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LOYOLA UNIVERSITY CHICAGO

SIMULATION USING A STANDARDIZED PATIENT TO MEASURE PERCEPTION AND
CONGRUENCY OF SPIRITUAL CARE FOR A VETERAN FROM THREE PERSPECTIVES
TO INFORM NURSING EDUCATION AND PRACTICE

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN NURSING

BY

MARY E. DESMOND

CHICAGO, IL

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This is dedicated to my brothers, Jimmy and Charlie, and brother-in-law Terry, Vietnam Veterans, and to my sisters, Irene and Cathy, for paving my path into nursing.

Lord, you have probed me, you know me:
you know when I sit and stand;
you understand my thoughts from afar.
My travels and my rest you mark; with all my ways you are familiar.
Even before a word is on my tongue, Lord, you know it all.
Behind and before you encircle me and rest your hand upon me.
Such knowledge is beyond me, far too lofty for me to reach.

Psalm 139: 1-6

PREFACE

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
PREFACE	v
LIST OF TABLES	xvi
LIST OF FIGURES	xvii
ABSTRACT	xviii
CHAPTER ONE: INTRODUCTION	1
Spiritual Care Has Historical Roots in Nursing	2
Spiritual Care Is a Professional Nursing Mandate	3
Professional Practice Statements Include Spiritual Care	3
Nursing Education Requirements Include Spiritual Care	4
Patients Want and Need Spiritual Care	5
Patients Value Spirituality	5
Spirituality Is Associated With Better Health	8
Spiritual Care Is Associated With Patient Satisfaction and Quality of Care	10
Spiritual Care and Patient Satisfaction	10
Spiritual Care and Reimbursement	12
Barriers in Providing Spiritual Care	13
Barriers in Patients Receiving Spiritual Care	13
Nurses' Perception of Providing Spiritual Care	14
Summary	14
CHAPTER TWO: LITERATURE REVIEW	17
Literature Review	17
Definition of Spirituality	18
Attributes of Spirituality	18
Meaning and purpose	18
Connection	19
Transcendence	20
Hope	21
Spirituality Is Different Than Religion Yet Can Be Connected	22
Philosophical Grounding and Theoretical Framework	23
Watson's Theory of Transpersonal Caring	24
Caritas consciousness	24
The caring moment	24
Moral commitment	26
Caring and uncaring energy	26
Burkhart/Hogan Spiritual Care in Nursing Practice Theory (SCiNP)	27
Patient cue	28

Decision to engage	28
Spiritual intervention	28
Emotional response	28
Search for meaning	28
Formation of spiritual memory	28
Spiritual well-being	29
Spirituality Measurement Tools	29
Spiritual Care Literature	33
Prerequisites to Providing Spiritual Care	34
Recognizing Patient Cues of a Spiritual Need	35
Spiritual assessment using tools	35
The Joint Commission requirements for assessment	35
Various types of spiritual inquiry forms	35
Spiritual assessment tools in practice	36
The FICA spiritual history tool	37
The HOPE tool	37
The Client Spiritual Assessment Tool (CSAT)	38
Standardized terminology	40
Recognition of patient cues in the moment	40
Situational verbal and non-verbal cues	41
Behavioral verbal and non-verbal cues	42
Physical environmental/meaningful object/social support/family/religious cues	42
Environmental cultural/higher power/faith rituals cues	43
Veteran culture	43
Decision to Engage/Not Engage in Spiritual Encounter	44
Barriers in nursing education	45
Spiritual care content in nursing textbooks	45
Lack of conceptual clarity in textbooks	46
Barriers in nursing practice	47
Barriers in providing spiritual care	47
Personal nurse barriers	48
Spiritual Care Intervention	48
Nurse's way of being	49
Nurse as channel, demonstrates caring presence and listening	49
Promoting connections with self/reflection/meaning and purpose	50
Connecting to meaningful experiences	51
Connecting to nature/music/arts	52
Connecting to the arts	53
Connecting to sources of support	53
Connecting to pets	54
Connecting with higher power/faith rituals	54
Positive or Negative Immediate Emotional Response	55
Positive consequences of providing spiritual care for nurses	55
Negative consequences in providing spiritual care for nurses	56
Nurse spiritual growth and compassion satisfaction	56

Search for Meaning in Encounter to Promote Spiritual Well-Being	57
Spiritual Care Education	58
Pre-licensure Spiritual Care Educational Programs	58
Retreat and online pedagogy clinical course	59
Spiritual care education program and clinical component	59
Spiritual care education seminar and clinical component	60
Spiritual care content integrated into junior and senior year curriculum	61
Staggered start control and intervention competency course	61
Mission trip	62
Self-study for both pre-licensure and practicing nurses	63
Spiritual Care Undergraduate Education Without Research Component	64
Integration into medical/surgical course and care mapping	64
Judeo-Christian content, case study, and patient interview	64
Post Licensure Spiritual Care Hospital Education	65
Hospital-based two-hour in-service	65
Forty-five-minute hospital-based in-service	65
Simulation	66
Clinical Simulation as an Evidence-Based Pedagogy	66
INACSL Best Practice Standards	68
Use of a Standardized Patient	68
Clinical Simulation Standardized Patient and Debriefing	69
Simulation Used in Research	69
End-of-Life Spiritual Care Simulation With Standardized Patient	69
Development of simulation	70
Development of questionnaire	71
Experimental study	71
Evaluating use of best practices	71
Data analysis	72
Mother/baby spiritual care simulation	72
Pre-simulation and prebriefing content	73
Simulation scenario	73
Evaluating use of best practices	73
Data analysis	74
Veteran Simulation	74
Summary	75
Gaps in the Literature	75
Evidence-based spiritual assessment tools	75
Spiritual care for a veteran simulation	76
Spiritual care for a veteran nurse performance tool	76
Congruence in patient perceived and nurse perceived spiritual care	76
 CHAPTER THREE: METHOD	 78
Introduction	78
Aim 1: Develop a Spiritual Care Simulation and Companion Performance Checklist	78
RQ 1	78

Aim 2: Determine the Congruence in Spiritual Care Provided From the Registered Nurse, Standardized Patient and Independent Observer	78
RQ 2.1	78
RQ 2.2	79
RQ 2.3	79
Aim 3: Determine Whether Experiencing a Spiritual Care Simulation Affects RN Perceived Ability to Provide Spiritual Care	79
RQ 3.1	79
RQ 3.2	79
RQ 3.3	79
Human Subjects/Ethical Considerations	80
Institutional Review Board Approval	80
Participant consent process	81
Study Site	82
Study Site and Union Approval	82
Aim 1 Methods: Simulation and Performance Checklist Development Procedure	83
Design for Aim 1	83
Literature review	83
Creating the simulation	89
Objective	89
Central story	89
Determining the patient characteristics	90
Focused assessment	91
Script	91
Creating the Performance Checklist	91
Stimulation Environment	91
Selection of Debriefing Method	92
Psychometric Testing of the Simulation and Spiritual Care Cue and Intervention	
Checklist	92
Content validity	92
Content experts	93
Face validity evaluators	94
Aim 1 Data Collection	94
Aim 1 Data Analysis	95
RQ-1	95
Standardized Patient	96
Standardized patient qualifications and characteristics	96
Standardized patient training	96
Pilot testing	98
Aim 2: Methods to Measure Congruence in Perception	98
Aim 2 Design	98
Sample	98
Power analysis	99
Recruitment	100
Aim 2 Variables	102

Demographics	102
Patient cue	102
Spiritual care intervention	102
Patient cue(s) for anxiety	103
Spiritual care intervention(s)—anxiety	103
Patient cue(s) for physical suffering	103
Spiritual care intervention(s)—physical suffering	103
Patient cue(s) of fears	104
Spiritual care intervention(s)—fears	104
Patient cue(s) for music	104
Spiritual care intervention(s)—music	105
Patient cue(s) for meaningful object	105
Spiritual care intervention(s)—meaningful object	105
Patient cue(s) for veteran culture (past)	106
Spiritual care intervention(s)—veteran culture (past)	106
Patient cue(s) for veteran culture (present)	106
Spiritual care intervention(s)—veteran culture (present)	107
Patient cue(s) for family support	107
Spiritual care intervention(s)—family support	107
Patient cue(s) for social support	107
Spiritual care intervention(s)—social support	108
Patient cue(s) for religion	108
Spiritual care intervention(s)—religion	108
Patient cue(s) for chaplain	109
Spiritual care intervention(s)—chaplain	109
Patient cue(s) for Bible	109
Spiritual care intervention(s)—Bible	109
Aim 2 Data Collection	110
Aim 2 Data Analysis	111
RQ 2.1	111
RQ 2.2	112
RQ 2.3	113
Aim 3: RN Perceived Ability to Provide Spiritual Care	113
Aim 3 Design	113
Sample	113
Aim 3 Variables	113
Demographics	113
Perceived ability to provide spiritual care	114
Perceived ability to provide spiritual interventions	114
RN search for meaning in encounter (meaning making)	114
Aim 3 Instrumentation	114
Spiritual Care Inventory (SCI)	114
Aim 3 Data Collection	115
Aim 3 Data Analysis	115
RQ 3.1	115

RQ 3.2	115
RQ 3.3	116
CHAPTER FOUR: RESULTS	117
Data Management, Entry and Data Cleaning	117
Aim 1 Results	118
Research question 1	118
Content Validity Results	118
First round content validity results	118
Second round content validity results	119
Third and fourth rounds content validity results	119
Fifth round content validity results	121
Standardized Patient Practice Pilot Testing	122
Pilot Testing the Simulation	123
Summary of pilot findings	123
Aim 2 and 3 Sample and Sample Characteristics	124
Aim 2 Results	125
Research question 2.1	125
Data cleaning	126
Findings	126
Anxiety	127
Physical suffering	127
Chaplain	127
Bible	128
Social support	128
Religion	128
Music	128
Veteran culture (past)	128
Meaningful object	128
Family support	129
Veteran culture (present)	129
Fears	129
Research question 2.2	129
Data cleaning	129
Findings	130
Anxiety	131
Physical suffering	131
Fears	132
Chaplain	132
Bible	132
Music	132
Religion	132
Social support	133
Meaningful object	133
Veteran culture (past)	133

Family support	133
Veteran culture (present)	133
Research question 2.3	134
Data cleaning	134
Findings	134
Anxiety	135
Physical suffering	136
Chaplain	136
Social support	136
Bible	137
Religion	137
Veteran culture (past)	137
Music	137
Veteran culture (present)	137
Fears	137
Meaningful object	138
Family support	138
Aim 3 Results	138
Research question 3.1	138
Data cleaning	138
Statistical assumptions for dependent <i>t</i> -test	138
Findings	139
Research question 3.2	140
Data cleaning	140
Statistical assumptions for dependent <i>t</i> -test	140
Findings	141
Research question 3.3	141
Data cleaning	141
Statistical assumptions for the dependent <i>t</i> -test	141
Findings	142
CHAPTER FIVE: DISCUSSION	143
Limitations of the Study	143
Simulation Equipment	143
Standardized Patient	143
Patient Characteristics in Simulation	144
Spiritual Care Cue and Intervention Checklist	145
Limitation of Kappa Statistic and Percent Agreement	145
Testing	146
Sample Limitations	146
Strengths of the Study	147
Theory and Psychometric Testing	147
Standardized Patient	148
Reliable and Valid Tool	149
Simulation	149

Simulation and Spiritual Care	150
Spiritual Care in Nursing Practice	151
Importance of Measuring Congruence	152
RN-SP-IO congruence	152
RN-SP congruence	153
RN-IO congruence	154
Script, SCCL Revision, and Nursing Education	154
SCCL Item: Anxiety	155
SCCL Item: Physical Suffering	155
SCCL Item: Fears	155
SCCL Item: Music	155
SCCL Item: Meaningful Object	155
SCCL Item: Veteran Culture (Past)	156
SCCL Item: Veteran Culture (Present)	156
SCCL Item: Family Support	156
SCCL Item: Social Support	156
SCCL Item: Religion	156
SCCL Item: Chaplain	157
SCCL Item: Bible	157
Nursing Education	157
Study Findings and the Extant Literature	157
Simulation and Spiritual Care	157
Meaning Making	158
Advancing the SCiNP Theory	158
Gaps Resolved	159
Implications for Research, Theory, Education, and Practice	160
Research	160
Promoting reflective practice/self care	160
Theory	161
Education	161
Practice	162
Watson Caring Theory and VA Affiliations	162
Conclusion	163
APPENDIX A: COPYRIGHT FOR FIGURE 1 (A THEORETICAL MODEL)	165
APPENDIX B: SPIRITUAL CARE ATTRIBUTES/PERSPECTIVES/THEORY	167
APPENDIX C: LITERATURE REVIEW OF SPIRITUAL CARE	174
APPENDIX D: VA IRB APPROVAL LETTER, CHAIR, RESEARCH AND DEVELOPMENT COMMITTEE	185
APPENDIX E: VA IRB APPROVAL LETTER, ASSOCIATE CHIEF OF STAFF, RESEARCH SERVICE	187

APPENDIX F: VA IRB APPROVAL LETTER, IRB COORDINATOR	189
APPENDIX G: VA IRB AMENDMENT APPROVAL LETTER, ASSOCIATE CHIEF OF STAFF, RESEARCH SERVICE	192
APPENDIX H: VA IRB AMENDMENT/REVISION REPORTING FORM, PRINCIPAL INVESTIGATOR	194
APPENDIX I: VA IRB AMENDMENT APPROVAL LETTER, IRB COORDINATOR	197
APPENDIX J: VA IRB AMENDMENT APPROVAL REPORT OF FINDINGS, IRB REVIEW BOARD	199
APPENDIX K: LOYOLA UNIVERSITY CHICAGO, IRB APPROVAL LETTER	202
APPENDIX L: LOYOLA UNIVERSITY CHICAGO, IRB AMENDMENT APPROVAL LETTER	206
APPENDIX M: EMAIL INVITATION TO VA REGISTERED NURSES TO PARTICIPATE IN STUDY	208
APPENDIX N: STUDY INFORMATION SHEET	210
APPENDIX O: INACSL STANDARDS OF BEST PRACTICE: SIMULATION SM	213
APPENDIX P: PREBRIEFING/FOCUSED ASSESSMENT/SIMULATION SET-UP/ CLINICAL SCENARIO SIMULATION SCRIPT	217
APPENDIX Q: PLUS-DELTA DEBRIEFING FORM	226
APPENDIX R: ADDITIONAL DEBRIEFING FORM USED IN SECOND PILOT SESSION STUDY AND RESEARCH STUDY DEBRIEFING SCRIPT	228
APPENDIX S: EMAIL INTRODUCTION TO REVIEW THREE AND FOUR CONTENT EXPERTS	230
APPENDIX T: UNIVERSITY OF ILLINOIS AT CHICAGO, DR. ALLAN L. AND MARY L. GRAHAM CLINICAL PERFORMANCE CENTER USE OF MATERIALS PERMISSION LETTER	232
APPENDIX U: G-POWER ANALYSIS FOR SAMPLE SIZE AT 0.80 POWER	234
APPENDIX V: G-POWER ANALYSIS FOR SAMPLE SIZE AT 0.80 AND 0.95 POWER	236
APPENDIX W: G-POWER ANALYSIS FOR SAMPLE SIZE AT 0.95 POWER	238

APPENDIX X: INCLUSION CRITERIA SCRIPT	240
APPENDIX Y: EMAIL REMINDER TO VOLUNTEER RN PARTICIPANTS	245
APPENDIX Z: VA AGENT CASHIER VOUCHER FOR HONORARIA	247
APPENDIX AA: PARTICIPANT DEMOGRAPHIC COLLECTION SHEET	249
APPENDIX BB: DESCRIPTIVE SAMPLE CHART	252
APPENDIX CC: FINAL SPIRITUAL CARE CUE AND INTERVENTION CHECKLIST	254
APPENDIX DD: CALCULATION KAPPA	256
APPENDIX EE: SPIRITUAL CARE INVENTORY INSTRUMENT	258
APPENDIX FF: SPIRITUAL CARE INVENTORY INSTRUMENT AUTHOR PERMISSION LETTER	260
APPENDIX GG: CONTENT VALIDITY REVIEW ONE SUMMARY	262
APPENDIX HH: CONTENT VALIDITY REVIEW TWO SUMMARY	269
APPENDIX II: CONTENT VALIDITY REVIEW THREE SUMMARY	275
APPENDIX JJ: CONTENT VALIDITY REVIEW FOUR SUMMARY	281
APPENDIX KK: PILOT SESSION/STUDY PRE-SCRIPT	287
APPENDIX LL: PILOT SESSION POST SPIRITUAL CARE CLINICAL SCENARIO SIMULATION DEBRIEFING SCRIPT	289
APPENDIX MM: DRAFT SPIRITUAL CARE SIMULATION CHECKLIST FOR FIRST PILOT SESSION	291
APPENDIX NN: DRAFT SPIRITUAL CARE SIMULATION CHECKLIST FOR SECOND PILOT SESSION	293
APPENDIX OO: UNIVERSITY OF WASHINGTON FACULTY DEVELOPMENT SIMULATION MODULES COMPLETED	295
REFERENCES	297
VITA	320

LIST OF TABLES

Table 1. Spirituality and Spiritual Care Tools in the Literature	30
Table 2. Content Validity Evaluation of Script Cue(s) and Intervention(s)	84
Table 3. Spiritual Care Cue Script and Intervention Checklist Development Summary	121
Table 4. RN-SP-IO Interrater Congruence Spiritual Care Checklist Summary	126
Table 5. RN-IO Interrater Congruence Spiritual Care Checklist Summary	130
Table 6. RN-IO Interrater Congruence Concept Anxiety	131
Table 7. RN-IO Interrater Congruence Concept Physical Suffering	131
Table 8. RN-IO Interrater Congruence Concept Fears	132
Table 9. RN-SP Interrater Congruence Spiritual Care Checklist Summary	135
Table 10. RN-SP Interrater Congruence Concept Anxiety	136
Table 11. RN-SP Interrater Congruence Concept Physical Suffering	136
Table 12. Spiritual Care Inventory and Subscale Paired Differences Table	140

LIST OF FIGURES

Figure 1. Burkhart and Hogan (2008) spiritual care in nursing practice middle range theory	27
Figure 2. Substruction: Theoretical model, study variables, and operational measures	80
Figure 3. Histogram spiritual care inventory pre-post change scores	139
Figure 4. Histogram spiritual intervention sub-scale pre-post change scores	141
Figure 5. Histogram meaning making sub-scale pre-post change scores	142

ABSTRACT

Spiritual care refers to a purposeful process of helping another find meaning and purpose in life through a mutual connection. Providing spiritual care is a professional nursing mandate, yet nurses report barriers in education and practice. Veterans want spiritual care to promote quality of life, and to cope with military experiences and chronic conditions. Patients report receiving less than desired spiritual care and nurses report infrequent provision of spiritual care. It is also unclear how congruent patients and nurses are in their perceptions of spiritual care. A spiritual care simulation and performance checklist was developed using a review of the literature, content validity expert review, and pilot testing. Forty registered nurses (RNs) who provide care for veterans engaged in a 10-minute simulation and 10-minute debriefing with a standardized patient (SP). To assess congruence in perceived performance of spiritual care, the RN, SP, and independent observer (IO) completed the checklist independently before debriefing. RN participants completed the Spiritual Care Inventory before and after the simulation to determine whether the simulation/debriefing experience affected their perceived ability to provide spiritual care. Interrater congruence supports construct validity for three checklist items (anxiety, physical suffering, and chaplain). Lack of congruence could be due to different raters, need for checklist revision, and nursing education. Findings support simulation and debriefing as an effective strategy for improving RN perceived ability to provide spiritual care ($p < .001$).

Keywords: content validity index, education, kappa statistic, nursing, simulation, spirituality, spiritual care, standardized patient, veteran.

CHAPTER ONE

INTRODUCTION

Spiritual care is a professional mandate in nursing, and patients want and benefit from spiritual care, but both nurse educators and practicing nurses are unsure how to integrate spiritual care in education and practice (Adegbola, 2006; American Nurses Association [ANA], 2010a; Burkhart & Schmidt, 2012; Bussing & Koenig, 2010; Gallison, Xu, Jurgens, & Boyle, 2013; Lundmark, 2006; Pearce, Coan, Herndon, Koenig, & Abernethy, 2012; Rushton, 2014; Timmins, Murphy, Neill, Begley, & Sheaf, 2015; Timmins & Neill, 2013; Williams, Meltzer, Arora, Chung, and Curlin, 2011). Spiritual care is facilitating another's spirituality. In this study, spirituality is generally defined in the following way:

[T]he human quest for a unified experience of life that aligns personhood toward the highest values one perceives. As such, it addresses the human impulse toward meaning-seeking and purposeful existence, toward self-realization and connection with self, others, and/or a Higher Power. (Burkhart & Schmidt, 2012, p. 316)

Spiritual care is an intentional caregiving process designed to increase patients' spiritual well-being (Burkhart & Hogan, 2008; Puchalski, 2012). Spiritual care occurs when the nurse is able to recognize the verbal and/or non-verbal spiritual cues at the time the patient expresses them and makes a conscious choice to provide spiritual care. Spiritual care includes "promoting patient connections with self, others, and/or a Higher Power" to promote the patient's exploration of meaning and purpose in life (Burkhart & Schmidt, 2012, p. 316). Spiritual care is an essential part of nursing care.

Spiritual care is important in nursing practice, but there are several problems in

actualizing spiritual care in nursing practice. Although professional nursing practice and education require spiritual care, patients want and need spiritual care, and spiritual care is associated with healthcare quality, nurses are not consistently taught how to provide spiritual care (Burkhart & Hogan, 2008; Lundmark, 2006; Timmins et al., 2015). Nurses are also unsure how to integrate spiritual care in practice (Burkhart & Schmidt, 2012; Lundmark, 2006; Timmins et al., 2015). Research is needed to better understand how spiritual care is perceived in practice and how spiritual care can be taught in nursing education programs. This study examined spiritual care in nursing practice with registered nurses (RNs) who care for veterans with a chronic illness using simulation with a standardized patient (SP) at a United States Department of Veterans Affairs (VHA) hospital. This chapter will describe the importance of spiritual care research including its history in nursing, professional and educational mandates, veteran unique needs, health benefits, link to quality of care measures, barriers in nursing education and practice, and patient and nurse perspectives.

Spiritual Care Has Historical Roots in Nursing

Spiritual care has historical roots in nursing and continues to be an important dimension of nursing care. Florence Nightingale, the founder of modern nursing, saw nursing as spiritual and encouraged nurses to include nature in healing by providing optimum environments for patients to heal (Baly, 1991; Calabria & Macrae, 1994; O'Brien, 2011; Watson, 2008). Nursing also has religious historical roots as nursing grew out of the Catholic religious orders in the Middle Ages (O'Brien, 2011). Religious orders saw meeting the physical needs of patients as a chance to provide spiritual care (Sultz & Young, 2008). Nightingale described the art of nursing as including religious belief in God: "For what is having to do with dead canvas or cold

marble compared with having to do with the living body—the temple of God’s spirit; It is one of the fine arts; I had almost said, the finest of the fine arts” (as cited in Baly, 1991, p. 68). From a historical perspective, the first Latin translations regarding spirituality were “...The ‘spiritual’ person (*pneumatikos, spiritualis*) is one whose life is guided by the Spirit of God... Thus the Pauline sense of *spiritus* and *spiritualis* stands behind this first appearance of the word” (Principe, 1983, p. 130). The historical roots of spirituality include Christian spirituality, which grew out of the Catholic faith tradition and belief in God.

Spiritual Care Is a Professional Nursing Mandate

Professional nursing organizations include spirituality in their professional statements describing nursing practice and nursing education.

Professional Practice Statements Include Spiritual Care

Today, professional nursing has also recognized the importance of spirituality and spiritual care as a professional requirement in nursing practice. The *Nursing: Scope and Standards of Practice* “Standard 1. Assessment” includes a mandate that the nurse be competent in performing a complete assessment, which includes the spiritual/transpersonal dimensions of health (ANA, 2010a, p. 32); and “Standard 4. Planning” mandates that the nurse be able to create a personalized care plan that includes the patient’s “...values, beliefs, [and] spiritual and health practices” (ANA, 2010a, p. 36). The *Nursing’s Social Policy Statement* identifies the human as comprising “mind, body, and spirit” (ANA, 2010b, p. 6), and acknowledges nursing knowledge must include the ability to address one’s “physical, emotional, and spiritual comfort, discomfort, and pain” (ANA, 2010b, p. 13). Provision One in the *Code of Ethics for Nurses* identifies the nurse’s relationship to the patient as one that is

respectful of the patient's religion and spiritual belief systems (American Nurses Association [ANA], 2015). Code One in the International Council of Nurses *The ICN Code of Ethics For Nurses* mandates the nurse foster an environment where the spiritual beliefs of the person, family, and larger society are valued (International Council of Nurses [ICN], 2012). The American Nurses Association (2010a) *Nursing: Scope and Standards of Practice* mandates that the RN provide holistic (body, mind, spirit) patient-centered care. Holistic care includes spiritual care, which is acknowledged in nursing's professional practice statements.

Nursing Education Requirements Include Spiritual Care

In order for nurses to practice spiritual care, it must be taught in nursing education. The inclusion of spiritual care education is included in four of *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing [AACN], 2008). To begin with, "Essential One: Liberal Education for Baccalaureate Generalist Nursing Practice" emphasizes the inclusion of the spiritual views of different cultures (AACN, 2008, p. 10-12). Second, "Essential Seven: Clinical Prevention and Population Health" states education must include interprofessional collaborative patient centered care, which includes one's cultural and spiritual realms to promote one's health and reduce illness and injury (AACN, 2008, p. 23-26). Third, "Essential Eight: Professionalism and Professional Values" states nursing education must include evidence-based care that encompasses culturally diverse spirituality (AACN, 2008, p. 26-29). Fourth, "Essential Nine: Baccalaureate Generalist Nursing Practice" stresses the reality of the diverse society and need for nurses to know how to care for various spiritual needs (AACN, 2008, p. 29-33). Spiritual care has been identified as an essential part of a baccalaureate nursing education.

The Quality and Safety Education for Nurses (QSEN), a national initiative funded by the Robert Wood Johnson Foundation in response to the Institute of Medicine (IOM) report, *To Err is Human: Building a Safer Health System* (Dolansky & Moore, 2013, para. 1), focuses on improving nursing education around quality and safety. QSEN has incorporated addressing patient values and beliefs in the patient-centered care competencies as a quality measure (Cronenwett et al., 2007; QSEN Institute [QSEN], 2014, para. 1). These standards and competencies support the importance of spiritual care in nursing education for professional nursing practice. Therefore, spiritual care is not only grounded in nursing's history, it is required in nursing practice and education.

Patients Want and Need Spiritual Care

Patients value spirituality, particularly at life changing times, and need spiritual care to cope with chronic illness. Research also indicates that spirituality is associated with better physical, psychological, and social health, as well as patient satisfaction.

Patients Value Spirituality

Americans value spirituality and religiosity as described in recent polls (Pew Research Center: Religion & Public Life, 2015). A national telephone poll conducted by the Pew Research Center in 2007 and repeated in 2014 indicated that Americans value spirituality, but that perception changed over time ($N = 35,000$) (Lipka, 2015). Findings indicated that there is a decline in American's religiosity, and those with no religious affiliation have become more secular, whereas those acknowledging a religion have remained consistent in practices. Older more faithful religious generations are being replaced with a greater number of non-religious younger generations interested in non-religious spiritual practices (Lipka, 2015). The American

population has diverse spiritual and religious beliefs, but value both.

Research also indicates specific high-risk patient populations such as those with chronic illness and at end-of-life value spirituality. Those with chronic illness have associated spirituality as a source that helps their “quality of life” (QOL) (Adegbola, 2006, p. 42; Bussing & Koenig, 2010, p. 18). Edwards, Pang, Shiu, and Chan (2010) conducted a systematic meta-study qualitative review of end-of-life and palliative care literature and identified specific spiritual care needs such as “finishing business, forgiveness and reconciliation, letting go and acceptance, life review and reminiscence, involvement and control [of their care] and a positive outlook” ($n = 19$) (p. 765). In addition, they found relationships as dominant spiritual needs and, when severed, resulted in spiritual distress (Edwards et al., 2010). End-of-life presents unique spiritual care needs, and spiritual care at end-of-life can enhance quality of life.

Spirituality is important in bereavement. Balboni et al. (2010), as part of *The Coping with Cancer Study* during (2002-2008), conducted a prospective, multisite study with cancer patients and caregivers using baseline patient questions, chart review, two-to-three weeks’ post-death caregiver questions looking at spiritual care from the medical team, QOL at end-of-life, and religious coping ($n = 343$). Findings indicated that when spiritual requests were satisfied at end-of-life by the medical care team (doctors, nurses, and chaplains), a substantial increase in the use of hospice care ($p = .003$) occurred as compared to patients whose spiritual needs were not met (Balboni et al., 2010, p. 445). For those patients who had “high religious coping” and whose spiritual needs were satisfied, there was an increased use of hospice care ($p = .004$) and less intense care than those not spiritually supported (Balboni et al., 2010, p. 445). Those who received “spiritual support” by the medical team ($p = .007$) or by pastoral care ($p = .003$) had

better QOL scores when close to death (Balboni et al., 2010, p. 445). Spiritual care at end-of-life is associated with higher use of hospice and improvement in QOL as compared to patients whose spiritual needs were not addressed.

Spirituality is important in coping with cancer. Pearce et al. (2012) conducted a cross-sectional study at a large medical center surveying hospitalized patients diagnosed with terminal cancer on whether they received spiritual care aligned with their needs, and if a lack of spiritual care received from their care team, faith community, and from the chaplain was related to harmful outcomes ($N = 150$). Findings showed most of the patients received the spiritual care they wanted. However, “42/150” of the patients received less spiritual care than hoped for (Pearce et al., 2012, p. 2270). The researchers discovered a positive relationship between when spiritual care received was not as high as the patient wanted along with higher “depressive symptoms” ($p = 0.013$), and decreased “meaning and peace” ($p = 0.042$) (Pearce et al., 2012, p. 2269). Of the patients surveyed, rates of patient satisfaction scores would rise 35% with the inclusion of spiritual care (Pearce et al., 2012, p. 2269). Spiritual care is beneficial to those with chronic disease and at end-of-life and has an impact on patient satisfaction scores.

Veterans have “unique spiritual needs” (Chang et al., 2012, p. 615). Veterans, an important subset of the population, also seek out spiritual care to cope with depression and post-traumatic stress disorder (PTSD) (Bonner et al., 2013). Many veterans have spiritual needs related to their deployment (Wynn, 2015). Almost one in four deaths per day, greater than 1,800 daily at various healthcare sites, includes a veteran, indicating that this specific population potentially has spiritual needs due to both their military experiences and experiences at end-of-life (as cited in Chang et al., 2012; as cited in Freeman & Berger, 2009). Chang et al.

(2012) conducted a qualitative study of spiritual needs and spiritual care at end-of-life with veterans ($n = 17$) and family members ($n = 9$). The authors found veterans' spiritual needs include time to reflect on negative war experiences, connection to the divine/faith traditions, and connection to sources of love and support. Although veterans express a desire to have more extensive chaplain visits, they acknowledge that other healthcare professionals, which include nurses, can address their spiritual needs (Chang et al., 2012). Veteran patients desire and need spiritual practices to cope with illness and disease.

Spirituality Is Associated With Better Health

Koenig (2012) conducted a systematic review of the religious and spirituality literature between the years 1872 and 2010 and found that those with higher religious and spiritual well-being and practices are physically, psychologically, and socially healthier. Physically, higher religious and spiritual practices are associated with “better health behaviors...less alcohol and drug use, less cigarette smoking, more physical activity and exercise, better diet, and safer sexual practices” (Koenig, 2012, p. 12). Psychologically, religious and spirituality research indicated that spiritual practices helped with “coping and imbues negative events with meaning and purpose—is related to better mental health [including] (less depression, lower stress, less anxiety, greater well-being, and more positive emotions)” (Koenig, 2012, p. 12). Socially, religious and spirituality “involvement is associated with greater social support, greater marital stability, less crime/delinquency, and greater social capital [as religious and spiritual groups] promote social relationships” (Koenig, 2012, p. 12). This research indicates that spirituality is associated with better physical, psychological, and social health indicators.

Jim et al. (2015) conducted a meta-analysis systematic review (> 101 samples) with over 32,000 patients coping with chronic illness and discovered that higher spirituality and religiosity is associated with better health indicators. The authors concluded that religiosity and spirituality were positively associated with self-reported physical health (Jim et al., 2015). Sherman et al. (2015) in a meta-analysis (78 samples) with patients with cancer ($n = 14,277$), found a modest positive relationship between one's spirituality and religion to social health, including the ability to sustain meaningful roles and personal relationships despite having a malignancy. This body of research indicates that spirituality is associated with better physical, psychological, and social health indicators, which has led to The Joint Commission (TJC) standard that mandates assessment and provision of spiritual care for patients, especially at end-of-life (Clark, Drain, & Malone, 2003).

The psychoneuroimmunology (PNI) literature suggested that spiritual practices are protective against chronic illness. Holt-Lunstad, Steffen, Sandberg, and Jensen (2011) examined the link between spiritual well-being (SWB) and risk for cardiovascular disease, measuring biomarkers of both married men and women ($N = 100$) who place a high value on religion. The participants wore an ambulatory blood pressure cuff for 24 hours, had fasting blood tests, and completed depression and stress measures. Findings revealed that those with a high score of SWB exhibited significantly lower 24-h systolic blood pressure ($p < .001$), hs-C-reactive protein ($p = .04$), fasting blood sugar ($p = .006$), and triglycerides ($p = .09$) (Holt-Lunstad et al., 2011, p. 481–482). The findings also discovered a potential association of SWB to lower stress ($p = .002$) and depression ($p < .001$). This study suggested the physical mechanism of action involving the stress response that caused this better health and SWB

might protect one's cardiovascular system. The importance of these health indicators demonstrated the effect of one's SWB as a preventative measure against chronic disease. This research suggests an association between SWB and health.

Spiritual Care Is Associated With Patient Satisfaction and Quality of Care

Spiritual care is associated with patient satisfaction scores and is a component of measuring healthcare quality. These quality measures can affect hospital reimbursement from Medicare.

Spiritual Care and Patient Satisfaction

Spiritual care concepts are included in patient satisfaction tools. Williams et al. (2011) examined data collected between January 2006 and June 2009 ($n = 3,141$) from medical patients' in-patient surveys and 30-day post-discharge surveys from a large academic center, which included patient perceptions of their spiritual needs and whether the healthcare team discussed those needs with the patient. Findings revealed patients who did have their spiritual needs discussed ($n = 1128$) had a greater likelihood of rating their satisfaction of care at the maximum level in the following four areas: "extremely satisfied with doctors' care," "always had confidence and trust in doctors," "coordination & teamwork among doctors and nurses was excellent," and "would rate overall care received at hospital as excellent" even if they did not desire their spiritual needs be addressed (Williams et al., 2011, p. 1270). Addressing hospitalized patient's spiritual needs can positively impact patient satisfaction scores.

Healthcare institutions can also partner with Press Ganey Associates to measure the patient's hospital experience. Press Ganey partners with over 20,000 healthcare organizations collecting and analyzing data to improve the patient experience (2015a). Press Ganey offers

quality measures that combine the HCAHPS required questions with customized scientifically developed patient-centered questions (2015b). These questions include whether the healthcare workers discussed their “emotional/spiritual needs” (Hodge & Wolosin, 2014, p. 138; Press Ganey, n.d., p. 1). This question is grounded in extensive theoretical and scientific research related to emotions, spiritual needs, and patient perception of care (Press Ganey, n.d.). This quality measure for patient perception of emotional and spiritual care in healthcare has shown a significant correlation between meeting patient’s “emotional/spiritual needs and hospital profitability” ($r = 0.38, p = 0.002; n = 82$) (Press Ganey, n.d., p. 3). Patient satisfaction measures that include addressing spiritual needs suggests the importance of spiritual care with patient satisfaction.

Elements of spiritual care are included in patient satisfaction instruments in healthcare. Several widely accepted national patient satisfaction and quality of care instruments include attributes of spiritual care. One in-patient satisfaction of care quality measure required for all hospitals participating in the Inpatient Prospective Payment System (IPPS) is the Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) survey (Centers for Medicare & Medicaid Services [CMS], 2015, June). The HCAHPS survey has 32 questions with 21 questions specifically addressing patient perspectives of quality of care (CMS, 2015, June). Of the four questions specific to nursing communication, two of the survey questions ask if nurses were considerate and respectful and whether they listened to the patients’ needs (Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS], 2015, March). Battey (2012) references the “holistic health paradigm” and connection of these HCAHPS questions regarding the nurse’s communication with the patient as relevant to

“spiritual care” (p. 1014). Although these questions are not specifically addressing a spiritual need, the communication attributes of listening and reflection correspond to spiritual care interventions (O’Brien, 2011; Wallace et al., 2008; Wright, 2008). The VA in-patient hospital system also utilizes the same HCAHPS tool to measure patient experience, only their tool is entitled “VA Survey of Healthcare Experiences of Patients (SHEP)” (Centers for Medicare & Medicaid Services [CMS], 2016).

Spiritual Care and Reimbursement

The HCAHPS scores are an important quality measure for health systems in that they promote market share and affect hospital reimbursement for Medicare (Centers for Medicare & Medicaid Services [CMS.gov], 2015). Therefore, nursing communication is important to patient satisfaction, but also impacts a hospital’s performance ratings and reimbursement (Press Ganey, 2013). HCAHPS results are made available to the public to promote healthcare quality transparency as a means of hospital comparison (CMS.gov, 2015). HCAHPS scores increase accountability to the public, and serve as a motivator and incentive for hospitals to improve care. These quality results measure patient experience (CMS, 2015, June) and are included in the Medicare reimbursement calculation. As part of the Value-Based Purchasing Program (Hospital VBP), Medicare reimbursement to hospitals per fiscal year is based on four elements. One of the elements relates to HCAHPS scores with 30% for 2015 and 25% for 2016 as a percentage towards the overall reimbursement calculations (CMS, 2015, June). Spiritual care is associated with patient satisfaction, and quality of care measures and can affect reimbursement.

Barriers in Providing Spiritual Care

Although nursing professional standards and guidelines require spiritual care, patients want spiritual care, and spirituality is associated with better health, there are many barriers in providing spiritual care, including barriers related to both education and practice. Hoffert, Henshaw, and Mvududu (2007) created a spiritual care education program to improve student nurse's skills in performing a spiritual assessment. This program was developed based on the four common barriers in healthcare cited in the literature that impact the breakdown in addressing the patient's spirituality and providing spiritual care (Hoffert et al., 2007). These barriers include the following: Nurses' lack of clarity in their role linked to lack of education; lack of awareness and ease with their own spirituality; lack of clarity related to the concepts "religion" and "spirituality"; and discomfort with use of current tools to assess patient's spirituality (Hoffert et al., 2007, p. 66). These barriers in nursing education and practice will be expanded upon in Chapter Two.

Barriers in Patients Receiving Spiritual Care

Research indicates inpatient spiritual needs are not consistently addressed or provided. Balboni et al. (2007) conducted a multi-site study with patients diagnosed with terminal cancer and their unpaid caregivers, and found that just over 70% of participants revealed very little to no spiritual care provided by healthcare professionals, and very little to no spiritual care provided by a faith community ($N = 230$) (Balboni et al., 2007). Williams et al. (2011) discovered that "41%" of medical inpatients surveyed ($n = 1,135$) wanted their religion/spiritual concerns discussed, with "only half" reporting they had that conversation (p. 1265).

Pearce et al. (2012) found most patients received the spiritual care they wanted, yet many received less than they hoped. Each healthcare organization may address spiritual care assessment and care differently. A gap remains in addressing inpatient spiritual needs and providing spiritual care during hospitalization.

Nurses' Perception of Providing Spiritual Care

Taylor, Mamier, Ricci-Allegra, and Foith (2017) conducted “four cross-sectional, descriptive studies” of nurse’s perceived provision of spiritual care “during the past 72-80 [hours] of work” ($n = 1030$) (p. 32). The Nurse Spiritual Care Therapeutics Scale (NSCTS) (see Table 1) was completed electronically to determine the frequency of nurses’ perception of provision of spiritual care, with secondary data analysis results suggesting infrequent provision of spiritual care (Taylor et al., 2017, p. 31). Other startling results from this study include that “17-33% (depending on NSCTS items)” of nurses reported not performing a spiritual screen on patients (Taylor et al., 2017, p. 30). These findings regarding nurses’ perception of providing spiritual care align with the patient’s claim of less than desired provision of spiritual care received.

Summary

Patients desire and need spiritual care. Veterans have special spiritual care needs (Chang et al., 2012; Wynn, 2015). Spiritual care is a measure of quality care (Press Ganey, n.d.) and is a professional nurse mandate to provide this care (American Nurses Association [ANA], 2010a), yet research suggests that nurse educators and practicing nurses are unclear as to their role in teaching and providing spiritual care (Burkhart & Hogan, 2008; Cone & Giske, 2012; Lundmark, 2006; Timmins et al., 2015; Timmins & Neill, 2013). Patients report

receiving less than desired spiritual care (Pearce et al., 2012; Williams et al., 2011), and recent research on nurses' perception of provision of spiritual care suggests nurses provide infrequent spiritual care (Taylor et al., 2017). It is also unclear how congruent patients and nurses perceive spiritual care. The lack of congruence between the patient's desired spiritual care and the nurse's infrequent provision of spiritual care supports the need for research to study the incongruence. Research is needed to clarify the nurse's role in providing spiritual care that is both supportive to patients and consistent with professional nursing practice. Research is also needed to identify education pedagogies in teaching this type of care. Therefore, the aim of this study was to develop an evidence-based spiritual care clinical simulation scenario for an in-patient veteran diagnosed with "risk for spiritual distress" as defined in NANDA-I (Herdman & Kamitsuru, 2014, p. 374), and a companion spiritual care performance checklist to study perception of spiritual care in nursing practice. This includes evaluating the psychometrics of that simulation and performance checklist, and determining whether simulation is an effective pedagogy in teaching nurses how to provide spiritual care. This study answered the following research questions:

- (1) To what degree can a spiritual care clinical scenario simulation with a standardized patient reflect evidence-based spiritual care assessments and interventions for a patient at risk for spiritual distress?
- (2.1) To what degree does observed spiritual care (recognition of patient cue and provide spiritual intervention) measured by an independent observer, align with both registered nurse and standardized patient perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

- (2.2) To what degree does registered nurse perceived spiritual care (recognize cue and perform spiritual intervention) align with an independent observer perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?
- (2.3) To what degree does registered nurse perceived spiritual care (recognize cue and perform spiritual intervention) align with patient perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?
- (3.1) Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability to provide spiritual care?
- (3.2) Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability to provide spiritual interventions?
- (3.3) Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability for meaning making?

CHAPTER TWO

LITERATURE REVIEW

This chapter will present a description of spirituality and spiritual care as defined in the literature. A description of the philosophical grounding based on the philosophy of Watson's transpersonal caring theory (Watson, 2008, 2010) will be discussed. The Burkhart and Hogan (2008) spiritual care in nursing practice (SCiNP) theory, which provides the theoretical framework for the study will be presented. This chapter will also present current research related to spiritual care in nursing education and practice, as well as the current gaps in the literature.

Literature Review

The following section will provide a discussion of the attributes of spirituality based on a review of the literature in nursing, medicine, social work, religion, and business. This literature review was conducted using CINAHL, PubMed, PsycINFO, and ERIC databases using search terms "concept analysis," "spirituality," "nursing," and "spiritual care," limited to English within years 2002-2013; a PubMed search was performed using three keywords—"spirituality," "spiritual care," and "pastoral care"—and limited to systematic reviews; and a PsycINFO search that included search terms "spirituality," and "pastoral care," limited to English. This search also included ATLA, CINAHL, and EBSCO databases for literature on spirituality in the workplace, religion, and social work. Additional spirituality articles identified in the articles reviewed were also included. An updated literature review was also conducted using Scopus, CINAHL, and EBSCO databases using the search terms "caring theory" and "Watson," "concept analysis,"

“education,” “nursing,” “simulation,” “spiritual care,” “spiritual-well being,” “standardized patient,” and “veteran,” limited to English during the years 2010-2016. In addition to the updated literature search described above, the reference list from a dissertation on spirituality was also used as a guide (Baele Vincensi, 2011).

Definition of Spirituality

The early literature in spirituality defined spirituality, and differentiated spirituality from religiosity. The meaning of spirituality is personal and depends on what the individual believes is the essence of being human. The concept of spirituality has been discussed since the early philosophers, but has re-emerged in the 1990s in the more current literature. Much of the 1990s literature began with defining the concept. The literature converged on four attributes of spirituality. These attributes included: meaning and purpose, connection, transcendence, and hope. Each attribute of spirituality will be explained individually.

In defining spirituality, religion will also be discussed, as it is closely related to spirituality. Also important for this study are two other components of spirituality: nature and the arts (Burkhart & Hogan, 2008; Burkhart & Schmidt, 2012).

Attributes of Spirituality

Meaning and purpose. Meaning and purpose refer to the ability for humans to contemplate one’s meaning and purpose in life, which remains a consistent attribute of spirituality in the literature (Sessanna, Finnell, & Jezewski, 2007; Stephenson & Berry, 2015; Weathers, McCarthy, & Coffey, 2016). Nursing describes the human spirit as what gives life and the ability to live in the moment, reflect on what’s past, and plan for the future, as well as recognizing that the process may involve struggle (Lane, 1987). Nursing identifies patient’s

reflection on meaning and purpose, which may also include the meaning of illness (McBrien, 2006). In medicine, meaning and purpose in life are central to the definition of spirituality (Anandarajah & Hight, 2001; Todres, Catlin, & Thiel, 2005). The social work literature defines spirituality as including meaning and purpose (Barker, 2007; Barker & Floersch, 2010; Carroll, 2001; Hodge & Horvath, 2011). Healthcare professionals such as social workers have also identified components of spirituality as including the ability for humans to make meaning out of difficulties (Barker & Floersch, 2010). In the business literature, contemplating one's meaning in life involves the pursuit for meaningful work (Ashmos & Duchon, 2000; De Klerk, 2005; Karakas, 2010; Krishnakumar & Neck, 2002) and a desire for meaning and purpose over income (De Klerk, 2005; Konz & Ryan, 1999). Workplaces not integrating spirituality tend to experience higher levels of truancy, turnover, and anxiety, whereas spiritual work environments have positive outcomes (Thompson, 2000; Krishnakumar & Neck, 2002). Employees tend to leave work environments that provide no meaning (Krishnakumar & Neck, 2002; Van Tonder & Ramdass, 2009). Research with nurses in the workplace discovered meaning and purpose as an important dimension of nursing practice (Burkhart & Hogan, 2008). Humans live out their spirituality by seeking meaning and purpose in everyday life events.

