

Gardner-Webb University

Digital Commons @ Gardner-Webb University

Doctor of Nursing Practice Projects

Hunt School of Nursing

Summer 2021

Spiritual Dimensions of Care: Need for Spiritual Care Interventions in Nursing Clinical Practice

Jillian Jack

Gardner-Webb University, jjack@gardner-webb.edu

Follow this and additional works at: <https://digitalcommons.gardner-webb.edu/nursing-dnp>



Part of the [Palliative Nursing Commons](#)

Recommended Citation

Jack, Jillian, "Spiritual Dimensions of Care: Need for Spiritual Care Interventions in Nursing Clinical Practice" (2021). *Doctor of Nursing Practice Projects*. 15.

<https://digitalcommons.gardner-webb.edu/nursing-dnp/15>

This Project – Full Written is brought to you for free and open access by the Hunt School of Nursing at Digital Commons @ Gardner-Webb University. It has been accepted for inclusion in Doctor of Nursing Practice Projects by an authorized administrator of Digital Commons @ Gardner-Webb University. For more information, please see [Copyright and Publishing Info](#).

**Spiritual Dimensions of Care: Need for Spiritual Care Interventions in Nursing
Clinical Practice**

by

Jillian Jack

A project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the degree of
Doctor of Nursing Practice

Boiling Springs, North Carolina

2021

Submitted by:

Jillian Jack

7/21/2021
Date

Approved by:

Tina Lewis DNP, FNP-C, ACHPN, CEN

7/21/2021
Date

Abstract

Empirical research has identified emerging evidence concerning the value and importance of spirituality in the provision of nursing care. Spiritual well-being has important implications for a patient's well-being and there is evidence that points to the association between spirituality, individual healthcare outcomes, and quality of life (QOL). Assisting patients in meeting their spiritual needs is also recognized internationally. Despite the fact that spiritual care is an essential part of nursing care, there remains a gap concerning spiritual care practices in the nursing clinical environment. The magnitude of the problem has to do with the lack of spiritual care education training. This deficit has significant implications on the quality of life of the chronically ill patient. Spiritual care provides a sense of strength and support that chronically ill patients can draw from. This allows for improved quality of life. Developing competency to be able to care for patients with spiritual issues, continues to be a challenge in the clinical environment. One of the most important approaches to ensure the proper delivery of spiritual care to patients dealing with their chronic illness is through ongoing educational training for nurses in the clinical environment. This training will allow for competency in spiritual care delivery.

Keywords: spirituality, spiritual care, spiritual needs, spirituality and nursing care, spirituality, and quality of life.

Acknowledgements

First and foremost, I must give all honor, all praises, and thanks to the most High and Almighty God, who has continuously guided me, through countless blessings, knowledge, and opportunities that have afforded me the ability to complete this DNP written Dissemination.

Apart from my efforts through God's sustaining presence, the success of this thesis depends largely on the encouragement and guidance of many others. I would like to take this opportunity to express my gratitude to the people who have been instrumental in the successful completion of this thesis. My dearest mother for her love and unfailing prayers and encouragement. My daughter for her tremendous love and support in caring for her mother, making sure that I stayed healthy. My siblings, who showed their support through love and prayers and simply just being proud of me because of my endeavors. Last but certainly not least, all the faculty at Gardner-Webb, who was instrumental in making this educational journey the most fulfilling, and most impactful education period ever experienced. To all, my sincere gratitude.

Table of Contents

Problem Recognition	9
Potential Evidence-Based Solutions/Interventions	10
Desired Goal and Outcome	10
Problem Statement	11
Summary/Conclusion of Search for Evidence Process	11
Needs Assessment to Identify Gap	11
Targeted Population	12
PICO (T) Question Guiding the Inquiry	12
Literature Review	12
Specific Literature	13
General Literature	17
Summary/Conclusion of Search for Evidence Process	18
Needs Assessment	19
Suitable Sponsors and Stakeholders Identified	19
Organizational Assessment	19
Available Resources	21
Desired and Expected Outcomes	21
Team Selection	21
Cost/Benefit Analysis	22
Scope of Problem Defined	23
Goals, Objectives, and Mission Statement	24
Projects Purpose	25

Projects Outcome Objectives	26
Mission Statement.....	27
Theoretical Underpinnings.....	27
Jean Watson’s Caring Science, Theory used to Guide Project.....	27
How Watson’s Theory Applies to this Project	28
How Watson’s Theory is Incorporated into Entire Project.....	30
Conclusion	32
Work Planning	33
Project Management Tool.....	33
Timeline	34
Budget	35
Evaluation Plan	37
Implementation	39
Threats and Barriers.....	39
Monitoring of Implementation.....	44
Project Closure.....	46
Conclusion	46
Interpretation of Data	47
Quantitative Data	47
Process Improvement Data	58
Outcomes of the Project.....	58
What Changed Because of this Project.....	59
Impact of this Project and How it was Measured	60

How This Project Will Be Sustained	60
Measurements that Can be Collected in the Future	60
Conclusion	61
References	62
Appendices:	
A: CTE Diagram	68
B: The Plan-Do-Study-Act (PDSA) Document	69
C: Consent Form	72
D: Invitation Flyer	74
E: Pocket Guide Resource	75

List of Figures

Figure 1: SWOT Analysis	20
Figure 2: GANTT Chart.....	34
Figure 3: Work Breakdown Structure (WBS)	35
Figure 4: Budget Chart.....	36
Figure 5: Quality Improvement Chart.....	38
Figure 6: The Plan-Do-Study-Act Model	43
Figure 7: Visual Presentation of Question 1	49
Figure 8: Visual Presentation of Question 2	50
Figure 9: Visual Presentation of Question 3	51
Figure 10: Visual Presentation of Question 4	52
Figure 11: Visual Presentation of Question 5	53
Figure 12: Visual Presentation of Question 6	54
Figure 13: Visual Presentation of Question 7	55
Figure 14: Visual Presentation of Question 8	56
Figure 15: Visual Presentation of Question 9	57
Figure 16: Visual Presentation of Question 10	58

List of Tables

Table 1: SCCS Question # 1	48
Table 2: SCCS Question # 2	49
Table 3: SCCS Question # 3	50
Table 4: SCCS Question # 4	51
Table 5: SCCS Question # 5	52
Table 6: SCCS Question # 6	53
Table 7: SCCS Question # 7	54
Table: 8 SCCS Question # 8	55
Table 9: SCCS Question # 9	56
Table 10: SCCS Question #10	57

Problem Recognition

Spiritual care is an essential aspect when providing care to a patient. The scientific evidence to support the role of spiritual care in promoting and improving quality of life (QOL) is abundant. Still, to date, there remain identified gaps between practice and evidence allowing for a deficit of spiritual care provided by nurses.

Evidence-based education on spiritual care interventions is missing in the nursing environment. Research continues to suggest that nurses' knowledge and skills related to spiritual care are not adequate because of poor role preparation.

In reviewing the literature, significant gaps were still apparent in the current evidence base literature for spiritual care practice and education: (1) Best et al. (2020) concluded that “better education can help the healthcare practitioner avoid being distracted by their own fears, prejudices, and restraints and attend to the patient and his/her family. This EAPC white paper encourages and facilitates high quality, multi-disciplinary, academically and financially accessible spiritual care education to all palliative care staff”, (2) Harrad et al. (2019) concluded that “in general, student and qualified nurses are aware of the importance of providing spiritual care and are hindered by a lack of education about how best to implement such care”, (3) Farahani et al. (2019) concluded that “designing and implementing theoretical and practical training courses in the form of in-service training programs can help to overcome the existing problems and may be effective in promoting the provision of spiritual care”, (4) Atashzadeh-Shoorideh et al. (2018) concluded “it is of great importance to pay due attention to the different aspects of spiritual care and enforce factors that can act as facilitators in this area and remove the barriers to spiritual care. This aim is attainable through educating the parents and medical staff, (5) Kincheloe et al.

(2018) concluded “evidence-based spiritual care (SC) toolkit has the propensity to help nurses meet spiritual needs of hospitalized patients and families. However, successful implementation and sustainability require organizational support, funding for resources and SC training for staff”, (6) Wu et al. (2016) concluded “the findings of this study indicate the need for further educational preparation in spiritual care for nurses. Specifically, additional teaching materials are required that are more directly related to spiritual care”, (7) Melhem et al. (2016) concluded “spiritual care courses appeared to have a positive impact on their perception of spirituality and spiritual care. Enhancing nursing care by integrating standardized spiritual care into the current nursing care, training, and education should also be emphasized, and (8) Ramezani et al. (2014) in their published literature, concluded, “the findings can facilitate further development of nursing knowledge and practice in spiritual care and facilitate correction of common misconceptions about the provision of spiritual care”.

Potential Evidence-Based Solutions/Interventions

Review of the current evidence-based literature above provided solutions/interventions of scientific support for the proposed education of spiritual care for nurses to help nurses meet the spiritual needs of patients and families.

Desired Goal and Outcome

Support for the desired goals and outcomes was obtained from the reviewed literature. The desired goals were: (1) the education/training content will have a positive effect on nurse’s perception of spirituality and provide increased knowledge and skills in spiritual care delivery for chronically ill patients, and (2) nurses will be enabled to

consider the importance of providing quality spiritual care that includes support of the patient's spirituality.

The desired outcomes due to training/education were: (1) ensure nurses are competent and have the expertise to provide spiritual care that is relevant in practice and (2) competencies will guide spiritual care.

Problem Statement

Nurses lack knowledge in spiritual nursing care that has the potential to improve the wellbeing and healthcare outcomes of patients with acute on chronic diseases.

Summary/Conclusion of Search for Evidence Process

Strong evidence of the positive impact of spiritual care on patients' wellbeing and healthcare outcomes was obtained from each article reviewed. There was a general consensus that providing spiritual care is hindered by a lack of education about how best to implement such care.

Needs Assessment to Identify the Gap

The effect of spirituality on nursing continues to be profound. "Nursing philosophy is fundamentally based on an ethos of holistic care, however, spiritual aspects of care are often neglected" (Ali et., al, 2018). This needs assessment is a systematic approach to examine the gap in nursing practice surrounding nurse's inability to provide needed spiritual care that enhances the quality of life (QOL) for patients with chronic illnesses. Finding the discrepancy between the deficit of spiritual care and the ability to provide this care, must be measured appropriately.

Target Population

To identify if ongoing educational training for nurses caring for patients with a chronic illness, is the key to rectify this problem issue, a question statement is needed. The question statement was if educational training for nurses would improve their knowledge of and confidence in using spiritual care to enhance the quality of life for patients who have a chronic illness?

PICO (T) Question Guiding the Inquiry

For nurses working in a clinical setting, caring for patients with chronic illnesses (P) will an educational intervention to increase spirituality/spiritual care knowledge, (I) compare to no educational training, (C) affect the health and wellbeing of chronically ill patients, and (O) significant improvement in nurses' ability to provide spiritual care to patients with a chronic disease will lead to enhancement in the QOL for the patient.

Literature Review

The body of literature reviewed agrees that spiritual care is an essential part of nursing care in practice and that many patients have spiritual needs related to illness. Therefore, the patient's spiritual needs must be addressed because, the patient's quality of life, their satisfaction with care, and health care costs are impacted. The literature reviewed which included international studies identified a deficiency of spiritual care nursing practices and a great need for educational training on the importance of spiritual nursing care in the clinical environment. The databases used for the literature review included CINAHL, Pub med, MEDLINE, ProQuest, and the Cochrane Library. Keywords used in the literature search included spirituality, holistic health practices, spiritual nursing care, nursing education, spiritual care competency, quality of life, and

chronic illness. The search covered literature published between 2008-2019. An extensive review of many articles was completed, all of the articles had the same consensus on the importance of spiritual care in nursing practice and the need for educational training in the spiritual care of patients. Of these articles, the following were specific to the evidence of positive outcomes of spiritual care education training for effective application in the nursing practice environment.

Specific Literature

Although most nurses are efficient in providing adequate care for the physical dimensions of the patient's care, they lack the knowledge of how to provide vital spiritual nursing care needed. Jeong et al. (2016) conducted a study that employed a non-equivalent control group pretest-posttest design on a quasi-experimental basis. Subjects were 93 nurses (46 in an experimental group and 47 in a control group) with more than 2 years' clinic experience, attending a bachelor program at K University in the city of Korea. The program consisted of courses with 2.5 hours per week for 7 weeks. The results indicated scores of spiritual needs and spiritual nursing competence increased significantly in the experimental group. The score of spirituality and spiritual well-being also increased in the experimental group, but not significantly. This study concluded that the spiritual care module education program was considered to be an effective nursing intervention education course. Nurses educated with this program seemed to perform better nursing interventions for subjects facing difficulties or confusion by helping them restore and cope with those problems by themselves. Therefore, it is recommended that the spiritual care module education should be settled as a regular course of nursing

college with consideration to the corrections and supplements mentioned in this study (2016).

Hu et al. (2019) conducted a study 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 control (wait-listed) group (47 people) using a coin-toss method. The study group received one spiritual care group training session every 6 months based on their routine nursing education; this training chiefly consisted of lectures by experts, group interventions, clinical practice, and case sharing. The control group participated in monthly nursing education sessions organized by the hospital for 12 continuous months. This study concluded a spiritual care training protocol for nurses based on the concept of mutual growth with patients enhances nurses' spiritual well-being and spiritual care competencies (2019).

Vlasblom et al. (2011) stated spirituality training for nurses may be necessary to give spiritual care the attention it deserves. These authors conducted a trial "spirituality and nursing care" training which was provided to nurses from four different nursing wards in a non-academic, urban hospital. Prior to the training and 6 weeks after the training, nurses and all patients were asked to fill up a questionnaire. In addition, the number of referrals from nurses to the chaplaincy was examined. Compared to before (n=44 patients), after the training (n=31) the patients from the intervention wards experienced more receptiveness and support when asking questions about illness and meaning. There were also specific changes in nurses' attitudes and knowledge, changes in clinical practice such as documenting spiritual needs, and the number of referrals to the

chaplains was higher. The results indicated that training in spiritual care for nurses may have positive effects on health care that patients can experience (Vlasblom et al., 2011).

Attard et al. (2014) conducted a study aimed to identify the predictive effect of pre-and post-registration 'taught' study units in spiritual care competency of qualified nurses/midwives. The study used a purposive sample of 111 nurses and 101 midwives that were eligible to participate in the study. Quantitative data were collected by the Spiritual Care Competency Scale (SCCS) (Van Leeuwen et al., 2008) [response rate: nurses (89%; n=99) and midwives (74%; n=75)]. The results of the study showed that overall nurses/midwives who had undertaken the study units on spiritual care scored higher in the competency of spiritual care. Although insignificant, nurses scored higher in the overall competency in spiritual care than the midwives. Attard et al. (2014) concluded 'taught' study units on spiritual care at pre- or post-registration nursing/midwifery education may contribute towards the acquisition of competency in spiritual care.

A study by Lind et al. (2011) used the Avatar Likert scale to monitor patient satisfaction after spiritual care training of nurses. Respondents who strongly agreed that nurses addressed their spiritual and emotional needs increased by approximately 10% each quarter after spirituality training was given to nurses. The medical records were also checked for the number of times nurses consulted with pastoral care services and how often the spiritual care plan was used. The recorded use of the spiritual care plan increased from no previous use to one to four uses per month during the first 3 months after the spiritual training. Nurses stated that they were more comfortable with assessing spirituality needs and delivering interventions for spiritual care issues after the training (2011).

