The Development of a Consensus - based Spiritual Care Education Standard for Undergraduate Nursing and Midwifery Students: An Educational Mixed Methods Study.

INTRODUCTION

This paper reports on the process and outcomes of a European educational project aiming for the development of a consensus - based spiritual care competency standard for undergraduate nursing and midwifery education. The standard was developed as part of a Funded European Erasmus+ K2 Strategic Partnership (2016-2019), named as the EPICC project ('Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care') (www.epicc-project.eu; McSherry et al, 2020).

The EPICC project involved 3 key groups of leading scholars in spiritual care. One group were the strategic Partners from 6 universities who coordinated the project, 31 EPICC Participants, who were nursing/midwifery educators form 21 European countries and 18 EPICC Participants+ namely; key-stakeholders, students, members of the public, professional bodies, patient groups (McSherry et al 2020). The aims of the EPICC project were:

1) to develop a European Standard for Spiritual Care that focused on undergraduate nursing and midwifery education. The content and application of the Standard was during the whole process considered within the cultural contect and the language of the country in which it will be used. For this purpose, the Standard allowed for flexibility without losing its fundamental content.
2) to establish a sustainable network and partnerships with European and international nursing and midwifery (N/M) educators and researchers to enable the sharing of experiences and resources to inform the teaching of spiritual care.

Background

Significant evidence highlights the impact of spirituality on health, well-being and quality of life (Koenig et al. 2012), indicating it is important to patients/clients internationally (Selman et al, 2017). It is also integrated within international healthcare guidance and policy (e.g. European Association for Palliative, 2020; World Health Organization, 2002). The EPICC project adopted the European Association for Palliative Care's (EAPC) definition of spirituality ; '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' (Nolen et al., 2011). This definition recognises the multidimensional field of spirituality namely;

The existential challenges (e.g. questions concerning identity, meaning, suffering and death, guilt and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, love and joy), value based considerations and attitudes (what is most important for each person, such as relations to oneself, family, friends, work, things nature, art and culture, ethics and morals, and life itself) and the religious considerations and foundations (faith, beliefs and practices, the relationship with God or the ultimate). The EPICC project adapted the NHS Education for Scotland (NES) definition of spiritual care (NHS Scotland, 2010) to include a focus on wellbeing: 'That care which recognises and responds to the needs of the human spirit when faced with life changing events (such as birth, trauma, ill health, loss) or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires' (NHS Scotland, 2010, p. 6).

The development of a European Spiritual Care Education Standard was instigated by the recognition of the importance of spiritual, religious and cultural aspects of people's lives on their wellbeing. The European Commission (2008), recommends that the caring professions are educated in this respect. Nurses and midwives are examples of the caring professions and their responsibility for spiritual care is clearly written into their Codes of Ethics (e.g. ICM 2014, ICN 2012) and educational guidelines (e.g. NMC 2018). Nurses' and midwives' perception of spiritual care is that it forms part of their everyday practice (Giske & Cone 2015). However, international evidence shows that nurses and midwives feel unprepared to provide spiritual care requesting more education (van Leeuwen and Schep-Akkerman, 2015). Spiritual care education is variable in terms of how it features in nursing and midwifery curricula, content, means of delivery and assessment. (Lewinson et al 2015).

Possible reasons for this variation are the uncertainty about the meaning of spirituality and the lack of clarity about what constitutes a suitable curricular content and modes of assessment. Furthermore, there is also the conflicting stance of some regulatory bodies regarding its importance. For example, in the UK the Nursing and Midwifery Council (NMC) states that at point of registration nurses should be able to 'carry out comprehensive assessments that take

account of cultural and spiritual factors….' (NMC, 2018) yet is hesitant to include the spiritual dimension within its Code of Practice (2015), by proposing a biopsychosocial model of care. The International Council of Nurses (ICN) identifies the nurses' role as promoting "an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected'' (ICN, 2012, p.2). The Malta Code of Ethics (CNM, 2020), supports this for nurses and midwives, stating that the nurse is to "recognize and respect the uniqueness of every patient/client's biological, psychological, social and spiritual status and needs'' (2020, p.8). Since patients are attended by different members of the multi-disciplinary team, these codes of ethics also address the holistic care of health care professionals that contribute towards patients' safety. Notwithstanding the complexity and barriers to the spiritual dimension of care such as, the absence of an agreed definition, the personal expression of spirituality and the lack of personal experiences for students (Cone & Giske 2017, Kuven & Giske 2019), nurses and midwives are expected to address this aspect of care, which is considered as an integral aspect of nurses'/midwives' practice. Another reason for the patchy inclusion of spirituality within pre-registration nurse/midwifery education programmes is the result of lack of guidance and the absence of rigorous and validated competences in spiritual care to guide the education.