Connection. Connection refers to relating to people or things in a meaningful way. This attribute differs from the first attribute in that connection requires at least two things that connect. The nursing literature defines this connection as existing between oneself, other people, God, or other source of power (Burkhart & Hogan, 2008; Newlin, Knafl, & Melkus, 2002). The early nursing literature describes how the spirit becomes visible through “connecting or belonging” (Lane, 1987, p. 333). Connection remains a consistent attribute of

spirituality in the nursing literature (Sessanna et al., 2007; Stephenson & Berry, 2015; Weathers et al., 2016). The medical literature repeatedly defined spirituality as being relational (Anandarajah & Hight, 2001; Lawrence, 2002; Post, Puchalski, & Larson, 2000; Todres et al., 2005). Social work has identified connectedness as important to one's spirituality (Barker & Floersch, 2010; Hodge & Horvath, 2011; Hodge & McGrew, 2005). A religion scholar describes the connection between religion and spirituality as a companionship and emphasizes a relationship existing between "spirit to body" (Schneiders, 2003, p. 181). Workplace spirituality has identified greater reliance for support from work connections due to societal factors such as downsizing, competitive world markets, and a decrease in personal community support (Ashmos & Duchon, 2000; Cash & Gray, 2000; De Klerk, 2005; Van Tonder & Ramdass, 2009). Spirituality includes the process of seeking meaningful connections.

Transcendence. Transcendence is an ability to move beyond where one is using energy, a life force, or an infinite power toward the future (Lane, 1987). Nursing has also referred to this spiritual energy as a "powerful resource" to help people cope with illness (Tanyi, 2002, p. 503). Transcendence remains a consistent attribute in the nursing literature (Sessanna et al., 2007; Weathers et al., 2016). Stephenson & Berry (2015) refer to this attribute as "self-transcendence," which is described as a personal process of growing and maturing (p. 1242). In medicine, spirituality is defined as having the ability to transcend (Anandarajah & Hight, 2001; Pembroke, 2008; Vachon, Fillion, & Achille, 2009). Palliative care medicine suggests spirituality definitions must include words such as "process" and "conscious" since humans can transcend (Vachon et al., 2009, p. 56). The social work literature described spirituality with terms such as power or force (Barker & Floersch, 2010; Hodge & McGrew,

2005; Seinfeld, 2012). In a workplace that recognizes the strength of spirituality, transcendence is seen with positive outcomes such as well-being (De Klerk, 2005; Gockel, 2004; Karakas, 2010; Marques, 2006, 2007); creativity (Karakas, 2010; Marques, 2006); high performance (Burkhart, Solari-Twadell, & Haas, 2008; Gockel, 2004; Marques, 2007); and philanthropy, or giving to others (Gockel, 2004; Karakas, 2010). Humans have an inner source of energy that can be empowering to transcend.

Hope. Hope is a belief that something better is possible in the future. The nursing literature identifies hope as an attribute of spirituality (Newlin et al., 2002). In a concept analysis of spirituality at end-of-life, hope was identified as an attribute (Vachon et al., 2009). Lane (1987) describes the spirit's desire to be free, with its ability to dream about new possibilities. Weathers et al. (2016) categorized hope as a consequence of one's spirituality rather than an attribute, and Stephenson and Berry (2015) placed hope in the belief category. Both Weathers et al. (2016) and Stephenson and Berry (2015) acknowledge the reality of the variability of the attributes of spirituality in the literature. The Medicine literature cites the World Health Organization (WHO) as recognizing the significance of hope in one's recovery (Culliford, 2002). Medicine associates spirituality as providing hope, which helps a person cope with illness (Post et al., 2000). Hope is also associated with peace (Anandarajah & Hight, 2001; Culliford, 2002). Inability to locate spiritual sources for hope is an element of the definition of spiritual distress in the medical literature (Anandarajah & Hight, 2001). The social work literature identified a qualitative study of social workers' definition of spirituality, which included hope (Barker & Floersch, 2010). Hope can provide strength and a sense of calmness and well-being despite the unknown future.

Spirituality Is Different Than Religion Yet Can Be Connected

Religion is an organized belief system with unique traditions specific to that tradition. The discussions of religion and spirituality as being interconnected continually surfaces in the nursing literature (Burkhart & Solari-Twadell, 2001; Pike, 2011; Polzer Casarez & Engebretson, 2012; Sessanna et al., 2007). Spirituality could, or could not, include religion (Buck, 2006). Nursing acknowledges one's spiritual beliefs are personal. The individual personally defines spirituality and religion, in that some individuals express their spirituality through religion, where others express their spirituality outside a religion (Burkhart & Solari-Twadell, 2001). The belief that spirituality is larger than religion remains in the nursing literature (Weathers et al., 2016). In the spirituality concept analysis of Sessanna et al. (2007), two of the themes included religion, which was identified as: "religious systems of beliefs and values" and "nonreligious systems of beliefs and values" (p. 252). Medicine acknowledges every human being is spiritual, but not all humans are religious (Vachon et al., 2009). The social work literature agrees that religion and spirituality are different, yet are connected (Barker, 2007; Barker & Floersch, 2010; Hodge, 2006; Hodge & Horvath, 2011; Hodge & McGrew, 2005; Seinfeld, 2012). The workplace literature explains religion as more about devotion related to religious beliefs (Cash & Gray, 2000; Karakas, 2010; Marques, 2007). The nursing, medicine, and social work literature acknowledge that spirituality and religion are different, yet can be part of one's spirituality.

Some workplaces recognize the importance of both spirituality and religion. Several religious traditions offer principles that employees carry with them as a human being into the workplace. For example, Christians believe they are called by God, Buddhists believe work

enriches one's life, and those from the Islamic faith have a code of work ethics (Krishnakumar & Neck, 2002). Some workplaces allow meditation (Cash & Gray, 2000); others have chaplains as part of their team (Cash & Gray, 2000; Gockel, 2004); and some organizations allow prayer groups and offer retreats (Cash & Gray, 2000; Karakas, 2010). Although religion and spirituality are different concepts, religion may impact one's spirituality. For this research, religiosity is defined as activities "associated with human expression of the rites and rituals of a particular faith tradition" (Burkhart & Hogan, 2008, p. 928). Knowing that religion may or may not be part of one's spirituality in healthcare is essential.

Philosophical Grounding and Theoretical Framework

Spiritual care is facilitating another's spirituality. The nursing literature guides spiritual care in nursing practice using theory (Burkhart & Hogan, 2008). This research will use both Watson's theory of transpersonal caring (2008) as the philosophical grounding and Burkhart and Hogan's (2008) spiritual care in nursing practice (SCiNP) middle-range theory as the theoretical framework to guide this study. Watson's Theory of Human Caring is a grand theory originally published in 1979 that provides a philosophical grounding for Watson's theory of Transpersonal caring (Watson, 2008). Watson's (2008) theory of transpersonal caring and Burkhart/Hogan's (2008) SCiNP are appropriate for this study because they are compatible in how they both approach spirituality and spiritual care. Rather than a survey of spiritual assessments, they both suggest that spiritual care is the nurse's caring presence and attentive awareness and compassionate response to the patient's spiritual needs for meaning and connection, while also identifying that the patient and nurse are touched by the encounter and

search for meaning through the human-to-human encounter (Burkhart & Hogan, 2008; Watson, 2008).

Watson's Theory of Transpersonal Caring

Watson's (2008) theory of human caring provides a philosophical underpinning for this study in its definition of several foundational concepts, including "*Caritas Consciousness*," the "caring moment," moral commitment to care, and caring and uncaring energy.

Caritas consciousness. Nurses enter into care situations with a level of awareness by the nurse described as "*Caritas Consciousness*," (Watson, 2008, p. 80). Watson defines "*Caritas*" as cherishing, loving, and a generous spirit (2008, p. 39). Bringing both "love and caring" is the invitation to "transpersonal caring," which opens oneself to facilitate healing for oneself, other people, and the world (Watson, 2008, p. 40). Watson claims "love is the highest level of consciousness and the greatest source of all healing in the world" (2008, p. 40). Developing this level of caring consciousness is an underlying assumption of nursing care and should exist prior to entering a care situation, which can facilitate patient and nurse's spirituality (Watson, 2008). The term "*Caritas Consciousness*" refers to the embodiment of the attributes of caring embedded in Watson's Ten Caritas Processes (Wagner, 2010, pp. 3-7; Watson, 2008, pp. 80-81). Some of these processes of "*Caritas Consciousness*" include development of presence, compassion, and sensitivity with an intentionality that helps the nurse stay with and care for the deep spiritual needs that exist for humans.

The caring moment. The theory of transpersonal caring describes the inter-connection between the patient and nurse when the nurse is noticing and being fully present to another (Wagner, 2010; Watson, 2008). The "caring moment" is when the nurse sees and connects with

the inner spirit of another, and both the patient and nurse transcend into deeper realizations gaining new perspectives and self-awareness (Wagner, 2010, p. 1; Watson, 2008, p. 82).

Spiritual care requires a prerequisite of compassionate care (Watson, 2010).

The “caring moment” includes the following concepts: A collective past, phenomenal field, intersubjective, caring occasion, and transpersonal caring. A “collective past” is the individual’s personal life story, experiences, and energetic field (Watson, 2010, p. 114). The phenomenal field is “the subjective and intersubjective meanings of both participants” (Watson, 2008, p. 79). Intersubjective means “the uniting of two or more persons’ subjective realities to create a new perspective; that which emerges out of the shared relationship and inner unique life world of their subjective perceptions and experiences” (Watson, 2010, p. 288). A “caring occasion” is when two people come together, and a chance to care forms (Watson, 2010, p. 116). According to Watson these caring occasions are intentional (2010).

In the “caring moment” both nurse and patient have the ability to mobilize power to facilitate innate healing in the moment (Watson, 2010, p. 118). Watson’s transpersonal caring theory describes the relationship between the nurse and patient during a “caring moment” in terms of a transpersonal sharing of spiritual energy during the “caring moment” within the phenomenal field (Watson, 2010, p. 118). The nurse and patient each enter the “caring moment” with a “collective past” (Watson, 2010, p. 114). In that “caring moment” each spiritual phenomenal field affects each other and merge to become one in the “caring moment,” which is the moment of transpersonal caring (Wagner, 2010). This sharing of spiritual energy affects both patient and nurse, enlarges each other’s perspectives of the world, and remains with one another beyond that moment into the future (Watson, 2010).

Moral commitment. The nurse is aware of the ethical moral commitment to care (Watson, n.d.). The nurse's "*Caritas Consciousness*" creates space that protects and allows the person to make meaning with self or other (Watson, n.d.). The nurse is intentionally focusing soul-to-soul on cues to promote holistic health, removing barriers that hinder healing, connecting the person to innate healing. The nurse notices verbal and non-verbal cues and acts in providing spiritual care. This deeper consciousness requires the nurse to a lifetime of personal and professional self-development with an awareness of his or her own humanity and woundedness (Watson, n.d.). Although the "Caritas Nurse" will not have a "transpersonal caring connection" or "caring moment" with each patient, possessing a "*Caritas Consciousness*" as a moral compass to guide one professionally is "ideal" (Watson, 2008, p. 82).

Caring and uncaring energy. Watson (2008) cites Halldorsdottir's (1991) research of caring and uncaring behaviors, which maintain if the nurse does not possess a "*Caritas Consciousness*" the nurse can actually bring harmful energy into the field. This energy has been categorized as "Five Basic Modes of Being with Another" (Halldorsdottir, 1991, p. 39). These include from the highest to lowest as: "life-giving (biogenic)," "life-sustaining (bioactive)," "life-neutral (biopassive)," "life-restraining (biostatic)," and "life-destroying (biocidal)," which can be potentially harmful (Halldorsdottir, 1991, p. 38). The highest mode is a "life-giving or biogenic mode of being with another [which] is the truly human mode of being and is represented by healing love. This mode involves loving benevolence, responsiveness, generosity, mercy, and compassion" (Halldorsdottir, 1991, p. 44). The nurse that cultivates and possesses a "Caring Literacy" toward "(caring-loving) consciousness" radiates a life-giving

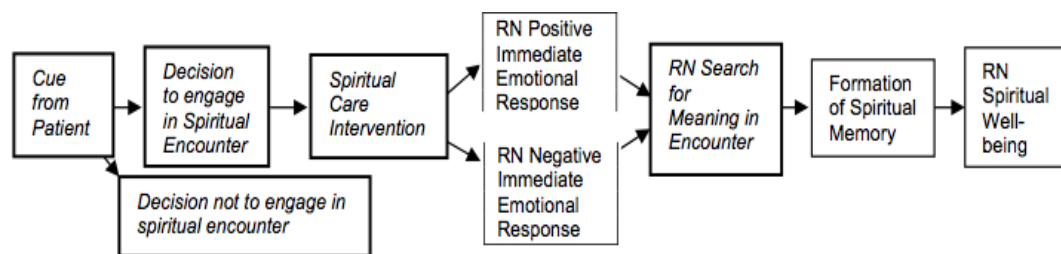
energy, “biogenic,” that permeates the environment, allowing her/him a higher chance of engaging in and experiencing a “transpersonal caring-healing moment” (Watson, 2008, p. 26).

A nurse’s caring presence can promote a positive caring encounter with the patient.

Burkhart/Hogan Spiritual Care in Nursing Practice Theory (SCiNP)

The Burkhart/Hogan (2008) theory of Spiritual Care in Nursing Practice (SCiNP) is the middle range theory that guided this study. The SCiNP describes an intentional process of spiritual care in nursing practice in seven categories that affect both patient and nurse (as shown in Figure 1).

Figure 1. Burkhart and Hogan (2008) spiritual care in nursing practice middle range theory



Note. From L. Burkhart and N. Hogan (2008), *Qualitative Health Research*, p. 931. Copyright 2008 by Sage (for permission see Appendix A).

The SCiNP theory was discovered through a grounded theory study with four focus group interviews with registered nurses (RN) ($n = 24$) who worked across the continuum of care and cared for chronically ill patients in a large medical center (Burkhart & Hogan, 2008). Data analysis from the original four focus groups indicated that an additional focus group with nurse managers was needed to clarify the emerging theory (Burkhart & Hogan, 2008). Therefore, an additional focus group was added that included unit nurse managers ($n = 9$), which confirmed the seven categories discovered from the original focus groups (Burkhart & Hogan, 2008). For spiritual care to occur the nurse creates an atmosphere of trust, love and

caring, and the patient is open to receiving spiritual care (Burkhart & Hogan, 2008). The theory includes seven categories.

Patient cue. The first category in the process is recognizing a patient cue for a spiritual need (Burkhart & Hogan, 2008). Cues can be verbal, non-verbal, or situational.

Decision to engage. The second concept is “decision to engage,” which is when the nurse decides whether to engage or not engage in this spiritual encounter (Burkhart & Hogan, 2008, p. 932). If the nurse does not choose to engage in the spiritual encounter—due to time constraints, lack of collegial support, or spiritual depletion—spiritual care does not occur. If the nurse decides to engage, the nurse performs spiritual interventions (Burkhart & Hogan, 2008).

Spiritual intervention. The third concept is “spiritual care intervention,” in which there is an intentional, shared spiritual connection between the patient and nurse (Burkhart & Hogan, 2008, p. 932). Spiritual care interventions include facilitating patient reflection, connection to others, and/or connecting to God or other source of higher power (Burkhart & Hogan, 2008).

Emotional response. The fourth category of the SCiNP theory occurs after the nurse-patient spiritual encounter when the nurse experiences a positive or negative emotional response to the spiritual encounter (Burkhart & Hogan, 2008).

Search for meaning. The fifth category of the process is when nurses search for meaning from the encounter. This reflection is when the nurse searches for meaning through reflection with self, others, or through own faith traditions. These strategies for reflection are similar to the strategies of providing spiritual care interventions (Burkhart & Hogan, 2008).

Formation of spiritual memory. The sixth category is forming a long-term memory from the encounter and is contingent on whether the nurse found meaning in the spiritual

encounter. There are three pathways toward “formation of spiritual memory”: (a) where a negative spiritual care encounter holds a memory that is distressing (no meaning found); (b) where a positive spiritual care encounter becomes a positive memory (meaning found); and (c) an initial negative spiritual encounter becomes a positive memory (meaning found) (Burkhart & Hogan, 2008, p. 934).

Spiritual well-being. The seventh category is “nurse spiritual well-being” (Burkhart & Hogan, 2008, p. 935). Spiritual well-being is a personal dimension of self that is affected by life experience and the degree to which one finds meaning and purpose in life. These individual spiritual encounters and reflective practices affect the nurse’s overall spiritual well-being (Burkhart & Hogan, 2008). Poor spiritual well-being can lead to spiritual depletion, which can affect the nurses’ decision to engage in spiritual care in the future (Burkhart & Hogan, 2008).

Spirituality Measurement Tools

Measuring spirituality is essential in healthcare as numerous patients count on their spirituality as a resource that affects their well-being (Gray, 2006). There are multiple spiritual care tools in the literature that measure different aspects of spirituality. A concise description of spirituality and spiritual care measurement tools found in the nursing spiritual care literature is shown below in Table 1. Of these, Reed’s (1987) Spiritual Perspective Scale (SPS) and Paloutzian & Ellison’s (1991/2009) Spiritual Well-Being Scale (SWBS) have been used more frequently, as they were developed and validated in the 1980s.

Table 1. Spirituality and Spiritual Care Tools in the Literature

Tool & Tool Author(s)	Concept Measured	Reliability	Validity	References
Nurse Spiritual Care Therapeutics Scale (NSCTS) 17-items, 5-point Likert Scale (Mamier & Taylor, 2015)	Frequency of nurse provided spiritual care	(1) Cronbach's alpha = .93 (2) Cronbach's alpha = .94	Content Validity Index 0.88 Item-total correlations 0.40 to 0.80 & One factor 0.41 to 0.84, using Exploratory Factor Analysis (EFA)	(1) Mamier and Taylor (2015) (2) Taylor et al. (2017)
Spiritual Care Competence Scale (SCCS) 27-items, 5-point Likert Scale (van Leeuwen, Tiesinga, Middel, Post, and Jochemsen, 2008, 2009).	Six spiritual-care-related nursing competencies 1. Assessment and implementation of spiritual care (Cronbach's alpha = 0.82) 2. Professionaliz[ation] and improving the quality of spiritual care (Cronbach's alpha = 0.82) 3. Personal support and patient counseling (Cronbach's alpha = 0.81) 4. Referral to professionals (Cronbach's alpha = 0.79) 5. Attitude towards the patient's spirituality (Cronbach's alpha = 0.56) 6. Communication (Cronbach's alpha = 0.71) (van Leeuwen, Tiesinga, Middel, Post, and Jochemsen, 2008, 2009).		Average inter-item correlation > 0.25 (van Leeuwen et al., 2007 as cited in van Leeuwen et al., 2008). Good test-retest reliability (van Leeuwen et al., 2009).	van Leeuwen and Cusveller (2004) — original tool development van Leeuwen, Tiesinga, Middel, Post, and Jochemsen, (2008, 2009) Linegang (2014)

Table 1 (cont.)

Spiritual Care-Giving Scale 35-items, 6-point Likert Scale (Tiew & Creedy, June, 2012)	Perspectives about spiritual care and spirituality	(1) Cronbach's alpha = 0.86 (2) Cronbach's alpha = 0.869	Review of the literature; expert review; pilot testing; final testing with nursing students Test-Retest Factor Analysis supports five factors	(1) Tiew and Creedy (June, 2012) (2) Tiew, Kwee, Creedy, and Chan (June, 2013)
Spiritual Care in Practice (SCIP) 12-items, 5-point Likert Scale (Burkhart & Schmidt, 2012)	Measures frequency of recognition of patient cue and providing spiritual care	Cronbach's alpha = 0.91	Prior psychometric testing with RNs in grounded theory study (Burkhart & Hogan, 2008)	Burkhart and Schmidt (2012)
Spiritual Care Inventory (SCI), 17-items, 5-point Likert Scale 3 subscales: Spiritual Care Intervention (SI) (4-items) Meaning Making (MM) (10-items) Faith Rituals (FR) (3-items)	Nurse perceived ability to provide spiritual care	(1) Cronbach's alpha SI = 0.87 MM = 0.94 FR = 0.88 (2) Cronbach's alpha SI = 0.80 MM = 0.88 FR = 0.80	Factor analysis supported construct validity of the tool explaining 57.33% of the variance and yielding 17 items	(1) Burkhart et al. (2011) (2) Burkhart and Schmidt (2012)
(Burkhart, Schmidt, & Hogan, 2011)				

Table 1 (cont.)

Spiritual Care Perspective Scale-Revised, (SCPS-R) 10-items, 5-point Likert Scale (Taylor et al., 1999 as cited in Taylor et al., 2008, p. 1131).	Attitude toward spiritual caregiving	Face validity spiritual care nurse scholars Cronbach's alpha = 0.82 (Taylor et al., 1999 as cited in Taylor et al., 2008); Cronbach's alpha = 0.75 (Taylor et al., 2008)	Valid unidimensional factor analysis (Taylor et al., 1999 as cited in Taylor et al., 2008)	(Taylor et al. 1999 as cited in Taylor et al., 2008)
Spiritual Perspective Scale (SPS), 10-items, 6-point Likert Scale (Reed, 1986, 1987)	Perspectives of spirituality	(1) Cronbach's alpha = 0.93; 0.95 (2) Cronbach's alpha = 0.888 (3) Cronbach's alpha = 0.90	Modifications from Reed (1986) analysis stated in Reed (1987): No inter-item correlations < 0.41; Average intercorrelations range 0.57-0.68	(1) Reed (1987) (2) Dunn, Handley, and Dunkin (2009) (3) Cerra and Fitzpatrick (2008)
Spiritual Well-Being (SWBS) scale Dr. Paloutzian & Ellison 20-items tool, 6-point Likert Scale Overall SWBS and two sub-scales Existential Well-Being (EWB) and Religious Well-Being (RWB)	Perceived spiritual quality of life from two perspectives: Overall Spiritual Well-Being with two sub-scales EWB & RWB	(2) Cronbach's alpha EWB = 0.83 RWB = 0.95 (3) Cronbach's alpha = 0.89 (4) Cronbach's alpha SWB = 0.915 RWB = 0.951 EWB = 0.853	(1) Test-Retest Over 4 studies 0.96 0.99 0.96 0.98 EWBS 0.86 0.98 0.98 0.73 SWBS 0.93 0.99 0.99 0.82	(1) Cited in > 400 sources (Paloutzian & Ellison, 1991/2009) (2) Burkhart and Schmidt (2012) (3) Cerra and Fitzpatrick (2008) (4) Dunn, Handley, and Dunkin (2009)

Table 1 (cont.)

The Spirituality and Spiritual Care Rating Scale (SSCRS) 17-items, 5-point Likert Scale (McSherry, Draper, & Kendrick, 2002)	Nurses' perceptions of spirituality and spiritual care	(1) Cronbach's alpha = 0.64 (2) Cronbach's alpha Spirituality = 0.77 Subscales: Spiritual Care = 0.69 Religiosity = 0.71 Personalized Care = 0.65	(1) Using Principal Component (PC) Factor Analysis 4-construct validity 1) Spirituality 2) Spiritual Care 3) Religiosity 4) Personalized Care	(1) McSherry, Draper, and Kendrick (2002) (2) Wallace and O'Shea (Nov/Dec, 2007)
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Spiritual Care Literature

Since spirituality and spiritual care are metaphysical concepts, research includes philosophical inquiry, qualitative research, quantitative research, evidence-based guidelines, and standards of care. In addition to research, the literature review will include expert opinion and literature from the Veteran's Administration (VA), which is dedicated to serving the unique healthcare needs of veterans.

The research related to spiritual care converged on several categories of the SCiNP theory, including prerequisites of spiritual care (nurse's caring presence), patient cue, decision to engage or not engage, spiritual care intervention, and both the positive and negative impact of spiritual care on the nurse (Burkhart & Hogan, 2008). Therefore, the literature will be described using these categories. Several spiritual assessment tools that guide recognition of patient cue will be discussed. The following section will also elaborate and provide details from

the current literature and research in spiritual care (see attributes in Appendix B and literature review in Appendix C). This section will end with gaps in the literature and a description of how this study will address some of the gaps.

Prerequisites to Providing Spiritual Care

The literature presents the prerequisites as abilities in living out a caring presence (Baldacchino, 2008; Como, 2007; Deal & Grassley, 2012; Hoffert et al., 2007; Monareng, 2012; Pesut, 2013; Watson, 2008). This refers to the embodiment of caring attributes when entering into a spiritual care encounter. These attributes include respect (Deal & Grassley, 2012; Giske & Cone, 2012; Hoffert et al., 2007; Wallace et al., 2008); honoring patient's beliefs (Barss, 2012; Battey, 2012; Deal & Grassley, 2012; Monareng, 2012); love (Burkhart & Hogan, 2008; Como, 2007; Monareng, 2012; Wright, 2008); compassion (Battey, 2012; Wright, 2008); and sensitivity (Giske & Cone, 2012; Ramezani, Ahmadi, Mohammadi, & Kazemnejad, 2014; Wallace et al., 2008).

Burkhart and Hogan (2008) conducted a grounded theory study and found that nurses needed to demonstrate love and compassion for a spiritual encounter to occur. Taylor, Park, and Pfeiffer (2014) in a phenomenological study with Christian nurses ($n = 14$) who were considered highly religious studied how being Christian impacts spiritual care. They found establishing a relationship with the patient first as essential, as well as being sensitive and respectful of patient's values and belief system. Nurses also need to be self-aware not to push one's own religion on patients to prevent harm (Taylor et al., 2014). These communication and relationship building skills and attributes are essential prerequisites to spiritual care.

Recognizing Patient Cues of a Spiritual Need

Recognizing patient cues is defined as recognition of a spiritual need (Burkhart & Hogan, 2008). The literature presents spiritual assessment tools and patient cues (situational, cultural, verbal, non-verbal, and environmental) that indicate the need for spiritual care.

Spiritual assessment using tools. The *Nursing's Social Policy Statement* Professional Nursing Practice Standard 1 of the nursing process is competency in assessment (ANA, 2010b). The following section will include an overview of spiritual assessment including TJC requirement, tools in practice and research, and standardized terminology in nursing.

The Joint Commission requirements for assessment. Cues may be detected during formal spiritual assessments. The Joint Commission (TJC) mandates assessment and provision of spiritual care for patients (Clark et al., 2003). TJC is a nationally recognized accreditation agency that certifies over 20,000 healthcare establishments in the United States (US) (The Joint Commission [TJC], 2015). TJC provides a list of suggested questions to assess patient's spirituality (The Joint Commission, Revised Nov. 24, 2008). However, TJC does allow each organization freedom in the design, content, and required credentials necessary to perform a spiritual assessment (TJC, Revised Nov. 24, 2008). Although TJC has a standard, there is no consistent spiritual assessment tool identified in the literature.

Various types of spiritual inquiry forms. Since the initiation of TJC mandate for spiritual assessments, debates began about who should collect the assessment data, and what constituted a spiritual screening, spiritual history, and spiritual assessment (Cadge & Bandini, 2015). Chaplain Larocca-Pilts (2008) describes a spiritual screening as typically completed one

time upon admission and includes an inquiry of whether the patient has any spiritual, religious, or cultural needs during their hospital stay. A spiritual history is also brief and includes inquiries about the patient's spirituality and coping tools, although the spiritual history can be ongoing and change as the course of the patient's health issues evolve. If there are any concerns about the patient's inability to use their spirituality in coping, an assessment should be conducted by a chaplain (Fitchett, 2012; Kalish, 2012; Larocca-Pilts, 2008; Puchalski, 2012). The tools in healthcare to inquire about one's spirituality range from brief to comprehensive, as well as initial and ongoing, with the chaplain recommended to conduct the more in-depth assessment.

Spiritual assessment tools in practice. Spiritual assessments ask more detailed questions and are more time-consuming to administer than a spiritual screening (Fitchett, 2012; Puchalski, 2012). There are multiple spiritual assessment tools in the literature that measure different dimensions of spirituality (Cadge & Bandini, 2015; O'Brien, 2011). Cadge and Bandini (2015) conducted a literature review on spiritual assessment tools in healthcare and discovered that tools were initially developed in the 1960s and 1970s by pastoral care, nursing, mental health, and eventually medicine and social work. Stoll (1979) created the first nursing guide for spiritual assessment in 1979 (Cadge & Bandini, 2015; O'Brien, 2011). Stoll (1979) provided suggested questions to guide inquiry into one's spirituality in four sections that addressed both religion and spirituality (Cadge & Bandini, 2015; O'Brien, 2011). Stoll also recommended informing the patient that the purpose of the spiritual history is to identify what gives them strength in order to provide excellent care (1979). The 1980s saw the first spiritual tool assessments created by physicians, as well as spiritual assessment tools for hospice and

palliative care patients (Cadge & Bandini, 2015). The literature consistently described the FICA and HOPE narrative spiritual history tools, which were created by physicians to guide the recognition of a spiritual need. However, it is unclear how often they are used in practice. The development of these tools marks the shift to include holistic care in healthcare (Cadge & Bandini, 2015).

The FICA spiritual history tool. The FICA tool was designed for use with older adults and uses the acronym FICA to explore one's spirituality with open-ended questions rather than a checklist (Puchalski, 2012). The FICA acronym: "F—Faith and belief; I—Importance; C—Community; A—Address in care" (Puchalski, 2001, p. 34). The FICA tool has been tested for use in the clinical setting (Borneman, Ferrell, & Puchalski, 2010). In a study with cancer patients ($n = 76$) using the Functional Assessment of Cancer Therapy QOL Tools, "City of Hope-QOL Tool," Cronbach's alpha of 0.93, analysis verified correlation to aspects of QOL spirituality domain (Borneman, 2011, p. 1; Borneman et al., 2010, p. 166). The authors concluded the results are suggestive that the FICA tool is reasonable to use to assess spirituality (Borneman et al., 2010). The FICA tool is the only spiritual assessment tool on the evidence-based nursing resource website, Hartford Institute for Geriatric Nursing (Borneman, 2011).

The HOPE tool. Anandarajay and Hight (2001) used the acronym HOPE: "H—sources of hope, strength, comfort, meaning, peace, love and connection; O—the role of organized religion for the patient; P—personal spirituality and practices; E—effects on medical care and end-of-life decisions" (p. 81). The HOPE tool has not been psychometrically tested (Anandarajay & Hight, 2001; Puchalski, 2012). The HOPE tool served as a guide to include spirituality in the medical clinical assessment, yet created much controversy over whose role it

was to complete the assessment, how to best have these conversations with patients, and identifying concerns related to unclear religion and spirituality conceptual definitions (Cadge & Bandini, 2015).

The Client Spiritual Assessment Tool (CSAT). Nurses can recognize cues with ongoing assessments inquiring about one's spirituality (Battey, 2012), or when asking the patient questions about fears and anxiety and/or what resources gives them strength and helps with coping (Shelly, 2000). A nurse-developed Client Spiritual Assessment Tool (CSAT) is a comprehensive assessment form that is intended to be spontaneous, and includes a list of cues to observe for as a guide to assessment of "Spiritual Integrity" or "Spiritual Distress" (Hoffert et al., 2007, p. 68). The researcher developed the CSAT based on Catterall's standards for developing a tool and a review of the literature (Hoffert et al., 2007). The development of the CSAT also included McSherry and Draper's philosophy based on Stoll's (1979) description of spirituality using horizontal and vertical descriptors, with the vertical axis referring to one's relationship to a higher power and the horizontal axis representing one's beliefs and connection to others (Hoffert et al., 2007). There is no content validity process noted for the development of the CSAT, and the author acknowledged that further study was needed (Hoffert et al., 2007).

The CSAT has five sections that mirror the nursing process. The assessment tool includes looking for "signs of meaning, relationship, hope, and joy" with a checklist as either present, aligned to the "spiritual integrity" column, or absent, aligned to the "spiritual distress" column (Hoffert et al., 2007, p. 68). Some of these items include assessment for family/friends, overall self-care, employment, hobby, religious items, handling of situation, and assessment for the presence of a smile. Based on those assessments, five questions are provided to help the

nurse acknowledge what was noticed in the environment to help guide further exploration with the patient. The form states that the patient is the director of the dialogue once trust and connection between the patient and (student) nurse has occurred. This section also includes eight questions to help the nurse explore more about the patient's home life, what brings them happiness, identification of any goals, coping methods, and whether the patient would like prayer. This section has two columns indicating listening for the presence or absence of patient expression including "signs of meaning, relationships, hope, and joy" (Hoffert et al., 2007, p. 68). There is space to choose a diagnosis, set goals, choose possible spiritual care interventions, and evaluate the effect of those interventions. This form also notes that one's spirituality is unique and is an ongoing process (Hoffert et al., 2007). This researcher was unable to find any further information or use of this assessment tool in the literature.

There are over 40 spiritual assessment tools today in the U.S. healthcare literature, which cause a gap in understanding their actual use and in how the inter-disciplinary team uses them, and a lack of conceptual clarity on what constitutes a spiritual assessment (Cadge & Bandini, 2015). The gap in the interprofessional exchange of tools assessing spirituality and communication among the team limits collaboration (Cadge & Bandini, 2015). Chaplain and researcher Fitchett (2012) suggest that no further spiritual care assessment tools be created, but rather the focus needs to be on reviewing those that exist and investigating them through research to help determine best practice. A review of the literature in nursing also discovered no consistent spiritual care tools or education on using them (Timmins et al., 2015; Timmins & Neill, 2013). There is an opportunity for interprofessional collaboration, education, and research related to assessing spirituality in healthcare.

Standardized terminology. The *Nursing's Social Policy Statement* Professional Nursing Practice Standard 2 of the nursing process is competency in diagnosis (ANA, 2010b). There is standardized terminology supported by research to reflect spiritual care. These include NANDA-I, Nursing Intervention Classification (NIC), and Nursing Outcomes Classification (NOC), all supported by the American Nurses Association (Burkhart & Androwich, 2009; NANDA International [NANDA-I], 2017). NANDA-I identifies actual and potential spiritual care diagnoses associated with one's spirituality, and provides standardized nursing diagnoses that are evidence-based and can guide the nurse in assessing and initiating care-planning (Herdman & Kamitsuru, 2014). Spiritual distress has been defined as a nursing diagnosis through NANDA-I of "a state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being" (Herdman & Kamitsuru, 2014, p. 372). The nursing diagnosis "risk for spiritual distress" has been defined by NANDA-I as "vulnerable to an impaired ability to experience and integrate meaning and purpose in life through connectedness within self, literature, nature, and/or a power greater than oneself, which may compromise health" (Herdman & Kamitsuru, 2014, p. 374). Patients at "risk for spiritual distress" include those experiencing life transitions, chronic disease, environmental relocation, and addictions (Herdman & Kamitsuru, 2014, p. 374). NANDA-I provides nurses with the structure to guide diagnosis and care planning to promote and enhance healthcare (Herdman & Kamitsuru, 2014).

Recognition of patient cues in the moment. The recognition of patient cues for spiritual care may occur in the moments during the initial encounter or throughout the day while caring for the patient (Burkhart & Hogan, 2008). Smyth and Allen (2011) in a two-phase,

mixed method explanatory descriptive design, using a questionnaire followed by focus groups with nurses ($n = 16$) on a 25-bed acute care medical unit, found spiritual assessment as one of four themes. Nurses stated spiritual care assessment occurs during routine care without formal assessment once a connection was made between the nurse and patient (Smyth & Allen, 2011). Recognition of cues for spiritual care included watching patient relationships, sleep trends, physical discomfort, and emotional struggles. The study found spiritual care occurred through both verbal and non-verbal cues including communication, observation, and listening (Smyth & Allen, 2011). To recognize the patient cue, the nurse must use her/his senses (sight, sound, touch, taste, and smell). This recognition includes paying attention, noticing any verbal, non-verbal, situational, behavioral, physical environmental, and cultural cues for a spiritual need. These cues are further described in the following sections.

Situational verbal and non-verbal cues. Patient cues for spiritual care can be situational expressed verbally and non-verbally. Nurses need to be attentively aware of life events and emotions expressed as potential cues for recognizing a spiritual care need. These life events include when people have illness, life style change, uncertain diagnosis, chronic disease, disability, when making decisions, when something threatens their life, and at end-of-life (Burkhart & Hogan, 2008; Herdman & Kamitsuru, 2014; McSherry & Ross, 2012; Mitchell, Bennett, & Manfrin-Ledet, 2006; O'Brien, 2011; Shelly, 2000). Patients with a sudden illness have the potential for spiritual difficulties associated with worry about possibly dying or their infirmity (O'Brien, 2008). Post-operative patient spiritual needs can arise from fears associated with uncertainty related to the operative findings especially if the surgery was because of cancer (O'Brien, 2008). Situational verbal and non-verbal cues can arise at any time.

Patient cues can be present as signs of spiritual distress (O'Brien, 2011). Cues for spiritual needs can occur through the recognition of spiritual distress (Battey, 2012; Deal & Grassley, 2012; Mitchell et al., 2006). These signs include anxiousness, tears, tiredness, fears, and insomnia (Herdman & Kamitsuru, 2014). At "risk for spiritual distress" cues can include anxiousness, barriers to supportive connections, change with faith tradition rituals/spiritual practices, sadness, and stress (Herdman & Kamitsuru, 2014, p. 374). Patient needs for spiritual care can be expressed through situational verbal and non-verbal cues.

Behavioral verbal and non-verbal cues. Cues of a spiritual need may be behavioral verbal or non-verbal (Battey, 2012; Burkhart & Hogan, 2008). Deal and Grassley (2012) in a qualitative phenomenological study of perceptions of spiritual care with nurses ($n = 10$) from both acute and chronic hemodialysis units found patient cues can include behaviors that include expressions of angry emotions related to the loss associated with their disease. Paying attention to patient's non-verbal communication includes awareness of their body language and mood (McSherry & Ross, 2012; Shelly, 2000). Taylor et al. (2014) in their phenomenological study with Christian nurses ($n = 14$) discovered the need to establish a connection with the patient was necessary before providing spiritual care, as well as ongoing observation (Taylor et al., 2014). More specifically, statements such as the need to "tread softly...listen and pick up cues," and watching for non-verbal behaviors such as "body language and facial expressions" are seen as essential for spiritual care (Taylor et al., 2014, p. 2618). Spiritual care cues may be expressed through verbal and non-verbal emotional and physical behavioral cues.

Physical environmental/meaningful object/social support/family/religious cues. Cues for a spiritual need in the physical environment include observing for any personal belongings

such as photos, religious items, sacred texts, or prayer books (Como, 2007; Giske & Cone, 2012; McSherry & Ross, 2012; Monareng, 2012; Shelly, 2000). Physical environmental assessment also includes observation of any relationships, witness of external forms of prayer, or how the patient spends their time (e.g., watching television) (Shelly, 2000). In communication with the patient, it is important to initially be listening for "...spiritual themes such as meaning, hope, connection, religious rituals, beliefs, and values" (Puchalski, 2012, p. 203). Spiritual needs can be observed through cues in the environment such as through people, what is said or not said, or through objects that may hold deeper meaning for the patient. Observing the patient's environment for cues promotes spiritual care.

Environmental cultural/higher power/faith rituals cues. Patient cues for spiritual care can be cultural, which for some include religion and spirituality. TJC has developed a road map, *Advancing Effective Communication, Cultural Competence, and Patient-and-Family Centered Care*, to assist healthcare workers with the assessment and identification of patient and family's "cultural, religious, or spiritual beliefs and practices that influence care" (The Joint Commission [TJC], April 3, 2014, p. 15). This roadmap includes helpful tips focused on patient-centered care such as assessing the hospital environment for items that may conflict with the patient's traditions and removing them per patient desires; respecting privacy and gender care concern; and assessing for use of integrative health and healing (IHH) and/or one's spiritual practices (TJC, April 3, 2014).

Veteran culture. Cultures can also include unique groups such as veterans. Hobbs (2008), a veteran and Advanced Practice Nurse (APN), described the veteran culture formed from the shared lived experience of war, which frequently includes trauma. The veteran culture

has its own language, emblems and places they gather (Hobbs, 2008). Hobbs (2008) emphasized that cultural competency in nursing must also include the veteran culture, which goes beyond just one's ethnic background. The veteran culture affects nursing practice. In fact, the American Association of Colleges of Nursing (AACN) has partnered with the Department of Veteran's Affairs, national nursing professional organizations, and nursing schools in creating an initiative called "*Joining Forces*" to help better serve and care for our veterans (American Association of Colleges of Nurses [AACN], 2017b). One initiative included the creation of a tool kit with valuable resources entitled "*Joining Forces: Enhancing Veterans' Care Tool Kit—General Resources*" (American Association of Colleges of Nursing [AACN], 2017a).

This education provided by the AACN supports the fact that the veterans have unique needs. This tool kit includes a link on the AACN website to resources developed by VALU, VA Learning University (Sept, 2011). This includes an online course titled, "*Military Culture: Awareness Training*," which provides an overview explaining the various wars, military branches, customs, and conflicts (American Association of Colleges of Nurses [AACN], 2017b). In addition, this training emphasizes that war experiences are extreme and can impact those involved in different ways (AACN, 2017b). Service in the military affects one's health (Johnson et al., 2013). Nurses need to be aware of the veteran culture, both present and past experiences, and connections that can influence one's spirituality and need for spiritual care.

Decision to Engage/Not Engage in Spiritual Encounter

Nurses' "decision to engage" in spiritual care includes a shared connection (Burkhart & Hogan, 2008, p. 932). Nurses' decision to "not engage in [the] spiritual encounter" includes

educational and organizational barriers (Burkhart & Hogan, 2008, p. 932). Barriers to providing spiritual care in nursing practice include barriers in nursing education, nursing practice, and personal barriers.

Barriers in nursing education. Although spiritual care is a professional requirement and spiritual care should be included in nursing education programs, research suggests that practicing nurses do not know how to provide spiritual care. Spiritual care education as required by the AACN (2008) is an essential component of an evidence-based practice (EBP), high quality baccalaureate nursing education, yet there is a lack of spiritual care education in nursing curricula (Burkhart & Hogan, 2008; Kalish, 2012; Lundmark, 2006; Mitchell et al., 2006; Timmins et al., 2015; van Leeuwen et al., 2008). There is also a lack of spiritual care nursing role models in practice for nursing students to learn from (Baldacchino, 2008; Barss, 2012; Giske & Cone, 2012; Lovanio & Wallace, 2007). The rise in technology in education and focus on physical care has also overshadowed holistic care education (Cooper, Chang, Sheehan, & Johnson, 2013). The lack of education in spiritual care is a barrier in providing spiritual care.

Spiritual care content in nursing textbooks. Nursing textbooks are one method nurses learn how to provide spiritual care. A literature review revealed three nursing textbook analyses of spirituality content. McEwen's (2004) review discovered the foundational nursing textbook spirituality content complete, yet only occasional spiritual care content in the majority of other nursing textbooks. Pesut's (2008) review of ($n = 10$) fundamental nursing textbooks used by first year nursing students discovered "fairly well" developed content on religion, spirituality, and implementing spiritual care (p. 169). However, Pesut (2008) noted some textbooks may not

be as complete in content as others, and, suggests educators provide additional resources. The nursing textbook review of Timmins et al. (2015) conducted in the United Kingdom (UK) found among the books reviewed ($n = 130$) only 20 books that included a chapter on spirituality, and 43 of the books had no spirituality content (p. 280). In order to carry out the mandate to care for patients holistically, the content of spiritual care in fundamental nursing textbooks needs to be woven through all patient care scenarios rather than treat it as a separate entity in a separate chapter (Timmins et al., 2015). If the textbook does not provide a clear teaching strategy, that confusion can translate to the classroom and patient care settings.

Lack of conceptual clarity in textbooks. Pesut (2008) also identified several conceptual definition concerns surrounding spirituality in the fundamental nursing textbooks reviewed. To begin with, most of the textbooks separate the concepts of religion and spirituality and do not mention humans as being holistic (Pesut, 2008). Timmins et al. (2015) also discovered the lack of nursing textbooks distinguishing the difference between religion and spirituality in the UK. Other conceptual concerns noted the concept of “suffering” is missing in fundamental nursing textbooks and instead is labeled as “spiritual distress” (Pesut, 2008, p. 170). This conceptual confusion eliminates the possibility that one may suffer while hospitalized and still have spiritual well-being (Pesut, 2008). Lastly, Pesut noted the way in which spirituality is conceptualized in the nursing fundamental textbooks assumes one’s intellectual ability is needed for meaning and purpose, which marginalizes those without intellectual ability (2008). Lack of spirituality conceptual clarity in nursing textbooks can impact spiritual care in nursing practice.

In addition, despite the nursing literature's claim for the importance of the nurse's self-examination of the concepts of "spirituality and religion" to better understand how their viewpoint might affect their encounters with those they care for, there was a gap in nursing fundamental textbooks to guide the reader in this process (Pesut, 2008, p. 169). Other problems related to spiritual care assessment in nursing education include lack of uniformity and training with assessment tools (Timmins et al., 2015). Nurse educators frequently feel unsure how to teach spiritual care content, which leads to problems in planning teaching spiritual care education due to lack of clarity (Lundmark, 2006; Timmins et al., 2015). Inadequate education leaves the nurse feeling ill prepared to provide spiritual care (Lundmark, 2006; Mitchell et al., 2006; Timmins et al., 2015). Without more explicit assumptions, conceptual definitions, and explanation of the dimensions and process associated with one's spirituality in healthcare in nursing textbooks, nurses can have a misperception of spiritual care in nursing practice, which impacts patient care.

Barriers in nursing practice. There are barriers in nursing practice, in addition to nursing education. There are barriers in providing spiritual care, and barriers in patients receiving spiritual care.

Barriers in providing spiritual care. Several research studies have identified barriers for nurses in providing spiritual care. Barriers include: time constraints (Burkhart & Hogan, 2008; Gallison et al., 2013; Monareng, 2013; Rushton, 2014); lack of education (Monareng, 2013; Rushton, 2014); and unclear definition of spirituality (Rushton, 2014). There is also confusion specifically in conducting spiritual assessments and diagnosing spiritual issues. Problems with concept clarity can inhibit the nurse from choosing the correct nursing diagnosis

(Hoffert et al., 2007). Research also indicates that nurses perceive spirituality as a personal matter and have trouble differentiating between preaching and tending to one's spiritual needs (Gallison et al., 2013). Nurses also have difficulty fulfilling a patient's spiritual requests if the patient's tradition differs from the nurse (Gallison et al., 2013). Nurses often are unsure of their role in providing spiritual care (Gallison et al., 2013; Rushton, 2014) and refer patients to chaplains instead of being the provider of the spiritual care (Cooper et al., 2013; van Leeuwen et al., 2008). The problem with relying on chaplain services to provide spiritual care is that some institutions have reduced or even eliminated chaplain services due to financial issues (Battey, 2012). Since nurses are with patients around the clock, and a chaplain may not be available to provide spiritual care, administration must be supportive of the nurse's role in meeting patient spiritual care needs (Battey, 2012). Nurses are unsure how to provide spiritual care and the organization affects the ability to provide spiritual care.

Personal nurse barriers. The literature has also identified personal barriers in avoiding spiritual encounters. Personal barriers can include the nurse's own exhaustion or compassion fatigue (Burkhart & Hogan, 2008; Deal & Grassley, 2012). Compassion fatigue is defined as "a state where the compassionate energy that is expended by nurses has surpassed their restorative processes, with recovery power being lost" (Coetzee & Klopper, 2010, p. 237). This supports the need for nurse's self-care.

