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REVIEW

Educational interventions and strategies for spiritual care in nursing and healthcare students and staff: A scoping review

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Abstract

Aims and objectives: To map existing evidence about educational interventions or strategies in nursing and allied healthcare concerning students' and staffs' spiritual care provision.

Background: Spiritual care is an important part of whole person care, but healthcare staff lack competence and awareness of spiritual issues in practice. To rectify this, it is important to identify what educational approaches are most helpful in supporting them to provide spiritual care.

Design: A scoping review using the PRISMA-ScR checklist.

Method: Searches in the databases CINAHL, MEDLINE, ATLA and ERIC were conducted for papers spanning January 2009–May 2020. Search terms were related to spirituality, spiritual care, education and clinical teaching. Appraisal tools were used.

Results: From the 2128 potentially relevant papers, 36 were included. The studies were from 15 different countries and involved nurses, physicians and other health-related professions, and both quantitative, qualitative and mixed methods were used. The results are presented in three themes: *Understanding of spirituality*, *Strategies in educational settings*, and *Strategies in practice settings*. The review points to great diversity in the content, lengths and setting of the educational interventions or strategies.

Conclusions: Courses in spiritual care should be implemented in curricula in both undergraduate and postgraduate education, and several studies suggest it should be mandatory. Courses should also be available for healthcare staff to raise awareness and to encourage the integration of spiritual care into their everyday practice. There is a need for greater consensus about how spirituality and spiritual care are described in healthcare settings.

Relevance to clinical practice: Spiritual care must be included both in monodisciplinary and multidisciplinary educational settings. The main result of spiritual care courses is in building awareness of spiritual issues and self-awareness. To ensure the

provision of spiritual care for patients in healthcare practices, continuing and multidisciplinary education is recommended.

KEYWORDS
education, healthcare, nursing, practice, scoping review, spiritual care, spirituality

1 | INTRODUCTION

Spiritual care is essential in caring for the whole person, and nurses have a responsibility to provide care with respect for human rights, values, customs and spiritual beliefs (International Council of Nurses, 2012). Likewise, other professions working with patients and clients in health and social care settings acknowledge that spiritual care must be an integral part of their services (Cobb et al., 2012; Cook & Powell, 2021). The impact of spirituality on health is clearly demonstrated, and the spiritual health of patients should therefore be supported (Steinhauser et al., 2017). Selman et al. (2018) found that patients report that spiritual care is missing due to lack of time or de-prioritisation, and that research should address fostering skills and qualities of human connectedness in healthcare staff.

Paal et al. (2014) point to the importance of 'competency-based spiritual care education, practical training and maintaining the link between spiritual care education and clinical practice' (p. 1). Spiritual nursing care is often invisible because it is integral to good nursing care and therefore difficult to delineate (Hawthorne & Gordon, 2020). In medicine, practitioners are often hesitant to include spiritual care in clinical practice because of lack of high-grade evidence (Kannan & Gowri, 2020). To mitigate such obstacles, scholars have an international recognition of the importance of education, training, mentoring, policy and research in building a multidisciplinary evidence base for spiritual care (Ali et al., 2018; Puchalski et al., 2014). Therefore, it is necessary to understand more about what types of teaching and learning strategies that foster development of spiritual care competencies in nurses, other healthcare professionals and students in clinical practice.

This study is a scoping review, which is suitable for identifying available evidence into how research is conducted and for recognising knowledge gaps. This approach is therefore useful for practice, education, research and policymaking (Munn et al., 2018; Peterson et al., 2017).

What does this paper contribute to the wider global clinical community?

- Educational curricula can prepare nursing and other healthcare students to provide spiritual care. Content should be threaded throughout the curriculum, and courses should be mandatory. In addition, healthcare staff should be provided courses to keep up the focus upon continuous spiritual care competence development.
- Teaching and learning strategies which focus on self-reflection, group reflection, case discussions or patient simulation, as well as working in multidisciplinary teams are most useful in preparing students and staff to provide spiritual care; they foster development of new skills and awareness of spiritual issues.
- There is need of further research to establish the long-term effect of education in spiritual care, and greater consensus about how to describe spiritual care in healthcare settings.

1.1 | Background

Spirituality is understood, in accordance with the European Association for Palliative Care (Best et al., 2020), as multidimensional, including existential challenges, value-based considerations and attitudes, and religious considerations and foundations. It is dynamic and is concerned with people's quest for meaning and purpose, connection and transcendence (Rykkje et al., 2011; Weathers et al., 2016). The World Health Organization (WHO) (2002) includes these elements in its spiritual quality of life measure. Furthermore, this understanding of spirituality has been adopted for student nurse/midwifery education across Europe (EPICC Project, www.epicc-network.org). Spiritual care is:

> Care which recognises and responds to the human spirit when faced with life-changing events (such as birth, trauma, ill health, loss) or sadness, and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires
>
> (McSherry et al., 2020, p. 8)

A qualitative literature review of nurse education and practice of spiritual care found nurse awareness of their lack of knowledge, understanding and skills, as well as desire to improve their competencies (Lewinson et al., 2015). Many nurses report barriers in providing spiritual care, and that participating in spiritual care

programmes in education or at work is associated with enhanced preparedness and competencies (Green et al., 2020). Spiritual care training and development of new models for spiritual care education is needed for all staff having contact with patients both in hospital and community healthcare (Austin et al., 2017; Gijsberts et al., 2019). The study of Petersen and Schiltz (2020) presenting an effective 4-credit, semester-long undergraduate spiritual care course focused on care of patients facing the end-of-life, with participants from nursing, pre-medicine, athletic training, business, economics, and religious studies, is a promising example of multi-professional collaborative learning. Another study involving various rehabilitation professionals found that a brief training programme can improve perceptions and practice of spiritual care, although ongoing training is recommended to ensure the retainment of knowledge (Jones et al., 2020). A review of studies on spiritual care training in different health professionals found positive patient outcomes (Paal et al., 2015). Thus, there is evidence implying that incorporation of spiritual care into healthcare education and practice is needed and that increased awareness and openness toward spirituality and improved knowledge and skills can benefit healthcare receivers.

Today, there is a large body of evidence regarding spiritual care competency and education (Attard et al., 2019; Best et al., 2020; Cone & Giske, 2018; Ross et al., 2016). However, the international EPICC (Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care) project network (van Leeuwen et al., 2020; McSherry et al., 2020), found great inconsistency in how spirituality is addressed within programmes of nurse and midwifery education across Europe. The project resulted in a best practice standard for spiritual care education, providing a set of competencies (knowledge, skills, and attitudes) to assess nurses' and midwives' abilities to provide spiritual care, as well as learning tools. The authors acknowledge that all knowledge about spiritual care is not transferable or universally acceptable due to cultural and contextual differences between countries. The authors also realise there is need for evidence to build a more coherent and standardised approach toward how spiritual care competencies can be achieved in education and in practice settings.

1.2 | Aims

The purpose of this scoping review was to map existing evidence about educational interventions or strategies in nursing and allied healthcare concerning students' and staffs' spiritual care provision. The included studies provided evidence, either by quantitative measures or by qualitative evaluation, on interventions or strategies that helped the participants develop knowledge and skills in spiritual care. The review was broadened to include relevant sources of evidence from both nursing and allied health professions, given the current emphasis upon interprofessional cooperation in healthcare services.

Research question: *What is the existing evidence base regarding teaching and/or learning strategies concerning spiritual care provision in healthcare students and staff?*

2 | METHODS

The study is part of a project regarding the development of spiritual care in nursing and healthcare education and practices (SEP project, www.spiritualcare.no). The six authors are from different international educational institutions: five experienced nurse researchers in spirituality (LRy, LRo, WM, PC, TG) and one research librarian (MBS).

This study focuses upon spiritual care competencies for healthcare students and healthcare staff with the primary focus upon nursing and was guided by evidence-based methods for scoping reviews (Peters et al., 2015; Peterson et al., 2017). The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) extension for scoping reviews (PRISMA-ScR) checklist (Tricco et al., 2018) was used (Appendix S1). The PRISMA-ScR flowchart (Figure 1) was adapted, so the review involved the following steps:

1. Identification of records by systematic search
2. Screening records by titles and abstracts
3. Assessment for eligibility based on full text
4. Critical appraisal
5. Records included

2.1 | Study identification – search and initial screening (step 1)

The search strategy was developed in collaboration with research librarians, and several trial searches were discussed with the project group before deciding collectively upon the final strategy and databases to be included. In the last decade, the number of studies on the topic has increased. The authors decided to limit the inclusion to approximately 10 years, and because the study was planned in 2019, the inclusion year was set to 2009. This decision is reasonable as both healthcare practice and education are in continuous development and change, thus newer studies were likely to be most helpful for achieving the study aim. Different study designs and healthcare fields were included, as well as both education and practice; the broad scope of the study made it difficult to design a 'perfect' strategy. Although there is no guarantee finding all the best studies, hand searches were also undertaken to ensure not missing out on relevant studies. The search terms and strategy can be found in Appendix S2.

