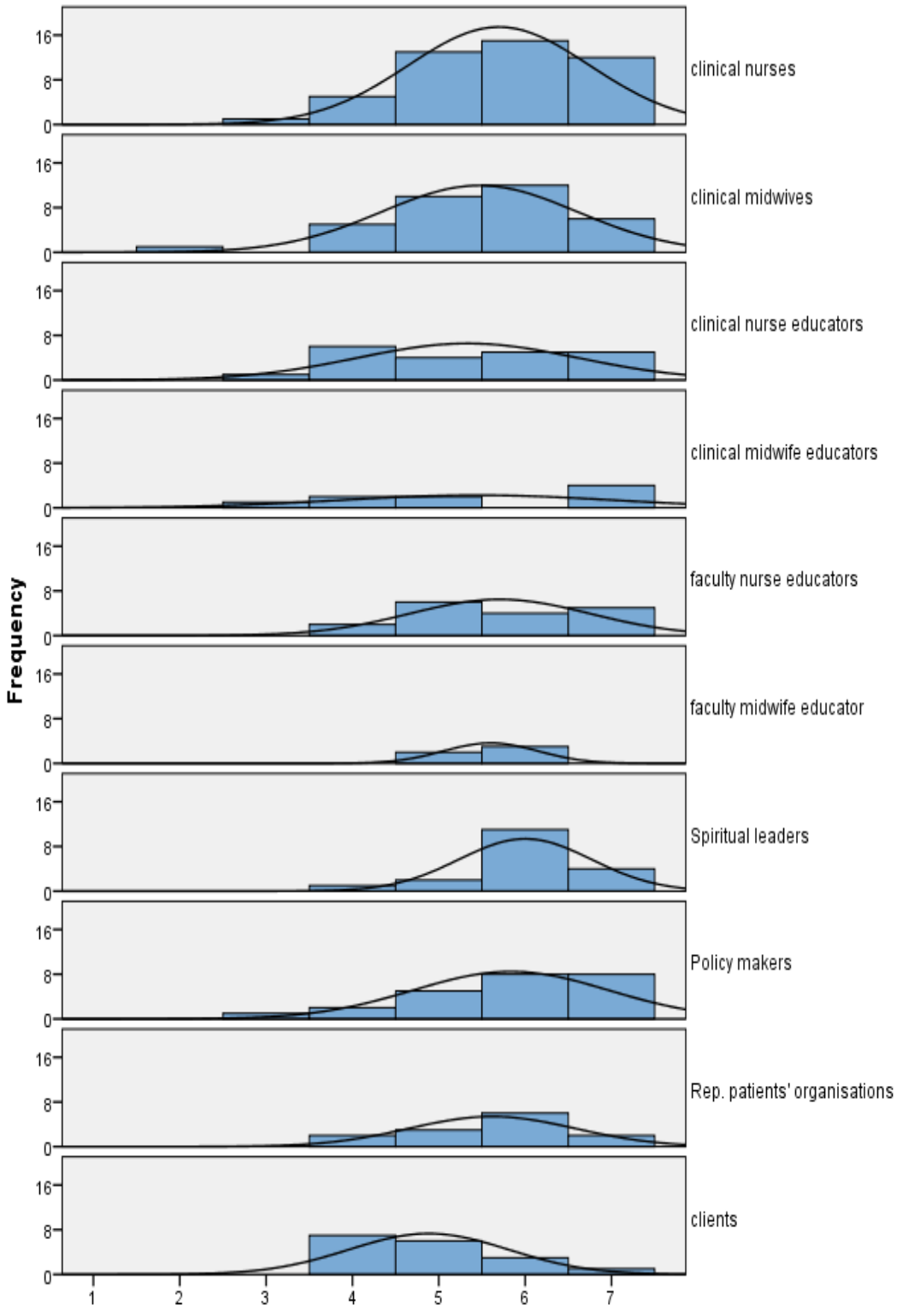
38. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all health care system



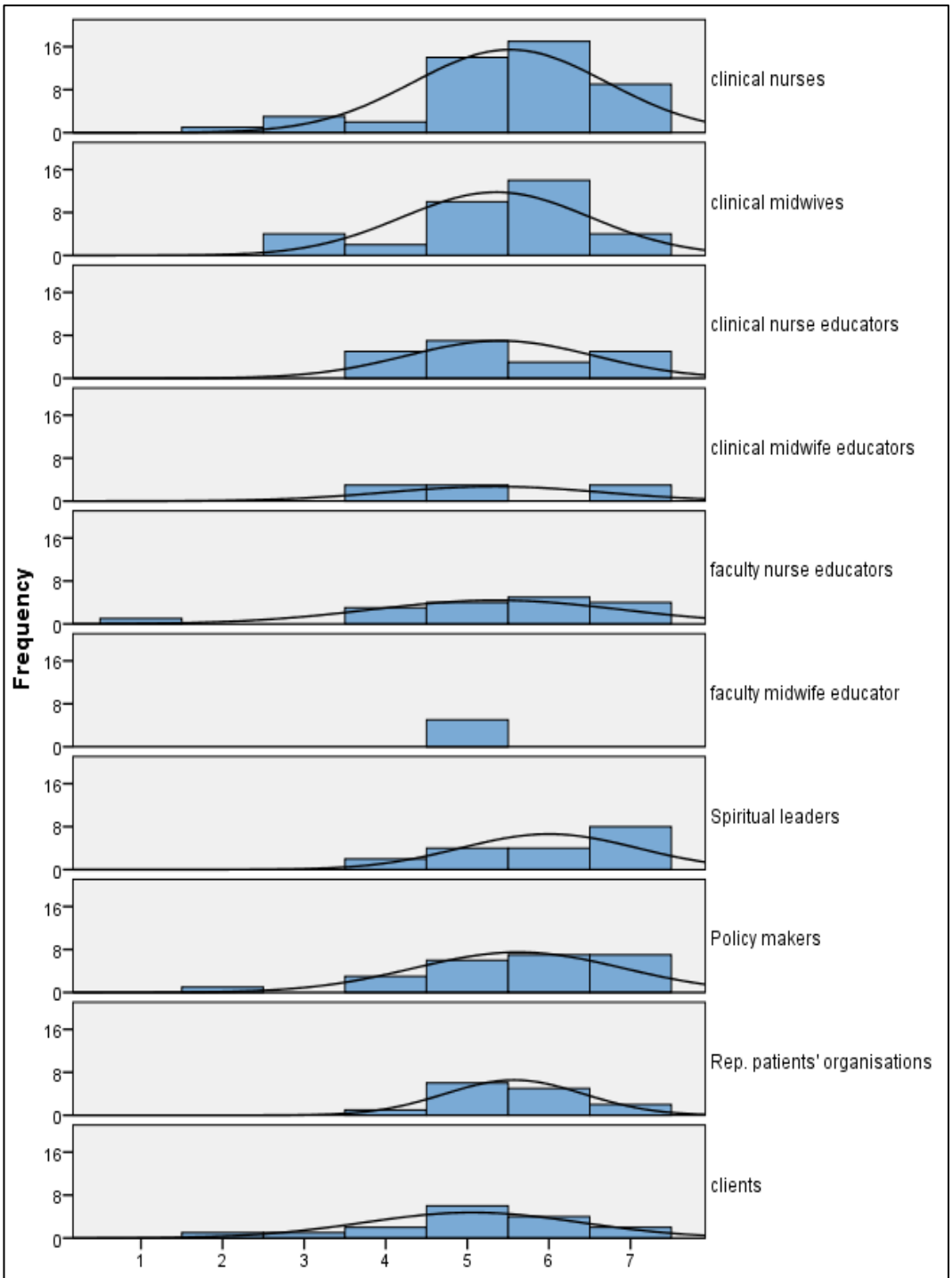
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (using an established tool) and informal (listening to the clients' experiences) assessment methods