Spiritual Care Intervention

The literature describes forms of spiritual care interventions. These include a nurse's way of being and intentional activities that promote a patient's spiritual connectedness. These

specific interventions will be discussed below, in addition to specific interventions related to the veteran population.

Nurse's way of being. The caring presence of the nurse brings healing into the environment (Watson, 2008; Wagner, 2010). Deal & Grassley's (2012) phenomenology study described earlier with nurses who care for kidney dialysis patients discovered 5 themes ($n = 10$). One of the themes was "Drawing Close," which discovered tight bonds formed between the patient and nurse, with a subtheme: "Spiritual care is a way of being" (Deal & Grassley, 2012, p. 474). To practice holistically, the nurse needs to know how to respond therapeutically to the spiritual realm while also being able to attend to the needs of one's body and mind.

Nurse as channel, demonstrates caring presence and listening. Nurse as channel means actively connecting with the patient to create a caring, healing presence to facilitate spiritual well-being. This is the nurse's intention, but it is unclear whether the patient is receiving this information. Monareng (2012) and Como (2007) found caring presence to be a main attribute of spiritual care. Lane refers to this as being hospitable (1987). This environment created by the nurse includes "...love, hope, and compassionate caring" (Burkhart & Hogan, 2008, p. 931). Spiritual care interventions can include creating comfortable environments; creating a "holy atmosphere" (Deal & Grassley, 2012, p. 474); and quiet environments (Baldacchino, 2006). In a qualitative study with emergency room nurses ($n = 10$), one participant described caring presence and listening by creating a comfortable environment for a patient who suffered an abdominal aneurysm, who was not cleared for the operation, and who was asking if he was going to die, by moving him to a peaceful spot, dimming the lights, and sitting with him (McBrien, 2010). The Taylor et al. (2014) phenomenological study with nurses

found Christian nurses describing this companionship of providing spiritual care as a response to God, and to spread his love using abstract terms such as “connector,” “witness,” “instrument,” and “channel” to describe their caring presence (p. 2616).

This caring presence can include silence (Como, 2007; Giske & Cone, 2012); sitting with the patient (Deal & Grassley, 2012; Giske & Cone, 2012; Wright, 2008); touch (Belcher & Griffiths, 2005; Giske & Cone, 2012; Nardi & Rooda, 2011); holding hands (Deal & Grassley, 2012; Giske & Cone, 2012); and eye contact (Deal & Grassley, 2012; Giske & Cone, 2012). Spiritual care interventions include therapeutic communication such as listening and reflection (Belcher & Griffiths, 2005; Como, 2007; Giske & Cone, 2012; Wallace et al., 2008; Wright, 2008). Nurse as spiritual companion can include spiritual interventions such as pausing, sitting in chair, making eye contact, listening to patient, and/or providing a comforting touch.

Promoting connections with self/reflection/meaning and purpose. Spiritual care promotes meaningful connections to intentionally search for meaning in situation (Burkhart & Hogan, 2008). This includes acknowledgement (Wright, 2008), listening to stories (Belcher & Griffiths, 2005; Como, 2007; Giske & Cone 2012), and probing/exploring one’s meaning and purpose in life (Belcher & Griffiths, 2005; Deal & Grassley, 2012; Monareng, 2012; Puchalski, 2012; Wallace et al., 2008; Wright, 2008) about one’s fear and concern (Baldacchino, 2006; Wallace et al., 2008); and inquiring about one’s coping methods during stressful times or with sickness (Puchalski, 2012). Therapeutic communication is necessary in providing spiritual care. Watson (2008) discusses this activity as using silence to give the patient time before expressing their thoughts. Spiritual care interventions that promote connections with oneself require the nurse to give complete attention to the patient’s sharing of what is meaningful to them, while

responding therapeutically and without judgment. This spiritual care intervention includes demonstrating a caring presence and listening, exploring patient's concerns, stating a supportive statement, and/or what is important to them without interfering with the process.

Connecting to meaningful experiences. Meaning is derived from life experiences, which occur in the past, present or future. Reflecting on past experiences can give meaning. Particularly for veterans, veteran spiritual interventions include time to reflect on war experiences and connecting to sources of love and support (Chang et al., 2012). This can include connecting the veteran to past wartime experience and present civilian experiences through the reflective process. Hobbs, a veteran and APN, highlights that the veteran culture has a unique communication style all their own, with emblems and places to socialize (2008). Initiatives have been taken to thank the veterans for their service. Robert A. McDonald, Secretary, Department of Veterans Affairs stated, "Our nation's Vietnam War commemoration is a long-overdue opportunity for all Americans to recognize, and thank our Vietnam Veterans and their families for their service during one of America's longest wars" (Petersen, 2016, para. 3). There is a structured program entitled *We Honor Veterans* in collaboration with the National Hospice Palliative Care Organization that highlights the importance of thanking a veteran for their service, especially at the end-of-life, which also provides a list of best practices when holding an event for a veteran (National Hospice and Palliative Care Organization, n.d.). Gratitude is a spiritual practice (Como, 2007). It is also important to plan for future meaningful experiences (Burkhart & Hogan, 2008; Wallace et al., 2008). This discussion includes listening to what the patient hopes for, which may include future plans or trips that are meaningful.

Connecting to nature/music/arts. Spiritual care interventions can include connecting to nature and the arts (Belcher & Griffiths, 2005; Burkhart & Hogan, 2008; Como, 2007).

Connecting to nature can include going outdoors or bringing the scenery indoors. One method of bringing nature indoors to patient rooms is through the C.A.R.E.^R channel that combines nature scenes with music that can be viewed 24/7 through mediums such as televisions throughout any healthcare setting (Healing Healthcare Systems, 2016). The C.A.R.E.^R channel is currently used in over 800 healthcare centers and is associated with decreasing stress, anxiety, and improving patient satisfaction rates (Healing Healthcare Systems, 2016). The VA (Veteran's Affairs) hospital used for this study site offers the C.A.R.E.^R channel. Patients may also bring in their own music. Spiritual care can include inquiry into patient's music preferences, and/or connecting them to their music devices such as to headset/earplugs. Music and nature have benefits for patients in healthcare settings.

In a qualitative grounded theory study with cancer patients ($N = 52$) on music's role pre- and post-cancer diagnosis, participants found music as supporting one's spirituality and beneficial to stress reduction associated with the medical treatment (Ahmadi, 2013). Some participants discussed positive spiritual benefits such as promoting peace and reflecting one's religiosity (Ahmadi, 2013). A qualitative, explorative study conducted by Monareng (2013) in South Africa with nurses, ($n = 4$ individual and $n = 28$ in focus groups) explored how the nurse describes and provides spiritual care. A common spiritual care intervention provided by nurses was "singing spiritual songs" as a means to provide comfort (Monareng, 2013, p. 4). Music, song, and art remain in the literature as spiritual practices (Como, 2007). Research supports

music as a coping strategy during illness, and some nurses consider singing to their patients' spiritual care.

Connecting to the arts. Spiritual care interventions can include connecting one to the arts (Belcher & Griffiths, 2005; Burkhart & Hogan, 2008; Como, 2007; Deal & Grassley, 2012; Mitchell et al., 2006), and/or reciting mantras, dance, and yoga (Quinn, 2014). Hurdle and Quinlan (2014) in a qualitative study with professional artists ($n = 12$) who performed in a hospital's healing arts program discovered the arts provided "respite" for patients, families, and staff (p. 80). The healing arts program also changed the hospital environment to be more inspiring and promoted connections (Hurdle & Quinlan, 2014). It was found that the nurse was key to facilitating the healing artist's encounter, or connection, to the patient (Hurdle & Quinlan, 2014). Hurdle and Quinlan (2014) align Watson's transpersonal caring theory to the healing arts as impacting both the nurse and patient. The nurse facilitates, makes the connection to the healing arts for the patient, yet the nurse also benefits from the healing art's effect in reducing work stressors or emotional pain (Hurdle & Quinlan, 2014). The healing arts in healthcare have a positive impact on patients, visitors, and staff.

Connecting to sources of support. Spiritual care interventions include connections to resources that promote hope (Baldacchino, 2006; Burkhart & Hogan, 2008; Deal & Grassley, 2012; Wallace et al., 2008; Wright, 2008), and provide support (Monareng, 2012; Wallace et al., 2008). TJC acknowledges the importance of connecting patients to sources of support as they encourage patients at end-of-life to identify a support person who would provide comfort, and also to inform staff of the person designated to make decisions for them (The Joint Commission [TJC], April 3, 2014). This can include support groups, prayer groups, a spiritual

leader, and also referrals for ethical concerns (Quinn, 2014). Dunn, Handley, and Dunkin (2009) in a descriptive, correlational study on spiritual perspectives and spiritual well-being with RNs ($n = 33$) from a mother/baby hospital unit found spiritual care interventions included phoning support persons such as their families and pastors. Connecting patients to sources of support is spiritual care.

Connecting to pets. Spiritual care interventions can also include connecting patients to animals (Smyth & Allen, 2011; Quinn, 2014). Havey, F. R. Vlasses, P. H. Vlasses, Ludwig-Beymer, and Hackbarth (2014) in a retrospective study with post-op joint replacement patients ($n = 46$, both groups) found Animal-Assisted Therapy (AAT) decreased the use of pain medication in patients receiving AAT as compared to patients not receiving AAT ($p = 0.007$). AAT is a volunteer program that brings trained animals approved to serve as a companion to promote well-being (Havey et al., 2014). Sources of support are personal and can include family, friends, support person, groups, and pets.

Connecting with higher power/faith rituals. Spiritual care interventions include connecting patients to faith traditions (Belcher & Griffiths, 2005; Burkhart & Hogan, 2008; Deal & Grassley, 2012; Wallace et al., 2008) and to religious texts (Como, 2007; Deal & Grassley, 2012; Monareng, 2012, 2013; O'Brien, 2011; Shelly, 2000), as well as honoring time and space for prayer (Belcher & Griffiths, 2005; Como, 2007; Deal & Grassley, 2012; TJC April 3, 2014; Mitchell et al., 2006), and use of rosary (Mitchell et al., 2006). Rituals are also important including use of special clothing at time of death (TJC, April 3, 2014), and habits of praying, meditating, or yoga (Como, 2007; Puchalski, 2012). Experts in spiritual care (interdisciplinary team) such as chaplains or pastoral care can facilitate connection to a Higher

Power (Baldacchino, 2006, 2010; Deal & Grassley, 2012; TJC, April 3, 2014; Puchalski, 2012). TJC suggests consulting with a chaplain for spiritual assessments and inquiry into helpful modalities to help with relaxation and dealing with health situations (TJC, April 3, 2014). Dunn et al. (2009) discovered spiritual care from nurses on the mother/baby hospital unit included reading scripture, praying, baptizing babies, and connecting to a chaplain. Connecting one to their Higher Power/faith rituals is individual and may or may not include religion.

Positive or Negative Immediate Emotional Response

There are positive and negative consequences related to the phenomenon of providing spiritual care. Providing spiritual care is an intimate relationship where both the patient and nurse are impacted (Burkhart & Hogan, 2008; Deal & Grassley, 2012). The following sections describe both positive and negative consequences to providing spiritual care in nursing practice for both patients and nurses.

Positive consequences of providing spiritual care for nurses. Ramezami et al. (2014) found in a concept analysis on spiritual care using over articles ($n = 150$) and books ($n = 7$), positive consequences of providing spiritual care for nurses included greater spiritual consciousness and work satisfaction. Consequences for patients included “healing, greater spiritual well-being, psychological adaptation, and patient satisfaction” (Ramezami et al., 2014, p. 216). In a grounded theory study with nurses, providing spiritual care was found to be a rewarding part of being a nurse (Burkhart & Hogan, 2008). According to Puchalski (2012), “Spirituality is what can lead to restoration of health for the patient and restoration of professional call for the clinician” (p. 197). There are benefits to providing spiritual care for patients and nurses.

Negative consequences in providing spiritual care for nurses. Research has shown that providing spiritual care can lead to emotional exhaustion. Research has demonstrated emotional drain in nurses caring for dialysis patients who are angry and have spiritual distress (Deal & Grassley, 2012). Due to the taxing nature of tending to patients' spiritual distress, caring for these individuals can lead to nurse spiritual distress, compassion fatigue, and burnout (Deal & Grassley, 2012). With the nature of close human connection in nursing, nurses are at risk for compassion fatigue and burnout in any area of nursing (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Neville & Cole, 2013). Deal and Grassley's (2012) research with nephrology nurses who identified risk for burn-out emphasized nurse self-care as essential to reduce burn-out. Some of their recommendations included "critical incident stress debriefing, grief support, prayer, personal reflection, and meditation" (Deal & Grassley, 2012, p. 479). Providing spiritual care has both positive and negative outcomes for both the patient and nurse. Reflection is essential.

Nurse spiritual growth and compassion satisfaction. Neville and Cole (2013) performed a nonexperimental, descriptive, correlational study with nurses from a community hospital ($n = 214$). Two tools were used: The Professional Quality of Life Scale (ProQOL-R-V) has three subscales—Compassion Fatigue (CF) ($\alpha = .77$); Burnout (BO) ($\alpha = .71$); and compassion satisfaction (CS) ($\alpha = .91$) (Stamm, 2010)—and the Health-Promoting Lifestyle Profile II ($\alpha = .94$) (unpublished) (Walker & Hill-Polerecky as cited in Neville & Cole, 2013). Findings showed a strong correlation between the nurses' personal growth in spirituality and compassion satisfaction ($r = 0.53, p < .001$), and inversely related to burnout ($r = -0.50, p < .001$) (Neville & Cole, 2013). This research supports the importance of the need for nurses to

also facilitate their own spirituality as a way to promote health, strengthen job satisfaction, and decrease burnout and compassion fatigue (Neville & Cole, 2013). It is also important for nurses to tend to their own spirituality.

Search for Meaning in Encounter to Promote Spiritual Well-Being

Reflective practice is a method used to process one's emotions after providing spiritual care to promote nurses' spiritual well-being (Burkhart & Hogan, 2008). A study with pre-licensure and graduate students has shown a correlation between emotional intelligence and spiritual well-being, supporting reflective practice in nursing education (Beauvais, Stewart, & DeNisco, 2014). Beauvais et al. (2014) performed a descriptive correlational design measuring the relationship between emotional intelligence and spiritual well-being using a secure website for data collection with nursing students (pre-licensure and graduate) ($n = 124$). The researchers found a relationship between Emotional Intelligence (EI) and Spiritual Well-Being (SWB) (Beauvais et al., 2014). More specifically, for pre-licensure and graduate nursing students there was a significant correlation between "managing emotions" and existential well-being ($r = .308, p < .001$), and overall SWB ($r = .191, p = .034$) (Beauvais et al., 2014, p. 169). The authors concluded that providing spiritual care in nursing has a progressive impact on the nurse, which affects their emotional and spiritual energy levels, suggesting that these spiritual encounters affect the nurses' overall SWB (Beauvais et al., 2014). The authors conclude that spiritual care education in nursing should include processing of emotions to teach spiritual care and enhance spiritual well-being (Beauvais et al., 2014). The authors also point out that reflective practice is often included in spiritual care education programs (Beauvais et al., 2014). Improving RN ability to provide spiritual care while attending to their own spiritual well-being

through reflective practice, promotes providing patients the spiritual care they need (Burkhart & Hogan, 2008).

Spiritual Care Education

Another body of spiritual care literature relates to nursing education. These research studies develop spiritual care programs and measure the effectiveness of those programs. The majority are stand-alone courses that consist of 6–10-week immersions or a semester class. Thirteen spiritual care education programs used various methods, which included retreats, face-to-face courses, online courses, in-service, self-study, simulation, and an experiential study in Lourdes, France. These programs were all different time frames ranging anywhere from 45 minutes, to 90 minutes, two hours, three hours, twelve hours, twenty-seven hours, twenty-nine hours, and a six-day mission trip. Recurring content in the programs included the following: religion/ spirituality definitions (7); reflection (10); spiritual self-assessment (6); patient spiritual assessment (6); use of different types of spiritual assessment forms (4); NANDA-I diagnosis (spiritual well-being and spiritual distress) (4); Scripture/Judeo-Christian (3); and care-mapping (1). Some of these spiritual care pedagogies were threaded through the course and clinical curricula. Of the 13 programs, 11 of the programs were evaluated with psychometrically supported instruments and demonstrated significant findings. Other programs evaluated student success based on specific course assignments meeting program objectives. Some of the educational programs were funded by a grant. The following describes each program and method of evaluation for pre-licensure and practicing nurses.

Pre-licensure Spiritual Care Educational Programs

Pre-licensure programs reviewed in the study included retreats, courses, course work

within another course, simulation, self-study, and mission trips, which will be described.

Retreat and online pedagogy clinical course. This spiritual care educational program consisted of a retreat pedagogy along with an online clinical component. Burkhart and Hogan's (2008) SCiNP theory was used to create the "*Spiritual Care Educational and Reflective Program*" (SCERP) (p. 317). SCERP is a six-week program that was created by both nursing and pastoral care faculty and included one full day retreat with experiential, group discussion, and reflection using the Ignatian Examen method (Burkhart & Schmidt, 2012, p. 316). A private university portal site was created for online weekly reflection of a spiritual care encounter with feedback from faculty and fellow classmates. The educational program concluded with a half-day retreat (Burkhart & Schmidt, 2012). In a pre-post randomized control trial (RCT) measuring the effectiveness of the program with senior nursing students ($n = 59$) run concurrently with the capstone clinical experience found the program statistically significantly increased student nurses' perception of providing spiritual care and use of reflective practices using the Spiritual Care Inventory (SCI) ($p < .01$) and Spiritual Care in Practice (SCIP) tools ($p < .05$) (see Table 1) (Burkhart & Schmidt, 2012). Previous research using factor analysis supported the subscales of the tools as described earlier in this chapter (Burkhart et al., 2011).

Spiritual care education program and clinical component. A pilot program, entitled "*Spirituality in Nursing*," included a half-day class was led by Sr. O'Brien and a chaplain for support, plus weekly spiritual care content for ten weeks during clinical (Lovanio & Wallace, 2007, p. 44). The program incorporated Callister, Bond, Matsumura, and Mangum's (2004) spiritual care model that threads the AACN's Essentials of Baccalaureate Education for

Professional Nursing into education (Lovanio & Wallace, 2007). Each student was assigned a specific resident in a long-term care facility with specific spiritual care interventions to use, which included connection to self, nature, arts, and higher power through reflection, walking outside, music, and faith traditions/praying (Lovanio & Wallace, 2007). This program used a video in place of the live course for two of the students. Journaling was used for reflection and as a form of evaluation. Students were assigned readings and care planning assignments using NANDA-I. A pre-post test design with nursing students ($n = 10$) revealed a significant increase ($p = .018$) in spiritual care knowledge using the Spirituality and Spiritual Care Rating Scale (SSCRS) (see Table 1) (Lovanio & Wallace, 2007).

Spiritual care education seminar and clinical component. Hoffert et al. (2007) developed a 90-minute seminar, “*Spirituality in Nursing*,” guided by Watson’s caring theory to teach student nurses how to overcome the top four barriers to assessing one’s spirituality (p. 67). These barriers identified the following: role ambiguity; uncertainty of own spiritual beliefs; lack of “religion” and “spirituality” concept clarity; and uncomfortable assessing spirituality using current methods (Hoffert et al., 2007, p. 66). The intervention was held with junior nursing students during the first four-week clinical gerontology rotation ($N = 54$). This intervention included the 90-minute seminar, an initial self-spiritual assessment, and measuring perceived comfort and ability in performing a spiritual assessment, with supported psychometrics (Hoffert et al., 2007). The student nurses performed a spiritual assessment on a patient during the four-week clinical rotation using the Client Spiritual Assessment Tool (CSAT) also developed for this study (Hoffert et al., 2007). The pre-post design measuring the student nurses’ ($n = 38$) comfort with conducting a spiritual assessment showed a statistically

significant improvement in the student nurses' "knowledge" and "comfort" ($p < .001$) (Hoffert et al., 2007, p. 70).

Spiritual care content integrated into junior and senior year curriculum. A spiritual care education program integrated into junior and senior year's curriculum was designed after six faculty members attended a weekend, off-site education program at Harvard, entitled "*Spirituality in Healthcare*" (Wallace et al., 2008, p. 4). The revisions to the curriculum included spirituality objectives to every course with junior year focused on spiritual concept definitions, assessment, evaluation and scholarly reading (Wallace et al., 2008). Senior year curriculum focused on a weekly two credit hour theory class, "*Professional Nursing: Leadership & Management*," and one credit hour clinical (Wallace et al., 2008, p. 4). Spiritual content included the nursing process, nurse-patient relationship, and learning how to provide spiritual care even when busy (Wallace et al., 2008).

The program was evaluated using a pre-post test design with junior ($N = 33$) and senior ($N = 34$) nursing students measuring the effect of the curriculum on "nursing student's knowledge about spirituality and spiritual care" using the Spirituality and Spiritual Care Rating Scale, (SSCRS) (Wallace et al., 2008, p. 6) (see Table 1). The pre-post test scores demonstrated a statistically significant increase in "spirituality knowledge and attitudes" only for the senior students ($p = .004$) (Wallace et al., 2008, abstract). This study demonstrated the importance of faculty preparation to enhance spiritual care education.

Staggered start control and intervention competency course. Van Leeuwen et al. (2008) created a spiritual care course using a quasi-experimental (staggered starts/three time points) crossover design (pre-post test) with a sample of ($N = 97$) nursing students from two

Christian schools in the Netherlands (intervention group $n = 49$; control group $n = 48$) (p. 2776). The variables measured were the effect of the course on student nurse perceived spiritual care competencies using the Spiritual Care Competence Scale (SCCS), plus an additional questionnaire about the participant's own spirituality, religiosity, life reflection, and perspective of holistic nursing care. The intervention group participated in the 6-week spiritual care course that included concepts, interviewed a chaplain, communication skills, assessment, and reflection, and had clinical while the control group did not participate in this class.

Both groups took the SCCS pre-intervention. At six weeks both intervention and control groups repeated the SCCS and analyzed two vignettes (religion focus and spiritual focus) created to determine any difference between the groups competence in assessment of "spiritual needs" (van Leeuwen et al., 2008, p. 2776). The intervention group demonstrated a statistically significant increase in spiritual care nursing competencies ($p < .05$) (see Table 1) (van Leeuwen et al., 2008, p. 2775). The groups demonstrated no statistically significant difference in the spiritual vignette, but there was a statistically significant increase in scores for the religious vignette (van Leeuwen et al., 2008, p. 2778). The study was designed with a staggered start for the control group, who started the program during the 14th week. This study indicates a spiritual care program can improve student's spiritual care competencies.

Mission trip. Baldacchino's (2010) descriptive exploratory study evaluated the effect of a six-day Lourdes mission trip with student nurses ($n = 7$), which included a 10-hour theory class, "*Spirituality for Health Carers*" and a voluntary clinical placement (p. 358). Lourdes is a religious site located in France, and is known as the apparition site of the Blessed Mary where many tourists visit yearly (Baldacchino, 2010). Thirty-one students participated in the course.

The students are given a choice to go to Lourdes where they help care for the ill, or participate in a five-hour voluntary clinical placement. The Lourdes mission trip consisted of 33 travelers who were ill, family members, an Archbishop, a physician, nurses, the students, author, and other assistants. The seven students were given an introductory session by a physician and nurse who had previous mission experience at Lourdes (Baldacchino, 2010).

Qualitative data were collected from journal entries written during the mission trip, a reflection assignment submitted at the conclusion of the mission trip, and a focus group collected one week after the mission trip ($n = 7$). Qualitative analysis using content analysis revealed four themes: “Team building, holistic care, trustful nurse-client relationship and strengthening personal spirituality” (Baldacchino, 2010, p. 358). This faith-based pedagogy provides an experiential opportunity to provide spiritual care and includes reflective practice.

Self-study for both pre-licensure and practicing nurses. Taylor, Mamier, Bahjri, Anton, and Petersen (2008) evaluated a six-week self-study course in spiritual care, including self-reflection, meaning making, and communication strategies from a workbook titled, “*What Do I Say? Talking with Patients About Spirituality?*” with an optional DVD (p. 1134). The participants were RNs employed at a faith-based hospital and a non-faith-based hospital, and student nurses from a faith-based university and a non-faith-based university. In a pre-post test design measuring the effect of the self-study program on “attitude, ability, spiritual experience, and knowledge” participants demonstrated a statistically significant increase ($p < 0.0001$) in “attitude, ability, spiritual experience, and knowledge” measured using multiple tools ($N = 201$) (Taylor et al., 2008, p. 1131; 1135). The measurement tools were the following: Daily Experience Scale (DSES) ($\alpha = 0.92$); Spiritual Care Perspective Scale-Revised, (SCPS-R)

($\alpha = 0.75$) (see Table 1); the Response Empathy Scale (RES) scores (modified for this study with interrater reliability using two raters 0.86–0.82, and the Communicating for Spiritual Care Test (CSCT) (true/false) (Taylor et al., 2008, p. 1134). Findings indicate that self-study programs in spiritual care are effective.

Spiritual Care Undergraduate Education Without Research Component

Two educational programs were described in the literature as courses without published research support.

Integration into medical/surgical course and care mapping. Mitchell et al. (2006) integrated spiritual care education into a medical-surgical course. Content included conducting a self-spiritual assessment, performing spiritual assessments on patients, and developing three care maps for end-of-life patients based on NANDA-I. Competent spiritual care knowledge was evaluated based on completing three care maps for patients in the clinical setting (Mitchell et al., 2006). This program introduced a variety of teaching modalities to teach spiritual care.

Judeo-Christian content, case study, and patient interview. Baldacchino (2008) spiritual care education program for fourth-year diploma nursing students in Malta consisted of a two-hour course per week for eleven weeks aligned with clinical, closing with a seven-hour session with a chaplain in attendance ($n = 65$) (Baldacchino, 2008). The program included a variety of teaching tools such as case studies, small groups, and self-reflection with Judeo-Christian content, guided by prior nursing education programs including the “ASSET” model created by Narayanasamy (1999). The “ASSET” model is a spiritual care nursing education program that includes knowing oneself and the nursing process (Narayanasamy, 1999, p. 276) The success of Baldacchino’s (2008) program was based on the student passing a clinical case

study presentation and patient interview to assess for spiritual distress and ability to cope. The patient interview was conducted using Baldacchino's (2003) "Use and Helpfulness of Spiritual Coping Strategies" (as cited in Baldacchino, 2008, p. 558). Baldacchino (2008) found the group too large, labor intensive, and the case studies challenging to grade. This study suggests smaller cohorts and/or more faculty participation with implementation of this spiritual care pedagogy.

Post Licensure Spiritual Care Hospital Education

Hospital-based two-hour in-service. Two in-services in the literature were given to practicing nurses in the hospital setting. Cerra and Fitzpatrick (2008) conducted an exploratory pilot pre-post design spiritual care education study with post-licensure nurses with hospital RNs from medical/surgical and cardiac departments measuring effect on SWB and spiritual perspectives of nurses ($N = 41$). The two-hour presentation was modeled after Narayanasamy's ASSET (1999) model, which included content related to knowing oneself, spirituality, and elements of spiritual care presented in a lecture format with personal examples (Cerra & Fitzpatrick, 2008). The authors found a statistically significant increase ($p < .0005$) in nurses' spiritual perspectives measured using Reed's Spiritual Perspective Scale (1986, 1987) but not in spiritual well-being using the Spiritual Well-Being Scale (SWBS) (see Table 1) (Cerra & Fitzpatrick, 2008). Participants who went to a faith-based school had significantly higher existential well-being (EWB) pre-post change scores ($p < 0.001$) ($n = 7$) (Cerra & Fitzpatrick, 2008). This two-hour hospital in-service pedagogy supports the ability to effect change in practicing nurses' spiritual perspectives in a short time frame.

Forty-five-minute hospital-based in-service. Linegang (2014) conducted a quasi-experimental pilot pre-post design, 45-minute scripture-based spiritual care hospital in-service

with pediatric nurses ($n = 32$). This in-service was given by faculty from a university using Dr. Sharon Christman's "*Faith-Hope-Love Model of Spiritual Care for Nurses*" in program (Christman & Mueller, 2017; Linegang, 2014, p. iii). The Van Leeuwen et al. (2008, 2009) Spiritual Care Competence Scale (SCCS) was used to measure effect of educational programs on competence with "communication, assessment and implementation of spiritual care, personal support, patient counseling, professionalization and improving quality of spiritual care, attitudes toward patient's spirituality, and referral" (see Table 1) (Linegang, 2014, p. 19). A significant increase was found for communication ($p < 0.01$); assessment and implementation of spiritual care ($p < 0.01$); personal support and patient counseling ($p < 0.01$); professionalization and improving quality of spiritual care ($p < 0.01$) (Linegang, 2014, p. 19-20). The two variables that showed non-significant pre-post change scores were: attitudes toward patient's spirituality and referral (Linegang, 2014, p. 19). This 45-minute hospital in-service pedagogy supports the ability to effect change in some spiritual competencies of practicing pediatric nurses as measured by the SCCS in a short time frame.

Simulation

This section will provide an overview of simulation as an evidence-based pedagogy, a discussion of the International Nursing Association for Clinical Simulation and Learning (INACSL) best practices, SP guidelines, and the Plus-Delta debriefing to support this research study. In addition, two spiritual care research studies using an SP and one simulation specifically designed to teach nursing students unique care needs of veterans will be presented.

Clinical Simulation as an Evidence-Based Pedagogy

Simulation is an evidence-based pedagogy used in nursing education that creates an

interactive, safe environment that reflects real patient scenarios and uses all three domains of learning (Meakim et al., 2013). The three domains include “cognitive (knowledge), affective (attitude), and psychomotor (skills)” (INACSL Standards Committee, 2016b, p. S26). Cant and Cooper (2010) in a systematic review of quantitative simulation education using medium to high-fidelity manikins in nursing found simulation to be a “valid teaching/learning” method in all studies reviewed when following best practices ($N = 12$) (p. 3). Hayden, Smiley, Alexander, Kardong-Edgren, and Jeffries’ (2014) landmark National Council of State Boards of Nursing (NCSBN) research study used a randomized control longitudinal multi-site design to examine whether clinical simulation could be a substitute for clinical instruction in pre-licensure nursing programs (p. S6). The sample was obtained from ten pre-licensure nursing schools (five associate degree (AD) and five baccalaureate degree (BSN) with randomization into one of three groups (Hayden et al., 2014, p. S6). The control group had the usual clinical experience, and was allotted up to 10% for simulation, the second group had one-quarter of clinical time substituted by simulation, and the third group had half of their clinical time substituted by simulation (Hayden et al., 2014, p. S3).

Hayden et al. (2014) in a sample of first year nursing students ($n = 666$) found there was no statistically significant difference in “clinical competency as assessed by clinical preceptors and instructors” ($p = .688$); “comprehensive nursing knowledge assessments” ($p = .478$); or “NCLEX^R pass rates” ($p = .737$) when using simulation for “up to half of traditional clinical hours” (p. S3). This study supports simulation as an effective pedagogy. Following the NCSBN study, simulation guidelines were written for pre-licensure schools of nursing, including the INACSL best practices (Alexander et al., 2015; INACSL Standards Committee, 2016c, p. S3).

INACSL Best Practice Standards

INACSL is a professional simulation nursing organization whose mission is to improve nursing practice and patient safety using evidence-based standards for simulation (International Nursing Association for Clinical Simulation and Learning [INACSL], 2015b). The first INACSL standards were published in 2011 based on a review of the literature, best practices, and responses from those with INACSL membership and simulation experts. Today, INACSL established a Standards Committee consisting of experts chosen based on criteria (International Nursing Association for Clinical Simulation Learning [INACSL], 2015a). The revised INACSL Standards of Best Practice: SimulationSM includes eight standards: “Simulation design; outcomes and objectives; facilitation; debriefing; participant evaluation; professional integrity; simulation-enhanced interprofessional education; and simulation glossary” (INACSL Standards Committee, 2016d, p. S48). The INACSL standards provide guidance for the entire clinical simulation process and are supported by the evidence.

Use of a Standardized Patient

A standardized patient (SP) is defined as: “a person trained to consistently portray a patient or other individual in a scripted scenario for the purposes of instruction, practice, or evaluation” (by Robinson-Smith, Bradley, and Meakim, 2009, as cited in Meakim et al., 2013, p. S9). Standardized patients are recommended over a manikin when education is focused on verbal and non-verbal responses (Sideras et al., 2013). Standardized patients help provide assessments of human-to-human communication and social skills (Dhingra & Kerns, 2012). Standardized patients also allow students to experience and receive immediate face-to-face feedback on the patient’s perception of both their verbal and non-verbal behaviors, which can

enhance the student's way of being in the future (Hargraves, 2012). Research conducted by Fink, Linnard-Palmer, Ganley, Catolico, and Phillips (2014) has shown SPs are effective in teaching spiritual care in simulation.

Clinical Simulation Standardized Patient and Debriefing

Debriefing allows for reflective practice of emotions and feedback after the simulation (INACSL Standards Committee [INACSL], 2016a). The 2003/2006 NLN/Laerdal study recommends debriefing time should equal amount of simulation time (Jeffries & Rizzola, 2006). There are seven debriefing methods cited in the INACSL standards of best practice (INACSL Standards Committee [INACSL], 2016a). The Plus-Delta (+/Δ) method is a recommended INACSL debriefing method (INACSL Standards Committee [INACSL], 2016a). When used in simulation debriefing, the Plus-Delta allows for reflection of the things that went well in the simulation (+) column, and anything that might be changed in the (Δ) column. The debriefing should include both positive and helpful feedback and refer back to specific occurrences (Onori, Pampaloni, & Multak, 2012).

Simulation Used in Research

The focus of this literature review is to summarize the literature using simulation for research purposes. The following section will describe and evaluate the process of simulation development and report measurement strategies of spiritual care simulations found in the literature.

End-of-Life Spiritual Care Simulation With Standardized Patient

Fink et al. (2014) performed a quasi-experimental pilot study on end-of-life spiritual care with junior nursing students (control & intervention group) using a SP to measure the

effects of three 45-minute simulation scenarios, each reflecting a different religion (Catholic, Judaism, Islam) ($N = 54$). There were several steps in conducting this study: development of the simulation, training the SP, developing the Spiritual Care at the End-of-Life Questionnaire, data collection during the simulation study, and data analysis. The intervention group consisted of first semester students who participated in three 45-minute end-of-life simulations using an SP and real-life clergy portraying the role of clergy and visitor ($n = 30$) (Fink et al., 2014). The control group, second semester students did not participate in the three-simulation intervention ($n = 24$) (Fink et al., 2014). The following describes the phases of the study.

Development of simulation. The three end-of-life scenarios were created together by nurse educators and members of the specific faith tradition and reviewed by pastoral experts (Fink et al., 2014). Use of content experts to design simulation scenarios follows INACSL Standards of Best Practice: SimulationSM Standard IX: Simulation Design (Lioce et al., 2015). The 45-minute scenario depicted an elderly woman with terminal cancer with an ethical issue involving a disagreement between her son who “held the advance directive” and wanted all measures taken to continue medical care, whereas her daughter who had a close bond with the mother wanted to let the patient die peacefully (Fink et al., 2014, p. 561). The SPs had experience with the process, were given a script and taught how to appear as an end-of-life patient. Religious experts, dressed in their religious clothing, helped set up the scenarios with authentic religious items pertinent to each faith tradition, and played the clergy role visiting with the patient and families (Fink et al., 2014). This supports fidelity with true-to-life scenarios which is included in the INACSL Standards of Best Practice: SimulationSM Standard IX: Simulation Design (Lioce et al., 2015).

Development of questionnaire. Team members created the Spiritual Care at the End-of-Life Questionnaire for this study to evaluate the participants' "knowledge and confidence in providing spiritual care to religious patients at the end-of-life" (Fink et al., 2014, p. 562). Each member of the research team developed items to measure knowledge, ultimately selecting 15 items that encompassed the learning objectives, with content and face validity measured by three faith tradition experts (Fink et al., 2014). The content and face validity was an iterative process with three occurrences (no formal content validity index process identified), which included hand-written responses followed with a review by a doctorally prepared expert researcher (Fink et al., 2014). The article did not identify the process each expert used to develop his or her items, or how many of the 15 items selected for the questionnaire were created from nursing or the pastoral research team member.

Experimental study. Each group consisted of six to eight students that rotated through each faith tradition section (Fink et al., 2014). The section started with a short lesson on the faith tradition from the religious expert, followed with the clergy entering the patient's room for a "religious consultation," and then a "follow-up family meeting" (Fink et al., 2014, p. 562). It is not clear if the faith tradition education was considered part of the 45-minute simulation. The family meeting was scripted and described the family dilemma between the patient's children with a plan for the patient. Debriefing occurred with the experts and participants for roughly 15-20 minutes about ways to intensify emotional relief for the patient. There was time for the participants to ask questions.

Evaluating use of best practices. Fink et al. (2014) describe three sections to the simulation including information sessions at three different stations, time with patient, and a

family post-conference stating each scenario lasted 45-minutes. It is not clear how long the debriefing was, as the article states “an additional 15 to 20 minutes” (Fink et al., 2014, p. 562). INACSL Standards of Best Practice: SimulationSM Standard VI: The Debriefing Process recommends the possible need for longer debriefing when the scenario is complex or emotional (Decker et al., 2013). It is not clear from the pilot study whether the SP was part of the debriefing (Fink et al., 2014).

Data analysis. The data showed the intervention group had a statistically significant higher score than the control group on the pre-post scores on “perception of knowledge and skill” ($p < .001$) with a statistically significant higher score pre-post in “actual knowledge” ($p = .04$) using a newly developed Spiritual Care at the End-of-Life Questionnaire ($\alpha = .76, .79$) (Fink et al., 2014, p. 564). A Visual Analog Scale (VAS) from 0 mm (no confidence) to 100 mm (very confident) was used to measure self-confidence with providing care for a terminal patient (VAS1), and confidence with providing care to someone with a different faith tradition (VAS2). There were statistically significant increases for the intervention group in both variables in comparison to the control group: VAS1 ($p = .001$) and VAS2 ($p = .005$) (Fink et al., 2014, p. 564). Satisfaction scores were obtained from the intervention group ($n = 12$) using a 10-item survey taken via Survey Monkey with almost 84% students responding to the SP presented a true-to-life experience during the simulation, and results suggested participation in the program was helpful (Fink et al., 2014). The spiritual care simulation intervention with an SP was an effective methodology.

Mother/baby spiritual care simulation. Costello, Atinaja-Faller, and Hedberg (2012) developed a quasi-experimental pre-post test pilot study, evaluating a 2-hour simulation with

nursing students during their mother/baby course measuring perception of competency in the provision of spiritual care pre-post simulation using the Spiritual Care Competence Scale (SCCS) ($N = 52$) (see Table 1). There were several steps discussed in conducting this study, which is described below.

Pre-simulation and prebriefing content. One-week prior to the actual simulation day, the students received a scenario mapping and the “details” of the scenario (Costello et al., 2012, p. 279). The simulation prebriefing included spiritual care education, which included the TJC spiritual care behavioral assessment tool sample questions, case studies, discussions of self-awareness, and cultural care (Costello et al., 2012).

Simulation scenario. Faculty and students performed the spiritual care scenario (Costello et al., 2012). The patient described in the simulation scenario was a young, single mom who just gave birth and had no social support. Her 18-month old son recently died after falling from an apartment window. The patient currently lived in a homeless shelter and had no contact with family for more than a year (Costello et al., 2012).

Evaluating use of best practices. The Costello et al. (2012) study incorporated several INACSL Standards of Best Practice: SimulationSM Standard IX: Simulation Design such as participant preparation, prebriefing, and fidelity, although they did not identify each INACSL standard specifically (Lioce et al., 2015). These best practices recommended were reflected in the Costello et al. (2012) study in that the students received the scenario one week prior, there was prebriefing, and fidelity existed as the patient had realistic spiritual needs, TJC spiritual assessment reference tool was included, and there was a discussion of the chaplain’s role. It was not clear how the simulation scenario was developed or how the students or faculty were

trained to play the role of the patient. It was also not clear how the 52 students were grouped for simulation and debriefing, and there was no discussion related to length of the scenario or debriefing.

Data analysis. The pre-post test design showed a statistically significant increase in SCCS change scores in spiritual care competence from pre-intervention to post-intervention in “student’s attitudes toward patient spirituality ($p < .001$), in obtaining referrals ($p < .001$), in assessment of spiritual needs ($p < .001$), and in support ($p < .001$)” (Costello et al., 2012, p. 280).

Both spiritual care simulations described support simulation as an effective educational and research strategy.

Veteran Simulation

Anthony, Carter, Freundl, Nelson, and Wadlington (2012a) as part of a VA Nursing Academy created a simulation scenario entitled *Care of the Veteran* designed to help teach veteran-focused care to student nurses (p. e146). The objectives included performance of the nursing process, maintaining safety, and proper communication centered on caring for a veteran with multiple medical conditions in a hospital setting. The content of the simulation integrated unique experiences seen within the veteran culture such as PTSD, different military services, service-connected disability, homelessness, and suicide risk (Anthony et al., 2012a, p. e148). This simulation provided an educational experience for these conditions and highlighted supportive services available to veterans (Anthony et al., 2012a, p. e148). One teaching outcome of this simulation was also to “value the service and sacrifice of veterans” (Anthony et al., 2012a, p. e146). In addition to the simulation scenario, a Vietnam Veteran companion

checklist was created to assess student ability to meet objectives (Anthony et al., 2012b). There was no mention of spirituality or spiritual care in this simulation. The veteran culture has distinctive needs, and simulation is a pedagogy that can teach veteran centered care.

Summary

Nursing care is holistic, therefore having the knowledge and skill to tend to the body, mind, and spirit is essential to nursing education and practice. Yet, there are barriers in spiritual care nursing education and in the provision of spiritual care in nursing practice. There is a variety of effective spiritual care educational pedagogies for both pre-licensure and practicing RNs. The pre-licensure programs have a wide range in hours and are more time-consuming than those programs offered in the hospitals for practicing RNs. Reflective practice, defining the concepts of religion and spirituality, chaplain presence, and both self and patient assessment remains a theme in spiritual care educational programs. Of importance is the shorter programs offered for both students in the simulation lab and in-services for practicing RNs as effective pedagogies for spiritual care education. Simulation using an SP to teach spiritual care holds promise as a teaching strategy.

Gaps in the Literature

There are significant gaps in spiritual care education and practice, which include: evidence-based spiritual assessment tools, spiritual care simulations for veterans, and measurement tools for nurse performance of spiritual care in simulation. Each will be addressed below.

Evidence-based spiritual assessment tools. There are multiple spiritual assessment tools in healthcare, and spiritual care measurement tools available to measure aspects of

spirituality/religion in the literature. Yet, a barrier repeatedly found in the literature is in including spiritual assessment in education (Timmins et al., 2015). There was one spiritual care assessment tool (CSAT) created by a nurse in the literature that identified cues and interventions to guide student nurses with performing a spiritual assessment (Hoffert et al., 2007). However, the CSAT was not psychometrically tested, and no further published results using the CSAT exist in the literature (Hoffert et al., 2007).

Spiritual care for a veteran simulation. Veterans have unique spiritual needs (Bonner et al., 2013; Chang et al., 2012; Wynn, 2015). Simulation is an evidence-based teaching method (Meakim et al., 2013). There were no spiritual care simulations for a veteran found in the literature.

Spiritual care for a veteran nurse performance tool. There are categories of spiritual care cues and spiritual care interventions found in the literature that are universal, yet specific cultures such as veterans have unique spiritual needs. There are no tools available in the literature to measure nurse performance of spiritual care for a veteran during simulation.

Congruence in patient perceived and nurse perceived spiritual care. Literature exists presenting nurse perspectives of spiritual care and patient perspective of spiritual care, but little research exists to reconcile those perspectives. Also, separate measures for patient and nurse perceptions of spiritual care exist in the literature. However, no tool exists in the literature for measuring congruence of perception of spiritual care from both the nurse and patient perspective using simulation at the point of care.

There is a need to develop evidence-based spiritual care simulations with a companion performance checklist with psychometric evaluation. This provides an opportunity to measure

perception congruence between observers on nurse performance of spiritual care in simulation to provide insight into construct validity. This research addresses three gaps: (1) develop a spiritual care simulation for a veteran with companion performance checklist; (2) measure perception of spiritual care from three perspectives; (3) and determine whether participating in a clinical spiritual care simulation experience (prebriefing, simulation, and debriefing) following INACSL Standards of Best PracticeSM with an SP increases nurse's perceived ability to provide spiritual care. This study could fill these gaps in the literature.

CHAPTER THREE

METHOD

Introduction

The purpose of this quantitative study is to develop and psychometrically evaluate an evidence-based spiritual care simulation and companion performance checklist. The simulation and performance checklist was created to determine the congruence between independent observer (IO) observed spiritual care, RN perceived spiritual care, and patient perceived spiritual care during a spiritual care clinical scenario simulation with an SP role-playing a veteran at “risk for spiritual distress” (Herdman & Kamitsuru, 2014, p. 374). This study also investigated the effect of experiencing a spiritual care clinical scenario simulation/debriefing on RN perceived ability to provide spiritual care in practice.

The following sections explain the aims and research questions (RQ) for this study.

Aim 1: Develop a Spiritual Care Simulation and Companion Performance Checklist

RQ 1. To what degree can a spiritual care clinical scenario simulation with a standardized patient reflect evidence-based spiritual care assessments and interventions for a patient at risk for spiritual distress?

Aim 2: Determine the Congruence in Spiritual Care Provided From the Registered Nurse, Standardized Patient and Independent Observer

RQ 2.1. To what degree does observed spiritual care (recognition of patient cue and provide spiritual intervention) measured by an independent observer align with both registered

nurse and standardized patient perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

RQ 2.2. To what degree does registered nurse perceived spiritual care (recognize cue and perform spiritual intervention) align with an independent observer perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

RQ 2.3. To what degree does registered nurse perceived spiritual care (recognize cue and perform spiritual intervention) align with patient perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

Aim 3: Determine Whether Experiencing a Spiritual Care Simulation Affects RN Perceived Ability to Provide Spiritual Care

RQ 3.1. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability to provide spiritual care?

RQ 3.2. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability to provide spiritual interventions?

RQ 3.3. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability for meaning making?

The methods per aim will be discussed separately as they all differ. The Burkhart/Hogan (2008) SCiNP theory guided all three phases of the research study: simulation development, measure of perceived congruence of providing spiritual care, and the effectiveness of simulation as a pedagogy in teaching spiritual care. A substruction of the theoretical model, study variables, and operational measures outlined in this chapter are shown

below in Figure 2. The following section will also describe human subjects protection and study site.

