Nurse Education Today 34 (2014) 697–702

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Student nurses perceptions of spirituality and competence in delivering spiritual care: A European pilot study

Linda Ross [a,*,1], René van Leeuwen [b,2], Donia Baldacchino [c,3], Tove Giske [d,4], Wilfred McSherry [e,5], Aru Narayanasamy [f,6], Carmel Downes [g,7,8], Paul Jarvis [h,9], Annemiek Schep-Akkerman [i,10]

[a] School of Care Sciences, Faculty of Life Sciences and Education, University of South Wales, Pontypridd, Wales CF37 1DL, UK
[b] Reformed University for Applied Sciences, Grasdorpstraat 2, 8012EN Zwolle, The Netherlands
[c] Faculty of Health Sciences, University of Malta, Malta
[d] Haraldsplass Deaconess University College, Ulriksdal 10, 5009 Bergen, Norway
[e] Centre for Practice and Service Improvement, Faculty of Health, Staffordshire University/The Shrewsbury and Telford Hospital NHS Trust, Stafford, United Kingdom
[f] University of Nottingham, Faculty of Medicine & Health Science, School of Nursing, Midwifery & Physiotherapy, Room 75, D Floor, Queens Medical Centre, Nottingham NG7 2HA, UK
[g] National Centre for the Protection of Older People, Health Sciences Centre, University College Dublin, Belfield, Dublin 4, Ireland
[h] School of Care Sciences, Faculty of Life Sciences and Education, University of South Wales, Pontypridd, Wales CF37 1DL, UK
[i] Reformed University of Applied Sciences, Grasdorpstraat 2, 8012 EN Zwolle, The Netherlands

ARTICLE INFO

Article history:
Accepted 17 September 2013

Keywords:
Spirituality
Spiritual care
Nurse education
Spiritual care competence

SUMMARY

Background: Spiritual care is expected of nurses, but it is not clear how undergraduates can achieve competency in spiritual care at point of registration as required by nursing/midwifery regulatory bodies.
Aims: To describe undergraduate nurses'/midwives' perceptions of spirituality/spiritual care, their perceived competence in delivering spiritual care, and to test out the proposed method and suitability of measures for a larger multinational follow-on study.
Design: Cross-sectional, multinational, descriptive survey design.
Methods: Author administered questionnaires were completed by 86% of the intended convenience sample of 618 undergraduate nurses/midwives from 6 universities in 4 European countries in 2010.
Results: Students held a broad view of spirituality/spiritual care and considered themselves to be marginally more competent than not in spiritual care. They were predominantly Christian and reported high levels of spiritual wellbeing and spiritual attitude and involvement. The proposed method and measures were appropriate and are being used in a follow-on study.
Conclusions: The following are worthy of further investigation: whether the pilot study findings hold in student samples from more diverse cultural backgrounds; whether students' perceptions of spirituality can be broadened to include the full range of spiritual needs patients may encounter and whether their competence can be enhanced by education to better equip them to deliver spiritual care; identification of factors contributing to acquisition of spiritual caring skills and spiritual care competency.

Introduction

The spiritual aspect of life is recognised as having an important part to play in health, wellbeing and quality of life. This can be seen in: work globally (e.g. WHO, 2002a); the increasing body of scientific evidence indicating that spirituality has significant mental and physical health benefits (e.g. Koenig et al., 2012) and that spiritual care is integral to patients' wellbeing (Ross, 2006; Nixon et al., 2013); the attention given to spiritual care within health services e.g. employment of hospital chaplains. A plethora of spiritual/religious care guidance, policy and education documentation is also available internationally (e.g. WHO, 2002b; NICE, 2004; Department of Health, 2009; www.palliatief.nl).

Spiritual care is expected of nurses as can be seen internationally in nursing codes of ethics (e.g.Malta Code of Ethics, 1997; International

