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Abstract

Intensive care unit (ICU) nurses play a crucial role in providing physiological stabilizing care in a dynamic and fast-paced environment, often marked by constant changes and variability in complex patients. Despite their specialization, the aspect of spiritual care tends to be overlooked, particularly in the context of end-of-life care. This is significant because previous studies have shown that a lack of spiritual care leads to poorer health outcomes, decreased coping, increased depression, and diminished quality of life for patients. This research proposal aims to investigate the spiritual care competency among ICU nurses who partake in spiritual care based training, with the overarching goal of promoting holistic patient care, especially for patients approaching the end of life. The literature review encompasses a threefold examination of spiritual care practice from diverse perspectives, including those of nurses, patients, and chaplains. The focus is on identifying barriers to spiritual care nursing practice, understanding the impacts of spiritual care on patients' well-being (or the lack thereof), exploring nurses' perceptions regarding their capacity to provide spiritual care, and evaluating the effectiveness of spiritual training sessions. Building upon these insights, a quasi-experimental study has been designed to assess the effects of spiritual care training on improving nurse competency and enhancing holistic patient care. The findings from this research have the potential to contribute to the development of targeted interventions and training programs that address the specific spiritual care needs of ICU nurses, ultimately enhancing the quality of care provided to patients, particularly those nearing the end of life.

Key words: critical care nursing, spiritual care competency, end-of-life

Introduction

Spiritual care is a fundamental aspect of nursing practice, involving the provision of respect, compassion, full presence, and support in the pursuit of personal meaning (Abu-El-Noor, 2016). It is a crucial element within holistic care, a hallmark of nursing that encompasses the comprehensive needs of individuals, including physical, psychological, mental, emotional, cultural, and spiritual dimensions. Unlike other disciplines, nurses play a unique role in providing holistic care as they spend the most time fostering relationships with patients at the bedside. Nurses are usually the first to detect changes in a patient's status and have the opportunity to empower patients and families during what is often a difficult time for them. Nurses stand out from other professions as they dedicate their focus to the comprehensive well-being of individuals by concentrating on all aspects of care. Within busy and fast-paced critical care environments, spiritual care is largely neglected as critical care nurses are more equipped with the knowledge and skills to provide physiological stabilizing care. Research suggests that unmet patient spiritual needs lead to poorer health outcomes, decreased coping, diminished quality of life, and increased depression (O'Brien et al., 2018). Spiritual care contributes to spiritual, emotional, and psychosocial well-being. It is important for intensive care unit (ICU) nurses to know how to deal with the needs and wants of patients regarding the spiritual aspects of end-of-life care. This thesis aims to identify and analyze ways to improve spiritual care competency in the ICU for nurses who are caring for end-of-life patients. This is an essential part of treating patients with respect and dignity and providing them with a sense of peace as they approach death. Not all ICU patients approach death–some can stabilize and recover. Yet, the emphasis of this research paper is specifically on individuals reaching end of life. This specific demographic was chosen due to their heightened need for spiritual care related

to the critical nature of ICU admissions, complex medical scenarios, and uncertainty surrounding prognoses. All ICU patients can benefit from spiritual care, especially those reaching end-of-life.

When examining the importance of spiritual care and end-of-life considerations, the following Healthy People 2030 Objective relates to the problem this research proposes to address: Increase the proportion of adults whose healthcare providers involved them in decisions about their health care as much as they wanted (U.S. Department of Public Health). This research contributes to the Healthy People 2030 objective by promoting nurses' advocacy for autonomous patient decision-making, addressing spiritual needs, and fostering empathy, particularly for those at end-of-life. Involving patients in healthcare decisions and considering these spiritual beliefs is a way of promoting dignity and respect for them. Neglecting spiritual needs has significant negative outcomes on patients' emotional and mental well-being.

Problem Statement

Literature states how ICU nurses lack confidence, competence, and sufficient training to meet a patient's spiritual needs at end-of-life (Green, 2020). The choice of using the term "competence" for this study instead of "humility" or "sensitivity" was based on the fact that competency is a skill routinely employed and assessed in healthcare settings, whereas, the latter terms involve more subjective evaluations and are often tailored to individual circumstances. In the absence of standardized guidelines from the American Association of Critical Care Nurses (AACN) delineating the responsibilities of ICU nurses in spiritual care, it is difficult to assess the quality of spiritual care that ICU nurses provide due to the subjectiveness of "spiritual care." There is a broad consensus on the essence of spiritual care during the end of life; however, there is minimal focus on it in clinical practice (Noome et al., 2016). Additionally, end-of-life is defined as a stage where an individual is confronted with a life-limiting illness marked by

irreversible decline, with anticipated survival measured in months or less (Hui et al., 2014). ICU end-of-life patients have numerous comorbidities and a higher risk of mortality, making it essential for ICU nurses to acknowledge and support patients spiritually. There is a growing need to assess current practices for dying care and spiritual support nursing interventions to improve nurses' competency in spiritual care within their scope of practice (Kisvetrová et al., 2016).

Research Question

How can critical care nurses improve their spiritual care competency to promote holistic patient care towards end-of-life?

Can critical care nurses enhance their competence in delivering holistic end-of-life care through participation in spiritual care training?

Hypothesis

Enhanced education and training in spiritual care for critical care nurses will lead to a clinically and statistically significant improvement in delivering holistic care to end-of-life patients.

Literature Review

This literature review is comprised of articles from the following databases: CINAHL, PubMed, and the National Library of Medicine. Keywords utilized to find relevant articles include spiritual care, spirituality, spiritual training, holistic care, end-of-life, patient-centered care, critical care nurses, intensive care, and competency. The literature review examined spiritual care from three diverse perspectives: those of nurses, patients, and chaplains. Most articles illustrated critical care nurses' perspectives regarding their competencies and the barriers they face in delivering spiritual care, which aligns with our research problem statement. In terms of patients, some articles focus on ICU end-of-life patients specifically, while others focus on

ICU patients in general and those who have recovered. Regardless, all articles about ICU patients provide insight into the effectiveness of spiritual care interventions. Several articles describe chaplain perspectives, which highlight their unique insights into how spiritual care is being carried out in nursing practice. Spiritual care encompasses a set of competencies used in the nursing process, such as fostering therapeutic connections between patients and nurses, engaging in attentive listening, demonstrating empathy, and offering religious amenities for patients' specific religious beliefs (Ebrahimi et al., 2017).