Figure 2. Substruction: Theoretical model, study variables, and operational measures

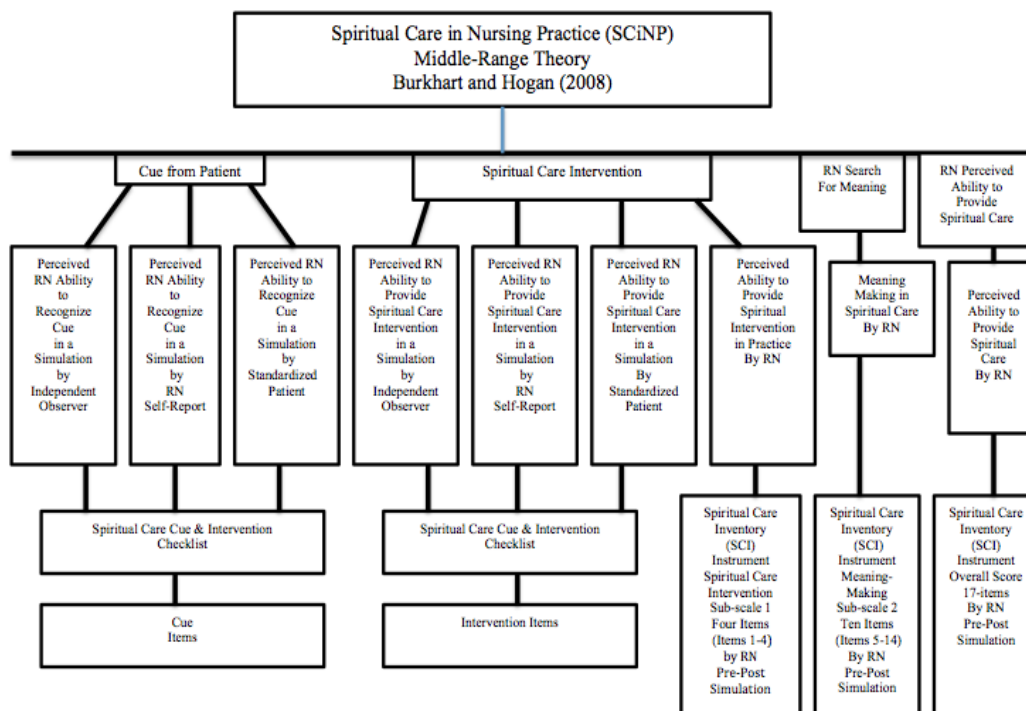


Figure 2. Theoretical model, study variables and operational measures

Human Subjects/Ethical Considerations

Institutional Review Board Approval

To protect the “safety and rights” of the participants, the proposal and amendments were submitted and approved by the Institutional Review Board (IRB) at the VA hospital and LUHS prior to beginning the study to ensure the protection of human rights (see Appendices D through L). IRB addendum approval included a request to pilot-test the spiritual care clinical scenario simulation with an RN who works in the community, two Loyola nursing clinical

faculty, and six senior nursing students who were completing their capstone Clinical Role Transition (CRT) practicum at the VA. This researcher has completed the IRB Collaborative Institutional Training Initiative (CITI) research training modules required at both the VA and LUHS (Collaborative Institutional Training Initiative, n.d.).

Participant consent process. Informed consent with RN participants was obtained using a two-step process. Initial information was provided to potential RN participants by email (see Appendix M) with researcher contact information and with a hard copy study information sheet (see Appendix N). In addition, the Chief of Education Services and Designated Learning Officer from the VA study site attended face-to-face information sessions at unit staff meetings without the unit manager present to avoid coercion. Questions were answered in person during those meetings and/or over the phone using a script as further described in the recruitment section of this chapter. The subjects were informed that they could choose to participate or not participate in the research study and that they may withdraw consent at any time without consequence. Participation or non-participation would not affect their work performance evaluation and their nurse managers would not be informed of their participation or have access to research data. The participants were also asked not to share details of the study with other RNs to minimize impacting research results. Participation occurred off work time.

The second step of the consent process occurred on the scheduled study date. This researcher reviewed the study 1:1 with each participant, provided the participant with a hard copy of the information sheet, and answered any questions. If the participant chose to participate in the study, final verbal consent was obtained at that time on the day of the simulation prior to data collection as approved by the IRB. If participants experienced an

adverse event of psychological or spiritual distress, the participant would be given contact phone numbers for the chaplain, VA Employee Assistance Program (EAP), and the Veterans' Crisis Line as stated in the IRB. No participant required or asked for additional support contact phone numbers during this portion of the study.

Study Site

Study Site and Union Approval

The study site was at a VA hospital located in the mid-western region of the United States. The VA hospital has almost 500 beds and six community-based outpatient clinics offering primary, extended, and specialized care for chronic conditions employing approximately 700 RNs. The research was conducted outside of the nurses' tour of duty (before and after scheduled work hours, not using compensation time, or during lunch time). Because the RNs are unionized, the union was notified to ensure a collaborative relationship with the nurses per VA policy. The VA study site Chief of Education Service and Designated Learning Officer initiated the union approval process per VA protocol, which included collaborating with union representatives in the Human Resources Department and submitting a letter requesting nurse participation in the study. The process included a written notification, allowing 14 days for union response. No response was received from the union, which implies approval. If there was a response, the union had 30 additional days to negotiate.

Study designs and methods differed based on the aim. Therefore, the research method will be described per research aim.

Aim 1 Methods: Simulation and Performance Checklist Development Procedure

The purpose of this aim was to create and psychometrically evaluate a simulation that included evidence-based patient cues for a veteran needing spiritual care and companion checklist that included spiritual care intervention(s) provided by nurses. The development of the spiritual care cue and intervention concepts, procedures to develop the simulation scenario and Spiritual Care Cue and Intervention Checklist (SCCL) concurrently, overview of simulation environment, SP qualifications, prebriefing, and debriefing method will be discussed. This will be followed by a description of the psychometric testing, which includes content expert and face validity selection, instrumentation, data collection, and data analysis description.

Design for Aim 1

The design for Research Question 1 was a psychometric development and evaluation of the spiritual care simulation script and companion simulation checklist. This included a literature review, script development, checklist development and psychometric evaluation.

Literature review. The initial process in this design began with a literature review for patient spiritual care cue and nursing spiritual intervention concepts as previously described in Chapter Two. Table 2 describes the concepts identified in the literature with references. The concepts relate to both patient cues and spiritual interventions. The patient cues were used to create the simulation script mapped to the spiritual care interventions used to create the checklist from the literature (Aschenbrenner, Milgrom, & Settles, 2012).

Table 2. Content Validity Evaluation of Script Cue(s) and Intervention(s)

Patient Cues for Needing Spiritual Situational Cues for Anxiety:	Spiritual Care Nursing Interventions Intervention(s) to reduce anxiety:
<p>Verbal cues: Verbalizing having a bad morning; MD delayed telling him his test results; Asks nurse if he/she knows test results; Hopes results are not bad. Cues (Belcher & Griffiths, 2005; Herdman & Kamitsuru, 2014).</p> <p>Non-verbal cues (Herdman & Kamitsuru, 2014) include: Tapping hands on tray table anxiously; wringing hands; wipes tears out of eyes.</p>	<ul style="list-style-type: none"> • Pauses (Deal & Grassley, 2012). • Makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012). • Listens to patient (Belcher & Griffiths, 2005; Como, 2007; Wallace et al., 2008; Wallace & O’Shea, 2007). • Provides a comforting touch (Belcher & Griffiths, 2005; Deal & Grassley, 2012). • May state supportive statement (Baldacchino, 2006; Belcher & Griffiths, 2005; Wallace et al., 2008). Statement such as: “This must be difficult, I’m sorry,” and/or “Is there anything I can do for you?” • “What helps you get through hard times?” (Belcher & Griffiths, 2005; Burkhart & Hogan, 2008). • Distractor item: The first includes a lack of exploration from the nurse regarding fears and concerns such as: “I don’t know the test results. The doctor will have to discuss your test results with you.” Explore fears as spiritual care (Baldacchino, 2006; Wallace et al., 2008). • Distractor item (opposite of supportive statement) from nurse: “Don’t worry, you will be fine.”

Table 2 (cont.)

Behavioral Cues for Physical Suffering:	Intervention(s) to Reduce Physical Suffering:
<p>Verbal cues: Verbalizing he had a terrible night and did not sleep. Complained the pillow is like a rock and was agitated. Requested pillow from home. Had sequential compression devices (SCDs) on. Verbalizing the SCDs bug him and he wants them off. States he will get up later. Assess cues (Smyth & Allen, 2011).</p> <p>Non-verbal cues: Had a blank stare and withdrawal. Assess non-verbal cues (Herdman & Kamitsuru, 2014; Taylor et al., 2014).</p>	<ul style="list-style-type: none"> • Attempts to provide comfort measures (McBrien, 2010). • Stopped the physical assessment or tasks (Deal & Grassley, 2012). • Makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012). • Listens to patient (Belcher & Griffiths, 2005; Como, 2007; Wallace et al., 2008; Wallace & O'Shea, 2007). • Provides a comforting touch (Belcher & Griffiths, 2005; Deal & Grassley, 2012). • May state supportive statement (Belcher & Griffiths, 2005; Wallace et al., 2008) such as: "This must be difficult, I'm sorry" (Burkhart & Hogan, 2008). • Distractor item: Offer to medicate patient with IV pain medication (patient had just received oral pain medication). This includes lack of exploration from the nurse regarding his fears and concerns. Exploration of fears (Baldacchino, 2006; Wallace et al., 2008). • Distractor item was non-therapeutic communication: The nurse continued assessment, ignores complaints or brushes off patient concerns, offers false reassurance such as, "You'll be fine."

Table 2 (cont.)

Situational Cues for Fears:	Intervention(s) to reduce fears:
<p>Verbal cues: Verbalizing he was tired (non-verbal cue was patient yawning), he heard noise in the hall at night, and was worrying about his test results. He verbalized he was afraid the results would be bad. He stated his father and brother who died of colon cancer were so sick, lost weight, were in pain, and throwing up. He verbalizes how he's uncomfortable in this place and just wants to go home. Listen (Belcher & Griffiths, 2005; Herdman & Kamitsuru, 2014; Smyth & Allen, 2011).</p> <p>Verbalizing he needs music to fall asleep stating poor sleep since Vietnam and the waiting is making it worse. Sleep cues (Smyth & Allen, 2011).</p> <p>Non-verbal cue: Headset for his music on night stand.</p>	<ul style="list-style-type: none"> • Encourages patient to talk about his fears. (e.g., asking more about his fears about test results, having cancer, father/brother cancer experience) (Baldacchino, 2006; Belcher & Griffiths, 2005; Burkhart & Hogan, 2008; Wallace et al., 2008). • Stopped the physical assessment or tasks (Deal & Grassley, 2012), makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012). • Listens to patient (Belcher & Griffiths, 2005; Como, 2007; Wallace & O'Shea, 2007; Wallace et al., 2008). Observe sleep trends (Smyth & Allen, 2011). • Offers patient music/headset (Ahmadi, 2013; Como, 2007; Deal & Grassley, 2012; Healing Healthcare Systems, 2016; Wallace & O'Shea, 2007). • Distractor item: Nurse continues assessment and tells patient she/he will request a sleeping pill order to help him sleep better at night. (Does not or stop the physical assessment as cited above). • Distractor item non-therapeutic communication: Tells patient not to worry about the family history of colon cancer.

Table 2 (cont.)

Physical Environmental Cues: Non-Healing Environment, Meaningful Item	Intervention(s) to create healing environment and connect to meaningful item:
<p>Verbal cues: Verbalizing the room was a mess. States he was cold, requests blanket that his deceased brother gave him. He verbalizes he wishes his brother was with him, as he would be making him laugh.</p> <p>Non-verbal cue: Blanket his brother gave him on chair. Meaning and purpose (Baldacchino, 2006; Burkhart & Hogan, 2008; Deal & Grassley, 2012; Monareng, 2012; Wallace et al., 2008).</p>	<ul style="list-style-type: none"> • Pauses, makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012). • Listens to patient (Belcher & Griffiths, 2005; Como, 2007; Wallace et al., 2008). • Provides a comforting touch (Deal & Grassley, 2012). • Helped him put blanket on bed. States, “It must be nice to have your brother’s blanket” (Burkhart & Hogan, 2008; Wallace et al., 2008). • Asks about the importance of the blanket from home and/or relationship with brother (Burkhart & Hogan, 2008; Deal & Grassley, 2012; Monareng, 2012; Wallace et al., 2008). • Distractor item: Does not straighten room. May state, “Housekeeping should come by later.” • Tries to clean room (e.g., straighten room, states housekeeping will come to empty the garbage). Provides blanket to patient.
<p>Veteran Culture Environmental Cues:</p>	<p>Intervention(s) to promote veteran culture:</p>
<p>Verbal cues: Asks for his Vietnam War veteran hat. Verbalizes he went to Vietnam at 18 years old and is a Marine. States he lost a lot of friends there, and that his brother who was in the Army was shot, survived. He states he loves his motorcycle and has a motorcycle trip with his wife and other vets planned that he’s looking forward to and hopes he can go (Baldacchino, 2006; Belcher & Griffiths, 2005; Newlin et al., 2002).</p> <p>Non-verbal cue: Picture of motorcycle group on nightstand and Vietnam (Cone & Giske, 2012).</p>	<ul style="list-style-type: none"> • Deliberately asked patient questions about the importance of the hat, trip, and/or war experiences (Burkhart & Hogan, 2008; Chang et al., 2012; Como, 2007; Wallace et al., 2008). • Pauses, makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012). • Listens to patient (Belcher & Griffiths, 2005; Como, 2007; Wallace et al., 2008; Wallace & O’Shea, 2007). • Provides a comforting touch (Belcher & Griffiths, 2005; Deal & Grassley, 2012). • Invites conversation about war experiences or trip plans (Belcher & Griffiths, 2005; Burkhart & Hogan, 2008; Chang et al., 2012; Como, 2007; Wallace et al., 2008).

Table 2 (cont.)

Verbal and Non-Verbal Cues for Social Support/Connections with Family/Friends:	Intervention(s) to promote social support and connections with family and friends:
<p>Asks if his wife is there yet, verbalizes that he hopes she did not have car trouble. Verbalizes that he is usually the driver, it's just him, his wife and dog now at home. Also states desire to go home, and asks nurse if she/he could call his wife (Baldacchino, 2006; Burkhart & Hogan, 2008)</p> <p>(If RN asks about any family or friend he can call/or notices family picture on nightstand) SP would respond: That his daughter does not know he is hospitalized and that she will be mad when she finds out (Chang et al., 2012; Cone & Giske, 2012; Deal & Grassley, 2012; Wallace et al., 2008).</p> <p>Non-verbal cues: Picture of family on nightstand and cell phone. Crosses arms when talks about his daughter. Supportive connections (Burkhart & Hogan, 2008; Cone & Giske, 2012).</p>	<ul style="list-style-type: none"> • Pauses (Deal & Grassley, 2012). • Sits in chair (Cone & Giske, 2012; Deal & Grassley, 2012). • Makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012). • Listens to patient (Belcher & Griffiths, 2005; Como, 2007; Wallace et al., 2008; Wallace & O'Shea, 2007). • Provides a comforting touch (Belcher & Griffiths, 2005; Deal & Grassley, 2012). • Asks if there is any other family or friend he can call; talks about family relationships or encourages him to reach out to family/friends, dog; encourages patient to call wife or helps him call her (Baldacchino, 2006; Burkhart & Hogan, 2008; Chang et al., 2012; Deal & Grassley, 2012; Wallace et al., 2008). • Distractor item: Responds that wife is not here yet. She states the wife will probably come soon. Lack of exploration of fears and concerns (Baldacchino, 2006; Wallace et al., 2008).
Verbal and Non-Verbal Cues for Connection with Higher Power/Faith Rituals:	Intervention(s) to promote connection with Higher Power and Faith Rituals:
<p>Verbalizes that he is afraid of the test results, and hopes that someone is with him when he gets the test results. If nurse offers the chaplain he responds "yes." He states it's all in the Bible and God's words speak to him. States that his wife probably has told the whole church to pray for him, and also informed his pastor (Baldacchino, 2006; Deal & Grassley, 2012; TJC, April 3, 2014; Monareng, 2012; Wallace et al., 2008).</p>	<ul style="list-style-type: none"> • Pauses (Deal & Grassley, 2012). • Sits in chair (Deal & Grassley, 2012; Giske & Cone, 2012). • Makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012). • Listens to patient (Belcher & Griffiths, 2005; Como, 2007; Wallace et al., 2008). • Provides a comforting touch (Belcher & Griffiths, 2005; Deal & Grassley, 2012). • Explicitly acknowledges his fears (Baldacchino, 2006; Wallace et al., 2008).

Table 2 (cont.)

<p>If the RN offers chaplain visit, SP states yes he would like to see the chaplain.</p>	<ul style="list-style-type: none"> • Offers to call the chaplain. Calls chaplain, or suggests calling home pastor (Baldacchino, 2006; Burkhart & Hogan, 2008; Como, 2007; Deal & Grassley, 2012; TJC, April 3, 2014; Wallace & O’Shea, 2007); prays with patient (Dunn et al., 2009; Gallison et al., 2013; Monareng, 2013; Taylor et al., 2014), and/or explores faith rituals (Burkhart & Hogan, 2008; Deal & Grassley, 2012; Monareng, 2012; Wallace et al., 2008). • Distractor items: Lack of exploration of fears and concerns (Baldacchino, 2006; Wallace et al., 2008): • Indicates that the MD will be there that afternoon to discuss his test results. • Ignored comment or states, “I’m not religious.”
<p>Non-verbal cues: opens hands and makes sign of cross when referring to God. Bible on nightstand. Higher Power cue (Belcher & Griffiths, 2005; Burkhart & Hogan, 2008; Cone & Giske, 2012; Monareng, 2013).</p>	

Creating the simulation. This was accomplished following Drexel University’s guide for creating the mini-case scenario (Gordon, 2012). The INACSL Standards of Best Practice: SimulationSM were also used to develop the prebriefing, simulation, and debriefing (see Appendix O). The steps to create the clinical simulation scenario will be described below:

Objective. Develop a nurse participant objective for the clinical simulation scenario.

Central story. A central story was created describing the patient and scenario. The clinical simulation scenario was adapted from one developed for an undergraduate medical/surgical class with her verbal permission (Dr. Lisa Burkhart, personal communication, October 1, 2015). The clinical simulation scenario was created to reflect a 64-year-old male, African American, Baptist, and Vietnam War veteran with several chronic health conditions including colon cancer, chronic obstructive pulmonary disease (COPD), diabetes, and post-traumatic stress disorder (PTSD). He is two days post-colectomy and is diagnosed with colon

cancer. He is waiting for the pathology reports from his surgeon for prognosis and treatment. He has a family history of colon cancer (brother and father) that both died from the disease. The patient's nasogastric tube was discontinued that morning and his pain is managed with oral medication. He is married and has a daughter and grandchild who live out of town. He is a retired Marine who served in the Vietnam War. He is active with Veteran groups. He was expecting to see his surgeon that morning to learn of his prognosis and treatment plan, but was informed that the surgeon is delayed for eight hours.

Determining the patient characteristics. The characteristics of the simulated patient in the scenario were chosen to reflect the common characteristics of a Vietnam War veteran, which are supported in the literature. The Vietnam Era was between 1964 and 1975 (RAND Corporation, 2015). Hispanic and African Americans comprise the two highest minority veteran ethnic groups in the US today with the average age of a Vietnam War veteran 67 years of age (RAND Corporation, 2015). A survey taken in 2007 found almost 80% of African Americans acknowledge having a faith tradition as significant, with forty percent claiming the Baptist faith tradition (Pew Research Center, 2009). Veterans also have the highest percentage of cancer, COPD, diabetes, gastroesophageal reflux disease (GERD), hearing loss, and PTSD over non-veterans (RAND Corporation, 2015). Data collected in 2013 showed African American men had the greatest rate of acquiring colorectal cancer in the US male population (Centers for Disease Control and Prevention [CDC], 2016). During the initial development of the spiritual care clinical scenario simulation and SCCL, this researcher met face-to-face with an expert nurse educator at the VA to review the clinical scenario and provide feedback to the accuracy and fidelity of a war veteran patient. This expert holds a Doctor of Nursing Practice

(DNP), had been a VA nurse educator for six years and was an adjunct clinical nurse faculty member with baccalaureate student nursing during their medical/surgical rotation. This VA nurse expert also confirmed the simulated patient's medication list for accuracy with a VA pharmacist.

Focused assessment. This includes the clinical information that was given to each RN participant prior to entering the simulation as part of prebriefing (Meakim et al., 2013).

Script. The initial draft of the script included: opening line, patient cues listed in Table 2 from the literature, and SP responses to possible RN participant's responses during the simulation.

Creating the Performance Checklist

The script and the items generated for the SCCL were created concurrently based on the central story, incorporating the spiritual care cues and interventions identified in the literature as shown in Table 2. The checklist had four columns. The first column listed seven cues and the second column listed spiritual care intervention(s) that corresponded to the respective cue from the script. The final two columns indicate if the nurse performed or did not perform the intervention. The nurse only needed to perform one of the spiritual care intervention(s) within the item to count as performed. Both the simulation and SCCL were developed concurrently to ensure concepts mapped into both. The final script and checklist after psychometric evaluation is discussed in Chapter Four.

Simulation Environment

The simulation lab located on the VA campus is a well-lit enclosed room, which includes a bed, nightstand, two chairs, and tray table to resemble an in-patient hospital room.

Simulation labs are intended to duplicate actual life situations (Dhingra & Kerns, 2012). There is a control room adjacent to the simulation lab with a one-way mirror and portable speaker system (baby monitor), which allowed for visualization and communication between the observer and the RN and simulated patient. The control room was also used as office space for an RN in the education department. Accommodations were made for the control room to be free of any staff during the study time. There was adequate space with a table and four chairs for debriefing in the simulation lab. To ensure consistency in the simulation room set-up for each scenario a checklist for the researcher and SP was created (see Appendix P).

Selection of Debriefing Method

The Plus-Delta debriefing method was chosen. This included a form with two columns, one titled Plus (+) and one titled Delta (Δ) (see Appendix Q). The RN participant and the SP had the opportunity to take notes on the form prior to verbal debriefing. The participant and SP could also refer to their completed SCCL in the debriefing. This researcher used a script to maintain consistency with the debriefing process with all participants (see Appendix R).

Psychometric Testing of the Simulation and Spiritual Care Cue and Intervention

Checklist

Content validity. The next steps include psychometric evaluation of the simulation using content experts and Content Validity Index (CVI) (Polit, Beck, & Owen, 2007). Content validity measures the degree of the “content domain” (Waltz, Strickland, & Lenz, 2010, p. 165). Face validity was assessed with practicing nurses, SP training, and pilot testing. Content validity was addressed by developing the simulation using the literature, elements of the INACSL Standards of Best Practice: SimulationSM (see Appendix O), which are consistent with

the revised INACSL Standards of Best PracticeSM (INACSL Standards Committee [INACSL], 2016d), and NANDA-I (Herdman & Kamitsuru, 2014).

Content experts. Content experts had expertise in both spiritual and veteran care (Grant & Davis, 1997). The SP's race in the clinical scenario is African American; therefore, one African American RN was included in each round of the expert panel content validity review. A doctoral prepared simulation certified expert also evaluated the spiritual care clinical scenario simulation and checklist multiple times throughout the development process as recommended (Aschenbrenner et al., 2012; Kerns & Dhingra, 2012; Waxman, 2010). There is a difference of opinion in the number of experts required. The minimum of three experts was accomplished for reviews one and two; five experts were utilized for reviews three and four; and four experts for review five (Polit et al., 2007).

The content experts for round one and two were from within the VA system and were formally invited by the Chief of Education Services and Designated Learning Officer per protocol. The experts from the VA included a Catholic priest/chaplain who was also a veteran, and also selected were practicing nurses with expertise caring for veterans, with spiritual care to evaluate the plausibility of veteran culture and spiritual care. The nurse experts from the VA held advanced nursing degrees with certification, clinical and education expertise. The majority of the expert panel for rounds three through five were from outside the VA system. These experts were doctorally prepared RNs who had clinical expertise, research and publications in spiritual care. This researcher communicated with the experts by phone and email. An email was sent to the experts with an overview of the project accompanied with the instructions and the cue and intervention spiritual care clinical scenario simulation (see Appendix S).

Face validity evaluators. The face validity evaluators were the three practicing nurses who participated in the pilot study. The three nurses provided verbal feedback for the scripted scenario and SCCL after the pilot-testing debriefing. All three nurses stated that the script and SCCL appeared to adequately represent and measure spiritual care for a veteran (Trochim & Donnelly, 2008).

Aim 1 Data Collection

Once the content experts were secured for the initial review, an electronic copy of the simulation scenario with instructions, researcher contact information, and return date were sent to the content experts. The instructions included conceptual definitions as recommended (Grant & Davis, 1997). The content experts were first asked to evaluate whether the simulation scenario reflected a person who is at risk for or is in spiritual distress with (yes) or (no) response, with additional space for comments. The experts were provided with the definition of spirituality and spiritual care, and were given the objective, patient history, clinical scenario, orders, medications, and instructions/door sign with up to date patient information that included vital signs, new lab values, and current situation. The experts were asked first to evaluate the script and determine if there were any risk factors, triggers, or cues that may indicate a need for spiritual care, and also rate how well the four nursing intervention(s) (two of which were distractors) reflect a spiritual care intervention. The rating of both the cue(s) and intervention(s) used a scale 1 = *Does not reflect*; 2 = *Somewhat reflects*; 3 = *Mostly reflects*; and 4 = *Completely reflects*. Chapter Four will describe the credentials, number of content reviewers for each round, and results. A round robin was planned until achieved 100% congruence between the experts.

Aim 1 Data Analysis

RQ 1. To what degree can a spiritual care clinical scenario simulation with a standardized patient reflect evidence-based spiritual care assessments and interventions for a patient at risk for spiritual distress?

The simulation script and companion SCCL was iteratively developed based on the literature review of key attributes of spiritual care and the expert review. For each round of content validity ratings, a tool indicating each concept, the script operationalizing the concept, and a rating scale was provided to the content experts. Assessment of the content validity of the spiritual care script with cues and interventions was done using the Content Validity Index (CVI), an extensively used method among nursing scientists. The CVI measures agreement between raters on relevancy of each item and also includes qualitative feedback (Polit et al., 2007). An Item-CVI (I-CVI) of 0.78 is the minimum acceptable I-CVI for three or more experts (Polit et al., 2007). The Scale-CVI/Average (S-CVI/Ave) is computed by dividing the total I-CVI by the number of items. Based on the criteria suggested by Polit et al. (2007), a .78 I-CVI or greater with 3-4 experts has “good content validity” (p. 459); and the S-CVI-Ave of .90 or greater as recommended as having “excellent content validity” (p. 467). This researcher calculated the I-CVI score for the scenario script and intervention items. Based on the I-CVI score, revisions were made to the script and interventions by this researcher. The revised copy with instructions was sent to the next set of content reviewers. This was an iterative process that continued until it reached 100% S-CVI-Ave. Chapter Four will present the findings and the final tool based on the psychometric testing.

Standardized Patient

An SP was used for this research study. The SP qualifications supported the validity of the performance and the SP training supported the reliability of the performance.

Standardized patient qualifications and characteristics. The SP in this study is a professional actor with ten years of experience as an SP. He also received SP training at the Dr. Allan L. and Mary L. Graham Clinical Performance Center, University of Illinois, Chicago (UIC/GCPC), an accredited simulation center (2016) (chicago.medicine.uic.edu/grahamcpc/about_the_gcpc). To maintain fidelity to the simulation the SP was selected based on his race and approximate age to reflect the patient characteristics in the simulation. His qualifications as an SP support his ability to follow the script for the study. The SP was not a veteran, which was a criterion of the VA IRB.

Standardized patient training. The researcher trained the SP using recommended guidelines from human simulation experts (Wilson & Rockstraw, 2012). The SP training also incorporated SP training material from University of Illinois at Chicago College of Medicine, Dr. Allan L. and Mary L. Graham Clinical Performance Center (UIC/GPC), an accredited simulation center (Dr. Allan L. and Mary L. Graham Clinical Performance Center (n.d.–a; n.d.–b)) with permission (see Appendix T) (received from A. Binns-Calvey, personal communication, February 22, 2016). The SP training occurred over three consecutive sessions. A welcome letter was sent to the SP with location and training date information. The SP training workshop 1 was 2 hours; Workshop 2 was 5.5 hours; and Workshop 3 was 7 hours for a total of 14.5 hours of SP training. The SP was provided with a binder that included a draft of

the clinical scenario simulation and companion checklist, simulation set-up, Plus-Delta debriefing form, pilot study dates, and a map of the VA campus.

The SP was taught specific spiritual care cues and interventions the nurse could perform as recommended (Gordon, 2012). Phrases and words the SP was expected to state exactly were provided in written format to the SP as recommended (Okupniak, Cornele, & Feenan, 2012). The SP was also given additional patient history information (such as how many children he has, type of pet he has, his job history, and his symptoms before admission to the hospital) in the event the RN requests it, so the SP can speak freely (Okupniak et al., 2012, p. 53). The SP education also included providing the SP with a hard copy of information to review about colon cancer symptoms and management written in understandable language for patients from the National Institutes of Health (NIH) (National Cancer Institute, 2016) as recommended by the UIC/GCPC training guidelines (Dr. Allan L. and Mary L. Graham Clinical Performance Center, (n.d.-b) (received from A. Binns-Calvey, personal communication, February 22, 2016). Any questions the SP had were answered during the training sessions.

It was essential that the SP follow the script, which included the exact opening statement and mannerisms (Onori et al., 2012). To support the validity of the performance, the SP was instructed to follow the spiritual care clinical scenario simulation script. The SP training also included teaching the method of the Plus-Delta debriefing with instructions to provide both constructive and positive feedback (Hargraves, 2012). The SP was taught that the spiritual care clinical scenario simulation is a learning experience and feedback is to be given in a positive manner without scolding the participant (Onori et al., 2012). To avoid potential disagreement between the RN and SP, the SP was taught to avoid undesirable words during

debriefing such as: “shouldn’t, don’t, can’t, wouldn’t, wrong, [and] inappropriate” as recommended (Hargraves, 2012, p. 43). The SP had an opportunity to practice the simulation script and debriefing in the pilot testing described below.

Pilot testing. The pilot testing was a practice run-through of the spiritual care clinical scenario simulation, checklist completion, and debriefing with eight nurses or nursing students to refine the process (Aschenbrenner et al., 2012; Kerns & Dhingra, 2012; Waxman, 2010). This experience was voluntary, no names or other identifying information were collected, and participation in the feedback panel involved no contact with veterans. The results of the pilot testing are described in Chapter Four.

Aim 2: Methods to Measure Congruence in Perception

Aim 2 Design

For research questions 2.1, 2.2, and 2.3, a cross-sectional descriptive design was used to determine congruence in perception of spiritual care performance. The following section will describe the sample, power analysis, recruitment, variables and instrumentation, data collection, and data analysis.

Sample

A convenience sample of RNs who worked at a Midwestern VA healthcare system were recruited for this study. The health system included in-patient, out-patient, and community healthcare for veterans. Inclusion criteria states RN participants must be employed at least 0.5 full-time equivalent (FTE) as a practicing RN at the VA and provide direct care for veterans with chronic conditions. In addition, participants who have a personal relationship with the researchers or SP were excluded from the study to avoid any bias (Onori et al., 2012). A priori

power analysis was conducted to determine the sample size needed to determine significant change using the Spiritual Care Inventory (SCI) survey instrument (Burkhart et al., 2011). Estimation of the sample size and power for the current study is based on the SCI total and subscale effect sizes from a published randomized control trial (RCT) (Burkhart & Schmidt, 2012). Burkhart and Schmidt's (2012) study was the only available reference to date that can be used for effect size estimation.

Power analysis. The sample was based on the G-Power analysis (Faul, Erdfelder, Buchner, & Lang, 2009), with an alpha of 0.05 for a two-tail *t*-test, and a power of 0.80, based on previous research measuring change scores of the SCI and its subscales (Burkhart & Schmidt, 2012).

Based on the previous research (Burkhart & Schmidt, 2012), measuring a change SCI score with an effect size of 1.35 with an alpha of 0.05 for a paired two-tail *t*-test at a power of 0.80, a sample of 7 participants are recommended (see Appendix U). For the SCI spiritual interventions (SI) subscale, the effect size was 0.59 with an alpha of 0.05 for a paired two-tail *t*-test at a power of 0.80, a sample of 25 participants is recommended (see Appendix U). For the SCI meaning making subscale, the effect size was 1.25 with an alpha of 0.05 for a two-tail *t*-test at a power of 0.80, a sample of 8 participants are needed (see Appendix V). The total recommended sample to effect change based on the SCI spiritual intervention sub-scale is 25 participants.

Although the recommended power in estimating sample sizes is 0.80 (Hulley et al., 2007), the intervention in the Burkhart and Schmidt (2012) study was a six-week intervention, while this study is using only a one-time simulation. Therefore, this study was sampled to

account for the shorter intervention at 0.95 power. Using G-Power (Faul et al., 2009) with the same effect sizes mentioned above with a power of 0.95, the SCI total score recommend 10 participants, SCI spiritual interventions (SI) subscale recommend 39 participants (see Appendix V), and SCI meaning making recommend 11 participants (see Appendix W) (Burkhart & Schmidt, 2012). Recruitment continued until the total of 40 sample participants funded by the study was reached, which exceeded the highest recommended sample of 39 participants by one participant for 0.95 power.

Recruitment. Recruitment included several steps. This researcher created a study script invitation describing the project goals to ensure consistent information was presented to all potential participants (see Appendix X). This study script was first sent in a broadcast email to all potential VA RN staff members with contact information (see Appendix M). Information sessions were held at 14 staff meetings and one shared governance education meeting without nurse managers present to avoid coercion, where the study script invitation was read aloud by the Chief of Education Services and Designated Learning Officer, Director of Nursing Education, and/or this researcher with all questions answered. A copy of the consent and the information letter was distributed so that potential participants could review the consent prior to choosing to volunteer. The information letter is different than the consent form in that the VA has a specific structure for consent forms, and the information letter is formatted with the same information in a more easily readable format (see Appendix N). RNs could sign up as a participant during the information meetings or contact the researcher at a later time. This researcher's business cards with contact information were also left at each recruitment session along with the research study information sheet.

Another script was created when a potential participant contacted the researcher to learn more about the study. When an RN signed up as a participant or responded to the broadcast email, the researcher followed the script to ensure participant eligibility, clear communication of logistics, and complete step 1 of the consent process, as described under the Protection of Human Rights section (see Appendix X). The phone script included inclusion criteria, details about the study, description of simulation, definition of SP, scheduling requirements, honoraria, dress attire, reminder options, and study location. The RN participants were also notified that nurse managers would not know who volunteered to participate in the study, as participation must occur off scheduled work time (before or after tour of duty, not using compensation time, or during lunch time per IRB).

Simulation study times were scheduled for the on-site simulation lab based on participant availability (daytime, evening, and two Saturdays) in two-hour time frames to allow for adequate time between the simulation and interview data collection times. An email reminder was sent to volunteer participants (see Appendix Y). Subjects were notified they would receive \$100 honoraria funded by a grant through the VA Office of Nursing Services. The honoraria amount was consistent with an average reimbursement rate of \$50.00 per hour, which was approved by the IRB. The participants were also notified that they would be given a voucher for the \$100 honoraria immediately after completing the study to be redeemed at the VA Agent Cashier within 30 days of the study per VA policy (see Appendix Z).

Aim 2 Variables

Demographics. The demographic information was obtained using a VA nursing demographic survey that was modified by the researcher to describe the sample (see Chapter Four and Appendix AA) with descriptive sample chart (see Appendix BB).

Patient cue. Recognition of patient cue is conceptually defined as recognition of a patient's spiritual need (Burkhart & Hogan, 2008). This variable is operationalized in the simulation script and includes verbal, non-verbal, and situational elements of the script. Psychometric support for the script and the SCCL are described in Aim 1. Each patient cue is paired with spiritual intervention(s). A more detailed definition of both follows.

Spiritual care intervention. Spiritual care intervention is conceptually defined as “intentional nursing care interventions to promote the patient's spirituality” (Burkhart et al., 2011, p. 2467). This is operationalized in the SCCL. Performance of a spiritual intervention is measured using a nominal scale of performed/not performed on the SCCL. There are several possible behaviors per spiritual intervention listed on the SCCL. Performance on one of the behaviors constitutes performance of the spiritual intervention. Psychometric support for the SCCL is addressed in Aim 1.

There are seven concepts of Patient Cues that correspond with 12 Spiritual Care Interventions. These concepts include anxiety, physical suffering, fears, music, meaningful object, veteran (past), veteran (present), family support, social support, religion, chaplain, and Bible. Each concept is listed below with their related patient cues and spiritual interventions. Each patient cue and spiritual intervention is defined and operationalized below.

Patient cue(s) for anxiety. This is conceptually defined as patient behaviors associated with “a feeling of apprehension caused by anticipation of danger” (Herdman & Kamitsuru, 2014, p. 323). This is operationalized by the following SP verbal cues in the script: He was having a bad morning; he made comments the physician was not arriving until later than expected to inform him of his test results; and he asks the nurse if she/he knows results, and states that waiting is awful. The non-verbal cues include tapping his hands on the tray table anxiously and moving his feet.

Spiritual care intervention(s)—anxiety. This is conceptually defined as nursing interventions to decrease “feeling of apprehension caused by anticipation of danger” (Herdman & Kamitsuru, 2014, p. 323). This is operationalized in the SCCL behaviors that include the nurse demonstrating caring presence and listening related to test results, pauses, sits in chair, makes eye contact, listens to patient, provides a comforting touch, or may state a supportive statement.

Patient cue(s) for physical suffering. This is conceptually defined as patient behaviors associated with physical suffering, with suffering defined as “an individual’s experience of threat to self and is a meaning given to events such as pain or loss” (Kahn & Steeves, 1986, p. 623). This is operationalized by the following SP verbal cues in the script: He is complaining of no sleep; his pillow was like a rock; he wants own pillow; he is hungry; the clear liquid diet is cold; and colon cancer is awful. Non-verbal cues include an unfinished breakfast tray.

Spiritual care intervention(s)—physical suffering. This is conceptually defined as the nursing interventions to reduce the threat that is causing the physical suffering and promote meaning making of the pain or loss related to the suffering (Burkhart & Hogan, 2008). This is

operationalized in the SCCL behaviors that include the nurse demonstrating caring presence and listening related to physical suffering, stopping the physical assessment or tasks, pauses, sits in chair, makes eye contact, listens to patient's concerns, and/or provides a comforting touch. May state supportive statement.

Patient cue(s) of fears. This is conceptually defined as patient behaviors associated with a “response to perceived threat that is consciously recognized as a danger” (Herdman & Kamitsuru, 2014, p. 336). This is operationalized by the following SP verbal cues in the script: Stating that he is tired; he heard noises in the hall at night; he is worrying about results; he is afraid of the test results; and he discusses his father and brother's colon cancer experience of weight loss, vomiting, and pain that he does not want. The non-verbal cues included the SP yawning in the script.

Spiritual care intervention(s)—fears. This is conceptually defined as nursing interventions to reduce the perceived threat or danger through reflection (Burkhart & Hogan, 2008). This is operationalized in the SCCL behaviors that include the nurse encouraging the patient to talk about his fears (e.g., asking more about his fears about test results, having cancer, father/brother cancer experience).

Patient cue(s) for music. This is conceptually defined as patient behaviors indicating insomnia and use of music as coping mechanism associated with fears (defined above) since lived experience in Vietnam War (Ahmadi, 2013). This is operationalized by the following SP verbal cues in the script: Stating since Vietnam he has had trouble sleeping and needs music to fall asleep. Non-verbal cues include a head-set on nightstand and SP yawning in the script.

Spiritual care intervention(s)—music. This is conceptually defined as nursing interventions to promote coping strategies and connection to the arts (Ahmadi, 2013; Burkhart & Hogan, 2008). For this simulation, that connection occurs through music. This is operationalized in the SCCL behaviors that include the nurse demonstrating the importance of music. For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, “Sounds like you have difficulty sleeping. Does the music help you sleep in the hospital? Would you like to listen to your music now?” and/or explores what type of music he enjoys.

Patient cue(s) for meaningful object. This is conceptually defined as patient behaviors indicating a search for meaning and connection to others through meaningful objects (Burkhart & Hogan, 2008). In this simulation, the meaningful object was the brother’s blanket. This is operationalized by the following SP verbal cues in the script: He is cold and asks the nurse for the blanket (on the chair) mentioning that his brother wanted him to have the blanket. He states that his brother loved the blanket and he wished his brother who died were there because he would be making him laugh.

Spiritual care intervention(s)—meaningful object. This is conceptually defined as nursing interventions to promote connection to objects that hold meaning, and promote patient reflection related to that object (Burkhart & Hogan, 2008). This is operationalized in the SCCL behaviors that include the nurse recognition of the importance of the blanket and/or brother. May state supportive statement. For example, “It seems that the blanket from your brother is meaningful to you.”

Patient cue(s) for veteran culture (past). This is conceptually defined as patient behaviors indicating a veteran status due to past active service in the military (Vietnam War) (Veterans Authority [VA], 2017, para. 1). The military is a culture with its own language, emblems, and places they gather (Hobbs, 2008). This is operationalized by the following SP verbal cues in the script: He asks the nurse for his Vietnam War hat; states that his brother was shot in Vietnam; verbalizes it was a bad time, and that he lost a lot of friends during the Vietnam War. The environmental cues for past veteran culture include a Vietnam War veteran hat and a framed picture of a veteran's motorcycle group on the bedside table.

Spiritual care intervention(s)—veteran culture (past). This is conceptually defined as nursing interventions that demonstrate respect for military service and meaningful past experiences associated with military service (Burkhart & Hogan, 2008). This is operationalized in the SCCL behaviors that include the nurse demonstrating a caring presence and listening related to past veteran experiences. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement related to veteran culture: "It sounds like you lost a lot of friends. That must be hard for you." May explore the importance of the hat, and/or thanks him for his service.

Patient cue(s) for veteran culture (present). This is conceptually defined as patient behaviors indicating a present connection to veteran groups (Burkhart & Hogan, 2008). 'Veteran' and 'culture' are defined above. This is operationalized by the following SP verbal cues in the script: He is looking forward to a motorcycle trip to Washington, D.C. over Memorial Day with the veteran group and his wife. He verbalizes that he just bought a new trike, and states "I hope I can still go." The environmental cues for present veteran culture

include a framed picture of a veteran's motorcycle group (Rolling Thunder^R) on the bedside table.

Spiritual care intervention(s)—veteran culture (present). This is conceptually defined as nursing interventions to promote connectedness with current veteran groups (Burkhart & Hogan, 2008). This is operationalized in the SCCL behaviors that include the nurse recognition of veteran picture on bedside table or deliberately asked patient questions about the importance of current veteran supportive connections such as the Rolling Thunder^R group and/or his hope to participate in the Memorial Day parade/motorcycle ride.

Patient cue(s) for family support. This is conceptually defined as patient behaviors indicating disconnect from his family support, which consists of immediate family in this simulation (O'Brien, 2008). This is operationalized by the following SP verbal cues in the script: Verbalizes worry his wife may be lost, mentions his dog, his desire to go home, and that his daughter lives out of town. Non-verbal cues include family picture on the bedside table, and SP crosses his arms when he talked about his daughter.

Spiritual care intervention(s)—family support. This is conceptually defined as nursing interventions to promote connections to family (Burkhart & Hogan, 2008). This is operationalized in the SCCL behaviors that include the nurse demonstrating a caring presence and listening related to family supports. For example, pauses, makes eye contact, sits in chair, listens to patient, and/or provides a comforting touch. May state supportive statement—for example, "It seems like you really miss home. Tell me more about it."

Patient cue(s) for social support. This is conceptually defined as patient behaviors of indicating a need for social support. Social support is defined as helpful, protective, mutual

relationships that enhance one's sense of comfort (Langford, Bowsher, Maloney, & Lillis, 1997). This is operationalized by the following SP verbal cues in the script: He has a wife; he is concerned that his wife may be lost because she is late, and that he has a daughter who lives out of town. The non-verbal cues include a cell phone and family picture on the bedside table.

Spiritual care intervention(s)—social support. This is conceptually defined as nursing interventions to promote connections to extended family and friends (Burkhart & Hogan, 2008). This is operationalized in the SCCL behaviors that include the nurse recognition of family picture on bedside table and/or promotes connection with family. Asks him if he wants her to call his wife, another family member, or friend.

Patient cue(s) for religion. This is conceptually defined as patient behaviors indicating a need to participate in rites and rituals associated with a faith tradition (Burkhart & Hogan, 2008). This is operationalized by the following SP verbal and non-verbal cues in the script: Verbal expression of being afraid of his [pathology] results; states "It's in God's hands," and opens hands as the non-verbal cue. He also states he hopes his wife arrives in time to be with him to hear the results. The SP states his pastor knows he is in hospital, and that his wife has everyone praying.

Spiritual care intervention(s)—religion. This is conceptually defined as nursing interventions to promote connection to God and/or Higher Power, as appropriate (Burkhart & Hogan, 2008). This is operationalized in the SCCL behaviors that include the nurse demonstrating a caring presence and listening related to religion. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It seems like your faith is a source of strength for you."

Patient cue(s) for chaplain. This is conceptually defined as patient behaviors of a religiosity indicating a deeper need for spiritual care and support from the chaplain (Burkhart & Hogan, 2008). This is operationalized by the following SP verbal and non-verbal cues in the script: Being afraid of his [pathology] results stating, “It’s in God’s hands,” opening his hands as the non-verbal cue. He also states he hopes his wife arrives in time to be with him to hear the results. The SP states his pastor knows he is in hospital and his wife has everyone praying. If the nurse asks the SP if he wants the chaplain he responds, “Yes.”

Spiritual care intervention(s)—chaplain. This is conceptually defined as nursing interventions to contact the chaplain to see patient, per patient request (Burkhart & Hogan, 2008). This is operationalized in the SCCL behaviors that include the nurse offers to call chaplain and makes connection by calling the chaplain if patient requests.

Patient cue(s) for Bible. This is conceptually defined as patient behaviors of a religiosity defined above with need or request for scripture (Burkhart & Hogan, 2008). This is operationalized by the following SP verbal and non-verbal cues in the script: Being afraid of his [pathology] results stating, “It’s in God’s hands,” opening his hands as the non-verbal cue. He also states he hopes his wife arrives in time to be with him to hear the results. The SP states his pastor knows he is in hospital and his wife has everyone praying. The non-verbal cue includes a Bible on the bedside table. If the nurse asks if he has a favorite verse or if he wants the nurse to read a verse, he states “Yes, Psalm 139.”

Spiritual care intervention(s)—Bible. This is conceptually defined as nursing interventions to promote use of scripture, as indicated or requested (Burkhart & Hogan, 2008).

This is operationalized in the SCCL behaviors that include the nurse recognition of/offers the Bible on the bedside table and/or nurse may read verse. (see Appendix CC for final SCCL).