Wallace et al. (2008) conducted a study that evaluated a program's effectiveness in improving nursing student's knowledge of spiritual care among older adults, using pretests and posttests to measure students' knowledge about spirituality and spiritual care. The study used a 17-item pretest and posttest tool with a 5-point Likert-like scale that asked respondents to choose an answer from strongly disagree (1) to strongly agree (5) based on their opinion about the item. Construct validity was tested on a sample of 549 nurses. Paired t-tests were used to compare pretest and posttest junior and senior student scores before and after the spirituality and spiritual care were added to the curriculum. The test results showed a statistically significant positive difference between the pretest and posttest scores. The nursing students had more knowledge and were more comfortable with practicing spirituality interventions after completing the curriculum (2008).

Moghimian et al. (2019) conducted a study aimed to explore the inter-professional dimensions of spiritual care for chronically ill patients. An exploratory qualitative study was done in Isfahan, Iran, on a purposive sample of 25 participants including patients, family caregivers, nurses, physicians, psychologists, social workers, and religious counselors. Data were collected through semi-structured interviews and analyzed through conventional content analysis. The study concluded that spiritual care has different dimensions. Its delivery necessitates adequate knowledge and expertise, close inter-professional collaboration, effective teamwork, and an efficient patient referral system (2019).

O'Brien et al. (2018) conducted a qualitative study to explore nurses' and healthcare professionals' perceptions of spiritual care and the impact of spiritual care

training on their clinical roles. The study recruited a total of 21 generalist and specialist nursing and healthcare professionals from North West and South West England who undertook spiritual care training between 2015–2017. Participants were required to do a minimum of 3 months post-training. Digitally audio-recorded semi-structured interviews lasting 11–40 min were undertaken in 2016–2017. Data were subjected to thematic analysis. From the results of the study, two main themes were identified, recognizing spirituality, with subthemes of what spirituality means and what matters, and supporting spiritual needs, with subthemes of recognition of spiritual distress, communication skills, not having the answers, and going beyond the physical. The study concluded supporting patients as they approach the end of life needs a skilled workforce, acknowledging the importance of spiritual care, and having skills to address it are central to the delivery of the best holistic care.

General Literature

The literature review noted a growing body of evidence that indicated spiritual care training as the main element needed to enable nurses to better perceive patients' needs for spirituality and spiritual care. Vargas-Escobar et al. (2019) stated in the discussion section of their article, titled 'Effects of an Educational Intervention Delivered to Senior Nursing Students to Strengthen Spiritual Care for People with Chronic Illness' has made mention of many researched articles that have the same consensus, on the need for spiritual care training. Under the discussion section, Vargas-et al. (2019) indicated that, in the study of Cruz et al. (2017) the results noted 54% of the participants mentioned having poor training in this area and even having difficulties dealing with conversations related to death despite recognizing the importance of these topics, an issue that is also

pointed out in other studies by Ramos et al. (2016) and Rushton et al. (2015). Rushton et al. (2015) reported that a significant proportion of students may perceive indifference regarding patients' need for spiritual help and other measures associated with spiritual support, such as rituals related to faith and hope. Also mentioned under the discussion section of Vargas-Escobar and Guarnizo-Tole's (2019) article was the study by Espinha et al. (2013), in which 76% of students believed that spirituality has an influence on health, but only 10% felt prepared to provide this type of care (Vargas-Escobar & Guarnizo-Tole, 2019). Noted in the main theme of all of the studies were "inadequate or insufficient education on the subject of spirituality could impede providing spiritual care in practice and to not meeting the spiritual needs of chronic patients" (Vargas-Escobar & Guarnizo-Tole, 2019).

Summary/Conclusion of Search for Evidence Process

The identified PICO (T) question asked about an intervention, comparing educational training intervention with no educational training intervention. The literature consistently suggested that the knowledge and skills of nurses related to spiritual care in practice were not adequate because of poor role preparation. The literature indicated strong evidence that the intervention of educational training in spiritual care delivery will modify the perceptions of spirituality and how to provide spiritual care. Nurses will then be equipped with the ability to deliver needed spiritual care to patients with chronic illnesses. The barrier most strongly cited in literature was a lack of or inadequate training.'

Needs Assessment

Suitable Sponsors and Stakeholders Identified

Organizational buy-in and support from key sponsors and stakeholders for program effectiveness will require the involvement of the administrative leaders, nurse leaders/managers, nurses, nurse mentors, support staff, program participants (nurses), health education personal, human resources, materials management, and IT support. The process of building strong relationships with stakeholders requires analyzing each stakeholder, assessing their influence, keeping them informed and involved, and understanding their expectations. Stakeholders will then be more involved with the work of the project and the collective focus of interest would be to affect nurse's ability to become knowledgeable about spiritual care and become competent in providing such care to their chronically ill patients. The views of the nurse will be given priority.

Organizational Assessment

When conducting the organizational assessment, key concepts of focus will be to analyze the organization's environment (the different contexts that affect the organization and its performance) and motivation (understanding the organization's culture). In the assessment process, it is necessary to assess the preparedness of the organization to adopt the transformation, in doing so, it will be necessary to meet the suitable sponsors and stakeholders, observe the dynamics of the clinical environment and assess the four aspects that are strengths, weaknesses, opportunities, and threats of the organization's resource.

The SWOT analysis (Figure 1) is a tool used to assess an organization's strengths, weaknesses, opportunities, and threats. A SWOT analysis is often performed for DNP projects and helps to proactively guide the project (Zaccagnini & White, 2017).

Figure 1

SWOT Analysis

<p>Strengths</p> <ul style="list-style-type: none"> - Managerial personnel on board who possess good judgement skills, has strong prioritization and strategizing abilities, has effective, efficient communication skills, and has the ability to empower individuals in the project team. - There is organizational buy-in and support. Human resource professionals play a key role in designing and managing the wellness program. Professionals will put together a cost-effective assessment and an evaluation protocol that will generate solid, strategic information for the self-care program implementation. - Professional certified personal with the expertise, experience, and capabilities needed to carry out program plans for self-care with the right type of planning, implementation, and maintenance. Understanding the need to generate and sustain nurse engagement in the self-care program to achieve health management goals. - Informational personnel provides support for key aspects of the educational training program such as the learning environment relating to enhancement and facilitation of teaching and learning activities. 	<p>Weaknesses</p> <ul style="list-style-type: none"> - Human resources are costly and this is the largest portion of the training program budget. The organization has other competing priorities for financial resources which could influence the allocation of financial resources for the education program. - Budget resources for ongoing long-term maintenance of the program in terms of continuing education may be limited, hindering sustainability of implemented program goals. - Nurses with holistic certification will be beneficial in the planning, implementation, and maintenance of this spiritual care education program. Resources to hire a certified holistic nurse may not be available.
<p>Opportunities</p> <p>Opportunities recognized are:</p> <ul style="list-style-type: none"> - The lack of attention to a patient's spiritual need constitutes a significant opportunity for improvement. - Patient satisfaction will be greatly improved – -Because there is a relationship between the care of a patient's spiritual and emotional needs with overall patient satisfaction, there will be less stress and absenteeism among staff. - The educational program will comprehensively not only help nurses become experts at addressing the spiritual needs of patients, but nurse's spiritual health will also be positively impacted. 	<p>Threats</p> <ul style="list-style-type: none"> - An area of difficulty would be nurse's receptiveness to buy-in; how to get nurses motivated to become involved in the program, particularly when they are very stressed and the burnout level is high. - The current culture may be cynical and fatigued and this would decrease efforts to change.

Available Resources

Available resources include managerial resources, human resources (HR), health education personal, and informational resources. Aspects of how these resources will be effective for the implementation and sustainability of this educational program are discussed in the strengths section of the SWOT analysis. Resources must support educational training activities to achieve the specific intended result.

Desired and Expected Outcomes

The purpose of the project was to provide nurses with evidence-based educational training on spiritual care. The most valuable impact will be the desired and expected outcome which has to do with the very purpose for which the educational training program will be created. Therefore, the important outcome is that the educational training would improve nurses' knowledge of how to provide comprehensive holistic spiritual care to patients with chronic illnesses. This greater knowledge and understanding of how to apply spiritual care in practice should occur in nurses as a result of the educational intervention. Performance should point towards fulfillment.

Team Selection

The DNP project team was responsible for supporting, overseeing, and approving DNP project work. In conjunction with the DNP project chair, team selection consisted of the practice partner chosen from the practice learning environment and the project committee member chosen from the practice learning environment.

The DNP project chair had the task of helping me manage and facilitate the DNP project by guiding the essential steps towards the completion of this important project.

These steps included the monitoring of progress, revising project plans as needed in order to ensure that the necessary activates were incorporated, and ensuring IRB compliance.

The practice partner was a support person within the DNP project setting, who assisted with a variety of activities related to and aligned with the achievement of the DNP essentials. These activities consisted of meeting with stakeholders at the practice setting to gain approval/support for the DNP project, attending meetings, etc.

The DNP project committee member had the important responsibility of providing guidance and direction in the development and implementation of the DNP project towards the final project defense stages. The committee member provided constructive feedback and gave specific expectations for project improvement, and also evaluated readiness to proceed with the implementation of the proposed project.

Cost/Benefit Analysis

To identify all costs associated with the proposed action, a cost/benefit analysis was needed to compare the financial costs with the benefits of the project implementation. The cost-benefit analysis consisted of fixed costs, variable costs, expenses, and potential revenue. Fixed costs involved costs for payroll expenses, IT support, clerical support, and materials for tutoring. Variable costs involved ongoing health education to establish stability and strength for program functions. Expenses would involve costs for (1) personnel services which is cost associated with time; time spent by staff on program planning, program promotion costs, technology costs, staff training time, employee participation, program incentive costs, (2) material costs (tangible items needed to provide the intervention and for program support) to include holistic care items such as aromatherapy oils, computer hardware, and software cost, (3)

service costs needed for the program workshop available for each shift, (4) cost associated with the provision of incentives to encourage participation. Potential revenue would involve the organizational long-term savings due to (1) nurse satisfaction and increased nurse retention, and (2) long-term health costs (spiritual distress is prevalent among patients with chronic illnesses and is associated with poor quality of life and increased healthcare costs).

Significant costs for this program will center around labor costs for training. The cost will be incurred for nurses attending the educational training, In-kind donations which include donated time and services will also be included in the cost analysis. When looking at potential revenue concerning long-term costs, the total benefits are higher than the total costs, and the project would be a potentially worthwhile investment.

Scope of Problem Defined

The magnitude of the problem has to do with the lack of spiritual care education training. This deficit has significant implications on the quality of life of chronically ill patients. To define the scope of this problem which is ‘Gap in Nursing Practice Concerning Spiritual Care’, it is necessary to talk about the significance of why spiritual care for chronically ill patients is of critical importance and needs to be addressed in the clinical practice environment. Spiritually care provides a sense of strength and support that chronically ill patients can draw from. This allows for improved quality of life.

“People with chronic illness have identified spirituality as a resource that promotes Health-related quality of life” (Megari, 2013). The question then is, how is spirituality currently approached in the clinical setting, and to what extent do nurses feel competent in assessing and delivering spiritual care in practice? Developing competency

to be able to care for patients with spiritual issues, continues to be a challenge in the clinical environment. One of the most important approaches to ensure the proper delivery of spiritual care to patients dealing with their chronic illness is through ongoing educational training for nurses in the clinical environment. This training will allow for competency in spiritual care delivery.

Goals, Objectives, and Mission Statement

Reclaiming the link between spirituality and healthcare through ongoing evidence-based educational training is of critical importance. The World Health Organization in 1998, recognized the importance of including spirituality in the care of patients to affect the healing process. This recognition states “until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and faith. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realize the value of elements such as faith, hope, and compassion in the healing process. The value of such ‘spiritual’ elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension, emphasizing the seamless connections between mind and body” (World Health Organization (WHO), 1998). Spiritual care which is compassionate care involves the serving of the whole person that is the physical, the emotional, the social, and the spiritual being. It is important to note that “health is not just the absence of disease, it is a state of physical, psychological, social and spiritual well-being” (World Health Organization, *Precis of discussion*, 1948). In order to reclaim this link between spirituality and healthcare, one

must appreciate that spirituality and religion are not synonymous. “Religion refers to an organized system of beliefs shared by a group of people and the practices related to that system, such as the practices of rituals, worship, prayer, meditation, style of dress, and dietary observations” (Burkhardt & Nagai-Jacobson, 2016). Spirituality on the other hand “is the essence of one’s being and is integral to all persons. Spirituality is a manifestation of each person’s wholeness and being that is not subject to choice but simply is. Being spiritual is integral to the human experience in the same way that being physical, emotional, and sexual are part of being human. Religion is chosen. Spirituality is expressed and experienced in many ways, both within and beyond the context of religion” (Burkhardt & Nagai-Jacobson, 2016).

In order to provide a balance of care towards a better quality of life, spiritual care needs to be a part of the healing process for patients. “The work of healing requires recognition of the spiritual dimension of each person, including the healer, and an awareness that spirituality permeates every encounter. The shared relationship acknowledging the common humanity and connectedness between the caregiver and the receiver, which is basic to healing, is a manifestation of spirituality (Burkhardt & Nagai-Jacobson, 2016). Spiritual care is necessary and important because it has implications for an individual’s health and well-being; such care provides support in helping patients to process what is happening to them.

Projects Purpose

The purpose of this project was to assess nurses’ knowledge of spirituality and spiritual care and provide nurses with evidence-based educational training information on spirituality and spiritual care, in order to fill knowledge gaps in the clinical practice

environment. This project aims to increase nurses' preparedness and ability to provide spirituality assessments and care in the clinical practice setting.

Projects Outcome Objectives

The intent of this DNP project was to fill the knowledge and practice gap among nurses regarding the application of spiritual nursing care. The following quote by Swinton (2005) provides the essence of this project. The quote is as follows: "illnesses are deeply meaningful events within people's lives, events that often challenge people to think about their lives quite differently. Spirituality sits at the heart of such experiences. A person's spirituality, whether religious or non-religious, provides belief structures and ways of coping through which people begin to rebuild and make sense of their lives in times of trauma and distress. It offers ways in which people can explain and cope with their illness experiences and in so doing discover and maintain a sense of hope, inner harmony, and peacefulness in the midst of the existential challenges illness inevitably brings. These experiences are not secondary to the 'real' process of clinical diagnosis and technical care. Rather they are crucial to the complex dynamics of a person's movement towards health and fullness of life even in the face of the most traumatic illness" (Swinton, 2005). This project has three objectives:

- (1) Evaluation of nurses' knowledge of spirituality: the use of a spirituality and spiritual care rating scale will be utilized to measure the nurses' knowledge, attitudes, and beliefs about spirituality and spiritual care practices.
- (2) Provide evidenced-based educational training on spiritual assessment/spiritual care.

- a. Nurses will become aware of the need to not only respond to the patient's physical need but also respond to spiritual needs that occur.
 - b. Nurses will gain an understanding that the spiritual dimensions of people's lives require compassionate caregiving.
 - c. Nurses will gain an understanding of their own spirituality and how to nurture it to make it become part of their professional growth.
- (3) Determine if the educational training on spirituality, improved nurse's knowledge and preparedness/ability to apply in practice in order to deliver spiritual care.

Mission Statement

Commitment to the belief that offering spiritual care which is compassionate care and emotional support will be and is a vital source of healing and improves the quality of life for patients with a chronic illness. To embrace the learning experience in doing this research and will provide the highest quality of evidence-based education that would allow for an increase in knowledge and ability to provide spiritual care in the clinical environment.