Competence is defined as a set of traits and characteristics which form the basis for optimal performance. Competency for nurses refers to a combination of knowledge, skills, abilities, and behaviors that enable them to provide safe, effective, and high-quality care to patients. It is essential for nurses to continuously assess and enhance their competence to provide the most optimal patient care (Ebrahimi et al, 2017). Cited literature was chosen based on their keywords, relevance to our research question, and the validity and reliability of the research.

Nurses' Perspectives on Spiritual Care

Riahi et al. (2018) conducted a study aimed at exploring the impact of spiritual intelligence training on the competency of critical care nurses in delivering spiritual care. Eighty-two nurses participated, with 40 nurses in the experimental group and 42 nurses in the control group. Participants were recruited from critical care units in hospitals connected to Lorestan University of Medical Sciences in Iran. Inclusion criteria comprised at least one year's experience in critical care, a Bachelor's degree in nursing, and no prior involvement in spiritual intelligence training or related research. All participants provided informed consent, and the study received approval from Lorestan University's Research Ethics Committee. The experimental group underwent an eight-week workshop training program, consisting of eight

sessions lasting 90 minutes each, while the control group did not receive any intervention. The King's Spiritual Intelligence Scale and Scale for Assessment of the Nurse's Professional Competence in Spiritual Care (SANCSC) were the tools used for data collection. Questionnaires were administered to both groups, and the experimental group was assessed before and after the training sessions. Analysis of the collected data using SPSS software revealed the effectiveness of the training on spiritual care competency, as indicated by the experimental group's scores post-training. The study highlighted a significant gap in education related to spiritual care among nurses, with 89% reporting a lack of prior training in this area (Riahi et al., 2018). Noteworthy strengths of the research include its emphasis on the positive impact of spiritual training on nursing education, how it addresses inadequacy in training and education for spiritual care, and the barriers to its provision. However, limitations include a relatively small participant pool, a geographically restricted study area, and the specific cultural context of Iran, which may introduce potential differences in nursing care compared to the United States.

In their study, Green et al. (2019) explored registered nurse's perceptions of spiritual care education, competence, and barriers. The first research question investigated nurses' perceptions of their spiritual care competence and their spiritual care provision frequency. The second research question focused on identifying barriers to providing spiritual care. Lastly, the third research question examined the relationship between spiritual care training and nurses' preparedness to provide spiritual care. The study highlighted barriers hindering nurses from delivering spiritual care, including a deficiency in spiritual care education, individual spiritual beliefs, perceived time constraints, challenges in meeting patient needs differing from their own, and concerns about inadvertently promoting a particular faith (Green et al. 2019). The methodology employed a descriptive, cross-sectional study, incorporating demographic

questions, the Spiritual Care Competency scale, the Nurses' Spiritual Care Therapeutic scale, the Spiritual Care Practice questionnaire subscale, and open-ended questions. The study involved 2,274 registered nurses in post-licensure programs at Southeastern public state universities, encompassing RN-BSN, MSN, and DNP programs. Ethical approval from the university's institutional review board ensured the protection of subjects' rights and privacy, adhering to ethical standards. The results indicated that many participants felt ill-prepared to provide spiritual care, highlighting a prevalent lack of workplace training in this area. A noteworthy study finding was the positive correlation between spiritual care education in work and pre-license programs, improving spiritual care competence. However, limitations included the homogeneity of the sample and the absence of continuous nursing assessment over time. Overall, the study underscored the necessity of incorporating spiritual care education into RN job training and pre-licensure programs.

Hu et al. (2019) conducted a study aimed at establishing a spiritual training protocol and evaluating its efficacy among oncology nurses. The research recruited ninety-two nurses from a cancer treatment hospital, randomly assigning them into two groups using a coin-toss method. The intervention group comprised 45 participants, while the control group had 47, constituting a non-randomized controlled trial. The control group participated in once-a-month nursing education sessions led by the hospital over a period of 12 months. In contrast, the study group participated in a spiritual training session every 6 months, involving more comprehensive activities such as expert lectures, interactive discussions, group interventions, and case sharing. Informed consent was obtained from all participants, and the study received approval from the Institutional Review Board of the School of Nursing at Jilin University. A baseline survey was conducted before the intervention to collect background information, and after each training

session, nurses completed training feedback questionnaires to assess the outcomes. Following the conclusion of all spiritual training sessions, both groups underwent assessments using the Spiritual Care Competency Scale (SCCS) adapted as a Chinese version and Spiritual Health Scale (SHS). One-on-one interviews were also conducted to evaluate the intervention's effectiveness. Results indicated that the study group nurses exhibited higher scores in spiritual health and competency compared to the control group (Hu et al., 2019). Consequently, the study suggests that a spiritual care training protocol improves nurses' spiritual well-being and competencies. A notable strength of the research lies in the developed protocol's potential to enhance nurses' knowledge in spiritual care, which leads to the improved quality of patient care. However, a limitation of the study is the large representation of head nurses or those with higher seniority, prompting a recommendation for future research to focus on assessing the training protocol's effectiveness with less experienced nurses (Hu et al., 2019).

O'Brien et al. (2018) investigated nurses' and healthcare professionals' perceptions of spiritual care and how spiritual care training influenced their roles in clinical settings. The researchers conducted a qualitative study using digitally audio-recorded interviewees to explore participant experiences with the spiritual care course, skills acquired, and influence on their clinical practice. A total of 21 generalists, specialist nurses, and healthcare professionals from North West and South West England undertook the 3-month spiritual care training. An ethical committee approval was obtained to safeguard the study's participants. After the training ceased and the data was thematically analyzed, researchers found that the providers were more proficient in their ability to empower patients, address spiritual needs, identify signs of spiritual distress, and employ communication skills tailored to spirituality. Participants reported having improved delivery of spiritual and holistic care after the spiritual care training as before the

study, participants initially lacked confidence in their competence and held preconceived beliefs about spirituality. This study's main strength is the spiritual care training's efficacy in preparing nurses to offer optimal spiritual and holistic care practices for patients approaching the end of life, ensuring their comprehensive well-being. Geographical and cultural variations compared to the nursing care model in the U.S. and differences in patient demographics are weaknesses of this study.