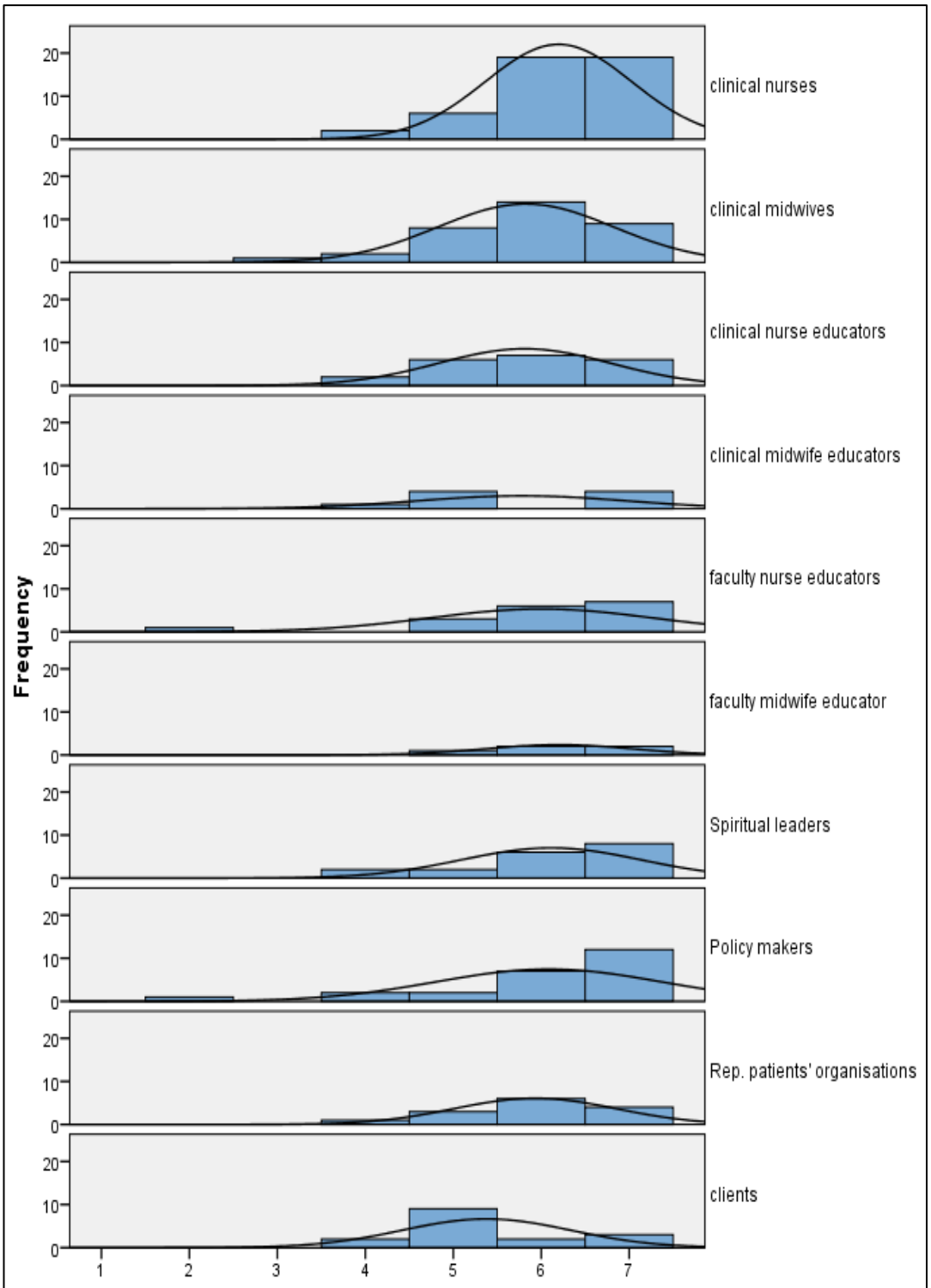
40. Identify signs of spiritual distress in clients and family (e.g. pain, anxiety, guilt, loss, and despair) and plan to address this distress while being aware of barriers to spiritual care such as lack of time and education



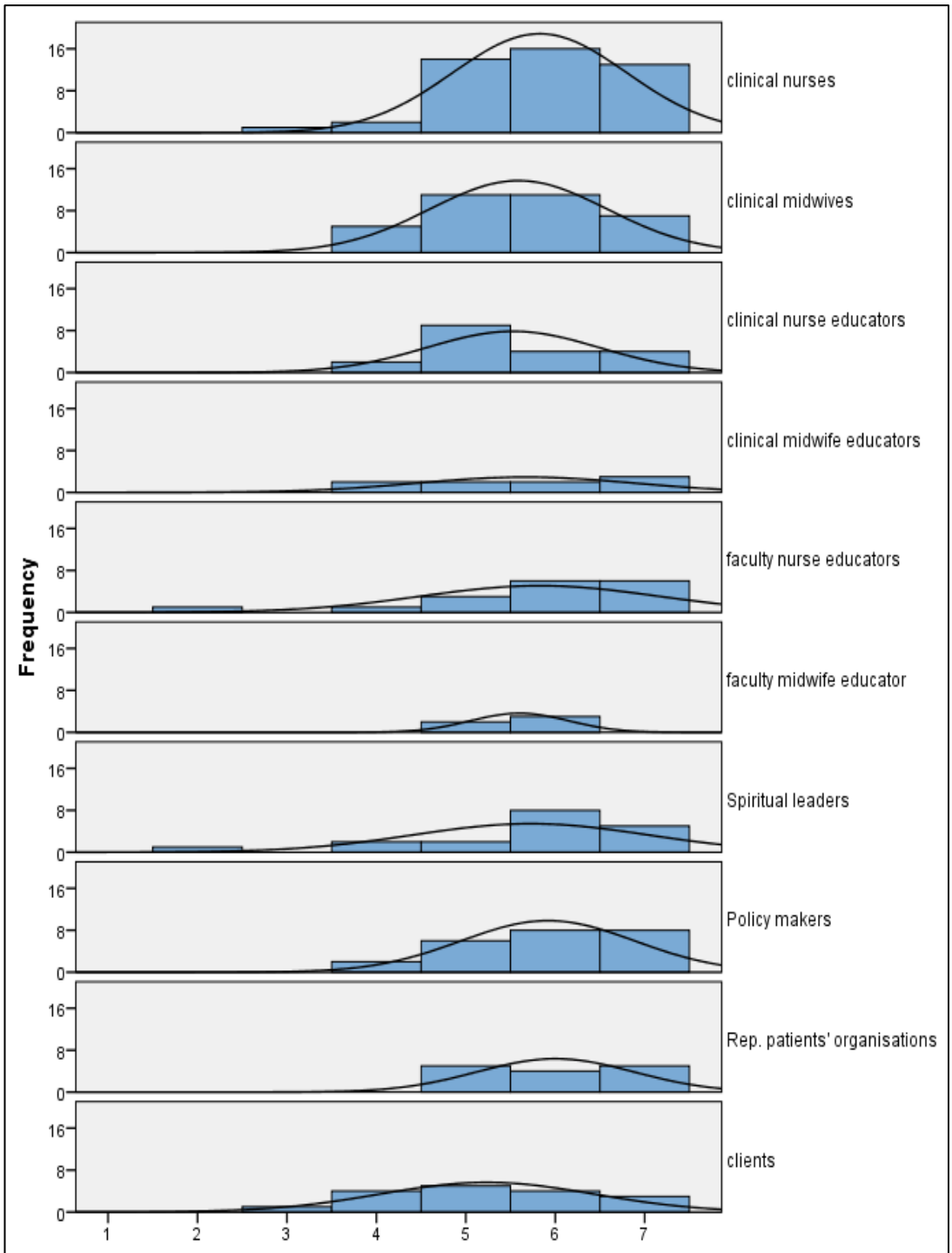
41. Plan spiritual care while identifying its intersections (shared elements) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns



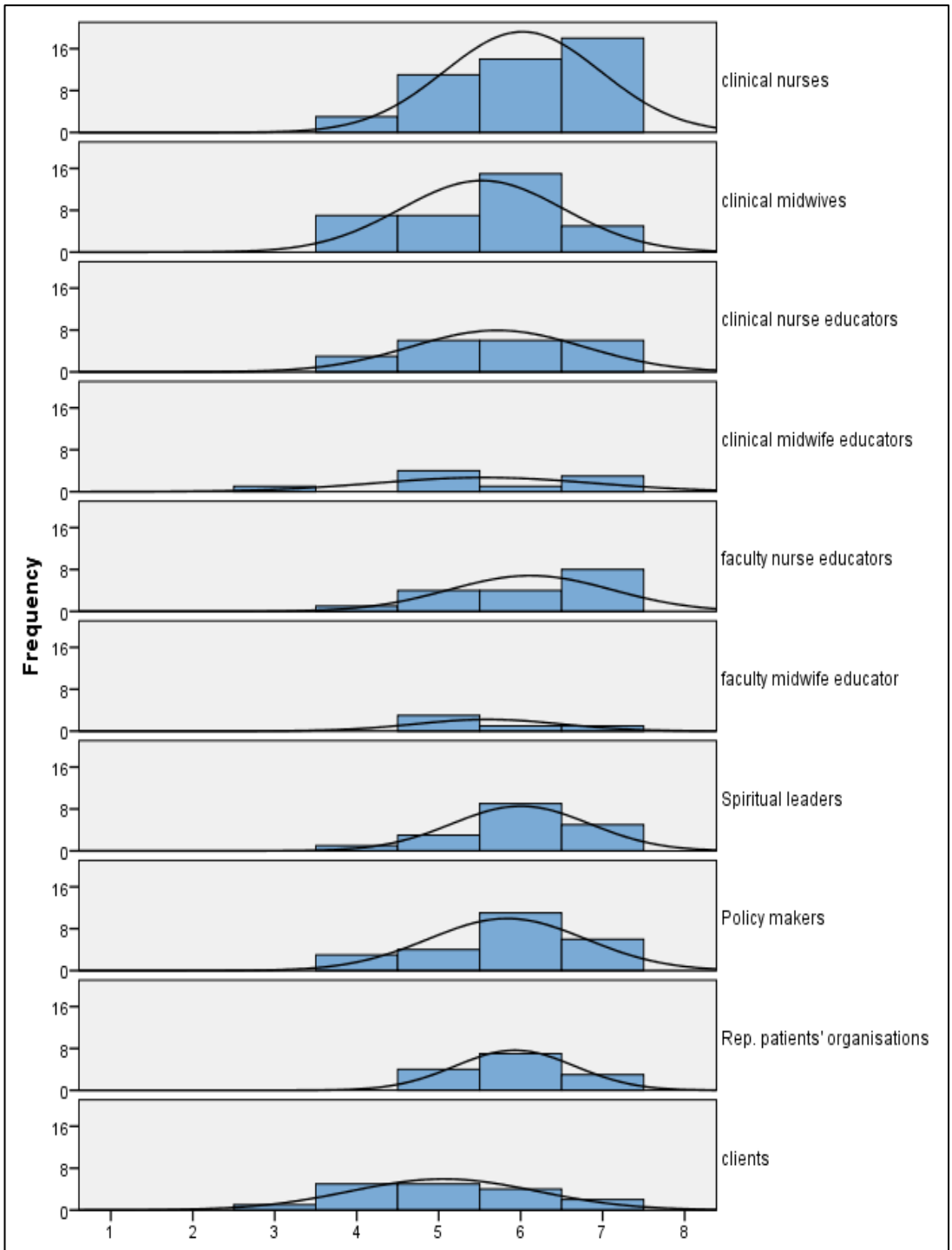
42. Develop spiritual care models which integrate client-centered care and a problem–based approach while focusing on holistic individualized care



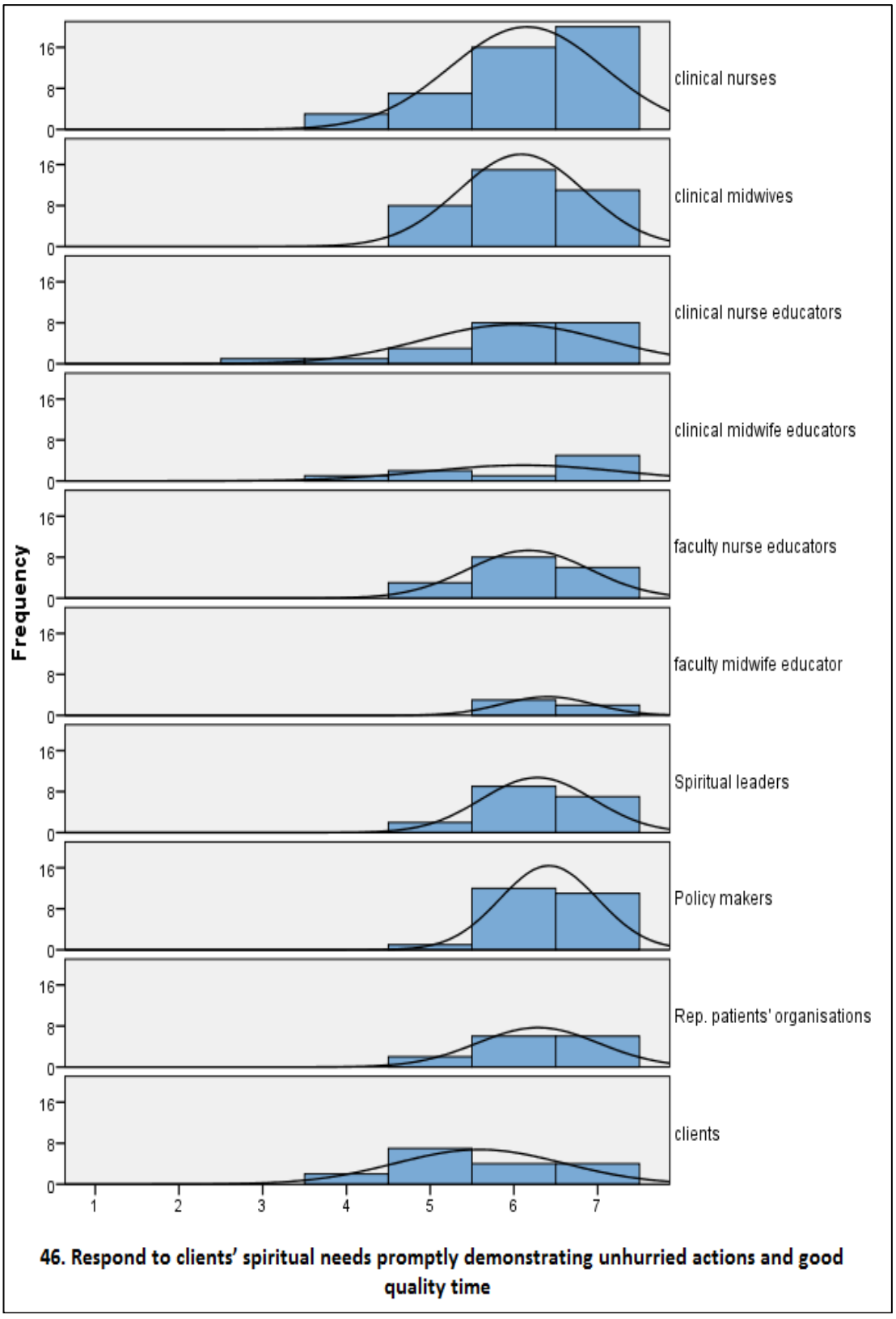
43. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically



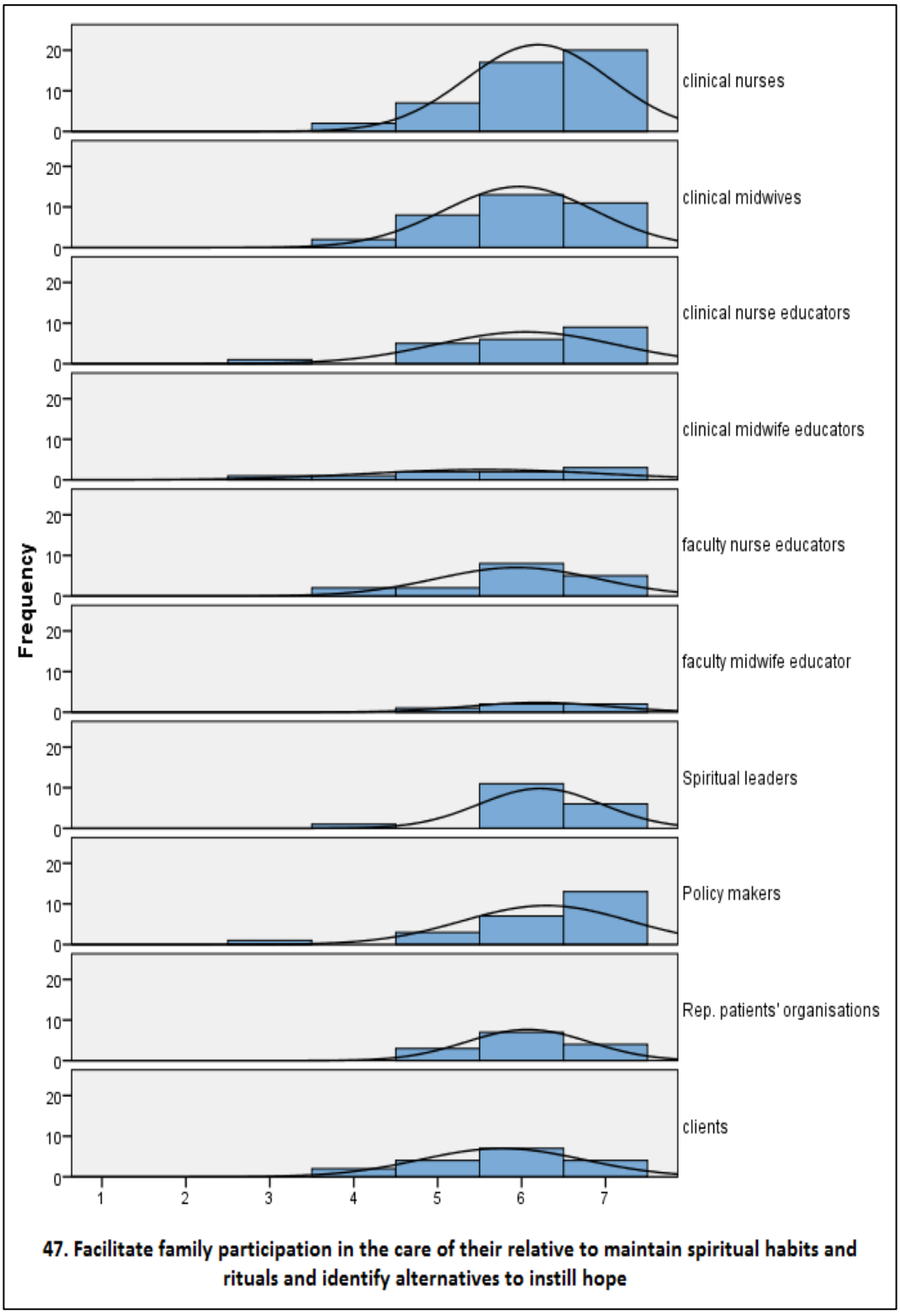
44. Understands the 'ministry of ACTION' in conveying spiritual care. i.e. helping clients find meaning in their suffering and addressing compassionately their spirituality while maintaining patience, tact, perseverance and discipline



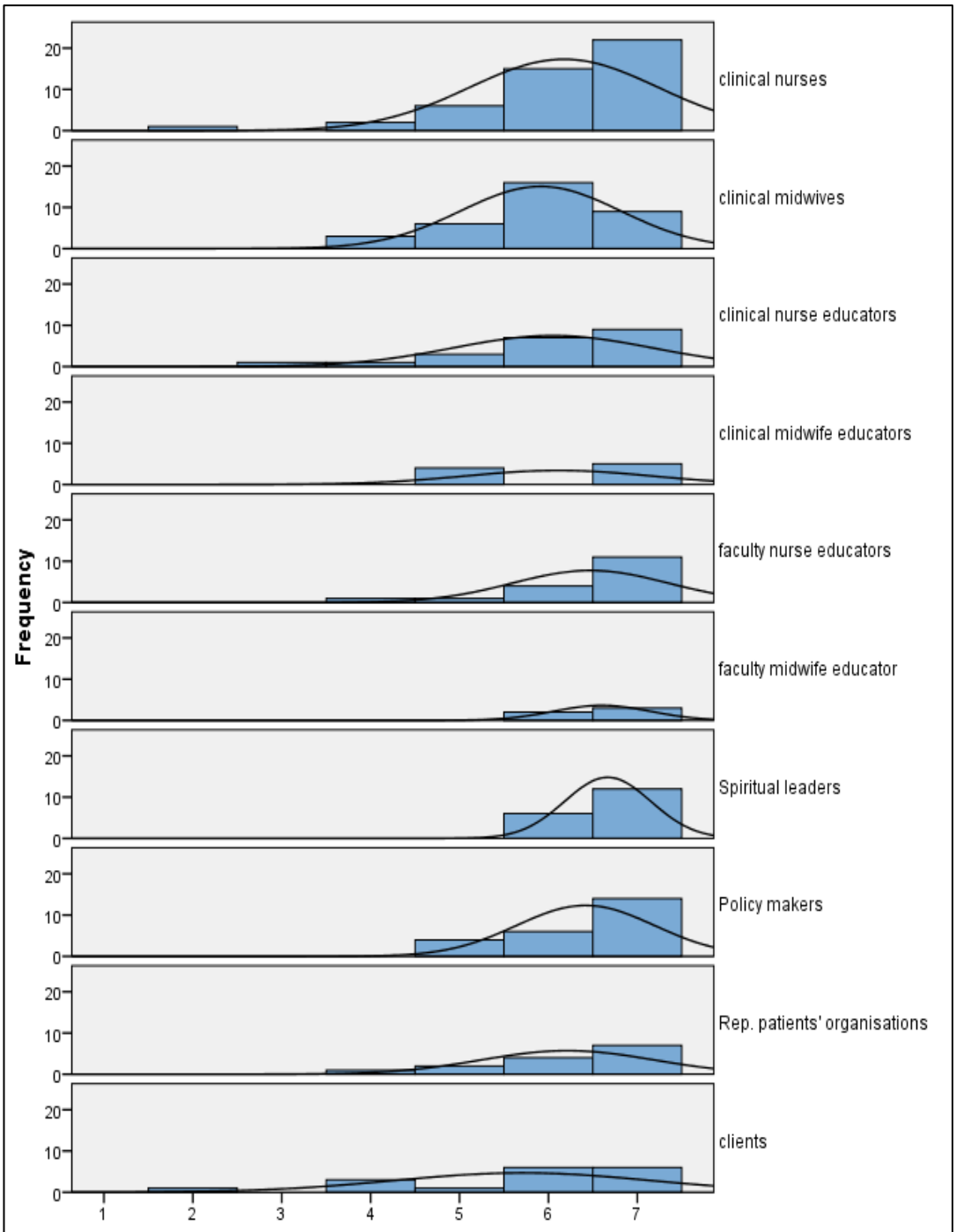
45. Provide spiritual care interventions sensitively by promoting clients' positive self- concept (e.g. positive coping techniques), monitoring spiritual expression while respecting clients who do not conform with advice on their health