The NMC in the UK, in line with the European Qualifications Framework (EQF) (2008), defines competence as "the proven ability to use knowledge, skills and personal, social and/or methodological abilities in the work or study situations and in professional and personal development" (p. 11), referred to as "responsibility and autonomy." Competence learning is dominant in todays professional education in general and more specifically in nursing and midwifery education. Utilising a competency-based learning methodology helps to provide healthcare professionals with the relevant knowledge, skills and attitudes necessary to practice with some degree of confidence (Kelly, 2012).

Different studies have been conducted exploring the development of spiritual care competence and are described in literature (Kelly, 2012). (Van Leeuwen & Cusveller (2004) developed a literature based spiritual care competency framework comprising of the following six competences: handling own values and convictions, addressing spirituality in a culturally sensitive and caring manner, assessment, planning, providing and evaluation of spiritual care, contribution to quality assurance within the organization. Based on this study van Leeuwen et al. (2009) developed and validated a tool to assess spiritual care competence, called the Spiritual Care Competence Scale (SCCS). This scale contains the following six subscales: attitude

towards patient spirituality, communication, assessment and implementation of spiritual care, referral, personal support and counselling, professionalisation and improving the quality of spiritual care the nursing.

The demand and importance of integrating spiritual care competence in nursing/midwifery education has been echoed through research (Attard & Baldacchino 2014). Thus, building on the work of Van Leeuwen & Cusveller (2004) and Leeuwen et al. (2009), Attard et al (2019a, b) looked at spiritual care competences in nursing and midwifery for undergraduate students. Using a modified Delphi consensus-based approach seven domains of spiritual care competences describing 54 competency items were identified. The domains are knowledge of spiritual care, self-awareness and use of self, communication and interpersonal skills, ethical legal issues, quality assurance in spiritual care, assessment and implementation of spiritual care, informatics in spiritual care. These studies give insight in the need for spiritual care competences for N/M and from the basis for the development of the EPICC European project core competency standard in spiritual care.

The need to develop spiritual care competences and learning objectives that are internationally accepted and applicable in diverse cultural educational N/M contexts came forward from the recommendations of longitudinal studies among N/M students in higher education in different European countries (Ross et al., 2014, 2016, 2018). These studies showed that N/M students develop spiritual care competences during their education and students' perception of spirituality and their personal spirituality contributes to the development of spiritual care competence. Other studies also show the need for research to benefit teaching approaches, and the further exploration of teaching content and strategies (Lewinson et al., 2015). This raises questions about which competences are required by nurses/midwives at the point of registration and how these competences can be validated?

THE STUDY

Aim

The limitations of the studies exploring spiritual care competence is because they were conducted with a specific focus on the nursing profession and in a single country with certain cultural features for example religious beliefs and values. This makes generalisation and applicability of the findings within a broader professional, international and cultural context difficult. From this perspective the aim of The EPICC project was to develop a consensus-based

Spiritual Care Education Standard for Undergraduate N/M Students to use in undergraduate programmes. In this study participants aim to agree upon the following research questions:

- What are the core spiritual care competences that undergraduate nursing and midwifery students should possess at point of registration allowing flexibility and adaptation in different international and cultural educational contexts?
- What learning outcomes could be defined in terms of knowledge, skills and attitudes, that are essential for the development of those competences?

Design

With the use of qualitative and quantitative research methods a mixed methods design was used (Tashakorri & Teddlie (2003). Within the scope of this study this consisted of a series of facilitated action learning cycles which were qualitative conducted and consensus based quantitative online surveys based on the principles of Delphi research (Polit et al., 2012). The action learing cycles took place in so called learning and teaching events in which an interative process of learning and discussion between participants took place and were they worked towards a certain level of consensus about the standard. Real consensus was asked on every single element of the standard in online surveys. On forehand was decided that consensus should be reached when >90% of the partcipants agreed with the content of every single element of the standard.

Sample/Participants

The three EPICC groups of scholars (collectively known as EPICC participants) participated in the survey which provided a significant contribution to the development of the Spiritual Care Education Standard. The groups participation can be viewed diagrammmatically as an equilateral triangle, that represented a unity in the way they were working to that common goal (McSherry et al. 2020). This approach is novel and innovative in that it emphasises the importance of true collaboration and co-production.

A total of fifty-eight (n=58) participants coming from 21 European countries (Austria, Belgium, Croatia, Czech Republic, England, Denmark, Germany, Greece, Ireland, Lithuania, Malta, The Netherlands, Norway, Poland, Portugal, Scotland, Spain, Sweden, Turkey, Ukraine, Wales) participated in the consensus-based online surveys. These participants were identified through EPICC Partners' networks and through an advertisement on Research Gate. Participants were

included when they are identified as experts in spiritual care in education and/or spiritual care research in nursing and/or midwifery. Before the start of the study the participants committed themselves to participate in all five phases of this study. The participant were recruited by means of purposive and snowball sampling. The sample size was limited because of budgetary reasons.