Theoretical Underpinnings

Jean Watson's Caring Science, Theory used to Guide Project

Jean Watson's Caring Science Theory is a theological framework that best fits the researcher's personal philosophy. Because the framework of Watson's caring theory is the promotion of holistic care, this theoretical framework is also the best fit to provide guidance for spiritual care in clinical practice. Watson's caring science theory is considered most beneficial in guiding the project. Watson's theory mainly concerns how nurses care for their patients. Briefly stated in Watson Caring Science (2017)

“The application of Watson’s theory is demonstrated as the practice of loving-kindness, equanimity, authenticity, enabling, cultivating a spiritual practice; developing a relationship that is helping-trusting; enabling the expression of both positive and negative feelings; having a caring-healing practice; a willingness to learn for the caring experience; being able to engage in a teaching-learning experience that is genuine; enabling and creating environments that are healing; caring for basic needs, both spiritual and physical; and, being open to spirituality”.

Watson believes that “spirituality upholds foremost importance in our profession and ascertains that the care of the soul remains the most powerful aspect of the art of caring in nursing (Cara, 2003). “The ability to connect with and embrace the spirit or soul of the other as they face life-limiting illness is at the heart of providing spiritual care” (Costello, 2018). Watson’s theory encourages nurses to genuinely engage spiritually with their patients, in order to allow the promotion of health not only through medical means but through spiritual means.

How Watson’s Theory Applies to this Project

Watson’s caring theory is most relevant to and applies to this project issue because it provides principles that underpin the importance of spiritual care in clinical practice. In Watson’s framework, spirituality is described as being the central idea in her theory “Watson describes nurses working within this framework as promoting the mind, body, and spirit, regardless of the health problem, age, or life circumstances. Caring theory, according to Watson, is relevant in understanding the importance of hope and spirituality to one’s well-being” (Touhy, 2001).

Watson emphasized the importance of nurses offering spiritual support in a caring environment. This caring environment is sustained when nurses maintain emotional sensitivity and caring attitudes.

The major elements of Watson's theory are (a) the Carative factors, which is now known as the concept of clinical Caritas processes, (b) the transpersonal caring relationship, and (c) the caring occasion/caring moment. Of these three major elements, the concepts of the clinical Caritas processes, more specifically, two of the 10 Caritas processes, are the main concepts used in guiding this project.

"Watson viewed the "Carative factors" as a guide for the core of nursing. She used the term Carative to contrast with conventional medicine's curative factors. Her Carative factors attempt to honor the human dimensions of nursing's work and the inner life world and subjective experiences of the people we serve" (Watson, 1997, p. 50). Watson continued to evolve her theory to then introduce the concept of clinical Caritas processes, which has now replaced her Carative factors. According to Cara, in her journal article titled, A Pragmatic View of Jean Watson's Caring Theory, the reader will be able to observe a greater spiritual dimension in these new processes (2003). Caritas Process #2 and #5 are the specific clinical processes chosen to guide this quality improvement intervention.

In these two clinical processes, Watson (2001), explains their concept as:

- (2) Being authentically present and enabling and sustaining the deep belief system and subjective life world of self and the one-being-cared-for.

- (5) Being present to, and supportive of, the expression of positive and negative feelings as a connection with a deeper spirit of self and the one-being-cared-for. (Watson, 2001, p. 347).

Jean Watson's theory of Caring Science truly supports the need for holistic nursing care. "Upholding Watson's caring theory not only allows the nurse to practice the art of caring, to provide compassion to ease patients' and families' suffering, and to promote their healing and dignity but it can also contribute to expanding the nurse's own actualization" (Cara, 2003).

This framework can provide the "development of caring and healing practices that can facilitate spiritual care" (Costello, 2018). Just as the purpose of Watson's caring theory is to positively influence the health and quality of life of patients, so too is the aim of this project which seeks to improve nurse's ability to effectively provide spiritual care to the chronically ill patient to ultimately influence the health and quality of life for the patients we serve.

How Watson's Theory is Incorporated into Entire Project

Spirituality is an important aspect of nursing care for patients with a chronic illness, this means, attending to the patient's basic spiritual needs would be critically important. These basic needs include needs "related to love and belonging, hope, meaning and purpose, faith, and belief, making the most of remaining time (Ross & Austin, 2015). The implementation of Watson's theory, in this quality improvement project, using the two Caritas Processes mentioned above, is geared to help nurses become aware of and improve their ability to provide spiritual care to patients with chronic illness in the clinical environment. Watson's concept of clinical Caritas processes

is utilized to support the development of this project. The problem recognized here, which is the lack of spiritual care interventions in the clinical environment, identifies with the absence of the clinical Caritas processes in Watson's theory. The evidence-based literature on this project's issue is abundant, and in the literature, one of the main indicators or best practices noted to fix this issue is ongoing evidence-based training education. Watson's Caritas Processes, #2 and #5 will be used as the basis to facilitate this spiritual care education intervention for nurses in the chosen clinical environment.

The educational training would include training on caring practices based on the ideas of the two chosen Caritas processes. Caritas process #2 implemented in the spiritual care education training program materials, would educate on the importance of the following caring practices:

- (1) Sitting at eye level with patient,
- (2) Practice of deep listening-be fully present,
- (3) Resist the impulse to fix patient problems. Develop a level of comfort sitting in silence (Costello, 2018).

The understanding of the importance of these clinical practices will facilitate the understanding of how the nurse can be authentically present and enabling, and able to sustain the deep belief system and subjective life world of self and one-being cared for. Caritas process #5 implemented in the spiritual care education training program materials, would educate the nurse on the importance of the following caring practice:

- Explore existential concerns including life review, assessment of hopes, values, fears, meaning purpose, and belief about the afterlife (Costello, 2018).

The understanding of the importance of this caring practice will facilitate the understanding of how to be present to, and supportive of the expression of positive and negative feelings of patients. The Conceptual-theoretical-empirical structure (CTE) diagram (Appendix A) provided a general perspective of what is important to observe.

This education intervention is geared to enhance nurse's knowledge of spiritual care which would allow for increased ability to be able to address patients' spiritual needs on basic levels. Incorporating the concepts of these two Caritas processes into the formulation of this education intervention is essentially important to help enlighten nurses on how to assist with the basic spiritual needs of the patient. Watson's theory is incorporated into the entire project to help illuminate or emphasize the importance of spiritual care in clinical practice. The theory's concepts will be used to discuss the relationship between spirituality and caring. Evaluation of this education intervention will be sort through the use of the survey tools. All data collected from the pre/post-test survey will use to analyze the change in knowledge/understanding from the pre-education survey to the post-education survey.

Conclusion

Ultimately, Jean Watson's theory of caring has a strong connection to the principles of this quality improvement project and what this project is wanting to accomplish. In healthcare practice, Watson's theory of caring encourages an open approach to spiritual care, in order to allow a more positive experience in the healthcare environment for all parties. Watson's concept of clinical Caritas processes undoubtedly indicates spiritual care as having a strong influence on the health-related dynamics of a

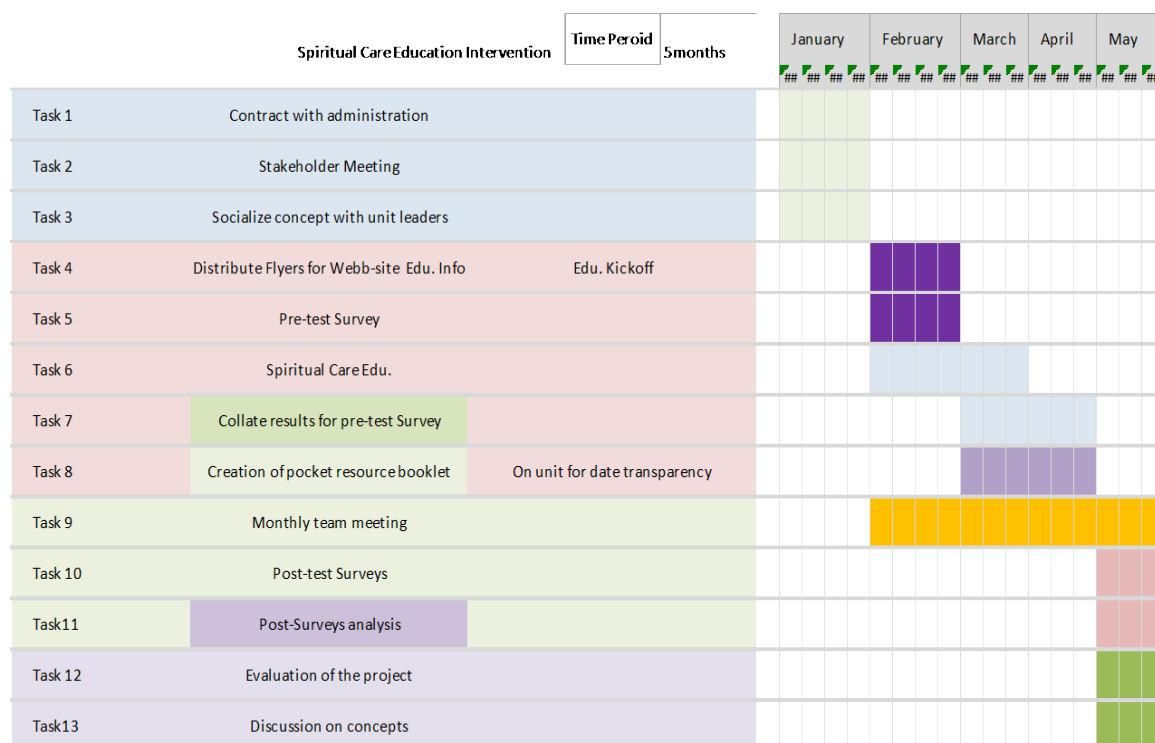
patient, the patient's attitude as well as their behavior, and should be fully incorporated in normal nursing care.

Work Planning

The success of this project depends on the development of project management tools which include milestones, a timeline, and a budget for implementation of this project plan. Management tools will provide the structure needed to help keep this project plan on track and ensure the project's success. Assessment of Spiritual Dimensions of Care: Need for Spiritual Care Interventions in Nursing Clinical Practice, DNP project, is a quantitative study designed to survey the knowledge and level of competency in providing spiritual care to chronically ill patients in the Geriatric Extended Care/Community Living Care (CLC) units of the Salisbury VA.

Project Management Tool

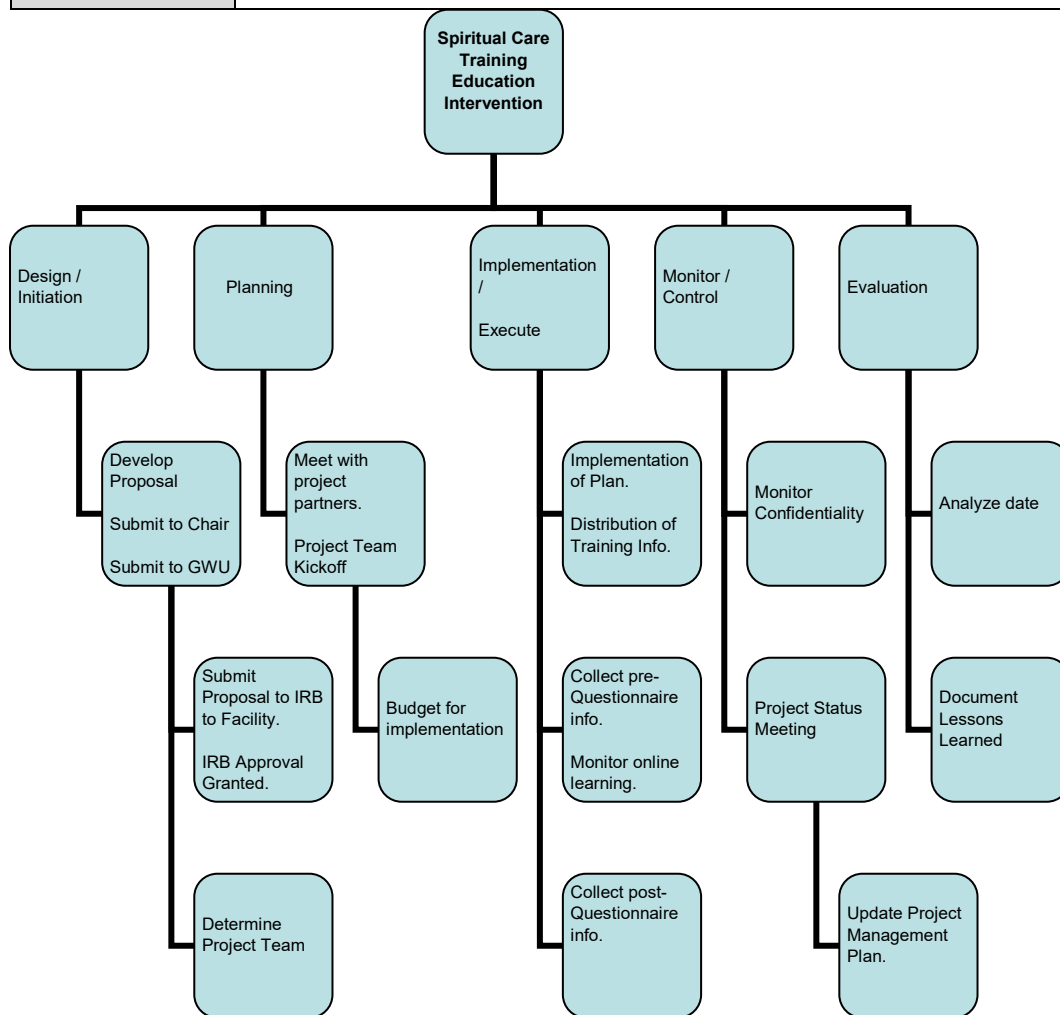
Assessment of nurses' knowledge and level of competency in providing spiritual care and education intervention is outlined in the GANTT chart (figure 2). This chart provides an estimation of the time each step should occur. The tasks outlined, will be applied over a period of 5 months. The intervention started in February 2021 with data compilation starting in May 2021. Steps may need to be altered and timing adjusted as necessary as the project matures.

Figure 2*GANTT Chart***Timeline**

A structured approach required to complete project objectives is provided in the Work Breakdown Structure (WBS). The work breakdown structure provides the framework for how the interventions, implementations, and evaluations are developed. These detailed steps must be completed before project implementation.

Figure 3*Work Breakdown Structure (WBS)*

Project Name:	<i>Spiritual Dimensions of Care: Need for Spiritual Care Interventions in Nursing Clinical Practice</i>
Project Manager:	Jillian Jack
Date:	10/18/2020

**Budget**

Budget for assessment of nurses' knowledge and level of competency in providing spiritual care and education intervention will have minimal cost. Significant time spent for the program centered around the web education setup. The use of the

spiritual care survey questionnaire is at no cost. In-kind donations, which are contributions or donations of service and time, are also included in the cost analysis. In addition, one statistical expert with statistical analysis skills will be recruited to participate in the analysis of the data. The project team will take on additional responsibilities to educate and work with the team in implementing the intervention.

Figure 4

Budget Chart

Type of Expense	Cost
Training	3 Months
Project Lead	\$0
Assistant Chief Nurse, Nurse Managers (4 participants at \$85/hr. X 8 hours total meeting times.	\$2,720 (In-kind)
Approximate cost for 50 RNs/LPNs for time spent in online training	\$6000
Material cost to include Web education set up. Approximate cost	\$500
Use of Questionnaire tool	\$0
Pre and post-survey analysis	\$300
Project team meetings	\$1400 (In-kind)

The Gantt Chart and the Work Breakdown Structure (WBS), estimates the critical path duration of the project as well as identifies the critical activities that must be considered toward project completion. These tools help to define how this project will be monitored, controlled, and executed. The project manager would ensure that the resources in place, such as the budget and staff time, be appropriate to allow the program's activity to be produced. The budget contains calculating direct and indirect

costs needed. This work planning activity seeks to point-point needed tasks required to achieve project outcomes.