In step 1, structured searches were made by MBS in the databases Medline, CINAHL, Eric, and ATLAS. In addition, LRy did substantial hand searches for eligible articles in CINAHL, ProQuest and Google Scholar. All records were downloaded into EndNote and duplicates

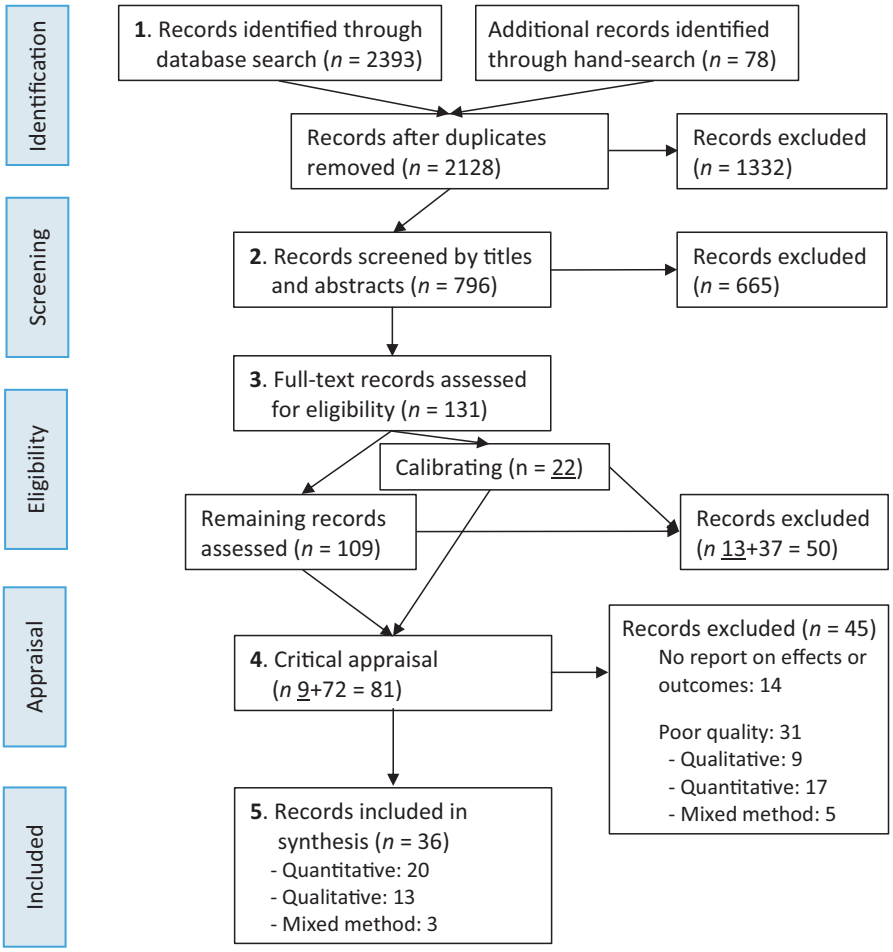

FIGURE 1 PRISMA-Scr flow chart of study selection (adapted from Tricco et al., 2018)

TABLE 1 Eligibility criteria

Inclusion criteria	Exclusion criteria
• Published between 2009 (January 1st) and 2020 (May 30th) • Spiritual care • Healthcare related • English language • Strategies or interventions related to teaching or learning • Empirical research: Study design including qualitative, quantitative, or mixed method	• Non-empirical research: Study design including concept analysis, review articles, theoretical studies, service evaluation • Short publications such as presentations, posters, editorials, comments, abstracts, opinions, briefs *Added in step 4:* • *No report on effects or outcomes related to the intervention or strategy*

were removed. LRy and MBS screened the records using EndNote. The inclusion and exclusion criteria were applied (see Table 1).

2.2 | Selection of sources of evidence (step 2 and 3)

In step 2, 796 records were screened by titles and abstracts. LRy, MBS and TG individually marked each record by 'Include, Exclude, or Maybe' in the screening programme Rayyan (Ouzzani et al., 2016). The three authors met to discuss records with incongruent marks. The authors were unsure of 22 records marked 'Maybe' and decided to discuss these with the whole team. Therefore, step 3 started with assessment of these 22 records.

In step 3, the team was divided into three groups: LRy & MBS, LRo & WM, PC & TG. Each group was assigned 2/3 of the 22 articles, thus there was overlap between the groups. Both group members read their assigned full text articles independently, then met and agreed upon inclusion or exclusion. Afterwards, the three groups came together for a 'calibration' meeting discussing the 22 records, resulting in 13 being excluded and 9 included.

Next, the remaining 109 records were assigned evenly across the three groups without overlap, and the members of each group read their articles independently, followed by a paired discussion of eligibility. Step 3 ended with a joint meeting where all groups presented their assessments. In this process, a greater overview of the types of research in the records was achieved. This helped the team to become more coherent in their opinion of whether to include or

TABLE 2 Quality appraisal tools

Tools	Questions	Grading
Quality Assessment Tool for *Quantitative* Studies (EPHPP) Dictionary for the Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies	18 questions in 8 sections: A Selection bias: 2Q (questions) B Study design C Confounders: 2Q D Blinding: 2Q E Data collection methods: 2Q F Withdrawals and drop-outs: 2Q G Intervention integrity: 3Q H Analysis: 4Q	A global rating based on section A–F: • Strong (no Weak ratings) • Moderate (one Weak rating) • Weak (two or more Weak ratings)
Appendix H Quality appraisal checklist – *qualitative* studies (pages 206–217)	14 questions in 6 themes: 1. Theoretical approach: 2Q 2. Study design 3. Data collection 4. Trustworthiness: 3Q 5. Analysis: 6Q 6. Ethics	Three types of responses according to the theme Overall assessment with three grades: • Strong (++) • Moderate (+) • Weak (-)
Mixed methods appraisal tool (MMAT), version 2018	2 screening questions (for all types) – S1, S2 5 questions each for these methods: 1. Qualitative 2. Quantitative RCT 3. Quantitative non-randomised 4. Quantitative descriptive 5. Mixed methods	Three types of responses: Yes, No, Can't tell No overall score/rating We filled out S1, S2, method 1 and 5, and either method 2, 3 or 4 for studies with both qualitative and quantitative results

exclude records, resulting in the inclusion and exclusion of 72 and 37 records, respectively. Altogether, 81 articles were included for critical appraisal.

2.3 | Critical appraisal (step 4)

Because the included studies varied in methodological quality, the authors decided to include a critical appraisal (Tricco et al., 2018). In step 4, commencing with the same three groups, each was assigned 27 articles for appraisal. Three different quality appraisal tools with supplementary guides were utilised, see Table 2. The EPHPP (Effective Public Healthcare Panacea Project, 2020) was used for quantitative studies, the NICE checklist appendix H (National Institute for Health Care Excellence, 2012) for qualitative studies, and the mixed-method tool (Hong et al., 2018) for studies that included both quantitative and qualitative results.

Both group members evaluated each article independently, then came together to agree upon the final grading. During this process, the whole group met twice to discuss the appraisal process and became more consistent in filling out the checklists. The process led to the decision to add one more exclusion criterion, see Table 1. Thus, 14 studies that did not report on effect or outcomes related to the intervention or strategy, were excluded. In addition, several studies with poor quality were excluded: nine qualitative studies with an overall assessment grade *Weak (-)*, 17 quantitative studies with the rating *Weak* in four or more of sections A–F, and five mixed-method studies with seven or more questions with the responses *No* or *Can't tell*.

In this step, each group also extracted data as presented in Table 3 and Appendix S3. The extraction of data was done according to a table developed in the planning of the review. The table was tested on a few studies (Peters et al., 2015) and adjusted to include the key information on all studies.

2.4 | Records included (step 5)

After the final discussion about exclusion of 45 studies based on critical appraisal, the authors agreed upon including 36 studies in the scoping review. The three groups worked with parts of the results separately and then discussed the findings. Consensus was reached on which studies to include and what the next steps would be.

2.4.1 | Synthesis

The initial synthesis of results was done by the first author and discussed in two group meetings, before authors agreed upon the final summary as presented in the results. The diversity of studies regarding both setting, participants, method and especially the educational content, was a major challenge. For example, studies using similar questionnaires were expected to be grouped. However, there were a wide range of questionnaires and scales, and no studies used the exact same combination of questionnaires/scales. It was equally difficult to analyse the qualitative studies because of the diversity.

TABLE 3 Overview of the included studies (More information in Appendix S3)

Study	Authors (year)	Title	Country	Aim
S1	Vargas-Escobar and Guarnizo (2020)	Effect of an educational intervention delivered to senior nursing students to strengthen spiritual care for people with chronic illness	Colombia	Measure the effect of an educational intervention for nursing students to strengthen their perceptions of the importance of providing spiritual care for people with chronic illness
S2	Bandini et al. (2019)	Interprofessional Spiritual Care Training for Geriatric Care Providers	USA	Assess the efficacy of a one-day spiritual care workshop for non-chaplain clinicians who provide care to elderly long-term care residents in a nonhospital setting
S3	Hu et al. (2019)	Effectiveness of spiritual care training to enhance spiritual health and spiritual care competency among oncology nurses	China	Evaluate the effects of a spiritual care programme for oncology nurses, including benefits such as positive changes in spiritual health and higher levels of spiritual care competencies
S4	Huehn et al. (2019)	Integrating Spiritual Care During Interprofessional Simulation for Baccalaureate Nursing Students	USA	Explore the experience of senior baccalaureate nursing students utilising the hospital chaplain while caring for a suicidal patient with acute medical needs in the emergency department
S5	Kelley et al. (2019)	Religious Community Partnerships: a Novel Approach to Teaching Psychiatry Residents about Religious and Cultural Factors in the Mental Health Care of African-Americans	USA	Explore the use of community partners and non-psychiatry faculty to provide this education within psychiatry residency programmes
S6	Kuven and Giske (2019)	Talking about spiritual matters: First year nursing students' experiences of an assignment on spiritual conversations	Norway	Explore how first year nursing students experienced a compulsory assignment that asked them to carry out a conversation with someone about spiritual aspects of nursing care and to reflect about it in relation to nursing
S7	O'Brien et al. (2019)	Meeting patients' spiritual needs during end-of-life care: A qualitative study of nurses' and healthcare professionals' perceptions of spiritual care training	UK	Investigate the impact of spiritual care training on nurses and other Health Care Professionals (HCPs) related to their ability to meet patients' needs during end-of-life care
S8	Özveren and Kırca (2019)	Influence of Palliative Care Training on Last-Year Nursing Department Students' Perception on Regarding Spirituality and Spiritual Care: A Single-Group Pretest-Posttest Intervention Study	Turkey	Measure the effect of a palliative care course on the level of perception of spiritual and spiritual care in student nurses Measure the opinions of student nurses about spiritual care
S9	Smothers et al. (2019)	Efficacy of an educational intervention on students' attitudes regarding spirituality in healthcare: a cohort study in the USA	USA	Determine if an educational intervention focused on the role of spirituality in healthcare positively affects medical students' attitudes and perceptions relating to this topic
S10	van der Vis-Sietsma et al. (2019)	The impact of a practice-based educational strategy on the development of spiritual competencies of nursing students	Netherlands	Insight into the impact of a practice-based educational strategy on perceived spiritual competence development from the perspective of bachelor nursing students, and identify factors that influence their learning experiences