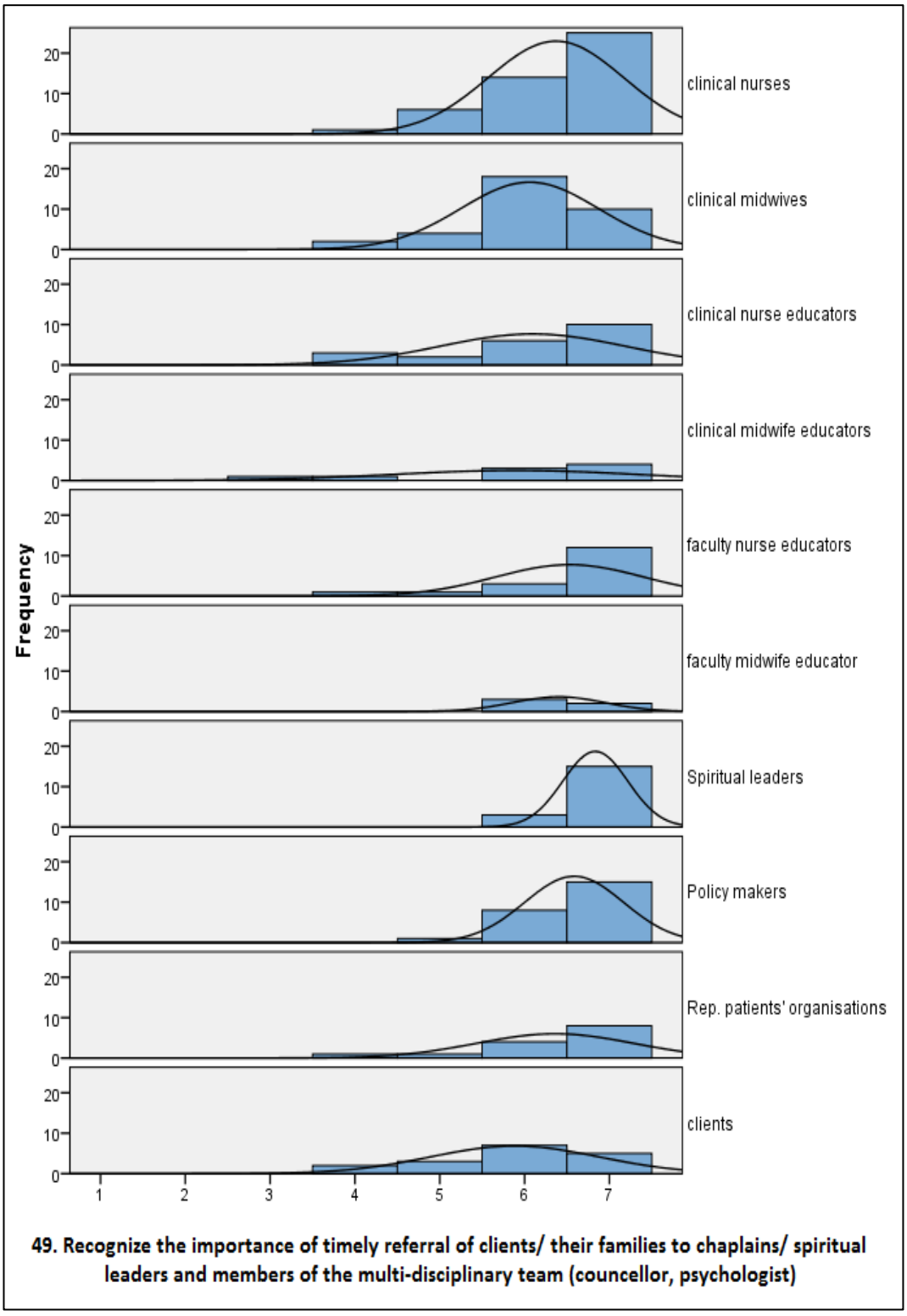
46. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time