Aim 2 Data Collection

Data collection took place using the VA hospital simulation (SIM) lab located within the hospital's nursing education department to simplify attendance around RN work schedules. The data collection process followed five steps per participant and lasted approximately one hour:

- (1) The researcher obtained final RN consent. The participant completed the demographic survey and the Spiritual Care Inventory (SCI) pre-test. Prebriefing included verbal orientation of the simulation environment followed by the participant reading the focused assessment (30 minutes).
- (2) The RN participant completed the simulation. During the simulation, the researcher completed the "Spiritual Cue & Intervention Checklist" (SCCL) as the independent observer through a one-way mirror (10 minutes).
- (3) Immediately after the simulation, the RN participant and SP in separate rooms completed their version of the "Spiritual Care Cue & Intervention Checklist" (SCCL) identifying what activities each felt was performed or not performed. Both also completed the Plus-Delta worksheet (10 minutes).
- (4) The researcher led a debriefing with the RN participant and SP using the Plus-Delta method. The facilitator began the debriefing by thanking the participant and SP for their participation. The method included asking the RN participant for a one word to describe their emotions, and what went well in the simulation and what could be improved. After

the RN participant responded, the SP also stated what went well and what could be improved from his perspective as a patient. This perspective was based on the congruence with nurse behaviors described during SP training (10 minutes).

(5) RN completed SCI post-test (5 minutes).

Aim 2 Data Analysis

Data analyses for RQs 2.1, 2.2, and 2.3 were performed using raw percent match, and kappa statistic using IBM SPSS Version 23 (Armonk, NY), and Stata Version 14 (College Station, TX) statistical analysis software, respectively. The research question and data analysis plan will be explained for each research question. Then, a description of observed percent match, kappa statistic, kappa benchmarks, and the reasons to report both observed agreement and kappa will be provided.

RQ 2.1. To what degree does observed spiritual care (recognition of patient cue and provide spiritual intervention) measured by an independent observer align with both registered nurse and standardized patient perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

This question was analyzed using raw percent match and Fleiss kappa comparing the SCCL scores of the RN participant, SP, and independent observer. The descriptive statistics included the valid (n), raw percent agreement, and the Fleiss kappa output, which include the kappa value, Standard Error (SE), and p value per item on the SCCL.

Fleiss kappa statistic is an adjusted agreement statistic for more than two raters (Fleiss, 1971). There are multiple benchmarks to interpret kappa in the literature (Fleiss, Levin, and Paik, 2003; Landis & Koch, 1977). Landis and Koch (1977) benchmarks will be used to

interpret these research findings. These benchmarks to interpret strength of agreement above chance include the following: “< 0.00 poor; 0.00–0.20 slight; 0.21–0.40 fair; 0.41–0.60 moderate; 0.61–0.80 substantial; 0.81–1.00 almost perfect” (Landis & Koch, 1977, p. 165).

RQ 2.2. To what degree does registered nurse perceived spiritual care (recognize cue and perform spiritual intervention) align with an independent observer perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

This research question was analyzed using raw percent match and Cohen’s kappa comparing the SCCL scores of the RN participant and the independent observer. The kappa analysis included review of a cross tabulation, kappa value, SE, and *p* value.

Cohen’s kappa is mostly used to measure agreement between two judges to check the interrater reliability (Howell, 2013). Both the kappa score and percent agreement were needed to answer the research questions (Brennan & Hays, 1992; Cicchetti & Feinstein, 1990; McHugh, 2012). Percent agreement and kappa are considered consensus measures, which assume the raters will have a shared understanding of the “construct under observation, and to reach consensus (exact agreement)” (Polit & Beck, 2008, p. 455). A limitation of the percent agreement is that it can overestimate matched agreement since it does not consider random agreement, whereas the kappa statistic removes random chance (Brennan & Hays, 1992; Kerns & Dhingra, 2012; Viera & Garrett, 2005). The kappa statistic reflects differences removing random chance. However, the kappa statistic requires that the data be symmetrically distributed across cross tabulations. Feinstein and Cicchetti (1990) found that extreme agreement or disagreement between the raters causes an imbalance in the cross-tabulation, leading to an

unrealistic agreement estimate. If this assumption is not met, the denominator is deflated. In those cases, percent match is the more meaningful indicator of agreement (Cicchetti & Feinstein, 1990; McHugh, 2012). The benchmark for Cohen's kappa for this simulation is .7–1.0 (Kerns & Dhingra, 2012, p. 82). An example of a cross-tabulation and kappa calculation is provided (see Appendix DD).

RQ 2.3. To what degree does registered nurse perceived spiritual care (recognize cue and perform spiritual intervention) align with patient perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

This research question was analyzed using raw percent match and Cohen's kappa comparing the SCCL scores of the RN participant and SP. The kappa analysis included review of a cross tabulation, kappa value, *SE*, and *p* value.

Aim 3: RN Perceived Ability to Provide Spiritual Care

Aim 3 Design

For research questions 3.1, 3.2, and 3.3, a pre-post design was used to determine whether RN perceived ability to provide spiritual care, spiritual interventions, and search for meaning in encounter changed due to participating in a spiritual care simulation experience (prebriefing, simulation, and debriefing).

Sample

The sample is the same as Aim 2.

Aim 3 Variables

Demographics. The descriptive demographics are described in Aim 2 (see Appendix BB).

Perceived ability to provide spiritual care. This is conceptually defined as a purposeful process of a nurse recognizing a patient's need for spiritual care, choosing to engage in a spiritual care encounter, and providing spiritual interventions (Burkhart & Hogan, 2008). This is operationalized using the Spiritual Care Inventory (SCI) instrument total score items 1-17 (Burkhart et al., 2011) (as shown in Appendix EE; author permission for the SCI is shown in Appendix FF).

Perceived ability to provide spiritual interventions. This is conceptually defined as “intentional nursing care interventions to promote the patient's spirituality” (Burkhart et al., 2011, p. 2467) and is operationalized using the SCI Spiritual Interventions (SI) Subscale items 1–4.

RN search for meaning in encounter (meaning making). This is conceptually defined as “nurse spiritual reflective practices and meaning interpretations of nurse-patient spiritual encounters” (Burkhart et al., 2011, p. 2467) and is operationalized using the SCI Meaning Making (MM) Subscale items 5–14.

Aim 3 Instrumentation

Spiritual Care Inventory (SCI). The SCI is a 17-item instrument listing spiritual care activities describing spiritual interventions (4 items), meaning making (10 items), and faith rituals (3 items) and measures of perceived ability to engage in those activities (as shown in Appendix EE) (Burkhart et al., 2011). Each item is measured on a 5-point Likert scale, where 1 is strongly disagree and 5 is strongly agree. The tool was initially developed based on the Burkhart/Hogan grounded theory study (2008), with the initial draft of the tool including at least three items corresponding to each category of the theory using language from the original

qualitative data. This grounds the items into the actual nurse experience. Factor analysis supported construct validity of the tool explaining 57.33% of the variance and yielding 17 items with three subscales: spiritual care interventions (Cronbach's alpha = .82), meaning making (Cronbach's alpha = .92), and faith rituals (Cronbach's alpha = .86) (Burkhart et al., 2011, p. 2467-68). The final tool was retested with a new sample, yielding high Cronbach's alpha scores: .87, .94, and .88, respectively (Burkhart et al., 2011, p. 2468).

Aim 3 Data Collection

Each RN participant completed the SCI pre-simulation and completed the post SCI after simulation/debriefing as described under Aim 2.

Aim 3 Data Analysis

The following describes how each Aim 3 research question was analyzed using IBM SPSS software Version 23 (Armonk, NY).

RQ 3.1. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability to provide spiritual care?

This question was answered using dependent paired *t*-test of the pre-post test change scores of the SCI instrument Total Score (Burkhart et al., 2011).

RQ 3.2. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability to provide spiritual interventions?

This question was answered using dependent paired *t*-test of the pre-post test change scores of the Spiritual Interventions (SI) subscale (items 1-4) of the SCI instrument (Burkhart et al., 2011).

RQ 3.3. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability for meaning making?

This question was answered using dependent paired *t*-test of the pre-post test change scores of meaning making (MM) subscale (items 5-14) of the SCI instrument (Burkhart et al., 2011).

CHAPTER FOUR

RESULTS

This chapter will present the findings in two sections. The first section will present the data management process. The second section will present the findings answering the research questions for Aims 1, 2 and 3.

Data Management, Entry and Data Cleaning

The content validity findings were received from the experts via email and kept by the researcher. Per VA policy, all participant study files were stored in this researcher's locked VA office in a locked file cabinet (hard copies) and in a password protected secure data file computer system (electronic copies). A master study participant spreadsheet using Microsoft Excel spreadsheet was created by this researcher, which included contact information such as email address, phone number and scheduled study date. A hard copy folder was maintained for each participant, which included the scripted information sheet with their contact information, consent form, data collection tools, and agent cashier voucher filed numerically in a locked file cabinet in this researcher's VA office. After data were collected, the data collection sheets were scanned and uploaded into the password protected secured participant folder in the VA computer system and tracked using a scan tracking sheet for completeness. The scanner and computer system require a government issued access card to use for security purposes. A separate folder to track the honoraria vouchers, which included a unique number and distribution date, was stored in this researcher's VA office locked file cabinet.

As data were collected, the demographics, SCCL data for RN, SP, and IO, plus the pre- and post-SCI participant data were entered into the Microsoft Excel spreadsheet(s). The data were then coded and cleaned. Some surveys included multiple answers. In this case, the data were coded “77.” Some items were discarded if SP went off script and were coded “88.” Missing values were coded as “99.” The data cleaning process included reviewing all cells for any missing data. All data entry was triple checked against the surveys.

Aim 1 Results

Research question 1. To what degree can a spiritual care clinical scenario simulation with a standardized patient reflect evidence-based spiritual care assessments and interventions for a patient at risk for spiritual distress?

Content Validity Results

A total of five rounds of expert review with iterative script and checklist revision were needed to reach the CVI benchmark of 100%. A summary of the findings is listed in Table 3.

First round content validity results. The first two rounds of experts were from the VA. The first round included three expert clinical practitioners with knowledge and experience specific to the veterans’ population: (1) a Catholic priest/VA chaplain, who was also a veteran; (2) an Advanced Oncology Certified Clinical Nurse Specialist (AOCNS), and (3) an in-patient mental health nursing manager and geriatric Advanced Practice Nurse (APN). The two RN content experts returned their content validity electronically. There were 24/31 items < .78 I-CVI given the distractors in the initial tool. Four items could not be scored due to missing data or multiple ratings from one rater in different categories. Of the 31 items, a 14.35 I-CVI total/31.00 with a Scale I-CVI/Ave = .46 (as shown in Appendix GG). Modifications to the script and

interventions to the SCCL after review one included: Elimination of the distractor items; enhanced verbal cues of suffering in the script; removed non-healing environment construct; added further exploration of loss of friends in Vietnam and home life in script; and reduced content in the script in the Higher Power section with modifications to the spiritual care interventions in the SCCL.

Second round content validity results. The second round of content experts included the first round of experts plus one oncology/hospice Advanced Practice Nurse (APN) from a chronic care VA in-patient unit. The literature stated the same experts, a subset, or a new set of experts can be utilized (Polit et al., 2007). In light of the spiritual care in nursing practice focus of this study, the priest/chaplain's second content validity was reviewed and comments noted, but were not included in the I-CVI score. The I-CVI had 13/19 items $< .78$ I-CVI, with the Scale I-CVI/Ave = $.77$ (Polit et al., 2007) (as shown in Appendix HH). Modifications to the script and interventions to the SCCL tool included: Description of RN entry into the simulation and SP initial statement; responses from SP for non-therapeutic responses from RN; removed non-verbal of wiping tears out of eyes; added SP response if RN offers to call for medication for insomnia; changed location of veteran trip to enhance fidelity and added veteran group picture on nightstand; changed script to not include nurse offering Bible, but rather the patient must ask for it; added identification of SP favorite Bible passage; removed prayer as item option and included prayer under Bible passage item.

Third and fourth rounds content validity results. The third and fourth round of content validity review consisted of a new panel of five content experts. This expert panel included three PhD prepared nurse faculty who were selected based on their knowledge and expertise in nursing

research related to spiritual care, which also included scholarly writing disseminated in the nursing literature (Grant and Kinney, 1992; Grant & Davis, 1997). Two VA nurses (one DNP and one APN), who both were also adjunct nursing faculty members at a local university, served on this expert panel. Additional instructions were given to the new panel of experts, which included the focused assessment and a summary statement and description of the seven categories of cues in the script (anxiety, physical suffering, insomnia due to fears, physical environmental cues of meaningful items, veteran culture environmental cues, social support/family/friends, and faith rituals) to add clarity. Round 1 and 2 asked if the script reflected a person who is at risk for or is in spiritual distress. This statement was changed after round 2 to: After reading this focused assessment, does this scenario accurately reflect a person who is at risk for spiritual distress?

The CVI for round 3 was 21/21 items and the Scale I-CVI/Ave was .88 (see Appendix II). Modifications to the script and interventions for SCCL tool after round three included: Removal of the term “holistic” in the participant objectives and instructions; non-verbal patient cue for anxiety was changed from wringing hands to moving feet; eliminated RN statements “I’m sorry,” and “That must be difficult,” and exploration of coping strategies; removed comfort measure items; added SP statement of PTSD related to insomnia; added RN inquiry and SP response about his music preferences; emphasis added to script on how much the SP misses his brother; expansion on his desire to go on motorcycle trip; and added the daughter lives out of town. Modifications after round four included: Replaced the statement, “Why is this happening to me? I feel so helpless,” with “Colon cancer is awful!” and added SP response of “yes” if RN offers to read the Bible. The Scale I-CVI/Ave for round 4 was 1.0 (see Appendix JJ).

Fifth round content validity results. The fifth round was needed to clarify one sentence in the script related to “Colon cancer is awful!” vs. “Having colon cancer is awful.” The final round included four out of five experts, as one expert was unavailable. The Scale I-CVI/Ave was 100% agreement (see Table 3 for summary, Appendix P for final script, and Appendix CC for final SCCL).

Table 3. Spiritual Care Cue Script and Intervention Checklist Development Summary

	Content Validity Review 1	Content Validity Review 2	Content Validity Review 3	Content Validity Review 4	Final Tool Review 5
Reviewers	3 VA experts 2 RNs 1 Chaplain	3 VA RN experts	5 RN experts 2 VA 3 Academia	Same 5 RN experts as round 3	4/5 RNs from review 3 & 4
Total items	Creation of 35 items	Revised items from 35 to 22 items	Revised items from 22 to 21 items	Revised items from 21 to 19 items	12-item tool
Number of Patient Cues	7	7	7	7	7
Number of Spiritual Care Interventions	28	15	14	12	12

Table 3 (cont.)

CVI	24/31 items < .78 I-CVI	13/19 items < .78 I-CVI	4/21 items < .78 I-CVI	Each Item I-CVI score = 1.0	Each Item I-CVI score = 1.0
4-point scale & qualitative comments	Scale S-I-CVI/Ave = 0.46	Scale S-I-CVI/Ave = 0.77	Scale S-I-CVI/Ave = 0.88	Scale S-I-CVI/Ave = 1.0	Scale S-I-CVI/Ave = 1.0
	Included distractors			Item C-1 rated by 4 raters = 1.0	Item C-1 confirmed by 4 raters
Refer to Appendix for Detailed Summary	Appendix GG	Appendix HH	Appendix II	Appendix JJ	Appendix P (Final Script) & Appendix CC (Final SCCL)

Note. Item-Content Validity Index (I-CVI); Scale Item Content Validity Index/Average (S-I-CVI/Ave).

Standardized Patient Practice Pilot Testing

The first pilot practice session took place in the VA simulation room with a spiritual care RN expert and with the SP (acting as simulated patient) reading from the hardcopy script, with this researcher observing. The checklist and debriefing method was also reviewed with the SP. This practice pilot was also discussed over the phone with a certified simulation nurse expert for feedback. In addition, one simulation certified PhD prepared RN reviewed the spiritual care clinical scenario simulation and checklist for accuracy, flow, and timing. Findings indicated that the SP was able to follow the script and presented a realistic performance.

Pilot Testing the Simulation

The prebriefing, simulation, checklist, and debriefing was pilot-tested with eight individuals and the SP for flow and timing, as well as checklist completion. Pilot participants included one RN from the community, two RN faculty, three student nurses, and two nurse educators at the VA. The pilot included completing the surveys, as well as participating in the simulation and debriefing. A script was utilized immediately pre-study (see Appendix KK) and immediately post-debriefing to gain feedback from the pilot study participants (see Appendix LL). Feedback indicated the need for the Plus-Delta written form, which was included in the simulation data collection process, as well as asking participants to provide a one word emotional response to the simulation. A second pilot included these changes to evaluate flow and timing, which was acceptable. The debriefing script used in the second pilot was also used in the research study (See Appendix R). The SP was able to participate in all eight pilot simulations.

Summary of pilot findings. The one-hour allotted time was adequate for consent, data collection and debriefing. All necessary equipment needed for the spiritual care clinical scenario simulation was available and in good condition. The feedback from the pilot study participants regarding the SCI and SCCL data collection tools were positive. The draft of the SCCL used in pilot-testing session one (see Appendix MM) was revised based on the feedback and expert review for pilot-testing session two (see Appendix NN). The demographic sheet was revised based on participant feedback to include additional information regarding past nursing experience, current nursing practice at the VA, and provide more space to write on the demographic sheet. The SP was given an opportunity to ask questions or raise any concern about

the script after each pilot test of the spiritual care clinical scenario simulation with the researchers and the participants. No suggestions were made to improve the spiritual care clinical scenario simulation or debriefing method by the participants or the SP. Additional SP training regarding script issues noted during the simulation was conducted 1:1 with the SP by the researcher. The pilot simulations provided an opportunity to practice the prebriefing, clinical scenario simulation, complete the forms, and debrief as recommended (Saewert & Rockstraw, 2012).

Aim 2 and 3 Sample and Sample Characteristics

The final sample of participants was 40 registered nurses. Participant recruitment was completed within one month. Overall there was only one participant no show on the scheduled study date who when followed up with, opted out of the study. Four nurses were excluded from the study because they were in nursing education or management positions and provided no direct care to patients.

The majority of the sample was female ($n = 37, 92.5\%$) with male participation ($n = 3, 7.5\%$). Two study participants had missing data for gender, yet were counted as female based on two researcher(s)' face-to-face encounter with the participants. There was a bimodal age distribution with 35 percent between ages 27–49 and 65 percent between the ages 50–65. The average age of the study participants was ($M = 52.6$ years old, $SD = 8.77$). The sample was predominately Caucasian ($n = 21, 52.5\%$), with Asian ($n = 13, 32.5\%$), Hispanic ($n = 5, 12.5\%$) and African American ($n = 1, 2.5\%$). The majority of the sample was Catholic ($n = 24, 60\%$), followed by Non-Catholic Christians ($n = 13, 32.5\%$), and those claiming no religious affiliation ($n = 3, 7.5\%$). The age and race/ethnicity sample characteristics are representative of the

population of staff nurses at the VA study site. VA data shows the mean RN age as 48.62 with 47% Caucasian, 35% Asian, 12% African American, 4% Hispanic, and 2% American Indian.

On average, participants worked 25 years as a nurse ($SD = 11.25$). The majority of participants (65%) had previous experience practicing in both inpatient and outpatient units, with the highest (57.5%) having general medical/surgical experience. On average, participants worked 9 years at the VA ($SD = 7.49$) ranging from 5 months to 33 years. The majority of the participants held a bachelor's degree in nursing (BSN) ($n = 18$), followed by a master's degree in nursing science (MSN) ($n = 10$), unspecified bachelor's degree ($n = 4$), associate degree ($n = 3$), non-nursing master's degree ($n = 3$), diploma in nursing ($n = 2$), and one participant held a non-nursing doctorate degree. The majority of the participants' current specialty area at the VA included outpatient ($n = 13$, 32.5%), followed by inpatient ($n = 12$, 30%), operating room ($n = 9$, 22.5%), and outpatient mental health ($n = 6$, 15%). The majority of the participants were not veterans (85%) (see Appendix BB).

Aim 2 Results

There are three research questions that address Aim 2, which determine the interrater congruence during a clinical simulation of nurse performance of spiritual care intervention(s) between registered nurse (RN), standardized patient (SP), and independent observer (IO), and between pairs RN-IO, RN-SP.

Research question 2.1. To what degree does observed spiritual care (recognition of patient cue and provide spiritual intervention) measured by an independent observer align with both registered nurse and standardized patient perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

Data cleaning. Missing data on RN, SP, and/or IO SCCL were distributed across the items as follows: physical suffering (2); fears (2); music (1); meaningful object (2); veteran past (1); family support (1); social support (3); religion (1); and Bible (6). The Bible item was counted as N/A and not included in the analysis when the SP went off script by asking the nurse for the Bible rather than waiting for the nurse to notice the cue for the Bible. The missing data were eliminated from the analysis, which accounts for the changes in (*n*).

Findings. The assumptions for the Fleiss kappa statistic were met, which includes more than two raters using a nominal scale (Fleiss, 1971). Raw percent match was hand calculated using Microsoft Excel and IBM SPSS Version 23 (Armonk, NY). Fleiss coefficient kappa statistic was calculated using IBM SPSS Version 23 (Armonk, NY). A summary of the valid (*n*), raw percent agreement, Fleiss kappa, Standard Error (*SE*), and *p* value per spiritual intervention item on the SCCL is described in Table 4. The findings for each of the concepts on the 12-item SCCL will be discussed in subsections following Table 4.

Table 4. RN-SP-IO Interrater Congruence Spiritual Care Checklist Summary

RN-SP-IO	Valid N	Raw Percent Agreement	Kappa (SE)	<i>p</i> -value
Anxiety	39	100%	No kappa	No value
Physical Suffering	38	97%	-.009 (.094)	.925
Chaplain	39	82%	.761 (.092)	< .001
Bible	33	76%	.676 (.101)	< .001
Social Support	36	69%	.591 (.096)	< .001
Religion	38	76%	.41 (.094)	< .001

Table 4 (cont.)

Music	38	53%	.367 (.094)	< .001
Veteran Culture (Past)	38	53%	.348 (.094)	< .001
Meaningful Object	37	57%	.123 (.095)	.197
Family Support	38	61%	.090 (.094)	.334
Veteran Culture (Present)	39	31%	.076 (.092)	.409
Fears	37	59%	.024 (.095)	.799

Note. The variation in sample size is due to missing data.

Anxiety. The raw percent agreement was perfect. There was no variability between the three raters' RN-SP-IO; therefore, kappa could not be calculated as shown in Table 4. The interrater raw percent match is within the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Physical suffering. The raw percent agreement was 97%. There was little variability between the three raters' RN-SP-IO, as shown in Table 4. Fleiss kappa was ($K = -.009, p = .925$), which is inconsistent with the raw percent agreement; therefore the 97% interrater match is the better statistic (Cicchetti & Feinstein, 1990; McHugh, 2012). The interrater raw percent match is within the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Chaplain. The raw percent agreement was 82%. Overall, the three raters, RN-SP-IO had “substantial” agreement between their judgments ($K = .761, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is within the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Bible. The raw percent agreement was 76%. Overall, the three raters, RN-SP-IO had a “substantial” agreement between their judgments ($K = .676, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is slightly below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Social support. The raw percent agreement was 69%. Overall, the RN-SP-IO had “moderate” agreement between their judgments ($K = .591, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Religion. The raw percent agreement was 76%. Overall, the three raters, RN-SP-IO had “moderate” agreement between their judgments ($K = .41, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165). However, this is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Music. The raw percent agreement was 53%. Overall, the three raters, RN-SP-IO had “fair” agreement between their judgments ($K = .367, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165). However, this is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Veteran culture (past). The raw percent agreement was 53%. Overall, the three raters, RN-SP-IO had “fair” agreement between their judgments ($K = .348, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165). However, this is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Meaningful object. The raw percent agreement was 57%. However, the kappa was not statistically significantly different from chance agreement. Overall, the three raters, RN-SP-IO

had “slight” agreement between their judgments ($K = .123, p = .197$) (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Family support. The raw percent agreement was 61%. However, the kappa was not statistically significantly different from chance agreement. Overall, the three raters, RN-SP-IO had “slight” agreement between their judgments ($K = .090, p = .334$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Veteran culture (present). The raw percent agreement was 31% and the kappa was not statistically significantly different from chance agreement. Overall, the three raters, RN-SP-IO had “slight” agreement between their judgments ($K = .076, p = .409$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Fears. The raw percent agreement was 59%. However, the kappa was not statistically significantly different from chance agreement. Overall, there was “slight” agreement among the judgments of the three raters, RN-SP-IO ($K = .024, p = .799$) (Landis & Koch, 1977, p. 165), which is below the desired minimum .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Research question 2.2. To what degree does registered nurse perceived spiritual care (recognition cue and perform spiritual intervention) align with an independent observer perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

Data cleaning. Missing data on RN and IO’s SCCL were distributed across the items as follows: physical suffering (1); fears (2); music (1); meaningful object (2); veteran culture (past) (1); family support (1); social support (2); religion (1), and Bible (6). The variation in sample size is due to missing data as described above.

Findings. The five statistical assumptions for Cohen’s coefficient kappa statistic were met (Laerd, 2015a). These assumptions include categorical measurement (performed) or (not performed), no overlapping of categories either (performed) or (not performed) implying not rating both or in-between, paired observations RN-IO, symmetric cross-tabulations, independent ratings, and two pre-determined fixed raters (Laerd, 2015a). The total raw agreement percentage was hand calculated using the Microsoft Excel spreadsheet and with IBM SPSS Version 23 (Armonk, NY). A summary of the valid (*n*), raw percent agreement, Cohen’s kappa, Standard Error (*SE*), and *p* value per spiritual intervention item on the SCCL is described in Table 5. The findings for each of the concepts on the 12-item SCCL will be discussed following Table 5.

Table 5. RN-IO Interrater Congruence Spiritual Care Checklist Summary

RN-IO Congruency Item	Valid N	Raw Percent Agreement	Kappa (<i>SE</i>)	<i>p</i> -value
Anxiety	39	100%	-	-
Physical Suffering	38	100%	-	-
Fears	37	84%	-	.
Chaplain	39	92%	.847 (.084)	< .001
Bible	33	91%	.816 (.101)	< .001
Music	38	79%	.559 (.138)	< .001
Religion	38	84%	.533 (.162)	< .001
Social Support	37	76%	.504 (.142)	.002
Meaningful Object	37	73%	.337 (.157)	.025
Veteran Culture (Past)	38	61%	.219 (.152)	.162

Table 5 (cont.)				
RN-IO Congruency Item	Valid N	Raw Percent Agreement	Kappa (<i>SE</i>)	<i>p</i> -value
Family Support	38	66%	.151 (.141)	.249
Veteran Culture (Present)	39	46%	.113 (.085)	.238

Note. The variation in sample size is due to missing data.

Anxiety. The raw percent agreement was perfect. There was no variability between the RN-IO pair as shown in Table 6 therefore kappa could not be calculated. The interrater 100% raw match meets the desired .7–1.0 interrater kappa range (Kerns & Dhingra, 2012).

Table 6. RN-IO Interrater Congruence Concept Anxiety

Anxiety	IO Performed	Total
RN	39	39
Total	39	39
Measure of Agreement Kappa	Value	-

Physical suffering. The raw percent agreement was perfect. There was no variability between the RN-IO pair as shown in Table 7 so kappa could not be calculated. The interrater 100% raw match meets the desired .7–1.0 interrater kappa range (Kerns & Dhingra, 2012).

Table 7. RN-IO Interrater Congruence Concept Physical Suffering

Physical Suffering	IO Performed	Total
RN	38	38
Total	38	38
Measure of Agreement Kappa	Value	-

Fears. The raw percent agreement was 84%. There was no variability between the RN-IO pair as shown in Table 8 therefore kappa could not be calculated. The interrater 84% raw match meets the desired .7–1.0 interrater kappa range (Kerns & Dhingra, 2012).

Table 8. RN-IO Interrater Congruence Concept Fears

Fears	IO Performed	Total
RN Not Performed	6	6
Performed	31	31
Total	37	37
	Value	
Measure of Agreement Kappa	-	

Chaplain. The raw percent agreement was 92%. There was “almost perfect” agreement between the RN-IO judgments ($K = .847, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is within the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Bible. The raw percent match was 91%. There was “almost perfect” agreement between the RN-IO judgments ($K = .816, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is within the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Music. The raw percent agreement was 79%. There was “moderate” agreement between the RN-IO pair judgments ($K = .559, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165). However, this is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Religion. The raw percent agreement was 84%. There was “moderate” agreement between the RN-IO judgments ($K = .533, p < .001$), statistically significantly different from

chance agreement (Landis & Koch, 1977, p. 165). However, this is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Social support. The raw percent agreement was 76%. There was “moderate” agreement between the RN-IO judgments ($K = .504, p = .002$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165). However, this is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Meaningful object. The raw percent agreement was 73%. There was “fair” agreement between the RN-IO pair judgments ($K = .337, p = .025$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165). However, this is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Veteran culture (past). The raw percent agreement was 61%. However, the kappa was not statistically significantly different from chance agreement. There was “fair” agreement between the RN-IO pair judgments ($K = .219, p = .162$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Family support. The raw percent agreement was 66%. However, the kappa was not statistically significantly different from chance agreement. There was “slight” agreement between the RN-IO pair judgments ($K = .151, p = .249$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Veteran culture (present). The raw percent agreement was 46% and the kappa was not statistically significantly different from chance agreement. There was “slight” agreement between the RN-IO pair judgments ($K = .113, p = .238$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Research question 2.3. To what degree does registered nurse perceived spiritual care (recognize cue and perform spiritual intervention) align with patient perceived spiritual assessments and interventions in a spiritual care clinical scenario simulation with a standardized patient?

Data cleaning. Missing data on RN and SP's SCCL were distributed across the items as follows: physical suffering (1); fears (2); music (1); meaningful object (2); veteran culture (past) (1); family support (1); social support (2); and religion (1), and Bible (6). The variation in sample size is due to missing data.

Findings. The five statistical assumptions for Cohen's coefficient kappa statistic were met (Laerd, 2015a). These assumptions include categorical measurement (performed) or (not performed), no overlapping of categories either (performed) or (not performed) implying not rating both or in-between, paired observations RN-IO, symmetric cross-tabulations, independent ratings, and two pre-determined fixed raters (Laerd, 2015a). The total raw agreement percentage was hand calculated using the Microsoft Excel spreadsheet and with IBM SPSS Version 23 (Armonk, NY). A summary of the valid (n), raw percent agreement, Cohen's kappa, Standard Error (SE), and p value per spiritual intervention item on the SCCL is described in Table 9. The findings for each of the concepts on the 12-item SCCL will be discussed in subsections following Table 9.

Table 9. RN-SP Interrater Congruence Spiritual Care Checklist Summary

RN-SP Congruency Item	Valid N	Raw Percent Agreement	Kappa (SE)	<i>p</i> -value
Anxiety	39	100%	-	-
Physical Suffering	38	97%	-	-
Chaplain	39	87%	.745 (.105)	< .001
Social Support	37	81%	.628 (.122)	< .001
Bible	33	79%	.585 (.133)	< .001
Religion	38	79%	.269 (.157)	.015
Veteran Culture (Past)	38	66%	.258 (.159)	.106
Music	38	61%	.252 (.137)	.082
Veteran Culture (Present)	39	67%	.235 (.163)	.141
Fears	37	68%	.224 (.149)	.11
Meaningful Object	37	68%	.136 (.129)	.233
Family Support	38	66%	.089 (.084)	.185

Note. The variation in sample size is due to missing data.

Anxiety. The raw percent agreement was perfect. There was no variability between the RN-SP pair, as shown in Table 10 therefore kappa could not be calculated. The interrater 100% raw percent match meets the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Table 10. RN-SP Interrater Congruence Concept Anxiety

Anxiety	SP Performed	Total
RN	39	
Total	39	39

Value	
Measure of Agreement	-
Kappa	

Physical suffering. The raw percent agreement was 97%. There was no variability between the RN-SP pair, as shown in Table 11 therefore kappa could not be calculated. The interrater 97% raw percent match meets the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Table 11. RN-SP Interrater Congruence Concept Physical Suffering

Physical Suffering	SP		Total
	Not Performed	Performed	
RN Performed	1	37	38
Total	1	37	38

Chaplain. The raw percent agreement was 87%. There was “substantial” agreement between the RN-SP pair judgments ($K = .745, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is within the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Social support. The raw percent agreement was 81%. There was “substantial” agreement between the RN-SP pair judgments ($K = .628, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Bible. The raw percent agreement was 79%. There was “moderate” agreement between the RN-SP pair judgments ($K = .585, p < .001$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Religion. The raw percent agreement was 79%. There was “fair” agreement between the RN-SP pair judgments ($K = .269, p < .015$), statistically significantly different from chance agreement (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Veteran culture (past). The raw percent agreement was 66%. However, the kappa was not statistically significantly different from chance agreement. There was “fair” agreement between the RN-SP pair judgments ($K = .258, p = .106$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Music. The raw percent agreement was 61%. However, the kappa was not statistically significantly different from chance agreement. There was “fair” agreement between the RN-SP pair judgments ($K = .252, p = .08$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Veteran culture (present). The raw percent agreement was 67%. However, the kappa was not statistically significantly different from chance agreement. There was “fair” agreement between the RN-SP pair judgments ($K = .235, p = .141$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Fears. The raw percent agreement was 68%. However, the kappa was not statistically significantly different from chance agreement. There was “fair” agreement between the RN-SP

pair judgments ($K = .224, p = .11$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Meaningful object. The raw percent agreement was 68%. However, the kappa was not statistically significantly different from chance agreement. There was “slight” agreement between the RN-SP pair judgments ($K = .136, p = .233$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Family support. The raw percent agreement was 66%. However, the kappa was not statistically significantly different from chance agreement. There was “slight” agreement between the RN-SP judgments ($K = .089, p = .185$), (Landis & Koch, 1977, p. 165), which is below the desired .7–1.0 kappa interrater range (Kerns & Dhingra, 2012).

Aim 3 Results

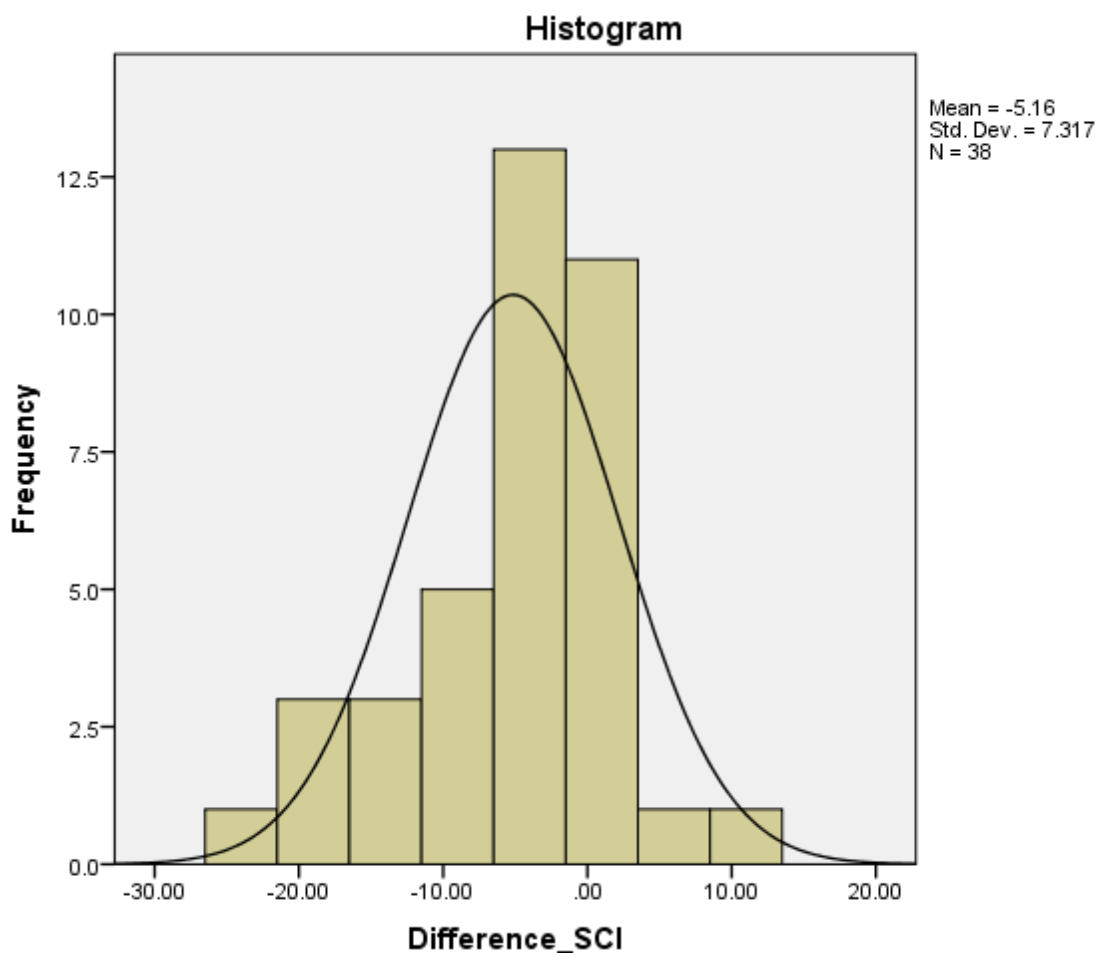
There are three research questions that address Aim 3, which is to determine whether experiencing a spiritual care simulation affects RN perceived ability to provide spiritual care.

Research question 3.1. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability to provide spiritual care?

Data cleaning. The missing data included (1) item on the SI subscale, and (1) item on the MM subscale.

Statistical assumptions for dependent *t*-test. The assumption of normality required to perform a dependent paired *t*-test for the total Spiritual Care Inventory (SCI) pre-post change score was met by visual inspection of the classic bell shape curve histogram, shown in Figure 3 (Field, 2013; Laerd, 2015b).

Figure 3. Histogram spiritual care inventory pre-post change scores



Note. Distribution of the change score.

Findings. Findings indicated a statistically significant increase in RN perceived ability to provide spiritual care after participating in the simulation experience (prebriefing, simulation, and debriefing) ($p < .001$) (see Table 12). Consistent with previous research, the tool demonstrated good internal consistency ($\alpha = .940$), with a medium effect size ($d = 0.70$).

Table 12. Spiritual Care Inventory and Subscale Paired Differences Tables

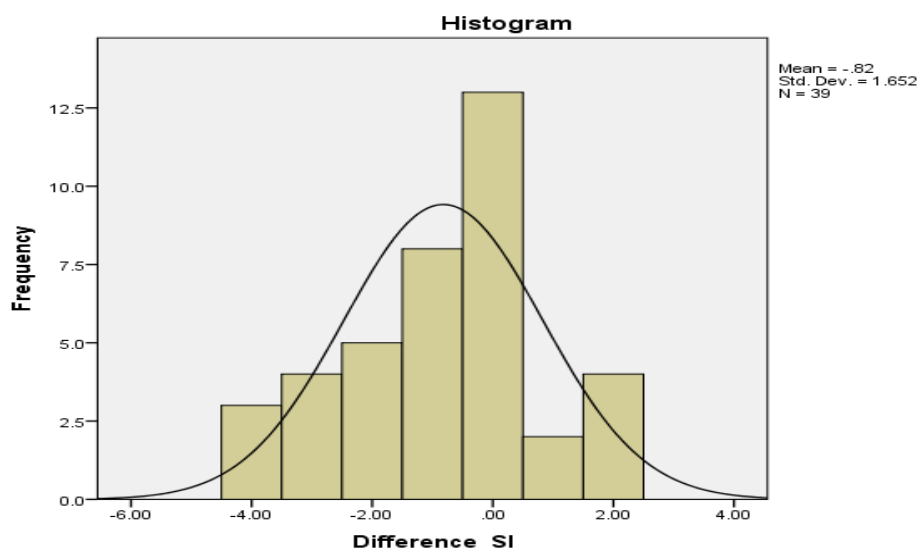
	Paired Differences							
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
				Lower	Upper			
Post SCI–Pre SCI	5.15789	7.31724	1.18701	2.75278	7.56301	4.345	37	< .001
Post SI–Pre SI	.82051	1.65230	.26458	.28490	1.35613	3.101	38	.004
Post MM–Pre MM	3.84615	5.46057	.87439	2.07604	5.61627	4.399	38	< .001
Post FR–Pre FR	.32500	1.50874	.23855	-.15752	.80752	1.362	39	.181

Research question 3.2. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability to provide spiritual interventions?

Data cleaning. Of the 40 participants, 39 participant scores were valid on the SI subscale as one participant checked two responses (both 4 and 5) on the 1-5 Likert scale. Therefore, this participant's data were not included in the overall mean SI change score.

Statistical assumptions for dependent *t*-test. The assumption of normality required to perform a dependent paired *t*-test for the total Spiritual Intervention (SI) pre-post change score was met by visual inspection of the classic bell curve histogram, shown in Figure 4 (Field, 2013; Laerd, 2015b).

Figure 4. Histogram spiritual intervention sub-scale pre-post change scores



Note. Distribution of the change score.

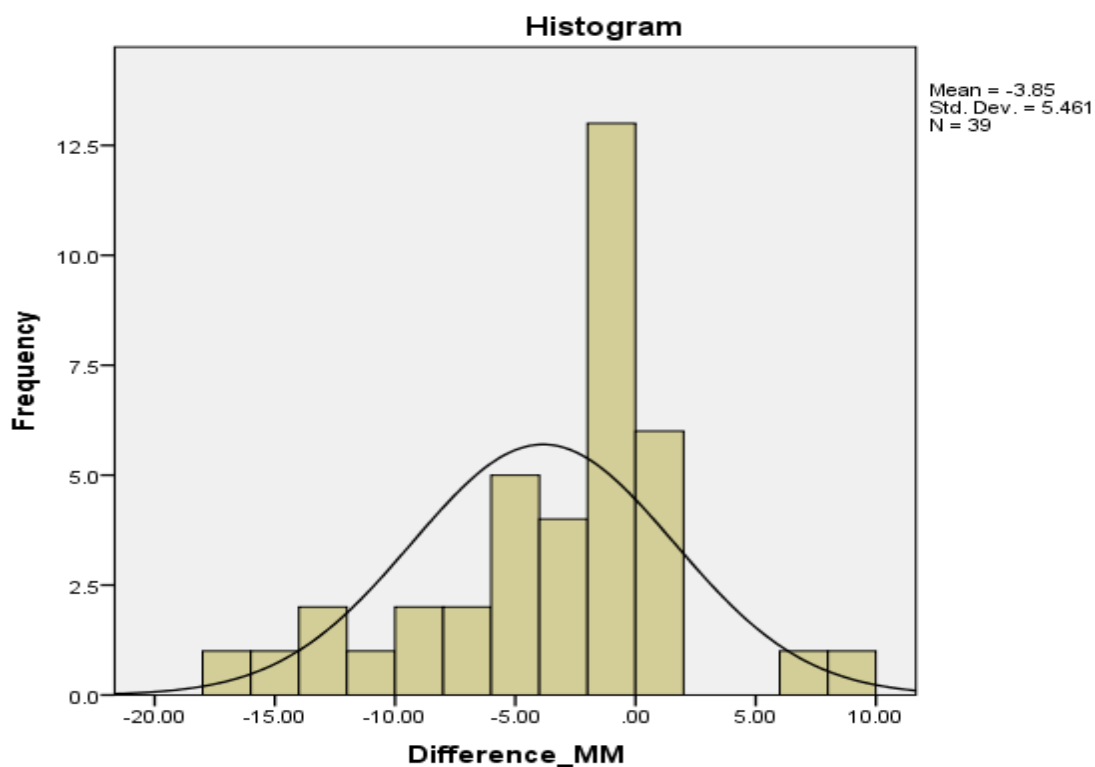
Findings. As shown in Table 12, participants demonstrated a statistically significant increase ($p = .004$) in perceived ability to provide spiritual interventions after participating in the simulation experience (prebriefing, simulation, and debriefing). Consistent with previous research, the subscale demonstrated good internal consistency ($\alpha = .899$), with a medium effect size ($d = .50$).

Research Question 3.3. Does participating in a spiritual care clinical scenario simulation change registered nurse perceived ability for meaning making?

Data cleaning: Of the 40 participants, 39 were valid for the meaning making scale.

Statistical assumptions for the dependent *t*-test. The assumption of normality required to perform a dependent paired *t*-test for the Meaning Making (MM) pre-post change score was met by visual inspection of the classic bell curve histogram, shown in Figure 5 (Field, 2013; Laerd, 2015b).

Figure 5. Histogram meaning making sub-scale pre-post change scores



Note. Distribution of the change score.

Findings. As shown in Table 12, participants demonstrated a statistically significant increase ($p < .001$) in perceived ability for meaning making after participating in the simulation experience (prebriefing, simulation, and debriefing). Consistent with previous research, the subscale demonstrated good internal consistency ($\alpha = .935$), with a medium effect size ($d = 0.50$).

CHAPTER FIVE

DISCUSSION

The purpose of this study was to develop a spiritual care clinical scenario simulation and companion performance checklist to assess congruence in perceived spiritual care from three perspectives RN, SP, and IO. The research study also investigated whether the prebrief, simulation, and debriefing intervention affected the RN's perceived ability to provide spiritual care. This chapter will first discuss the strengths and limitations followed by a discussion of key findings related to simulation science, spiritual care in nursing practice, and spiritual care education. An evaluation of the SCCL with recommended revisions will be presented. A discussion of the results with the extant literature, gaps filled, implications for nursing research, theory, practice, and education based on the research findings will also be presented.

Limitations of the Study

Simulation Equipment

The simulation lab at the VA uses a baby monitor as the device to hear the dialogue between the SP and the RN from the simulation lab to the control room where the IO was positioned. There were several occasions when it was difficult to hear the dialogue completely between the SP and RN, which was noted on the performance checklist. Purchasing high quality audio equipment would minimize this limitation in the future.

Standardized Patient

Although the SP was trained for the spiritual care clinical scenario simulation and was an

experienced SP, he varied from the script at times, which resulted in a loss of data. For example, the SP asked the nurse for the Bible rather than wait for the RN to notice the cue that there was a Bible on the nightstand. In those cases, the item for that encounter was not included in the results. When discussing these occurrences with the SP, the SP acknowledged times when he just wanted to help the participant or he realized what he did after he already asked the RN for the Bible. This impulse for the SP to help the participant is consistent with other research (Jarosinski & Webster, 2016, p. 539). One theme found in the study was “stepping into the shoes of the educator” where the SP is aware of student gaps and wanted the student to succeed even though they knew the need to stay within the script (Jarosinski & Webster, 2016, p. 543). Ongoing evaluation to keep the script standardized is essential.

Although the script was standardized, there were occasions when the SP did not state the entire script depending on the progression of dialogue with the nurse. In those cases, if the dialogue was not mentioned in the simulation there was a chance that both the SP and RN marked (not performed) on the checklist, rather than not assessed. There were times when the RN participant asked the researcher about items on the SCCL that were not in the simulation scenario, indicating that the SP perhaps did not give the cue for a particular item. It was also noted during the study that the script included the SP’s concern about being able to attend a trip that occurred on Memorial Day due to surgery. Adjustments to the script had to be made to adjust for the timing of the SP planned trip, as data collection occurred in June and July.

