

Abstract

Background. Nurses and midwives care for people at some of the most vulnerable moments of their lives, so it is essential that they have the skills to give care which is compassionate, dignified, holistic and person-centred. Holistic care includes spiritual care which is concerned with helping people whose beliefs, values and sense of meaning, purpose and connection is challenged by birth, illness or death. Spiritual care is expected of nurses/midwives but they feel least prepared for this part of their role. How student nurses/midwives can be prepared for spiritual care is the focus of this study.

Objectives. 1. To describe undergraduate student nurses/midwives perceptions of spirituality/spiritual care, their perceived competence in giving spiritual care and how these perceptions change over time. 2. To explore factors contributing to development of spiritual care competency.

Methods. Prospective, longitudinal, multinational, correlational survey design. A convenience sample of 2193 undergraduate nursing/midwifery students (69% response rate, **dropping to 33%**) enrolled at 21 universities in 8 countries completed questionnaires capturing demographic data (purpose designed questionnaire) and measuring perception of spirituality/spiritual care (SSCRS), spiritual care competency (SCCS), spiritual wellbeing (JAREL) and spiritual attitude and involvement (SAIL) on 4 occasions (start of course n=2193, year 2 n=1182, year 3 n=736, end of course n=595) between 2011-2015. Data were analysed using descriptive, bivariate and multivariate analyses as appropriate.

Results. Perceived competency increased significantly over the course of students' study which they attributed to caring for patients, events in their own lives and teaching/discussion in university. Two factors were significantly correlated with perceived spiritual care competency: perception of spirituality/spiritual care, where a broad view was preferable, and personal spirituality, where high spiritual wellbeing (JAREL) and spiritual attitude and involvement (SAIL) scores were preferable.

Conclusions. **Our study is limited by a high attrition rate common to longitudinal research, but we have provided the first international evidence that perceived spiritual care competence is developed in undergraduate student nurses/midwives and that students' perceptions of spirituality and personal spirituality contribute to that development. Implications for teaching and learning and student selection are discussed.**

Background

The nursing and midwifery professions provide care for people across the lifespan trajectory in a diverse range of settings at significant times of their lives such as at birth and death. How they care for people at such times may leave a lasting impression, therefore, it is imperative that nurses/midwives have the necessary skills and competence to provide care that is safe, holistic and person-centered and is delivered with respect, dignity and compassion.

The European Commission (2010) highlights the importance of the spiritual, religious and cultural aspects of people's lives to their sense of wellbeing, and recommends that the caring professions are educated in this respect; nurses and midwives are obvious examples. The route to registration as a nurse/midwife in most countries is after a period of study at an academic institution involving a combination of academic study and clinical practice, each with their associated forms of assessment (e.g. International Council of Nurses 2012a). Nurses/midwives are expected to be competent in caring for the whole person (body, mind and spirit e.g. **Schuurmans 2012**, International Confederation of Midwives 2014), but there is emerging international evidence indicating that they feel inadequately prepared for spiritual care (e.g. Schep-Akkerman and van Leeuwen 2009 [Netherlands], Egan et al 2017 [New Zealand]).

Educational preparation

The late 1990s saw an emerging rhetoric about the importance of the educational preparation of nursing and midwifery students for delivery of spiritual care (e.g. Ross 1996, McSherry et al 2008). Recently, Lewinson et al (2015) undertook a systematic review of the literature on spiritual care preparation in pre-registration nursing programmes internationally. The review identified 28 international studies which reinforces what is already known; that nurses and midwives feel least prepared for spiritual care and they want further training. **The review also reported studies, limited by small sample sizes and cross-sectional design, suggesting that nurse education programmes may raise students' spiritual awareness and may develop their confidence in engaging with spiritual care (e.g. Attard 2014).**