Abu-El-Noor (2016) analyzed intensive care unit nurses' comprehension and provision of spiritual care for patients approaching the end of life. This qualitative research study emphasized the significance of shifting medicine from a cure-based model to a holistic, spiritual, and religious approach for end-of-life patients. Researchers conducted open-ended question interviews with thirteen ICU nurses in Gaza Strip, Palestine, and organized participants' transcripts into different categories: the Essence of Spirituality, Spiritual Care Provision, Recognizing Spiritual Needs, and Implementations to Fulfill Spiritual Needs (Abu-El-Noor, 2016). All of the participants were Muslim and actively provided end-of-life care (EOLC) within the ICU. This study received approval from the Ministry of Health in Gaza Strip and participants' confidentiality was safeguarded through the use of pseudonyms. Interview questions revolved around nurses' experiences with providing spiritual care and dealing with spirituality. The findings revealed that the lack of standardized health policies related to spiritual care led to difficulties in defining spiritual terms and promoting spiritual well-being through nursing practice. Additionally, the researchers discovered various implicit and explicit practices performed by some nurses, such as performing prayer, encouraging patients to express their feelings, and lengthening family visitations to provide spiritual care (Abu-El-Noor, 2016).

Kisvetrová et al. (2016) developed a cross-sectional, descriptive study evaluating the practices of 29 ICU nurses in the Czech Republic concerning dying care and spiritual support interventions. The study was approved by a local ethics committee and the nurses provided their informed consent. The study, spanning 14 months, utilized a 31-item questionnaire consisting of 24 dying care interventions and 7 spiritual support interventions from the Nursing Interventions Classification (NIC) system. A Likert Scale assessed nurses' opinions on factors potentially affecting EOLC, such as care frequency, patient length of stay, staffing conditions, time options for providing dying care, nurses' attitudes towards death, and palliative care education (Kisvetrová et al. 2016). Findings unveiled that frequently employed spiritual care and end-of-life interventions centered around nurses' attentiveness, helpfulness, and meaningful connections with patients. These interventions not only enhanced the patients' respect and dignity but also alleviated suffering. The role that nurses play is crucial for end-of-life patients grappling with the fear of losing dignity due to their life-limiting illness. Positive correlations were established between RN education in EOLC and spiritual support interventions with bolstered participation in courses and positive opinions on the significance of training. A greater number of spiritual interventions were observed in cases of longer ICU stays and higher staffing levels. This study's strength lies in its emphasis on educating about EOL care, staff support, and patient and family-centered communication to enhance spiritual care in nursing. A limitation of this study involves the Czech community's tendency towards secularization and the concerns surrounding institutionalization for end-of-life patients.

Patients' Perspectives on Spiritual Care

Bulut et al. (2023) conducted a study looking at the impact of spiritual interventions on the spiritual well-being, loneliness, hope, and life satisfaction of patients undergoing treatment in

intensive care. These interventions, known to offer various advantages to patients, contribute to enhancing the overall quality of patient care. The research incorporated randomized pre-test, post-test, and control groups, involving intensive care unit patients with chronic progressive diseases. The study received approval from an ethics committee, and the necessary permits were obtained from the Provincial Health Directorate and the relevant hospital. Furthermore, written consent was secured from all participating patients. The total participant count was 64, with 32 assigned to the intervention group and 32 to the control group. Patients in the intervention group underwent 8 sessions twice a week, where they received spiritual nursing interventions based on the Traditions - Reconciliation - Understanding - Searching - Teachers (TRUST) Model. Conversely, the control group received standard nursing care. The TRUST model utilized in the study serves as a comprehensive spiritual assessment and care model applicable to both healthcare providers and recipients. It empowers nurses to establish and maintain therapeutic relationships while identifying the spiritual needs of patients. Post-intervention, the study's results demonstrated a positive impact of spiritual care administered in the intensive care unit on patients' spiritual well-being, hope, loneliness, and life satisfaction levels (Bulut et al., 2023). Strengths of the study include confirming the effectiveness of the TRUST model as an inclusive spiritual assessment and care approach. It further affirms that nurses in the ICU can foster a spiritually supportive environment by addressing patients' spiritual concerns through available spiritual care services in hospitals. Limitations include the absence of a follow-up study and the utilization of a relatively small sample size. Additionally, participants exhibited culturally diverse characteristics, and the research conducted in Turkey may introduce potential cultural distinctions from nursing care practices in the United States.

Eaton et al. (2023) conducted a study with the aim of exploring the requirements of critical illness survivors through palliative care perspectives. Participants for the research were recruited from the post-intensive care unit clinic at UPMC Mercy, a medical center in the United States. The participants included seventeen people aged 34–80 who had experienced and survived through critical illness. The majority of these survivors attended a post-ICU clinic between June 2018 and March 2020. Employing qualitative methods, specifically semi-structured interviews and framework analysis, the study revealed six themes aligned with palliative care concepts, with one being spiritual changes and significance (Eaton et al., 2023). The study, conducted in February to March 2021, involved interviews occurring anywhere from 13 to 33 months following participants' initial intensive care stay. Inclusion criteria included community-dwelling individuals who are 18 years or older, previously admitted to an ICU, access to phone or internet for an interview, and English speakers. Exclusion criteria included residence in skilled nursing or assisted living, those with an anticipated life expectancy of 6 months or less, and active enrollment in hospice, as those patients may be familiar with or already receiving palliative care interventions. Results have shown that integrating palliative care through techniques such as spiritual and social support could contribute to the evaluation and recovery process of critical illness survivors (Eaton et al., 2023). Strengths of the study include its focus on palliative care elements applicable to critical illness survivors, as well as the identification of ongoing needs among survivors 13–33 months after their initial ICU stay. Limitations include the exclusive collection of interview data from participants at a single site, the absence of perspectives from family and caregivers, and the omission of critical illness survivors who did not follow up at a post-ICU clinic setting. The study's design and protocol received approval from the University of Pittsburgh Institutional Review Board (IRB). Despite

not directly focusing on end-of-life patients, the research underscores the necessity of spiritual care in the needs of ICU patients.