Methods, data collection and analysis	Participants and Setting	Appraisal (score)
Randomised explanatory and experimental study with two groups (experimental and control) Pre-post survey: Spirituality and Spiritual Care Rating Scale (SSCRS) Spanish version	90 senior nursing students (45 in each group) enrolled in the second semester of the year 2017 at a private university	Quantitative (Moderate)
Pre-post and 3-month follow up survey: A modified version of an instrument used by Robinson et al., originally developed by Puchalski, assessing ability in providing spiritual care, comfort level and knowledge of spiritual issues	68 clinicians and a committee of culture change liaisons at Hebrew SeniorLife, included 22 nurses, 9 social workers, 3 chaplains, 17 personal care assistants, 5 therapists, 12 others: activities assistant, coordinator, manager, physician, resident services, life enhancement, wellness coach	Quantitative (Strong)
Nonrandomised controlled trial, using a coin-toss method to divide into two groups (study and control) Pre-post survey: Spiritual Health Scale (SHS)	92 clinical nurses (45 in study, 47 in control) at a cancer treatment hospital in a single province	Quantitative (Moderate)
Data collection: Following the simulation, participants were asked to freely narrate their experience Descriptive analysis	16 senior nursing students in their last semester of prelicensure nursing programme at an art college who offers a 4-year bachelor's programme in nursing	Qualitative (+)
Pre-post survey: A 10-item self-made questionnaire assessing attitudes and perceptions of (a) the value of spirituality to the mental health of African Americans, (b) comfort in talking with patients about spirituality, and (c) willingness to involve clergy in a team approach to treatment	All 51 adult and child psychiatry residents (medicine) at an academic psychiatric hospital participated in a required workshop Answers pre-test: 38, post-test: 19	Quantitative (Moderate)
Data collection: Students reflective logs with a short summary of the conversation and their experiences of doing the assignment, varied from 750–1500 words Analysis into categories	385 of 528 first year nursing students from four cohorts (2015–2018) at one secular and one Christian university college The percentage of students in each cohort who participated varied between 54–88%	Qualitative (++)
Data collection 3–18 months post-course: Telephone interviews lasting 11–40 min, interview guide focus upon experiences of the course, skills development and impact on clinical practice Analysis through an iterative thematic approach	Purposive recruitment of 21 participants: 9 nurses, 2 doctors and 10 HCPs from Hospice or Hospital End-of-life care	Qualitative (++)
Single-group intervention study with pre-post survey: Spirituality and Spiritual Care Grading Scale (SSCGS) Turkish version Pre survey: A self-made questionnaire on opinions regarding spiritual care	70 students at a Faculty of Health Sciences, these were volunteers from a population of 100 nursing students in the 4th year taking the palliative care courses during the fall semester of 2017–2018	Quantitative (Weak)
Cohort study using a non-intervention group for baseline comparison Pre-post survey: a self-made 18-item measurement of student's attitudes toward, comfort with, and perceptions of religion/spirituality (R/S) in healthcare	Cohort of 110 second-year medical students in clinical rotation at an undergraduate medical institution affiliated with an academic medical centre, included in pre-test: 84, post-test: 71 Control group (only baseline comparison): 52 students who had completed their clinical rotations without participating in the R/S curriculum	Quantitative (Moderate)
Data collection in two steps: 30 reflective reports (sample 1) focusing on learning experiences, and 9 semi-structured interviews (sample 2) with focus upon experiences of the assignment, real-life situations, spiritual awareness and expertise Descriptive, thematic analysis	Two purposive samples of 3rd year bachelor nursing students at a Christian University of Applied Sciences, in the first sample 51 of 57 accepted to participated and 30 reports were selected, in the second sample 9 of 23 participated (the sampling ended when saturation was reached)	Qualitative (++)

(Continues)

TABLE 3 (Continued)

Study	Authors (year)	Title	Country	Aim
S11	van de Geer et al. (2018)	Multidisciplinary training on spiritual care for patients in palliative care trajectories improves the attitudes and competencies of hospital medical staff: Results of a quasi-experimental study	Netherlands	Explore training methods for spiritual care (SC) for healthcare professionals in hospitals, measure the effects of the training on barriers to SC and SC competencies, and generate hypotheses for further research
S12	Hvidt et al. (2018)	Developing and evaluating a course programme to enhance existential communication with cancer patients in general practice	Denmark	Describe the development and evaluation phases of the course
S13	Kincheloe et al. (2018)	A Spiritual Care Toolkit: An evidence-based solution to meet spiritual needs	USA	Measure if spiritual perspectives of nurses, patients, and family differs Evaluate if an evidence-based spiritual care (SC) toolkit meets SC needs of patients, families, and nurses in the acute care environment
S14	van de Geer et al. (2017)	Training hospital staff on spiritual care in palliative care influences patient-reported outcomes: Results of a quasi-experimental study	Netherlands	Measure effects of spiritual care (SC) training in palliative care (PC) on patients' perceptions of their care and treatment, focused on healthcare professionals' attention to patients' life issues and their existential and spiritual distress
S15	Koenig et al. (2017)	Effects of a 12-Month Educational Intervention on Clinicians' Attitudes/Practices Regarding the Screening Spiritual History	USA	Measure effect of an educational intervention on changes in attitudes and practices of physicians (MDs) and mid-level practitioners (MLPs) toward more controversial practices such as praying with patients, sharing personal religious beliefs with patients, and encouraging patients' own religious beliefs for health reasons
S16	Osório et al. (2017)	Effect of an educational intervention in 'spirituality and health' on knowledge, attitudes, and skills of students in health-related areas: A controlled randomised trial	Brazil	Measure effect of an educational intervention about spirituality and health on knowledge, attitudes, and skills of students in health-related areas
S17	Peterson et al. (2017)	An online educational programme improves paediatric oncology Nurses' knowledge, attitudes, and spiritual care competence	USA	Evaluate the impact of an online spiritual care educational programme on paediatric nurses' attitudes, knowledge and competence to provide spiritual care to children with cancer at the end-of-life
S18	Strand et al. (2017)	Nursing students' spiritual talks with patients - evaluation of a partnership learning programme in clinical practice	Norway	The overall objective of the study was to explore the impact of the intervention on the nursing students' knowledge, awareness and competence in addressing spiritual issues with patients

Methods, data collection and analysis	Participants and Setting	Appraisal (score)
Pragmatic multicentre quasi-experimental trial on patient-reported and healthcare professional-reported outcomes, part of an exploratory action research study Pre-post (1 and 6 months) surveys: Spiritual Care Competence Scale (SCCS); Spiritual Attitude and Involvement List (SAIL)	Baseline data from 270 of 374 Healthcare professionals from 8 teaching hospitals, working in 8 multidisciplinary teams in regular wards (4 pulmonology, 2 oncology, 1 internal medicine, 1 renal) and 1 team of palliative care consultants Pre-test: 255 (214 nurses, 41 physicians), post-test 1m: 124 (105 nurses, 19 physicians), post-test 6m: 65 (57 nurses, 8 physicians)	Quantitative (Weak)
Mixed-Method, guided by the UK Medical Research Council's (MRC) framework for complex interventions Pre-post survey: Bandura's self-efficacy scale and open comments on the training Individual, semi-structured telephone interviews with participants to explore further processes of change, utilising a hermeneutically inspired thematic content analysis	20 general practitioners (GPs) and residentials in training to become GPs attended the course, of whom 19 GPs answered questionnaires and 15 GPs were interviewed	Mixed method
Quasi-experimental descriptive with comparison of results between nurses and patients/family members Post surveys: Spiritual Perspective Scale (SPS); Spiritual Care Patient and Family Toolkit Survey; Nurse's Spiritual Care Toolkit Survey	54 nurses and 132 adult patients and family members at two acute care units (oncology-pulmonary and surgical-oncology) at two hospitals	Quantitative (Weak)
Quasi-experimental study with two groups (intervention and control), part of an exploratory mixed-methods action research study Pre-post surveys: indicators for SC and PC; 15 items on patients' physical and psychosocial symptoms using the Utrecht Symptom Diary; 4 spiritual items adapted from the Distress Thermometer; 26 items from the Spiritual Attitude and Interests List (SAIL); 6 items from the NIVEL report on consumer quality indicators of PC	6 hospitals, where 8 multidisciplinary teams of healthcare professionals received training (8 wards), 7 wards served as control 85 palliative patients included, in pre-test: 29 intervention, 19 control and in post-test: 24 intervention, 13 control	Quantitative (Weak)
Single-group experimental, test of 4 hypotheses Pre-post (1 and 12 months) survey: A self-made questionnaire assessing attitudes and practices regarding prayer, sharing and encouraging patients' beliefs/faith, referral to chaplains, and future willingness	A convenience sample of 1082 were invited, 520 primary care clinicians, 427 MDs, 93 MLPs (nurse practitioners or physician's assistants) agreed to participate, from 220 practices in the Adventist Health System (AHS), Protestant health care	Quantitative (Weak)
A trial using block randomisation into intervention and control group Pre-post surveys: Duke University Religion Index (DUREL) Spanish version; a self-made theoretical knowledge questionnaire; an adaptation of Curlin's instrument 'Religion and Spirituality in Medicine, Perspectives of Physicians'; Checklist for practical evaluation based on the FEPICATA	86 interprofessional (43 medicine, 34 nursing, 6 physiotherapy, 3 psychology) first- and second-year students (43 in each group) enrolled in the course 49 included in analysis (25 in intervention, 24 in control)	Quantitative (Moderate)
Prospective, longitudinal study Pre-post and 3-month follow up survey: Spiritual Care Competence Scale (SCCS); Spirituality and Spiritual Care Rating Scale (SSCRS)	200 paediatric nurses who provide direct care to children with cancer volunteered to participate, 112 completed the educational programme and the surveys at all 3 time points (44% attrition)	Quantitative (Weak)
Data collection post-course: retrospective focus group interviews at the end of the students' clinical practice, with a focus on the nursing students' experiences in talking with patients about spiritual concerns Analysis using qualitative content analysis into categories	18 bachelor nursing students in a university college, placement was in a ward in a church-affiliated and government-funded hospital 3 focus groups: first; 11 of 13 2nd year students, second; 3 of 12 2nd year students, third; 4 of 4 3rd year students	Qualitative (++)

