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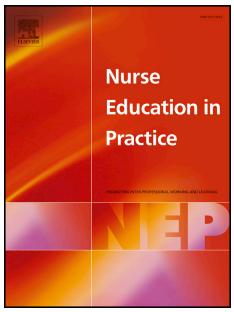

Developing a spiritual care competency frameworkfor pre-registration nurses and midwives

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DEVELOPING A SPIRITUAL CARE COMPETENCY FRAMEWORKFOR PRE-REGISTRATION NURSES AND MIDWIVES

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ABSTRACT

This paper identifies competencies in spiritual care from an in-depth literature review and develops a theoretical framework for competencies in spiritual care.

It forms part of a larger modified Delphi study which recruited international nursing/midwifery experts. Using Braun & Clarke's (2006) adapted six-phase content thematic analysis, 7 domains and 116 competency items were generated from an in-depth literature review in three areas; spirituality and spiritual care, spiritual care education, and spiritual care curricular contents.

Keywords: spirituality, spiritual care, spiritual care education, competencies, nursing/midwifery.

INTRODUCTION

There is a concerted move in the UK following the Francis Report (2013) to make nursing and midwifery services safer, sensitive, and compassionate (Moloney & Gair 2015; RCM 2016; Watterson, 2013). Evidence indicates that patients' spiritual needs are not adequately met in hospital despite its perceived value (Ross et al., 2013; Baldacchino, et al 2014). This suggests a spiritual care gap in nursing/midwifery education which contradicts the demands of regulatory bodies (RCN, 2012). Research recommends formal integration of spirituality within nursing/midwifery curricula to enable competent delivery of spiritual care. Existing spirituality competency frameworks mostly address palliative and end-of-life care but not the spiritual needs of clients in the wider contexts of nursing/midwifery care. In this paper we explore the competencies that define scope of spiritual nursing/midwifery practice.

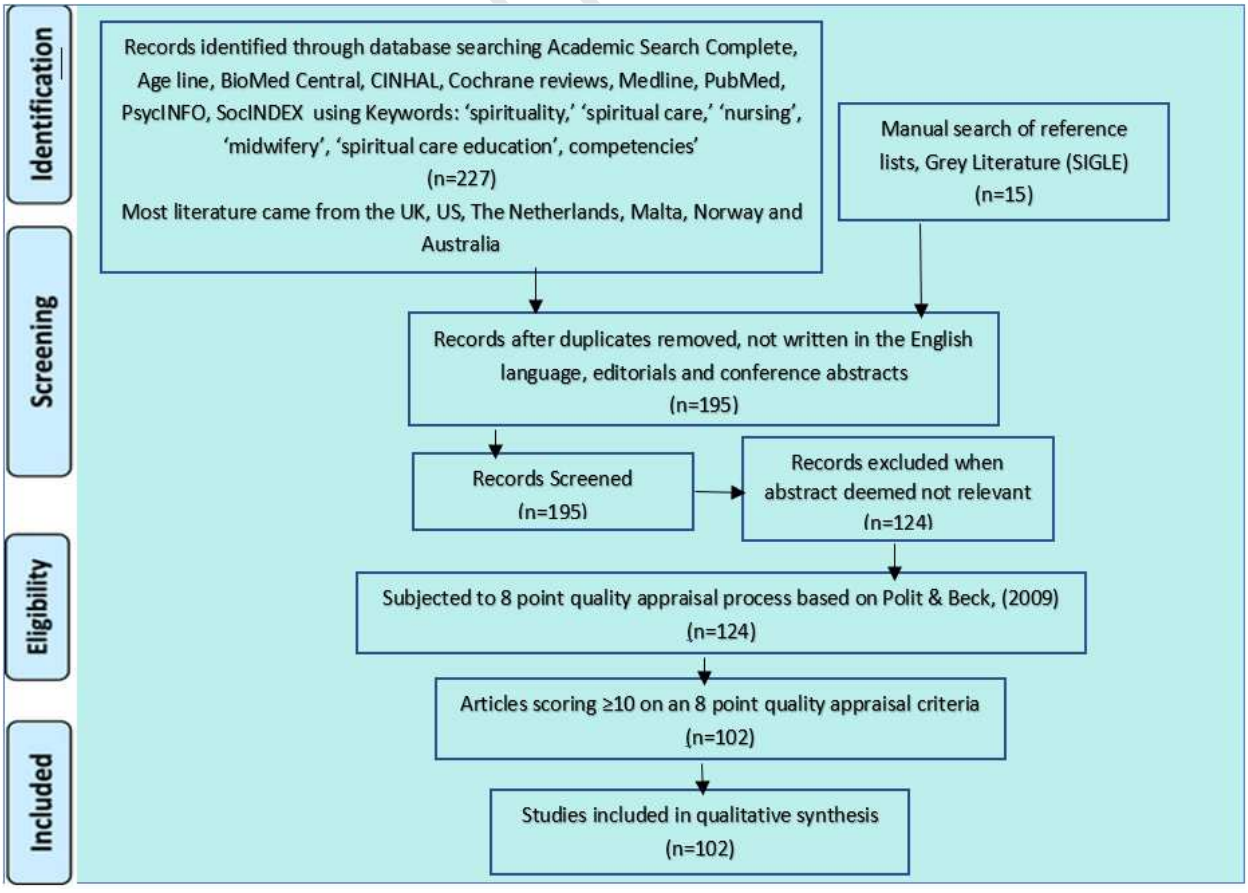
Spiritual practice acknowledges the interplay of mind, body and spirit where 'the whole is greater than the sum of the individual parts' (McSherry & Ross, 2010, p6).