Chaplains' Perspectives on Spiritual Care

Labuschagne et al. (2020) conducted a study to observe the delivery process of spiritual care in the Medical Intensive Care Unit (MICU). An objective of the study was to explore the activities of chaplains in the MICU concerning decision-making. This study focused on spiritual care for MICU patients and families across four healthcare institutions from February to April 2017. Participants for this study were selected through convenience sampling, drawing groups of individuals from 4 hospitals, comprising 3 medical centers and 1 community hospital with a faith-based orientation. Each location received approval from the Institutional Review Board. The requirement for written informed consent was exempted, most likely because the study involves participants who are deceased or have already been discharged, and obtaining consent from each individual would not be feasible. Inclusion criteria included patients 18 years or older who either passed away in the MICU or were discharged to palliative or hospice care. The study primarily employed descriptive analysis, with results displaying that 78% of the patients received a total of 485 spiritual care visits. A substantial 77% of encounters encompassed emotional and spiritual assistance, with a mere 15% involving decision-making support, facilitated through interactions such as family meetings or discussions regarding the care plan (Labuschagne et al., 2020). The number of patients receiving spiritual care surged as they were nearing death or preparing for discharge. The findings indicated that spiritual care was extended to the majority of patients and their families in end-of-life scenarios. The limited involvement of MICU chaplains in healthcare decisions prompts recommendations for enhancing their participation within the ICU. Strengths of the study include its contribution to comprehending the spiritual care offered

to patients and families in the MICU. It also emphasizes the collaborative efforts required from both spiritual care providers and healthcare workers to enhance spiritual care provision in the ICU. However, a weakness of the study is that the results may not be universally applicable to everyone receiving care in the MICU and may not accurately depict the spiritual care given in other hospital settings.

Noome, et al. (2016) centered their study on chaplain's perspectives regarding ICU nurses's roles, responsibilities, and competencies in delivering spiritual aspects of end-of-life care. The researchers recruited 11 Dutch chaplains from the National Chaplain Association with diverse spiritual backgrounds, such as Roman Catholicism, Hinduism, Humanism, and Buddhism. Eight worked in a community hospital specifically in the ICU. This was an exploratory study in which the chaplains were divided into two focus groups. The National Chaplain Association participated in a focus group interview, where they described the role of ICU nurses regarding spiritual aspects of EOLC. The interviews yielded five major themes: 1) awareness of ICU nurses, 2) communication, 3) nursing interventions, 4) multidisciplinary care, and 5) education about the spiritual aspects of EOLC (Noome et al., 2016). The chaplains unanimously stressed the importance of ICU nurses being self-aware of their identity and spiritual background, setting aside personal backgrounds to understand the spiritual needs of others. Effective communication, including non-verbal communication, emerged as a crucial nursing intervention for understanding a family's dynamic, actively supporting the family member's needs, and involving chaplains in their multidisciplinary care during EOLC. The results highlighted the necessity for ongoing spiritual care education by chaplains to enhance the knowledge and competency of ICU nurses. A key strength of this study is its unique perspective from a discipline outside of nursing, integrating knowledge from various spiritual and religious

experts, thus diversifying the study population and fostering inclusiveness. One aspect this study was lacking was its limited access to chaplains for focus groups and a geographical constraint. While the study provides significant insights applicable to spiritual care in the US, conclusions may differ from chaplain practices in the Netherlands.

Proposal for Further Study

Theoretical Framework

The theoretical framework that is relevant to this study is Jean Watson's "Philosophy and Theory of Transpersonal Caring," also known as "Caring Science." It is specifically relevant to the concepts of spiritual end-of-life care and end-of-life decision-making, which is subjective and allows individuals to have some control over their end-of-life experience. Personal values and beliefs, along with interpersonal communication, greatly influence the decision-making process (Murali, 2019). The purpose of Watson's theory aims to highlight the uniqueness of nursing practice in providing care for human beings, and it also works to shift the focus from curing disease to the individual. Her work can be utilized to encourage modern-day nurses to provide more holistic care through advocating for individualized patient and family-centered care (Murali, 2019). Jean Watson's Caring Science and Caritas Processes provide a framework for nurses to foster deep connections with the patient through compassion, authentic listening, presence, and a healing atmosphere. She describes compassion as a crucial aspect of care during the end of life, and how spiritual care involves compassionate presence.

The importance of self-care is another key element of Dr. Watson's work. When nurses can care for themselves, they can better support the intensity of care for their patients (Costello, 2018). Nurses should provide competent, compassionate, and culturally sensitive care for patients and families from the time of diagnosis through the end of life. Providers who are fully

present and listen deeply help create a sense of trust with patients, which allows them to share their deep concerns. Patients are then able to establish transpersonal relationships with nurses who support them spiritually and face their life-limiting illnesses with less spiritual distress (Costello, 2018).

Methodology

This study's objective is to determine whether training can improve nurses' competency in delivering spiritual care to patients. The research design proposed is a quasi-experimental study that will take place over the course of 6 months. A quasi-experimental design is an optimal choice for this study as it incorporates pre-test and post-test measurements, encompassing the collection of baseline data, implementation of an intervention, and evaluation tools used for assessing competency. The study design is inspired by previous research about the effectiveness of spiritual care training and competency among oncology nurses (Hu, Jiao, & Li, 2019). The independent variable is the type of training that each group receives, and the dependent variable is the level of competency the nurses acquire, which will be assessed through various tools. The data collection tools are a demographic data survey, a 27-item Spiritual Competency Care Scale (SCCS), and pre- and post-training open-ended questionnaires. Spiritual care competency will be measured through the use of SCCS and the free response written questionnaires. Participants will be recruited through voluntary sign-ups from the Kaiser and Providence Hospital intensive care units. Kaiser and Providence are renowned hospital systems in California, and past clinical experience in these settings has shown that the nurses are highly qualified individuals who would benefit from additional training. Participants will fill out a demographic survey to gather pertinent data and screen their eligibility for this study. They will be screened based on pre-existing characteristics, such as age, gender, location, work experience, religion, educational

degree, year(s) of work experience as a registered nurse, experience working with end-of-life patients, and any prior experience with spiritual care training. Individuals excluded from the study include those with less than one year of experience working in a critical care unit, individuals who may withdraw part way through the study due to retirement, pregnancy, or other life circumstances, and non-English speaking persons. Recruited participants will be given a pre-training questionnaire and spiritual care competency scale survey to assess baseline competency. Nurses will be randomly divided into two groups: Group A (control) and Group B (intervention). There will be a sample size of 100 registered nurses, with 50 nurses divided into each group. Group A will receive monthly training sessions lasting 2 hours each as part of their routine nursing education provided by the hospital. Their training consists of PowerPoint lectures without interactive activities. On the other hand, Group B will participate in a more comprehensive monthly 3-day workshop, with each lasting 4 hours. This workshop consists of in-depth lectures delivered by community leaders representing various denominations, group interventions, case sharing, and clinical simulation exercises regarding spiritual care.