Patient Characteristics in Simulation

The simulation was designed for spiritual care for a veteran who was of the African American race and Baptist faith. These characteristics limit generalizability to other races and

faith traditions.

Spiritual Care Cue and Intervention Checklist

Another limitation of the study was the SCCL was a new checklist developed for this study so there was no baseline data. Another limitation was several participants checked the box in between (performed) and (not performed) columns on the SCCL rather than choose one or the other, which resulted in missing data. Some participants were unclear how to complete the SCCL. The items on the SCCL listed several possible interventions within the item and some participants marked on the SCCL they (performed) some of the interventions identified for that particular item but not all the possible interventions within the item. The participant only needed to perform one intervention within the item for it to count as performed. These examples related to the completion of the SCCL identified the need for more explicit instructions in completion of the tool in the future to avoid potential misunderstanding of directions. The IO did provide the RN with instructions on completing the SCCL and informed the RN that there was no right or wrong answer when filling out the checklist. The literature points out students may feel that they failed if their performance was less than optimal and view their action as “right” or “wrong,” which could bias the results (Janzen et al., 2016, p. 41).

Limitation of Kappa Statistic and Percent Agreement

Analysis and interpretation of the SCCL results between the interrater observations using the kappa statistic was difficult due to the limitations with kappa estimate, and percent agreement does not account for rater chance agreement (Brennan & Hays, 1992; McHugh, 2012). Another limitation with percent agreement is it limits generalizability, as there is no *p*-value associated with the value. There are different benchmarks for kappa, and a difference of opinion in what

kappa level constitutes a good match.

Wasson, Parsi, McCarthy, Siddall, and Kuczewski (2015) also found limitations with kappa using simulation with a SP to evaluate a participant from multiple perspectives using a new Clinical Ethics Skills (ACES) tool “due to both high observed and expected agreement rates” (p. 109). Wasson et al. (2015) surmised that the low agreement between multi-raters in their simulation study with a SP might have been related to a lower performance of the participant in the simulation, or in their case, it was easier to identify the participant achieved the performance measure such as, “Done” versus “Not Done” or “Done Incorrectly” (Wasson et al., 2015, p. 111). Other possible reasons for incongruence between raters include items counted as (performed) could be interpreted in different ways based on the observer’s experience and possible bias, and items that involve “communication and interpersonal skills” might not be as straightforward as other step-by-step skills checklists often found in patient care settings (Wasson et al., 2015, p. 111). The reasons cited by Wasson et al. (2015) could also apply to the possible low interrater congruence on some items in this research study. Complete agreement between raters is rare due to variation with human observation especially when finer judgments are necessary (McHugh, 2012).

Testing

It was appropriately 30 minutes between the completion of the pre-SCI to the completion of the post-SCI. There is a risk for threat to internal validity, practice effect, due to the possibility of the participant being sensitized to the tool after completing the pre-SCI (Polit & Beck, 2008).

Sample Limitations

Another limitation of the study was the sample demographics. Although the gender and

age of the participants was consistent with the population of RNs in the United States, 30% of the sample held a master's degree, which is higher than the RN population at the VA and in the United States (ANA, 2014). All of the RN participants in the study worked at the VA, which limits generalizability to non-VA patient care environments, which is a threat to external validity (Polit & Beck, 2008). Another potential limitation includes the participants' lack of experience in using simulation with a standardized patient. Most of the RN participants stated they had only used simulation during cardiopulmonary resuscitation (CPR) training and had no experience with a SP. The nurses were also aware that this was a spiritual care study as it was clearly spelled out in the invitation, which could have impacted the results. It is possible that nurses who value spiritual care volunteered for the study, which could bias results. In addition, the nurses were given \$100.00 honoraria, which also could have influenced their participation in the study.

Strengths of the Study

Theory and Psychometric Testing

Strengths of this study include the fact that it was grounded in both theory and the literature. Dr. Burkhart, co-author of the spiritual care in nursing practice (SCiNP) theory, which was the theoretical basis for this study, and who was part of the research grant team, brought expertise to this study (Burkhart & Hogan, 2008). There is psychometrics to support the simulation and SCCL as described with the psychometric testing of the simulation, methodical training, and pilot testing. In addition, the content experts for the spiritual care clinical scenario simulation brought varied expertise both from the VA and academia (Grant & Davis, 1997). Another strength of this study was gaining baseline data from nurse participants who care specifically for veterans with chronic conditions to advance knowledge on spiritual care in

nursing practice for veterans. The RN participants were interested in the study as it only took one month to recruit the sample. Although this study was considered a low stake formative assessment in simulation using a performance measure (Kerns & Dhingra, 2012), it did use methods suggested for “summative or high-stakes performance evaluation” such as content validity measures of the scenarios, maintained fidelity, and tested reliability of the performance measure (Shelestak & Voshall, 2014, p. e257). This study was guided by evidence-based practice standards.

Standardized Patient

Another strength was that the SP in this study was a professional actor with ten years of experience as an SP, and the same SP was used for each encounter. A frequent comment to the IO from the RN participants at the conclusion of each spiritual care clinical simulation was “He should win an award,” or “He was amazing, so real.” Other comments from some of the RNs showed concern for the SP such as, “Is he going to be ok?” The comments from the RN participants demonstrate the real-to-life performance by the SP. Also, observation was conducted by the IO at the time of the simulation, and by the RN and SP immediately post simulation, which is a benefit for recall (Rockstraw, 2012). Although the SP was role-playing a patient, RN participants value the person-to-person feedback (positive and areas for improvement) from the SP using the Plus-Delta and SCCL. For example, the SP would often comment on the nurse’s caring presence that he felt through the tone of voice and/or eye contact besides specific interventions noted on the SCCL, which is feedback the nurse possibly may not receive in day-to-day work environments.

Reliable and Valid Tool

The SCI tool used to measure perceived ability to provide spiritual care, spiritual care interventions, and meaning making pre- and post-simulation and debriefing is a valid and reliable tool as discussed in Chapter Three (Burkhart et al., 2011). This tool has not been used previously in simulation research so these findings expand the knowledge of nurse perceived ability to provide spiritual care using simulation, and also supports the reliability of the SCI tool.

Simulation

The process to create the simulation and SCCL was an iterative process over five content expert reviews with both VA and non-VA nursing personnel using the Content Validity Index (CVI), qualitative feedback, and Scale Content Validity Index Average (S-CVI/Ave), a common method for tool development in nursing (Polit et al., 2007). Having content experts from both the VA and academia was very helpful in the refinement process as each expert added a different perspective to help further refine the simulation script to reach a 100% Scale I-CVI Ave. Creation of the scenario and companion checklist to achieve the degree of high scale content validity was a time-consuming process that included defining the concept of spiritual care, inclusion of quality items, exceptional experts, and thorough instructions to the reviewers (Polit et al., 2007). This process also included ongoing communication with the content experts by email and/or phone, and included two in-person encounters requested by two content reviewers (one with the first review and one with the third review). Polit et al. (2007) highlighted the value of the qualitative comments received from the experts in writing and in person as a possible demonstration of content competence and pledge to the assignment. The content experts in this study provided both qualitative and quantitative responses, which supports their commitment to

this study. A possible benefit to this approach of instrument development was the anonymity of each expert, which helped reduce rater bias.

This researcher learned the process and effort for both face validity and the CVI method necessary to create the spiritual care clinical simulation (see Appendix P) and the companion SCCL (see Appendix CC), which exceeded excellent content validity recommendations (Polit et al., 2007). The INACSL standards and simulation guidelines followed were essential to the creation and refinement of the evidence-based simulation, choosing the debriefing method, and guiding the SP training. This process informs nursing education research by describing how to create a theoretically grounded, evidence-based clinical spiritual care simulation, and companion performance checklist for a war veteran with psychometric support. This method derived patient cues and assessment data derived from the literature to guide script development and psychometric testing, while the performance checklist operationalized the spiritual interventions. Simulation research also provided a unique strategy to study perception of care from different individuals around a specific scenario. This research study was conducted with ($n = 39$) simulation and debriefing interventions to measure RN performance of recognition of spiritual care cues and interventions from the perspective of the RN-SP-IO, RN-SP, and RN-IO.

Simulation and Spiritual Care

Two spiritual care simulation research studies in the literature, one at end-of-life and one mother/baby, found evidence that suggests simulation was effective in teaching spiritual care to undergraduate nursing students as described in Chapter Two (Costello et al., 2012; Fink et al., 2014). There are additional simulations addressing end-of-life and palliative care in the literature. There were no spiritual care simulations for a veteran at risk for spiritual distress with chronic

health conditions and new cancer diagnosis in a medical/surgical setting found in the literature. There also were no spiritual care performance measurement tools for a veteran found in the literature, nor research that measured perception of nurse-provided spiritual care using simulation and a SP portraying a veteran. This newly created spiritual care simulation for a veteran at risk for spiritual distress in a medical/surgical setting and companion SCCL adds to the body of nursing knowledge. It provides elements of NANDA-I characteristics for a patient at risk for spiritual distress in addition to the evidence-based literature (Herdman & Kamitsuru, 2014). It also provides a method to measure perception of nurse performance of spiritual care using a SP, and simulation for education and research purposes for both practicing and student nurses. Many nurses in the study stated that they only had simulation experience for CPR training. Simulation can enhance education for practicing nurses as well as students. More research is needed to further develop the simulation with a companion checklist.

Spiritual Care in Nursing Practice

Three of the research questions (2.1, 2.2, and 2.3) sought to measure interrater congruence of RN performance of spiritual care (performed) or (not performed) from different perspectives using the SCCL: RN-SP-IO, and RN-IO, and RN-SP using the kappa statistic, which corrects for chance agreement (Cohen, 1960). Percent agreement values are common to study incongruence in observer ratings, in order to decrease the incongruence (Cicchetti & Feinstein, 1990). Both the kappa and percent agreement were reported with only one inconsistency between kappa and raw percent noted between the RN-SP-IO on the physical suffering item where the raw percent was the better statistic (Cicchetti & Feinstein, 1990). Using both the kappa statistic and percentage of agreement provided a strategy to evaluate differences

in perception (Cicchetti & Feinstein, 1990). The importance of studying interrater congruence, the kappa results, analysis, and SCCL will also be discussed.

Importance of Measuring Congruence

It is important to measure congruence of nurse provision of spiritual care from the patient, nurse, and external observer perspectives at the point of care because spiritual care is associated with health benefits (Adegbola, 2006; Bussing & Koenig, 2010; Jim et al., 2015) and satisfaction for both patients (Williams et al., 2011) and nurses (Burkhart & Hogan, 2008). Although there is research measuring provision of spiritual care perspectives from patients during and after hospitalization (Williams et al., 2011), and nurse perception after providing spiritual care (Taylor et al., 2017), there was no literature found measuring perspectives of the patient and nurse at the point of care. It is important to evaluate whether the intended spiritual care was received. Measuring congruence of performance of spiritual care at the point of care using simulation with an SP fills a gap by using statistics to study congruence and incongruence of patient-nurse-external observer perception of 12 spiritual interventions to inform both nursing education and practice.

RN-SP-IO congruence. The spiritual care interventions agreement between the three raters, RN-SP-IO related to patients' anxiety, physical suffering, and chaplain referral were near perfect, and "substantial" for Bible recognition (Landis & Koch, 1977, p. 165), which demonstrate construct validity (Polit & Beck, 2008). The spiritual care interventions for social support and religion had moderate and statistically significant greater than chance agreement (Landis & Koch, 1977, p. 165), which provides some support for construct validity (Polit & Beck, 2008). The spiritual interventions for connection to music and past veteran culture

demonstrated fair but statistically significant greater than chance agreement, which suggests construct validity.

Four spiritual interventions demonstrated no significant agreement (fears, meaningful object, present veteran culture, and family support). The incongruence in the interrater kappa values for spiritual care performance between the RN, IO, and SP raters could exist because of the different viewpoints: Nurses who perceived they did or did not do something, the SP who rated they experienced or did not experience spiritual care, and the IO who believed they saw or did not see spiritual care provided. There is a gap in mutual agreement on these spiritual care items. It also could be related to lack of nursing education.

RN-SP congruence. There was “almost perfect” agreement between the RN-SP on two spiritual care interventions related to patient’s anxiety and physical suffering, with “substantial” agreement for chaplain referral (Landis & Koch, 1977, p. 165). This high agreement indicates that perceived care given by the nurse was received by the patient in these areas to some extent. This congruence between the RN-SP supports construct validity on these items (Polit & Beck, 2008). Although the spiritual care interventions for social support, Bible, and religion were less than the desired kappa range, they had statistically significant greater than chance agreement, which provides some support for construct validity (Polit & Beck, 2008). This is important, as what is given to the patient may not be received. The lack of congruence could also be due to the standardized patient receiving something that was not intentionally given. It depends on the type of match. Six categories of spiritual care interventions did not demonstrate significant agreement or meet the desired kappa agreement range: .7–1.0 (fears, music, meaningful object, veteran culture (past) and (present), and family support) (Kerns & Dhingra, 2012). Nursing is holistic

(ANA, 2010a) and this discrepancy in perspectives between the RN-SP support the need for nursing education to enhance provision of spiritual care to support patient-centered care and informs the content of that education.

RN-IO congruence. There was perfect raw agreement on two items between the RN-IO pair (anxiety and physical suffering), which supports construct validity (Polit & Beck, 2008). There was 84% raw agreement for fears item. There was statistically significant greater than chance agreement between RN participant and RN independent observer on six items (music, meaningful object, social support, religion, chaplain, and Bible), which supports construct validity (Polit & Beck, 2008). Of these, two spiritual care interventions (chaplain and Bible) had kappa values $> .8$ indicating “almost perfect” agreement, three “moderate” agreement (music, social support, and religion), and meaningful object “fair” agreement (Landis & Koch, 1977, p. 165). This suggests that it is possible to visually determine spiritual care is provided by an RN external observer. However, it is important to note that the IO is an expert in spiritual care. This congruence may be due to a common understanding of what is spiritual care in nursing practice. Three spiritual interventions demonstrated no significant agreement (past and present veteran culture, and family support) indicating potential areas of education. The results indicating an incongruence in understanding or addressing the veteran culture needs is consistent with the VA initiatives developed to enhance nursing knowledge of the veteran culture and their unique patient care needs (AACN, 2017b; Hobbs, 2008).

Script, SCCL Revision, and Nursing Education

The incongruences found in this research between the observers’ perceptions in spiritual care performance provide an opportunity to improve nursing education, research, and refine the

SCCL tool. These incongruent results between raters provide the opportunity to refine the SCCL (Polit & Beck, 2008). The next section will evaluate each concept and recommend inclusion, revision, or deletion of the item based on the study findings.

SCCL Item: Anxiety

Raw percent match supported construct validity. Based on complete agreement between the three raters, RN-SP-IO, this item will remain as written.

SCCL Item: Physical Suffering

Construct validity was supported by kappa and percent match values. Based on almost perfect agreement between the three raters, RN-SP-IO, this item will remain as written.

SCCL Item: Fears

The RN-IO pair had high agreement, which could be due to both observers being RNs. Based on the weak agreement between the RN-SP pair, this item requires revision. The low agreement between the RN-SP also suggests the need for increasing education on addressing patient fears through spiritual care interventions.

SCCL Item: Music

Because this item did not meet the .7 interrater agreement between the RN-SP pair, additional revisions in the music item and/or script content is needed, as well as indicating a need for more nursing education regarding use of music as a coping mechanism (Kerns & Dhingra, 2012).

SCCL Item: Meaningful Object

Based on the general disagreement between all raters, RN-SP-IO, the meaningful object

spiritual care item requires revision in both the script and SCCL, as well as indicating a need for more nursing education regarding connection to meaningful objects as a spiritual intervention.

SCCL Item: Veteran Culture (Past)

Based on the general disagreement between the pairs, the veteran culture (past) spiritual care item requires revision in both the script and SCCL, as well as indicating a need for more nursing education regarding connection to past veteran culture as a spiritual intervention.

SCCL Item: Veteran Culture (Present)

Based on the RN-IO and RN-SP raters' kappa values, indicating random agreement, the veteran culture (present) spiritual care item requires revision in both the script and SCCL, as well as indicating a need for more nursing education regarding connection to present veteran culture as a spiritual intervention.

SCCL Item: Family Support

The family support item requires revision, as all raters were showing no common understanding of this spiritual care intervention. Also, this item could be merged with the social support item, or better differentiating the two items so that the family item only refers to immediate family, and the social support item only refers to support systems other than family.

SCCL Item: Social Support

Since the observers were largely in agreement, the family picture environmental cue will move to the family support item to make the spiritual care intervention for social support checklist item more clearly related to non-family social support.

SCCL Item: Religion

Although the raters were in agreement, contacting the pastor or other faith community

leader will be added as an intervention to the checklist.

SCCL Item: Chaplain

This item will remain as written, as it had good construct validity with both kappa and percent match.

SCCL Item: Bible

Although there was substantial agreement between all three raters, RN-SP-IO, including the interventions of offering sacred text and religious items will be added to the checklist.

Nursing Education

The SCI pre-post findings show a statistically significant increase in RN perceived ability to provide spiritual care after participating in the ten-minute spiritual care clinical scenario simulation and ten-minute debriefing (Burkhart et al., 2011). This included a statistically significant increase in spiritual care interventions and meaning making, which was the intention of the simulation. These findings support that simulation is an effective teaching strategy, which is consistent with the literature (Costello et al., 2012; Fink et al., 2014). There was no other simulation study in the literature that used the SCI tool for comparison. This study adds to the literature as this spiritual care simulation is designed specifically for a veteran and has a companion performance checklist, which fills a gap in the literature.

Study Findings and the Extant Literature

Simulation and Spiritual Care

This study provides empirical evidence to support RN participation in a simulation with an SP increased nurse perceived ability to provide spiritual care, spiritual interventions, and

meaning making as measured by the SCI (Burkhart et al., 2011). In addition, the SCI had not previously been studied using simulation.

Meaning Making

The significant findings in the participant's perception of meaning making on the SCI tool (Burkhart et al., 2011) could have been influenced through participation in the prebrief, simulation and debriefing method used in this study. The experiential self-reflection using the Plus-Delta method, SCCL and debriefing with the SP aligns with the National League for Nursing (NLN) and INACSL call to increase debriefing as a pedagogy outside of simulation to enhance "meaning-makers" (National League for Nursing [NLN], 2015, p. 6). The critical reflection with debriefing is "the process of coming to know why an action was taken reveals the knowledge, assumptions, values, beliefs, and feelings behind the action and attaches meaning to information" (National League for Nursing [NLN], 2015, p. 3). The debriefing method in this study included both expressive writing on the Plus-Delta form and face-to-face reflection. Findings of this study support simulation and the Plus-Delta debriefing method as an effective educational pedagogy.

Advancing the SCiNP Theory

The SCiNP theoretical framework used in this study described spiritual care as a purposeful process of recognizing a patient cue for needed spiritual care, followed by a decision to engage or not engage in spiritual care and providing spiritual interventions (Burkhart & Hogan, 2008). Spiritual care affects both the nurse and the patient (Burkhart & Hogan, 2008). The first question the RN participant in this study was asked in the debriefing was to give a one-word description of their emotions at that moment (INACSL Standards Committee [INACSL],

2016a). Some of the RN responses were: “Concern and empathy”; “Deeply touched and moved”; “Emotional”; “Eye opener and humbling”; “Sad”; “Satisfying”; “Touched”; “Unprepared”; and “Very good.” These emotional descriptors after a 10-minute spiritual care simulation from the nurse participant exemplify the emotional response after a spiritual care encounter and the debriefing provided an opportunity for reflection. This study further advanced and supported the SCiNP theory (Burkhart & Hogan, 2008).

Gaps Resolved

The spiritual care clinical scenario simulation for a veteran and companion SCCL was developed to measure recognition of spiritual care cues and spiritual care interventions. The findings from this study contribute to the body of nursing knowledge, as this was a newly developed spiritual care clinical scenario simulation for a veteran at “risk for spiritual distress” (Herdman & Kamitsuru, 2014, p. 374) with a companion SCCL. This fills an education gap in creating an evidence-based simulation and provides a strategy to measure spiritual care using simulation. The SCCL is an evidenced-based tool that includes spiritual care cues and spiritual care interventions that nurses are mandated to know as part of professional nursing practice (ANA, 2010a). Also, the findings from the SCI demonstrate participation in the simulation experience (prebriefing, simulation, and debriefing) following INACSL Standards of Best PracticeSM and significantly improved RN perceived ability to provide spiritual care, spiritual interventions, and meaning making.

Implications for Research, Theory, Education, and Practice

Research

Research is needed to further refine the SCCL based on study findings. The refined SCCL tool could be used in a new study to explore congruence between raters and/or be used as a simulation spiritual care self-assessment teaching tool for both student and practicing nurses. Also, future research could measure sustained change in RN spiritual care practices post simulation. In addition, initiatives to promote spiritual care in practice can be evaluated and compared to patient satisfaction, using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (Centers for Medicare & Medicaid Services [CMS], 2015, June), and Press Ganey patient satisfaction change scores on hospital units where RN participated in the simulation experience could also add to the literature (Press Ganey, 2015a; Press Ganey, 2015b).

Promoting reflective practice/self care. In light of the RN emotions expressed during debriefing and potential for lingering emotions (Janzen et al., 2016), additional research could better evaluate that emotional response for further intervention. The findings from this study, and the reality of the emotional impact for both the RN from providing spiritual care, and risk for compassion fatigue, suggests a need to promote self-care. This is consistent with Janzen et al. (2016), Watson's transpersonal caring theory (2008), and Burkhart/Hogan (2008) SCiNP theory. All recommend nurse reflective practice to promote nurse self-care. Although SWB is the desired spiritual care outcome for both patient (Puchalski, 2012) and nurse (Burkhart & Hogan, 2008), spiritual well-being was not measured in this study. Future studies could include spiritual care educational programs for nurses, using this spiritual care scenario simulation and

companion SCCL, measuring the effect of the program on spiritual wellbeing in addition to perceived ability to provide spiritual care.

Theory

This study sought to determine whether this spiritual encounter is recognizable and measurable by an IO, which was verified through the completed SCCLs for each simulation experience. The philosophy for this study was Watson's transpersonal caring theory (2008) with Dr. Burkhart and Dr. Hogan's SCiNP (2008) as the theoretical framework. Although the RN and SP both verbalized positive spiritual care interventions and connection based on the SCCL in the debriefing, future theoretical research from this study could include the RN, SP, and IO also writing out any "caring moment" experienced during the simulation as part of the post simulation data collection (Watson, 2010, p. 118). Comparing the RN, SP, and IO similarities/dissimilarities in the chosen "caring moment" could help determine whether the "caring moment" is recognizable and measurable by different viewpoints to further develop the Watson Transpersonal Caring Theory (Watson, 2008; Watson, 2010, p. 118).

Education

The SCCL items for anxiety, physical suffering, and offer to call chaplain had high interrater congruence. Items on the SCCL that had lower congruence between observers included interventions addressing insomnia and fear, meaningful objects, present veterans' experiences, and family support. This suggests a need to develop and incorporate spiritual care education, as well as education related to veteran needs. This education could include listening skills, the importance of music and/or meaningful items as spiritual care. Although connection to Higher Power/Faith Ritual items were highly congruent and some nurses read from the Bible and

prayed, other participants verbalized discomfort especially if their faith tradition was different from the SP. These findings also highlight the need for increased nursing education and practice providing spiritual care for veterans, which could be done in the simulation environment. In addition, further incorporation of Watson's (2008) caring theory and Burkhart and Hogan's (2008) SCiNP into nursing education to promote reflective practice and self-care could reduce nurse compassion fatigue, but this also requires additional research.

Practice

Approximately “23 million veterans live in the United States and Puerto Rico” and only “8 million veterans are enrolled in the Veterans Health Administration (VHA)” (Anthony et al., 2012, p. e145). This leaves millions of veterans receiving healthcare in non-VHA centers (Anthony et al., 2012, p. e145; Johnson et al., 2013). Therefore, it is essential that both student nurses and practicing nurses know how to tend to the unique spiritual needs of the veterans.

Watson Caring Theory and VA Affiliations

Watson has developed the Watson Caring Science Institute (WSCI) for which three VHA hospitals have an affiliation (Watson Caring Science Institute [WCSI], 2015). These three VHA hospitals affiliated with WSCI include James A. Haley Veterans' Administration Medical Center (VHAMC) in Florida, Washington D.C. VHAMC, and the Atlanta VHAMC. Affiliation with WSCI indicates a commitment to integrate caring science into nursing policy and care for patients, families, staff and surrounding communities. WSCI affiliates must also provide evidence of investing in leadership to transform the environment to holistic health and healing through participation in programs such as the “Caritas Coaches” (WCSI, 2015, p. 1). The “Caritas Coach Education Program” (CCEP) is a reflective six-month program offered through

WCSI that is accredited through the American Nurses Credentialing Center (AACN) (Watson Caring Science Institute [WCSI], 2016, para. 2, 3). Affiliation with WCSI also requires a commitment to research that impacts safe, quality, patient care and patient perception of care provided (WCSI, 2015). More VHA hospitals could join Watson's Caring Science Institute (WSCI) and collaborate with other VHA hospitals currently affiliated with WSCI (Watson Caring Science Institute [WCSI], 2015). This simulation could be used to foster these initiatives.

Conclusion

These findings support CVI using content experts as a valid means to develop a spiritual care clinical scenario and companion performance checklist. The SP provided the opportunity to create a realistic patient care clinical situation for the encounter. This study provides data on how spiritual care is perceived in practice from multiple viewpoints using both the kappa statistic and percent agreement value. Interrater congruence using kappa statistic and percent match supported construct validity for three items on the SCCL (anxiety, physical suffering, chaplain). Further refinement is needed for the remaining items, simulation, and SCCL. Lack of interrater congruence could be due to a need for nursing education. Perceptions of spiritual care levels of congruence are different based on type of spiritual care and by rater. There was a statistically significant increase in RN perceived ability to provide spiritual care after experiencing the simulation experience (prebriefing, simulation, and debriefing) ($p < .001$). Nurse theorists Burkhart and Hogan (2008) and Watson (2008) imply that spiritual care is not an assessment survey, rather an awareness and assessment in the moment the need arises. The spiritual care clinical scenario simulation and companion SCCL was designed with that in mind.

This study supports that spiritual care can be observed and measured using simulation science. Although this simulation was designed for the unique needs of a veteran, spiritual care should be weaved into all simulation scenarios as nursing practice is holistic and there are benefits associated with spiritual care. It was evident through observing the scenario and participating in the debriefing that the RN was touched and impacted from the simulation experience. It was important for the observers to take the time to pause, sit, and process the simulation spiritual care experience, using both the written and face-to-face verbal connection to promote feedback, reflection, and meaning making. It is important for nurses to possess spiritual care companioning skills to promote meaning and purpose, connection, transcendence, hope, and ultimately SWB for self and others. Florence Nightingale, the founder of modern nursing saw nursing as spiritual and encouraged nurses to include nature in healing by providing optimum environments for the patients to heal, which includes soldiers (Calabria & Macrae, 1994). The same standard to nurses to provide optimum healing environments that include a caring presence, pausing, listening, compassionate, loving, and honorable care of the human spirit of our patients and nation's heroes, our soldiers and veterans remains today.

APPENDIX A

COPYRIGHT FOR FIGURE 1 (A THEORETICAL MODEL)



Title: An Experiential Theory of
Spiritual Care in Nursing Practice

Author: Lisa Burkhart, Nancy Hogan

Publication: Qualitative Health Research

Publisher: SAGE Publications

Date: 07/01/2008

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APPENDIX B

SPIRITUAL CARE ATTRIBUTES/PERSPECTIVES/THEORY

Literature Source	Purpose	Approach	Findings/Discussion	Spiritual Care
Batthey (2012, December)	Nurse spiritual care expert exploration of present standing of perspectives of nurse managers and regarding spiritual care and barriers; review of hospital accreditation, guidelines, and patient satisfaction surveys.	No identification of approach to literature review. Provides an overview of these areas: Problem Status of medical education and nursing education Hospital standards Holistic health Perspectives of hospital administration, managers, nursing students, and chaplains.	Barriers: Organization, lack of guidelines, and role. Stresses ethical concerns related to spiritual care; Spiritual care programs may not be for all nurses; need to assess maturity and willingness for programs. Proposes use of Humanizing Nursing Communication Theory (Duldt et al., 1984, Duldt & Giffin, 1985, & Duldt 1991, 2002 as cited in Batthey, 2012); author's spiritual care program, textbook and theory: Theory of Spiritual Care in Nursing Practice. She briefly describes the theory acronym "BVMGR": "Beliefs"; "Values"; "Meanings"; "Goals"; "Relationships" (p. 1017-1018).	Explains the goals of spiritual care as 5 R's: 1. Recognize spiritual distress and how patient defines spirituality. 2. Respond with human compassion. 3. Record adhering to legal, ethical, and organization. 4. Report to those applicable. 5. Refer to pastoral support (Duldt, 1991; Batthey, 2008; as cited in Batthey, 2012).

Literature Source	Purpose	Approach	Findings/Discussion	Spiritual Care
Como (2007)	Literature review of empirical and spiritual care literature.	Exploratory ROL 1986-2006 (<i>n</i> = 12). Categories: Patients Nurses	Categories: Definitions of spirituality; spiritual health; spiritual practice; Nurses; Patients. Defines spiritual practices and nursing spiritual care as facilitating one's spiritual practices (both existential and religious) seen as health promoting behaviors that can contribute to beneficial health outcomes.	In article Table 4 lists 40 spiritual practices that nurses can support (a few will be listed below): <ul style="list-style-type: none"> • Listening/silence • Life review • Religious symbols & sacred text • Prayer • Music/Song • Art • Caring • Complementary • Trust • Love • Presence • Gratitude

Literature Source	Purpose	Approach	Findings/Discussion	Spiritual Care
Kalish (2012)	Review spirituality and spiritual care evidence-based literature.	Exploratory ROL of research studies during (June 2010–December 2011) (<i>n</i> = 50).	<p>Two themes:</p> <ol style="list-style-type: none"> 1. Spiritual care outcomes including QOL; Barriers. 2. Development and Testing of Tools: FICA, SSCR, and SCGS). <p>Findings: Lack of clarity on concept of spirituality and team role providing spiritual care; no studies during this time period included interprofessional spiritual care provision; own spirituality impacts provision of spiritual care; Barriers include lack of education and team roles. Suggests need for defining interdisciplinary team roles; spiritual care education for interdisciplinary team. Also spiritual assessments should be conducted by experts, and “generalists” screen and obtain history.</p>	

Literature Source	Purpose	Approach	Findings/Discussion	Spiritual Care
Monareng (2012)	Aim: spiritual care operational definition and how spiritual care is provided. (South Africa)	Exploratory ROL (overview of literature using various sources) and qualitative study. Grounded theory Symbolic interactionism (SI) Individual ($n = 4$) Focus groups ($n = 4$) Walker & Avant concept analysis method. Audiotape and transcription of focus group interviews; constant comparison; coding. Nurses from an academic hospital in South Africa (variety of patient care units).	Provides chart of definitions of spiritual care from both the existential and religious perspectives. Antecedents: Spiritual discomfort; Nurse's self-awareness Sensitivity; Trust; and Spiritual competence. Attributes: see spiritual care column. Consequences: Spiritual integrity; sense of well-being; spiritual health. Qualitative study findings: Barriers: Deficit of knowledge; not top priority; no protocol to provide direction.	Main variable from ROL: "Caring presence" includes (hope, compassion, empathy, concern, respect). Defining attributes: <ul style="list-style-type: none"> • Caring presence • Meaning/purpose • Spiritual conversation • Transcendence • Harmony with connections For interview: Spiritual care in nursing includes: <ul style="list-style-type: none"> • nurse • Religious texts and symbols • Interaction for meaning with concern and love

Literature Source	Purpose	Approach	Findings/Discussion	Spiritual Care
Ramezani, Ahmadi, Mohammadi, & Kazemnejad (2014, June)	Concept analysis	Years 1950-2012 in English and Persian 151 articles and 7 books Walker & Avant concept analysis method.	Antecedents: Aware of the transcendent Self-aware Affiliated with faith tradition Sensitive Intentional Consequences: Nurse: Awareness of spiritual & job satisfaction Patient: Healing; SWB; Adapts psychologically; Patient satisfaction.	Healing presence Nurse (therapeutic) Intuition Patient focused (meaning) Explores Environment (nurtures) Therapeutic
Rushton (2014)	Identify barriers to spiritual care.	Exploratory ROL (<i>n</i> = 136)	Main barriers: Definition Lack guidelines Lack education Lack training Lack time. Recommend: Define spirituality and nurse's role for clarity, and training and education. Holistic care is essential to meet the patient needs.	NA

Literature Source	Purpose	Approach	Findings/Discussion	Spiritual Care
Wright (2008)	<p>Article is an author developed review of spiritual care model: Trinity Model seven spiritual care practices nurses can use with suffering.</p> <p>Nurse expert from Calgary shares private practice and research regarding suffering.</p>	NA	Author summarizes previous research she conducted and shares verbatim conversations.	<p>7 Spiritual Care Practices:</p> <ol style="list-style-type: none"> 1. Sit with patient; be present; stay focused; communicate therapeutically. 2. Allow sharing of story and its impact on life and relationships. 3. Active listening. Shared example of involving family in interpretation of staff plan. 4. Compassion, Love, and Connection. 5. Acknowledge both the person and the suffering. 6. Exploration of the meaning/purpose. 7. Offer hope.

APPENDIX C
LITERATURE REVIEW OF SPIRITUAL CARE

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Baldacchino (2006)	Determine spiritual care competencies: A) Two closed-end questions inquiring about patient spiritual distress situations and outcome evaluation. Plus 5 open-ended questions: nursing care related to spiritual distress/what enhances and/or is a barrier to providing spiritual care/learning/and comments. B) Qualitative study–detailed interview.	Descriptive, exploratory two-part study; Nurses from Malta caring for myocardial infarction patients. Part A: (<i>n</i> = 77) Part B: Stratified random (<i>n</i> = 14) Content validity of questions through expert RN, chaplain, and ethicist. Interviews required translation.	Four main competencies: 1) Nurse as professional and person. 2) Delivery of care using nursing process. 3) Nurse communication with patient, team, and larger educational/clinical organizations. 4) Ethical protection Barriers: Time, heavy workload, lack privacy, perceive it is chaplain’s role; different faith tradition from patient; lack spiritual tools; lack education; lack reflection. Spiritual Care: <ul style="list-style-type: none"> • Empathy • Quiet environment • Religious coping • Instill hope • Meaning & purpose • Family connection • Refer to chaplain • Inter-collaboration

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Belcher & Griffiths (2005, September)	Determine: Nurses' Personal and professional spirituality; Spiritual practices; Ability to incorporate own spirituality to patient care including any discomfort.	Descriptive, qualitative survey with 15 open-ended questions with hospice nurses ($n = 204$). Content analysis of survey questions.	Own spirituality expressed through own faith rituals, prayer, meditation, journaling, and music; > 50% had relationship with Higher Power. 1) Reasons might not provide spiritual care: If patient doesn't believe in God; Patient not communicative; Short length of stay; different religion of patient or organization; family issues; beliefs differ from patient Barriers: Lack knowledge; No tool; Embarrassment; Hesitant; Reliance on Chaplain/Social Worker; Patient/Family relationships; Time; Workload. 1) How did RN learn spiritual care? Hospice work; pastoral care team; own religion and education; 3) Further spiritual care. 4) Collaborate with team Spiritual Care: <ul style="list-style-type: none"> • Verbal and non-verbal communication. • Be positive; Express hope; Respect; Empathy. • Support; Prayer (silent and verbal if requested or if appropriate); Humor; Art; Storytelling; Therapeutic touch; Healing touch; Ask patient; Listen to stories; Empathy; Trust; Assess habits Check non-verbal cues such as symbols (religious items). • Also includes support and encouragement to colleagues.

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Deal & Grassley (2012, November-December)	Explore nephrology nurses caring for hemodialysis patients in acute/chronic units.	Qualitative interviews (half hour to one hour) inquiring about a spiritual care memory, patient's spiritual distress; own spirituality and spiritual growth (<i>n</i> = 10) saturation. Recorded and transcribed using Colaizzi's (1978) phenomenological method; participants were sent transcription to add anything if desired.	Five themes: Patient/nurse get close; nurses rely on own spiritual resources; sense patient's spiritual distress; lack of resources; deep connection and emotional element and cost associated with spiritual care. Barriers: Time, lack of space, emotional, afraid to overstep boundaries. Spiritual Care: <ul style="list-style-type: none"> • Intimate • Listen • Touch • Sit • Look in eyes • Kindness • Respect • Connect to religious support/chaplains • Religious text • Prayer • Create "holy" environment (p. 476)

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Dunn, Handley, & Dunkin (2009, March)	Explore spirituality, SWB and spiritual care.	Descriptive, correlational RNs working on maternal/infant unit ($n = 33$). Spiritual Perspective Scale Spiritual Well-Being Scale Two Qualitative questions: How often assess spiritual needs and what interventions provide. Analysis: Descriptive and correlational stats. Qualitative using Colaizzi's method (themes/descriptions).	Sig. correlation SPS and SWBS and subscales RWB & EWB. Qualitative: 1. Assessment: Most stated on admission and first time with patient; 4 rare. 2. Spiritual care (see spiritual care column). Highly religious sample; No correlation to religious attendance possibly due to working long shifts on weekends. Spiritual Care: <ul style="list-style-type: none"> • Prayer for patient and self • Refer to chaplain or own clergy • Bible • Rituals • Assist baptisms • Listen • Talk • Answer questions • Touch • Hugs • Positive words • Respect beliefs and culture • Connect family

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Garrison, Xu, Jurgens, & Boyle (2013, June)	Identify barriers in provision of spiritual care to hospital in-patients.	Exploratory, descriptive with nurses working on medical units of major medical center ($n = 120$); Online survey Conceptual framework: Synergy model Spiritual Care Practice Tool (SCP)—Likert 1-5; 2 part: I—measures % nurses providing spiritual support II—% barriers (Vance, 2001) I—($\alpha = .87$) II—($\alpha = .64$) Plus two open-ended questions: First: Identify barriers; Second: Identify a meaningful spiritual care intervention provided. Analysis: Descriptive statistics for SCP data; Content analysis with qualitative questions.	SCP findings: I—Approximate nurse provision of spiritual care at best level was 1/3 nurses; 96% ($n = 114$) know spiritual care part of role; almost 50% have rare participation in own spiritual practices. II—Barriers reported: Time (68%) Privacy/beyond scope (50%) 1/3 unsure if was preaching; Different beliefs than nurse (21%). Open-ended question to identify barriers: <ul style="list-style-type: none"> • Time (39%) • System (30%) • Patient resisting (17%) • Lacking education (17%) Open-ended questions: Meaningful spiritual care provided: <ul style="list-style-type: none"> • Make referrals (44.3%) • Pray with patients/families (34%) • Be present to patients/families (17%) • Use hospital resources (13%)

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
McBrien (2010, July)	Explore ER nurses spiritual care practice.	<p>Descriptive, exploratory.</p> <p>RNs work in Emergency Room in Ireland ($n = 10$).</p> <p>Semi-structured interviews and reflective journal kept by researcher (pilot tested first with 5 RNs).</p> <p>Template analysis</p>	<p>3 themes: Connectedness, Belief/Faith and Hope, and 13 sub-themes of spiritual care described in spiritual care column.</p> <p>Barriers:</p> <ul style="list-style-type: none"> • Time • Lack of privacy • Lack of education <p>Spiritual Care:</p> <ul style="list-style-type: none"> • Sit • Listen • Prayer • Comfort measures • Presence • Honesty • Empathy • Connection • Religion/Chaplain • Spend time • Help • Reassure • Touch

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Monareng (2013)	<p>Explore and describe how nurses' provide spiritual care.</p> <p>Unstructured individual: "What do you understand by spiritual nursing care and how do you provide such care for your patients?" (Monareng, 2013, p. 3).</p> <p>Individual interviews guided focus group six questions.</p>	<p>Qualitative, explorative, descriptive study with RNs working at a public hospital in South Africa ($N = 28$).</p> <p>Individual ($n = 4$), Focus group ($n = 24$), observation, and field notes.</p> <p>Audiotaped Transcribed verbatim; Coding Constant comparison Symbolic interactionism (SI).</p>	<p>Derived four themes:</p> <ol style="list-style-type: none"> 1. "Meaning of spiritual nursing care" (p. 4). 2. "Nurse relationships in the health care context" (p. 5). This included the nurse and patient's relationship. Some participants referred to patient made in image of God and the importance of treating the patient as a human not a room number or by disease. 3. "Provision of spiritual nursing care" (p. 5). As listed in spiritual care column. Also discovered spiritual care was provided on nurses' own initiative, not required as nurse. 4. "Challenges in the provision of spiritual nursing care" (p. 6). <p>Barriers: State inadequate education, different beliefs from patient and nurses; different cultures; need for mutual consent from patient; limited time.</p> <p>Spiritual Care:</p> <ul style="list-style-type: none"> • Respect person as a holistic human being. • Good attitude • Compassion/Courteous • Promote transcendence • Reciting scripture • Symbols for prayer • Refer to chaplain or patient's own spiritual leader • Most common were: Prayer & singing spiritual songs

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Nardi & Rooda (2011, July-August)	Explore senior nursing students' awareness of and application of spiritual care interventions. Included NANDA-I, NIC, and NOC.	Exploratory mixed method with senior nursing students ($n = 86$) from two different programs (one private/one public). The Spirituality Scale was developed for study using ROL. With construct validity by experts from Parish Nurse program (# not identified) ($\alpha r = .949$). Scale has 3 parts: Demographics; open-ended question (How spiritually connected are you?; 45 questions 30 related to beliefs/values and 15 to interventions. (76-161 possible points) T-test, regression analysis; Factor analysis revealed 5 themes to create spiritual care practice theory.	No significant difference between groups ($p = .507$). Combined mean 128.76 On The Spirituality Scale. 98% students in private school report learning spiritual care whereas 39% of students in public school). 5 Factors: 1. Value and support others 2. Use of nursing process 3. Use of self (need relationship/prayers/own energy impact) 4. Interventions 5.Outcomes. Qualitative questions 3 themes: 1. Metaphysical 2. Aware of metaphysical 3. Emotional experience and rewards of providing spiritual care. Developed a practice theory: Nurse aware of patients' needs leads to nurse's interventions and mutual agreement with patient outcomes Included in the practice theory developed: Prayer Meditation Presence Assessment Support Facilitation

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Smyth & Allen (2011)	Explore and describe nurse's definition of spirituality and provide spiritual care.	2-phase mixed methods explanatory descriptive 8-item questionnaire (content verification by palliative intercollaborative team). Phase 2: Three unstructured focus group with nurses from a medical acute care unit (terminally ill patients) in rural area in Australia. Questionnaire and focus group sequential analysis and triangulation; Themes from transcribed data and coding. No mention of audiotape. Notes from researcher.	Four themes: Understand spirituality; Assessing spirituality; Barriers to providing spiritual care; and education. Lack clarity in defining spirituality; no formal assessment tool; do assess and provide spiritual care. Patients are placed on an acute care unit. Barriers: Time, organization, staffing/colleagues different opinions, high acuity, if patient non-communicative. Spiritual Care: <ul style="list-style-type: none"> • Be with them • Have pets visit • Connect minister • Hold hands • Assess cues • Listen, observe how interacts, sleep habits, pain, emotions

Author/Source	Study Question & Purpose	Design/Sample/ Instrument/Analysis	Findings/ Spiritual Care
Wallace & O'Shea (2007, Nov-Dec)	Perceptions of older nursing home residents at end-of-life on spirituality and spiritual care.	Quantitative descriptive survey with residents from two faith-based nursing homes ($n = 26$). Spirituality & Spiritual Care Rating Scale (SSCR) with (4-subscales) For this study: 1. Spirituality ($\alpha = .77$) 2. Spiritual Care ($\alpha = .69$) 3. Religiosity ($\alpha = .71$) 4. Personalized care ($\alpha = .65$)	SSCR (0-68) Mean 51.36 Indicates moderate view of spirituality (less on religiosity). Participants suggest the following to support their spiritual health: <ul style="list-style-type: none"> • Connect to religious support • Kindness • Spend time listening • Presence • Respect • Support friendships and needs related to forgiveness • Play music • Time in nature

APPENDIX D

VA IRB APPROVAL LETTER, CHAIR, RESEARCH AND DEVELOPMENT COMMITTEE

Department of Veterans Affairs
Memorandum

DATE: January 25, 2016

FROM: Chair, Research and Development Committee

TO: Associate Chief of Staff, Research Service (

SUBJ: Research Project Approval

1. The project, "Research to Support an Organizational Culture of Spiritual Care in VA Patient Care," _____, PROMISE#0001, was approved by the R&D Committee on January 25, 2016. The project has received all of the appropriate subcommittee approvals and is ready for authorization by the ACOS. The following subcommittees have forwarded their approvals.

Research and Development

IRB	<input checked="" type="checkbox"/>	N/A
IACUC	<input type="checkbox"/>	N/A
Safety	<input type="checkbox"/>	N/A
Radiation Safety	<input type="checkbox"/>	N/A

2. Please contact me with any questions or concerns.

Thank you.

Chair, R&D Committee

cc: Research Project File

APPENDIX E
VA IRB APPROVAL LETTER,
ASSOCIATE CHIEF OF STAFF, RESEARCH SERVICE

**Department of
Veterans Affairs**

Memorandum

Date: January 25, 2016

From: Associate Chief of Staff, Research Service (

Subj: Research Project Approval

-
1. Your project "Research to Support an Organizational Culture of Spiritual Care in VA Patient Care," PROMISE#0001, was approved by the R&D Committee on January 25, 2016 and research can be initiated.
 2. If modifications are made in your protocol, approval must first be obtained from the appropriate subcommittees (i.e. Human Studies, IACUC, Research Safety/Biosafety, Hospital, and Radiation).
 3. If you have any questions, please contact _____, Research and Development Committee Coordinator.

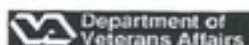
Thank you.

Acting Associate Chief of Staff, Research

cc: Research Project File

APPENDIX F

VA IRB APPROVAL LETTER, IRB COORDINATOR



Memorandum

INSTITUTIONAL REVIEW BOARD

DATE: January 22, 2016

TO: _____

FROM: _____
IRB Coordinator

RE: IRB #15-079: Research to Support an Organizational Culture of Spiritual Care in VA Patient Care

Dear _____

We have reviewed your request for expedited approval of the new study listed above. This type of study qualifies for expedited review under VA (FDA) and DHHS regulations category # 6 and 7.

This is to confirm that the Chairperson of the Institutional Review Board (IRB) has approved your application. The approval date for this study is 1/22/2016. This approval will be reported at the 2/1/2016 IRB meeting.

You are approved to enroll up to 50 subjects.

This protocol was considered to be minimal risk.