Drawing on the Weeks et al (2017) model we identify cognitive, functional and ethical items in spiritual care for nurses/midwives from a literature review in three areas; spirituality and spiritual care, spiritual care education and curricular contents. This informs recommendations for spiritual care competencies development, and a theoretical model to underpin a spiritual care competency framework.

METHOD

Data Collection

Table 1 summarises the literature reviewing process using the PRISMA (2009) Flow diagram



Findings

Most studies addressed palliative care, oncology and mental health. Qualitative research on spirituality and spiritual care in nursing/midwifery is useful for understanding how individuals derive meaning from their surroundings, and how meaning may influence behaviour. The few randomised controlled trials (RCTs) identified were mostly concerned with the effects of religion and faith on various health outcomes (e.g. Koenig 2012). The main themes from the literature are:

- Nurses' perceptions and response to clients' spiritual needs.
- Concept clarification and role issues.
- Clients' perceptions of the spiritual dimension of care.
- Spiritual assessment and interventions.
- Culture and spiritual care research.
- Education and training on spiritual care issues.

These are summarised below.

Nurses' perceptions and response to clients' spiritual needs.

Research indicates that nurses tend to focus on patients' religious needs rather than non-religious spiritual needs (Pike, 2011; Kalish, 2012). Nurses either do not respond to clients' spiritual needs, respond haphazardly, or refer patients to other professionals. Nurses ignore spiritual aspects to avoid emotional involvement with clients' problems (McSherry, 2006), and perceive spiritual care as 'added extra' (Clarke, 2013). Providing spiritual care is determined by nurses' spiritual care education, and their ability to prioritise the spiritual

dimension of care (Swinton, 2001). However, nurses report feeling unprepared to address spiritual needs, being unclear about the concept of spirituality, and their role in spiritual care.

Concept clarification and role issues

The literature focuses on conceptualising and defining spirituality and its relationship with religiosity, holistic care and cultural issues (Holloway et al., 2011; Kalish, 2012). There is no consensus about a universal definition (Swinton & Patterson, 2010), an ambiguity between spiritual and psychosocial care (Clarke, 2009), and no theoretical framework to guide effective spiritual care (Narayanasamy, 2004). However, spiritual care is considered integral to nursing practice (Baldacchino, 2014), although nurses often interpret spiritual needs in religious terms (Ross 2006) and refer to clergy (McSherry & Jamieson, 2013).

Clients' perceptions of the spiritual dimension of care

The spiritual dimension of care is important to believers and non-believers (Ross, 2006; Draper, 2012). It involves patients finding meaning in their life and illness through their relationship with their God, spiritual practices e.g. prayer, maintaining connection with their family and friends (Hodge et al., 2012), morality, death and dying (Ross, 2006). In the absence of religious affiliation, clients' needs are respected by the withholding of prayers and reference to God. There was also preference for physician-assisted suicide (Smith-Stoner, 2007). Acknowledging diversity in clients' spirituality is important in spiritual care, but this tends to make spiritual assessment more complex (Draper, 2012).