Over the last two decades, there has been a growing realization, underpinned by a strong evidence base, of the importance of spiritual care for health and wellbeing (e.g. Koenig et al 2012) reflected in its inclusion in the work of international health bodies (e.g. World Health Organization (WHO 2002), the European Association for Palliative Care [EAPC] <http://www.eapcnet.eu/> no date). However, despite a proliferation of research **indicating that spiritual care is important to patients/clients internationally (e.g. Balboni et al 2017, Selman et al 2017)**, the utilization and application of research findings within practice seems to be patchy outside of palliative care. For example, in England, a national audit (Royal College of Physicians, 2016) found that the 'personal, religious and spiritual beliefs' of people who were at end of life was consistently poorly addressed within acute hospitals. The reasons for this are unclear but two contributory factors may be **staff feelings** of inadequacy in dealing with spiritual issues and lack of training (RCN 2011a) of its membership. This sense of unpreparedness extends to Europe (Schep-Akkerman and van Leeuwen, 2009), New Zealand (n=472, Egan et al 2017) and to other healthcare professionals in Australia (n=437, Austin et al 2017). Answers to the questions raised by Ross back in 1996 (p40) about whether 'nurses who had been taught spiritual care were any better at giving it than those who were not' and about how spiritual care should be taught, have still not been adequately answered.

A possible explanation for this slow progress may be because spirituality assumes low priority in already packed education programmes (Lewinson et al 2015). This situation is not helped, for example in the UK, by mixed messages given by the professional regulatory body, the Nursing and Midwifery Council (NMC). The NMC states that nurses should be competent in spiritual care at point of registration (NMC 2010), yet it is reluctant (Smith 2015) to include spirituality within its Code of Practice (NMC 2015), despite: calls for its inclusion (McSherry and Ross 2015); international evidence that spiritual care is important to patients (Koslander et al 2013) and pregnant women (Bélanger-Lévesque et al 2016); evidence (cited above) of benefits to health and wellbeing. **In other countries, such as Norway (Kunnskapsdepartementet, 2008) and Denmark (NSF, 2016) governments use terms like 'humanity', 'culture' and 'dignity' rather than 'spirituality'**. Reluctance to embrace spirituality more explicitly may be because of the persisting misconception that spirituality is synonymous with religion making it professionally and politically contentious. **Additionally, spirituality and spiritual care are not easy to measure so may not be valued by health care administrators whose focus is on measurable outcomes.**

The meaning of spirituality

There has been considerable debate internationally across disciplines about the precise meaning of spirituality and the need for/possibility of reaching a definition (e.g. Swinton 2006). Internationally the WHO (2002) identifies 8 domains of spirituality which are reflected in definitions adopted in

healthcare practice in the USA (Puchalski 2014), in the UK (RCN 2012) and in Europe by the EAPC. The EAPC offers the following definition which guided this investigation:

“Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred.’ (<http://www.eapcnet.eu/> no date).

Spiritual care is at the heart of everyday nursing/midwifery practice (Clarke 2013). It is a core value running through nursing/midwifery practice. Nurses/midwives have been calling for over two decades for education to prepare them for spiritual care (RCN 2011, Lewinson et al 2015). The questions of what that education should look like and what ingredients are necessary for development of spiritual care competency are as yet unanswered. Whilst spiritual care competences have been developed in the UK for chaplaincy (NHS Education Scotland, no date) and for palliative care (Marie Curie, no date), this work has just begun for nurses and midwives (Baldacchino 2006 [Malta], van Leeuwen et al 2009 [Netherlands], Attard et al 2014 [Malta]) and requires further development.

This paper reports the findings of a study which starts to shed some light on these questions. It builds on a previous cross-sectional pilot survey of 531 undergraduate nursing/midwifery students from 4 European countries (Ross et al 2014, 2016) which highlighted that personal spirituality of the student and how they view spirituality were factors correlated with their perceived competency in spiritual care. What is not currently known is whether these findings hold in a larger more culturally diverse student sample, whether spiritual care competency develops during preparatory nurse/midwifery courses of study, and what factors enhance development of competency.

Aims

1. To describe how student nurses’/midwives’ perceive spirituality and spiritual care and how this changes over time.
2. To describe how competent student nurses/midwives perceive themselves to be in delivering spiritual care and how this changes over time.
3. To explore the factors contributing to development of perceived spiritual care competency.

Methods

The study was designed as a prospective, longitudinal, multinational, correlational survey.

Ethics

Prior to commencement of the study, ethical approval was obtained from ethics committees within participating universities and external organisations as required by each country. Participation was voluntary and anonymity and confidentiality were assured.

Sample

The sample population was 3175 undergraduate nursing/midwifery students enrolled at 21 universities in 8 countries in September 2011. A convenience sample of 2193 students was recruited from attendees in class by the authors plus additional nurse lecturers for the multiple universities in the Netherlands (overseen by RvL) and Norway (overseen by TG), 1-2 weeks after verbal and written information about the study was given out by them. A paper set of questionnaires was completed at that point (n=2193) and during class at the start of years 2 (n=1182), 3 (n=736) (and 4 for

Netherlands which had a 4 year course) and at the end of the course (n=595). Paper copies of the questionnaires were scored by the authors using an agreed scoring protocol which had been developed for the pilot study (Ross et al 2014).