* Corresponding author at. School of Care Sciences, Faculty of Life Sciences and Education, University of South Wales, Pontypridd, CF37 1DL, UK.
E-mail addresses: linda.ross@southwales.ac.uk (L. Ross), rleeuwen@gh.nl (R. van Leeuwen), donia.baldacchino@um.edu.mt (D. Baldacchino), Tove.giske@haraldsplass.no (T. Giske), w.mcsherry@staffs.ac.uk (W. McSherry), Aru.Narayanasamy@nottingham.ac.uk (A. Narayanasamy), carmel.downes@ucd.ie (C. Downes), paul.jarvis@southwales.ac.uk (P. Jarvis), aschep-akkerman@gh.nl (A. Schep-Akkerman).
[1] Tel.: +44 1443 483109; fax: +44 1443 483118.
[2] Tel.: +31 634781680.
[3] Tel.: +356 2340 1847.
[4] Tel.: +47 55979630.
[5] Tel.: +44 1785 353630.
[6] Tel.: +44 115 823 0808.
[7] Tel.: +353 1 716 6462.
[8] Work undertaken whilst at the University of South Wales.
[9] Tel.: +44 1443 483614; fax: +44 1443 483019.
[10] Tel.: +31 38 4255573; fax: +31 38 4230785.

0260-6917/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.nedt.2013.09.014

Council of Nurses, 2000; Nursing and Midwifery Council, 2008) and nurse education guidelines (e.g. Quality Assurance Agency for Higher Education, 2001; Kunnskapsdepartementet, 2008; NMC, 2010; V and VN, 2012). For example, in the UK, The NMC expects:

> "All nurses must carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement."
>
> [NMC, 2010; p18]

Despite the inclusion of spiritual care within nurse education guidelines, there is still uncertainty as to how the subject should be formally taught and integrated within pre-registration/undergraduate nurse education programmes. Research is starting to address this question.

Defining Spirituality/Spiritual Care

Within nursing, whilst spiritual care is expected, there is no single shared definition of 'spirituality' and 'spiritual care' (McSherry and Ross, 2010). Indeed there is the view that constructing an authoritative definition of spirituality may not be possible and indeed may be unhelpful (Swinton and Pattison, 2010). Some critique spirituality and argue that it is all about psychosocial needs (Paley, 2008), however, studies done by the World Health Organization Quality of Life Spirituality, Religion and Personal Beliefs group (WHOQOL SRPB Group, 2006) have developed eight facets that can assist in distinguishing the spiritual from the psychosocial. They are: connectedness to a spiritual being or force, meaning of life, awe, wholeness and integration, spiritual strength, inner peace/serenity/harmony, hope and optimism, and faith.

In a similar vein, in order to guide nursing practice, the Royal College of Nursing (2011) summarises the main attributes of spirituality (derived from a wide range of definitions): hope and strength; trust; meaning and purpose; forgiveness; belief and faith in self, others, and for some belief in a deity/higher power; peoples' values; love and relationships; morality; creativity and self-expression.

The RCN also offers nurses guidance on the practice of spiritual care (Royal College of Nursing, 2012a,b) and quotes the following definition:

> (Spiritual care is) '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]

Spiritual Care Competency

Several nursing academics (van Leeuwen and Cusveller, 2004; Baldacchino, 2006) have grappled with the conceptual, theoretical and practical challenges of developing competencies in spiritual care. One of the main limitations of these investigations is the homogenous samples and the Judaeo-Christian focus (Tiew and Creedy, 2011). They do, however, raise vital questions about: the nature of spirituality; the relationship of spiritual care within nursing practice; what competence in spiritual care means and how it can be measured; and if nurses can be taught spiritual care (Bradshaw, 1997), something that many studies have called for (Ross, 1996; McSherry et al., 2008).

Spiritual care competency has been defined as the knowledge, skills and attitudes required for spiritual care delivery, and a measure of spiritual care competency has been developed (van Leeuwen et al., 2009). Emerging evidence indicates that spiritual care teaching may result in: a broadening of nurses, and in some cases students', understanding and knowledge of the complex nature of spirituality; enhanced spiritual awareness; a more client-centred approach; improved communication skills and personal impact (van Leeuwen et al., 2008; Giske and Cone, 2012; Cooper et al., 2013). Clinical practice may offer students additional opportunities for acquiring the knowledge, skills and attitudes necessary for spiritual care (Giske, 2012), but it remains to be seen what impact clinical staff acting as role models may have. Robust conclusions cannot be drawn from these studies, however, because of variation in interventions, research methods, samples and methodological rigour.