Spiritual assessment and interventions

Tools have been developed to rate patient spirituality, spiritual distress and spiritual coping (Baldacchino, 2011; Taylor, 2008; Puchalski et al., 2009; van Leeuwen et al., 2008; McSherry & Ross, 2010; Holloway et al., 2011). Testing and development is variable raising questions about value, efficacy and appropriateness (Draper, 2012). There is general agreement that spiritual needs assessment is every healthcare professional's responsibility, and growing interest in competency models that differentiate levels of engagement (Gordon & Mitchell, 2004; NHS, Scotland, 2009). There is less evidence on spiritual care interventions designed to respond to spiritual needs. Literature identifies integrated models of care and spiritual assessment as an integral part of the intervention (Puchalski, 2009; Clarke, 2013).

Cultural and spiritual care research

Most spirituality/spiritual care research is descriptive and correlational. The relational nature of spirituality and culture necessitates more in-depth research. Sensitivity to cultural or religious diversity might inhibit nurses/midwives from responding to spiritual needs (Cockell & McSherry, 2012; Ross et al., 2013; Baldacchino et al, 2014).

Education and training on spiritual care issues

Nurses consider that spiritual care enhances nursing care quality, but they are not educationally prepared to meet patients' spiritual needs (McSherry & Jamieson 2013; Draper 2012, Pike 2011, Holloway et al., 2011; Kalish 2012).

Spirituality and spiritual care in midwifery

The place of spiritual care in midwifery is reflected in UK maternity care policies (DH, 2010; NMC, 2012). Research on midwifery spiritual care is small-scale, exploratory and descriptive using qualitative methods. Some literature presents women's birth narratives exploring

childbearing and spirituality (Schneider, 2012; Klassen, 2001; Crowther & Hall 2015), and childbirth as a liminal event, (Hall, 2010; Crowther & Hall 2015) and needs further exploration. Research on the spiritual nature of labour/birth is limited (Callister & Khalif, 2010).

Spirituality in midwifery is ill-defined, and is synonymous with religion. It is a broad concept which includes: meaning and purpose (Lydon-lam, 2012), existential meaning (Prinds et al., 2014), 'transcendence of hope and dream into a real living being' (Ayers-Gould, 2000, pp.16), renewed hope and 'peace of mind that enables people to accept and live with otherwise insolvable problems' (Flandermeyer, 2008, pp.122). For religious women, the influence of religiosity on birth suggests it may bring women closer to God (Klassen, 2001; Cioffi, 2004). Although there are methodological limitations, the positive relationship of spirituality and childbirth indicates that spiritual care is important to women in uncomplicated and complicated pregnancies, and birth (Carver & Ward, 2007). This is consistent with research where a positive relationship is found between spirituality and health (Koenig, 2012).

Hodnett et al; (2007) review of RCTs highlights that midwives' spiritual care during labour appears to be effective in birth outcomes (decrease in caesarean births, less use of pharmacological analgesia, fewer low Apgar scores at birth, shortened labour duration, and increased rate of successful breastfeeding). Midwife presence incorporates intimacy, respect, patience and creates a space conducive to birth, while maintaining professional boundaries (Callister & Khalif 2010; McSherry & Jamieson, 2013).

A positive birth experience is correlated to higher levels of spiritual resources in women, with reduced rates of post-natal depression (Jesse et al., 2005). Spiritual resources also

enhance women's coping mechanismswhen experiencing pregnancy loss (Dailey & Stuart, 2007). Online support groups and websites of bereaved individuals are frequently used (Krysinska & Andriessen, 2010), and although small-scale, the positive relationship between spiritual resources and coping is recognised in nursing research (Koenig, 2012; Baldacchino et al, 2014). Studies on different organisational models of midwifery care indicate the benefits of communication and interpersonal relationships between midwife and client (England & Morgan, 2012), compassionate care (Hall, 2013) and companionship with women (Walsh, 2012) i.e. the journey of 'being with women, not doing to women' (Fahy, 1998, pp.12). Other new research areas in midwifery include workplace spirituality e.g. birthing place (Hammond et al., 2013), and neonatal care environments (Caldeira & Hall, 2012).