Data collection

Data collection took place consecutively in an iterative process of consensus development in five phases (see Table 1) that were redundant executed over the period June 2017 until February 2019. Data collection consisted of online surveys in which respondents were asked to score their agreement with the content of N/M spiritual care competences and learning objectives in terms of knowledge, skills and attitudes. Face-to-face meetings were also held to discuss the competences and learning objectives identified.

At the start of the process in phase 1 participants were asked to score their level of agreement on a 5-point Likert scale (1 = fully disagree- 5= fully agree) with each competency from the list of 54 competences in spiritual care developed by Attard (2015). The outcome of this survey was used for further discussion in the face-to-face meetings. Competences that scored >75% agreement and over were included for further discussion in a Teaching and Learning event (TLE) held in October/November 2017 in the Netherlands (TLE1) and in Malta in September 2018 (TLE2).

These Teaching and Learning events consisted of small workgroups and plenary sessions. Working in small groups guaranteed that every participants opinions could be put forward. These sessions lasted between 1,5 – 2 hours and were moderated and reported on flip charts to instigate further discussion for the purpose to achieve consensus on the competences' elements of the standard. A moderator guided the plenary discussions. Each group drafted a standard, then the different draft standards were merged, only omitting duplications. The merged draft then was discussed until consensus was reached. Consensus was measured by a raise of hand. Consensenus was reached by 90% agreement. This ongoing iterative procedure guaranteed a valid and credible development of the N/M spiritual care educational standard.

Between TLE1and TLE2 (December 2017 – June 2018) participants were asked to pilot this first common draft in their own educational practice (e.g. in curriculum and course development and training). Outcomes were reported on an evaluation form and at the start of TLE2 (e.g.

objectives, activities, involvement, used parts of the standard, helpfulness, obstacles). After TLE2 the partipants formulated a final draft of the N/M 'EPICC Spiritual Care Education Standard'. All elements of the standard (including the preamble, the competences, and the learning objectives) were circulated by e-mail (survey questionnaire) to gain participants agreement using a 5-point Likert scale. Agreement was reached when 90% of the respondents scored agree to fully agree (point 4 and 5 of the Likert scale) Table 1 presents on overview of the phases of data collection in the consensus procedure.

Ethical considerations

Prior to data collection full ethical approval was obtained form the Lead Partner's University Ethics Committee. Participation was entirely voluntary and information concerning the project and what participation entailed were distributed to all the participants. Written consent was gained form the participants. All the data collected was anonymised and no participant is referred to by name. All information and data gathered were stored on University encrypted servers.

Data analysis

Data gathered from the surveys (phases 1 and 5) were analysed by descriptive statistics using SPSS Version V25. The outcomes of the group meetings (phases 2 and 4) were discussed in plenary meetings. Written reports of these meetings were made, and themes of these reports were recorded on flip charts to generate more discussion during the meeting. Outcomes of these meetings were analysed and synthesized in plenary sessions in draft versions of the standard. In follow-up meetings participants worked on gaining further agreement. The analysis of phase 3 (implementation) was based on the presentations delivered by the participants about the application of the draft standard in their own educational practice. These presentations were also recorded.

Validity and reliability

By using a consensus based approach the different before mentioned methodological measures were used to obtain validity and reliability. Essential in the process was that every participant felt heard and could bring forward their input in the process. For that reason the mixed method approach was suitable. Group meetings were not only plenary but took also place in smaller

group. The surveys offered the opportunity to give final personal opinions. Consensus was strickly determined on before made criteria.

RESULTS

Phase 1: The group consensus agreement

In this phase agreement was measured on:

A working definition of spirituality

The respondents in this phase (n=35) in general were positive about adopting the EAPC definition as the working definition in this project, commenting that it is a broad definition which takes into account a variety of spiritual perspectives. Participants found it suitable, useful, easily understood, accessible, comprehensive and functional. Some respondents commented on some terms in the definition as, 'transcendent', 'sacred', and 'dynamic' to be not fully clear. Some respondents found the definition complex in its length. Agreement on the final working definition of spirituality was undertaken in phase 2.

The nursing/midwifery spiritual care competences

From the results of the online survey 13 competences achieved <75% level of consensus. With 38 competences consensus of >75% was and 15 of these 38 had a level of <90 % consensus (see Table 2). These results provided the first insight into what the respondents thought are the core comptences in spiritual care. These were further discussed in phase 2.

Spiritual care competences' learning objectives

In this phase the respondents defined different learning objectives in terms of knowledge, skills and attitudes which they thought were important for spiritual care N/M undergraduate education. Table 3 shows an overview of these learning objectives. Further discussion of the objectives followed in phase 2 of the analysis.