(Continues)

TABLE 3 (Continued)

Study	Authors (year)	Title	Country	Aim
S19	Yang et al. (2017)	Effect of a spiritual care training programme for staff on patient outcomes	Singapore	Determine effect of a spiritual care training programme for palliative care healthcare professionals on patient quality of life (QoL) and spiritual well-being
S20	Anandarajah et al. (2016)	A 10-Year Longitudinal Study of Effects of a Multifaceted Residency Spiritual Care Curriculum: Clinical Ability, Professional Formation, End of Life, and Culture	USA	To examine both the immediate and long-term effects of a required, multifaceted, longitudinal residency spiritual care curriculum on a group of physicians interviewed several times over 10 years
S21	Cooper and Chang (2016)	Undergraduate nurse students' perspectives of spiritual care education in an Australian context	Australia	Impact of spiritual care teaching on students' preparedness for spiritual care
S22	Hemming et al. (2016)	Chaplains on the Medical Team: A Qualitative Analysis of an Interprofessional Curriculum for Internal Medicine Residents and Chaplain Interns	USA	To identify perceived benefits and challenges experienced by participants in the curriculum
S23	Mitchell et al. (2016)	Developing a Medical School Curriculum for Psychological, Moral, and Spiritual Wellness: Student and Faculty Perspectives	USA	To explore the perspectives of medical students and chaplaincy trainees regarding a curriculum to facilitate reflection on moral and spiritual dimensions of caring for the critically ill and to train students in self-care professional practices
S24	Robinson et al. (2016)	Efficacy of training interprofessional spiritual care generalists	USA	Evaluate the effectiveness of one-day, simulation-based workshops to prepare interprofessional clinicians to function as capable, confident, and ethical spiritual care generalists
S25	Awaad et al. (2015)	A Process-Oriented Approach to Teaching Religion and Spirituality in Psychiatry Residency Training	USA	Assess the effect of the intervention on residents' competency, practice patterns, and attitudes toward spirituality
S26	Musarezaie et al. (2015)	A Study on the Efficacy of Spirituality-Based Intervention on Spiritual Well Being of Patients with Leukaemia: A Randomised Clinical Trial	Iran	Measure the efficacy of a spirituality-based intervention on the spiritual well-being of patients with Leukaemia
S27	Tornøe et al. (2015)	A mobile hospice nurse teaching team's experience: training care workers in spiritual and existential care for the dying-a qualitative study	Norway	Illuminate a pioneering mobile hospice nurse teaching team's experience with teaching and training care workers in spiritual and existential care for the dying in nursing homes and home care settings
S28	Vermandere et al. (2015)	The Ars Moriendi Model for Spiritual Assessment: A Mixed-Methods Evaluation	Netherlands	Investigate the experiences of nurses and physicians using the Ars Moriendi Model (AMM) for spiritual assessment in palliative home care

Methods, data collection and analysis	Participants and Setting	Appraisal (score)
A cluster-controlled trial, 4 teams allocated to the control group and 3 teams to the intervention group Pre-post survey: Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being (FACIT–Sp) whic includes Functional Assessment of Cancer Therapy–General (FACT–G)	Palliative care clinical teams of 4–7 seven healthcare professionals (doctors and nurses) from two organisations: Division of Palliative Medicine providing inpatient hospital palliative care consultation services and Hospice Care providing home palliative care service 253 of 733 palliative care patients included, in pre-test: 118 intervention, 120 control and in post-test: 70 intervention, 74 control	Quantitative (Moderate)
Longitudinal data collection three times over 10 years, in-depth, semi-structured individual interviews (30–60 min): intervention group in 2001 pre-educational intervention, in 2003 as graduates immediately postintervention, and in 2011 as practicing physicians (eight-year postintervention); comparison group as graduates in 2001 A multistep process of analysis, influenced by grounded theory	A stratified purposeful and criterion sampling: The 13 physicians receiving the curriculum was the class of 2003 at a 13–13–13 family medicine residency, the comparison group was the 13 in class of 2001	Qualitative (+)
Data collection post-course using in-depth semi-structured interviews (15–45 min) with questions relating to provision of spiritual care to patients Analysis using Colaizzi's method	6 bachelor nursing students (first semester of their second year) from one of 2 campuses in a tertiary institution with a Christian orientation	Qualitative (+)
Data collection post-course: Six separate focus group interviews lasting 30–60 min (one with 10 physicians, three with groups with 4, 3, and 3 respectively of chaplain interns, and two groups with 4 and 6 medical residents) to identify perceived benefits and challenges Analysis with coding and themes	30 participants (10 attending physicians, 10 chaplains, 10 internal medical residents) from the first 2 years of the curriculum at a Medical Center	Qualitative (++)
Data collection: individual interviews (30–60 min) for faculty and 7 focus groups (90–120 min) for students (2 divinity, 5 medical), using a semi-structured interview guide developed by an interdisciplinary expert panel The methodology included triangulated analysis, involvement of multidisciplinary perspectives (medicine, sociology, and theology) and reflexive narratives, while the coding followed principles of grounded theory	44 students and faculty were recruited through a chain-referral sampling at a medical school and a divinity school (25 medical students, 8 medical faculty, 8 divinity students, 3 divinity faculty/staff)	Qualitative (++)
Pre-post and 3-month follow up survey: A self-made questionnaire focused on 15 spiritual generalist skills that were adapted from the work of Puchalski	115 interprofessional practitioners (physicians, nurses, social workers, psychologists, child life specialists) in a quaternary care academic paediatric hospital voluntarily enrolled the workshops 79 (68.6%) completed the survey all three times	Quantitative (Strong)
Pre-post survey: A modified version of the Course Impact Questionnaire, assessing personal and professional spiritual attitudes, competency, professional practice, and qualitative feedback through written comments	The mandatory course was delivered to postgraduate psychiatry residents (physicians), two cohorts from year 4 and year 3 20 residents completed the course	Quantitative (Weak)
A single-blind two-group double-phase randomised clinical trial Pre-post (3 days) survey: Palutzian & Ellison Spiritual Well-being Questionnaire	64 hospitalised adult patients (32 per group) diagnosed with leukaemia and admitted to the intensive care unit at a hospital	Quantitative (Weak)
Data collection: one focus group interview (80 min) A qualitative phenomenological hermeneutical approach influenced by Ricoeur's philosophy, analysis according to the method of Lindseth & Norberg	All 3 members of the mobile spiritual and existential care teaching team in end-of-life care (expert hospice nurses from a city hospice)	Qualitative (++)
A convergent, parallel, mixed-methods design, an offshoot of an RCT Data collection: a self-made survey was used to investigate first impressions after a spiritual assessment; a semi-structured telephone interview 3–6 weeks post engagement explored participants experiences with using the AMM	17 nurses and 4 family physicians (FPs) from palliative home care in the RCT's intervention arm participated in the quantitative phase, and 19 nurses and 5 FPs in the qualitative phase 28 patients were included for spiritual assessment	Mixed method

(Continues)

TABLE 3 (Continued)