Ethical Considerations

The study will be approved by the IRB to ensure the ethical protection of human subjects, and participants will receive informed consent regarding the study procedures and their confidentiality rights. Participants have the right to withdraw or refuse to answer any questions. Names of participants will be completely anonymous and will not be used in the study.

Data Collection

Data will be collected using the following tools: a demographic data questionnaire, pre-training questionnaire, post-training questionnaire, and the Spiritual Care Competency Scale (attached in Appendix C). The demographic data questionnaire will be given to participants prior

to the training to gather information on participants and determine eligibility. A pre-training questionnaire will also be given before the training to determine their baseline understanding of spiritual care before the intervention is implemented. The open-ended questions ask about the participant's current knowledge of spirituality, how they assess and implement patient's spiritual needs into the plan of care, their comfort level in initiating conversations about spirituality, what they believe are barriers in providing spiritual care, and any trainings or resources they believe would help enhance their ability to provide spiritual care. The Spiritual Care Competency Scale (SCCS), created by René Van Leeuwen, consists of 27 statements used to assess nurses' competency around spiritual care. The statements are categorized into 6 competencies: assessment and implementation of spiritual care, professionalization and improving the quality of spiritual care, personal support and patient counseling, referral to professionals, attitude towards the patient's spirituality, and communication (Leeuwen, 2009). Responses are scored using a Likert-type scale, spanning from "strongly disagree" (1) to "strongly agree (5)." The scale's validity was measured through factor analysis; reliability was measured with Cronbach's alpha coefficient (Leeuwen, 2009). The SCCS has demonstrated satisfactory reliability and validity. After the training is completed, the Spiritual Care Competency Scale will be given again so scores can be compared before and after the training. A post-training questionnaire will also be given, with different questions about their experience providing spiritual care to a patient, their perceptions of the training sessions, their ability to collaborate with chaplains and other spiritual care providers, and strategies they use to provide spiritual care for those with diverse backgrounds. These open-ended questions assess participants' confidence, competence, and experiences with practicing spiritual care after taking the spiritual care training sessions, as well as their application of spiritual care knowledge and skills in patient care. The purpose of the

Spiritual Care Competency Scale and post-training questionnaire is to assess the effects of the training sessions on the nurse's competency.

Data Analysis

The quantitative data consists of the results taken from the Spiritual Care Competency Scale. Analysis of Variance (ANOVA) is a statistical test that analyzes changes in results between variables and differences among the two groups in a data set. By applying ANOVA, researchers can determine whether the observed differences in mean scores between the groups are statistically significant. A significant difference suggests that the spiritual care training intervention had an impact on the outcome. A t-test will be utilized to compare the pre-intervention and post-intervention scores of the two groups.

The qualitative data consists of the responses taken from both the pre-training and post-training questionnaires. A faculty expert knowledgeable in analyzing qualitative data would be consulted. A content analysis of the data from both questionnaires will be performed to identify common themes and ideas of nurses' perceptions of spiritual care. Responses will also be reviewed to determine a correlation between education and competency, and their perceptions of the educational intervention.

Conclusion

This study is vital as it seeks to address the lack of education around spiritual care and the need for more spiritual training. Improved spiritual care in nursing practice fosters stronger interpersonal relationships between patient and nurse, enhancing the quality of care, and addressing the communication gap regarding spiritual care at end-of-life while maximizing patient involvement in the health decision-making process. The research proposal outlines a strategic plan that holds the potential to shape the nursing field, fostering increased spiritual

competency and integrating more spiritual considerations into patients' plans of care. As nurses, acquiring this knowledge of spiritual care enables nurses to deliver more holistic care, concentrating on the spiritual dimension of patients' well-being.

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Contributions

Joint Contributions:

- Collaborative discussions on study design and methodology.
- Joint refinement of theoretical framework and research instruments.
- Equal involvement in finalizing the manuscript.

Individual Contributions:

- Joanne Nguyen:
    - Developed the vision for this thesis, outlining its purpose and scope.
    - Authored the abstract, succinctly summarizing the research.
    - Addressed ethical considerations integral to the study.
    - Formulated clear and concise hypotheses and research questions.
    - Refined inclusion/exclusion criteria for participant recruitment to ensure precision and targeting.
    - Contributed to the design of distinct methodologies for both control and intervention groups.
    - Curated and analyzed pertinent literature from prominent scholars, including O’Brien, Abu-El-Noor, Kisvetrová, Green, and Noome
- Dana Bagis:
    - Conceptualized and facilitated the overarching development of the study design methodology.
    - Organized the table of contents, ensuring a logical and structured flow throughout the thesis document.
    - Contributed to the exploration of patient perspectives through literature articles

- Analyzed pertinent literature from prominent researchers, including Bulut, Eaton, Hu, Labuschagne, and Riahi

Appendix A: Lit Review

Authors/Citation	**Purpose/Objective of Study**	**Sample - Population of interest, sample size**	**Study Design**	**Study Methods**	**Major Finding(s)**	**Strengths**	**Limitations**
O'Brien, M., Kinloch, K., Groves, K., & Jack, B. (2018). Meeting patients' spiritual needs during end‐of‐life care: A qualitative study of nurses' and healthcare professionals' perceptions of	To explore nurses' and healthcare professionals' perceptions of spiritual care and the impact of spiritual care training on their clinical roles.	Utilized 21 generalist and specialist nursing and healthcare professionals from North West and South West England	Adopted a qualitative methodology.	Studied population of interest who undertook spiritual care training for 3 months. Interviewed & digitally recorded participants via telephone, focusing on their general experiences taking the spiritual care course, the skills	Before undertaking the spiritual care training, participants were unconfident in terms of their competency and preconceived ideas about spirituality. Afterward, the staff was able to empower their patients, support their spiritual needs,	Informs the effectiveness of spiritual care training in preparation of nurses as they support patients' approach to life, ensuring the best spiritual and holistic care practices are provided for patients.	Research poses geographical and potential cultural differences from the United States' model of nursing care as well as patient demographics. Only one data collection time point was conducted. Lack of familial and patient