Phase 2: Preamble and first draft of the N/M EPICC Spiritual Care Education Standard

Final agreement on a working definition of spirituality and spiritual care

During the first Teaching and Learning Event which took place in the Netherlands, the EAPC, (Nolan, 2011) working definition of spirituality was further discussed. It was agreed

unanimously to adopt this definition as the working definition for the EPICC project. Notwithstanding that the definition was developed for palliative care, respondents agreed that it could be applied to other health care contexts as it defines key elements of spiritual care needs relevant to other diverse patient groups. Consequently, the definition was included in the narrative of the preamble of the EPICC Spiritual Care Education Standard.

Participants thought that it was important that the preamble should also include a working definition of spiritual care that would provide a frame of reference around what spiritual care in nursing/ midwifery is all about. Unanimously the NHS Scotland (2010) definition of spiritual care was chosen by the participants. Discussion took place about the inclusiveness of the definition for both the nursing and midwifery disciplines. From the discussion it was decided to include in the terms 'life events' and 'birth'as these would enhance application to the midwifery. After the discussion consensus was reached and the definition for spiritual care reads:

> *'spiritual care is care which recognises and responds to the human spirit when faced with life-changing events (such as birth, trauma, ill health, loss) or sadness, and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in a compassionate relationship and moves in whatever direction need requires'.*

Participants also felt that the preamble should enhance the application of the Spiritual Care Education Standard within the diverse cultural context and the language of the country in which the standard is used. Other issues raised and discussed were the agreement on the terms to be used in the standard. It was decided that the terms 'person and individual' would be used interchangeably to refer to 'patient', 'client', 'service user', 'pregnant woman', 'carer', 'family member', 'relative', 'care recipient' These conceptual and textual decisions lead to the first draft of the standard preamble that were put before the participants in a next phase for final agreement.

Development of a first draft of the EPICC Spiritual Care Education Standard (Standard)

The next step in the second phase of the consensus process was discussion about the agreed spiritual care competences and learning objectives. The focus of this exercise was to have a manageable set of competences from the agreed competences in phase 1 of the analysis which

included the competences with a >90 agreement (n=15) (Table 1). After a first round of discussion a set of 9 competences were iteratively formulated for further discussion. This means that competences from the list at the start of this phase were not fully removed but parts were combined. The learning objectives for these competencies were developed and discussed. This led to the formulation of the first draft of the spiritual care competences and their learning objectives by the EPICC participants. Continuing discussion took place in small group sessions and plenary sessions in the following week until the final version of a first draft of the Standard was finalised (see table 4).

Phase 3: Application and evaluation of the draft Standard in educational institutions.

In this phase of the project, participants coming from various European educational institutions were asked to evaluate the developed standard in their own educational institution and to provide feedback on this experience. An evaluation template was developd for this purpose. A total of fourteen templates were submitted. Feedback from these templates revealed that respondents agreed with the standard and thought it was useful in nursing and midwifery curricula, course development and policy making about spiritual care. In general, participants commented that the standard was a very positive step in the right direction in terms of being relevant for N/M undergraduate education. Respondents also commented about the complexity of the standard as they found that 9 competences may be too demanding to teach in the programme. Furthermore, they thought that some competences overlapped and could be included in other competences. The feedback from this phase of the study was further discussed in phase 4

Phase 4: Presentation, reflection and development of the EPICC Standard

In this round the participants reflected on the outcomes of phase 3 and worked further on a final draft of the EPICC Standard. Participants provided a presentation about the application of the standard in their own educational practice and the outcomes of it. Table 5 shows a brief overview of outcomes of the submitted templates and their country of origin. The implementation period had provided all participants time for personal reflection together with colleague lecturers, students, and policy makers. Based on the evaluations of the 9 competences in phase 3 and the discussions in meetings that followed, the participants agreed that a set with lesser essential competences would allow for better communication and integration of the standard in the diverse healthcare educational environments. Textual amendments were also

discussed such as repetition of learning objectives and the identification of knowledge, skills and attitudes to specific competency items

To work on this feedback, small group sessions were scheduled to discuss how overlapping competences and learning objectives could be collapsed in a more all-inclusive standard. Using an iterative process, the identified 9 competences in the draft version of the standard were reduced to a comprehensive set of 4 core spiritual care N/M competences. The original competences 1 and 3 were collapsed as *Competence 1 and named 'Intrapersonal spirituality'* and this competency focused on the awareness and understanding of spirituality. Competences 2 and 4 were collapsed to *Competence 2 and named 'interpersonal spirituality'*. This competency focused on the persons' and professionals' relationship on a spiritual level. Competences 6, 7 and 8 were collapsed to *Competence 3 and named 'Assessment and planning for spiritual care'* and competences 5 and 9 were identified as *Competence 4 and named 'Intervention and evaluation of spiritual care'*.

Based on these four competences the learning objectives were reviewed for consistency and comprehension. Overlaps were removed and learning objectives were categorised under cognitive (knowledge), functional (skills) and ethical (attitudes) competences (Weeks et al., 2017). Thus, after round 4 the final version of the standard was formulated which was presented to the participants and asked for their agreement in Phase 5.