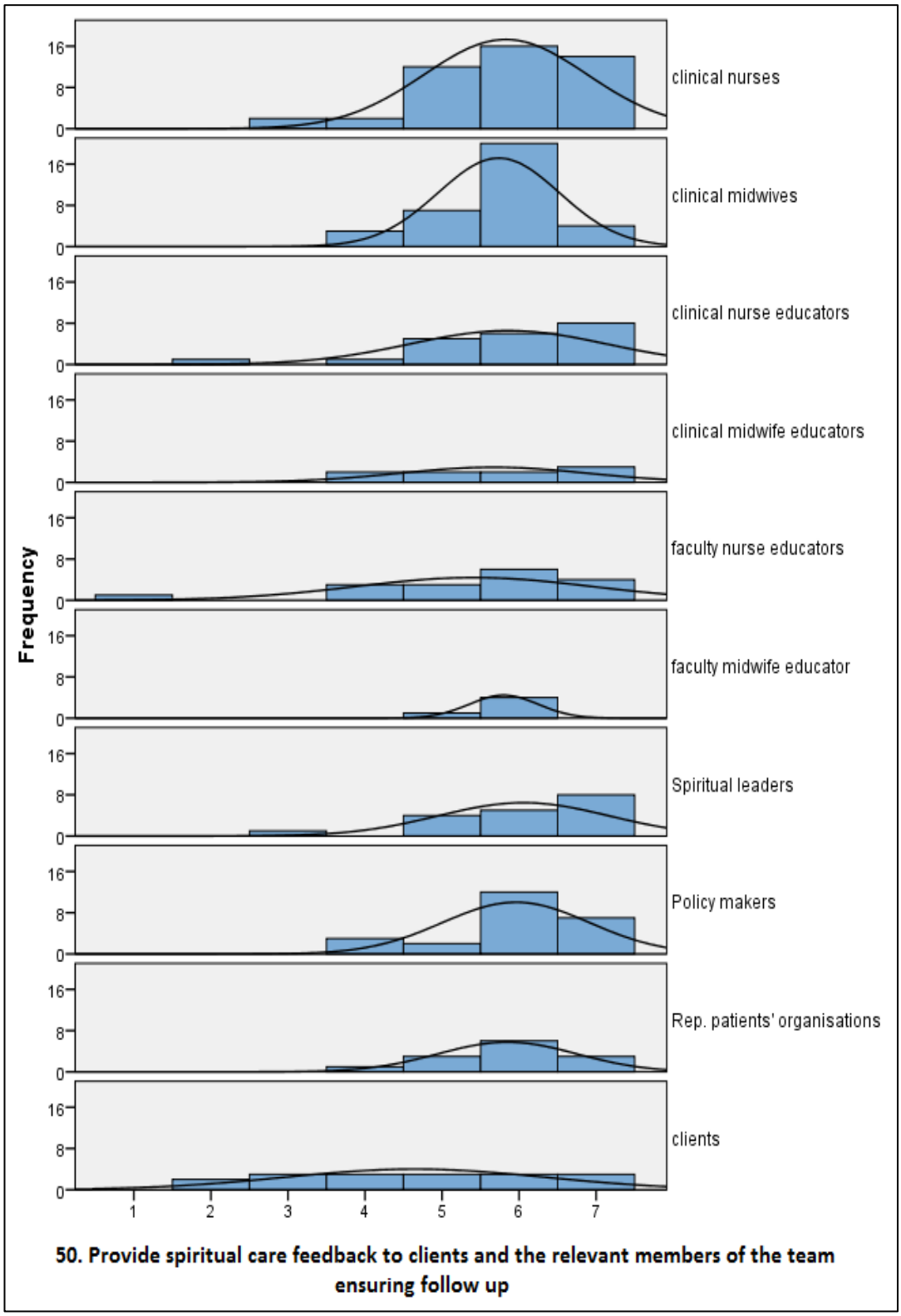
47. Facilitate family participation in the care of their relative to maintain spiritual habits and rituals and identify alternatives to instill hope



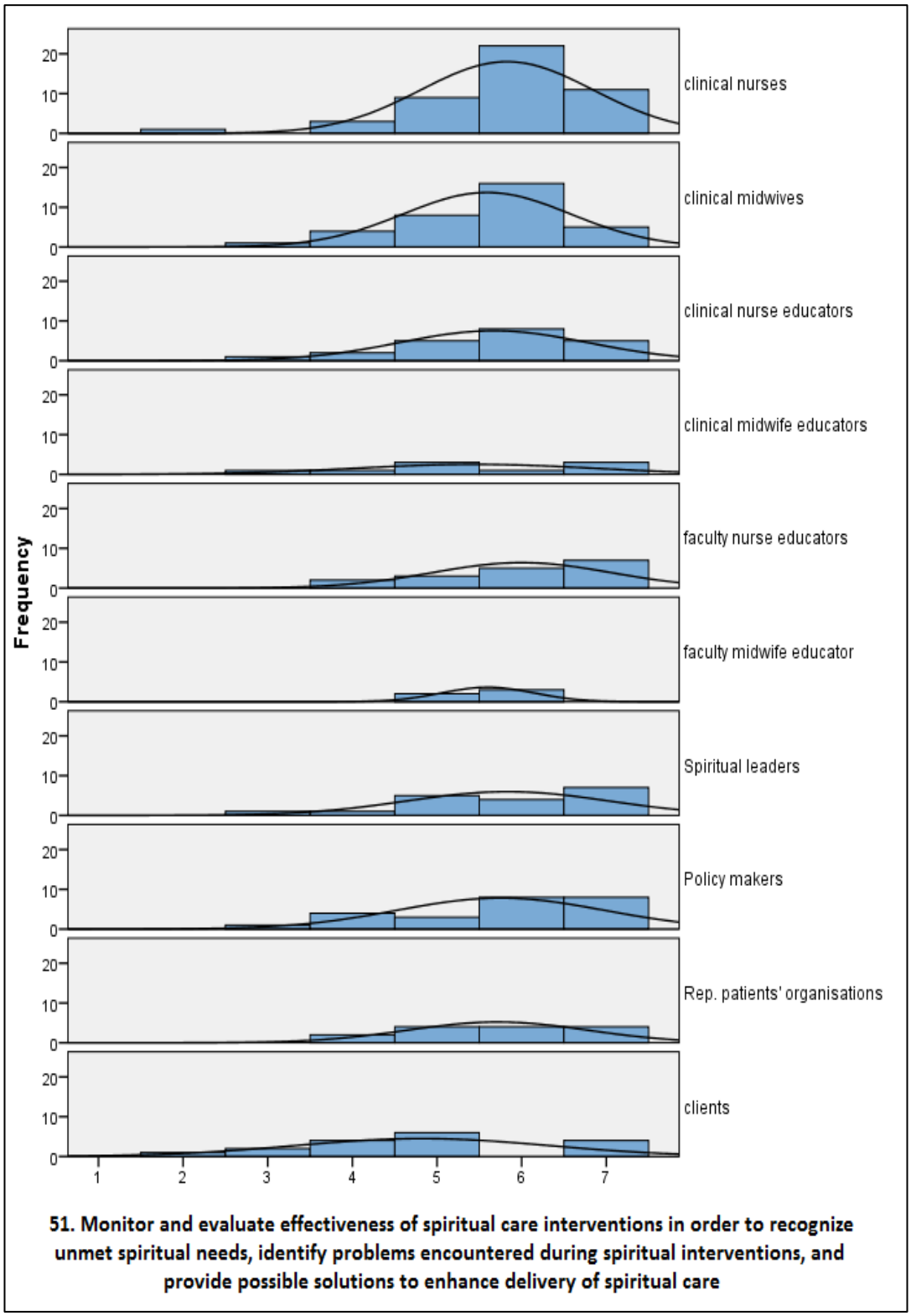
48. Recognize and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team