spiritual care training. *Journal of Clinical Nursing*, 28(1-2), 182–189. https://doi.org/10.1111/jocn.14648				they developed, and the impact on their clinical practice.	recognize spiritual distress, and utilize spirituality-specific communication skills.		perspectives on the impact in clinical practice.
Abu-El-Noor, N. I. (2016). ICU nurses' perceptions and practice of spiritual care at the end of life: Implications for policy change. *Online Journal of Issues in Nursing,*	The purpose of this study is to assess and explore end-of-life spiritual care provided by ICU nurses. There is an emphasis on	Thirteen ICU Registered nurses in Gaza Strip, Palestine (5 females, 8 males; 3 with master's degrees, rest with BSN) participated in the	Qualitative Research Study	The study involved open-ended interviews with questions about their spiritual care experiences and perceptions on spirituality.	Nurses found it challenging to define spirituality and spiritual care due to the lack of a standardized language. Nurses experienced difficulty promoting their patient's spiritual	Indicators for spiritual care needed in terminally ill/ dying patients. Evidence of health status and close environmental observations were utilized to assess patients' spiritual	Participants and patients' responses are congruent with their Muslim religion, limited to only one population and a small sample size. Further studies are needed to learn how

21(1). https://doi.org/10.3912/ojin.vol21no01ppt05	transitioning from cure-based to holistic, spiritual, and religious care for end-of-life patients.	study. All participants were Muslims actively providing end-of-life care in the ICU.			well-being as a result of this lack of clarity. Findings indicated that extending family visitations, engaging in prayer, and encouraging direct expression of feelings offered comfort to patients.	needs. Offers solutions for the problem statement.	healthcare providers overcome barriers to providing spiritual care and meeting the spiritual needs of patients with different diagnoses.
Kisvetrová, H., Školoudík, D., Joanovič, E., Konečná, J., & Mikšová, Z. (2016). Dying care interventions in the	Assessed registered nurses' practices in dying care and spiritual support interventions in ICUs in the	A total of 450 questionnaires were distributed to a sample of 29 ICU nurses across four Czech Republic regions	Cross-sectional descriptive study	Utilized two questionnaires and Likert scale assessments. One questionnaire included a total of 31 nursing activities (24	Registered nurses most frequently "treated individuals with respect and dignity" and least frequently "facilitated discussion of funeral	Described the positive correlation between the importance of RN education about EOL care, staff support, and improved communication to	Lack of a standardized survey to address study goals. Specific to Czech society where secularization is

intensive care unit. *Journal of Nursing Scholarship*, 48(2), 139–146. https://doi.org/10.1111/jnu.12191	Czech Republic. Identified correlations between specific factors and the frequency of nursing intervention classification (NIC) interventions used.	(Olomouc, Moravian-Silesian, Zlin, and Prague) over 14 months. Participants were RNs providing direct ICU patient care for at least 1 year, with signed informed consent. 94.2% of respondents were female. Participants' ages ranged from 23 - 59 years old. ICU experience		dying care interventions and 7 spiritual support interventions). The 24 dying care interventions were somatic and psychosocial activities that offered support of the patient as well as their family members. The 7 spiritual care interventions were related to spirituality and consisted of religious and non-religious	arrangements" as a spiritual care intervention. Dying care and spiritual support interventions were enhanced when nurses attended palliative care courses and expressed more positive opinions regarding the importance of education in a palliative care setting. More spiritual interventions were also conducted with longer ICU stays and	provide better care for patients and their families.	popularized and dying patients have fears about institutionalized care during long-term care. CR lacks diversity and multicultural patients, compared to the United States. Cultural differences may influence prioritized spiritual activities for CR patients compared to the U.S.

		ranged from 1 year to 38 years.		activities. The second questionnaire consisted of 7 factors that could impact EOL care.	higher staffing.		
Green, A., Kim‐Godwin, Y. S., & Jones, C. B. (2019b). Perceptions of spiritual care education, competence, and barriers in providing spiritual care among registered nurses. *Journal of Holistic*	Explore registered nurses' perspectives on spiritual care competency, readiness, and obstacles to delivering spiritual care.	A total of 2,274 RNs enrolled in post-licensure programs at Southeastern public state universities, including RN-BSN, MSN, and DNP participated in the study.	A descriptive, cross-sectional study, employing both quantitative and qualitative research.	Utilized online surveys, demographic questions, the Spiritual Care Competency scale, the Nurses' Spiritual Care Therapeutic scale, the Spiritual Care Practice questionnaire subscale, and	Highlighted the crucial need for spiritual care education, particularly in pre-license programs and workplace settings to increase competency and the frequency of spiritual care provision. The lowest scores were observed	The research revealed a positive correlation between self-reported spiritual care competence and spiritual care education. The study adeptly defines pertinent terms such as holistic care and spiritual care, explicitly addressing	The subjective nature of self-report tools, a homogeneous sample, and the absence of continuity in assessing nurses' knowledge over time.

Nursing, 38(1), 41–51. https://doi.org/10.1177/08980101198852266				open-ended questions. Statistical analyses included Pearson correlations, chi-square tests, and NORA to detect significant differences.	in the domain of implementing spiritual care, with a significant absence of spiritual care training at the workplace reported.	three primary research questions.	
Noome, M., Kolmer, D. B. G., Van Leeuwen, E., Dijkstra, B. M., & Vloet, L. (2016). The role of ICU nurses in the spiritual aspects of end-of-life care in	To investigate ICU nurse's responsibilities and role in regard to spiritual end-of-life care from the perspectives of chaplains.	11 Dutch chaplains from the National Chaplain Association, eight of whom worked in ICU settings within a community	Exploratory study	The association participated in a focus group interview, where they described the role of ICU nurses regarding spiritual aspects of EOLC. The five major	The chaplains uniformly agreed that it was essential for ICU nurses to be self-aware of their identity and their spiritual background, transcending personal biases to understand	A strength of this study is its use of clear and explicit definitions of terms, such as end-of-life care, spiritual needs, and spirituality. Provides a unique, unbiased perspective from a	Limited access to chaplains for the focus groups and the study being conducted in the Netherlands, potentially affecting the generalizability of conclusions to

the ICU: an explorative study. *Scandinavian Journal of Caring Sciences*, 31(3), 569–578. https://doi.org/10.1111/scs.12371	Explore ways in which ICU nurses can enhance their ability to meet the spiritual needs of EOLC patients and their families, drawing insights from a different discipline.	hospital. These chaplains represented diverse spiritual backgrounds, such as Roman Catholicism, Hinduism, humanism, and Buddhism.		themes identified from the interviews included 1) awareness of ICU nurses, 2) communication, 3) nursing interventions, 4) multidisciplinary care, and 5) education about the spiritual aspects of EOLC.	the spiritual needs of others. Understanding a family's dynamic, actively supporting the family members' needs, and involving chaplains in their multidisciplinary care were deemed essential for providing adequate care. The study underscored an ongoing need for spiritual care education to increase the knowledge and competency of ICU nurses, which can be	non-nursing provider. Integrates knowledge from spiritual and religious experts of all kinds, increasing the diversity of the study population, and the trustworthiness of the study.	chaplains practicing in the United States.