Phase 5: Consensus survey on final draft of the Standard

In this phase an online consensus survey was executed to measure the level of agreement among the participants regarding all single elements of the EPICC Standard (preamble, competences, learning objectives).

The survey was completed by 37 EPICC participants (6 partners, 21 participants and 10 participants+) from 16 different European countries. Thirty of these respondents had a background in nursing and /or midwifery education and 7 participants had administrative, clinical and/or managerial backgrounds. Results of the survey showed high level of agreement on all elements of the EPICC Standard. Table 6 shows the respondents level of agreement with the different elements in the spiritual care standard.

DISCUSSION

Pre-registration spiritual care nurse/midwifery education

According to existing spiritual care competence profiles (Attard, 2015, van Leeuwen & Cusveller, 2004) the standard show similarities in its content and focussess on core N/M spiritual care competences. It is unique that in this study for the first time consensus has been reached across 21 European countries on i) the core spiritual care knowledge, skills and attitudes that can be expected of student nurses and midwives at point of registration and ii) how spirituality and spiritual care are defined for undergraduate nurse/midwifery education. Both of these landmark achievements are detailed in the co-produced EPICC Standard presented in this paper. The EPICC Standard is changing and enhancing pre-registration nurse education across Europe; for example it has been embedded within undergraduate curricula in all 6 universities and Lublin Medical University Poland.

Implications for practice

The EPICC Standard provides important new evidence-based guidance for educators on the design, delivery and recruitment to undergraduate nursing/midwifery programmes, specifically:

i) course content; the EPICC Standard sets out the knowledge students need in order to provide spiritual care, and therefore the topics that courses should cover.

ii) skills and attitudes that should be cultivated in students. Along with The EPICC Standard an EPICC Matrix was developed which underpins The Standard and that outlines how these skills and attitudes can be enhanced. For example by: creating a teaching/learning environment which encourages student discussion and reflection on students' beliefs/values, life events, as well as on their experiences of caring for patients/clients. (See http://blogs.staffs.ac.uk/epicc/resources/epicc-gold-standard-matrix-for-spiritual-care-education/). In the EPICC project also a toolit with spiritual care learning strategies was developed by the EPICC participants. This toolkit provides teaching and learning activities that worked well for participants in enhancing student learning about spiritual care. The strategies are explicitely refered to the competencies from the EPICC standard they work on. The toolkit can be retrieved from the EPICC website.

iii) recruitment of students. In addition to academic qualifications, the Matrix outlines personal qualities and values (such as compassion, warmth, empathy) key to spiritual care that universities may look for in selecting students onto their courses.

Wider cultural relevance

The EPICC Standard may have wider cultural relevance beyond the 21 participating European countries. Educators and clinicians from as far afield as Brazil, China, Venezuela, USA, Canada and Kenya have become members of the EPICC Network (June 2020) and the EPICC Project has over 200 Research Gate followers from Asia, Africa, North/South America and Australasia (November 2019). This global interest suggests that the EPICC Standard may be relevant cross culturally.

Utility beyond pre-registration nursing and midwifery

Although the Standard was co-produced for undergraduate student nurses and midwives, it is attracting wider interest from those responsible for educating other healthcare students and existing healthcare staff. For example the EPICC Standard is a mandatory requirement of all commissioned pre-registration contracts in Wales from 2022 for the following professions: paramedicine, dietetics, physiotherapy, occupational therapy, speech and language therapy, podiatry, diagnostic radiography and therapeutic radiotherapy and oncology, operating department practitioners, physicians associates and PTP healthcare science programmes. In Wales the Standard is to be embedded in preceptorship and health support worker programmes too. At Viaa University Netherlands the Standard has been embedded in the E-learning programmes for post-registration nurses and specialist spiritual care practitioners. One of the tools in the Toolkit is recommended by the EAPC in its White Paper for the education of multidisciplinary palliative care practitioners across Europe (Best, et al. 2020).

Policy

The EPICC Standard is providing a frame of reference for policy making within professional organisations and healthcare organisations. For example, the UK Board of Health Care Chaplains sets out its expectation that non-specialist spiritual care givers, such as nurses, will demonstrate the competences set out in the EPICC Standard (UKBHC 2020). The United Hospitals of North Midlands NHS Trust in England similarly expects its staff to meet the competences set out in the EPICC Standard, which has been adopted in full in its Spiritual Care Policy Document (UHNM 2019).

Strengths

A major strength of the EPICC Standard, and the Matrix underpinning it, is that they were based upon strong international evidence (Attard et al. 2019 a, b; van Leeuwen et al 2009; Ross et al.