Not attending to clients' spiritual midwifery needs is attributed to low consensus about a spirituality definition (Hall, 2010), birth medicalisation (Hodnett et al., 2007), care discontinuity (Hatem et al., 2008; Dahlberg & Aune, 2013) and the lack of midwifery education on spiritual care (Hall, 2010). Research recommends midwifery education should include:

- Religious, cultural practices and beliefs of women influencing birth (Hollins, 2006).
- Freedom to practise rituals significant to women's beliefs at home or hospital (Hall, 2013).
- Spiritual assessment (Hall, 2010; Lydon-Lam, 2012).
- Childbirth choices and decision-making influenced by spirituality (Miller & Shriver, 2012).

- Midwives' self-awareness to prioritise women's spirituality and beliefs (Klassen, 2001).

Spiritual care in pre-registration nursing/midwifery education

Despite the lack of consensus about spirituality/spiritual care, there is consensus that it is important and needs co-ordinated and systematic investigation (NMC, 2010; RCN, 2010; Carson, 2011; Draper, 2012; Cockell & McSherry, 2012; Cooper et al., 2013). The lack of spiritual care education in pre-registration nursing/midwifery curricula may be due to existing clinical practice issues, lack of curricula guidance, and ill-equipped lecturing environments.

Barriers to spiritual care in clinical practice (Baldacchino, 2011; Balboni et al., 2014) include: lack of knowledge, lack of time, poor staff awareness of their own spirituality, staff imposing their own spirituality, misconceptions about nurses' role in providing spiritual care, and avoiding spiritual matters due to poor competence (Taylor et al., 2008; Baldacchino, 2011; McSherry, 2006).

Few studies identify pre/post-registration curricula content on spiritual care (O'Shea et al., 2011; Vlasblom et al., 2011; Baldacchino, 2011). Most US nursing faculties don't define spirituality and the knowledge needed to develop spiritual competency (Lemmer 2002). This may result from a discrepancy between teaching and assessing spirituality/spiritual care, ensuring competence at the point of registration, and delivering it in practice (Timmins & Neill 2013). Research is needed on how spiritual care competencies could be achieved.

Education institutional barriers include: Ill-prepared lecturers using 'trial/error' teaching methods (Baldacchino, 2011) and specific academic institution initiatives (McSherry, 2006).

Large scale, cross-cultural, longitudinal research is needed to explore nurse/midwife educators' understanding of spirituality education, and effective spiritual care teaching methods for class/practice.

'Taught' vs. 'caught' spiritual care

Bradshaw (1997) argues that spirituality is 'caught' rather than 'taught', i.e. learnt from clinical placement role models. The effectiveness of learning through role models is not disputed provided that clinical role models demonstrate appropriate knowledge, skills and attitudes for spiritual care (McSherry 2006; Giske, 2012). However, teaching spiritual care may also have a positive impact on nursing/midwifery students' learning by giving them tools to identify and strengthen their resources and enhance job satisfaction (Baldacchino, 2011; Vlasblom et al., 2011; Burkhart & Schmidt, 2012; Attard, et al, 2014). Research evaluating specific spiritual care programmes shows positive outcomes on students' spiritual knowledge and attitudes (Baldacchino, 2006; Taylor et al., 2009; Ross et al., 2013; Attard, et al, 2014). This suggests formally integrating spiritual care in nursing/midwifery education using relevant contents and teaching methods, followed by continuing professional development (van Leeuwen et al., 2008; Cooper et al., 2013).

Curricula contents in spiritual care education

Some researchers have outlined their experiences in teaching spiritual care to nursing/midwifery students (Mooney & Timmins, 2007). Fundamental to understanding the concept is the search for meaning of spirituality facilitated by reflective exercises on students' own spiritual status and awareness; the meaning and purpose of life events; communication and building meaningful relationships; knowledge of world religions, and providing spiritual care using the nursing process. Puchalski, et al (2009) emphasise

communication with clients. These findings should be interpreted with caution due to methodological limitations e.g. convenience samples, lack of randomised controlled trials, limited pre/post-test design use (O'Shea et al., 2011; Vlasblom et al., 2011), descriptive exploratory designs using small homogenous samples (Baldacchino, 2011), absence of creative teaching approaches (Mooney & Timmins, 2007), and limited generalisablity.