Some studies raise more fundamental questions such as to what extent personal characteristics influence how spiritual care is carried out (Ross, 1994, 1996). van Leeuwen et al. (2008) report that students' personal spirituality was the strongest predictor of perceived ability to provide spiritual care, and Taylor et al. (2008) found that it was frequency of attending religious services and spiritual experiences that contributed to students' attitude toward spiritual care. It was not whether participants were studying or working in a religious milieu, it was personal religiosity and spirituality that mattered. The importance of self-awareness and the ability to clarify personal values and beliefs are widely reported in the literature (Taylor et al., 2008; Giske, 2012) and require further investigation in relation to spiritual care.

A robust multinational study is needed to identify the factors which help student nurses/midwives to develop an understanding of the complex nature of spirituality and to acquire competency in spiritual care. Before such a study can commence it is necessary to identify and test out appropriate measures of study outcomes and the study method within an international context. Testing of the measures would also provide opportunity for the authors to capture how students' from a number of countries perceive spirituality/spiritual care and how they evaluate their competence in spiritual care; information useful to them in developing their spirituality teaching.

Method

Aims

1. To describe how student nurses/midwives perceive spirituality/spiritual care.
2. To describe how competent student nurses/midwives perceive themselves to be in delivering spiritual care.

Design

Cross-sectional, multinational, descriptive survey design using researcher administered questionnaires. This quantitative approach enabled large amounts of standardised data to be collected from entire student cohorts from 4 European countries in anonymised format in September 2010. It also provided the opportunity for the suitability of the measures and research method to be tested within a multinational context.

Sample

The target convenience sample was 618 undergraduate nursing/midwifery students at 6 universities in 4 countries (Table 1). A response rate of 86% was achieved; 531 students completed the questionnaires. Thus the findings can be considered to be representative of the target sample, but not necessarily of all student nurses undertaking nurse training in the countries included.

Participating universities were members of the European Spirituality Research Network for Nursing and Midwifery and were seeking to develop their spirituality teaching through this research. The selection also provided a mix of religious and secular universities. Ethical approval was obtained from ethics committees within each university and external organisations as required by each country. Participation of universities

Table 1
Origins of the sample.

Country	Type of university included (religious or secular)	Year of course	Total students present on day of data collection	No. of students completing full set of measures	% of sample completing full set of measures
Wales, UK	1 × secular	1	188	147	27.7
Malta	1 × secular	1	182	181	31.4
Netherlands	2 × religious 1 × secular	3, 4	136	136	25.6
Norway	1 × religious	1	82	67	12.6
Total			618	531	100.00

and students was voluntary and anonymity and confidentiality were assured.

The sample was given verbal and written information about the study 1–2 weeks in advance of the questionnaires being administered by the authors during class time. Those not wishing to participate returned blank forms.

Data Collection

Five questionnaires addressing the study aims were selected on the basis of fitness for purpose, validity and reliability from a review of the literature as follows.

The following three questionnaires were selected to capture personal characteristics of the sample as there was indication from the literature that students' personal spirituality, values and beliefs may impact upon their spiritual care practice.

- Purpose designed demographic questionnaire asking questions about gender, age, educational background, religious affiliation/life view etc.
- JAREL Spiritual well-being Scale (Hungelmann et al., 1996). JAREL measures spiritual wellbeing and contains 21 items scored 1–6 with high scores (maximum 126) indicating high spiritual wellbeing and low scores (lowest 21) indicating low spiritual wellbeing. The scale incorporates 3 subscales: faith/belief; life/self responsibility; life satisfaction/self actualization. All 21 items loaded at 0.50 or above for all 3 factors (Hungelmann et al., 1996). Treated as a categorical variable, JAREL measures three levels of spiritual wellbeing: low (0–50); medium (51–84) and high (85–126). JAREL was selected because of its inclusion of both existential and religious domains of spirituality ensuring relevance to religious and secular universities. It was specifically developed for nursing.
- Spiritual Attitude and Involvement List (SAIL, Meezenbroek et al., 2008). SAIL consists of 26 items arranged in 3 dimensions with 7 subscales: Connectedness to oneself (meaningfulness, trust, acceptance); to the environment/others (caring for others, connectedness with nature); to the transcendent (transcendent experiences, spiritual activities). Psychometric properties were tested in five samples differing in age, spiritual and religious background, and physical health. Factorial, convergent and discriminant validity were demonstrated, and each subscale showed adequate internal consistency and test-retest reliability (Meezenbroek et al., 2008). SAIL can be employed as a continuous measure ranging from 1 to 6 with higher scores indicating higher levels of spiritual attitude/involvement or it can be employed as a binary variable whereby high spiritual attitude/involvement is indicated by a SAIL score >4.