Waiver of informed consent is approved under 36 CFR 116.116(d)(1-4), and waiver of HIPAA authorization is approved under 38 CFR 16.110.

Prior to the interview portion of the study you must obtain a VA Form 10-3203 CONSENT FOR USE OF PICTURE AND/OR VOICE from each study subject. Failure to obtain this consent prior to recording the interview will constitute Non-Compliance on your part as the PI and you will not be allowed to use the data collected during the recorded interview.

Copies of the following IRB approved documents are attached to this message:

- Letter of Information (email message to RNs)
- VA Form 10-3203
- Spiritual Care in Practice Questionnaire
- Demographic Data Sheet
- Spiritual Care Inventory (SCI)

You are reminded of the VA data security requirements and requirements of the new VHA Handbook 1200.12 and Reporting of Adverse Event/Unanticipated Problems VHA 1058.01. VHA handbooks and Directives can be accessed at: <http://www1.va.gov/vapubs/>

You are granted permission to conduct your study as described in your application effective upon R&D approval. The study is subject to continuing review by the IRB and R&D on or before 1/21/2017, unless closed before that date.

As the principal investigator it is your responsibility to submit a completed Continuing Review request and supporting documents prior to 12/4/2016 to ensure timely review of your application. Failure to meet this deadline may cause the approval for this study to lapse.

REMINDERS:

- The Human Research Protection Plan is available. Please make sure you are familiar with your responsibilities.
- VA regulations require annual human subjects protection training. It is your responsibility to ensure all VA mandatory training is current for all personnel on this project and that the Research Office has copies of the most current certificates. The most current HSP training module may be accessed at: <http://www.citiprogram.org>
- A subject is considered enrolled if he/she agrees to and participates in any of the study activities, the number of subjects enrolled must be reported at the time of continuing review.
- Any changes to the study must be submitted and approved prior to implementation. Some changes may be approved by expedited review; others may require full board review.
- All Adverse Events (AE) (related or not related), Unanticipated Problems and Protocol Deviations are to be reported to the IRB. Any serious AE, Unanticipated Problems and Protocol Deviations must be reported within 5 days of PI identification.
- You are reminded that patient initials, name, birthdate, or other identifiers ARE NOT allowed to be referenced on the case report forms or data collections sheets
- Please note that once a study is closed all research records and study documents must be retained for 6 years after the cutoff date, or longer if required by other Federal regulations. The cutoff date is at the end of the fiscal year after completion of the research project (i.e. study closure). Example: If a study is closed at any time during this fiscal year (October 1, 2015 through September 30, 2016), the cutoff date is October 1, 2016 and the study records, at minimum, would need to be maintained in a locked cabinet in a locked room until October 1, 2022.
- All Applications, Handbooks, checklists and Reporting Forms are available electronically on the Research SharePoint site: <https://vaww.visn12.portal.va.gov/hin/svc/research/default.aspx>

Please contact me at _____
questions or require further information.

if you have any

APPENDIX G

VA IRB AMENDMENT APPROVAL LETTER, ASSOCIATE CHIEF OF STAFF,
RESEARCH SERVICE

Department of
Veterans Affairs

Memorandum

Date: May 23, 2016

From: Associate Chief of Staff, Research Service \ _____

Subj: Approval of Amendment

To:

1. The amendment to project "Research to Support an Organizational Culture of Spiritual Care in VA Patient Care," by Dr. _____ was approved by the R&D Committee on May 23, 2016. The _____ IRB approved the amendment on May 13, 2016.

2. If modifications are made in your protocol, approval must first be obtained from the appropriate subcommittees (i.e. Human Studies, IACUC, Research Safety/Biosafety, Hospital, and Radiation).

3. If you have any questions, please contact ' _____ , Research and Development Committee Coordinator, _____

Thank you.

Chair, R&D Committee

cc: Research Project File

APPENDIX H

VA IRB AMENDMENT/REVISION REPORTING FORM, PRINCIPAL INVESTIGATOR

**INSTITUTIONAL REVIEW BOARD
Amendment / Revision Reporting Form**

Please complete this form for all protocol/consent amendments and revisions and forward to the IRB Office, VA Hospital for review by the IRB. All information must be provided or the request may be delayed.

Principal Investigator:

Research to Support an Organizational Culture of Spiritual Care in VA Patient Care

Title of Study:

VA Project Number:

(Promise or IRB#)

15-079

Amendment/Revision: (Provide *complete* description below or attach description) If applicable - please provide a revised protocol incorporating changes.

For the research study (IRB #15-079), Research to Support an Organizational Culture of Spiritual Care in VA Patient Care, we wish to refine and evaluate the simulation tools we will be using in this study. This approach is a variant of the "Delphi method" for defining the best version of the techniques developed for the study to date. We will invite a nurse who works in the community, two nursing faculty, and six senior nursing students to participate in a practice run-through of the spiritual care simulation to assess usability of the simulation, face validity of the simulation checklist, as well as flow and timing of the simulation event. Although faculty and students will complete surveys and participate in interviews as part of the feedback and revision process, interviews will not be recorded, and no names or other identifying information will be collected. We are only seeking input from a group of individuals familiar with nursing situations in the care of VA patients. This opportunity will be offered to only senior nursing students who are completing their capstone Clinical Role Transition practicum at the VA, and established nurses as noted above. This experience is voluntary, and participation in the feedback panel involves no contact with veterans, PHI or medical records. The next step in the protocol itself will be recruitment of VA nursing staff as study participants.

Answer the Following Questions:

- Could this Amendment/Revision affect the participant's willingness to continue to participate in this study. (If yes, explain and include: plan for notifying participants)
1. Yes No
- Does this Amendment/Revision increase risk to the patient? (If yes, explain and include: plan for monitoring and revised consent)
2. Yes No
3. Is it Necessary to Make Changes to the Informed Consent? Yes No

If "YES," attach a copy of the revised consent with the changes highlighted. You may NOT enroll new participants using the amended format until the amendment/revision has been reviewed and the IRB has approved the consent.

If the informed consent is revised to include increased or additional risks, attach plan to inform active participants (and past participants if applicable).

4. Does this Amendment/Revision increase the study budget requirements? *(If yes, explain AND SEND A COPY TO CARES)* Yes No

-
5. Does this Amendment / Revision involve changes in Biosafety? *(If yes, explain AND SEND A COPY TO RESEARCH SAFETY COMMITTEE 151. Approval is required prior to IRB Review)* Yes No

6. Does this Amendment/ Revision involve changes in Radiation Safety? *(If yes, explain AND SEND A COPY TO RADIATION SAFETY COMMITTEE 151. Approval is required prior to IRB Review)* Yes No

Principal Investigator's Signature

Date

APPENDIX I

VA IRB AMENDMENT APPROVAL LETTER, IRB COORDINATOR



Memorandum

INSTITUTIONAL REVIEW BOARD

DATE: May 23, 2016 (Corrected study title)

TO: Education

FROM:

RE: PROMISE # 0001; IRB # 15-079; Research to Support an Organizational Culture of Spiritual Care in VA Patient Care

The Chairman of the Institutional Review Board (IRB) has reviewed your application for revision of the study listed above. The requested revision involves changes to the protocol as follows:

- This amendment is to request IRB review of the following documents (final versions):
 - a) Revised IRB Part III form (with tracked changes)
 - b) Participant demographic sheet
 - c) Email reminder sent to participants 1-5 days prior to the research simulation
 - d) Spiritual care simulation checklist (to be completed by standardized patient, independent observer and participant).
 - e) Spiritual care simulation script for standardized patient
 - f) Recruitment phone script describing study participation for potential participants
 - g) Participant honoraria sample voucher
 - h) Qualitative interview questions
 - i) Post-simulation debriefing questions and Plus-Delta sheet

This type of revision qualified for expedited review under VA and OHRP regulations: Minor change in previously approved research during the period for which approval is authorized.

This is to confirm that your request for revision is approved. This approval will be reported at the 6/6/2016 IRB meeting.

You are granted permission to conduct your study as revised effective immediately. The date for continuing review remains unchanged at 1/21/2017 unless closed before that date.


Please note that any further changes to the study must be submitted and approved prior to implementation. Contact me at _____ if you have any questions or require further information.


Sincerely,

IRB Coordinator

APPENDIX J

VA IRB AMENDMENT APPROVAL REPORT OF FINDINGS, IRB REVIEW BOARD

		Department of Veterans Affairs		REPORT OF FINDINGS INSTITUTIONAL REVIEW BOARD	
Project/Program Title		PROMISE #0001; IRB #15-079; Research to Support an Organizational Culture of Spiritual Care in VA Patient Care			
Principal Investigator					
VAMC		Meeting Date	Approved 10/16/10		
COMMITTEE DETERMINATIONS:					
1.	The information given in the Informed Consent under the Description of Research by Investigator is complete, accurate and understandable to a research subject or a surrogate who possesses standard reading and comprehension skills.	<input checked="" type="checkbox"/>	YES		
			NO		
2.	The informed consent is obtained by the principal investigator or a trained and supervisor designate under suitable circumstances.	<input checked="" type="checkbox"/>	YES		
			NO		
3.	Every effort has been made to decrease risk to subject(s)?	<input checked="" type="checkbox"/>	YES		
			NO		
4.	The potential research benefits justify the risk to subject(s)?	<input checked="" type="checkbox"/>	YES		
			NO		
5.	If subject is <u>incompetent</u> and surrogate consent is obtained, have all of the following conditions been met: a) the research can't be done on competent subjects; b) there is no risk to the subject, or if risks exist the direct benefit to subject is substantially greater; c) if any incompetent subject resists, he will not have to participate; d) if there exists any question about the subject's competency, the basis for decision on competency has been fully described.		YES		
			NO		
		<input checked="" type="checkbox"/>	N/A		
6.	If subject is paid the payment is reasonable and commensurate with the subject's contribution.	<input checked="" type="checkbox"/>	YES		
			NO		
			N/A		
7.	Members of minority groups and women have been included in the study population whenever possible and scientifically desirable.	<input checked="" type="checkbox"/>	YES		
			NO		
8.	Comments: Expedited criterion: Minor change in previously approved research during the period for which approval is authorized.				
The Committee has determined the following criteria have also been met:					
Conflict of Interest. Adequate steps to manage, reduce or eliminate potential or real conflicts of interest					
Investigator's Educational Requirements and Certification: The PI and all other investigators of this proposed research activity have met all current mandated educational requirements for the protection of human research subjects <u>and</u> the investigator is qualified through education, training, and experience to conduct the research					
Privacy and Confidentiality. Adequate provisions will be taken to protect the privacy of subjects and to maintain the confidentiality of individually-identifiable data.					
AMENDMENT:					

 Department of Veterans Affairs		REPORT OF FINDINGS INSTITUTIONAL REVIEW BOARD
Project/Program Title	PROMISE #0001; IRB #15-079; Research to Support an Organizational Culture of Spiritual Care in VA Patient Care	
Principal Investigator	_____	

This amendment is to request IRB review of the following documents (final versions):

- a) Revised IRB Part III form (with tracked changes)
- b) Participant demographic sheet
- c) Email reminder sent to participants 1-5 days prior to the research simulation
- d) Spiritual care simulation checklist (to be completed by standardized patient, independent observer and participant).
- e) Spiritual care simulation script for standardized patient
- f) Recruitment phone script describing study participation for potential participants
- g) Participant honoraria sample voucher
- h) Qualitative interview questions
- i) Post-simulation debriefing questions and Plus-Delta sheet

	<i>FULL BOARD</i>	<input checked="" type="checkbox"/> <i>EXPEDITED</i>	<i>EXEMPT</i>
RECOMMENDATION:	<input checked="" type="checkbox"/> <i>APPROVE</i>	<i>DISAPPROVE/REVISE</i>	

SIGNATURE OF CHAIRPERSON _____

IRB Chairperson/Co-Chairperson or Designee _____ Date: 5/12/16

APPENDIX K

LOYOLA UNIVERSITY CHICAGO, IRB APPROVAL LETTER



LOYOLA UNIVERSITY CHICAGO
 Health Sciences Division
 Institutional Review Board for the Protection of Human Subjects
 2160 South First Avenue
 Maywood, IL 60153

01/20/2017

NOTICE OF FULL APPROVAL OF A RESEARCH PROJECT

Investigator **Burkhart, Elizabeth**
 LU Number **208491**
 Title **Research to Support an Organizational Culture of Spiritual Care in VA Patient Care**

Date of Initial Review **02/10/2016**
 Type of Review **Expedited**
 Action of Initial Review **Full Approval**

IRB Findings **1. The study is of minimal risk and qualifies for expedited review 45CFR46.110, b-1, HHS Secretary Categories 6 and 7).**

2. The research is approved by and will be conducted at the VA. LUHS is not a performance site for the research.

Informed Consent Document required? **NO**
 Reason ICD not required

of Participants **50**
 Participants Compensated? **YES**

Amount (\$) **100**
 Compensation Schedule **End of participation**

IRB Number **208491021016**
 Date of Approval **02/10/2016**
 Frequency of Review **Annual**
 Date of First Review **01/13/2017**

ITEMS SUBMITTED FOR
 REVIEW

- 02/09/2016 VA IRB approval letter
- 02/09/2016 VA Research and Development approval letter
- 02/09/2016 Voice recording consent
- 02/09/2016 Demographic data collection sheet
- 02/09/2016 research proposal to VA Office of Nursing Services
- 02/09/2016 Desmond dissertation proposal for Aim 1
- 02/09/2016 VA Research Services approval letter
- 02/09/2016 Information letter to participants

- 02/09/2016 Spiritual Care Inventory

YOU HAVE FULL APPROVAL AND YOUR PROJECT MAY BEGIN.

The following is for your information and will help you meet local and federal IRB requirements.

1. You must use the final IRB-approved version of the Consent Document. Spelling and grammatical changes may be made as necessary, but any other changes require prior review and approval.
2. You are required to maintain complete records of this project. Any changes in the protocol and the Consent Document must receive prior IRB approval. Use the online Research Portal's Project Amendment form to report changes. A change to the protocol necessary for the immediate safety and welfare of a research participant may be implemented prior to IRB review and approval.
3. Federal Regulations require that projects undergo periodic review of research activity at least once a year. This review must be substantive. The frequency of review and next scheduled date of periodic review for your project can be found under the "Annual Review" tab in the Research Portal's IRB section. You will receive notification 4-8 weeks prior to the scheduled date of review. At that time, you must provide information regarding the status of the project. If the information is not received, the project will be suspended. It is important that you not let approval lapse.
4. The IRB must be notified any time that the project temporarily or permanently stops enrolling participants along with the reason. Use the online Closure form to submit these notifications.
5. Any notices or advertisements soliciting participation must receive prior IRB approval. Use the online Amendment reporting form.
6. The IRB must be notified PROMPTLY of all serious and any unanticipated adverse events associated with the project (or the device or the drug). This includes any notification received of adverse events occurring at other performance sites. Further guidance on adverse event reporting may be found at the Office for Human Research Protections web site;
<http://www.hhs.gov/ohrp/policy/AdvEvtntGuid.htm#Q5>

Reportable events include, but are not limited to:

a) a serious adverse event (including events that produce injury or death, an event

leading to hospitalization or lead to prolongation of a current hospital stay);

b) the enrollment of a patient on a study that is no longer enrolling participants;

c) pregnancy occurring on the study where the study excludes pregnancy;

d) any patient reporting a billing problem as a result of project participation;

e) any participant who has voiced a complaint about some aspect of the project

or the consent document;

f) any unanticipated, untoward, or unexpected adverse event not covered above including

rare adverse events or adverse events that occur at an unexpected rate

g) protocol deviations

h) investigational drug/device brochures, revisions

Adverse Protocol Events are reported through the online Research Portal.

7. The IRB may suspend the project to new participant enrollment or may suspend the participation of current subjects if there is a perceived safety and/or regulatory issue.

8. Prospective consent must be obtained from all research participants.

9. The IRB may review your records relating to this project, including signed consent documents.

10. The Institutional Review Board of Loyola University Medical Center is appropriately constituted and has been granted Federal Wide Assurance Number FWA00017487.

11. If you are unsure of your reporting requirements or of what is expected of you during the conduct of this research, please call the IRB Office (708-216-4608) or Dr. Kenneth Micetich (708-327-3144).

12. The Loyola Institutional Review Board is appropriately constituted as stipulated in 45cfr46 and is compliance with Good Clinical Practice Guidelines insofar as those guidelines are consistent with the U.S. Food and Drug Administration regulations (21 CFR Parts 50 and 56) and the Department of Health and Human Services regulations (45 CFR 46) pertaining to the protection of human subjects in research.


 Elaine Fluder
 Director
 Human Research Protections Program
 Loyola University Health Sciences Division

APPENDIX L

LOYOLA UNIVERSITY CHICAGO, IRB AMENDMENT APPROVAL LETTER

From: <portalprocess@lumc.edu>
Date: May 24, 2016 at 3:40:57 PM CDT
To: <Eburkha@luc.edu>
Cc: <Eburkha@luc.edu>
Subject: IRB Research Project 208491 Amendment

NOTICE OF REVIEW OF A RESEARCH PROJECT (Amendment)

Date: 05/24/2016

Investigator: Burkhart, Elizabeth

LU Number: 208491

TITLE: Research to Support an Organizational Culture of Spiritual Care in VA Patient Care

Dear Investigator,

An Amendment to the above-referenced research project has been reviewed by the Institutional Review Board.

The Amendment was assigned a status of Full Approval.

Details of this Board review can be accessed through the on-line Research Portal

or by clicking the following link:

<http://portal.luhs.org>

If you have any questions regarding this review action, please call the IRB Office (708-216-4608).

Kenneth Craig Micetich, M.D.

Chairman

Institutional Review Board for the Protection of Human Subjects
Loyola University Health Sciences Division

APPENDIX M
EMAIL INVITATION TO VA REGISTERED NURSES
TO PARTICIPATE IN STUDY

Dear _____ VA Registered Nurses,

I am writing to invite you to participate in a study about how nurses view their ability to provide spiritual care to Veterans. VA's Office of Nursing Service has provided funding for this study. This study has passed all of the required internal approval processes.

Spiritual Care is an important component of both professional nursing practice and holistic, patient-centered care for Veterans. Evidence suggests that Veterans want and need spiritual care—80% of Veterans reported wanting spiritual care in the health care setting. We define spiritual care as "promoting meaning and purpose in life."

We are seeking your input to help us learn about how to support nurses' ability to provide spiritual care. The research teams plans to recruit up to 50 _____ RNs who provide direct care to patients with chronic conditions and who work at least 50% FTE for the study. You do not have to consider yourself to be religious or spiritual in order to participate in this study and contribute meaningfully to the study.

Study participation will take approximately 2 hours and involves:

- Participation in a 10 minute simulation, _____ Education Service, with an actor playing the role of a Veteran at risk for spiritual distress.
- Completion of 2 short surveys (before and after the simulation)
- Debriefing after your simulation experience
- Participation in an 1-1 interview with a researcher about your experience in providing spiritual care, whether the organization supports/does not support spiritual care, and potential initiatives to support spiritual care

Participation is strictly voluntary and must be scheduled only during your off-duty/off-work time. All information will be kept strictly confidential. Managers will not know of your participation unless you tell them yourselves.

If you are eligible to participate in the study and complete the simulation and interview, you will receive a \$100 honorarium. Data collection will begin in April and continue throughout the summer. If you are interested in participating, you can let us know you are interested now. We will continue to recruit until we have reached our target sample size of 50 RN participants.

Attached is an information sheet further describing the study. If you would like additional information or are interested in participating in the study, please contact Ms. Mary Beth Desmond at _____

Sincerely,

APPENDIX N
STUDY INFORMATION SHEET

Dear _____ Registered Nurse,

You are invited to participate in a research study through _____ VA Education Service and _____. The purpose of the study is to better understand **spiritual care in nursing practice**, explore how simulation can teach spiritual care, and determine what education and organization initiatives can help promote spiritual care at the VA.

Who can participate? All _____ VA registered nurses who work at least .5 FTE on units where they provide care to Veterans who have chronic illness are invited to participate, excluding those units where patients are consistently unconscious. We hope to enroll 40 nurses to participate in the study. The study will take approximately 2 hours at a time when you are not scheduled to work. The study will be conducted in the simulation lab in _____ in Education Service. Upon completing the study, you will receive \$100 honoraria.

What will you do if you choose to participate? Participating in the study will include the following activities:

1. Complete two surveys at the beginning of the study.
2. Participate in a 10 minute simulation with a standardized patient (actor) playing the role of a Veteran in spiritual distress.
3. After the simulation, complete another survey about how you provided spiritual care in the simulation.
4. Share your thoughts with the standardized patient about how the simulation affected both of you.
5. Participate in a 1-1 interview with a researcher exploring your perspectives about spiritual care, educational needs in providing spiritual care, and suggestions for how the organization can help promote spiritual care. This interview will be audiotaped so that we may analyze the data at a later time.
6. Complete a final survey about spiritual care.

Potential Risks: We anticipate minimal risk in participating in the study. RN participants may feel psychological distress after the spiritual encounter, but we do not anticipate distress beyond a typical work day. If you experience adverse psychological or spiritual distress, you will be able to speak with a chaplain, and we will provide you with a list of mental health providers. Participating in this study is purely voluntary and you can withdraw from the study at any time. Participation is not associated with your work status, and managers will not know who participates in the study.

Potential Benefits: We do not anticipate a direct benefit to you, but you may feel a personal benefit from participating in the study. You may feel empowered to contribute to an organizational culture that supports holistic spiritual care. The results of this study

Informational Email to Participants

IRB approval date
1/22/2016

will lead to a research and education agenda that may benefit RNs and Veteran patients in the future, as well as improve the organizational culture of the VA.

Privacy: All survey and interview data will be kept confidential on a secured computer (server) in the _____ which is a division of the research center at _____. All research findings will be presented in aggregate and will not be linked to any one participant. This study is approved by the _____ Institutional Review Board to ensure the protection of human rights.

If you are interested in participating and/or have questions about the study, please contact _____ Chief, Education Service and Designated Learning Officer _____ Supervisor, Nursing Education at _____. We can also join your staff meetings (without your managers present) to talk about the study and answer any of your questions.

If you have concerns or questions about VA research or your rights about being a research participant, please call the IRB office at _____

Thank you for considering this request.

Sincerely,

Chief, Education Service and Designated Learning Officer

APPENDIX O

INACSL STANDARDS OF BEST PRACTICE: SIMULATIONSM

International Nursing Association for Clinical Simulation and Learning (INACSL) standards of best practice: SimulationSM

INACSL Standards of Best Practice: Simulation	Standard description and inclusion
Standard I: Terminology	<ul style="list-style-type: none"> • Standardized terminology is necessary to facilitate clear communication and understanding (Meakim et al., 2013). • The terminology used in the simulation was defined. These terms include: Clinical scenario (participant preparation, prebriefing, patient information, and objectives), and standardized patient (SP).
Standard II: Professional Integrity of Participant(s)	<ul style="list-style-type: none"> • The standard emphasizes essential to be professional and respectful of all participants. Confidentiality of all information pertaining to the simulation must be maintained to reduce bias and not impact learning objectives or research results (Gloe et al., 2013). • The professional integrity of participants was maintained by instructing all participants to maintain all simulation content before and after the simulation confidential with rationale to maintain integrity of the study. Constructive feedback was given honestly with respect shown towards all participants.
Standard III: Participant Objectives	<ul style="list-style-type: none"> • The standard emphasizes the need for clearly written objectives for participants to be available before the simulation. The objectives need to include all domains of learning, be appropriate to skill level, align with patient care, be evidence-based, holistic, reasonable to time allotted, and pilot tested (Lioce et al., 2013). • The participant objectives for this spiritual care clinical scenario simulation included all domains of learning, were appropriate for practicing RNs, and reasonable for the allotted time frame. The “Spiritual Care Cue & Intervention Checklist” was developed based on the evidence, is holistic, and was pilot tested.
Standard IV: Facilitation	<ul style="list-style-type: none"> • This standard states facilitation must include orientation to pre, during, and after simulation training for the participants (Franklin et al., 2013). Cues for the scenario can come from the patient and environment (Franklin et al., 2013). • Facilitation of the simulation and debriefing included the facilitator providing the SP with training to the role, script, education, and practice sessions.

	<ul style="list-style-type: none">• Facilitation of the prebriefing/simulation/debriefing included the facilitator providing all RN participants with an orientation to the simulation environment and providing an overview of all phases of the prebriefing/simulation/debriefing with questions answered.• The clinical simulation scenario included both patient and environmental cues.
Standard V: Facilitator	<ul style="list-style-type: none">• This standard reiterates the above standards that the facilitator present clear objectives and outcomes, maintain safety, fidelity, and appropriate content for the learner that is evidence-based. Facilitator reflects professionalism, encourages self-evaluation, reflection, and peer review in the debriefing process, and collects evaluation of simulation from participants (Boese et al., 2013).• The facilitator presented clear objectives and outcomes of the simulation during the consenting process. Safety was maintained through orientation to environment and all equipment was in working order. Fidelity was maintained by portrayal of real-life based on the evidence in the literature. Content was based on a review of the literature, as described in Chapter Two. The facilitator followed a script in the consenting process and debriefing process using the Plus-Delta method. Evaluation of the simulation was done during the pilot-testing phase. At the conclusion of the debriefing the facilitator asked the RN participant if they had any further comments.
Standard VI: The Debriefing Process	<ul style="list-style-type: none">• This standard requires debriefing be done by a competent facilitator in a trusting environment by a person who has observed the simulation. The standard requires adequate time be given for debriefing based on the objectives and content of scenario and offers some flexibility. The standard also recommends stating expectations for debriefing include a critical self-reflection. Debriefing should include positives and any gaps related to objectives (Decker et al., 2013).• The facilitator completed on-line simulation training modules at University of Washington (see Appendix OO), has two years of simulation experience as a graduate assistant and adjunct clinical faculty member, and critical incident debriefing training.• The debriefing process was pilot tested and deemed sufficient time. The SP received training on the debriefing process and the RN was oriented to the debriefing process with any questions answered.

Standard VII: Participant Assessment and Evaluation	<ul style="list-style-type: none"> This standard identifies assessment and evaluation types (formative, summative, or high-stakes evaluations) to measure objectives or outcomes desired. Formative evaluation promotes personal and professional growth to move toward meeting objectives. Summative evaluation focuses on the measuring of outcomes or achieving objectives. High-Stakes evaluation is used in high consequence situations (Sando et al., 2013). This spiritual care clinical scenario simulation is part of a research study and not an educational activity. Participant assessment and evaluation was accomplished with a degree of formative assessment occurring during the debriefing as the RN participant and SP evaluated the care provided.
Standard VIII: Simulation-Enhanced Interprofessional Education (Sim-IPE)	<ul style="list-style-type: none"> This standard is for interprofessional simulation (Decker et al., 2015), which is not applicable for this study.
Standard IX: Simulation Design	<ul style="list-style-type: none"> This standard has identified elements to be considered when designing a simulation to achieve objectives. These include assessment of need, objectives, formatting, clinical scenario, fidelity, facilitator, briefing, debriefing, evaluation, prepping participant, and testing design (Lioce et al., 2015). The clinical scenario simulation design included a literature review and synthesis to determine the evidence-based patient cues and interventions to be included in the simulation as well as using the experts to ensure that the simulation is accurate.

Note. The standards listed above are from The International Nursing Association for Clinical Simulation and Learning (INACSL) Standards of Best Practice: SimulationSM cited in the *Clinical Simulation in Nursing* journal. A citation for each INACSL standard described is listed within Appendix O. RN = Registered Nurse; SP = Standardized Patient.

APPENDIX P
PREBRIEFING/FOCUSED ASSESSMENT/SIMULATION SET-UP/
CLINICAL SCENARIO SIMULATION SCRIPT

FINAL—5-22-2016

Focused Assessment**RN Participant Objectives:**

Perform an initial nursing assessment of simulated standardized patient post-op day #2 S/P Colectomy (diagnosed with Colon Cancer). The nurse is beginning a 0730 - 1600 shift and this is her/his first morning encounter with this patient. The standardized patient will be in a hospital gown and sweatpants lying in the bed with a saline lock in left forearm.

Name: John Bell **MR#** 000123 **DOB:** 12/17/1952 **Allergies:** NKA **Code Status:** Full Code
Marital Status: M **Religion:** Baptist **Race:** African American
Military Service: Vietnam – Marine **Employment:** Retired
Past Medical Hx: PTSD, HTN, COPD, Type 2 DM **ETOH Use:** Social **TOB:** Quit 20 years ago
Ht: 5' 8" **Wt:** 155 lbs **Family Hx:** Father/Brother died of colon cancer

Emergency Contact: Hollie Bell **Relationship:** Spouse
Phone: 708-222-2222 (home); 708-222-2223 (cell)
Second Contact: Rochelle Jones **Relationship:** Daughter
Phone: 272-333-3333 (home); 272-333-2333 (cell)

Scenario: The patient presents to your medical-surgical unit post-op day number two (POD#2) following a colectomy for colon cancer. Mr. Bell knows he has cancer. Pathology reports to determine prognosis and treatment are pending. The patient has hypoactive bowel sounds, complaining of mild incisional pain (last received two 5/325 mg Norco tabs 45 minutes ago for a pain rating of 5/10) otherwise without complications. Nasogastric tube and Foley catheter discontinued this morning at 0600. IV saline lock patent in left forearm. Abdominal dressing is dry. Incision approximated and glued. Incentive Spirometer is at the bedside. Diet: Clear liquid, advance as tolerated. Morse rating: 40. His wife of 40 years plans to arrive later this morning.

Orders: Saline lock; vital signs every 4 hours; dry abdominal dressing to surgical site – change daily and prn; D/C Oxygen; Notify healthcare provider for: SBP < 100, HR > 120, Temp > 100.5, SP02 < 94%. Call healthcare provider if no void 6 hours after Foley catheter discontinued. Activity ordered is up as tolerated with one assist. Accucheck four times a day, before meals and at bedtime.

Medications:

- Lisinopril 10 mg by mouth daily
- Symbicort 160/4.5 two puffs by mouth twice a day
- Albuterol inhaler (90 mcg) two puffs every 4 hours as needed
- Metformin 500mg by mouth twice a day
- Prazosin 1 mg by mouth at bedtime

IRB approval date 5/13/2016
 Pages = 1 through 8

FINAL—5-22-2016

- Norco 5/325 mg 1-2 tabs by mouth every 4-6 hours as needed for pain when tolerates oral intake
- Hydromorphone hydrochloride 2 mg IV Push every 3-4 hours as needed for severe pain (>6) or pain not relieved by Norco
- Docusate Sodium 50mg/Sennosides 8.6 mg by mouth twice a day as needed for constipation

Instructions/Door Sign: Vital signs were recorded 30 minutes ago: T – 98.9 R- 20 P – 84 B/P - 138/80 SPO2 – 95%. Accucheck @ 0700 was 110. The resident just informed the patient that the surgeon has back-to-back surgeries today and will not be able to discuss the patient's pathology reports until 1600 or after. The patient was expecting the results of his pathology report this am. The RN-patient encounter will last ten minutes.

FINAL—5-22-2016

In preparation for the clinical simulation experience:

- Standardized patient to be in hospital gown and wearing own sweat pants
- ID wristband
- Saline lock left forearm
- Abdominal dressing with steri strips
- Raise patient's head of bed up 30 degrees
- Place an extra pillow on the chair
- Place on the bedside table a bible, cell-phone with earbuds (music), and Vietnam Veteran hat
- Place on bedside tray an incentive spirometer, half eaten clear liquid tray (120 ml tea, 60 ml apple juice)
- Prepare room (water pitcher/cups/gloves/phone/bedside table/garbage can/menu/box tissues/urinal/soap/toothbrush/towel)
- Wall clock/or clock visible to standardized patient
- Place patient's own blanket(from brother)/shoes on floor
- Phone in room (instructions next to phone to call operator for all pages)
- Two chairs in room
- Patient information board similar to patient room
- Family picture/Rolling Thunder picture at bedside
- Lab coat

FINAL—5-22-2016

Simulation Script with verbal responses from the patient, RN, wife, or chaplain:

[Begin Situational Verbal and Non-Verbal Cues for Anxiety]

(RN enters the patient's room and introduces her/himself):

Mr. Bell: "Hello."

(The following script will begin after the nurse begins the assessment. The intention is that the nurse is focused on the physical care and Mr. Bell will raise concerns while the nurse is performing the physical assessment.)

Mr. Bell: "This is a bad morning. They just told me that the doctor isn't coming until this afternoon to talk with me about the tests. I thought he was coming to see me this morning."

Mr. Bell: "Do you know the results of my test?"

(If RN says she/he doesn't know the test results and/or the doctor will discuss results).

Mr. Bell: "I hope the results aren't bad!" (tapping his hands on tray table anxiously)

(If RN demonstrates caring presence and listening related to test results. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement.

Mr. Bell: "Waiting is awful!" (Moving feet)

(If RN states something non-therapeutic such as "Don't worry, you will be fine," Mr. Bell is quiet, looks away, and continues to tap his hands.)

[Begin Behavioral Cues for Physical Suffering]

Mr. Bell: "I had a terrible night last night and didn't sleep at all. This pillow is like a rock." (agitation)

(If RN attempts to provide comfort measures, such as fluffs pillow, gives own pillow, offers to get him more clear liquids, or offers to help him up to chair)

Mr. Bell: "Well that doesn't feel right either. Can you just give me my pillow from home?"

(If RN gives patient own pillow)

Mr. Bell: "That's better."

FINAL—5-22-2016

(If RN offers to get patient up to chair patient states “No. Maybe later.”)

Mr. Bell: “I’m so hungry. I haven’t eaten in days!”

(If RN asks about the clear liquid breakfast tray)

Mr. Bell: “It was okay.”

(If RN asks what he means by “okay”)

Mr. Bell: “Well I don’t like jello and the broth was cold when I got it. I just want to eat regular food.”

(If RN demonstrates caring presence and listening related to physical suffering. For example, stopped the physical assessment or tasks, pauses, sits in chair, makes eye contact, listens to patient’s concerns, and/or provides a comforting touch. May state supportive statement.)

Mr. Bell: “Colon cancer is awful!”

(If RN continues assessment, ignores complaints or brushes off patient concerns, offers false reassurance such as, “You’ll be fine.”)

Mr. Bell: Blank stare and withdrawal

[Situational Verbal and Non-Verbal Cues for Insomnia and Fear]

Mr. Bell: “Oh, I’m so tired. I heard noises out in the hall all night. I keep worrying about my test results.” (Patient yawning)

Mr. Bell: “I have to listen to music to fall asleep. I don’t sleep well since Vietnam and now this waiting is making it worse.”

(If RN offers to call physician to get him medicine for insomnia)

Mr. Bell: “No, I already take something every night.”

(If RN encourages patient to talk about his fears, e.g., asking more about his fears about test results, having cancer, father/brother cancer experience)

Mr. Bell: “I’m really afraid the results are bad. I don’t want to have that awful chemo. My dad and brother had colon cancer. They were so sick. They lost so much weight. They were throwing up all the time and were in so much pain. I hope that doesn’t happen to me.”

(If RN tells patient not to worry, Mr. Bell becomes quiet and withdrawn.)

FINAL—5-22-2016

(If RN demonstrates importance of music: For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, “Sounds like you have difficulty sleeping. Does music help you sleep in the hospital? Would you like to listen to your music now?” and/or explores type of music he enjoys.)

Mr. Bell: “I like Motown, Old School songs.”

[Physical Environmental Cues (Meaningful Item)]

Mr. Bell: “I’m cold. Can I have my blanket?”

(If RN provides hospital blanket)

Mr. Bell: “I want my blanket over there. It was my brothers. He wanted me to have the blanket.”

(If RN recognizes the importance of the blanket and/or brother. May state supportive statement. For example, “It seems that the blanket from your brother is meaningful to you.”

Mr. Bell: “My brother died from colon cancer. He loved this blanket. Yea, he loved this blanket. I wish he were here. He’d be making me laugh.”

[Veteran Culture Environmental Cues]

Mr. Bell: “I can’t reach my hat. Can you get it for me?” (Vietnam Vet Marine hat)

(If RN gives patient his hat and asks about the importance of the hat)

Mr. Bell: “I went to Vietnam when I was 18 years old.”

Mr. Bell: “I lost a lot of friends there. My brother Jimmy got shot there. He was in the Army. He survived that, but it was a bad time.”

(If RN demonstrates caring presence and listening related to past Veteran experiences. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, “It sounds like you lost a lot of friends. That must be hard for you.” May explore importance of the hat, and/or thanks him for his service.

Mr. Bell: “Yeah. I have a big motorcycle trip this summer that I’ve been looking forward to. I hope I can still go.”

(If RN recognizes Veteran picture on bedside table or deliberately asked patient questions about the importance of current Veteran supportive connections such as the

FINAL—5-22-2016

Rolling Thunder group and/or his hope to participate in the Memorial Day parade/motorcycle ride)

Mr. Bell: “It’s a motorcycle trip in D.C. I just got a new trike for me and my wife. We are supposed to ride in a Memorial Day parade with the Rolling Thunder group. We ride to the Vietnam Memorial Wall. I don’t want to miss it.”

[Verbal Cues for Social Support/Connections with Family/Friends—Non-Verbal with Family Picture/Rolling Thunder Picture on Bedside Table]

Mr. Bell: “I’m worried about my wife. She is usually here usually here by now. I hope she didn’t get lost.” (either driving or in the hospital)

(If RN responds that wife is not here yet)

Mr. Bell: “I’m usually the driver. We are always together. It’s just me and my wife and dog. I just want to go home and chill out.”

(If RN demonstrates caring presence and listening related to family supports. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, “It seems like you really miss home. Tell me more about it?”)

(If RN suggests Mr. Bell call his wife and/or Mr. Bell asks RN to call his wife and/or Mr. Bell asks RN for his cell phone)

Hollie Bell (Wife): “I’ll be there as soon as I can. Please tell him I am on my way.”

(If RN recognizes family picture on bedside table and/or promotes connection with family/friend. Asks him if he wants her/him to call his wife, another family member, or friend)

Mr. Bell: “That’s my daughter, Rochelle. I wish she didn’t live out of town.” (crosses arms).

[Verbal/Nonverbal Cues for Connection with Higher Power/Faith Rituals]

Mr. Bell: “I’m afraid of the test results. It’s in God’s hands.” (opens hands)

(If RN discusses the tests and states the doctor will be there that afternoon)

Mr. Bell: “I hope my wife is with me when the doctor tells me the results.”

FINAL—5-22-2016

(If RN demonstrates caring presence and listening related to religion. For example, pauses, makes eye contact, listens to patient, and/or provides comforting touch. May states supportive statement: “It seems like your faith is a source of strength for you.”)

(Mr. Bell response if RN offers to call chaplain. Calls chaplain if patient requests.)

Mr. Bell: “Yes, I would like to see a chaplain.”

Chaplain: “I will be there as soon as I can.”

(Mr. Bell response if RN asks about his pastor/church)

Mr. Bell: “My pastor knows I’m here. He’ll visit me. My wife has everyone from church praying for me.”

(If RN recognizes Bible on the bedside table and/or asks patient if he wants his Bible and/or asks patient if he has a favorite verse)

Mr. Bell: “Yes, Psalm 139?” (puts hands in prayer)

(If RN asks if he wants her/him to read the verse)


Mr. Bell: “Sure.”

(If RN initiates reading the verse stop simulation immediately after)

At the end of the ten-minute simulation scenario announce the simulation is over. Instruct the RN to step out of the room to complete tools.

APPENDIX Q
PLUS-DELTA DEBRIEFING FORM

Plus-Delta

Plus	
(What went well for you providing holistic care during the simulation?)	(Would you do anything differently?)

ID # _____ Date: _____ Time: _____ Circle: RN Participant SP IO

IRB approval date 5/13/2016
Pages = 1

APPENDIX R

ADDITIONAL DEBRIEFING FORM USED IN SECOND PILOT SESSION STUDY

SESSION AND RESEARCH STUDY DEBRIEFING SCRIPT

Debriefing Script:

Thank you for participating in the simulation. We will take about 10 minutes to debrief the simulation.

Participant: Give me a one word description of your emotions now.

Let's share the evaluation forms:

- What went well for you providing holistic care during the simulation? Start with the nurse, then standardized patient
- Would you do anything different? Start with nurse, then standardized patient

APPENDIX S

EMAIL INTRODUCTION TO REVIEW THREE AND FOUR CONTENT EXPERTS

Subject line: Lisa Burkhart referred me to you as a content expert

Dear xxx,

Thank you for agreeing to participate as a content expert on the spiritual care study, entitled "Research to Support an Organizational Culture of Spiritual Care in VA Patient Care," funded by the VA Office of Nursing Services. If possible, please complete this survey this week and email your results to me at mdesmo1@luc.edu by Sunday, May 1st. This should take about 30 minutes. We do appreciate your time.

Your role is to evaluate a spiritual care simulation script and corresponding nursing intervention checklist. The script and checklist items were derived from the literature. We ask that you evaluate how well the script and checklist reflect those items. More specific instructions are included in the attached survey.

If you have any questions, please call me on my cell [REDACTED]. It is important that you understand the instructions, so please do not hesitate to call if you need clarification.

Again, thank you for helping support this important work in both spiritual care and in serving our nation's Veterans.

With gratitude,

Mary-Beth Desmond RN, MA, MSN, AHN-BC
PhD Candidate
Loyola University, Marcella Niehoff School of Nursing

APPENDIX T

UNIVERSITY OF ILLINOIS AT CHICAGO, DR. ALLAN L. AND MARY L. GRAHAM
CLINICAL PERFORMANCE CENTER USE OF MATERIALS PERMISSION LETTER

UNIVERSITY OF ILLINOIS
AT CHICAGO

College of Medicine
Dr. Allan L. and Mary L. Graham Clinical Performance Center
Department of Medical Education (MC 591)
808 South Wood Street, 986 CME
Chicago, Illinois 60612-7309



World Health Organization
Collaborating Centre in Educational
Development of Health Professionals
and Health Care Systems

July 22 2016

To Whom It May Concern:

Mary-Beth Desmond has permission for non-commercial use of Standardized Patient materials from the University of Illinois at Chicago Dr Allan L and Mary L Graham Clinical Performance Center, including documents regarding Feedback Training, Training Standardized Patients, and the Revised UIC Communication and Interpersonal Skills Scale (RUCIS). Materials may be modified as long as attribution is maintained.

To cite the RUCIS scale:

Iramaneerat C, Myford CM, Yudkowsky R, Lowenstein T: Evaluating the effectiveness of rating instruments for a communication skills assessment of medical residents. *Advances in Health Sciences Education* 2009; 14:575-594.

A handwritten signature in black ink that reads "Rachel Yudkowsky".

Rachel Yudkowsky MD MHPE
Director, Dr Allan L and Mary L Graham Clinical Performance Center
rachely@uic.edu

Chicago

Peoria

UIC

Rockford

Urbana-Champaign

APPENDIX U

G-POWER ANALYSIS FOR SAMPLE SIZE AT 0.80 POWER

Using 0.05 alpha and 0.80 power:

t tests - Means: Difference between two dependent means
(matched pairs)

Using SCI Diff N 28 Mean 9.4425 SD 6.95844

Analysis: A priori: Compute required sample size
Input: Tail(s) = Two
 Effect size dz = 1.356985
 α err prob = 0.05
 Power (1- β err prob) = 0.8
Output: Noncentrality parameter δ = 3.5902448
 Critical t = 2.4469119
 Df = 6
 Total sample size = 7
 Actual power = 0.8466342

t tests - Means: Difference between two dependent means
(matched pairs)

Using SCI SCI Int Diff 28 N Mean 1.2321 SD 2.07044

Analysis: A priori: Compute required sample size
Input: Tail(s) = Two
 Effect size dz = 0.5950909
 α err prob = 0.05
 Power (1- β err prob) = 0.8
Output: Noncentrality parameter δ = 2.9754545
 Critical t = 2.0638986
 Df = 24
 Total sample size = 25
 Actual power = 0.8145022

t tests - Means: Difference between two dependent means
(matched pairs)

Using SCI Faith Diff N 28 Mean 1.6429 SD 1.83008

Analysis: A priori: Compute required sample size
Input: Tail(s) = Two
 Effect size dz = 0.8977203
 α err prob = 0.05
 Power (1- β err prob) = 0.8
Output: Noncentrality parameter δ = 3.1097943
 Critical t = 2.2009852
 Df = 11
 Total sample size = 12
 Actual power = 0.8078434

APPENDIX V

G-POWER ANALYSIS FOR SAMPLE SIZE AT 0.80 AND 0.95 POWER

t tests - Means: Difference between two dependent means
(matched pairs)

Using SCI Refl N 28 Mean 6.2460 SD 4.98056

Analysis: A priori: Compute required sample size

Input: Tail(s) = Two
Effect size dz = 1.254076
 α err prob = 0.05
Power (1- β err prob) = 0.8

Output: Noncentrality parameter δ = 3.5470626
Critical t = 2.3646243
Df = 7
Total sample size = 8
Actual power = 0.8586175

t tests - Means: Difference between two dependent means
(matched pairs)

Using SCI Diff N 28 Mean 9.4425 SD 6.95844

Analysis: A priori: Compute required sample size

Input: Tail(s) = Two
Effect size dz = 1.356985
 α err prob = 0.05
Power (1- β err prob) = 0.95

Output: Noncentrality parameter δ = 4.2911634
Critical t = 2.2621572
Df = 9
Total sample size = 10
Actual power = 0.9671803

t tests - Means: Difference between two dependent means
(matched pairs)

Using SCI SCI Int Diff 28 N Mean 1.2321 SD 2.07044

Analysis: A priori: Compute required sample size

Input: Tail(s) = Two
Effect size dz = 0.5950909
 α err prob = 0.05
Power (1- β err prob) = 0.95

Output: Noncentrality parameter δ = 3.7163415
Critical t = 2.0243942
Df = 38
Total sample size = 39
Actual power = 0.9516348

APPENDIX W

G-POWER ANALYSIS FOR SAMPLE SIZE AT 0.95 POWER

t tests - Means: Difference between two dependent means
(matched pairs)

Using SCI Faith Diff N 28 Mean 1.6429 SD 1.83008

Analysis: A priori: Compute required sample size
Input: Tail(s) = Two
 Effect size dz = 0.8977203
 α err prob = 0.05
 Power (1- β err prob) = 0.95
Output: Noncentrality parameter δ = 3.9130721
 Critical t = 2.1009220
 Df = 18
 Total sample size = 19
 Actual power = 0.9588036

t tests - Means: Difference between two dependent means
(matched pairs)

Using SCI Refl N 28 Mean 6.2460 SD 4.98056

Analysis: A priori: Compute required sample size
Input: Tail(s) = Two
 Effect size dz = 1.252871
 α err prob = 0.05
 Power (1- β err prob) = 0.95
Output: Noncentrality parameter δ = 4.1553030
 Critical t = 2.2281389
 Df = 10
 Total sample size = 11
 Actual power = 0.9617567

APPENDIX X
INCLUSION CRITERIA SCRIPT

**Script for Evaluating Whether Potential Participants are Eligible to Participate in the
"Spiritual Care in Nursing Practice" Study**

"Hi, my name is Mary-Beth. Thank you for your interest in our "Spiritual Care in Nursing Practice" study. I have some questions I have to ask you, which will take approximately ten minutes to go through. Is this a good time for you to talk? If not, can we set up another time to talk?"