Competencies in spiritual care

Marie Curie Cancer Care developed the first spiritual care competency framework in 2003 (MCCC, 2003). Competency frameworks raised the profile of spiritual care and enhanced the integration of holistic care within palliative care. The profile recognises that different healthcare workers operate at different spiritual care competency levels. However, it lacked scientific evidence due to small sample size, and service user participation.

Van Leeuwen & Cusveller (2004) developed a spiritual care competency framework for use in pre-registration nurse education. It underwent psychometric testing and is available to assess student nurses' competency in spiritual care. The tool was tested on Christian students only but is effective in assessing pre-registration nursing students' spiritual care competency.

Baldacchino (2006) confirmed two domains (awareness and self-handling, and the spiritual dimension of nursing) of the three identified by van Leeuwen & Cusveller (2004). Other domains were nurses' competency in communication with patients, interdisciplinary team and educators, and safeguarding ethical issues in care. However, both frameworks are of

Christian orientation, and methodological limitations restrict generalisation. Rigorous research is needed to develop relevant spiritual care competencies, and a theoretical model to underpin formulation of a competency framework.

Competencies developed from the literature

The literature review findings were used to develop a spiritual care competency model. Braun & Clarke's (2006) six-phase content thematic analysis framework was adapted to identify themes/domains and competency items. This involved;

- Familiarisation with selected research articles through reading and noting initial potential themes and competencies in spiritual care.
- Systematic manual coding of potential competencies - collated to the relevant theme/sub-theme.
- Sorting and collating main over-arching competencies, themes and sub-themes followed.
- Developing a thematic map.
- Defining and naming themes, determining whether each theme captures the content of identified competency items.
- Reporting the identified themes/domains and competency items. Seven domains and 116 competency items in spiritual care emerged (Table 2).

Table 2. Competency items elicited from literature review

Domain 1: Body of knowledge in spiritual care	
1	Demonstrate broad understanding of spirituality integral to holistic care
2	Demonstrate knowledge and understanding of main world faiths
3	Appreciate that all individuals have a spiritual dimension and some have a religious element to their spirituality

4	Appreciate role of chaplains and spiritual leaders in providing spiritual care
5	Demonstrate knowledge in responding to questions of life's meaning and purpose clients might pose
6	Demonstrate knowledge of different beliefs and practices with particular reference to their influence during illness and birth
7	Seek resources that will inform nurses regarding health care options in line with client's religious/spiritual beliefs and practices
8	Demonstrate knowledge of formal spiritual assessment tools
9	Demonstrate knowledge of Informal methods of assessment using genericquestions on clients' feelings and concerns
10	Demonstrate knowledge in helping skills as attributes integral of spiritual
11	Recognise importance of prioritising spiritual dimension of care in providing care
12	Recognise that religion may be a significant element in client's life
13	Recognise nurses/midwives' role in providing spiritual care integral to holistic care
14	Value importance of a psycho-social approach to care while recognising ambiguity between spirituality and psychosocial care
15	Recognise spiritual dimension of care is important to believers and non-believers
Domain 2:	Self-awareness and use of self
16	Recognise importance of own spirituality and use of self in providing spiritual care
17	Recognise own limitations and access assistance from appropriate members of multi-disciplinary team
18	Demonstrate ability not to impose own beliefs in care
19	Demonstrate personal awareness of one's own values and beliefs
20	Recognise that their own spirituality may affect how they interact with clients beliefs
21	Appreciate value of own experiences without imposing such experiences on others
22	Appreciate importance of seeking reflective activities in meeting one's inner feelings in order to move on
Domain 3:	**Communication and interpersonal relationship in spiritual care**
23	Identify self-awareness as a resource to understand clients' inner feelings
24	Understand importance of verbal and non-verbal communication
25	Able to develop trusting relationships with clients and family in order to journey the illness with them
26	Able to listen actively, connect and maintain presence with client
27	Acknowledge importance of clients narrating their sufferings and pray with client if he/she requests (
28	Demonstrate support and presence in being with client