Perceptions of Spirituality/Spiritual Care

The Spirituality & Spiritual Care Rating Scale was selected to measure students' perceptions of spirituality and spiritual care (SSCRS, McSherry et al., 2002). It is a valid and reliable measure of spirituality/spiritual care with the intended sample. It has been used in over 42 studies in 11 countries demonstrating consistent levels of reliability & validity with Cronbach's alpha scores ranging from 0.64 (McSherry, 1997) to 0.84 (Khoshknab et al., 2010). There are 17 statements scored on a 5 point scale from 'strongly agree' to 'strongly disagree'. A high overall score indicates a broader view of spirituality (i.e. inclusive of both religious and existential elements) and spiritual care (i.e. facilitating religious rites/rituals as well as addressing patients' need for meaning, value, purpose, peace and creativity). In previous studies the SSCRS has produced a 4 factor model including: existential spirituality (view that spirituality is concerned with peoples' sense of meaning, purpose, value, peace and creativity i.e. items f,h,i,j,l); religiosity (view that spirituality is only about religious beliefs/practises i.e. items d,m,p); spiritual care (view of spiritual care in its broadest sense including religious and existential elements e.g. facilitating religious rituals and showing kindness i.e. items a,b,g,k,n) and personal care (taking account of peoples' beliefs and values and dignity i.e. items n,o,q) (McSherry et al., 2002). The Scale, however, has not yet been used to intentionally explore these factors within samples.

Spiritual Care Competence

The Spiritual Care Competency Scale (SCCS, van Leeuwen et al., 2009) was chosen to measure students' perceptions of their competence in delivering spiritual care. It is a valid and reliable measure of spiritual care competency with the intended sample. Cronbach's alpha domains range from 0.56 to 0.82. It has good homogeneity, average inter-item correlations >0.25 and good test-retest reliability (van Leeuwen et al., 2009). It contains 27 items scored on a 5 point scale from 'completely disagree' to 'completely agree', therefore the highest possible competency score is 135 and the lowest is 27. There are 6 subscales measuring: assessment and implementation of spiritual care; professionalization and improving the quality of spiritual care; personal support and patient counselling; referral to professionals; attitude towards patients' spirituality; communication. The SCCS can be employed as a continuous measure of competency ranging from 1 to 5 with higher scores indicating higher levels of perceived competency or it can be employed as a binary variable whereby competency is indicated by a mean SCCS score across all questions >3.5.

The questionnaires were translated from English into Norwegian and Dutch using a forward–backward translation protocol by two translators who were fluent in English. The two translations were compared by the researcher in charge. Adjustments were made with the consent of both translators resulting in a single version. This version was back translated into English by two bilingual translators who did not have access to the original English version of the questionnaire. The backward translation was compared and considered equivalent to the original version.

The construct validity of the translated questionnaires was tested by comparing them with the original versions and was demonstrated for almost all items.

The computed Cronbach's alpha, which is a reliability coefficient based on internal consistency, was 0.61 for the Dutch version and 0.80 for the Norwegian version indicating satisfactory to high reliability.

Table 2
Demographic characteristics of the sample (n = 531).