2014, 2016, 2018). Construction of the EPICC Standard through a transparent, rigorous, structured and intensive iterative process (as described in this paper) with input from participants from diverse cultural and professional backgrounds (education, research, practice, policy, management, service users) across 21 European countries is a further strength. This makes application of the EPICC Standard within different contexts possible.

Further research

There is a need to test the EPICC Standard in pre-registration nursing/midwifery programmes in continents beyond Europe, to establish if it is fit for purpose in different cultural settings. The EPICC Standard's suitability for pre- and post registration programmes of other healthcare professions programmes including N/M also requires similar testing internationally. Attard (2015) developed a post-registration spiritual care competency framework which may be more suitable for post-registration programmes but requires consensus testing in a similar way to that of the EPICC Standard for pre-registration education.

The EPICC Standard may be useful to students and those responsible for assessing them in determining whether they have met the required spiritual care competences at point of registration. A pilot study is currently testing a self-rating version of the EPICC Standard with undergraduate N/M students in six countries for this purpose.

LIMITATIONS

A weakness of this study is that, although a high level of consensus was reached on the final version of the EPICC Standard in phase 5, the sample in this round was relatively small (n=37). The EPICC Standard cannot be generalised beyond the 21 European countries in which it was developed. However, the fact that educators and practitioners from so many continents beyond Europe have already expressed an interest in it, suggests that it may well have wider cultural relevance. The fact that it is being used in the pre- and post-registration education of healthcare professions other than nursing and midwifery suggests that it has wider utility that originally intended.

CONCLUSION

This study resulted in a consensus based EPICC Spiritual Care Education Standard that is applicable within different international and cultural contexts. This EPICC standard may guide the further development of N/M spiritual care education, student assessment and research. It

425 can also be the starting point for discussing spirutal care competences in other healthcare
426 professions.

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Table 1 Phases of data collection in the consensus procedure June 2017 – February 2019		
Phase 1	Online survey	- Reflection on the working definition of spirituality (Nolan, 2011) - Score level of agreement in list of 51 spiritual care competences N/M should possess (Attard, 2015): 5 point Likert scale: 1 = fully disagree/5 = fully agree) - Deliver N/M spiritual care learning objectives in terms of knowledge, skills and attitudes
Phase 2	Development first draft of a spiritual care education standard	- Teaching and Learning Event 1 (TLE1), Netherlands - Input before meeting: outcomes Phase 1. - Discussing spiritual care competences and learning objectives in small groups and in plenary sessions. - Agreement on content of first draft standard by hand raising (consensus by 90% agreement).
Phase 3	Application and evaluation of the first draft of spiritual care education standard in N/M education	- Application and evaluation of first draft by participants in their own educational practice (way if implementation, what was helpful, what were obstacles?)
Phase 4	Reflection and further development of the spiritual care educational standard	- Teaching and Learning Event 2 (TLE2), Malta - Presenting outcomes Phase 3urther discussion about the standard in working groups and plenary sessions. - Consensus about second draft of spiritual education standard by hand raising (consensus by 90& agreement).
Phase 5	Online survey	- Agreement with every element of the final version of the standard (pre amble, competences and learning objectives). Scoring on 5-point Likert scale (1 = fully disagree- 5: fully agree). - Consensus when 90% of the participants agreed or fully agreed.

Table 2 Competences with >90 agreement/full agreement in phase 1	
Competence domain	Competence
Knowledge in spiritual care	Recognise the importance of the spiritual dimension (with or without religion) that sustains physical and mental well-being
	Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health
	Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care
Self-awarenss and the use of self	Be aware of own spirituality and use of self (e.g. own strengths, limitations, values, beliefs as a resource for spiritual care
	Recognise the possible impact of the nurse's/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care
	Acknowledge and respect the influence of clients' diverse cultural world views, beliefs and practices in the expression of their spirituality in healthcare

	Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (e.g. psychologists, chaplains, counsellors, spiritual leaders) as deemed necessary
Communication and interpersonal skills	Understand an apply the principles of the therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey
Ethica land legal issues	Appreciate the uniqueness of each person and their right to decline spiritual care
	Demonstrate sensitivity and respect for diversity in clients' and their family's religious/spiritual beliefs, values, practices and lifestyles (e.g. diet, sexual orientation)
	Acknowledge and respect the clients' right for information and informed consent to empower and facilitate decision-making regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices
	Disclose clients' spiritual/religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team, while maintaining confidentiality to safeguard clients' welfare
Assessment and implementation of spiritual care	Demonstrate the ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (using an established tool) and informal (listening to the clients' expressions) assessments methods
	Identify signs of spiritual distress in clients and family (e.g. pain, anxiety, guilt, loss, anger to God and despair and plan to address this distress while being aware of barriers to spiritual care, such as lack of time and education
	Recognise the importance of timely referral of clients/their families to chaplains and spiritual leaders and members of the multi-disciplinary team (e.g. counsellor, psychologist)
Competence domains and competences published by Attard (2015)	