The questionnaires

Students completed five questionnaires (Table 1) which were selected on the basis of fitness for purpose, validity and reliability from a review of the literature as previously described (Ross et al 2014).

Table 1 here

Analysis

Authors from each country scored the questionnaires and entered the data into identical SPSS files (PASW Statistics v18, used in the pilot). The 8 files (one from each country) were emailed to ASA at the data analysis centre in the Netherlands where they were merged into one file by ASA who undertook the analysis with PJ using an agreed analysis protocol. Analysis was performed to detect differences/relationships in the measures according to demographic factors. For dependent variables with scale outcomes, t-test/Mann-Whitney tests (depending upon distribution of dependent variable) and One-Way ANOVA/Kruskal Wallace tests were used for comparisons between independent groups, while paired t-tests were used for comparisons between non-independent groups (Bland, 2006). Spearman tests were used to determine correlational relationships between variables.

To establish the extent to which demographic factors contributed to perception of spirituality/spiritual care (SSCRS), competence (SCCS), spiritual attitude/involvement (SAIL), and spiritual well-being (JAREL), multiple regression analysis was performed for dependent variables with scale outcomes, while logistic regression analysis was performed for dependent variables with binary outcomes (Bland, 2006).

Students who had completed the questionnaires at the start (1st year) and at the end of their course were included in the analysis over time because they represented the end product of the nurse/midwifery education programme (n=351) and most regulatory bodies focus on competency at point of registration.

Results

The sample

Table 2 shows that 21 universities (14 secular, 7 religious) from 8 countries took part in the study. A total of 2193 students took part in year 1 from a possible 3175 giving an initial response rate of 69%. By the end of the study 595 students (non-paired sample) participated from a possible 1821 giving a response rate of 33%; many students were on placement and therefore difficult to reach. Attrition from the study was 73% and was due to two centres withdrawing (Scotland after year 2, an English centre after year 1 because of staff retirement) and natural attrition from courses. Three hundred and fifty one students completed questionnaires both at the start and the end of the study (paired sample). These figures reflect the challenges of undertaking longitudinal research.

Table 2 shows that on entry to the course the majority of the sample were female (88%) nursing students (96%), aged under 21 years (56%) and studying at secular universities (73%). The majority

were religious (67%), mainly Christian (62%), and practised their life view daily or weekly (59%). Over half (57%) reported experiencing life events which were mostly negative (54%).

Table 2 here

Personal spirituality

Table 3 reports the mean scores on all measures, for those completing questionnaires at the start (n=2193) and end of the study (n=595) (non-paired) and for those completing questionnaires both at the start and at the end of the study (n=351, paired).

Table 3 here

JAREL spiritual wellbeing. The mean score for the entire sample at the start of the course was 4.2 (n=2193) and for the paired sample was 4.3 (n=351), meaning that they were classified as having moderate spiritual wellbeing, and there was no change over the duration of the course (Table 3).

SAIL. The mean score for the entire sample at the start of the course was 3.9 (n=2193) and 4.0 for the paired sample (n=351) and these scores increased very slightly by the end of the course in both groups (+0.2 in the non-paired sample and +0.1 in the paired sample, $p < 0.01$, Table 3) and in all subscales. Using the binary cut-off point of >4 to indicate 'high' spiritual attitude/involvement, students narrowly missed out on being classified as 'high' at the start of their course, but were classified as 'high' by the end of the course.

Perceptions of spirituality and spiritual care (SSCRS) and how this changes over time.

Table 3 shows that the mean SSCRS total score at the start of the study for the whole sample (n=2193) was 3.8 and 3.9 for the paired sample (n=351). Thus at the start of the course, students considered spirituality and spiritual care to be broader than just religion.

There **was** a very small but statistically significant broadening of perception of spirituality/spiritual care over time in the overall score in both groups (+0.2 in the unpaired sample and +0.1 in the paired sample, $p < 0.01$). There **was** also a small but statistically significant broadening of perception in the subscales 'spirituality', 'spiritual care', 'religiosity' in both groups (+0.2 in the non-paired sample and +0.1 in the paired sample $p < 0.01$) and in personal care for the paired sample (+0.1, $p < 0.01$) but not for the non-paired sample (no change $p = 0.02$).