29	Assess barriers to effective communication, such as language, culture and religion and make appropriate adaptations
30	Listen to clients and their family, empathise and demonstrate presence
31	Recognise spiritual/religious resources as a coping mechanism in clients and their families experiencing loss
32	Understand importance of active listening to clients' narratives
33	Recognise need for companionship, support, trust and encouragement to clients and their families
34	Recognise that effective therapeutic nurse/midwife-client is core for provision of spiritual care
35	Adapt barriers to effective communication (such as fear) by demonstrating active listening and empathy
36	Demonstrate ability in building trustful relationships with clients and their families
37	Demonstrate good communication skills, such as good questioning techniques to elicit clients' life stories
38	Recognise essentials for a caring conversation such as communicating in language and terms they can understand, presence, touch and listening
39	Recognise connection with clients through verbal and non-verbal expressions, such as eye contact, warmth of the voice and praying with client
40	Recognise importance of a trustful relationship with clients to assess clients' inner thoughts and feelings
41	Demonstrate compassionate listening through attention, interest and time to dialogue with clients
42	Demonstrate understanding of clients' lived experiences to confide their spiritual concerns to alleviate their fear and anxiety
43	Appreciate touch as a means of communicating empathy, caring, affection and concern if not inhibited by clients' culture
44	Provide empathy, time, courage, therapeutic touch to clients
45	Acknowledge importance to practice rituals significant to clients' beliefs during hospitalisation or in community
46	Recognise spiritual care integral to any compassionate and client -centred health care system, honouring dignity of all people
47	Demonstrate ability to address spirituality with clients of different cultures
48	Ensure that clients have therapeutic presence of family, friends
49	Appreciate value of therapeutic presence and non-verbal communication in promoting clients' positive self-concept - hope, courage and support
50	Demonstrate an accepting non – judgemental attitude while communicating with clients' life concerns
Domain 4:	**Ethical and legal issues in spiritual care**
51	Show respect for clients' diverse religions, beliefs and practices.
52	Demonstrate non-judgmental behaviour towards clients' diversity
53	Respect clients' right for information when reaching decisions regarding their illness, care and treatment

54	Respect right to decline spiritual care
55	Demonstrate sensitivity and respect for diversity in care choices and health beliefs
56	Respect and acknowledge role of clergy and spiritual leaders in providing spiritual care
57	Restrict barriers to spiritual care such as lack of time among stake holders' desire for specialisation rather than humanisation
58	Demonstrate sensitivity and respect for client's diverse healthcare choices influenced by religious/spiritual beliefs and practices
59	Demonstrate sensitivity and respect to clients' decisions in their care, free from manipulation and coercion
60	Demonstrate non-judgmental attitudes to diverse spiritual beliefs
61	Acknowledge and respect confidentiality issues in addressing clients' spiritual healthcare needs
62	Acknowledge and respect clients' confidentiality when disclosing personal information to members of the multi-disciplinary team
63	Recognise ethical obligation to attend to clients' holistic needs abiding with ethical and legal principles
64	Restrict presence of too many healthcare professionals with consequent lack of privacy and continuity of care
65	Demonstrate sensitivity and responsiveness to clients' spiritual and health needs free from manipulation and coercion
66	Identify intersections of legal, ethical, religious/spiritual concerns and beliefs and seek advice
67	Protect clients' vulnerability in particular in times of illness and sufferings
68	Demonstrate tolerance and respect for clients' individual characteristics in their way of thinking
69	Provide consistent information about clients' welfare
70	Demonstrate a non-judgmental attitude towards clients and their families
71	Identify and respect clients' religious beliefs and practices that promote a positive self-concept and integrity
72	Safeguard healthcare providers' ethical and legal rights to protect and maintain professional boundaries
73	Respect and guard clients' right for autonomy and dignity
74	Disclose consistent information regarding clients' welfare in a sympathetic and tactful way
75	Maintain confidentiality when documenting clients' spiritual needs and interventions
Domain 5: Quality assurance in spiritual care	
76	Identify personal education, training and development needs in spiritual care and identify resources to access them