		% (n)
Gender (n = 531)	Female	85.1 (450)
	Male	14.9 (79)
Age (n = 529)	Up to 20	57.1 (302)
	21–25	22.9 (121)
	26–30	5.9 (31)
	31–40	8.9 (47)
	41 and over	5.3 (28)
Education (n = 497)	Secondary	66.4 (330)
	Further	29.8 (148)
	Higher	3.8 (19)
Type of course (n = 531)	Nursing	94.7 (503)
	Midwifery	5.3 (28)
Type of university (n = 531)	Secular	61.8 (328)
	Religious	38.2 (203)
Healthcare experience (n = 519)	No	59.9 (311)
	Yes	40.1 (208)
Number of years health care experience (n = 208)	1 year or less	38.0 (79)
	Over 1 yr to 5 yrs	41.8 (87)
	Over 5 years to 10 year	11.1 (23)
	Over 10 years	9.1 (19)
Life view (n = 519)	Christian*	80.1 (416)
	Atheist	5.8 (30)
	Humanist	3.0 (16)
	Agnostic	1.1 (6)
	Muslim*	0.6 (3)
	Jewish	0.4 (2)
	Buddhist*	0.2 (1)
	Hindu*	0.2 (1)
	Greek Orthodox*	0.2 (1)
	Other	9.6 (50)
Life view (n = 487)	Religious (those marked *)	87.1 (424)
	Non-religious	12.9 (63)
Life event (n = 514)	Yes	55.3 (284)
	No	44.7 (230)
Life Event (n = 217)	Positive	17.1 (37)
	Negative	82.9 (180)
Practice prayer (n = 525)	Never	31.2 (164)
	Daily	48.0 (252)
	Weekly	12.0 (63)
	Monthly	8.8 (46)
Practice meditation (n = 500)	Never	70.4 (353)
	Daily	8.6 (43)
	Weekly	12.2 (61)
	Monthly	8.8 (44)
Practice reading religious book (n = 521)	Never	55.1 (287)
	Daily	19.2 (100)
	Weekly	16.9 (88)
	Monthly	8.8 (46)
Practice religious meeting (n = 515)	Never	34.4 (177)
	Daily	3.5 (18)
	Weekly	47.4 (244)
	Monthly	14.8 (76)
Practice art (n = 517)	Never	48.0 (248)
	Daily	13.9 (72)
	Weekly	22.1 (114)
	Monthly	16.1 (83)
Practice rest in nature (n = 518)	Never	31.1 (161)
	Daily	6.4 (33)
	Weekly	29.2 (151)
	Monthly	33.4 (173)
Practice voluntary work (n = 515)	Never	60.4 (311)
	Daily	2.1 (11)
	Weekly	12.0 (62)
	Monthly	25.4 (131)

NB: Not all students completed all questions within all measures, therefore the numbers presented do not always add up to 531.

Data Analysis

Questionnaires were scored at country level and were posted by secure mail to the central analysing centre in Wales UK where the data were entered into PASW Statistics v18 for descriptive analysis. Demographic responses were categorised and the mean, median and standard deviation scores were calculated for the 4 standardised measures (SSCRS, SCCS, JAREL, SAIL).

Results

The Sample

Tables 1 and 2 show that the majority of the 86% responding (n = 531) were female nursing students in year 1, aged up to 20 years studying at secular universities. Interestingly, although most were studying at secular universities (62%), the majority were religious (87%), predominantly Christian (80%) and regularly prayed (60% daily/weekly) and attended religious meetings (51% daily/weekly). Just over a third sought rest in nature and practised art daily or weekly. Over half had experienced life events (55%) which were mostly negative, such as loss of a loved one/illness. Most (60%) had no previous healthcare experience and were educated to secondary level (66%).

Respondents rated highly on spiritual wellbeing (JAREL); 71.9% of the sample rated high, just over a quarter (28.1%) rated medium and no-one rated in the low category. This means that the majority rated high in faith/belief, life/self responsibility and life satisfaction/self actualisation.

The mean overall Spiritual Attitude and Involvement (SAIL) score for respondents (n = 529) was 4.05 (median = 4.04; SD = 0.56). Using the binary cut-off point of >4, just over half (53.9%) the sample was categorised as having high and just under half (46.1%) was categorised as having low spiritual attitude/involvement. Using the cut-off point of >4 for the 3 dimensions of the scale, 77.7% demonstrated a high sense of connectedness to self (mean 4.38, SD 0.56), 87.3% demonstrated a high sense of connectedness to the environment/others (mean 4.68, SD 0.65), and 21.4% demonstrated a high sense of connectedness to the transcendent (mean 3.22, SD 0.93).

Perceptions of Spirituality/Spiritual Care

The mean SSCRS score for respondents (n = 530) was 3.99 (per question) (median = 4.0; SD = 0.37) indicating a broad rather than specific view of spirituality/spiritual care. Table 3 shows that the sample tended towards an existential view of spirituality (mean = 3.81) but that they also viewed it as concerning only religious views/practices (mean = 3.94). This finding seems contradictory and may indicate that more work needs to be done on the SSCRS before the 4 factors can be used in this way; such work is in progress. Students considered both spiritual (mean = 4.29) and personal (mean = 4.01) care as important.

Perceived Competence in Delivering Spiritual Care

The mean SCCS score for respondents (n = 528) was 3.74 (Median = 3.74; SD = 0.42). Using the cut off point of >3.5, three quarters of respondents (75.4%) perceived themselves to be competent in delivering spiritual care while a quarter (24.6%) did not.