Perceptions of competence (SCCS) in spiritual care delivery and how this changes over time

The mean SCCS score at the start of the study for the whole sample (n=2193) and the paired sample (n=351) was 3.6 indicating that students considered themselves to be only just competent in spiritual care at the start of their course (using the cut-off point of >3.5).

Table 3 shows that there **was** a small but statistically significant increase in perceived competence over time in both groups of +0.4 ($p < 0.01$) and in each subscale in both groups. The most notable increases **were** in the subscales indicative of more specialised aspects of spiritual care where scores increased in both groups by 0.6 for 'assessment and implementation of spiritual care' and by between 0.5 and 0.6 for 'referral'. Increases of between 0.4 and 0.5 were also noted for 'professionalisation and improving the quality of spiritual care' and 'personal support and patient counselling'. The subscales 'attitude towards patients' spirituality' and 'communication' showed minimal improvement in both groups of between 0.1 and 0.2, but mean scores were high to start

with (4.4 and 4.5 respectively) compared with the other subscales where the mean scores were lower to start with (3.1-3.6).

Factors contributing to spiritual care competency

Table 4 shows that the factors highly and consistently (at all 4 time points) correlated with perceived competence **were**: perception of spirituality/spiritual care (SSCRS, range 0.32-0.55, $p < 0.01$), Spiritual Attitude and Involvement (SAIL, range 0.29-0.41, $p < 0.01$) and spiritual wellbeing (JAREL, range 0.15-0.33, $p < 0.01$). No clear picture emerged in relation to correlation of students' perceived competence with their practice of spiritual activities or experience of positive life events.

Figure 1 shows that students in the paired sample felt that caring for patients (63-72%) made the greatest contribution to their learning about spiritual care. Events in their personal lives (39-54%) and university linked activities, such as teaching and discussions in university/with other students, were important to a lesser extent (36-48%).

Table 4 and Figure 1 here

Factors contributing to CHANGE in spiritual care competency

Correlations were calculated between the personal factors shown in Table 4 and change in competency scores (SCCS) in the paired sample of 351 between the start and end of the study. Regression analysis highlighted that personal factors were of minor importance in change in competency.

Discussion

Perceived spiritual care competency

It is encouraging that students in our sample perceived themselves to be more competent than not in spiritual care at the start of their course, a finding which concurs with our pilot study (Ross et al., 2014). Perceived spiritual care competency also increased significantly over the course of students' studies (increase of 0.4). There are no studies that offer a direct comparison with these findings. Some studies reported that teaching programmes seemed to enhance nurses understanding and knowledge of spirituality and their practice of spiritual care, but most were limited by small sample sizes, lacked clarity in the rigour of the design, and were cross-sectional (Tiew and Creedy, 2011; Cooper et al., 2013; Attard et al., 2014). They also assumed that changes in enhanced understanding and practice were attributable to the teaching programmes, but they did not provide evidence for this. Our study offers the first such evidence by identifying that two factors, namely perception of spirituality/spiritual care and personal spirituality, were correlated with development of perceived spiritual care competency in a multinational sample of nursing and midwifery students; and confirm our pilot study findings (Ross et al 2016).

Factors contributing to development of perceived spiritual care competency

Personal spirituality

Our finding that higher perceived spiritual care competency correlated with higher spiritual wellbeing (JAREL) and spiritual attitude and involvement (SAIL) is in keeping with other studies which have suggested a link between personal spirituality and attitude towards (e.g. Taylor et al., 2008) and perceived ability to give spiritual care (e.g. van Leeuwen et al., 2008; Cone and Giske 2017). The fact that students' personal spirituality (JAREL and SAIL) changed little over the course of their studies raises the question of whether we should be selecting students with high scores on these

measures at course entry, and if so, what would represent a minimum score. In terms of the teaching and learning environment, reflective exercises focusing on own beliefs/values and how these impact on care, may be useful (but would require testing) in raising students self-awareness in light of evidence that health care professionals' beliefs and values may impact on care and treatment decisions (Seale et al date).