Evaluation Plan

Project intervention will be the implementation of web-based education training, with a focus on providing spiritual care for patients. The dependent variable of this project plan is nurse's feelings about their capacity to execute behaviors necessary to provide spiritual care/support to their patients. The Spiritual Care Practice (SCP) survey questionnaire tool would be used to evaluate spiritual care competencies in nurses of the Geriatric Extended Care/Community Living Care (CLC) units of the Salisbury VA facility. A pre/post-test survey will be used to assess this variable.

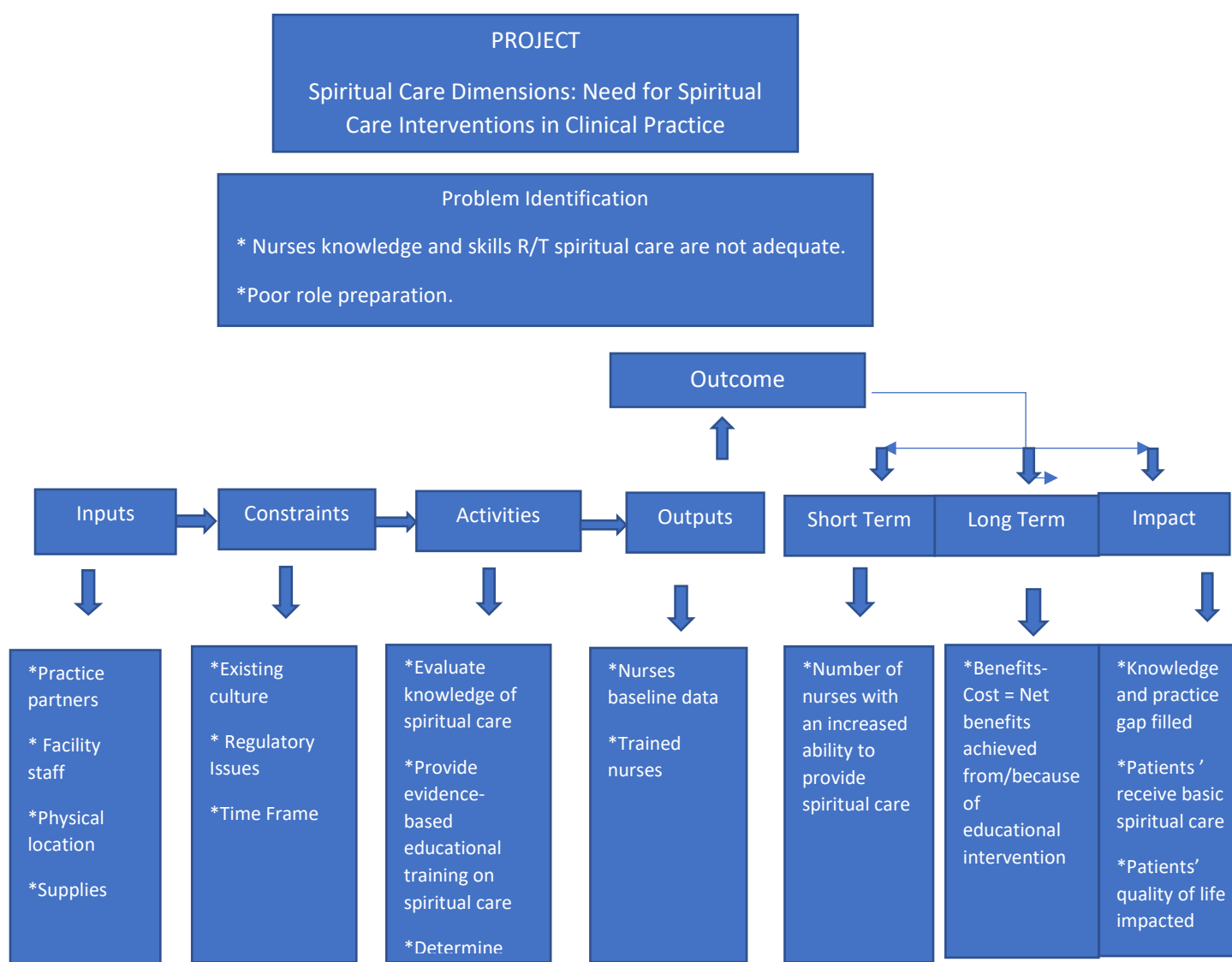
Examination of nurses' competency to ensure that they possess the ability to provide basic spiritual care to their chronically ill patients is necessary. The goal is to expand the role and influence of the nursing staff in the CLC units, over the next five months and lead the way to the understanding of spiritual care practices in which evidence-based practices direct care. Measures chosen to study outcomes and the processes of the intervention were in the area of nurse knowledge regarding the application of basic spiritual care for the improvement in quality of care for a chronically ill patient. Upon validation of the survey, nurses will complete a pre/post-test survey of which the data from the survey would be used in the evaluation of the effectiveness of the project plan intervention. When interpreting the outcome of this DNP project, the data collected post-intervention should be aligned with current evidence, which indicates a direct correlation between the lack of spiritual care interventions in promoting and

improving quality of life (QOL) and the lack of evidence-based education on spiritual care interventions, missing in the nursing clinical environment.

The following is a Quality Improvement chart with a look at measures needed for accomplishing the project plan. It includes what changes are going to be needed, what plan is needed to make these changes, how the plan is initiated and the plan results obtained.

Figure 5

Quality Improvement Chart



To obtain successful sustainability of the outcomes of this quality improvement project, ongoing education that revisits spiritual care information will need to be in place. This will allow for continued improvement in nurses' ability and willingness to provide spiritual care. Over time, nurses should get a better understanding of why spiritual care practices play such an integral role in compassionate, patient-centered care and then be able to see why spiritual care "is associated with the number of positive outcomes including a greater tolerance of the emotional and physical demands of illness amongst patients decreases in pain, stress and negative emotions, and lower risk of both depression and suicide" (Harred et al., 2019).

When nurses share a common vision of the important value that spiritual care practice play in the caregiver role, "better education can help the healthcare practitioner avoid being distracted by own fears, prejudices, and restraints and attend to the patient and his/her family" (Best et al., 2020). The basic spiritual needs of the patient must be acknowledged as being an important part of the nursing care practice.

Implementation

Threats and Barriers

This Doctor of Nursing Practice (DNP) quality improvement (QI) project reflects an area of care that is critical to patients with acute chronic diseases. The DNP candidate was able to identify major concepts concerning the gap in nursing practice as it relates to spiritual care in the clinical environment. The magnitude of the problem is focused on the lack of spiritual care education training, which leads to the approach to ensure the proper delivery of spiritual care to patients dealing with their chronic illnesses. The mechanism

to address this identified issue is through ongoing educational training related to spiritual care practices.

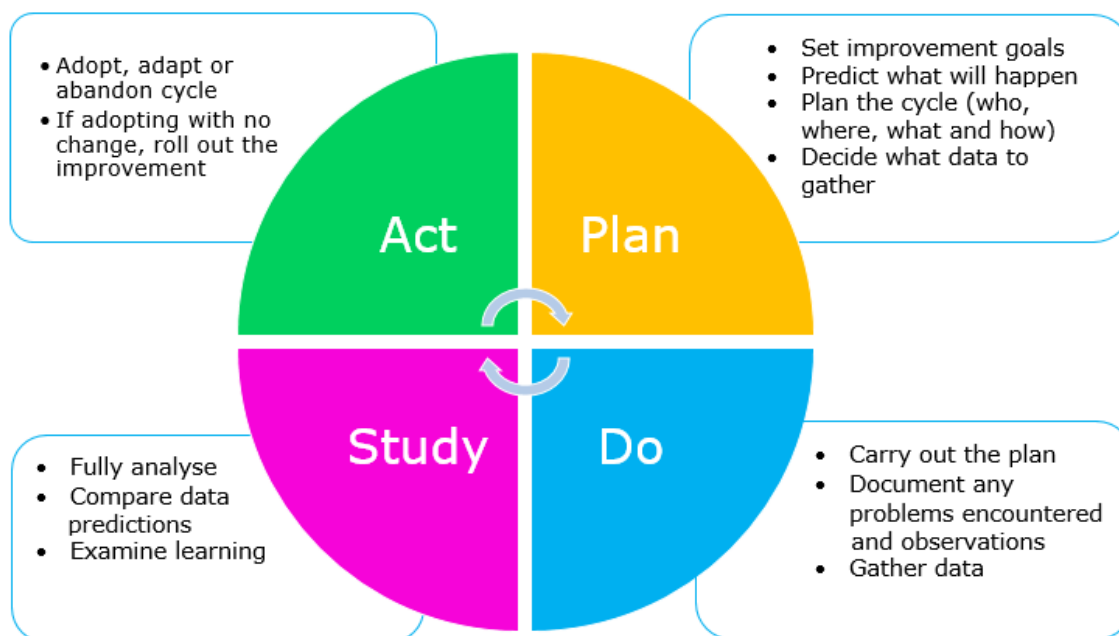
Consistent with the literature, several barriers to a Doctorate of Nursing Practice (DNP) project completion can exist. With the inception of this quality improvement project, locating a quality site to conduct this DNP project was the first challenge to overcome. Finding a facility that was willing to approve the implementation of this project was a significant barrier; facilities approached were reluctant to do so because of COVID-19 restrictions, which limited outside interactions in the facility. Ultimately, upon gaining interest in the project at the W.G. (Bill) Hefner Veteran Administrative (VA) Medical Center, located in Salisbury, NC., and working as a new employee on one of six Geriatric & Extended Care units, the DNP candidate began inquiring about the possibility of getting approved to implement this project in the area worked. Gaining access with the correct individuals were challenging, as contacts were only made via the VA system e-mail system. Due to COVID 19, many of the VA administrative/education personals were working remotely from home therefore, getting a face-to-face meeting or office visit with any of these individuals was not possible. Through many e-mail correspondences sent out over approximately 2 weeks, the DNP candidate was eventually contacted via e-mail and was informed that the University does have a clinical contract with this facility (Salisbury VA) and the DNP candidate was able to proceed with the clinical application process. The clinical application process for the VA contained a significant number of documents and forms to be signed and completed. The task of completing all the required information was a challenge but the completion of said documents was necessary to be able to move to the next step. Project approval through

the Institutional Review Board (IRB) at the University was first needed and was granted. This entire process was most intimidating but, in the end, the process went very smoothly. This project was then approved for the next step, which was submitted to Salisbury VA.

This DNP project was completed through a phased approach utilizing IDEA, the DNP project process model. In the models' 7th step, which was implementation, complications occurred when attempting to get this project approved for implementation at the VA site. IRB application from the University was submitted to the VA facility for review. One week had passed without notification of the receipt of this document, and so contact was made to check on the status. Several e-mails went out to the VA administrative education personal before getting a response, response noted that the DNP candidate's initial e-mail was not received. The project application was then resent, and an e-mail followed the next day kindly requesting confirmation of receipt of the application sent. No response from that e-mail was received. Upon several calls with voice messages left and e-mails sent, a response via an e-mail was received stating that this project was deemed as a research project and would require a full VA IRB review, or would need to be re-submitted with an in-depth proposal defining that the project was indeed a quality improvement project.

The Plan-Do-Study-Act (PDSA) model was the implementation model used to define this project as a QI project. The PDSA is an iterative, four-stage problem-solving model used for improving a process or carrying out change (Figure 1). Plan refers to effort and background work to propose change (Institute for Healthcare Improvement, 2016). Do refers to the implementation of the proposed change (Institute for Healthcare

Improvement, 2016). Study refers to the process of analyzing and evaluating the outcomes of the proposed change (Institute for Healthcare Improvement, 2016). Act refers to the redesigning the initial proposed change to account for the lessons learned during the Do and Study phases (Institute for Healthcare Improvement, 2016). The PDSA model is effective for small-scale changes that occur in a short time period and is especially effective in continuous quality improvement efforts. With the assistance of this project's practice partner, assistant chief nurse of the Geriatric and Extended Care, Community Living Center (CLC), the PDSA document was formulated (Appendix B). This document was then re-submitted to the VA administrative education personal for review and permission to implement. Permission via email was eventually received after 1 week. A formal letter of approval was needed for submission to the University, there was also a delay in obtaining this letter as well. The formal letter was received 5 days after the email was sent.

Figure 6*The Plan-Do-Study-Act Model**Werry Workforce (2818)*

Obtaining approval to implement this project at the VA was a long process, but this approval was key to unlock the next step of the DNP candidate's educational journey, implementation to improve patient outcomes. Military veterans, a unique patient population, have experienced a significant amount of trauma and so the need for spiritual care becomes salient. Spiritual care education training is identified as best practice to aid in developing nurse's knowledge and skills to care for patients' basic spiritual needs. Overcoming the threats and barriers mentioned above was well worth it because educating nurses on this dimension of care is necessary for clinical practice.

Monitoring of Implementation

The DNP candidate held primary responsibility for project implementation. After obtaining the University's IRB approval and approval from the administrative bodies of the Salisbury Veteran Administrative Health Care System, this project was conducted on the six units of the Geriatric and Extended Care, Community Living Center (CLC). These units provide short-term rehabilitation, long-term maintenance, respite care, and palliative and hospice care to our veterans. On these six units, there was a total of 50 full-time practicing nurses both Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) providing direct care to veterans. The efforts of this quality improvement project were aimed to improve services that impact health outcomes for veterans served in the Piedmont area of North Carolina. After the project received final approval from all required, one day was dedicated to announcing the education session. Announcements were first made to the unit managers via personal communication and e-mails. Managers were informed of the DNP candidate's effort to implement this project and were given a summary of the project's intention. With the assistance of the project's practice partner (assistant chief nurse of the six Geriatric and Extended Care units), an electronic invitation via the VA's email server was sent out to all nurses in the six Geriatric and Extended Care units, inviting them to participate in the learning activity. The email contained the DNP candidate's name, the purpose of the educational quality improvement (QI) project, the objectives of the educational QI project, the DNP candidate's contact number, and online login information to gain access to the attached informed consent form (Appendix B). Nurses were then able to proceed to the educational QI project

activity. An invitation flyer (Appendix C) with the information previously stated was also copied to the email.

Through the electronic Weebly.com platform participants were able to first engage in the online pre-test questionnaire, then proceeded to the online learning activity (educational content), and at the end of the activity, they were able to complete the post-test questionnaire. The pre-test questionnaire was estimated to be completed in approximately 5-10 minutes. The learning activity was estimated to be completed in approximately 30 minutes and the post-test questionnaire was estimated to be completed in approximately 5-10 minutes. There were no incentives offered or given for participation in this education project. The education and questionnaires were open to participants for 2 weeks and midway during this period, reminders were sent out in the form of a second email, and the flyer (Appendix C) which accompanied the initial invitation email was printed out and posted in the break room areas of the six Geriatric and Extended Care units. The DNP candidate continued to engage the setting and its nursing personnel through several periods of rounding on the units. These moments consisted of talks, discussing spirituality, and spiritual care. Many nurses were accepting of the discussions and were moved to participate in the educational activity to learn more on the topic. A printed spiritual care pocket-guide resource was given to nurses at the end of project completion. The resource contained information on the approach to spiritual assessment with examples, spiritual needs of the cognitively impaired, and information on self-care for nurses, stressing the importance of self-care which is critical to providing care for others (Appendix E).

Project Closure

At the culmination of this phase's activities, the questionnaires which represented a qualitative method based on the perceptions of the participants allowed for the qualitative method to be used to draw inferences from the data. All data from the pre-test questionnaire will be analyzed against the post-test questionnaire to determine the change in knowledge/understanding of how to provide basic spiritual care to patients. Of the 50 nurses on the six Geriatric and Extended Care units, 24 of the nurses participated in the project's activity (a 48% participation rate). As for the remaining 26 nurses (52%) some of the barriers to lack of participation might be due to, lack of time on the job, nurses' poor attitude towards research, and some of the nurses thought the length of the educational intervention was too long. Strong support for project implementation, however, was evident with nurse managers. Managers were supportive of the approach chosen as an opportunity to engage nurses in spiritual care learning activities which may result in an increased level of comfort for nurses to provide such care, to improve outcomes for veterans served.