Table 3
Spirituality & Spiritual Care Rating Scale (SSCRS) mean subscale scores (n = 530).

SCCRS subscale	Mean score (SD)
Existential spirituality (view that spirituality is concerned with peoples' sense of meaning, purpose, value, peace and creativity)	3.81 (0.47)
Religiosity (view that spirituality is only about religious beliefs/practises)	3.94 (0.60)
Spiritual care (view of spiritual care in its broadest sense including religious and existential elements)	4.29 (0.45)
Personal care (taking account of peoples' beliefs and values and dignity)	4.01 (0.51)

Table 4
Spiritual Care Competency Scale (SCCS) mean subscale scores (n = 528).

SCCS subscale	Mean score (SD)
Professionalisation and improving the quality of spiritual care	3.38 (0.67)
Assessment and implementation of spiritual care	3.45 (0.64)
Referral	3.63 (0.62)
Personal support and patient counselling	3.78 (0.58)
Attitude towards patients' spirituality	4.38 (0.60)
Communication	4.48 (0.54)

The mean score for each of the 6 subscales is reported in Table 4 and shows that students perceived themselves to have greatest competence in the areas of 'Communication' (mean = 4.48) and 'Attitude towards patients' spirituality' (mean = 4.38). This was also found when the cut-off point of >3.5 was used to indicate competency, with 98.1% and 93.6% of students perceiving themselves to be competent in these areas respectively (Table 5). Almost 80% perceived themselves to be competent in 'Personal support and patient counselling' (mean = 3.78). The areas in which higher proportions of students rated themselves as 'not competent' were related to 'Assessment and implementation of spiritual care' (mean = 3.45) and 'Professionalisation and improving the quality of spiritual care' (mean = 3.38).

Discussion

Conducting any large international study presents numerous challenges. This pilot study indicates that such a study is feasible in terms of execution, delivery of outcomes and that the measures are suitable for an international student sample.

Our study sample was largely female and Christian which is unsurprising given the countries and universities included. The findings may, therefore, not be representative of the countries included or of other European and non-European countries. Given this religious profile it is not surprising that the majority of students rated highly on spiritual wellbeing (JAREL) and just over half rated highly on spiritual attitude and involvement (SAIL), however it is not clear why only a minority demonstrated a high sense of connectedness to the transcendent. This finding may be explained by the wider spirituality literature's suggestion, that how an individual's faith is worked out and integrated or not within their lives is deeply personal and individual. Alternatively it may be because of the way the questions are asked in the two scales; religious respondents may not recognise themselves in the 'transcendent' questions in SAIL and JAREL is more explicit in its religious questions. Given that nursing and midwifery are caring professions with high levels of responsibility, it is encouraging that the majority of students rated highly in their sense of connectedness to others (SAIL) and in life/self responsibility (JAREL).

The fact that students held a broad view of spirituality/spiritual care is heartening. It remains to be seen if their views of spirituality can be broadened further as they progress through their programme of studies (as has been suggested by researchers such as Cooper et al. (2013) and if they develop an awareness of and sensitivity to the full range of spiritual needs with which their patients may present as outlined by the WHOQOL SRPB Group (2006) and the RCN (2011). It is encouraging that students considered both spiritual and personal care as important.

It is reassuring that respondents perceived themselves to be marginally more competent than not in spiritual care, especially as the majority had just started their courses. This finding may be accounted for by the fact that the majority were religious and regularly prayed/attended religious meetings i.e. their personal spirituality may have predicted their perceived ability to give spiritual care, as identified by van Leeuwen et al. (2008) and Taylor et al. (2008). They felt highly competent in the more humanistic and interpersonal aspects of spiritual care such as 'communication' and 'attitude towards patients' spirituality', which suggests that we are selecting the right type of student onto our courses; an encouraging finding at a time when the UK Government is looking at selection criteria for new nurse recruits (Calkin, 2013) because of national scandals highlighting poor care standards (Francis, 2013). Areas in which students felt least competent were the more specialist areas of spiritual care involving 'Assessment and implementation of spiritual care' and 'Professionalisation and improvising the quality of spiritual care', aspects which, if addressed within their education programmes, may enhance competency prior to registration. This would answer Bradshaw's (1997) question of whether spiritual care can be taught. We have only addressed perceived competency in this pilot study. It would be interesting to capture actual spiritual care competency when such measures become available; such work is underway.