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Table 3 Overview of learning objectives collected in phase 1	
Knowledge	• Conceptual aspects of spirituality and spiritual care: definitions of spirituality, holistic approach, relationship of spirituality anf health and illness • N/M's role in spiritual care: role of self and one's own spirituality in spiritual care, ways to assess and meet spiritual needs • Referral and collaboration: when, how and to who • Cultural and religious diversity
Skills	• Spiritual assessment patients' spiritual concerns, distress or needs • Reflection: on one's own spirituality and use of self in spiritual care • Communication: verbal/non-verbal meeting patients' spiritual needs. create/foster caring relationship, respond appropriately to patients with different spiritual world view/belief • Collaboration: other care givers, in multi-disciplinary team • Address the patient's spiritual needs systematically in the nursing process
Attitudes	• Person-centeredness, courageous and confident to provide good care

	• Caring compassionate, helpful, respectful, non-judgemental, open and approachable, sensitive, reliable and professional • Aware and self-reflective about one's own spirituality • Willingness to collaborate and communicate

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Table 4 First draft N/M Spiritual Care Education Standard adopted after round 2			
Competences	Knowledge	Skill	Attitude
1 Recognise the importance of the spiritual dimension that sustains physical and mental well-being	Understand the concept of spirituality Explain the impact of spirituality upon physical and mental health	Listen and interact authentically recognising the unique spirituality of each patient	Be open and respectful to the diverse nature of spirituality
2 Value knowledge and experience as important elements in dealing with the patients'/clients' and their families existential questions	Is familiar with and understands the ways that patients/clients and families use the specific set of indicators to express important	Recognise and respond sensitively and compassionately to important life questions.	Appreciate what is important for that person
3 Be aware of own spirituality and use of self as source for spiritual care	Understand your own values and believes, own strengths and limitations, and be aware of the impact of this on your own practice	The ability to reflect meaningfully upon your own values and beliefs. Recognise that personal values and beliefs maybe different form others	Shows willingness to explore beyond your personal comfort zone
4 Acknowledge and respect the patients'/clients' diverse cultural world views, beliefs and practices in relation to your own spirituality	Knows the philosophy of different world views and cultures in relation to health. Has knowledge of main aspects of common religious world views and their dynamics (profile synopsis, care of the ill and dying, role icons/symbols, maternal/paediatric).	The ability to interact with the patient/client about care related expectations in a meaningful dialogue	Be open, approachable and respectful
5 Demonstrate availability, authenticity and presence throughout the patients'/clients' journey within a caring and compassionate relationship	Understand the concepts availability, authenticity and presence. Understands the concepts of caring and compassion	Listen and interact authentically to patient language. Create and foster caring relationship with the patient/client. Building on trusting relationships	Adopts a caring compassionate empathic presence. Being respectful, non-judgemental, inclusive, open, approachable, welcoming and acccepting
6 Respect the patients'/clients' right to make informed decisions about their spirituality	Can explain legal and ethical aspects of informed decision making and patient/client autonomy	Acquitting and reflecting knowledge to respond appropriately in relationship with the patient/client	Shows respect and is non-judgemental
7 Document and share spiritual information about the patient/client	Know other professionals role regarding spiritual care,	Apply spiritual assessments and collaborate with other	Is aware of own role and limitations and shows

in a confidential manner within the multidisciplinary team	expertise and task of multidisciplinary team members in spiritual care	disciplines to document this collaboration	willingness to collaborate
8 Use informal/formal assessments to identify patients'/clients' spiritual resources and spiritual needs, and plan spiritual care	Know assessment methods to signal spiritual needs. Know signs and spiritual needs/distress and resources	Observation and communication (active listening). Recognizing and reflecting on spiritual needs and distress. Identify resources that enable the nurse/midwife to established spiritual care. Being able to perceive and seek clarity	Shows courage to be vulnerable. Adopts openess, attentiveness and acceptance
9 Provide appropriate spiritual care and make timely referral for additional spiritual support to relevant others if necessary	Know what limitations/barriers exist for spiritual care (personal, professional and organisational). Know what others or resources exist to refer	Reflection on and responding to limitations/barriers. Communicate with other disciplines. Gather information on additional spiritual support.	Shows professional humility and willingness to collaborate. Shows trustworthiness in seeking additional spiritual support

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Table 5 Outcomes of application draft N/M spiritual care educational standard