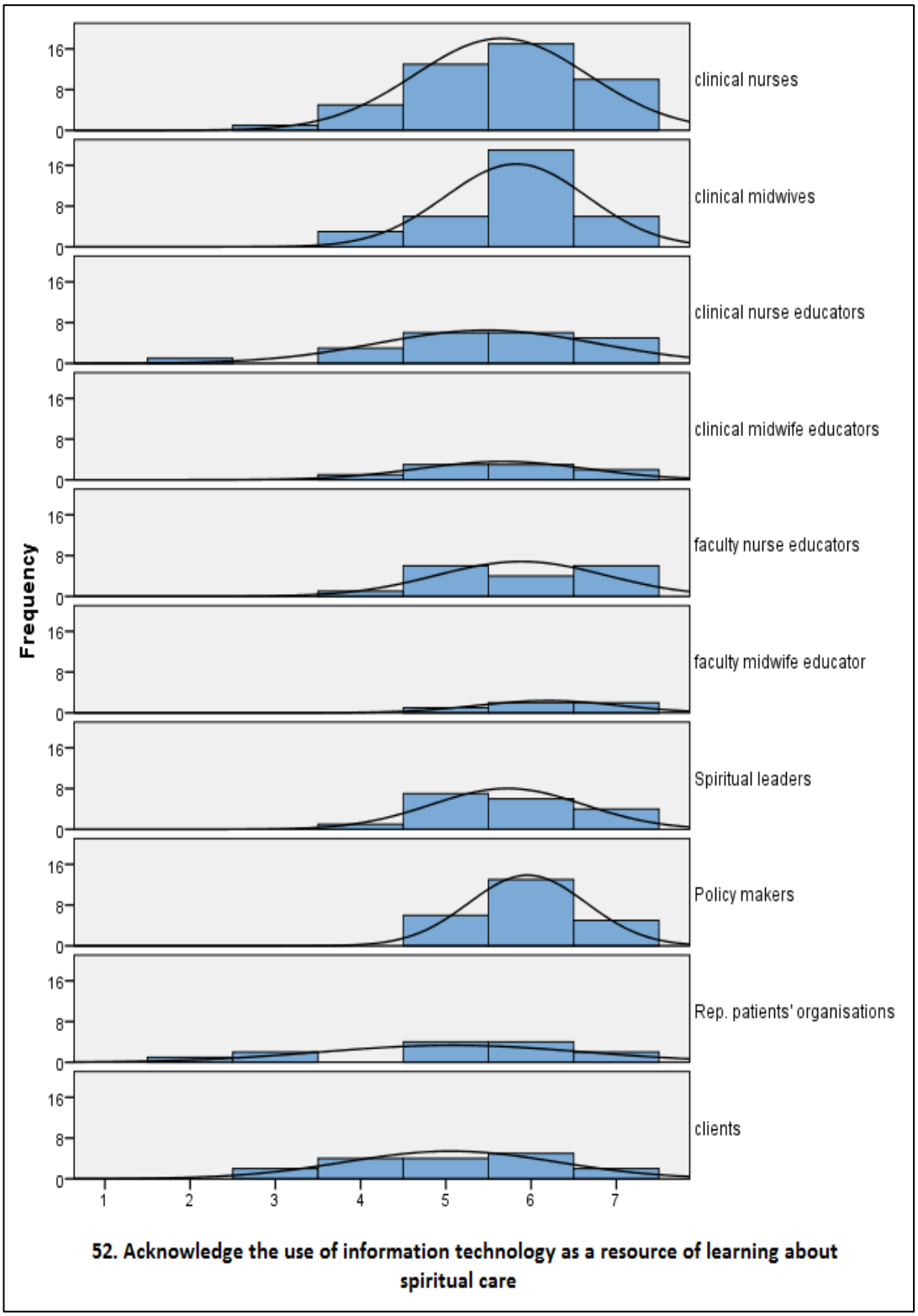
49. Recognize the importance of timely referral of clients/ their families to chaplains/ spiritual leaders and members of the multi-disciplinary team (councellor, psychologist)



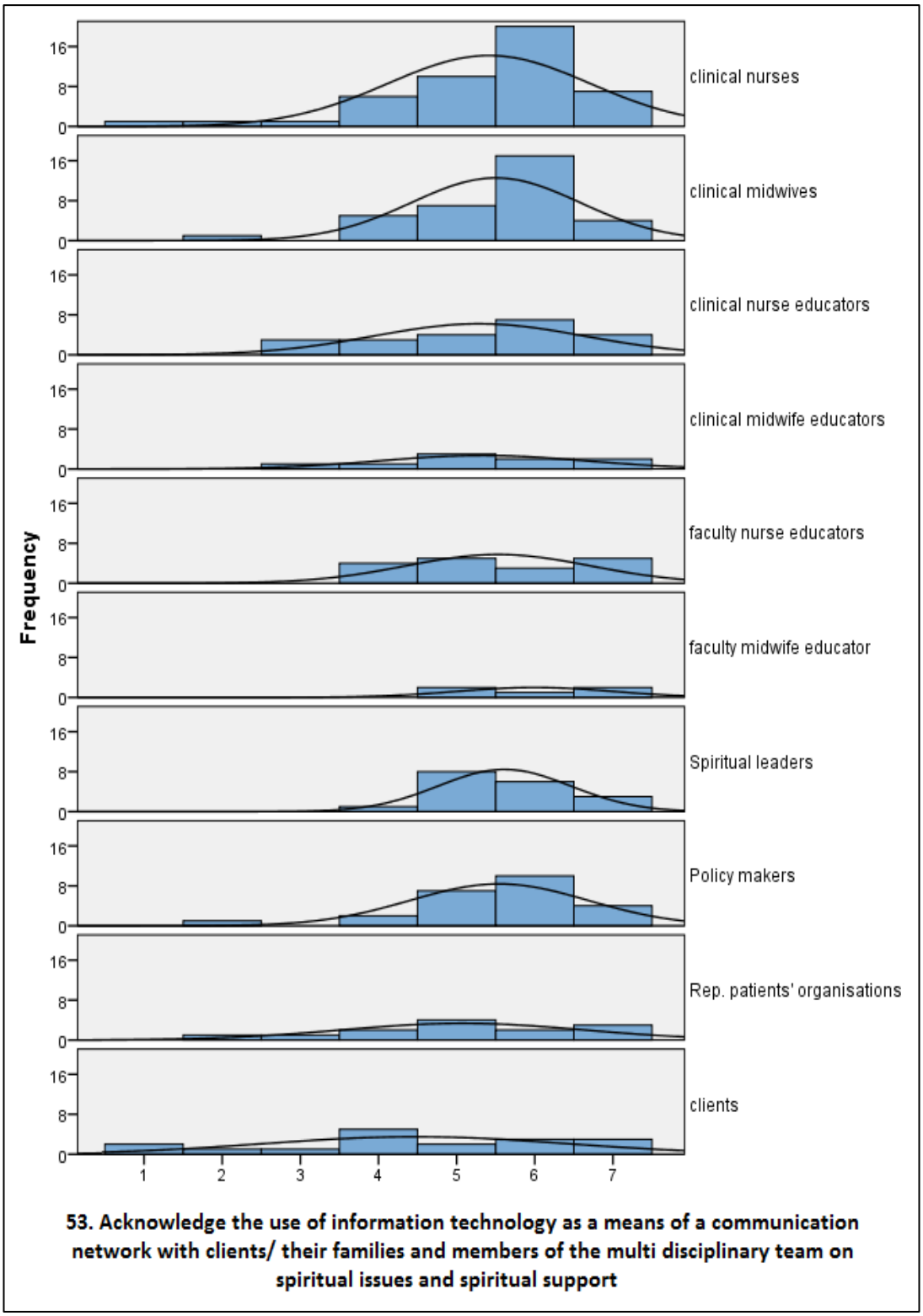
50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow up