Study	Authors (year)	Title	Country	Aim
S29	Ledford et al. (2014)	Using a teaching OSCE to prompt learners to engage with patients who talk about religion and/or spirituality	USA	To evaluate an innovation using an objective structured clinical examination (OSCE) as a teaching tool aimed to prompt learners to engage in mindful practice with patients who identify R/S as part of their biopsychosocial contexts
S30	Yilmaz and Gurler (2014)	The efficacy of integrating spirituality into undergraduate nursing curricula	Turkey	Identify the impact of the added integrated nursing curriculum on the level of knowledge and practice of spirituality among senior nursing students, by comparing the integrated curriculum (intervention) with the traditional nursing curriculum (control)
S31	Henoch et al. (2013)	Training intervention for healthcare staff in the provision of existential support to patients with cancer: a randomised, controlled study	Sweden	Assess the training intervention, communicative confidence when discussing existential issues with patients within curable cancer, and attitude toward caring for dying patients Assess relationships between demographics, sense of coherence and communicative confidence when discussing existential issues
S32	Vermandere et al. (2013)	Implementation of the ars moriendi model in palliative home care: A pilot study	Netherlands	Investigated the experiences of Flemish GPs, home nurses and patients with the Ars Moriendi Model (AMM) as a directive for spiritual conversations in palliative home care
S33	Burkhart and Schmidt (2012)	Measuring effectiveness of a spiritual care pedagogy in nursing education	USA	Develop and test a spiritual care programme (SCERP) to determine how it affects perceived ability to provide spiritual care and student's spiritual well-being
S34	Ellman et al. (2012)	Using Online Learning and Interactive Simulation to Teach Spiritual and Cultural Aspects of Palliative Care to Interprofessional Students	USA	To describe the development, implementation, and evaluation of an innovative programme that blends online learning with interactive simulation to teach medical, nursing, divinity, and social work students spiritual, cultural and interprofessional aspects of palliative care
S35	Vlasblom et al. (2011)	Effects of a spiritual care training for nurses	Netherlands	Determine the effects both patients and nursing staff experienced of a nurses' training in providing spiritual care
S36	Baldacchino (2010)	Caring in Lourdes: An innovation in students' clinical placement	Malta/ France	To outline the experiential learning of students who delivered spiritual care to pilgrims in Lourdes

Methods, data collection and analysis	Participants and Setting	Appraisal (score)
Data collection: immediate individual reflective journals, within a week followed by guided reflection in individual semi-structured interviews (15–25 min) The analysis into codes linked the journals and interview transcripts, then a quantitative analysis was done in a secondary analysis on frequency of codes and coding schema	28 volunteering participants at a family medicine residency at a suburban community hospital, 27 staff and resident physicians, 1 medical student	Qualitative (+)
A quasi-experimental two-group design with post survey (end of semester): A self-made questionnaire regarding knowledge, practice and definition of spiritual care; Spirituality and Spiritual Care Rating Scale (SSCRS) Turkish version	130 volunteers of 156 senior-year undergraduate nursing students at a 4-year university nursing programme (58 intervention, 72 control)	Quantitative (Strong)
A randomised two-group trial Pre-post and 5–6-month follow up surveys: Sense of Coherence (SOC–13); Attitudes Toward Caring for Patients Feeling Meaninglessness; Frommelt Attitude Toward Care of the Dying (FATCOD) Post survey: 4-item evaluation of the training	102 nurses from 3 hospices, 6 oncological wards and 2 palliative home care teams, randomisation by the researchers after stratification of the workplaces (60 intervention, 42 control) Post-test: 55 intervention, 34 control and 5–6-months: 42 intervention, 29 control	Quantitative (Moderate)
Data collection: individual, semi-structured interviews with 7 personnel and 4 patients, to assess their experience with the AMM Thematic analysis	33 GPs and 33 home nurses were invited to participate; 1 GP and 6 nurses accepted to participate of whom 4 succeeded in assessing their palliative patients at home using the AMM	Qualitative (++)
A two-group randomised controlled trial Pre-post surveys: Spiritual Care Inventory (SCI); Spiritual Care in Practice (SCIP); Spiritual Well Being Scale (SWBS) Programme evaluation survey: open-ended questions, using content analysis	2 cohorts of senior nursing students at a faith-based school; 110 traditional senior nursing students in their fourth year of a baccalaureate, 100 after-baccalaureate undergraduate nursing students in the final semester of a 13-month accelerated undergraduate programme (ABSN) 59 students, 27 traditional (13 intervention, 14 control; 25% response rate) and 32 ABSN students (15 intervention, 17 control; 31% response rate)	Quantitative (Weak)
Data collection 1: students' free-text responses on the online module to assess different professions interaction with the educational material, 2: post-workshop questionnaire to assess students' views on the quality and effectiveness of the programme Qualitative content analysis of free-text and open-ended response on the questionnaire, descriptive statistics and nonparametric tests of questionnaire responses	211 interprofessional respondents to reflections (146 medical students, 50 nursing, 15 divinity), and 309 respondents to questionnaire (205 medical, 65 nursing, 39 divinity) Social work excluded due to low representation	Mixed method
A trial with pre-post surveys: A self-made instrument and previously employed Dutch-language instruments, content of attitudes, behaviour, knowing, job satisfaction, experiences of difficulties regarding people with different life view The included patients differed at the various measuring moments due to short-term hospitalisation	Nurses and patients in four intervention wards (internal medicine, neurology, cardiology, coronary care) and one control ward (mixed pulmonary disease/urology) at a hospital with Christian identity 49 of 51 nurses received the entire training; control: 14 nurses, only data from intervention group reported 187 of 235 patients included, in pre-test 51 intervention, 24 control and in post-test: 81 intervention, 31 control	Quantitative (Moderate)
Data collection: individual reflective account based on a reflective diary written during the students' experience in Lourdes, and one focus group interview (90 min) with four questions Thematic content analysis	31 undergraduate students at a university undertook the study unity included a clinical placement, of whom 7 participated in the research (4 nursing and 3 midwifery)	Qualitative (+)

The best way to describe the studies was the chosen one; in addition, details about the studies are presented in Tables 3–5 and Appendix S3.

3 | RESULTS

An overview of the included studies with authors, year and title, country, aim, methods, participants and setting, and critical appraisal scores are presented in Table 3. The studies are numbered based on the year of publication from S1–S36; these numbers are referred to in the results. In addition to an overview of *Countries and settings* and *Methodologies*, these three themes are presented: *Understanding of spirituality*, *Strategies in educational settings*, and *Strategies in practice settings*. An overview of *teaching and learning strategies* are found in Tables 4 and 5. Details about the *educational content*, *courses and training* and the *full references* are found in Appendix S3.

3.1 | Countries and settings

The studies originate from 15 countries: 15 from the USA, 6 from the Netherlands, 3 from Norway, 2 from Turkey and 1 each from Australia, Brazil, China, Colombia, Denmark, Iran, Malta/France, Singapore, Sweden and the UK.

Nineteen studies were conducted in an educational setting: 10 studies in nursing education, five studies included medical students or residency and four studies were multidisciplinary. The majority of the 17 studies from different practice settings included more than one profession: (a) three studies from community-based healthcare, two including physicians and one multidisciplinary; (b) two studies from hospitals both including nurses; (c) two studies from paediatrics, one in nursing and one multidisciplinary; (d) three studies from oncology, two including nurses and one with patients; (e) seven multidisciplinary studies from palliative care.

3.2 | Methodologies

Twenty studies were quantitative: six RCTs (S1, S16, S19, S26, S31, S33), seven non-randomised trials or quasi-experimental (S3, S9, S11, S13–S14, S30, S35), and seven pre-post-test cross-sectional (S2, S5, S8, S15, S17, S24–S25). Thirteen studies (S4, S6–S7, S10, S18, S20–S23, S27, S29, S32, S36) were qualitative, and three studies (S12, S28, S34) reported on both qualitative and quantitative results although only one (S28) had a clear mixed-method design.

The quality of studies based on the critical appraisal varied: Three quantitative studies were rated *Strong*, eight *Moderate* and nine *Weak*, eight qualitative studies had an overall assessment grade *Strong (++)* and five *Moderate (+)*, while the three mixed-method studies did not have an overall assessment grading system.

3.3 | Understanding of spirituality

Eighteen studies (S2, S5, S7, S9, S11, S14, S20–S21, S23, S25–S30, S32, S34, S36) did not provide a clear understanding of spirituality. The other 18 studies provided information about how spirituality was understood, and the authors looked at the WHO (2002) criteria as a lens when analysing key attributes. Most frequently, spirituality was understood as meaning, purpose and faith (14 studies), followed by spiritual connection (nine studies) and transcendence and religion (both found in five studies). The most frequently combined attributes were spiritual connection, meaning and purpose and transcendence. Other attributes mentioned were spiritual or inner strength, awe and wonder, inner peace, hope and optimism, existence, self-realisation, values, beliefs, empowerment, love, compassion, nature, family, artistic expression, freedom, loneliness, death, relations, reciprocal sharing, holism, and more.

3.4 | Strategies in educational settings

Most studies involved bachelor nursing students or medical students/residents, while a few studies were across health programmes and included different professions. Several studies described interventions including students both in theoretical subjects and in their practice settings or training.

3.4.1 | Nursing students

Cooper and Chang (S21) evaluated an accredited spiritual care (SC) subject in the first year of *nursing bachelor education*. Students reported increased understanding and ability to include the spiritual in whole person care, the subject helped the students do develop an open mind to other religious beliefs and cultures, they were more able to recognise when to refer SC to other members of the multidisciplinary team, and they recognised spirituality as broader than religion and that it is individually interpreted. Participants also felt more comfortable talking with patients about religious beliefs after finishing the subject, and more prepared in assessing spiritual needs and providing SC.

Another SC educational and reflective programme (SCERP) for *nursing students* was tested by Burkhart and Schmidt (S33). Findings revealed significant increased ability in providing SC, particularly in complex family clinical situations. Findings also indicated improved use of reflective practices, which helped support students during stressful times. Also, Yilmaz and Gurler (S30) integrated spirituality into *nursing curricula* and focused on spirituality in nursing care throughout the nursing programme. The results in the intervention group were higher on the Spirituality and Spiritual Care Rating Scale, and they defined the terms of spirituality and SC more accurately than the control group. Likewise, Vargas-Escobar and Guarnizo-Tole (S1) conducted an education intervention for *nursing students* to strengthen SC for people with chronic illness. The study found that

it was possible to improve the perception of spirituality and SC in nursing using interventions that helped students acknowledge the importance of spirituality for chronically ill people.