Limitations

Our study is limited by its sample size and homogeneity. The inclusion of four countries did not produce diversity of life view (the majority of the sample was Christian). Although we obtained a high response rate (86%) it is possible that the exclusion of non-respondents introduced some bias. We captured students' perceptions at one point in time only.

Table 5
Proportion of students categorised as competent/incompetent using 3.5 cut-off point (n = 528).

SCCS subscale	% incompetent	% competent
Communication	1.9	98.1
Attitude towards patient spirituality	6.3	93.6
Personal support and patient counselling	21.3	78.7
Referral	38.0	62.0
Assessment and Implementation of spiritual care	42.9	57.1
Professionalisation and improving the quality of spiritual care	49.6	50.4

Conclusion

We have described how a sample of undergraduate nurses/midwives held a broad view of spirituality/spiritual care and that they perceived themselves to be competent in spiritual care delivery, particularly in the humanistic aspects. Whilst these findings are noteworthy, our sample was predominantly Christian and data were only collected at one point in time. It would be useful to explore if these findings hold in student samples in countries with more diverse cultural backgrounds, as called for by Tiew and Creedy (2011) and to examine any changes over time as students progress through their courses. The next step would be to identify the factors contributing to the acquisition of spiritual caring skills and competency so that education programmes could be tailored to help students deliver truly holistic care as per regulatory body requirements. Such a study is in progress involving universities from 13 countries using the method and measures that this pilot study identified as appropriate.

Funding Statement

The study was funded by the University of Glamorgan Research Investment Scheme.

Conflict of Interest

No conflict of interest has been declared by the authors.

Acknowledgements

We are grateful to the students who took part in the study.