Yes/ No

Yes - [continue]

No - ["Can we set up another time to talk?" end call]

When: _____

Best phone number to reach you: _____

"What is your full name? State your full name, please."

Inclusion criteria: Must be an RN who works at least 50% FTE with Veterans who have a chronic condition, is willing to participate in a 2 hour study (simulation and 1:1 interview scheduled during off work hours), and is unacquainted with the independent observer(s) or standardized patient.

"First, I have questions to determine whether you are eligible to participate in this study."

"Are you an RN at _____?"

Yes/ No

Yes - [continue]

No - [See below, end call]

"Do you currently work 50% FTE?"

Yes/ No

Yes - [continue]

No - [See below, end call]

"Do you care for Veteran patients with a chronic condition?"

Yes/ No

Yes - [continue]

No - [See below, end call]

"Do you provide hands on (direct) care to Veteran patients with a chronic condition?"

Yes/No

Yes - [continue]

No - [See below, end call]

IRB approval date 5/13/2016

Pages = 1 through 4

“What is the population of patients you work with?” _____

“Thank you for (calling back) or (for your interest in participating in the study). I’m sorry, but you don’t seem to meet the inclusion criteria for the study. But I’m so glad you called.”

“Are you available to participate in a 2 hour study which will include a ten-minute simulation with a standardized patient role-playing a Veteran and a 1:1 interview?”

Yes/No

Yes – [continue]

No – [See below, end call]

“Thank you for (calling back) or (for your interest in participating in the study). I’m sorry, but you don’t seem to meet the inclusion criteria for the study. But I’m so glad you called.”

“To avoid any bias it is important that you do not have a personal relationship with any of the study team members. Do you have any personal acquaintance with the study team members (Dr. Lisa Burkhart, Mary-Beth Desmond or _____?)”

Yes/No

Yes – [continue]

No – [See below, end call]

“Thank you for (calling back) or (for your interest in participating in the study). I’m sorry, you don’t seem to meet the inclusion criteria for the study. But I’m so glad you called.”

“Have you ever been a part of a research study?”

Yes / No

Yes – “Great. Let me review what this research study is about”

No – “OK, no worries. Let me review what this research study is about...”

“With this study, we want to learn more about nursing practice and opportunities to support holistic care for Veterans. If you choose to participate, your insight and experience could help us develop educational programs or interventions to benefit both Veterans and RNs. You will receive \$100 honoraria for participating.”

“This study will be conducted in Building _____ in the Simulation Lab, room _____ and will take approximately 2 hours. We **must** schedule this off your work time.” ✓

“Let me describe what will happen. We will begin with you completing a few short surveys. You will then participate in a 10 minute simulation with a standardized patient. After the simulation, you will have an opportunity to discuss the simulation experience with the standardized patient. Then we will ask you to complete a second survey. Finally, you will be asked to participate in a 1-1 audio-recorded interview with a researcher. The interview questions will include what went well in the simulation, any

behaviors you might change, any educational needs and personal goals you have for providing holistic care, organizational factors that support or hinder holistic care, and what organizational strategies that could promote holistic care.”

“Have you participated in a simulation before?”

Yes/No

Yes - **“Great. Do you have any questions about this simulation?”**

No - **“OK. No worries. Let me describe what a simulation is.”**

“Simulation refers to a type of experiential learning situation in which you will be asked to provide holistic care for a Veteran patient in a simulated environment. Simulation is a good way for us to better understand the provision of holistic care for patients. To make sure that the simulation is realistic, it is important to wear normal work attire. Therefore, please wear your uniform and bring them items you usually bring to work such as a stethoscope, scissors, and/or watch.

“Do you know what a standardized patient is?”

Yes/No

Yes - **“Great.”**

No - **“Basically a standardized patient is an actor playing the role of a patient.”**

Just a few more points:

“Your identity for the surveys, the simulation experience and the interview will be protected. You are asked to maintain confidentiality and not share the contents of the simulation or the interview with other RNs to avoid impacting the research results.”

“Do you agree?” Y/N

“The honoraria (\$100.00) voucher will be given to you immediately after completion of both the simulation and interview. You have thirty days to redeem the \$100.00 from the Agent Cashier using your voucher. You will need to bring a valid driver’s license with you for identification purposes. The Agent Cashier is located in Building Section just past the main police station. The Agent Cashier is open Monday through Friday from 0800-1600.”

Once again the scheduled time chosen must be before or after tour of duty (not during lunch break or using comp time). We have several options available to accommodate before and after work shifts including Saturdays. Can we schedule a time for you to participate in the study?

Yes/No

Yes - [continue]

No - [Would you like to set up another time to talk?]

Provide date/time options: Scheduled date/time: _____

“Is there a phone number we could contact you at if we need to? We expect that we would only call if there was some unforeseen issue that we would need to inform you about. Would it be

okay for us to leave a message on this number if we need to? Or is there another number you'd rather we use?"

Phone number:

"Do you have an email address that we could use to provide you with information regarding the research study with instructions that include the exact time and location? We will send you this information within the week of the study."

Email address:

"I will meet you in the lobby of Building _____. The study will be conducted in the simulation lab, which is located in _____. After the simulation and debriefing is completed you will go to _____ for the qualitative interview. _____ is on the second floor just above the PIV Badging Department."

"There is no obligation to participate. Should you decide not to participate in this study please call Mary-Beth, _____ email _____
Thank you very much for your time. Have a nice day!"

APPENDIX Y

EMAIL REMINDER TO VOLUNTEER RN PARTICIPANTS

Email information to RN participants within week of scheduled study time

Thank you for signing up to participate in the study, "Research to Support an Organizational Culture of Spiritual Care in VA Patient Care." You are scheduled on (date) at (time). Mary-Beth Desmond, the RN researcher for this study will meet you in the lobby of

_____ From there we will go to office _____ to review the study, answer any questions, obtain your consent and complete the forms for the study. Next, we will go to the simulation lab (). After the simulation and debriefing you will return to office _____ for the qualitative interview with Dr. Lisa Burkhart _____ is on the second floor above the _____

_____ Department. There is no obligation to participate. Should you decide not to participate in this study please call Mary-Beth at _____ or email _____

Once again, thank you very much for your time.

Mary-Beth Desmond, RN, MSN
Research Assistant

IRB approval date 5/13/2016
Page = 1

APPENDIX Z

VA AGENT CASHIER VOUCHER FOR HONORARIA

Research Participant _____



MEMORANDUM

Date: June 17, 2016

From: Research Service _____

Subj: Research Participant Reimbursement – Research to Support an Organizational Culture of Spiritual Care in VA Patient Care ONS Project _____

To: Agent Cashier

1. _____ has participated in the research study entitled “Research to Support an Organizational Culture of Spiritual Care in VA Patient Care” on _____ and has been authorized to receive \$100 (one hundred dollars) for reimbursement of his/her participation in this study.
2. This compensation is authorized under Obligation number _____ and Appropriation _____
3. Thank you for your attention in this matter.
4. **This MEMORANDUM will expire 30 days after the date posted on this voucher.**
5. For identification purposes, present your driver’s license along with this voucher to the Agent Cashier, _____

Signature of authorized staff member

_____ IRB approval date 6/20/2016

Revised 6/17/16

APPENDIX AA
PARTICIPANT DEMOGRAPHIC COLLECTION SHEET

Participant Demographic Sheet

1. Gender: M F
2. Age: _____
3. How long have you practiced nursing? _____(years)
4. How long have you practiced nursing at the VA? _____(years)
5. Nursing Experience: (Check all that applies)
 Inpatient
 Outpatient

Indicate specialty:

- General Medical/Surgical
- Oncology
- Neurology
- Cardiovascular
- Rehab/SCI/TBI/Extended Care
- ICU
- Psychiatric/Mental Health
- Home Health (adult)
- Ambulatory/Primary Care
- Emergency/Urgent Care
- Outpatient procedures/short term procedures
- Other -- please specify: _____

6. Current area of practice at the VA:
 Inpatient
 Outpatient
 Specialty:
 General Medical/Surgical
 Oncology
 Neurology
 Cardiovascular
 Rehab/SCI/TBI/Extended Care
 Women's Health
 ICU
 Psychiatric/Mental Health
 Home Health (adult)
 Ambulatory/Primary Care
 Emergency/Urgent Care
 Outpatient procedures/short term procedures
 Other -- please specify: _____

(Please complete both sides)

IRB approval date 5/13/2016
 Pages 1 through 2

7. Level of education (check all that apply):

- Associate
 Diploma
 Bachelors (specify: _____)
 MSN
 Masters (specify: _____)
 Doctorate (specify: _____)
 Other (specify: _____)

8. Ethnic group

- Caucasian
 African American
 Asian
 Hispanic
 Other (please specify: _____)

9. Religious preference

- Catholic
 Non-Catholic Christian
 Jewish
 Muslim
 None
 other (please specify: _____)

10. Veteran

- Yes, if so, what branch type _____
 No

ID #: _____ Date: _____ Time: _____

APPENDIX BB
DESCRIPTIVE SAMPLE CHART

Study Sample (<i>N</i> = 40)		
Mean age of respondent	52.55	
Gender of respondent	Female	37 (92.5%)
	Male	3 (7.5%)
Ethnicity	African American	1 (2.5%)
	Asian	13 (32.5%)
	Caucasian	21 (52.5%)
	Hispanic	5 (12.5%)
Religion	Catholic	24 (60%)
	Non-Catholic Christian	13 (32.5%)
	None	3 (7.5%)
Highest Level Education	Associate or Diploma degree	5 (12.5%)
	Bachelor's degree	22 (55%)
	Master's degree	13 (32.5%)
Current Specialty Area at VA	Out-Patient	19 (47.5%)
	In-Patient/Operating Room	21 (52.5%)
Veteran:		
Yes	5	(12.5%)
No	34	(85%)
Missing	1	(2.5%)

APPENDIX CC

FINAL SPIRITUAL CARE CUE AND INTERVENTION CHECKLIST

Final Checklist--5-3-2016

Spiritual Care Cue & Intervention Checklist

Cue(s)	Intervention(s)	Performed	Not Performed
B-2: Situational verbal and non-verbal cues for anxiety	a. Demonstrates caring presence and listening related to test results. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement.		
C-2: Behavioral cues for physical suffering	a. Demonstrates caring presence and listening related to physical suffering. For example, stopped the physical assessment or tasks, pauses, sits in chair, makes eye contact, listens to patient's concerns, and/or provides a comforting touch. May state supportive statement.		
D-2: Situational Verbal and non-verbal cues for insomnia and fear	a. Encourages patient to talk about his fears (e.g., asking more about his fears about test results, having cancer, father/brother cancer experience).		
	b. Demonstrates importance of music. For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, "Sounds like you have difficulty sleeping. Does the music help you sleep in the hospital? Would you like to listen to your music now?" and/or explores what type of music he enjoys.		
E-2: Physical Environmental Cues/ Meaningful Object	a. Recognition of the importance of the blanket and/or brother. May state supportive statement. For example, "It seems that the blanket from your brother is meaningful to you."		
F-2: Veteran Culture Environmental Cues	a. Demonstrates caring presence and listening related to past Veteran experiences. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement related to Veteran culture: "It sounds like you lost a lot of friends. That must be hard for you." May explore importance of the hat, and/or thanks him for his service.		
	b. Recognition of Veteran picture on bedside table or deliberately asked patient questions about the importance of current Veteran supportive connections such as the Rolling Thunder group and/or his hope to participate in the Memorial Day parade/motorcycle ride.		
G-2: Verbal & Non-Verbal Cues for Social Support/Connections with Family/Friends	a. Demonstrates caring presence and listening related to family supports. For example, pauses, makes eye contact, sits in chair, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, "It seems like you really miss home. Tell me more about it?"		
	b. Recognition of family picture on bedside table and/or promotes connection with family. Asks him if he wants her to call his wife, another family member, or friend.		
H-2: Verbal & Non-Verbal Cues for Connection with Higher Power/Faith Rituals	a. Demonstrates caring presence and listening related to religion. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It seems like your faith is a source of strength for you."		
	b. Offers to call chaplain. Calls chaplain if patient requests.		
	c. Recognition of/offers the Bible on bedside table. May read verse.		

ID #: _____ Date: _____ Time: _____ Circle: RN Participant SP IO

IRB approval date 5/13/2016
Page = 1

APPENDIX DD
CALCULATION KAPPA

Example of Cross-Tabulation for Kappa Calculation

		IO		
		Not Performed	Performed	Total
RN	Not Performed	11	4	15
	Performed	4	19	23
Total		15	23	38 IO/RN

Demonstration of the formula to hand calculate kappa for concept music using Hallgren's (2012)

example will be calculated below:

$$K = \frac{P(a) - P(e)}{1 - P(e)}$$

$$P(a) \frac{11 + 19}{38} = .79 P_{\text{Observed}}$$

$$IO \ 23/38 = .61 \quad RN \ 23/38 = .61$$

a = actual; e = expected; K = kappa

“The probability of obtaining agreement about the [performance of demonstration of importance of music] if ratings were assigned randomly between [raters] would be [.61 x .61 = 0.37], and the probability of obtaining chance agreement about the absence of [not performing demonstration of importance of music] would be [(1-.61) x (1-.61) or (.39) x (.39) = 0.15]. The total probability of any chance agreement [(performed/not performed)] would then be [0.37 + 0.15 = 0.52 P_{chance}] and K = [(.79-0.52)/(1-0.52) or (0.27/0.48) = .56]” (Hallgren, 2012, p. 27).

APPENDIX EE
SPIRITUAL CARE INVENTORY INSTRUMENT

Spiritual Care Inventory (SCI)

Please read each statement below and score how much you agree that the statement describes how you provide spiritual care to patients. Please answer these statements as they relate to you now.

Item	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I am present to patients when they express meaning in situations.	1	2	3	4	5
2. I listen to patients when they express meaning in situations.	1	2	3	4	5
3. I listen to patients when they are searching for meaning in situations.	1	2	3	4	5
4. I give patients an opportunity to express spiritual aspects of themselves.	1	2	3	4	5
5. After providing spiritual care, I take time to think about it during quiet time.	1	2	3	4	5
6. After providing spiritual care, I think about what I learned from the situation.	1	2	3	4	5
7. After providing spiritual care, I think about it when I am by myself.	1	2	3	4	5
8. Reflection helps me find meaning after providing spiritual care.	1	2	3	4	5
9. Reflection helps me accept distressing spiritual care experiences.	1	2	3	4	5
10. I learned how to provide spiritual care by reflecting on past spiritual care experiences.	1	2	3	4	5
11. Providing spiritual care is one of the things that keeps me in nursing.	1	2	3	4	5
12. After providing spiritual care, I find inner peace and understanding by talking with friends/family outside of work.	1	2	3	4	5
13. Reflection helps me grow spiritually after providing spiritual care in distressing situations.	1	2	3	4	5
14. Good memories of providing spiritual care makes me feel proud that I am a nurse.	1	2	3	4	5
15. After providing spiritual care, I find inner peace and understanding by reading scripture.	1	2	3	4	5
16. After providing spiritual care, I find support through prayer.	1	2	3	4	5
17. After providing spiritual care, I find inner peace and understanding by attending church.	1	2	3	4	5

ID #: _____ Date: _____ Time: _____

Pre-test _____ Post-test _____

February 7, 2007

IRB approval date 1/22/2016

APPENDIX FF

SPIRITUAL CARE INVENTORY INSTRUMENT AUTHOR PERMISSION LETTER



NIEHOFF
SCHOOL of NURSING

Lake Shore Campus
BVM Hall • 1032 W. Sheridan Road • Chicago, IL 60660
P • 773.508.3249 F • 773.508.3241 W • LUC.edu/nursing

September 14, 2015

Dear Mary Beth,

Thank you for your interest in the Burkhart Spiritual Care Inventory (BSCI).

You are granted permission to use the BSCI for non-commercial purposes. You may edit and translate the instructions for the instrument as appropriate for your sample(s). You may also change the formatting of the instrument to maintain a consistent presentation with any other instruments you may be using. Any translated and edited version of the instruments will remain my property, and I request you forward a copy of the edited version for my records.

The instrument may not be duplicated or reproduced in any publications. I would request a copy of any published manuscripts or abstracts of presentations that reference the BSCI. Please include the following credit in all published work that includes reference to the BSCI:

Burkhart, L., Schmidt, L. & Hogan, N. (2011). Development and psychometric testing of the Spiritual Care Inventory instrument. *Journal of Advanced Nursing*, 67(11), 2463-2472. doi: 10.0000/j.1365-2648.2011.05654.x

Finally, I would appreciate any feedback relating to the psychometrics of the BSCI along with your experiences with the measure.

Thank you again for your interest in the BSCI and I wish you the best in your efforts. Please do not hesitate to contact me if you have other questions or need further assistance.

Take care,

Lisa Burkhart, PhD, RN
Associate Professor
Marcella Niehoff School of Nursing
Loyola University Chicago
eburkha@luc.edu
773-508-2923

APPENDIX GG
CONTENT VALIDITY REVIEW ONE SUMMARY

Items (Script and comments described in detail above)	Three content experts responses Item–content validity index (I-CVI) Scores *Incomplete rating (not counted in overall rating I-CVI)			
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
B-1. Evaluating Script for Patient’s Situational Verbal and Non-Verbal Cues for Anxiety 3/3 = I-CVI = 1.00				3 raters
B-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to situational verbal and non-verbal cues for anxiety)				
B-2a. “I don’t know the test results. The doctor will have to discuss your test results with you.” 0/3 = I-CVI = 0	2 raters	1 rater		
B-2b. Pauses, makes eye contact, listens to patient, provides a comforting touch. “This must be difficult, I’m sorry.” 3/3 = I-CVI = 1.00			1 rater	2 raters
B-2c. “Don’t worry, you will be fine.” 0/3 = I-CVI = 0				3 raters
B-2d. “Is there anything I can do for you?” and/or “What helps you get through hard times?” 1/3 = I-CVI = 0.33		2 raters		1 rater
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects

C-1. Evaluating Script for Patient's Behavioral Cues for Physical Suffering 1/2 = I-CVI Requires at least 3 experts *(missing one overall rater and no rating for B & D) Missing data/I-CVI not scored	1 rater	1 rater		
			*1 rater (A & C)	
C-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to behavioral cues for physical suffering)				
C-2a. Attempts to provide comfort measures (e.g., fluffs pillow, gives own pillow, takes off SCDs and offers to help patient out of bed). 2/3 = I-CVI = .67	1 rater		1 rater	1 rater
C-2b. Offers to medicate pain with IV Hydromorphone 0/0 = I-CVI = 0	2 raters	1 rater		
C-2c. Stopped the physical assessment or tasks, makes eye contact, listens to patient. May state, "I'm sorry. This must be a difficult time." 2/3 = I-CVI = .67		1 rater	1 rater	1 rater
C-2d. Continues assessment, ignores complaints or brushes off patient concern, offers false reassurance such as, "You'll be fine." 0/3 = I-CVI = 0	3 raters			
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
D-1. Evaluating Script for Patient's Situational Verbal and Non-Verbal Cues for Insomnia and Fear 3/3 = I-CVI = 1.00				3 raters

D-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to situational verbal and non-verbal cues for insomnia and fear)				
D-2a. Encourages patient to talk about his concern (e.g., asking more about his fears about test results, having cancer, father/brother, war experiences) 3/3 = I-CVI = 1.00			1 rater	2 raters
D-2b. Continues assessment. Tells patient she/he will request a sleeping pill order to help him sleep better at night. 0/3 = I-CVI = 0	1 rater	2 raters		
D-2c. Stopped the physical assessment or tasks, makes eye contact, listens to patient. Explores sleep habits. Offers patient his headset (music). 2/3 = I-CVI = .67			1 rater	2 raters
D-2d. Tells patient not to worry about the family history of colon cancer. 0/3 = I-CVI = 0	3 raters			
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
E-1. Evaluating Script for Patient's Physical Environmental Cues (Non-Healing Environment, Meaningful Item) *Missing overall rating from one rater, unable to score I-CVI 1/2 = I-CVI	1 rater	*1 rater A & B	*1 rater C	1 rater *1 rater D
E-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to physical environmental cues)				

E-2a. Pauses, makes eye contact, listens to patient, provides a comforting touch. Helped him put blanket on bed. States, "It must be nice to have your brother's blanket." $2/3 = I-CVI = .67$	1 rater		2 raters	
E-2b. Asks about the importance of the blanket from home and/or relationship with brother. $3/3 = I-CVI = 1.00$			2 raters	1 rater
E-2c. Does not straighten room. May state, "Housekeeping should come by later." $0/3 = I-CVI = 0$	3 raters			
E-2d. Attempts to clean room (e.g., straighten up room, states housekeeping will come by to empty the garbage can). Provides blanket to patient. $0/3 = I-CVI = 0$	1 rater	2 raters		
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
F-1. Evaluating Script for Patient's Veteran Culture Environmental Cues *Missing overall rating from one rater, unable to score $2/2 = I-CVI$		*1 rater A	1 rater *1 rater B	1 rater *1 rater C, D, E
F-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to veteran culture environmental cues)				
F-2a. Gives patient the hat. $1/3 = I-CVI = .33$	1 rater	1 rater	1 rater	

F-2b. Deliberately asked patient questions about the importance of the hat, trip, and/or war experiences.	2 raters	1 rater		
$3/3 = I-CVI = 1.00$				
F-2c. Pause, makes eye contact, listens to patient, provides a comforting touch. Invites conversation about the war experiences or trip plans.	1 rater	2 raters		
$3/3 = I-CVI = 1.00$				
F-2d. States the hat is right there.	3 raters			
$0/3 = I-CVI = 0$				
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
G-1. Evaluating Script for Patient's Verbal and Non-Verbal Cues for Social Support/Connections with Family/Friends		*1 rater A	1 rater	1 rater
$2/2 = I-CVI$ Unable to score I-CVI				*1 rater B, C, D
G-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to verbal and non-verbal cues for social support/connections with family/friends)				
G-2a. Responds that wife is not here yet. She states the wife will probably come soon.	2 raters	1 rater		
$0/0 = I-CVI = 0$				
G-2b. Pauses, makes eye contact, listens to patient, provides a comforting touch. Asks if there is any other family or friend he can call.		1 rater		2 raters
$2/3 = I-CVI = .67$				
G-2c. Talks about family relationships or encourages him to reach out to family/friends, dog.		1 rater	1 rater	1 rater

$2/3 = I-CVI = .67$				
G-2d. Encourages patient to call wife or helps him call her. $1/3 = I-CVI = .33$		2 raters	1 rater	
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
H-1. Evaluating Script for Patient's Verbal and Non-Verbal Cues for Connection with Higher Power/Faith Rituals $2/3 = I-CVI = .67$		1 rater		2 raters
H-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to verbal and non-verbal cues for connections with higher power/faith rituals)				
H-2a. Indicates that the MD will be there that afternoon to discuss his test results. $1/3 = I-CVI = .33$	1 rater	1 rater	1 rater	
H-2b. Pauses, makes eye contact, listens to patient, provides a comforting touch. Explicitly acknowledges his fears. $2/3 = I-CVI = .67$		1 rater		2 raters
H-2c. Offers to call the chaplain. Calls chaplain, or suggests calling home pastor, prays with patient, and/or explores the use of faith rituals. $2/3 = I-CVI = .67$		1 rater		2 raters
H-2d. Ignored comment or states "I'm not religious." $0/3 = I-CVI = 0$	3 raters			

APPENDIX HH
CONTENT VALIDITY REVIEW TWO SUMMARY

Items (Script and comments described in detail above)	Three content experts responses Item–content validity index (I-CVI) Scores *Incomplete rating not counted in overall rating (I-CVI)			
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
B-1. Evaluating Script for Patient’s Situational Verbal and Non-Verbal Cues for Anxiety 3/3 = I-CVI = 1.00			(1 rater)	(2 raters)
B-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to situational verbal and non-verbal cues for anxiety)				
B-2a. Demonstrates caring presence and listening. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: “This must be difficult, I’m sorry.” 3/3 = I-CVI = 1.00			(1 rater)	(1 rater)
B-2b. Explores coping strategies. For example, may state: “How have you coped in the past when you are faced with hard times?” 3/3 = I-CVI = 1.00			(1 rater)	(1 rater)
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
C-1. Evaluating Script for Patient’s Behavioral Cues for Physical Suffering 2/3 = I-CVI = .67	(1 rater)		(1 rater)	(1 rater)
C-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention				
C-2a. Demonstrates caring presence and listening. For example, stopped the physical assessment or tasks, pauses, makes eye contact, listens to patient’s concern, and/or provides a		(1 rater)	(1 rater)	(1 rater)

comforting touch. May state supportive statement “I realize you are hungry. That must be difficult.”

$$2/3 = I-CVI = .67$$

	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
C-2b. Attempts to provide comfort measures (e.g., fluffs pillow, gives own pillow, offers to get him more clear liquids, offers to help him up to chair).	(1 rater)		(1 rater)	(1 rater)
$2/3 = I-CVI = .67$				
D-1. Evaluating Script for Patient’s Situational Verbal and Non-Verbal Cues for Insomnia and Fear		(1 rater)		(2 raters)
$2/3 = I-CVI = .67$				
D-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to situational verbal and non-verbal cues for insomnia and fear)				
D-2a. Encourages patient to talk about his fears (e.g., asking more about his fears about test results, having cancer, father/brother, war experiences)			(1 rater)	(1 rater)
$3/3 = I-CVI = 1.00$				
D-2b. Demonstrates importance of music: For example, stopped the physical assessment or tasks, makes eye contact, listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, “Sounds like you have difficulty sleeping. Does the music help you sleep in the hospital? Would you like to listen to your music now?”		(1 rater)		(1 rater)
$1/2 = I-CVI = 0.50$				
(one rater, missing data)				
Unable to score I-CVI				

	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
E-1. Evaluating Script for Patient's Physical Environmental Cues (Meaningful item) $2/3 = I-CVI = .67$		(1 rater)		(2 raters)
E-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to meaningful items)				
E-2a. Recognition of the importance of the blanket and/or brother. May state supportive statement. For example, "It seems that the blanket from your brother is meaningful to you." $2/3 = I-CVI = .67$		(1 rater)	(1 rater)	(1 rater)
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
F-1. Evaluating Script for Patient's Veteran Culture Environmental Cues $2/3 = I-CVI = .67$		(1 rater)		(2 raters)
F-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to veteran culture environmental cues)				
F-2a. Demonstrates caring presence and listening. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It sounds like you lost a lot of friends. That must be hard for you." $3/3 = I-CVI = 1.00$			(2 raters)	(1 rater)

F-2b. Deliberately asked patient questions about the importance of the hat, trip, trip concern, and/or war experiences. (1 rater) (1 rater) (1 rater)

$$2/3 = I-CVI = .67$$

	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
G-1. Evaluating Script for Patient's Verbal and Non-Verbal Cues for Social Support/Connections with Family/Friends $2/3 = I-CVI = .67$		(1 rater)		(2 raters)
G-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to verbal and non-verbal cues for social support/connections with family/friends)				
G-2a. Demonstrates caring presence and listening. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, "It seems like you really miss home. Tell me more about it?" $2/2 = I-CVI = 1.00$ *(for rater in-between 2 & 3, counted as missing data/unable to score I-CVI)			(1 rater)	(1 rater)
		*(1 rater)		
G-2b. Promotes connection with family. Asks him if he wants her to call his wife or another family member. $2/3 = I-CVI = .67$		(1 rater)	(1 rater)	(1 rater)
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects

H-1. Evaluating Script for Patient's Verbal and Non-Verbal Cues for Connection with Higher Power/Faith Rituals $2/3 = I-CVI = .67$	(1 rater)	(2 raters)
<hr/>		
H-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to verbal and non-verbal cues for connections with higher power/faith rituals)		
<hr/>		
H-2a. Demonstrates caring presence and listening. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It seems like your faith is a source of strength to you." $3/3 = I-CVI = 1.00$	(1 rater)	(2 raters)
<hr/>		
H-2b. Offers to call the chaplain. Calls chaplain if patient requests. $2/3 = I-CVI = .67$	(1 rater)	(2 raters)
<hr/>		
H-2c. Recognition of/offers the Bible on bedside table. May read verse. $2/3 = I-CVI = .67$	(1 rater)	(2 raters)
<hr/>		
H-2d. Prays with patient. $2/2 = I-CVI = 1.00$ (*for rating in-between 2 & 3, not counted in overall rating)	*(1 rater)	(2 raters)
<hr/>		

APPENDIX II
CONTENT VALIDITY REVIEW THREE SUMMARY

Items (Script and comments described in detail above)	Five content experts responses Item–content validity index (I-CVI) Scores *Incomplete rating not counted in overall rating (I- CVI)			
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
B-1. Evaluating Script for Patient’s Situational Verbal and Non-Verbal Cues for Anxiety $5/5 = I-CVI = 1.00$			(2 raters)	(3 raters)
B-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to situational verbal and non-verbal cues for anxiety)				
B-2a. Demonstrates caring presence and listening related to test results. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: “This must be difficult, I’m sorry.” $3/5 = I-CVI = .60$	(1 rater)	(1 rater)		(3 raters)
B-2b. Explores coping strategies. For example, may state: “What helps you get through hard times?” $3/5 = I-CVI = .60$	(2 raters)		(1 rater)	(2 raters)
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
C-1. Evaluating Script for Patient’s Behavioral Cues for Physical Suffering $4/5 = I-CVI = .80$		(1 rater)	(1 rater)	(3 raters)
C-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to behavioral cues for physical suffering)				

C-2a. Demonstrates caring presence and listening. For example, stopped the physical assessment or tasks, pauses, sits in chair, makes eye contact, listens to patient's concern, and/or provides a comforting touch. May state supportive statement: "I realize you are hungry. That must be difficult."	(2 raters)	(1 rater)	(2 raters)	
$3/5 = I-CVI = .60$				
C-2b. Attempts to provide comfort measures (e.g., fluffs pillow, gives own pillow, offers to get him more clear liquids, offers to help him up to chair).	(2 raters)	(1 rater)	(2 raters)	
$3/5 = I-CVI = .60$				
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
D-1. Evaluating Script for Patient's Situational Verbal and Non-Verbal Cues for Insomnia and Fear			(2 raters)	(3 raters)
$5/5 = I-CVI = 1.00$				
D-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to situational verbal and non-verbal cues for insomnia and fear)				
D-2a. Encourages patient to talk about his fears (e.g., asking more about his fears about test results, having cancer, father/brother, cancer experience).			(2 raters)	(3 raters)
$5/5 = I-CVI = 1.00$				
D-2b. Demonstrates importance of music: For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, "Sounds like you have difficulty sleeping. Does the music help you sleep in the hospital? Would you like to listen to your music now?"		(1 rater)	(1 rater)	(3 raters)
$4/5 = I-CVI = 0.80$				

	1	2	3	4
	Does not reflect	Somewhat reflects	Mostly reflects	Completely reflects
E-1. Evaluating Script for Patient's Physical Environmental Cues (Meaningful Item) $5/5 = I-CVI = 1.00$			(1 rater)	(4 raters)
E-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to meaningful item)				
E-2a. Recognition of the importance of the blanket and/or brother. May state supportive statement. For example, "It seems that the blanket from your brother is meaningful to you." $5/5 = I-CVI = 1.00$			(1 rater)	(4 raters)
	1	2	3	4
	Does not reflect	Somewhat reflects	Mostly reflects	Completely reflects
F-1. Evaluating Script for Patient's Veteran Culture Environmental Cues $5/5 = I-CVI = 1.00$				(5 raters)
F-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to veteran culture environmental cues)				
F-2a. Demonstrates caring presence and listening. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It sounds like you lost a lot of friends. That must be hard for you." May explore importance of the hat, and/or thanks him for his service. $5/5 = I-CVI = 1.00$			(1 rater)	(4 raters)

<p>F-2b. Recognition of veterans picture on bedside table or deliberately asked patient questions about the importance of current veterans supportive connections such as the Rolling Thunder^R group and/or his hope to participate in the Memorial Day parade/motorcycle ride.</p>	(5 raters)			
$5/5 = I-CVI = 1.00$				
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
<p>G-1. Evaluating Script for Patient's Verbal and Non-Verbal Cues for Social Support/Connections with Family/Friends</p>		(1 rater)	(1 rater)	(3 raters)
$4/5 = I-CVI = .80$				
<p>G-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to verbal and non-verbal cues for social support/connections with family/friends)</p>				
<p>G-2a. Demonstrates caring presence and listening. For example, pauses, makes eye contact, sits in chair, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, "It seems like you really miss home. Tell me more about it?"</p>			(1 rater)	(4 raters)
$5/5 = I-CVI = 1.00$				
<p>G-2b. Recognition of family picture on bedside table and/or promotes connection with family/*friend. Asks him if he wants her to call his wife, another family member, *or friend.</p>			(1 rater)	(4 raters)
$5/5 = I-CVI = 1.00$				
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects

H-1. Evaluating Script for Patient's Verbal and Non-Verbal Cues for Connection with Higher Power/Faith Rituals	(5 raters)		
$5/5 = I-CVI = 1.00$			
H-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to verbal and non-verbal cues for connections with higher power/faith rituals)			
H-2a. Demonstrates caring presence and listening related to religion. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It seems like your faith is a source of strength for you."	(5 raters)		
$5/5 = I-CVI = 1.00$			
H-2b. Offers to call chaplain. Calls chaplain if patient requests.	(1 rater)	(1 raters)	(3 raters)
$4/5 = I-CVI = .80$			
H-2c. Recognition of/offers the Bible on bedside table. May read verse.	(2 raters)		(3 raters)
$5/5 = I-CVI = 1.00$			

APPENDIX JJ
CONTENT VALIDITY REVIEW FOUR SUMMARY

Items (Script and comments described in detail above)	Five content experts responses			
	Item–content validity index (I-CVI) Scores			
	*Incomplete rating not counted in overall rating (I-CVI)			
	1	2	3	4
	Does not reflect	Somewhat reflects	Mostly reflects	Completely reflects
B-1. Evaluating Script for Patient’s Situational Verbal and Non-Verbal Cues for Anxiety 5/5 = I-CVI = 1.00			(2 raters)	(3 raters)
B-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to situational verbal and non-verbal cues for anxiety)				
B-2a. Demonstrates caring presence and listening related to test results. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state a supportive statement. 5/5 = I-CVI = 1.00			(1 rater)	(4 raters)
	1	2	3	4
	Does not reflect	Somewhat reflects	Mostly reflects	Completely reflects
C-1. Evaluating Script for Patient’s Behavioral Cues for Physical Suffering 4/4 = I-CVI = 1.00 *(missing one rater)				(4 raters)
C-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to behavioral cues for physical suffering)				
C-2a. Demonstrates caring presence and listening related to physical suffering. For example, stopped the physical assessment or tasks, pauses, sits in chair, makes eye contact, listens to patient’s concern, and/or provides a comforting touch. May state supportive statement. 5/5 = I-CVI = 1.00			(3 raters)	(2 raters)

	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
D-1. Evaluating Script for Patient's Situational Verbal and Non-Verbal Cues for Insomnia and Fear $5/5 = I-CVI = 1.00$			(2 raters)	(3 raters)
D-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to situational verbal and non-verbal cues for insomnia and fear)				
D-2a. Encourages patient to talk about his fears (e.g., asking more about his fears about test results, having cancer, father/brother cancer experience). $5/5 = I-CVI = 1.00$			(2 raters)	(3 raters)
D-2b. Demonstrates importance of music. For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, "Sounds like you have difficulty sleeping. Does the music help you sleep in the hospital? Would you like to listen to your music now?" and/or explores type of music he enjoys. $5/5 = I-CVI = 1.00$			(1 rater)	(4 raters)
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
E-1. Evaluating Script for Patient's Physical Environmental Cues (Meaningful Item) $5/5 = I-CVI = 1.00$			(1 rater)	(4 raters)
E-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to meaningful item)				

E-2a. Recognition of the importance of the blanket and/or brother. May state supportive statement. For example, “It seems that the blanket from your brother is meaningful to you.”	(1 rater)	(4 raters)
$5/5 = I-CVI = 1.00$		
1 Does not reflect	2 Somewhat reflects	3 Mostly reflects
4 Completely reflects		
F-1. Evaluating Script for Patient’s Veteran Culture Environmental Cues	(5 raters)	
$5/5 = I-CVI = 1.00$		
F-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to veteran culture environmental cues)		
F-2a. Demonstrates caring presence and listening. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: “It sounds like you lost a lot of friends. That must be hard for you.” May explore importance of the hat, and/or thanks him for his service.	(1 rater)	(4 raters)
$5/5 = I-CVI = 1.00$		
F-2b. Recognition of veterans picture on bedside table or deliberately asked patient questions about the importance of current veterans supportive connections such as the Rolling Thunder ^R group and/or his hope to participate in the Memorial Day parade/motorcycle ride.	(5 raters)	
$5/5 = I-CVI = 1.00$		
1 Does not reflect	2 Somewhat reflects	3 Mostly reflects
4 Completely reflects		

G-1. Evaluating Script for Patient's Verbal and Non-Verbal Cues for Social Support/Connections with Family/Friends 5/5 = I-CVI = 1.00	(2 raters)	(3 raters)		
G-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to verbal and non-verbal cues for social support/connections with family/friends)				
G-2a. Demonstrates caring presence and listening. For example, pauses, makes eye contact, sits in chair, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, "It seems like you really miss home. Tell me more about it?" 5/5 = I-CVI = 1.00	(1 rater)	(4 raters)		
G-2b. Recognition of family picture on bedside table and/or promotes connection with family/*friend. Asks him if he wants her to call his wife, another family member, *or friend. 5/5 = I-CVI = 1.00	(1 rater)	(4 raters)		
	1 Does not reflect	2 Somewhat reflects	3 Mostly reflects	4 Completely reflects
H-1. Evaluating Script for Patient's Verbal and Non-Verbal Cues for Connection with Higher Power/Faith Rituals 5/5 = I-CVI = 1.00				(5 raters)
H-2. Evaluating Whether the Nursing Intervention is a Spiritual Care Intervention (related to verbal and non-verbal cues for connections with higher power/faith rituals)				
H-2a. Demonstrates caring presence and listening related to religion. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It seems like your faith is a source of strength for you." 5/5 = I-CVI = 1.00				(5 raters)

H-2b. Offers to call chaplain. Calls chaplain if patient requests.	(2 raters)	(3 raters)
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$$5/5 = I-CVI = 1.00$$

H-2c. Recognition of/offers the Bible on bedside table. May read verse.	(2 raters)	(3 raters)
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$$5/5 = I-CVI = 1.00$$

APPENDIX KK
PILOT SESSION/STUDY PRE-SCRIPT

Introduction Script:

Hello. My name is Mary-Beth Desmond, I am also an RN and I am a nurse-researcher. Thank you for volunteering to participate in the “Spiritual Care in Nursing Practice” research study. It is important that you know that your time and opinion are valued and there is no right or wrong answer. No information about today will be shared with your manager or is considered part of your employment. I would like to give you an overview of what you can expect:

Data Collection

RN consent, baseline demographics and SCI pre-test, and instructions	Simulation	Complete two forms: a checklist describing your care and an evaluation form	Debrief with the standardized patient.	Complete a survey and discussion
20 min	10 min	10 min	10 min	10 min

I would like to read the consent to you at this time and then answer any questions you may have. Here is the information sheet that describes the study. Please read it now. Do you have any questions?

One more item: We ask that to maintain the integrity of the study. Please do not share the contents of the simulation/debriefing/interview with other RNs who work here.

I will need your verbal consent to participate in the first part of the study (simulation/debriefing). Do I have your consent?

APPENDIX LL
PILOT SESSION POST SPIRITUAL CARE CLINICAL SCENARIO
SIMULATION DEBRIEFING SCRIPT

Pilot Study Post-Debriefing Questions

1. Prior to beginning the simulation today, did you feel that the procedures and processes were clearly explained to you?
2. Do you feel that you had adequate time to fill out the forms prior to beginning the simulation?
3. Was the ten-minutes allotted for the simulation enough time for you?
4. Did you have any difficulties completing the post simulation checklist form?
5. Did you have any difficulties completing the Plus-Delta form?
6. Was the debriefing session with the standardized patient helpful to you?
7. Is there anything you would change in the flow/timing of this simulation study?
8. Is there anything else you would like to say about your experience here today?

APPENDIX MM

DRAFT SPIRITUAL CARE SIMULATION CHECKLIST FOR FIRST PILOT SESSION

DRAFT—4-19-2016

Spiritual Care Simulation Checklist

Cue(s)	Intervention(s)	Performed	Not Performed
B-2: Situational verbal and non-verbal cues for anxiety	a. Demonstrates caring presence and listening related to test results. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement related to waiting for the test results: "This must be difficult, I'm sorry."		
	b. Explores coping strategies. For example, may state: "How have you coped in the past when you are faced with hard times?"		
C-2: Behavioral cues for physical suffering	a. Demonstrates caring presence and listening related to physical suffering. For example, stopped the physical assessment or tasks, pauses, makes eye contact, listens to patient's concerns, and/or provides a comforting touch. May state supportive statement: "I realize you are hungry. That must be difficult."		
	b. Attempts to provide comfort measures (e.g., fluffs pillow, gives own pillow, offers to get him more clear liquids, offers to help him up to chair).		
D-2: Situational Verbal and non-verbal cues for insomnia and fear	a. Encourages patient to talk about his fears (e.g., asking more about his fears about test results, having cancer, father/brother, war experiences).		
	b. Demonstrates importance of music. For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, "Sounds like you have difficulty sleeping. Does the music help you sleep in the hospital? Would you like to listen to your music now?"		
E-2: Physical Environmental Cues/Meaningful Object	a. Recognition of the importance of the blanket and/or brother. May state supportive statement. For example, "It seems that the blanket from your brother is meaningful to you."		
F-2: Veteran Culture Environmental Cues	a. Demonstrates caring presence and listening related to Veteran culture. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement related to Veteran culture: "It sounds like you lost a lot of friends. That must be hard for you."		
	b. Deliberately asked patient questions about the importance of the hat, trip, trip concerns, and/or war experiences.		
G-2: Verbal & Non-Verbal Cues for Social Support/Connections with Family/Friends	a. Demonstrates caring presence and listening related to family supports. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, "It seems like you really miss home. Tell me more about it?"		
	b. Promotes connection with family. Asks him if he wants her to call his wife or another family member.		
H-2: Verbal & Non-Verbal Cues for Connection with Higher Power/Faith Rituals	a. Demonstrates caring presence and listening related to religion. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It seems like your faith is a source of strength for you."		
	b. Offers to call chaplain. Calls chaplain if patient requests.		
	c. Recognition of/offers the Bible on bedside table. May read verse.		
	d. Prays with patient.		

ID #: _____ Date: _____ Time: _____ Circle: RN Participant SP IO

APPENDIX NN

DRAFT SPIRITUAL CARE SIMULATION CHECKLIST FOR SECOND PILOT SESSION

DRAFT—4-26-2016


Spiritual Care Simulation Checklist

Cue(s)	Intervention(s)	Performed	Not Performed
B-2: Situational verbal and non-verbal cues for anxiety	a. Demonstrates caring presence and listening related to test results. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "This must be difficult, I'm sorry."		
	b. Explores coping strategies. For example, may state: "What helps you get through hard times?"		
C-2: Behavioral cues for physical suffering	a. Demonstrates caring presence and listening related to physical suffering. For example, stopped the physical assessment or tasks, pauses, sits in chair, makes eye contact, listens to patient's concerns, and/or provides a comforting touch. May state supportive statement: "I realize you are hungry. That must be difficult."		
	b. Attempts to provide comfort measures (e.g., fluffs pillow, gives own pillow, offers to get him more clear liquids, offers to help him up to chair).		
D-2: Situational Verbal and non-verbal cues for insomnia and fear	a. Encourages patient to talk about his fears (e.g., asking more about his fears about test results, having cancer, father/brother cancer experience).		
	b. Demonstrates importance of music. For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, "Sounds like you have difficulty sleeping. Does the music help you sleep in the hospital? Would you like to listen to your music now?"		
E-2: Physical Environmental Cues/Meaningful Object	a. Recognition of the importance of the blanket and/or brother. May state supportive statement. For example, "It seems that the blanket from your brother is meaningful to you."		
F-2: Veteran Culture Environmental Cues	a. Demonstrates caring presence and listening related to past Veteran experiences. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement related to Veteran culture: "It sounds like you lost a lot of friends. That must be hard for you." May explore importance of the hat, and/or thanks him for his service.		
	b. Recognition of Veteran picture on bedside table or deliberately asked patient questions about the importance of current Veteran supportive connections such as the Rolling Thunder group and/or his hope to participate in the Memorial Day parade/motorcycle ride.		
G-2: Verbal & Non-Verbal Cues for Social Support/Connections with Family/Friends	a. Demonstrates caring presence and listening related to family supports. For example, pauses, makes eye contact, sits in chair, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, "It seems like you really miss home. Tell me more about it?"		
	b. Recognition of family picture on bedside table and/or promotes connection with family. Asks him if he wants her to call his wife, another family member, or friend.		
H-2: Verbal & Non-Verbal Cues for Connection with Higher Power/Faith Rituals	a. Demonstrates caring presence and listening related to religion. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It seems like your faith is a source of strength for you."		
	b. Offers to call chaplain. Calls chaplain if patient requests.		
	c. Recognition of/offers the Bible on bedside table. May read verse.		

ID #: _____ Date: _____ Time: _____ Circle: RN Participant SP IO

APPENDIX OO
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VITA

Mary-Beth Desmond was born and raised in Chicago, Illinois. She attended Little Company of Mary Hospital School of Nursing in Evergreen Park, Illinois, where she earned her diploma in Nursing in 1984. She earned her Bachelor of Science in Nursing (BSN) degree in 1986 from Lewis University in Romeoville, Illinois. She earned a Master of Arts in Spirituality from Loyola University Chicago in 2010, and earned a Master of Science in Nursing in 2011 from Lewis University. She is a Board Certified Advanced Holistic Nurse, and a 2012 graduate of Dr. Jean Watson's Caritas Coach Education Program. She also obtained her Spiritual Director certificate from the Claret Center in Chicago, Illinois in 2012. She has completed online faculty development simulation modules through the University of Washington.

Mary-Beth has worked in a variety of patient care settings, predominantly at Adventist Hinsdale Hospital from 1989-2013. She worked in rehabilitation, orthopedics, pre-admission testing, and nursing education, and served as the first Personal Healthcare Advocate. She has served as a graduate assistant in the medical/surgical, mental health, simulation, and clinical lab courses in the BSN program at Loyola University, Chicago. She was adjunct faculty at Elmhurst College in the clinical setting, simulation, and lab, and at Lewis University in the graduate nursing program. In addition, she serves on the Board of Directors at the King-Bruwaert House Retirement Center in Burr Ridge, Illinois. Mary-Beth has accepted a full-time assistant professor position in the graduate nursing program at Lewis University starting in August 2017.