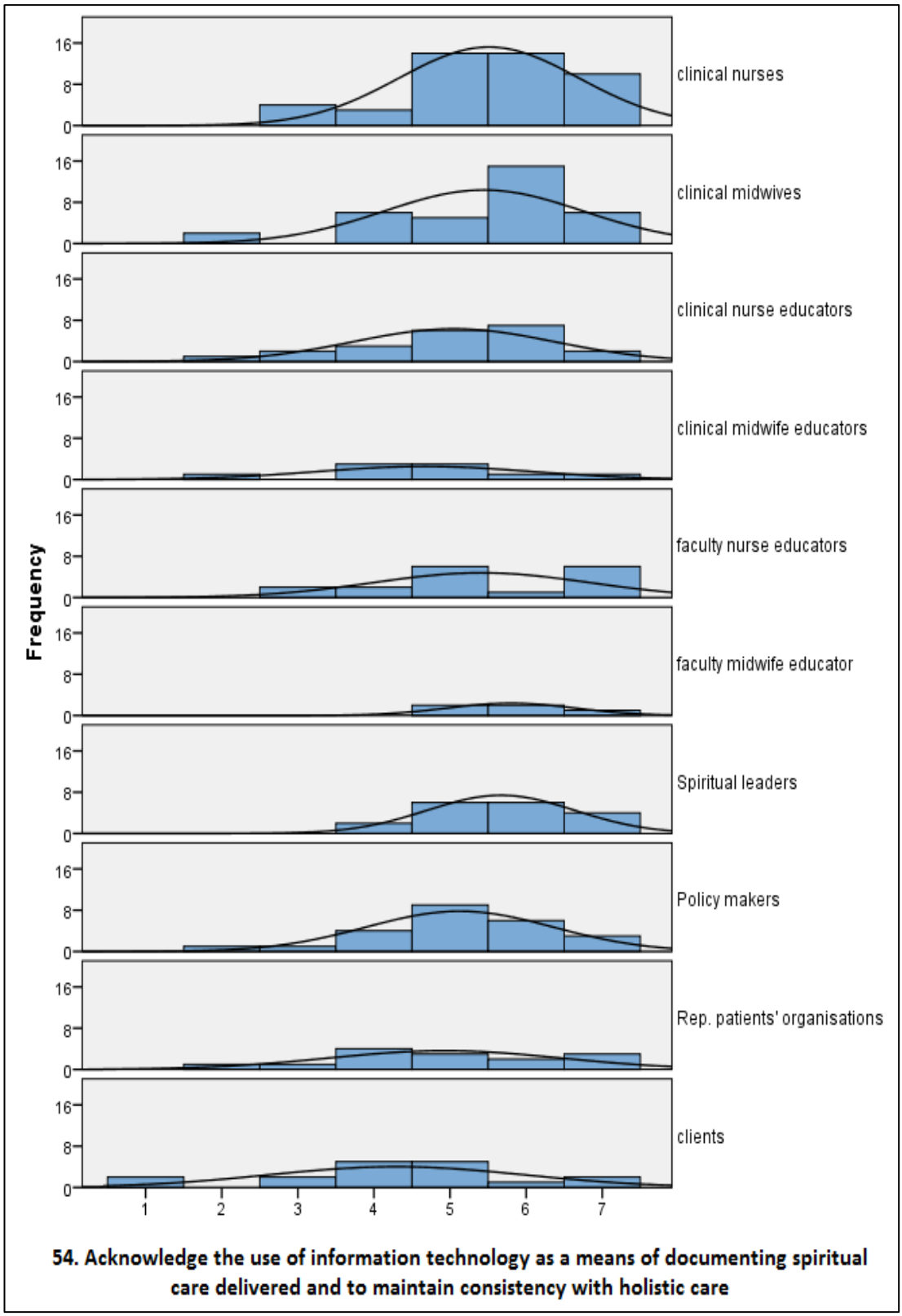
51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognize unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care



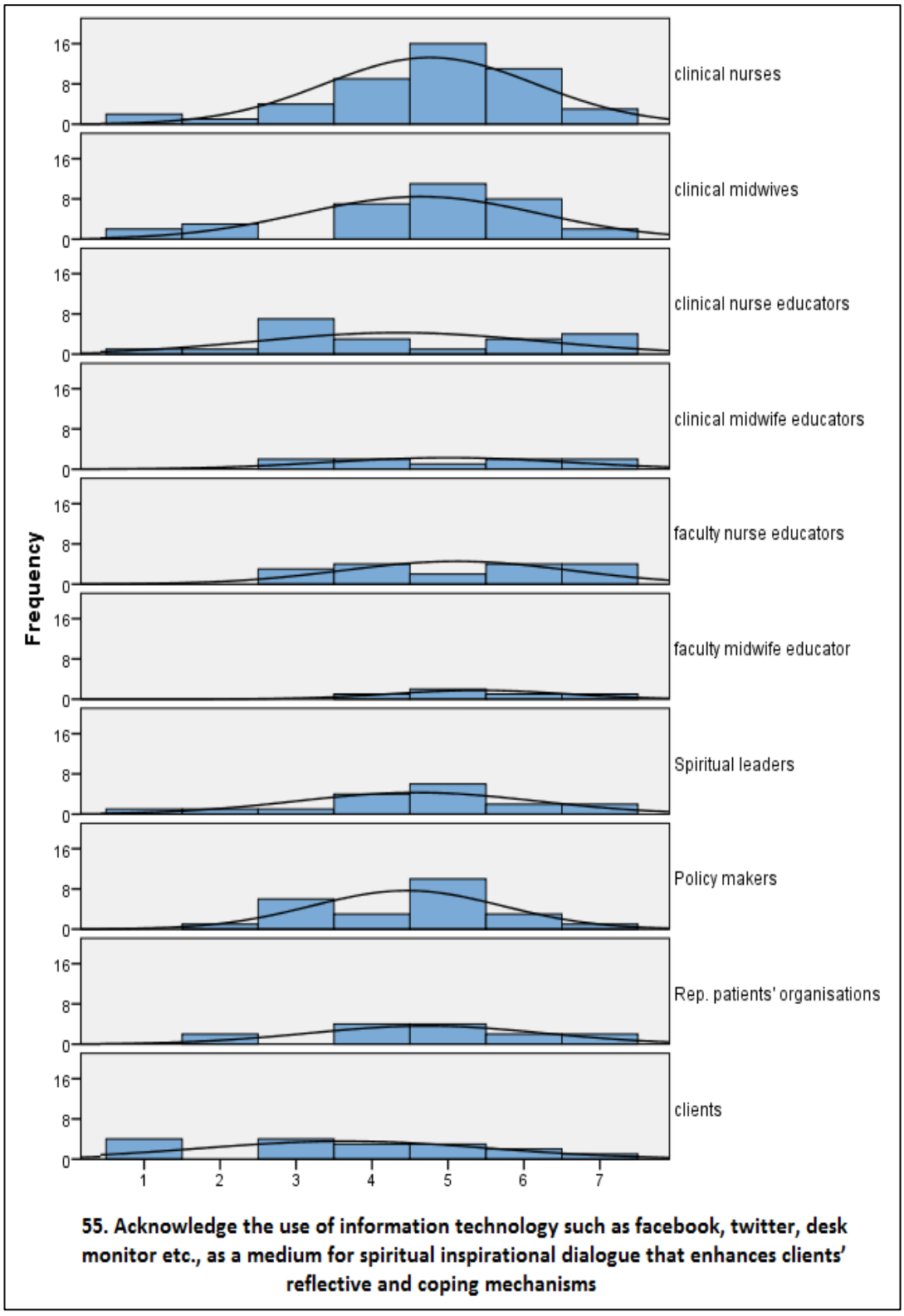
52. Acknowledge the use of information technology as a resource of learning about spiritual care



53. Acknowledge the use of information technology as a means of a communication network with clients/ their families and members of the multi disciplinary team on spiritual issues and spiritual support



54. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care



55. Acknowledge the use of information technology such as facebook, twitter, desk monitor etc., as a medium for spiritual inspirational dialogue that enhances clients' reflective and coping mechanisms

APPENDIX 32: AUTHOR'S PUBLICATIONS ON SPIRITUAL CARE

1. Nurses' and midwives' acquisition of competency in spiritual care: A focus on education.

2. The demand of competencies in spiritual care in nursing and midwifery education: a literature review.