Conclusion

Spiritual care training opportunities provided for nurses will help nurses develop the knowledge and skills needed to provide effective spiritual care. To provide such care, it would be necessary to facilitate the continued provision of spiritual care training to all nurses, both upon new hire and annually. Nursing leaders and nursing educators will be key individuals to help facilitate spiritual care education; fostering spiritual care education will, in turn, foster spiritual nursing practice.

Interpretation of Data

This quality improvement study was conducted using a descriptive quantitative design approach to examine the competency of nurses to provide spiritual care. The Spiritual Care Competence Scale (SCCS) questionnaire formulated in Google forms and was used as the pre-test/post-test method to compare test scores, investigating the difference between nurses' spiritual care knowledge and practice before and after participation in a 30-minute spiritual care web-based education online learning activity through the electronic Weebly.com platform. Study data were collected and managed using Google Forms electronic data capture tools. The survey questionnaires were anonymous, participants were not required to add their names or any identifying data. Data collected had no personal identifiers. A convenience sample of the 6 Geriatrics and Extended Care units of the Salisbury, NC VA system was used for this study. The initial invitation was sent to the 50 nurses on these units. A total of 48% (n=24) of nurses participated in the educational learning activity. To evaluate the project's effectiveness in improving participants' knowledge of spiritual care with chronically ill veterans, only 10 of the 27 questions on the SCCS pre-test/post-test questionnaire were analyzed. The data from the 10 SCCS pre-test questions were compared to the data from the same 10 questions in the SCCS post-test questionnaire. A Likert score, ranging 1 = Strongly disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly agree, scaled the participant's response.

Quantitative Data

Data were compared using a t-test statistic. The information from the pretest and posttest SCCS questionnaire was used to assess whether the educational intervention was

an effective method used to strengthen the nurses' knowledge of spirituality and spiritual care. Data responses were analyzed and noted in the following tables. Tables 1-10 along with figures 1-10 (a visual presentation of the data), depicted the pre-test and the post-test data for the 10 out of the 27 questions chosen to evaluate. All results were statistically significant ($p\text{-value} < .0001$).

Table 1 shows the results from respondents regarding their unprejudiced respect of a patients spiritual and/or religious beliefs. More than 90% of respondents responded in the affirmative.

Table 1

SCCS Question # 1

N=24	Pretest	Posttest
Strongly Disagree	2.70%	0.00%
Disagree	10.81%	0.00%
Neither	35.14%	5.41%
Agree	37.84%	43.24%
Strongly Agree	13.51%	51.35%
M	3.42	0.95
SD	4.46	0.60
p-value	<.0001	

Figure 7 is a visual representation of the data which shows that more than 90% of respondents agreed in the post-test, versus 51% pretest. This increase of 49% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

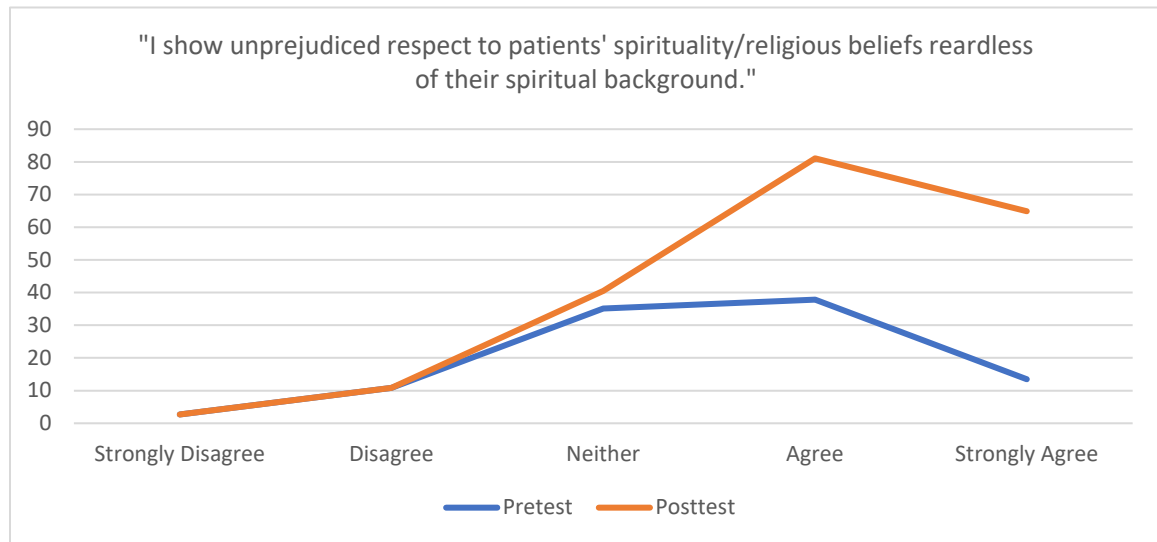
Figure 7*Visual Presentation of Question 1*

Table 2 shows respondents are open to patient's spirituality/religious beliefs even if they differ from their own. More than 95% of respondents responded in the affirmative.

Table 2*SCCS Question #2*

N=24	Pretest	Posttest
Strongly Disagree	2.70%	0.00%
Disagree	16.22%	0.00%
Neither	32.43%	5.41%
Agree	37.43%	43.24%
Strongly Agree	10.81%	51.35%
M	3.38	0.97
SD	4.46	0.60
p-value	<.0001	

Figure 8 is a visual representation of the data which shows that more than 95% of respondents agreed posttest, versus 48% pretest. This increase of 52% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

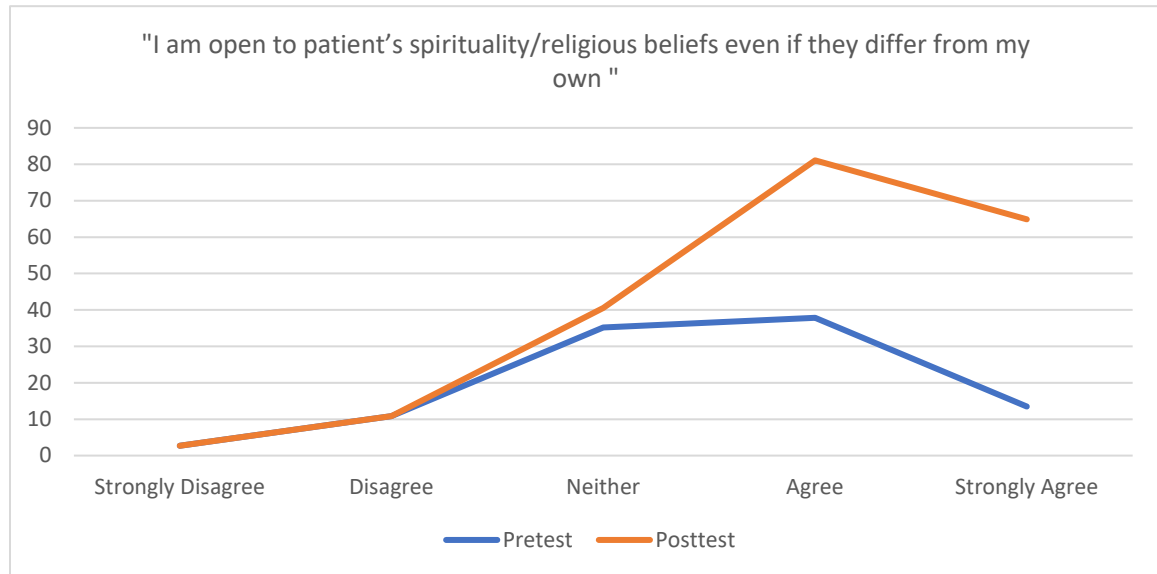
Figure 8*Visual Presentation of Question 2*

Table 3 shows respondents are able to listen actively to a patient's "life story" in relation to his/her illness/handicap. More than 95% of respondents responded in the affirmative.

Table 3*SCCS Question #3*

N=24	Pretest	Posttest
Strongly Disagree	5.41%	0.00%
Disagree	13.51%	0.00%
Neither	35.14%	2.70%
Agree	35.14%	35.14%
Strongly Agree	10.81%	62.16%
M	3.32	4.59
SD	1.01	0.54
p-value	<.0001	

Figure 9 is a visual representation of the data which shows that more than 95% of respondents agreed posttest, versus 45% pretest. This increase of 55% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

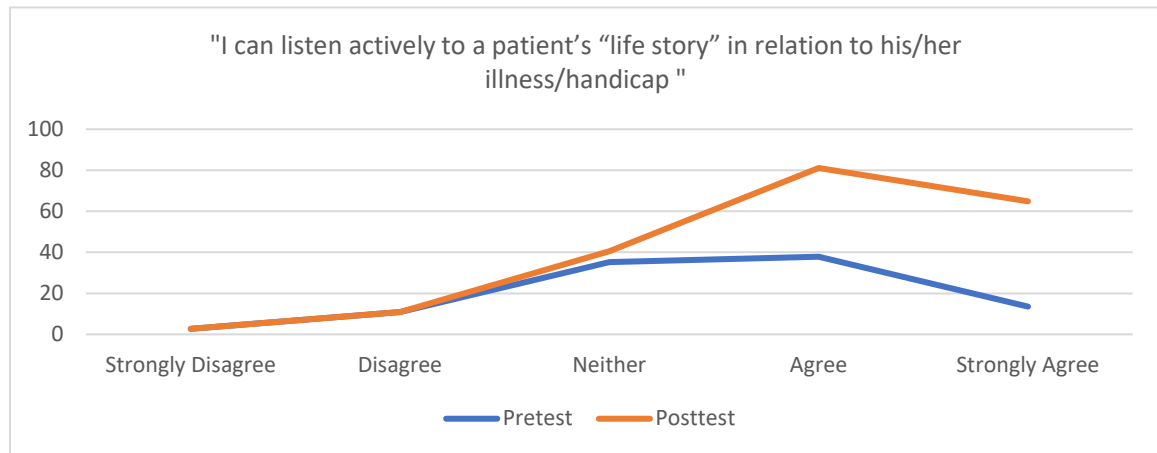
Figure 9*Visual Presentation of Question 3*

Table 4 shows respondents have an accepting attitude in their dealings with a patient (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere, and personal). Greater than 95% of respondents responded in the affirmative.

Table 4*SCCS Question # 4*

N=24	Pretest	Posttest
Strongly Disagree	5.41%	0.00%
Disagree	13.51%	0.00%
Neither	40.45%	0.00%
Agree	29.73%	45.95%
Strongly Agree	10.81%	54.05%
M	3.37	4.54
SD	1.00	0.50
p-value	<.0001	

Figure 10 is a visual representation of the data which shows that greater than 95% of respondents agreed posttest, versus 40% pretest. This increase of 60% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

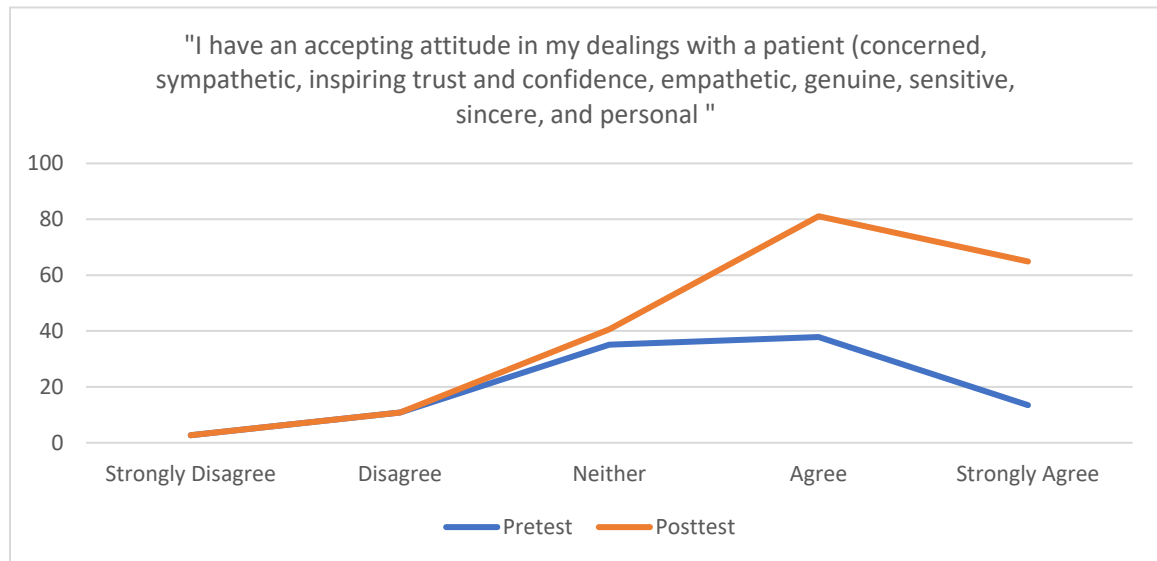
Figure 10*Visual Presentation of Question 4*

Table 5 shows respondents can report orally or in writing on a patient's spiritual needs. Greater than 90% of respondents responded in the affirmative.

Table 5*SCCS Question # 5*

N=24	Pretest	Posttest
Strongly Disagree	16.67%	0.00%
Disagree	22.22%	2.78%
Neither	33.33%	5.56%
Agree	22.22%	52.78%
Strongly Agree	5.56%	38.89%
M	2.78	4.28
SD	1.13	.69
p-value	<.0001	

Figure 11 is a visual representation of the data which shows that more than 90% of respondents agreed posttest, versus 27% pretest. This increase of 73% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

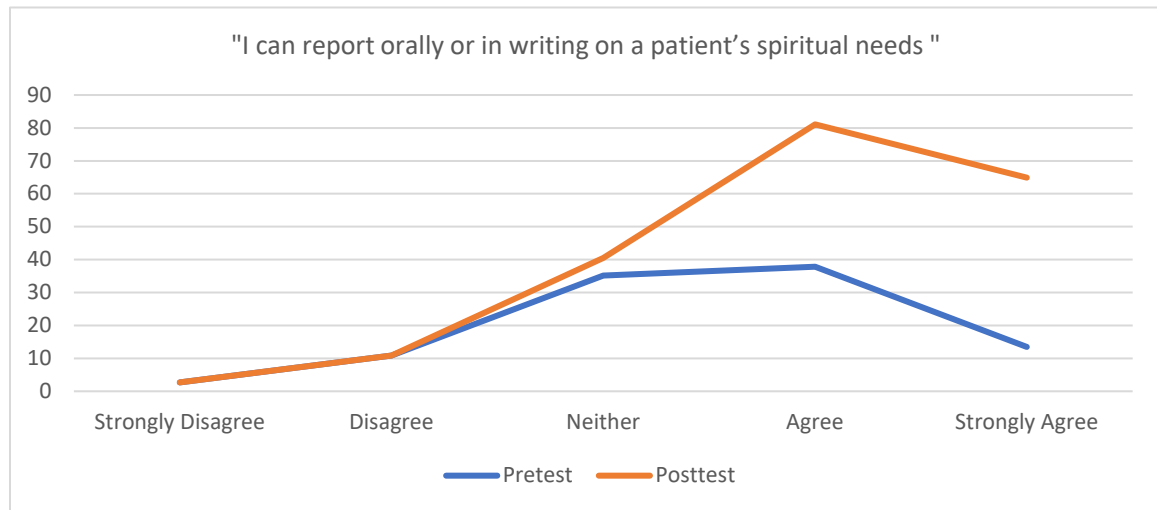
Figure 11*Visual Presentation of Question 5*

Table 6 shows respondents know when they should consult a spiritual advisor concerning a patient's spiritual care. More than 86% of respondents responded in the affirmative.