Perception of spirituality/spiritual care

Higher perceived spiritual care competency was also correlated with viewing spirituality/spiritual care broadly, not just in religious terms. We reported evidence that students' perceptions of these terms broadened further over the duration of their studies. Further analysis of our data is underway to ascertain if this happens to all students, or if there are some whose view does not broaden, who do not perceive themselves as being competent in spiritual care at point of registration and therefore for whom the offer of a place on a nursing/midwifery course may require careful consideration along with other evidence as part of the selection process.

Factors identified by students as important in their learning

Students in our sample attributed their development of spiritual care competency to a number of factors which may give educators clues about how they might design education programmes to best facilitate this development. For example, highest on students' list was caring for patients which links with Giske and Cone's (2012) finding that the clinical encounter may open up opportunities for spiritual learning. The implications are that spirituality teaching might be better placed in years 2 or 3 of courses, by which time students have had clinical experience to draw upon. Scenarios and reflective exercises that focus on patient encounters may serve as useful learning tools.

University teaching and discussion in university/with other students were additional factors identified as important by students in learning about spiritual care, suggesting that tutorials and discussion forums, whether on-line or face to face, may be helpful.

Life events did not feature strongly in our analysis as a factor contributing to development of perceived spiritual care competency (positive life events was weakly correlated at three time points only $p < 0.01$, Table 4). However, life events were identified by students as important in their learning about spiritual care and was also identified by Ross (1994) as important. Analysis of our sample's qualitative responses to this question may shed further light on this.

Further investigation is needed to determine: if spiritual care competency can be predicted; if students scoring low in competency improve and what contributes to improvement; if the study measures may be useful in student selection; which educational strategies are most effective in enhancing learning in spiritual care. A measure of actual rather than perceived spiritual care competency is needed.

Limitations

Attrition

A good response rate of 69% was obtained at the beginning of the study, dropping to 33% by the end mainly because students were on clinical placement and could not be reached. Attrition was 73%; reasons included withdrawal of participating universities from the study and natural attrition from courses. This is a major limitation and means that our findings cannot be generalised to the convenience or target samples. High attrition rates are a recognised problem in longitudinal studies with drop-out rates between 30-70% commonly reported (Gustavson et al 2012). Our attrition rate

of just over 70% is towards the high end of what is commonly reported but we could not find longitudinal studies of nursing courses, traditionally recognised as having high attrition rates (REF anyone??), to offer a direct comparison.

Diversity of life view

Our pilot study conducted in 4 countries highlighted the need to include greater diversity of life view (Ross et al 2016), however this was only achieved to a limited extent with a larger study sample derived from 8 countries. Although our main study sample was less religious than our pilot sample (67% compared with 87% in the pilot) and non-religious activities were practised (70%; meditation, art, rest in nature, voluntary work) just as much as religious ones (73%; prayer, reading religious books, visiting religious places), there was still a predominance of Christian students with little representation from other religions. This may be a reflection of European nursing cohorts in general. Unfortunately we were unable to obtain European data of the religious/non-religious profile of student nurses to compare our sample with. However, our UK sample was very similar to that of the UK student nurse/midwife profile from the most recent National Student Survey (which gathers feedback from UK final year undergraduate students about their experience of their courses) statistics; 53% of our sample were Christian compared with 44% nationally, 3% Buddhist compared with 2% nationally (Equality Challenge Unit 2011).

Conclusion

Following damning reports of poor care, such as the Francis Report (give ref), a great deal of attention has focussed on recruiting student nurses/midwives with the right values (refs) in order that they will be competent practitioners in both the art and science of nursing/midwifery at point of registration; spiritual care competency is one requirement. Our findings from a longitudinal multinational quantitative survey indicated that perceived spiritual care competency developed over the course of our sample's studies and that a high sense of personal spirituality and a broad view of what spirituality/spiritual care were about were important factors in that development. The question of whether these two attributes might be useful in selecting student nurses/midwives with the right values onto courses, the implications of our findings for developing best practice in spiritual care education, and further data analysis to identify if and how competency can be predicted are aspects being considered by nurse/midwifery educators across Europe as part of a three year Erasmus funded project. The project aims to develop an evidence based gold standard matrix for spiritual care education for undergraduate nurses/midwives, an educational toolkit and a website to act as a hub for international engagement and dissemination of best practice (EPICC Project give link).