Özveren and Kırca (S8) implemented palliative care training for *nursing students* and found that the perception of students regarding spirituality and SC increased significantly and was found to be above the middle; they suggested in line with their results, that the subject of SC should be included more into nursing education. Huehn et al. (S4) reported that a simulation-based training for *nursing students* increased their awareness and understanding of spirituality and the role of chaplains as members of the healthcare team. Simulation increased students' understanding of the importance of utilising the clergy as a resource and that chaplains can help bridge the gap between patients, their family and healthcare personnel. A study of Kuven and Giske (S6) performed in two *nursing schools* found no differences between the secular and diaconal school regarding students' reported challenges when performing a mandatory spiritual assessment and conversation about spiritual aspects. Students reported that they explored their own spirituality, were challenged to go beyond their comfort zone, and experienced that spiritual conversations provided an opening to understand the patient on a deeper level.

A practice-based educational strategy consisting of a SC assignment during a clinical placement for *nursing students* was performed by van der Vis-Sietsma et al. (S10). The assignment contributed to the development of competencies related to increased spiritual awareness through reflection, influenced students' personal experiences with SC, and stimulated students' ability to communicate with patients about spirituality and collect information about their spiritual needs. The assignment had limited effect on students' ability to provide, plan, report and evaluate SC, and to integrate spirituality in organisational policies.

The study of Strand et al. (S18) targeted both *nursing students* and *mentoring nurses* in clinical practice and the learning programme involved teaching sessions, guiding sessions and reflection groups. The intervention enhanced students' understanding of spirituality and their confidence to grasp the moment and discuss spirituality with patients. Students also experienced personal development. The nurses contributed to students' learning by role modelling, mentoring and challenging students to overcome barriers related to spiritual conversations.

A more unusual type of clinical placement was used in the study by Baldacchino (S36) where *nursing* and *midwifery students* participated in volunteer work assisting the sick on their spiritual pilgrimage journey from Malta to Lourdes, France. The placement challenged the students, and this experience influenced their learning as it gave them a sense of belonging to the support group and helped them to work in a team, delivering therapeutic, holistic care by achieving a trustful nurse-client relationship. In addition to writing reflective diaries during the journey, students participated in religious services and took care of the patients. Learning from the patients' lives, confiding in them and the impact of the pilgrimage itself, enriched the students' personal spirituality.

3.4.2 | Medical students and residents

The educational intervention of Smothers et al. (S9) focused on the role of spirituality in healthcare and found that *medical students'* attitudes and perceptions changed. Students expressed an increased willingness to include religious/spiritual (R/S) competency in their future practice, were more comfortable sharing their own R/S beliefs with a patient when appropriate and were more willing to approach a patient with R/S concerns. This suggests that a lecture and case discussion may be an effective educational tool, and a starting point for greater engagement with R/S tasks.

Awaad et al. (S25) delivered a mandatory course about religion and spirituality for *psychiatry residents* (physicians) in hospital clinics. They found that having an integrated programme of SC education within a curriculum can impact positively upon SC competence and pointed to the need of a consistent team of academics in the delivery of SC education. Kelley et al. (S5) found that their brief multidisciplinary workshop teaching *psychiatry residents* about the importance of considering religion in mental healthcare of African Americans can be an effective intervention to increase cultural sensitivity and multidisciplinary collaboration. Results showed increased scores on comfort in discussions with patients about spirituality, willingness to collaborate with clergy, and awareness of the importance of religion to mental health patients.

A *family medicine residency* SC curriculum was evaluated in a longitudinal study by Anandarajah et al. (S20), which found lasting positive effects on physicians' SC skills and their professional and personal formation. The evaluation revealed curricular effects; the comparison physicians struggled with SC skills and worries related to SC more than the intervention physicians. The study of Ledford et al. (S29) was also performed in a *family medicine residency*, and they used a teaching OSCE to prompt learners to engage in mindful practice with patients about R/S. The participants recognised the need for readiness to address the challenging communication topics of R/S and reflected on practiced strategies for such conversations. The educational innovation helped learners to become aware of and deal with difficult physician-patient communication topics.

3.4.3 | Multidisciplinary

The multidisciplinary study of Osório et al. (S16) included university students in *four health programs*, and the intervention was a course on spirituality and health. The educational intervention positively influenced attitudes about SC such as confidence in engagement with the spiritual, ease when talking about spiritual issues, and the importance of spirituality in healthcare. Education on practical spiritual interventions such as spiritual history taking and referrals to chaplains were found to facilitate those actions.

Another interprofessional study was conducted by Ellman et al. (S34) among *medical*, *nursing*, *divinity*, and *social work*, offering an online learning programme to teach students about spiritual, cultural

TABLE 4 Teaching and learning strategies in educational settings (More information in Appendix S3)

Profession	Type	Teaching and learning strategies
Nursing	A teaching programme (S21)	Students attended 3 h of face-to-face lectures per week for 13 weeks
	The Spiritual Care Educational and Reflective Program, SCERP (S33)	The SCERP was based on the Burkhart/Hogan theory of spiritual care and ran concurrently with the Clinical Role Transition (CRT) course. The SCERP consisted of two in-person retreats before and after CRT, as well as a web-based discussion during the CRT rotation. The study integrated both nursing and pastoral expertise
	An integrated nursing curriculum (S30)	In the first year, values and beliefs according to the Gordon's Functional Health Patterns were taught. During the second year, spirituality in adulthood and at advanced ages was taught. During the third year, real patient scenarios were taught to groups. Students in their senior year had a year-round internship with two semesters of 15 weeks each; they discussed concepts as they related to patient care plans that were then applied in the clinical settings with patients
	A single training session (S1)	A lecture related to people with chronic illness using a slideshow, a 15-min video, and handing out bookmarks
	A compulsory course (S8)	A course in palliative care, 2-h per week, 28 h in total. The course covered topics of pain, symptom control, loss, mourning, death and post-mortem care, spiritual care, spiritual distress as a nursing diagnosis, the role of nurses, and more
	Simulation (S4)	As part of a required behavioural health course, students were required to care for a patient following the overdose of a sedative hypnotic in an emergency department. The object was to understand the role of spiritual care in acute care. A consult with the hospital chaplain was available to the students
	A mandatory assignment (S6)	Students utilised Stoll's assessment guide in a conversation about the spiritual domain. Afterwards, students wrote a reflective log with a short summary of the conversation
	An assignment (S10)	An assignment during students' 20 weeks clinical placement. First students oriented themselves to theory on spirituality, then they interviewed a patient about their spirituality, afterwards students wrote a reflective report. No classroom teaching. Students received coaching form their clinical supervisor and university teachers
	A partnership learning programme (S18)	A programme between a college and a hospital. A teaching session on spiritual care for both clinical nurses and nursing students was given prior to the clinical placement. During students' placements, two guiding sessions for nurses mentoring students were given. As part of their clinical placement, the students participated in two reflection groups led by mentoring nurses, aiming to support and challenge students to recognise spiritual cues and engage in spiritual talks with patients
	Part of a study unit on Spiritual Health for Carers (S36)	The unit had a 10-h theoretical component and an experience of clinical volunteer work, assisting the sick on their spiritual pilgrimage to Lourdes, France, for 6 days. Students travelled together with a group of patients, the archbishop and Diocese of Malta, other healthcare practitioners, and families. Students wrote a reflective diary during their experience in Lourdes. After the experience, the students wrote a reflective account based on Gibbs Framework of Reflection
Medicine	The 'Clinical Skills Foundation' course (S9)	An intervention with a 60-min lecture and a 90-min small group, case-based discussion. Included the question: 'Is talking to patients about religious/spiritual concerns a necessary part of medicine, a transgression of professional boundaries, or something else?'
Medicine (psychiatry residents)	An integrated programme (S25)	The mandatory course had six theoretical sessions. All residents were engaged in outpatient clinical rotations concurrent with this course, allowing them the opportunity to reflect upon and adjust their own clinical practice in real time
	A 4-h workshop (S5)	Targeting African American Christian patients. A 2-h didactic session, small groups discussing clinical case scenarios, panel discussion with mental health providers, clergy, and faith-based counsellors
Family medicine residency	A longitudinal family residency programme (S20)	Multiple pedagogical methods including interactive didactics, small group discussions, direct clinical care, and experiential and reflection activities were used. The intervention group received training 7–9 h per year over 3 years. The curriculum covered spirituality, culture, from self-care to patient care, rounds with hospice chaplains, and incorporating spiritual care into practice
	A teaching OSCE followed by reflection (S29)	Written, dyadic, and group reflection add value to such an OSCE by allowing participants to reflect on difficult learning objectives over time. The aim was to prompt learners to engage in mindful practice with patients who identify religion/spirituality as part of their biopsychosocial contexts. Mindful practice includes active listening and discussion. The innovation was based on adult learning theory and social cognitive theory

(Continues)

TABLE 4 (Continued)

Profession	Type	Teaching and learning strategies
Multidisciplinary	A course on spirituality and health (S16)	The course included a theoretical module including seven video-classes viewed and discussed in groups, followed by theoretical-practical activities. Then, students received 4 h practical training through three patient simulations. The student groups visited a hospital and performed a spiritual history with inpatients, afterwards students discussed with the tutors. The course load was 14 h of theoretical classes and 10 h of practical activities over a 4-month period
	An online learning programme (S34)	Students completed an online interactive, multimedia clinical case component. Interactive features explained terminology and highlighted learning points. A video using professional actors depicted the team addressing goals of care, symptom management, spiritual challenges, and family conflicts with the patient and family. Afterwards students participated in a 90-min workshop, that utilised small group, interactive, problem-based learning
	An interprofessional intern partnership (S22)	Chaplain interns were paired with a medical team to work together 1 day per week for 4 consecutive weeks on a ward with a lower patient census where morning bedside work-rounds were standard. Chaplains and physicians could observe and learn from one another. Chaplains taught the medical team about their role, how to do a spiritual assessment, and were able to role model discussions about spirituality with patients
	A curriculum providing integrated training (S23)	The aim was to develop a medical school curriculum on religion and spirituality that facilitates psychological, moral, and spiritual experiences in caring for the critically ill. This was done through an interdisciplinary collaboration between a medical and a divinity school to integrate spiritual care training as part of the professional development of medical and chaplaincy students

and interprofessional aspects of palliative care. Results indicated that students of all professions recognised important issues beyond their own discipline, the roles of other professionals, and the value of team-collaboration. The programme also met its learning objectives and was rated highly for educational quality and usefulness for future professional work.