					achieved through chaplains serving as valuable educators.		
Bulut, T. Y., Çekiç, Y., & Altay, B. (2023). The effects of spiritual care intervention on spiritual well-being, loneliness, hope and life satisfaction of Intensive Care Unit Patients. *Intensive and Critical Care Nursing*, *77*, 103438. https://doi.org/10.10	To examine the effects of spiritual care interventions on the spiritual well-being, loneliness, hope, and life satisfaction of patients treated in intensive care.	Randomized pretest, post-test and control groups consisting of intensive care unit patients with chronic progressive diseases; 64 patients total with 32 in intervention group and 32 in control group	Experimental interventional study	Patients in intervention group received 8 sessions twice a week of spiritual nursing interventions according to the Traditions-Reconciliation-Understanding-Searching-Teachers (TRUST) Model, control group received routine nursing care	Following the intervention, the findings showed that spiritual care provided in the intensive care unit positively affected patients' spiritual well-being, hope, loneliness, and life satisfaction levels.	Describes the effectiveness of the TRUST model used in the study as an inclusive spiritual assessment and care model for both healthcare providers and receivers, confirms that nurses working in the ICU can develop a spiritually supportive environment by	No follow-up study conducted, small sample size, each individual had culturally different characteristics, research done in Turkey–poses potential cultural differences from nursing care in the United States

16/j.iccn.2023.103438						addressing spiritual issues of patients and making use of spiritual care services available in hospitals	
Riahi, S., Goudarzi, F., Hasanvand, S., Abdollahzadeh, H., Ebrahimzadeh, F., & Dadvari, Z. (2018). Assessing the effect of spiritual intelligence training on spiritual care competency in Critical Care Nurses. *Journal of*	To investigate the effect of spiritual intelligence training on the nurse's competence in spiritual care in critical care units	Performed on 82 critical care nurses (40 in experimental group and 42 in control group)	Semi-experimental study with two groups, pretest-posttest design	Experimental group participated in eight sessions of spiritual intelligence training, held in the form of workshops. No intervention was made in the control group. Scale for assessing nurses' competencies in spiritual care and	Results showed that the spiritual intelligence training had a positive effect on nurses' competence in spiritual care. 89% of nurses who participated did not have any prior education regarding spiritual care.	Emphasizes positive effect of spiritual intelligence training on nursing education, addresses lack of adequate training and education in spiritual care and barriers to providing spiritual care	Small number of participants, researching in a restricted geographic area, research is outside of US–takes place in Iran, potential cultural differences from nursing care in the United States

Medicine and Life, *11*(4), 346–354. https://doi.org/10.25122/jml-2018-0056				questionnaires were completed before, immediately after, and one month after the sessions in both groups.			
Eaton, T. L., Lewis, A., Donovan, H. S., Davis, B. C., Butcher, B. W., Alexander, S. A., Iwashyna, T. J., Scheunemann, L. P., & Seaman, J. (2023). Examining the needs of survivors of critical	To examine the needs of adult survivors of critical illness through a lens of palliative care	17 survivors of critical illness aged 34-80 recruited from a post intensive care unit of a mid-Atlantic medical center in the United States	Qualitative study	Interviews conducted February-March 2021 and occurred 13-33 months following the intensive care unit stay	Findings suggest that palliative care components such as symptom management, goals of care discussions, care coordination, and spiritual and social support may assist in the assessment and treatment of survivors	Study sheds light on components of palliative care that can be applied to the management of survivors of critical illness. Multiple domains of ongoing need were identified in survivors of critical illness 13–33 months	Interview data collected from community dwelling adults at a single site, family and caregiver voices not included in study, excluded survivors of critical illness who did not follow up at post ICU clinic setting

illness through the lens of palliative care: A qualitative study of survivor experiences. *Intensive and Critical Care Nursing*, *75*, 103362. https://doi.org/10.1016/j.iccn.2022.103362					of critical illness.	from their initial ICU stay	
Labuschagne, D., Torke, A.,	To describe the spiritual care	254 eligible patients identified	Retrospective observational	Observed delivery of spiritual care for	Spiritual care was provided to most	The study makes an important contribution	Results may not generalize to all ICU

Grossoehme, D., Rimer, K., Rucker, M., Schenk, K., Slaven, J., & Fitchett, G. (2020). Chaplaincy care in the MICU: Describing the spiritual care provided to MICU patients and families at the end of life. *American Journal of Hospice and Palliative Medicine®*, *37*(12), 1037–1044. https://doi.org/10.11	provided to patients and their families provided in the MICU (medical ICU)	during the study period, study conducted in convenience sample of 4 hospitals including three academic medical centers and a faith-based community hospital over a 3-month period	study	patients and families in the medical ICUs (MICUs) at 4 medical centers over a 3-month period. Inclusion criteria were death in the MICU or discharge to palliative care or hospice.	patients and/or families at the end of life. Low chaplain involvement in decision-making in the MICU suggests opportunities to improve chaplains' contributions to ICU care.	to understanding the spiritual care provided to patients and families in the MICU, Improving spiritual care provision in the ICU will require concerted efforts on the part of both chaplains and ICU clinicians responsible for coordinating care.	patients and families and may also not reflect the spiritual care provided to patients and families at other hospitals