References

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), pp 1460-1466

Austin, P, MacLeod, R, Siddall, P, McSherry, W and Egan, R (2017) Spiritual care training is needed for clinical and non-clinical staff to manage patients' spiritual needs. *Journal for the study of spirituality*, 7 (1). 50 -53 <http://dx.doi.org/10.1080/20440243.2017.1290031>

Balboni TA, Fitchett G, Handzo GF, Johnson KS, Koenig HG, Pargament KI, Puchalski CM, Sinclair S, Taylor EJ, Steinhauser KE (2017) State of the science of spirituality and palliative care research part II: screening, assessment and interventions. *Journal of Pain and Symptom Management*, 54, 3, 441-453

Baldacchino DR (2006) Nursing competencies for spiritual care. *Journal of Clinical Nursing*, 15, pp 885-896

Bélanger-Lévesque M, Dumas M, Blouin S and Pasquier J (2016) "That was intense!" Spirituality during childbirth: a mixed-method comparative study of mothers' and fathers' experiences in a public hospital. *BMC Pregnancy and Childbirth*, 294, DOI 10.1186/s12884-016-1072-z

Bland, M (2006) *An introduction to medical statistics* (3rd Edition). OUP, New York

Clarke J (2013) *Spiritual care in everyday nursing practice*. Palgrave Macmillan, Basingstoke

Cone P, Giske T (2017) Nurses' comfort level with spiritual care concerns. A mixed method study among working nurses. *Journal of Clinical Nursing*. DOI: 10.1111/jocn.13660

Egan R, Llewellyn R, Cox B., MacLeod R, McSherry W and Austin P (2017) New Zealand nurses' perceptions of spirituality and spiritual care: qualitative findings from a national survey. *Religions*, 8, (79) doi:10.3390/rel8050079

Equality Challenge Unit (2011) *Religion and belief in higher education: the experiences of staff and students*. <http://www.ecu.ac.uk/wp-content/uploads/external/religion-and-belief-staff-and-students-in-he-report.pdf> Accessed 22/8/16

European Commission (2010). *Europe 2020 Strategy* https://ec.europa.eu/info/strategy/european-semester/framework/europe-2020-strategy_en Accessed 6/9/17

Giske (2012) How undergraduate nursing students learn to care for patients spiritually in clinical studies – a review of the literature. *Journal of Nursing Management*, 20 (80), 1049-1057

Gustavson K, von Soest T, Karevold E and Røysamb E (2012) Attrition and generalizability in longitudinal studies: findings from a 15-year population-based study and a Monte Carlo simulation study. *BMC Public Health*, 12, pp 918. Available at <https://doi.org/10.1186/1471-2458-12-918>

Hungelmann J, Kenkel-Rossi E, Klassen L, Stollenwerk R (1996). Focus on spiritual well-being: harmonious interconnectedness of mind-body-spirit. Use of the JAREL Spiritual Wellbeing Scale. *Geriatric Nursing*, November/December, pp 262-266.

International Confederation of Midwives (2014) International Code of Ethics for Midwives. http://internationalmidwives.org/assets/uploads/documents/CoreDocuments/CD2008_001%20V2014%20ENG%20International%20Code%20of%20Ethics%20for%20Midwives.pdf (Accessed 12 September 2017)

International Council of Nurses (2012) <http://www.nln.org/professional-development-programs/international-council-of-nurses-education-network> (Accessed 18 September 2017)

Kunnskapsdepartementet (2008) Rammeplan for sykepleireutdanning. https://www.regjeringen.no/globalassets/upload/kd/vedlegg/uh/rammeplaner/helse/rammeplan_sykepleierutdanning_08.pdf

Koenig H, King D and Carson V (2012) Handbook of religion and health. OUP, New York

Koslander T, Lindström UÅ and Barbosa da Silva A. (2013) The human being's spiritual experiences in a mental healthcare context; their positive and negative meaning and impact on health - a hermeneutic approach. Scandinavian Journal of Caring Science. 27 (3), pp 560-8.

Lewinson L, McSherry W, Kevern P (2015) Spirituality in pre-registration nurse education and practice: A review of the literature. Nurse Education Today, 35, pp 806–814

McSherry W, Draper P, Kendrick D (2002) Construct validity of a rating scale designed to assess spirituality and spiritual Care. International Journal of Nursing Studies, 39, pp 723-734.