77	Participate in group discussion and experiential exercises to enhance spiritual awareness
78	Recognise role and responsibility of nurses/midwives in provision of spiritual care
79	Appreciate role and responsibility of other members of care team in provision of spiritual/religious care
80	Collaborate with members of healthcare team in providing spiritual/religious care
81	Recognise role of chaplains, social workers and other members of multi-disciplinary team in provision of spiritual/religious care
82	Recognise need for spiritual support of healthcare professionals
83	Collaborate in integration of spirituality in nursing/midwifery programmes
84	Demonstrate an ability to maintain appropriate professional boundaries
85	Understand importance of reflection on own practice in relation to meeting spiritual needs
86	Demonstrate personal growth, high moral values and lives directed to spiritual principles
87	Understand importance of reflection on own practice and make changes as required
88	Demonstrate attributes of understanding, caring, courage, reassurance and empowerment with clients
89	Demonstrate a 'positiveness' with clients by being genuine, instilling hope, integrating beliefs and prayer, and practising faith traditions
90	Demonstrate a professional attitude of trust and conduct
91	Appreciate vocational elements of profession in clinical nursing/midwifery basic care
92	Appreciate contribution of alternative therapies, such as meditation, music and creative art as spiritual care interventions
93	Participate in creation of a supportive, caring environment for clients and their families
94	Participate in creation of a spiritually healthy workforce, teamwork and support systems available
95	Foster an environment that determines spiritual well-being through calmness and quietness
96	Understand importance of own life experiences in own practice in relation to spiritual care
97	Recognise need to participate in learning events on spiritual care
98	Emphasise importance of personal and professional development, and spiritual formation of health care providers
Domain 6: Assessment and implementation of spiritual care	
99	Acknowledge role of nurses/midwives in assessing of clients' spiritual needs
100	Acknowledge use of formal and informal methods of spiritual assessment

101	Identify distinctions between spiritual and religious needs
102	Demonstrate ability to formally assess spiritual/religious needs
103	Demonstrate ability to assess spiritual/religious needs informally by observing cues and listening to clients' life experiences
104	Recognise spiritual conflict and distress in clients and their family
105	Ensure privacy, confidentiality and adequate time for spiritual assessment, planning and implementing spiritual/religious interventions
106	Plan and provide interventions that meet the clients' and family spiritual needs
107	Provide caring interventions to meet clients' needs in a humane way through their suffering whilst keeping up realistic hope
108	Comply with clients' request for prayer and other religious mementoes significant to the clients
109	Identify need to consult the chaplain/spiritual leader or members of multidisciplinary team as often as the client requests
110	Assist clients' to find meaning and purpose in their grief and sufferings
111	Evaluate care given and make adaptations to meet unmet spiritual/religious needs
112	Identify met spiritual/religious needs through clients' spiritual integrity displayed through internal peace, acceptance and meaningful behaviour
Domain 7: Informatics in spiritual care	
113	Identify importance of information technology to enhance knowledge on spiritual care
114	Use information technology to inform and guide nurses/midwives future evidence-based practice in various crises situations
115	Acknowledge use of information technology as a valuable learning tool, when dealing with spiritual care issues
116	Acknowledge use of information technology as a means of documenting spiritual care delivered