References

Baldacchino, D.R., 2006. Nursing competencies for spiritual care. J. Clin. Nurs. 15, 885–896.
Bradshaw, A., 1997. Teaching spiritual care to nurses: an alternative approach. Int. J. Palliat. Nurs. 3, 51–57.
Calkin, S., 2013. Caring experience to be compulsory for new nurse recruits. (http://www.nursingtimes.net/nursing-practice/clinical-zones/educators/caring-experience-to-be-compulsory-for-new-nurse-recruits/5056682.article).
Cooper, K.L., Chang, E., Sheehan, A., Johnson, A., 2013. The impact of spiritual care education upon preparing undergraduate nursing students to provide spiritual care. Nurse Educ. Today 33 (9), 1057–1061.
Department of Health, 2009. Religion or Belief. A Practical Guide for the NHS. Crown, London.
Francis, R., 2013. Report of The Mid Staffordshire NHS Foundation Trust Public Enquiry. Crown, London.
Giske, T., 2012. How undergraduate nursing students learn to care for patients spiritually in clinical studies — a review of literature. J. Nurs. Manag. 20 (80), 1049–1057.
Giske, T., Cone, P., 2012. Opening up to learning spiritual care to patients: a grounded theory study of nursing students. J. Clin. Nurs. 1, 2006–2015.
Hungelmann, J., Kenkel-Rossi, E., Klassen, L., Stollenwerk, R., 1996. Focus on spiritual well-being: harmonious interconnectedness of mind-body-spirit. Use of the JAREL Spiritual Wellbeing Scale. Geriatric Nursing 262–266 (November/December).
ICN, 2000. Code of Ethics for Nurses. ICN, Geneva.
Khoshknab, M.F., Mazaheri, M.S.B., Maddah, S.S.B., Rahgozar, M., 2010. Validation and reliability test of Persian version of The Spirituality and Spiritual Care Rating Scale (SSCRS). J. Clin. Nurs. 19, 2939–2941.
Koenig, H.G., King, D.E., Carson, V.B., 2012. Handbook of Religion and Health. OUP, New York.
Kunnskapsdepartementet, 2008. Rammeplan for sykepleierutdanningen. (http://www.regjeringen.no/upload/KD/Vedlegg/UH/Rammeplaner/Helse/Rammeplan_sykepleierutdanning_08.pdf).
Malta Code of Ethics, 1997. Maltese Code of Ethics for Nurses and Midwives. Nursing and Midwifery Board.Department of Health, Malta.
McSherry, W., 1997. A Descriptive Survey of Nurses' Perceptions of Spirituality and Spiritual Care. Unpublished Master of Philosophy Thesis, The University of Hull, Hull.
Spiritual Assessment in Healthcare Practice. In: McSherry, W., Ross, L. (Eds.), M&K, Keswick.
McSherry, W., Draper, P., Kendrick, D., 2002. Construct validity of a rating scale designed to assess spirituality and spiritual Care. Int. J. Nurs. Stud. 39, 723–734.
McSherry, W., Gretton, M., Draper, P., Watson, R., 2008. The ethical basis of teaching spirituality and spiritual care: a survey of student nurses perceptions. Nurse Educ. Today 28, 1002–1008.
Meezenbroek, E., Garssen, B., van den Berg, M., 2008. Spiritual Attitude and Involvement List (SAIL). Helen Dowling Institut, Utrecht, Netherlands.
NHS Education for Scotland, 2009. Spiritual Care Matters. An Introductory Resource for all NHSScotland Staff. NES, Edinburgh.
NICE, 2004. Guidance on Cancer Service. Improving Supportive and Palliative Care for Adults with Cancer. NICE, London.
Nixon, A., Narayanasamy, A., Penney, V., 2013. An investigation into the spiritual needs of neuro-oncology patients from a nurse perspective. BMC Nurs. 12 (2), 1–11.
Nursing & Midwifery Council, 2008. The Code. NMC, London.
Nursing & Midwifery Council, 2010. Standards for Pre-registration Midwifery Education. NMC, London.
Paley, J., 2008. Spirituality and nursing: a reductionist approach. Nurs. Philos. 9 (1), 3–18.
Quality Assurance Agency for Higher Education, 2001. Benchmark Statement: Health Care Programmes. QAAHE, Gloucester.
Ross, L.A., 1994. Spiritual aspects of nursing. J. Adv. Nurs. 19, 439–447.
Ross, L.A., 1996. Teaching spiritual care to nurses. Nurse Educ. Today 16, 38–43.
Ross, L., 2006. Spiritual care within nursing: an overview of the research to date. J. Clin. Nurs. 15, 929–930.
Royal College of Nursing, 2011. Spirituality in Nursing Care: A Pocket Guide. RCN, London.
Royal College of Nursing, 2012a. Spirituality in Nursing Care On-line Resource. (http://www.rcn.org.uk/development/practice/spirituality/about_spirituality_in_nursing_care).
Royal College of Nursing, 2012b. The RCN spirituality survey 2010. A Report by the RCN on Members' Views on Spirituality and Spiritual Care in Nursing Practice. RCN, London.
Swinton, J., Pattison, S., 2010. Moving beyond clarity: towards a thin, vague, and useful understanding of spirituality in nursing care. Nurs. Philos. 11, 226–237.
Taylor, E.J., Mamier, I., Bahjri, K., Petersen, F., 2008. Efficacy of a self-study program to teach spiritual care. J. Clin. Nurs. 18 (8), 1131–1140.
Tiew, L.H., Creedy, D.K., 2011. Student nurses' spiritual education perspective: a literature review. Singapore Nurs. J. 38, 39–54.
V & VN, 2012. Learning for the future. Nurses and Health Care Workers 2020, Part 1. Utrecht, The Netherlands (Leren van de toekomst. Verpleegkundigen en verzorgenden 2020, Deel 1. Utrecht. Nurses & Health Care Workers, Netherlands).
van Leeuwen, R., Cusveller, B., 2004. Nursing competencies for spiritual care. J. Adv. Nurs. 48 (3), 234–246.
van Leeuwen, R., Tiesinga, L.J., Middel, B., Post, D., Jochemsen, H., 2008. The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care. J. Clin. Nurs. 17, 2768–2781.
van Leeuwen, R., Tiesinga, L.J., Middel, B., Post, D., Jochemsen, H., 2009. The validity and reliability of an instrument to assess nursing competencies in spiritual care. J. Clin. Nurs. 18, 2857–2869.
WHOQOL SRPB Group, 2006. A cross-cultural study of spirituality, religion and personal beliefs as components of quality of life. Soc. Sci. Med. 62, 1486–1497.
World Health Organisation, 2002a. WHOQOL-SRPB Field Test Instrument. WHO, Geneva.
World Health Organisation, 2002b. http://www.who.int/cancer/palliative/definition/en/.
www.palliatief.nl/Themas/Ethiekenspirituelezorg/tabid/4098/Default.aspx.