Hemming et al. (S22) aimed to improve collaboration between physicians and chaplains through an interprofessional curriculum for *internal medicine residents* and *chaplain interns*. The chaplain interns were paired with the medical team (physicians and residents on rotation) at a hospital ward. The evaluation found that the physician learners became aware of communication skills for addressing spirituality, while chaplain interns enhanced their patient-centred care and were a source of support to the medical team. The study suggested that medical residents, attending physicians and chaplain interns working together in a partnership can result in rich learning about patient-centred communication, SC and team-based care. Collaboration between physicians and chaplains also had the potential for addressing provider distress.

Mitchell et al. (S23) explored how to develop an interprofessional curriculum to integrate SC training for *medical* and *chaplaincy* students, with the aim to educate professional caregivers in practices of self-care undergirding professionalism. The study found that the curriculum format should be delivered across the entire curriculum to facilitate realisation of growth, be required and not elective, and focus on experiential learning. In addition, the curriculum content should promote self-care and personal growth regarding professional integration of R/S values, identification of and addressing patient needs, understanding of structural/institutional dynamics, and discussion of controversial social issues.

3.5 | Strategies in practice settings

The different study settings varied from hospital wards to community-based studies; they were either targeting one or a few specific professions, although the newest studies tended to be multidisciplinary. Most studies only evaluated the participants' experiences, with a few studies (S14, S19, S26, S35) evaluating patient outcomes. The types of specialities ranged from paediatrics to older people, with most studies related to palliative care or cancer/oncology.

3.5.1 | Community based healthcare

Bandini et al. (S2) gave a one-day workshop on SC to *clinicians* who provide care to *elderly* long-term care patients. Overall average scores for clinicians' self-reported perceived ability in engaging in issues around spirituality with patients and their families increased from before the workshop to the post-workshop and three months later. The educational intervention of Koenig et al. (S15) targeted *primary care clinicians* (physicians and mid-level practitioners). The clinicians' attitudes regarding praying with patients, sharing faith with patients, and encouraging patients' own religious faith did not change much. However, behaviours changed more substantially; significant increases were found in frequency of praying with patients, willingness to pray with patients, sharing their faith with patients, and encouraging the patient's own religious faith.

Hvidt et al. (S12) developed a course to enhance existential communication with *cancer patients* in general practice. The *general practitioners* (GPs) gained awareness of existential, spiritual and religious needs and resources of patients. The course provided an

TABLE 5 Teaching and learning strategies in practice settings (More information in Appendix S3)

Profession	Type	Teaching and learning strategies
Community based care		
Geriatric care providers	A one-day workshop (S2)	Didactic use of PowerPoint, brief video on how to use the FICA instrument, live simulations with professional actors and debriefing opportunities, and presentation of spiritual resources
Physicians (MDs) and mid-level practitioners (MLPs)	An education training programme (S15)	The programme described spirituality and appropriate behaviours that clinicians could be involved in with patients, and boundaries that should not be crossed. It was delivered in segments (either in groups or on their own) over 12 months; participants could proceed at their own pace. They viewed 5 educational videos of about 45 min each that described how to integrate spirituality into patient care
General practitioner's (GPs)	A one-day vocational training (S12)	Continued medical education in existential communication with cancer patients. Main elements were knowledge building, self-reflection, and communication training. Professional actors facilitated role plays and feedback
Hospital based healthcare and acute care		
Nurses	Training in spiritual care (S35)	Four sessions of 4 h that were offered biweekly. In addition, the participants were asked to do homework assignments which consisted of preparing for the training session, writing reflection reports after every session, and a literature study
	A spiritual care toolkit training (S13)	Training sessions at work. Themes were the nurse's role, spiritual care and interventions, and more. The toolkit resources consisted of a culturally diverse selection of books, devotionals, hymnals, crosses and rosaries, music CDs, DVD movies and journals, arranged on two rolling carts
Paediatric healthcare		
Oncology nurses	A 3-h online self-study programme (S17)	Themes were spirituality, spiritual care and goals for children with cancer at the end-of-life and their families, therapeutic communication, spiritual assessment tools, and the nursing process. Fowler's stages of faith and Erikson's theory of psychosocial development were presented. The program included readings, videos, case studies, a blog written by a dying young woman, and online discussions
Interprofessional paediatric clinicians	Simulation-based training through workshops (S24)	Each workshop provided a full day of instruction. This included didactic presentations, a slideshow of photographs from hospital settings to highlight environmental cues, and videos demonstrating the use of the FICA spiritual screening tool. A case allowed participants to practice use of the FICA tool in pairs. Three simulated case enactments with professional actors as patients or family members followed. Supportive and interactive debriefings were facilitated immediately after each simulation. Opportunities to discuss, ask questions and share perspectives, and to receive additional coaching from the chaplain faculty members were provided
Cancer and oncology healthcare		
Nurses	Training sessions (S31)	Training including theoretical and practical elements with reflection in five 90-min sessions over an eight-week period. Between the training sessions, the participants read sections in the training material. Before the first session, each nurse wrote down a patient care situation with existential issues. Themes were existential topics, such as life and death, freedom, relationships, loneliness, and meaning
Patients with leukaemia	A 3-day intervention (S26)	This included two components of supportive presence and support for religious rituals. The patients were encouraged to express their feelings, needs and concerns through verbal and non-verbal communication, providing them with a detailed description of the disease and its therapeutic process, and responding to their questions by holding their hands while talking, touching them using a supportive approach, and active listening. The intervention was in two stages of 3 h each focusing on a spiritual approach to patients
Oncology nurses	Training sessions (S3)	One spiritual care group training session every six months. Lectures by experts, group interventions, clinical practice, and case sharing

(Continues)

TABLE 5 (Continued)

Profession	Type	Teaching and learning strategies
Palliative healthcare and hospice care		
Multidisciplinary	A 30-min training session (S19)	Topics were taking a spiritual history, identifying spiritual problems, and knowing when to refer to a spiritual care professional. Participants were taught to use the FICA tool to perform an assessment for spiritual problems, as part of their comprehensive assessment of newly referred patients
	Lessons (S11)	Groups of nurses and physicians at each ward received 1 or 2 lessons during working hours. Lessons were given by health-care chaplains using standard slides for presentation and selected teaching methods. The core skills were screening/assessing spiritual needs, counselling patients, and referring patients to specialists when the patients are in a crisis
	Spiritual care training (S14)	The training varied locally within the preliminary set of requirements of the study protocol. The core skills to train were screening or assessing spiritual needs, accompanying patients within a professional role and referring patients to specialists when the patients are in a crisis
	The Ars Moriendi Model (AMM) (S32)	The AMM is a communication aid for spiritual conversations in palliative care. The AMM is an inclusive, non-religious example of a return to older traditions regarding death, and it demands creative rethinking
	The AMM in palliative home care (S28)	The questions of the AMM are formulated in spoken language, and five tension fields are presented (i.e. autonomy, pain control, attachment and relations, guilt and evil, and the meaning of life). These five themes play a crucial role in the dying process, assisting the patient with making his or her own choices and facilitating communication among the patient, family members, and caregivers
	The 'Opening the Spiritual Gate' course (S7)	The course guide showed how to communicate about spiritual issues in end-of-life care using the Simple Skills Secrets, how to document existential concerns, and how to create an action plan to take back into the workplace. The guide directed participants to resources about specific religious rites and rituals
	A mobile hospice nurse spiritual and existential care teaching team (S27)	A hospice collaborated with primary healthcare administrators in a major city to create a teaching team. Nursing home and home care managers requested the mobile teaching team's services to provide on-the-job-support and supervision for care workers who felt anxious and uncertain about engaging in spiritual and existential care for dying patients

opportunity to reflect individually and with colleagues on personal values and convictions and how these could be included in their own healthcare practice, and GPs increased their confidence in existential communication. However, the course did not improve the ability to endure in situations without a solution or right answer, thus the authors suggested including training in enduring in meaningless and powerless situations.

3.5.2 | Hospital based healthcare and acute care

Vlasblom et al. (S35) tested how SC training for *nurses in hospital wards* can affect both patients and nursing staff. The patients from the intervention wards experienced more receptiveness and support when asking questions about illness and meaning. There were also changes in nurses' attitudes, knowledge and clinical practice such as documenting spiritual needs and the number of referrals to the chaplains were higher. The findings of Kincheloe et al. (S13) suggested that an evidence-based SC toolkit helps *nurses* meet spiritual needs of *hospitalised acute patients* and *families*. Implementation and sustainability required organisational support and sufficient resources and training for staff.