Table 6*SCCS Question # 6*

N=24	Pretest	Posttest
Strongly Disagree	16.22%	0.00%
Disagree	35.14%	5.56%
Neither	32.43%	8.33%
Agree	10.81%	50.00%
Strongly Agree	5.41%	36.11%
M	2.54	4.17
SD	1.06	0.80
p-value	<.0001	

Figure 12 is a visual representation of the data which shows that more than 86% of respondents agreed posttest, versus 16% pretest. This increase of 84% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

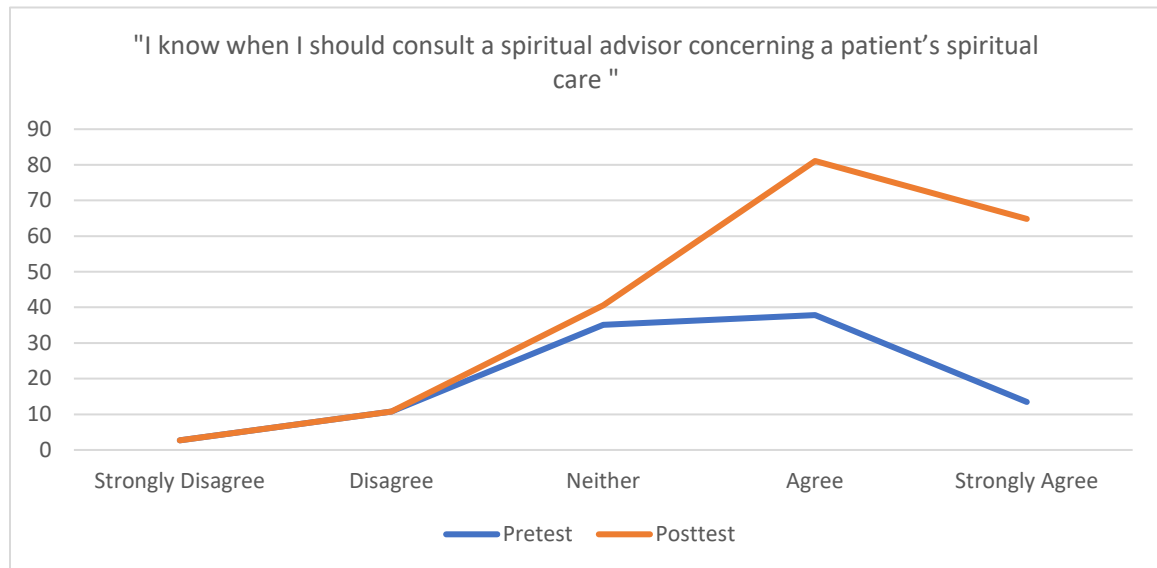
Figure 12*Visual Presentation of Question 6*

Table 7 shows respondents agree to have competency in providing patients with spiritual care. At least 77% of respondents responded in the affirmative.

Table 7*SCCS Question # 7*

N=24	Pretest	Posttest
Strongly Disagree	13.51%	0.00%
Disagree	32.43%	5.56%
Neither	35.14%	13.89%
Agree	13.51%	52.78%
Strongly Agree	5.41%	27.78%
M	2.65	4.03
SD	1.05	0.80
p-value	<.0001	

Figure 13 is a visual representation of the data which shows that at least 77% of respondents agreed posttest, versus 18% pretest. This increase of 82% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

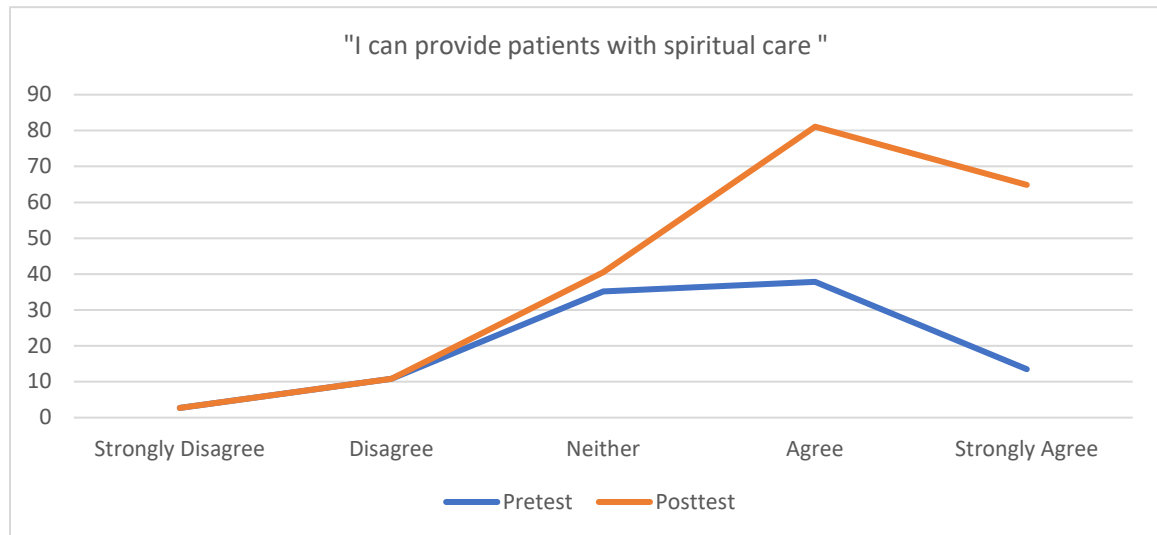
Figure 13*Visual Presentation of Question 7*

Table 8 shows respondents can help a patient continue his or her daily spiritual practices. More than 70% of respondents responded in the affirmative.

Table 8*SCCS Question # 8*

N=24	Pretest	Posttest
Strongly Disagree	16.22%	0.00%
Disagree	29.73%	2.70%
Neither	32.43%	24.32%
Agree	16.22%	45.95%
Strongly Agree	5.41%	27.03%
M	2.65	3.97
SD	1.10	0.79
p-value	<.0001	

Figure 14 is a visual representation of the data which shows that more than 70% of respondents agreed posttest, versus 21% pretest. This increase of 79% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

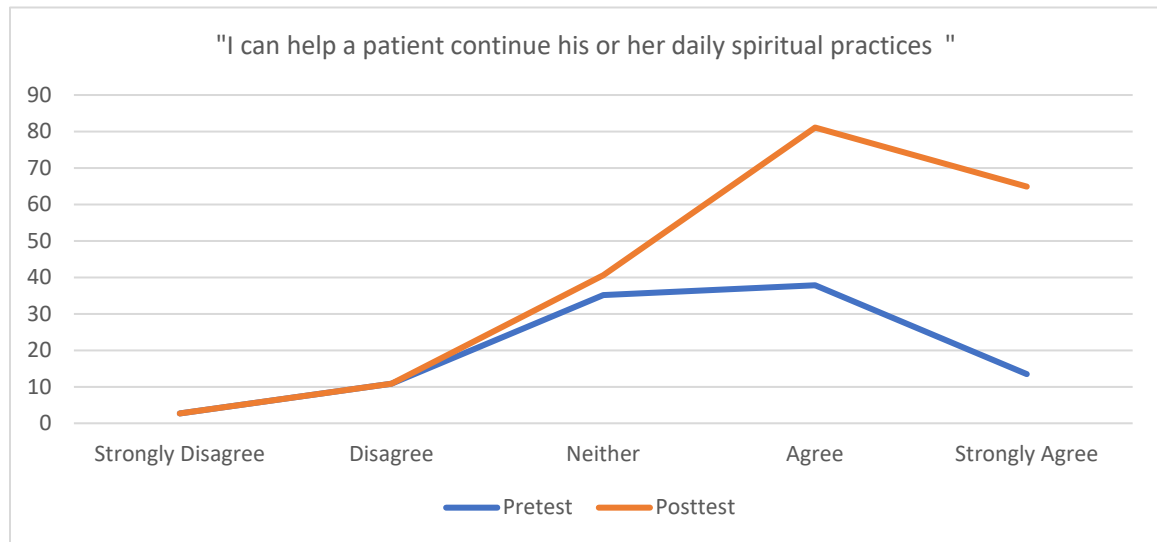
Figure 14*Visual Presentation of Question 8*

Table 9 shows respondents agree to be able to attend to patient's spirituality during the daily care. More than 70% of respondents responded in the affirmative.

Table 9*SCCS Question # 9*

N=24	Pretest	Posttest
Strongly Disagree	16.22%	0.00%
Disagree	32.43%	0.00%
Neither	32.43%	21.62%
Agree	16.22%	51.35%
Strongly Agree	2.70%	27.03%
M	2.57	4.05
SD	1.03	0.70
p-value		<.0001

Figure 15 is a visual representation of the data which shows that over 70% of respondents agreed posttest, versus 18% pretest. This increase of 82% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

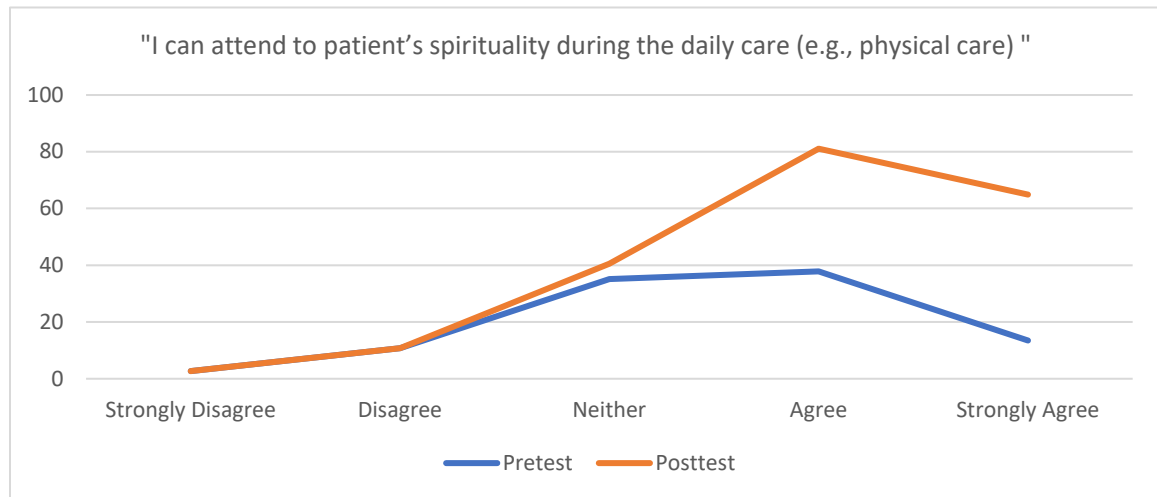
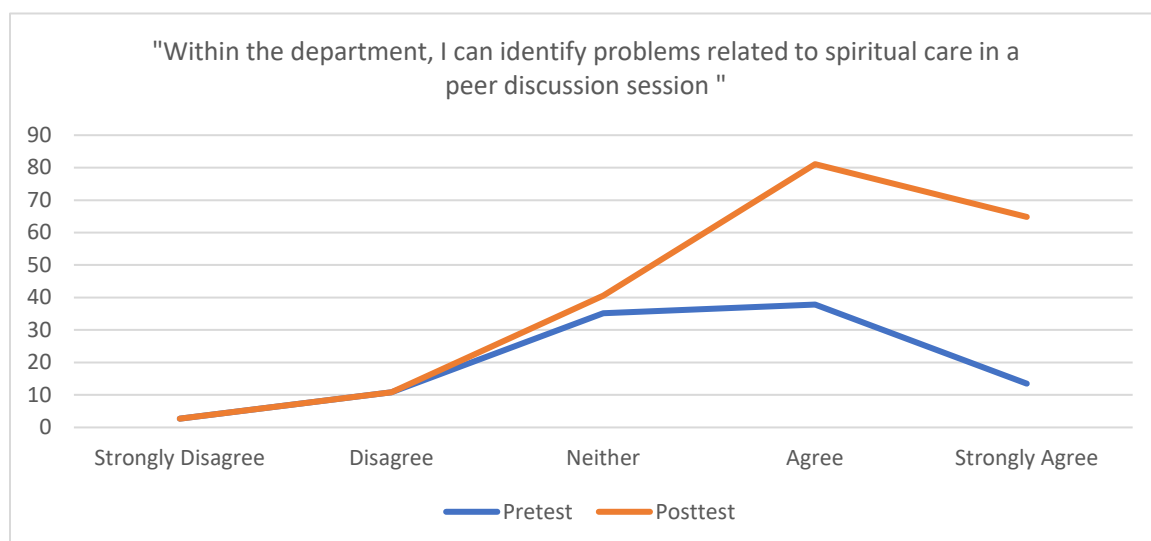
Figure 15*Visual Presentation of Question 9*

Table 10 shows respondents can identify problems related to spiritual care in a peer discussion session. At least 70% of respondents responded in the affirmative.

Table 10*SCCS Question # 10*

N=24	Pretest	Posttest
Strongly Disagree	18.92%	0.00%
Disagree	29.73%	8.11%
Neither	32.43%	21.62%
Agree	6.22%	40.54%
Strongly Agree	2.70%	29.73%
M	2.54	3.92
SD	1.06	0.91
P-value	<.0001	

Figure 16 is a visual representation of the data which shows that at least 70% of respondents agreed posttest, versus 18% pretest. This increase of 82% shows a positive inflection after the implementation of the Quality Improvement (QI) project.

Figure 16*Visual Presentation of Question 10*

The project results indicated that participants understood the importance of spiritual care as a significant aspect of care post-education implementation. The perception of participants' ability and attitude before the education intervention appeared as low to moderate levels, participants indicated that they did not feel they were prepared at pre-test to provide spiritual care for patients. The literature supports these findings concerning nurses' general understanding of the importance of providing spiritual care but many felt unable to respond adequately.

Process Improvement Data

Outcomes of the Project

The findings of this project support what is indicated in the literature. The literature shows educational training for nurses on spirituality and spiritual care, will contribute to increased awareness and competency to provide basic spiritual care. Identified in the post-test measurement, the results from this quality improvement project

indicated that the educational intervention did strengthen nurses' understanding and awareness about spiritual care in nursing practice. When looking at the results of this study, there were no significant differences to what was noted in other studies. Other studies reported nurses did gain greater awareness and understanding of how to perceive patients' needs for spirituality and spiritual care after educational training occurred. Therefore, it is possible to improve the perception of nurses concerning spirituality and spiritual care in nursing using educational interventions that will help nurses to acknowledge the importance of spirituality in the care of patients suffering from chronic diseases.

What Changed Because of this Project

The spirituality educational training lesson provided a change in nurses' attitude, knowledge, and specific competencies required to provide basic spiritual care. During the two-week intervention period, positive feedback about the content of the education material was provided to the DNP candidate while rounding on the units. The ability to now understand the concept of spirituality, spiritual health, and evaluating basic spiritual needs of patients were verbalized by some of the nurses. Many nurses paid attention to the section dedicated to encouraging nurses to remember to care for themselves located at the end of the education training, and the end of the pocket resource. The DNP candidate did stimulate conversation about spiritual self-care. In light of the understanding that nurses who take the time to care for them-self spiritually will have a first-hand understanding of the importance of spiritual well-being and therefore will be more apt to provide spiritual care in the clinical environment.

Impact of this Project and How it was Measured

During the interaction with nurses on the unit, many of the nurses were receptive to the information presented and verbalize support for this type of training to bring about awareness and increase knowledge on the subject of spirituality and spiritual care.