McSherry W, Gretton M, Draper P, Watson R (2008) The ethical basis of teaching spirituality and spiritual care: a survey of student nurses perceptions. Nurse Education Today, 28 (8) pp1002-1008

McSherry W and Ross L (2015) A spiritual shortfall? Nursing Standard, 29 (35) pp 22-23

Marie Curie. Spiritual and religious care competencies for specialist palliative care. (www.mariecurie.org.uk/healthcare no date). (Accessed 18 September 2017)

Meezenbroek E, Garssen B, and van den Berg M (2008). Spiritual Attitude and Involvement List (SAIL). Helen Dowling Institute, Utrecht, Netherlands.

NHS Education Scotland. Spiritual and religious care capabilities and competences for healthcare chaplains. NES, Edinburgh. (http://www.ukbhc.org.uk/sites/default/files/nes_chaplaincy_capabilities_and_competencies.pdf no date). (Accessed 18 September 2017)

NMC (2010) Standards for pre-registration nursing education. NMC, London

NMC (2015) The Code. NMC, London

NSF (2016) Yrkesetiske retningslinjer at <https://www.nsf.no/vis-artikkel/2193841/17036/Yrkesetiske-retningslinjer-for-sykepleiere>

Puchalski CM, Vitillo R, Hull SK, Reller N (2014) Improving the spiritual dimension of whole person care: reaching national and international consensus. *Journal of Palliative Medicine*, 17, (6), pp 642–656

Ross L A (1994) Spiritual aspects of nursing. *Journal of Advanced Nursing*, 19, pp 439-447.

Ross L A (1996) Teaching spiritual care to nurses. *Nurse Education Today*, 16, pp 38-43

Ross L, van Leeuwen R, Baldacchino D, Giske T, McSherry W, Narayanasamy A, Downes C, Jarvis P, Schep-Akkerman A (2014). Student nurses perceptions of spirituality and competence in delivering spiritual care: a European pilot study. *Nurse Education Today* 34 (5),pp 697–702.

Ross L, van Leeuwen R, Baldacchino D, Giske T, McSherry W, Narayanasamy A, Downes C, Jarvis P, Schep-Akkerman A (2016) Factors contributing to student nurses'/midwives' perceived competency in spiritual care. *Nurse Education Today*, 36, pp 445–451

Royal College of Nursing (2011) RCN spirituality survey 2010. <https://www.rcn.org.uk/professional-development/publications/pub-003861>. Accessed 10/8/17

Royal College of Nursing (2012) Spirituality in nursing care on-line resource. RCN, London

Royal College of Physicians (2016) End of Life Care Audit – Dying in Hospital: National report for England 2016 <https://www.rcplondon.ac.uk/projects/outputs/end-life-care-audit-dying-hospital-national-report-england-2016> (Accessed 10 August 2017)

Schep-Akkerman AE and van Leeuwen RR (2009) Spirituele zorg. Vanzelfsprekend, maar niet vanzelf. *Tijdschrift voor Verpleegkundigen (TvZ)*, 119, (11/12) pp 34-39.

Schuermans M (2012). Een nieuwe kijk op verpleegkunde. In: J. Lambregts & A. Grotendorst (2012). *Leren van de toekomst*, p.118. *Verpleegkundigen & Verzorgenden 2020*. Houten, Bohn, Stafleu and van Loghum

Selman LE, Brighton LJ, Sinclair S, Karvinen I, Egan R, Speck P, Powell RA, Deskur-Smielecka, Glajchen M, Adler S, Puchalski C, Hunter J, Gikaara N, Hope J (2017) patients' and caregivers' needs, experiences, preferences and research priorities in spiritual care: A focus group study across nine countries. *Palliative Medicine* DOI: 10.1177/0269216317734954

Smith J (2015) We believe it is better not to explicitly highlight spirituality. *Nursing Standard*, 29, (37), pp33

Swinton J (2006) Identity and resistance: why spiritual care needs 'enemies'. *Journal of Clinical Nursing*, 15 (7) pp 918- 928.

van Leeuwen R, Tiesinga LJ Middel B Post D and Jochemsen H (2008)The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care. *Journal of Clinical Nursing*, 17 (20), pp2768-81

van Leeuwen R, Tiesinga L, Middel B, Post D, Jochemsen H (2009) The validity and reliability of an instrument to assess nursing competencies in spiritual care. *Journal of Clinical Nursing*, 18, pp 2857–2869.

World Health Organisation (2002) WHOQOL-SRPB Field Test Instrument. WHO, Geneva