77/10499091209129 33							
Hu, Y., Jiao, M., & Li, F. (2019). Effectiveness of spiritual care training to enhance spiritual health and spiritual care competency among oncology nurses. *BMC Palliative Care*, *18*(1). https://doi.org/10.11	To establish a spiritual care training protocol and verify its effectiveness	This study recruited 92 nurses at a cancer treatment hospital in a single province via voluntary sign-up. The nurses were divided into two groups—the study group (45 people) and the	Randomized controlled trial	The study group received one spiritual care group training session every six months based on their routine nursing education; this training chiefly consisted of lectures by experts, group interventions, clinical practice, and	After 12 months of intervention, the nurses in the study group had significantly higher overall spiritual health and spiritual care competency scores as well as significantly higher scores on all individual dimensions compared with those in the control group	Results of this study have great relevance at a time when a worldwide shortage of nurses exists. The protocol developed in this study should also be used to improve nurses' spiritual care knowledge and skills to enable them to better satisfy patients' spiritual needs and	All participants in this study included nurses in various departments of a single cancer hospital. A considerable portion of these participants consisted of head nurses or nursing staff members in their respective departments - some uncertainty remains

86/s12904-019-0489-3		control group (47 people)—using a coin-toss method.		case sharing. The control group participated in monthly nursing education sessions organized by the hospital for 12 continuous months.		improve their nursing quality	concerning the effectiveness of the intervention protocol when applied to nurses with less seniority

Appendix B: Instruments & Tools

Demographic Questionnaire

By: Dana Bagis & Joanne Nguyen, Dominican University of CA, Department of Nursing

This questionnaire aims to assess the nurse's demographic data and whether the nurse is eligible to participate in this study.

Please fill in the blanks or check the appropriate boxes for each of the following questions.

1. How do you identify your gender?	Please describe: _____ ☐ Prefer not to answer
2. What is your age?	_____
3. What is your ethnicity?	☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ American Indian ☐ Pacific Islander ☐ Other: _____
4. What is your religion or spiritual practice?	☐ Atheist ☐ Catholic ☐ Christian ☐ Evangelical ☐ Hindu ☐ Jehovah's Witness ☐ Jewish ☐ Mormon ☐ Muslim/Islamic ☐ Protestant ☐ None ☐ Other: _____
5. What is your highest degree earned in Nursing?	☐ Associate ☐ Bachelor's ☐ Graduate/Master's Degree ☐ Doctorate
6. How many years have you been working as a Registered Nurse?	☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ 11-15 years ☐ 16-20 years ☐ 21-25 years ☐ Other: _____
7. How many years have you been working in the ICU/Critical Care Unit?	☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ 11-15 years ☐ 16-20 years ☐ 21-25 years ☐ Other: _____
8. Have you had any prior training in spiritual care?	☐ Yes ☐ No

Pre-Training Written Questionnaire:

1. What does spirituality mean to you in the context of nursing practice and why is it important in patient care?
2. How do you assess and implement a patient's spiritual needs into their plan of care?
3. How comfortable do you feel initiating conversations about spirituality to patients and their families? Are there specific factors that influence this comfort level?
4. In your opinion, what are the barriers to providing spiritual care to patients?
5. Are there specific trainings or resources you believe would enhance your ability to provide effective spiritual care to ICU patients?

Post-Training Written Questionnaire:

1. Can you share an experience where you provided effective spiritual care for a patient? What was the outcome?
2. What is your experience like providing spiritual care after receiving training?
3. How do you collaborate with chaplains and other spiritual care providers in the ICU to address patients' spiritual needs?
4. What strategies do you use to create a culturally sensitive and spiritually inclusive environment for patients with diverse backgrounds or spiritual beliefs?

By: Dana Bagis & Joanne Nguyen, Dominican University of CA, Department of Nursing

Spiritual Care Competency Scale (SCCS)
By: René van Leeuwen

For each item, please estimate your own level of competency by checking the box that best reflects the extent to which you agree or disagree with each statement.

Domain 1: Assessment and Implementation of Spiritual Care

	Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree
1. I can report orally and/or in writing on a patient's spiritual needs.					
2. I can tailor care to a patient's spiritual needs/problems in consultation with the patient.					
3. I can tailor care to a patient's spiritual needs/problems through multidisciplinary consultation.					
4. I can record the nursing component of a patient's spiritual care in the nursing plan.					
5. I can report in writing on a patient's spiritual functioning.					
6. I can report orally on a patient's spiritual functioning.					

Domain 2: Professionalisation and Improving the Quality of Spiritual Care

	Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree
7. Within the nursing ward, I can contribute to quality assurance in the area of spiritual care.					
8. Within the nursing ward, I can contribute to professional development in the area of spiritual care.					
9. Within the nursing ward, I can identify problems with spiritual care in peer discussion sessions.					
10. I can coach other care workers in the area of spiritual					

care delivery to patients.					
11. I can make policy recommendations on aspects of spiritual care to the management of the nursing ward.					
12. I can implement a spiritual care improvement project in the nursing ward.					

Domain 3: Personal Support and Patient Counseling

	Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree
13. I can provide a patient with spiritual care.					
14. I can evaluate the spiritual care that I have provided in consultation with the patient and in the disciplinary/ multidisciplinary team.					
15. I can give a patient information about spiritual facilities within the care institution (including spiritual care, meditation center, religious services).					
16. I can help a patient continue his/her daily spiritual practices (including providing opportunities for rituals, prayer, meditation, reading the Bible/Quran, listening to music)					
17. I can attend to a patient's spirituality during the daily care (e.g. physical care)					
18. 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.					

Domain 4: Referral

	Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree
19. I can effectively assign care for a patient's spiritual needs to another care provider/care worker/care discipline.					

20. At the request of a patient with spiritual needs, I can in a timely and effective manner refer him/her to another care worker (e.g. a chaplain/patient's own priest/iman)					
21. I know when I should consult a spiritual advisor concerning a patient's spiritual care.					

Domain 5: Attitude towards Patient's Spirituality

	Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree
22. I show unprejudiced respect for a patient's spiritual/religious beliefs regardless of his/her spiritual/religious background.					
23. I am open to a patient's spiritual/religious beliefs, even if they differ from my own.					
24. I do not try to impose my own spiritual/religious beliefs on a patient.					
25. I am aware of my personal limitations when dealing with a patient's spiritual/religious beliefs.					

Domain 6: Communication

	Completely Disagree	Disagree	Neither Agree or Disagree	Agree	Fully Agree
26. I can listen actively to a patient's 'life story' in relation to his/her illness/handicap.					
27. I have an accepting attitude in my dealing with a patient (concern, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere, and personal).					

Note. Adapted from "The validity and reliability of an instrument to assess nursing competencies in spiritual care," by R.V. Leeuwen, L. J. Tiesinga, B. Middel, D. Post, and H. Jochemsen, 2009, *Journal of Clinical Nursing*, *18*(20), 2857–2869.