Training in spiritual care will allow nurses to practice as mentors to other clinical professionals to help cultivate a culture of spiritual caring. This act will encourage the promotion of positive health outcomes for patients.

How This Project Will Be Sustained

To maintain the sustainability of this project, spiritual care in nursing practice, ongoing spirituality, and spiritual care education must be explicitly taught. This act will require the corporation and the effort of management to integrate such practices. Working with local administrators, nursing leaders, and nursing education personals to roll out the project's spiritual care education on a larger scale using the VA's Talent Management System (TMS), a website used for all required education training, will create the sustainability of this project. This rollout will provide required annual competency training on spiritual care education to every nurse. All annual required competency training is completed when hired; therefore, new nurses onboarding will be introduced to this important education training.

Measurements That Can be Collected in the Future

Future research may focus on the impact of nurses' personal spiritual health on their ability to provide spiritual care to their patients. The spiritual health of the nurse is a factor that influences their attitude toward spiritual care. Nurses who care for their spiritual health will have the ability to recognize and respond to patients' spiritual needs.

Nurses who experience spiritual health and well-being will be more capable of providing spiritual expressions of compassion, love, and hope, which constitutes the most basic approach to spiritual care, and what is needed in all aspects of nursing care. Future research may evaluate this potential benefit for nurses.

Conclusion

This DNP project focused on the spiritual aspects of nursing care that are often neglected in the clinical environment. Attention to a patient's spiritual health is just as important as their physical health. For nurses to become efficient in providing spiritual care to their patients, ongoing spiritual care training is necessary. Studies have shown short-term training courses to be effective in creating a sense of continued awareness and reinforces the nurses' ability to provide basic spiritual care.

References

- Ali, G., Snowden, M., Wattis, J., & Rogers, M. (2018). Spirituality in nursing education: Knowledge and practice gaps. *International Journal of Multidisciplinary Comparative Studies*, 5(1-3), 27-49.
- Atashzadeh-Shoorideh, F., Zakaryae, N. S., & Fani, M. (2018). The barriers and facilitators in providing spiritual care for parents who have children suffering from cancer. *Journal of Family Medicine and Primary Care*, 7(6), 1319–1326.
https://doi.org/10.4103/jfmpe.jfmpe_76_18
- Attard, J., Baldacchino, D. R., & Camilleri, L. (2014). Nurses' and midwives' acquisition of competency in spiritual care: A focus on education. *Nurse Education Today*, 34(12), 1460–1466. <https://doi.org/10.1016/j.nedt.2014.04.015>
- Best, M., Leget, C., & Goodhead, A. (2020). An EAPC white paper on multi-disciplinary education for spiritual care in palliative care. *BMC Palliative Care*, 19, 9.
<https://doi.org/10.1186/s12904-019-0508-4>
- Burkhardt, M. A., & Nagai-Jacobson, M. G. (2016). In Dossey, B. M., & Keegan, L. Holistic nursing: A handbook for practice.
- Cara, C. (2003). A pragmatic view of Jean Watson's caring theory. *International Journal for Human Caring*.
https://www.watsoncaringscience.org/files/PDF/Pragmatic_View.pdf

- Costello, M. (2018). Watson's caritas processes as a framework for spiritual end of life care for oncology patients. *International Journal of Caring Sciences May-August, 11(2)*, 639.
http://www.internationaljournalofcaringsciences.org/docs/1_costello_special_10_2.pdf
- Cruz, J. P., Alshammari, F., Alotaibi, K. A., & Colet, P.C. (2017). Spirituality and spiritual care perspectives among baccalaureate nursing students in Saudi Arabia: A cross-sectional study. *Nurse Education Today, 49*, 156–1
<https://doi.org/10.1016/j.nedt.2016.11.027>
- Espinha, D. C. M., Camargo, S. M. D., Silva, S. P. Z., Pavelqueires, S., & Lucchetti, G. (2013). Nursing students' opinions about health, spirituality and religiosity. *Revista Gaúcha de Enfermagem, 34(4)*, 98–106. <https://doi.org/10.1590/s1983-14472013000400013>
- Farahani, A. S., Rassouli, M., Salmani, N., Mojen, L. K., Sajjadi, M., Heidarzadeh, M., Masoudifar, Z., & Khademi, F. (2019). Evaluation of health-care providers' perception of spiritual care and the obstacles to its implementation. *Asia-Pacific Journal of Oncology Nursing, 6(2)*, 122–129.
https://doi.org/10.4103/apjon.apjon_69_18
- Harrad, R., Cosentino, C., Keasley, R., & Sulla, F. (2019). Spiritual care in nursing: An overview of the measures used to assess spiritual care provision and related factors amongst nurses. *Acta bio-medica: Atenei Parmensis, 90(4-S)*, 44–55.
<https://doi.org/10.23750/abm.v90i4-S.8300>

- 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), 104. <https://doi.org/10.1186/s12904-019-0489-3>
- Institute for Healthcare Improvement (IHI). (2016). Science of Improvement: Testing Changes.
<http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>
- Jeong, J. O., Jo, H. S., & Kim, S. hee. (2016). Effect of the spiritual care module education program for nurses. *The Journal of Korean Academic Society of Nursing Education*, 22(1), 51–62. <https://doi.org/10.5977/jkasne.2016.22.1.51>
- Kincheloe, D. D., Stallings Welden, L. M., & White, A. (2018). A spiritual care toolkit: An evidence-based solution to meet spiritual needs. *Journal of Clinical Nursing*, 27(7-8), 1612–1620. <https://doi.org/10.1111/jocn.14265>
- Lind, B., Sendelbach, S., & Steen, S. (2011). Effects of a spirituality training program for nurses on patients in a progressive care unit. *Critical Care Nurse*, 31(3), 87–90. <https://doi.org/10.4037/ccn2011372>
- Megari K. (2013). Quality of life in chronic disease patients. *Health Psychology Research*, 1(3), e27. <https://doi.org/10.4081/hpr.2013.e27>
- Melhem, G. A., Zeilani, R. S., Zaqqout, O. A., Aljwad, A. I., Shawagfeh, M. Q., & Al-Rahim, M. A. (2016). Nurses' perceptions of spirituality and spiritual care giving: A comparison study among all health care sectors in Jordan. *Indian Palliative Care*, 22(1), 42-49. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4768449/>

- Moghimian M., Irajpour A., & Arzani H. (2019). The inter-professional dimensions of spiritual care for chronically ill patients: A qualitative study. *Nursing and Midwifery Studies*, 8(1), 34-39.
<http://www.nmsjournal.com/text.asp?2019/8/1/34/247932>
- O'Brien, M. R., Kinloch, K., Groves, K., E., & Jack, B., A. (2018). Meeting patients' spiritual needs during end-of-life care: A qualitative study of nurses' and healthcare professionals' perceptions of spiritual care training. *Journal of Clinical Nursing*, 28, 182-189. <https://onlinelibrary.wiley.com/doi/abs/10.1111/jocn.14648>
- Ramezani, M., Ahmadi, F., Mohammadi, E., & Kazemnejad, A. (2014). Spiritual care in nursing: A concept analysis. *International Nursing Review*, 61(2), 211–219.
<https://doi.org/10.1111/inr.1209>
- Ramos, K. J., Downey, L., Nielsen, E. L., Treece, P. D., Shannon, S. E., Curtis, J. R., & Engelberg, R. A. (2016). Using nurse ratings of physician communication in the ICU to identify potential targets for interventions to improve end-of-life care. *Journal of Palliative Medicine*, 19(3), 292–299.
<https://dx.doi.org/10.1089%2Fjpm.2015.0155>
- Ross, L. & Austin, J. (2015). Spiritual needs and spiritual support preferences of people with end-stage heart failure and their caregivers: Implications for nurse managers. *J. Nurs Management*, 23, 87-95.
<https://onlinelibrary.wiley.com/doi/full/10.1111/jonm.12087>
- Rushton, C. H., Batcheller, J., Schroeder, K., & Donohue, P. (2015). Burnout and resilience among nurses practicing in high-intensity settings. *American Journal of Critical Care*, 24(5), 412–420. <https://doi.org/10.4037/ajcc2015291>

- Swinton, J. in Cobb, M. (Ed). (2005). *The Hospital Chaplain's Handbook*. Canterbury Press. Norwich.
- Touhy, T. (2001). Nurturing hope and spirituality in the nursing home. *Holistic Nursing Practice*, 15(4), 45-56. <https://pubmed.ncbi.nlm.nih.gov/12120495/>
- Van Leeuwen, R., Tiesinga, L.J., Middel, B., Post, D., & Jochemsen, H. (2008). The validity and reliability of an instrument to assess nursing competencies in spiritual care. *Journal of Clinical Nursing*, 18, 2857-2869. <https://doi.org/10.1111/j.1365-2702.2008.02594.x>
- Vargas-Escobar, L.M., & Guarnizo-Tole, M. (2019). Effect of an educational intervention delivered to senior nursing students to strengthen spiritual care for people with chronic illness. *International Journal of Nursing Education Scholarship*, 17(1). <https://doi.org/10.1515/ijnes-2019-0049>
- Vlasblom, J. P., van der Steen, J. T., Knol, D. L., & Jochemsen, H. (2011). Effects of a spiritual care training for nurses. *Nurse Education Today*, 31(8), 790–796. <https://doi.org/10.1016/j.nedt.2010.11.010>
- Wallace, M., Campbell, S., Grossman, S., Shea, J., Lange, J., & Quell, T. (2008). Integrating spirituality into undergraduate nursing curricula. *International Journal of Nursing Education Scholarship*, 5(1), 1-13. <https://doi.org/10.2202/1548-923x.1443>
- Watson Caring Science. (2017). *Jean Watson, PhD, RN, AHN-BC, FAAN, (LL-AAN)*.
Watson Caring Science: <https://www.watsoncaringscience.org/jean-bio/>
- Watson, J. (1997). The theory of human caring: Retrospective and prospective. *Nursing Science Quarterly*, 10(1), 49-52. <https://pubmed.ncbi.nlm.nih.gov/9277178/>

Watson, J. (2001). Jean Watson: Theory of human caring. In M.E. Parker (Ed.), *Nursing*

Theories and Nursing Practice (p. 347). Philadelphia: Davis.

<http://docshare03.docshare.tips/files/26827/268274013.pdf>

Werry Workforce. (2018). Plan Do Study Act Cycle (PDSA).

<https://werryworkforce.org/quality-improvement/pdsa>

World Health Organization [WHO]. (1948). Preamble to the constitution of the World

Health Organization as adopted by the International Health Conference New

York 19 June –22nd-July 1946.

World Health Organization [WHO]. (1998) WHOQOL and spirituality, religiousness and

personal beliefs: Report on WHO consultation. WHO. Geneva.

Wu, L. F., Tseng, H. C., & Liao, Y. C. (2016). Nurse education and willingness to

provide spiritual care. *Nurse Education Today*, 38, 36–41.

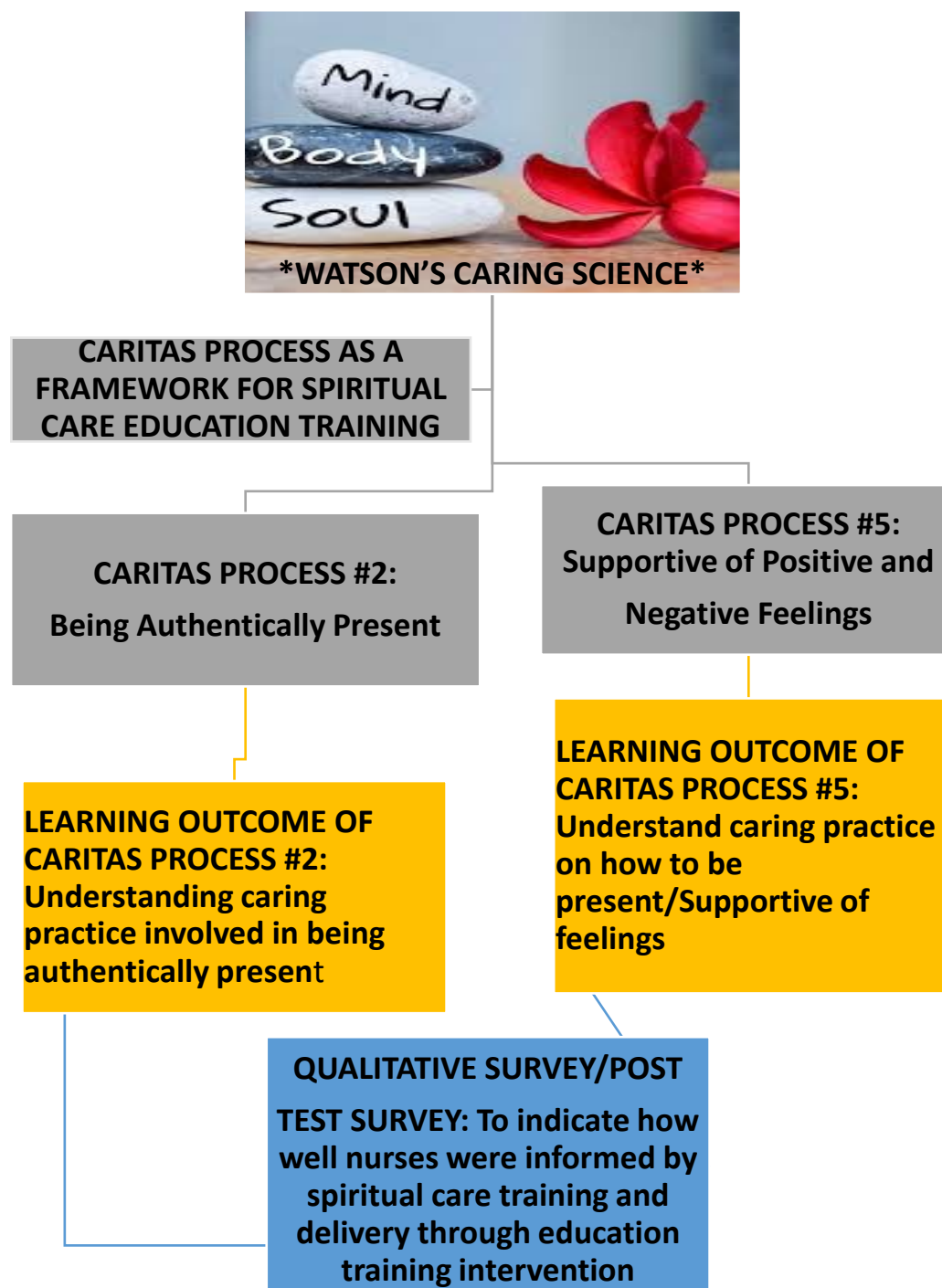
<http://doi.org/10.1016/j.nedt.2016.01.001>

Zaccagnini, M., & White, K. (2017). *The Doctor of Nursing practice essentials* (3rd ed.).

Burlington, MA: Jones & Bartlett Learning, LLC.