Country	Application standard	Outcomes
England	Evaluation standard	Captures essence, comprehensive achievable, well structured. 9 competences to much
	Implement specific competences in classroom learning	Importance of didactics (e.g. group discussion, poetry, cultural aspects)
	Views on standard from nursing and midwifery lecturers	For mapping curriculum. Midwifery emphasizes importance of spiritual (self) awareness
Poland	Translation, informing nurses and regulatory bodies, integration in curricula	Standard useful and implementation proceeds
Spain	Education design	Implementation in process. No obstacles reported
Belgium	Discussion about standard in curriculum and evaluate its content in education	Discussion about use term 'spirituality' (culture based). Keep it simple, standard looks complex
Denmark	Collecting spontaneous reflections form colleagues on the standard	Hesitation with word 'spirituality'. Academic, already embedded, overlaps, also found useful
	Initiating discussing about implementing standard in own organisation	Needed: more focus on personal spirituality of students and role of other professionals
Croatia	Screening curriculum and improving own teaching	Organisational circumstances make now implementation difficult
	Implementation in own education	Young students: difficulty with spiritual care; higher educated students show competence
Norway	Research among students about spiritual care in curriculum	Started discussion about spiritual care in curriculum
	Raising awareness among leaders, faculty, teachers	Initiated awareness/discussion on curriculum improvement
Scotland	Used in chaplain education development	Waiting for further funding to align nurses competences with chaplain competences

Wales	Map in existing spiritual care education, initiate discussion, engage stakeholders	Standard fit for purpose, achievable, guide for standard development
The Netherlands	Inform regulatory bodies and collect learning experiences from students	Positive response, useful for curriculum evaluation
Austria/ Germany	Use of standard in developing and planning teaching events	Diverse interest in students and teachers about application in teaching
Turkey	Work on specific competences with students	Spirituality perception and cultural sensitivity increased.
Malta	Evaluate the curriculum in team and integrate standard in own education	Most of the standard could be covered in the education.
	Map to existing curriculum, inform regulatory bodies	Standard seem fit for teaching. Engagements with clinical colleagues is important

Table 6: Elements in the spiritual care education standard and its level of agreement (n=37)

	% agree	% fully agree
Pre amble		
Definition of spirituality	38%	62%
Definition of spiritual care	32%	65%
Cultural context	21%	76%
Terminology	29%	65%
Competence 1: Intrapersonal spirituality: Is aware of the importance of spirituality on health and well-being	8%	89%
Knowledge: Understands the concept of spirituality	5%	92%
Knowledge: Can explain the impact of spirituality on a person's health and well-being across the lifespan for oneself and others	21%	76%
Knowledge: Understands the impact of one's own values and beliefs in providing spiritual care	11%	86%
Skills: Reflects meaningfully upon one's own values and beliefs and recognises that these may be different from other persons	19%	78%
Skills: Takes care of oneself	14%	81%
Attitude: Willing to explore one's own and individuals' personal, religious and spiritual beliefs	14%	76%
Attitude: Is open and respectful to persons' diverse expressions of spirituality	3%	94%
Competence 2: Interpersonal spirituality: Engages with persons' spirituality, acknowledging their unique spiritual and cultural worldviews, beliefs and practices	19%	81%
Knowledge: Understands the ways that persons' express their spirituality	16%	84%
Knowledge: Is aware of the different world/religious views and how these may impact upon persons' responses to key life events	16%	81%
Skills: Recognises the uniqueness of persons' spirituality	5%	89%
Skills: Interacts with, and responds sensitively to the persons' spirituality	11%	89%
Attitude: Is trustworthy, approachable and respectful of persons' expressions of spirituality and different world/religious views	8%	92%

Competence 3: Spiritual Care: Assessment: Assesses spiritual needs and resources using appropriate formal or informal approaches, and plans spiritual care, maintaining confidentiality and obtaining informed consent	16%	76%
Knowledge: Understands the concept of spiritual care	11%	89%
Knowledge: Is aware of different approaches to spiritual assessment	14%	86%
Knowledge: Understands other professionals' roles in providing spiritual care	16%	84%
Skills: Conducts and documents a spiritual assessment to identify spiritual needs and resources	14%	78%
Skills: Collaborates with other professionals	14%	86%
Skills: Be able to appropriately contain and deal with emotions	24%	70%
Attitude: Is open, approachable and non-judgemental	5%	95%
Attitude: Has a willingness to deal with emotions	22%	70%
Competence 4: Spiritual Care: Intervention and Evaluation: Responds to spiritual needs and resources within a caring, compassionate relationship	8%	92%
Knowledge: Understands the concept of compassion and presence and its importance in spiritual care	6%	94%
Knowledge: Knows how to respond appropriately to identified spiritual needs and resources	11%	89%
Knowledge: Knows how to evaluate whether spiritual needs have been met	11%	83%
Skills: Recognises personal limitations in spiritual care giving and refers to others as appropriate	14%	86%
Skills: Evaluates and documents personal, professional and organisational aspects of spiritual care giving, and reassess appropriately	28%	66%
Attitude: Shows compassion and presence	8%	92%
Attitude: Shows willingness to collaborate with and refer to others (professional/non-professional)	11%	89%
Attitude: Is welcoming and accepting and shows empathy, openness, professional humility and trustworthiness in seeking additional spiritual support	8%	92%

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