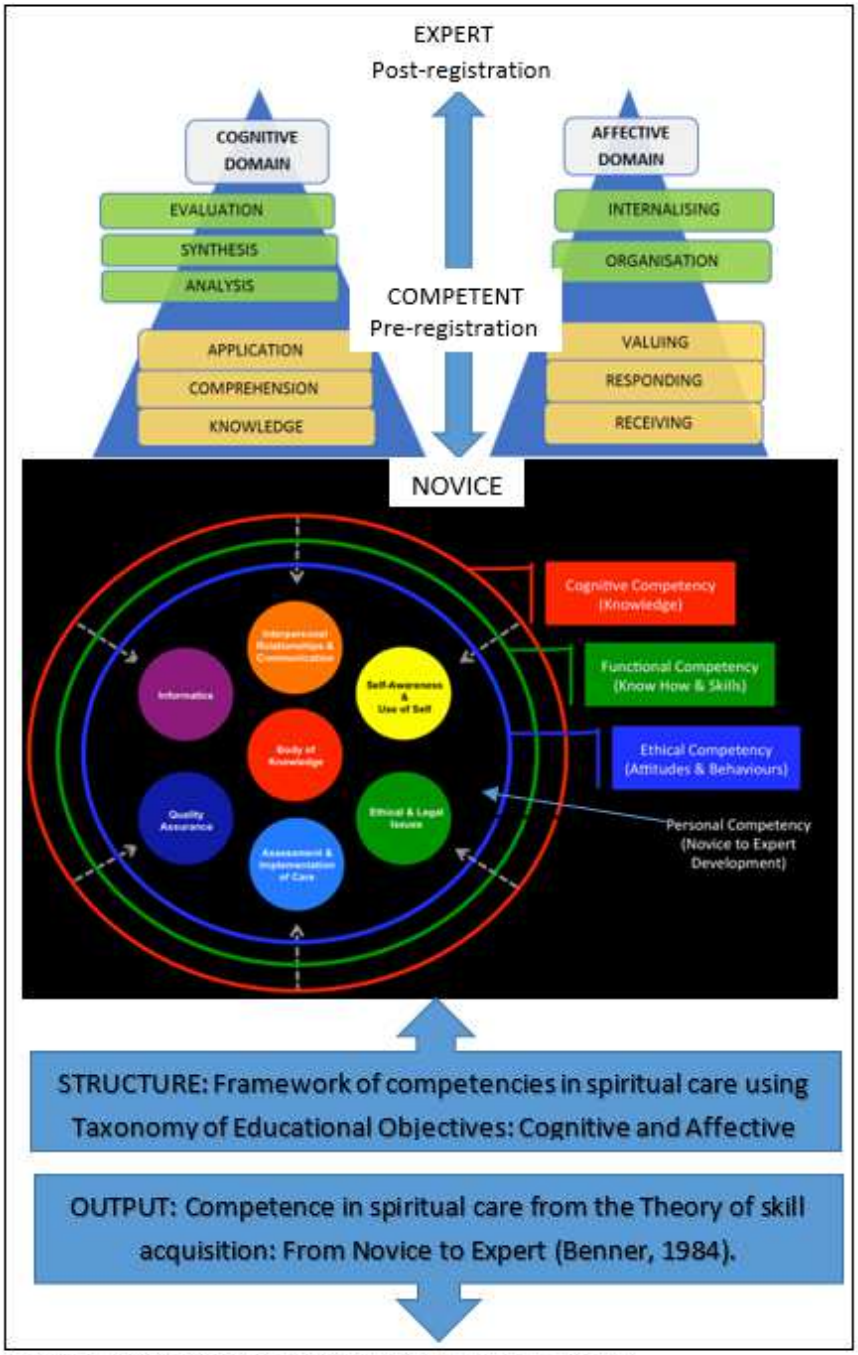
Theoretical framework for competency development

Figure I. summarises the integrated model of spiritual care competence. This underpins a spiritual care competency framework and supports two important phases in competence acquisition. Phase 1 is the 'structure' which incorporates the list of competency domains and items guided by the synthesis of knowledge (cognitive), skills (functional), attitudes (ethical) and reflection on experience (Weeks et al; 2017).

Phase 2 is achievement of personal competency in spiritual care along the novice-expert continuum, and continuing professional development cognitive and affective domains (Bloom, 1956). This provides nursing/midwifery educators with teaching and learning content and methodology.

These two theories indicate the barriers to translating competencies into clinical practice. Both theories categorise student learning needs in theoretical and clinical practice levels. Depending on the desired outcome, the theoretical and practical learning objectives are set to the student's appropriate level. Using teaching approaches that correspond to the student's learning needs level helps achieve the desired level of spiritual care competency.

Figure 1. Theoretical framework for the development of competencies in spiritual care



Source: Adapted from Benner, (1984); Bloom, (1956)

CONCLUSION

Using a competency-based approach addresses the educational mission of integrating the concepts of spirituality/spiritual care in education and practice. Competencies may be achieved over the span of an educational programme at pre-or post-registration level, over

a variety of nursing/midwifery settings. In clinical practice, the framework may foster a culture for spiritual care, instigating commitment and guidance to improve spiritual care standards, not only in the care provided to clients but also to colleagues by embracing a multi-disciplinary team spirit and continuing professional development.

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No conflict of Interest