Appendix A

CTE Diagram



Appendix B:

The Plan-Do-Study-Act Document

Background information:

Spiritual care which is compassionate care, is an essential aspect when providing care to a patient. Spiritual care involves the serving of the whole person that is the physical, the emotional, the social and the spiritual being. Published research continues to suggest that nurses' knowledge and skills related to spiritual care are not adequate, in part, due to poor role preparation. In general, "students and qualified nurses are aware of the importance of providing spiritual care but are hindered by lack of education about how best to implement such care" (Harrad et al., 2019). In order to provide balance of care towards a better quality of life, spiritual care needs to be a part of the healing process for patients. "The work of healing requires recognition of the spiritual dimension of each person, including the healer, and an awareness that spirituality permeates every encounter. The shared relationship acknowledging the common humanity and connectedness between the caregiver and the receiver, which is basic to healing, is a manifestation of spirituality (Burkhardt & Nagai-Jacobson, 2016). Spiritual care is necessary and important because it has implications for an individual's health and well-being; such care provides support in helping patients to process what is happening to them. The overall goal of spiritual nursing care is to address patient's fears/concerns and suffering with the intention to alleviate anxiety, instill hope, and empower patients to attain inner peace (Weathers, McCarthy, & Coffey, 2016). One of the most important approaches to ensure proper delivery of spiritual care to patients dealing with their chronic illness is through ongoing educational training for nurses in the clinical environment. Reclaiming the link between spirituality and health-care through ongoing evidence-based educational training is of critical importance.

Purpose:

In light of the trauma experienced by our veterans, the need for spiritual care becomes salient. In an effort to enhance spiritual care competency of nurses at the Veteran's Health Administration (VHA) Salisbury, Geriatrics and Extended Care in the six Community Living Center (CLC) units, the purpose of this proposed educational quality improvement (QI) project is to (a) Improve nurses understanding of methods and techniques used to assess patients' basic spiritual care needs when providing spiritual care to their patients and (b) determine the efficacy of the education intervention on nurses' knowledge of spiritual care practices and comfort in providing spiritual care through a pre-test and post-test quantitative survey. This will be achieved by (a) the use of the Spiritual Care Competence Scale (SCCS) survey tool, which is a valid and reliable instrument used for assessing nurses' competency in providing spiritual care. This tool will be used to self-rate individual confidence in providing basic spiritual based care. The SCCS survey tool has six sections with 27 questions totaled, this tool will be used as the pre-test and post-test questionnaire which measures six core domains of spiritual care-related nursing competencies with questions that evaluates participants understanding of spiritual care. (b) The implementation of a short web-based education training, with a focus on providing spiritual care to patients.

Analysis:

This study will be conducted using a descriptive quantitative design to examine the competency of nurses to provide spiritual care. The Spiritual Care Competence Scale (SCCS) questionnaire will be used as the pre-test/post-test method to compare test scores before and after the spirituality education training to evaluate its effectiveness in improving participants' knowledge of spiritual care with chronically ill patients. The SCCS is a valid and reliable instrument used for assessing nurses' competency in providing spiritual care. The items in the instrument were hypothesized from a competency profile regarding spiritual care.

Methodology/Framework:

PDSA Cycle for Learning and Improving:

The core improvement of quality is aimed at education. According to the literature, taking spiritual care training courses seems to be necessary to ensure that nurses have more efficiency in providing spiritual care to their patients.

Plan: Plan is to collect data, to identify level of competency to provide spiritual care to our chronically ill veterans.

Do: Educate.

Study: Review stats, make adjustments.

Act: Roll out on a larger scale to all units and staff. Work with nursing education to apply to other areas. Added to TMS.

Plan:

In the plan phase, evidence drafted from researched literature described the current problem and identified causes and alternatives. The literature suggested that nurses' knowledge and skills related to spiritual care are not adequate, in part, due to poor role preparation. The literature further identified that the lack of educational training in spiritual care practices creates the inability of nurses to respond to their patient's spiritual needs. This project proposed a solution to overcoming barriers to the implementation of spiritual care in nursing practice. The plan is to test for improvement, or need for change, using the educational training intervention with the target population that are nurses, both RN's and LPN's, and gain information as to the level of competency that the CLC nurses possess to provide spiritual care. Plan for this will occur over a period of six weeks.

Desired goal and outcome:

The desired goals will be (1) the education/training content will have a positive effect on nurse's perception of spirituality and provide increased knowledge and skills in spiritual care delivery for chronically ill patients, and (2) Nurses will be enabled to consider the importance of providing quality spiritual care that includes support of the patient's spirituality. Desired outcome due to training/education, will be (1) ensure nurses are competent and have the expertise to provide spiritual care that is relevant in practice, and (2) competencies will guide spiritual care practice.

Do:

In the do phase, this project plan will be conducted, observations will be made and data will be collected. This QI project involved creating a web-based educational training module with evidence-based information. A small test of change will be implemented and monitored for outcomes. Data collected will verify the effectiveness of the education training and establish if ongoing spiritual care education training is needed.

Study:

In the study phase, data will be analyzed by comparing pre-test scores with post-test scores and results will be reviewed to formulate a summary of what is learned and what adjustments will be needed to achieve success.

Act:

In the act phase, change will be refined based on what was learned from the test data. This project was created to improve spiritual care practice when providing care to our veterans, to help our veterans cope with their chronic condition. To achieve this goal the QI project will seek answers to the following questions. First, did the educational training module improve nurses' understanding of methods and techniques used to assess patients' basic spiritual care needs? Second, did the education training intervention provide the knowledge needed to help nurses feel confident to practice spiritual care? The proposal to improve based on the data examined will require working with nursing education to roll out the project on a larger scale to all units and staff, in other areas of care, and working towards TMS addition. In order to maintain the sustainability of spiritual care in nursing practice, ongoing spirituality and spiritual care education must be explicitly taught and this will require the full corporation and effort of management to integrate such practices.

Elements of the Education Training Intervention:

- (1) Website to online access for web-based educational training:

spiritualcareinnursingpractice.weebly.com

- (2) Spiritual Care Pocket-guide Resource below will be available for all nurses:

Appendix C:

Consent Form

	QI criteria definition	DNP project proposal
Purpose	Designed to implement knowledge, assess a process or program as judged by established/accepted standards	To enhance spiritual care competency of nurses
Starting Point	knowledge-seeking is integral to ongoing management system for delivering health care	Project provides healthcare delivery improvement
Design	adaptive, iterative design	Descriptive quantitative design
Benefits	directly benefits a process, system or program; might or might not benefit patients	This project directly benefits the CLC Residents and interdisciplinary care teams
Risks	does not increase risk to patients, with exception of possible patients' privacy or confidentiality of data	There is no risk to participants or CLC Residents
Participant Obligation	responsibility to participate as component of care	Participation is voluntary for RNs and LPNs in the CLC
Endpoint	improve a program, process or system	The program will improve nurse ability to provide spiritual care
Analysis	compare program, process or system to established standards	Data will be used to evaluate education effectiveness in improving participants' knowledge of spiritual care with chronically ill patients
Adoption of Results	results rapidly adopted into local care delivery	Education will be implemented for all CLC nurses
Publication/Presentation	QI practitioners encouraged to share systematic reporting of insights	Education will be developed to use on a larger scale throughout all CLC and other clinical areas of SVHCS

Spiritual Care Practice in the Clinical Care Environment of the Community Living Center (CLC)

You are being invited to participate in a Quality Improvement project about spiritual care practices in the clinical nursing environment. This QI project is being conducted by student, Jillian Jack of the Doctor of Nursing Practice program at Gardner-Webb University, Hunt School of Nursing. The objective of this QI project is to address the increasing attention for spiritual care in the clinical nursing environment and is geared to educate nurses of the CLC units on the critical need for spiritual care in nursing care practice.

There are no known risks if you decide to participate in this project, nor are there any costs for participating. The information you provide will help me to ascertain the level of spiritual care competency before and after the education activity. The information collected will help benefit how we provide spiritual care for our veterans to positively affect their quality of life. It is hopeful that the education activity may prompt you to ask questions about your own beliefs, your need for spiritual self-care and allow you to take time to look after your own spiritual wellbeing.

The electronic data base survey questionnaire before and after the education training is anonymous, you would not be required to add your name to the survey questionnaire, if you choose to participate. Data collected will have no personal identifiers. No one will be able to identify you, nor will anyone be able to determine which CLC unit you work on. No one will know whether you have participated in this study, so nothing you say on the questionnaire will in any way influence your present or future employment with Veteran's Health Administration of Salisbury. Survey information would be password protected and accessed only by the project manager (myself).

Your participation in this study is voluntary. If you choose to participate, please complete the pre-test survey questionnaire, which would then take you to the education learning activity and a post-test survey questionnaire will follow. At the end of the education learning activity there would be an evaluation survey to indicate how you view the effectiveness of the material presented. No one would have access to this information except for myself.

If you have any questions or concerns about completing the questionnaires or about the education learning activity, you may contact me at (336) 995-8754 or at jjack@gardner-webb.edu

The Gardner-Webb University Institutional Review Board has reviewed my request to conduct this project. If you have any concerns about your rights in this study, please contact Gardner-Webb IRB at email irb@gardner-webb.edu.

Appendix D:

Invitation Flyer



Jillian Jack:

DNP Candidate/Project Manager:

You are being invited to participate in a Quality Improvement project about spiritual care practices in the clinical nursing environment. This educational QI project is being conducted by student, Jillian Jack of the Doctor of Nursing Practice program at Gardner-Webb University, Hunt School of Nursing. The objective of this QI project is to address the increasing attention for spiritual care in the clinical nursing environment and is geared to educate nurses of the CLC units on the critical need for spiritual care in nursing care practice.

Objectives of this Quality Improvement project:

- Promote nurses' awareness of spiritual care practices needed to improve the quality of life for veterans with chronic illnesses.
- Effect change in nurses knowledge and understanding of spiritual care requirements of veterans.
- Improve preparedness/ability to apply spiritual care in practice.
- Encourage spiritual care of self for nurses' own spiritual well-being.

Online access at
www.
spiritualcareinnursingpractice.weebly.com

Informed consent available upon
access to site.

DNP Candidate/Project
manager's contact information:
336-995-8754

Appendix E:
Pocket Guide Resource

Spiritual care Pocket-guide Resource



For Nurses

Examples of Questions for the HOPE Approach to Spiritual Assessment

H: Sources of hope, meaning, comfort, strength, peace, love and connection

We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support?

What are your sources of hope, strength, comfort and peace?

What do you hold on to during difficult times?

What sustains you and keeps you going?

For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?

If the answer is "yes," go on to O and P questions.

If the answer is "no," consider asking: was it ever? If the

answer is "Yes," ask: What changed?

O: Organized religion

Do you consider yourself part of an organized religion?

How important is this to you?

What aspects of your religion are helpful and not so helpful to you?

Are you part of a religious or spiritual community? Does it help you? How?

P: Personal spirituality/practices

Do you have personal spiritual beliefs that are independent of organized religion? What are they?

Do you believe in God? What kind of relationship do you have with God?

What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g., prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)

E: Effects on medical care and end-of-life issues

Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relations with God?)

As a nurse, is there anything that I can do to help your access the resources that usually help you?

Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?

Would it be helpful for you to speak to a clinical chaplain/community spiritual leader?

Are there any specific practices or restrictions I should know about in providing your medical care? (e.g., dietary restrictions, use of blood products)

If the patient is dying: How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months?

American Family Physician January 1, 2001/volume 63, Number 1 www.aafp.org/afp

Spiritual Assessment Examples

Diagnoses (Primary)	Key feature from history	Example Statements
Existential	Lack of meaning / questions meaning about one's own existence / Concern about afterlife / Questions the meaning of suffering / Seeks spiritual assistance	"My life is meaningless" "I feel useless"
Abandonment God or others	lack of love, loneliness / Not being remembered / No Sense of Relatedness	"God has abandoned me" "No one comes by anymore"
Anger at God or others	Displaces anger toward religious representatives / Inability to Forgive	"Why would God take my child....it's not fair"
Concerns about relationship with deity	Closeness to God, deepening relationship	"I want to have a deeper relationship with God"
Conflicted or challenged belief systems	Verbalizes inner conflicts or questions about beliefs or faith Conflicts between religious beliefs and recommended treatments / Questions moral or ethical implications of therapeutic regimen / Express concern with life/death and/or belief system	"I am not sure if God is with me anymore"
Despair / Hopelessness	Hopelessness about future health, life Despair as absolute hopelessness, no hope for value in life	"Life is being cut short" "There is nothing left for me to live for"
Grief/loss	Grief is the feeling and process associated with a loss of person, health, etc.	"I miss my loved one so much" "I wish I could run again"
Guilt/shame	Guilt is feeling that the person has done something wrong or evil; shame is a feeling that the person is bad or evil	"I do not deserve to die pain-free"
Reconciliation	Need for forgiveness and/or reconciliation of self or others	I need to be forgiven for what I did I would like my wife to forgive me

Isolation	From religious community or other	"Since moving to the assisted living I am not able to go to my church anymore"
Religious specific	Ritual needs / Unable to practice in usual religious practices	"I just can't pray anymore"
Religious / Spiritual Struggle	Loss of faith and/or meaning / Religious or spiritual beliefs and/or community not helping with coping	"What if all that I believe is not true"

Puchalski, C. & Ferrell, B. (2009). Improving the Quality of Spiritual Care as a Dimension of Palliative Care: A Consensus Conference Convened February 2009. https://smhs.gwu.edu/gwish/sites/gwish/files/Improving_Spiritual_Palliative_Care.pdf

Spiritual needs of the cognitively impaired

We may think it not beneficial to provide spiritual care to the cognitively impaired patient, but this is not the case. VandeCreek(1999, as cited in Berry 2005) stated that persons possess more than memory and intellect; they also have emotion, relationship, imagination, will and aesthetic awareness. There is an explicit need to acknowledge and nurture the spirituality of the cognitively impaired patient to enhance their health and well-being

* Anyone who cares for cognitively impaired patients can take part in helping to recognize and meet his or her spiritual needs.

* Offering hope to cognitively impaired patients nurtures spirituality and enhances quality of life.

* Care givers can incorporate simple tools/activities in the care of the cognitive impaired patient to help maintain dignity, self-worth and a sense of peace even when there is little or no awareness of surroundings. These tools include:

- (1) Music
- (2) Touch
- (3) Prayer
- (4) Conversation when possible
- (5) Being present

Berry, K. (2005). Spirituality and the Cognitively Impaired. *Age in Action*, 20(1), 1-5.
https://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=1010&context=vcoa_casc

THANK YOU AND PLEASE TAKE TIME TO CARE FOR YOURSELF

As nurses, in our devotion to care for others, we also often neglect our own health. It is important for nurses to develop a personal plan of care so as to achieve a healthy work-life balance.

Tips to nurture your mind body and spirit from American Psychiatric Nurses Association:

- *Schedule your self-care. Set a time each week to focus on yourself the same way you schedule your work.
- *Take up a hobby. Find something that brings you joy and take time to do it.
- *Unplug. Turn off electronic devices (TV, cell phones etc.), leave work at work, and take a moment to unwind from the day.
- *Use self-talk. Engage in positive self-talk to remind yourself to think positively
- *Don't be afraid to say no.... If your schedule is already full, don't be afraid to say "no" to taking on additional responsibilities
- *But say yes to friends, family, and colleagues. Whenever possible, say "yes" to spending time with those you care about.
- *Do yoga. Yoga can help energize your body and focus your mind.
- *Focus on nutrition. As the saying goes, food is fuel. Eat a well-balanced meal to keep your body fueled
- *Get moving. Be it a bike ride, dog walk, or even a ballet class, exercise can help you unwind.
- *Go outside. Go for a long walk or hike in your local park, mountain, or beach.
- *Try meditation. Both transcendental and guided meditation can assist in promoting self-awareness.
- *Get a massage. Not only does massage address tension, it can also help you emotionally refresh.
- *Prioritize sleep. A good night of sleep can make a world of difference.
- *Listen to music. Music is an easy way to de-stress.
- *Embrace your spirituality. Whatever form you choose, you can lift your emotions by embracing spiritual practice.
- *Enjoy life! Take time to find the joy in your life and appreciate the good things when you can.

American Psychiatric Nurses Association. Self-Care Tip Sheet for Nurses.
<https://www.apna.org/files/public/APNASelfCareTipSheet.pdf>