3.5.3 | Paediatric healthcare

Petersen et al. (S17) conducted an online self-study programme for *paediatric oncology nurses*. By assessing and meeting the spiritual needs of children and their families, nurses were taught how to minimise their spiritual suffering and ensure that potential coping strategies are not lost. Statistically significant gains were found over the three months after participants' completion of the educational programme indicating that nurses needed time for new skills and knowledge to become integrated. Robinson et al. (S24) performed interprofessional simulation-based training of *paediatric clinicians*. Participants gained a better understanding of the role of chaplaincy, as well as how and when to make referrals. They discovered that spirituality need not be religious and that spiritual issues could be expressed and responded to in secular or religious language.

3.5.4 | Cancer and oncology healthcare

Henoch et al. (S31) developed a training intervention for *nurses* in *cancer* care. This study showed that short-term training with reflection improved the communicative confidence of healthcare staff, which

was important for healthcare managers with limited resources. The study of Musarezaie et al. (S26) was directed toward education of hospitalised *patients* with *leukaemia* and involved a three-day intervention with supportive presence and both theoretical and practical support for religious rituals. They found that the education resulted in improved spiritual well-being (SWB) in the intervention group, and the mean SWB score in the experimental group was significantly higher than the mean score in the control group. Hu et al. (S3) evaluated SC training in a hospital among *oncology nurses*. After the intervention, the nurses in the study group had significantly higher overall spiritual health and SC competency scores as well as significantly higher scores on all individual dimensions compared with those in the control group. The results showed that this protocol can boost nurses' spiritual health and SC competencies.

3.5.5 | Palliative healthcare and hospice care

The study of Yang et al. (S19) included *palliative* care *doctors* and *nurses*. They found that a brief SC training programme can enhance the improvement of global patient Quality of Life, but the effect on patients' spiritual well-being was not as evident. The *multidisciplinary* training by van de Geer et al. (S11), focused on SC for patients in *palliative* care trajectories and improved attitudes and competencies of SC in hospital healthcare professionals. The training improved participants' attention to the spiritual dimension, had positive effects on both nurses and physicians, and temporarily decreased barriers to SC for nurses. In an earlier study, van de Geer et al. (S14) measured effects of SC training for *healthcare professionals* in *palliative* care on patients' perceptions of their care and treatment, and the intervention group improved their attention to life issues and existential and spiritual distress. Other outcome measures showed no significant effects; however, effect of the SC training on the quality of care as reported by patients may be a short-term effect.

In a pilot study, Vermandere et al. (S32) evaluated the experiences of professional *caregivers* and *palliative care patients* using the Ars Moriendi Model (AMM) as a directive for spiritual conversations. Caregivers found the model useful in talks about spirituality at the end-of-life, stressing the importance of adjusting the questions to each patient and having several conversations. The patients appreciated the conversations and the support of their spiritual well-being and a companionship in their spiritual process, and they were stimulated by the questions in the model to think about their spiritual needs and resources. Later, Vermandere et al. (S28) investigated the experiences of *nurses* and *physicians* using the AMM in *palliative home care*. The AMM was a useful spiritual assessment tool that strengthened the patient-provider relationship. Guided by the model, professionals gathered information about the context, life story, and meaningful connections of patients, which enabled them to facilitate person-centred care.

O'Brien et al. (S7) explored how the 'Opening a Spiritual Gate' course impacted *nurses'* and *healthcare professionals*' perception of spirituality and the ability to meet spiritual needs during *end-of-life* care in clinical practice. The course effectively prepared participants to provide patient-led and individualistic SC, recognise spirituality including what it means and what matters, and support spiritual needs including recognition of spiritual distress, communication skills, not having the answers and going beyond the physical. Tornøe et al. (S27) explored the experiences of a mobile *hospice nurse team* that was teaching and training care workers in providing spiritual and existential care for the dying in nursing homes and home care settings. The situated bedside teaching and reflective dialogues were efficient ways to develop care workers' courage and competency to provide spiritual and existential end-of-life-care.

4 | DISCUSSION

This scoping review gives insights into strategies of how spirituality can be incorporated into teaching of healthcare students and practitioners. The findings demonstrate that nurses and other healthcare educators include spiritual care in educational curricula and use a wide range of strategies to teach and foster spiritual care skills and knowledge. Several studies report that provision of courses to healthcare staff help them to keep up the focus on spiritual care and contribute to their continuous competence development. The inclusion of spiritual care throughout the curriculum, and teaching/learning strategies like self-reflection, group reflection, case discussions or patient simulation, as well as working in multidisciplinary teams seem helpful in preparing students and staff to provide spiritual care. Such strategies and interventions may foster the participants' development of new skills and awareness of spiritual issues.

Although there is no clear consensus on the definition of spirituality among nurses globally, there is a common understanding that the definition needs to be broad, encompassing meaning and purpose, connectedness, and transcendence (Best et al., 2020; Rykkje et al., 2011; Weathers et al., 2016). Spiritual care thus addresses issues that affect what is deeply important to patients and their families and is a construct that needs to be taught in all basic nursing and healthcare curricula as part of whole person, patient-centred care. A challenge in the findings is that the attributes of spirituality are not defined or clearly described in most reports, and the authors may not be using or interpreting them in the same manner. Thus, the nursing profession should work toward a shared understanding of spirituality (Ali et al., 2018). Hvidt et al. (2020) discuss the dilemma that because spirituality is an aspect of being a human being it must be included in healthcare; however, it is difficult to grasp because each patient must be treated individually with respect to their unique understanding of spirituality and spiritual needs and resources. The interconnectedness between the individual and universal spirituality is clear, but there are many difficulties in describing what spiritual care is in any given context, thus making it complicated to do comparative meta-studies in this field of research.

In line with the review of Jones et al. (2021), the authors found great variation of methods, and the quality of the research was low in many studies. It was, nevertheless, our impression that the quality

of methodologies was better in the more recent studies, and there were more quantitative experimental studies than qualitative and mixed methods. Our findings also point to the great diversity in the educational interventions or strategies. Within the educational or didactic setting, the spiritual care content was difficult to compare because teaching content, length of teaching modules, and evaluation of learning were quite different, as found by other studies (Jones et al., 2021; Lewinson et al., 2015). Furthermore, the studies also varied regarding types of healthcare discipline, year of study, scope of clinical practice, and cultural or religious context. There are some promising studies within multidisciplinary education both in educational and practice settings. However, there is still a need for more studies in this field. Moreover, there is a lack of studies evaluating effects on the quality of care among recipients of spiritual care.

4.1 | Education of nursing and healthcare students

This review points toward the fact that spiritual issues are difficult, and many students and practitioners do not consider the spiritual domain as part of their responsibilities. Nonetheless, after attending courses, these attitudes change. As an example, Kuven and Giske (2019, S6) state that assignments in spiritual care are challenging and should not be voluntary, because students' resistance toward talking about spiritual matters changed after doing the assignment. Mitchell et al. (2016, S23) point out that if spiritual care becomes an elective course, then the attending students may be those who already are predisposed and interested in the subject when it is those that are not interested who would most benefit from participating, as found by Giske and Cone (2012). Therefore, one should consider that spiritual care courses and training should be mandatory. A finding across studies is that the subject of spiritual care should be included more into nursing, midwifery, and medical education, and it is a promising strategy to integrate multidisciplinary courses that would allow students to see the value of having all members of the healthcare team involved in this important domain of patient care.

Furthermore, this review finds that all strategies have an impact upon the participants' learning, providing new skills and awareness of spiritual issues. However, the content and length of courses differs very much and cannot be easily summarised. What can be concluded is that it is seemingly the awareness raised by attending courses that provides the effect. Whether through targeted readings, lectures, or group dialogue in or after class, the educational interventions resulted in the participants becoming more self-aware as they begun to know themselves better, and thus, they developed their intra-spiritual competence (van Leeuwen et al., 2020).

Our pre-assumption that students may learn about spiritual care in both theoretical and practice studies, has been confirmed through this review. Several studies implement spiritual care assignments into nursing students practice placements after they receive the didactic portion of their training (Kuven & Giske, 2019, S6; Strand et al., 2017, S18; van der Vis-Sietsma et al., 2019, S10). In medical residency programmes, different types of practice settings are used to enhance spiritual care competencies (Anandarajah et al., 2016, S20; Awaad et al., 2015, S25; Kelley et al., 2019, S5; Ledford et al., 2014, S29). This simply underlines the importance of having both didactic learning and clinical practice training where students and/or healthcare professionals can put into practice what they have learned in the classroom about the spiritual domain and spiritual care.

Long term effects might not be possible to establish unless there are longitudinal studies; however, it is uncertain whether it is the taking part in research and answering their questions or the course itself that provides the change in attitudes. Another challenge put forward by Daudt et al. (2019) is that courses do not necessarily produce a lasting effect; thus, there is a need for strategies that offer some kind of course or training on a regular basis. This is true of any skill learned in the classroom, which is why healthcare professional always have clinical practice that accompany academic learning, regardless of the content of a course. It is also recommended that students, when becoming professionals, must develop and sustain their spiritual care skills in their clinical practice (Jones et al., 2020). As such, there is need for ongoing recognition and focus upon spiritual care both in education and patient care; the awareness of the importance of spiritual issues must continually be reiterated, and there must be clinical practice to allow for spending time on spiritual caregiving. This should be included in mandatory work-based learning, and leaders have the responsibility to plan and implement such training as part of routine enhancement of clinical practice for all healthcare staff.

4.2 | Competence development of healthcare professionals in clinical practice

What is seen in studies that include evaluations by patients, is that they benefit from a change in practice after staff have attended courses. Hu et al. (2019, S3) claim that nurses with spiritual health have a better ability to recognise and respond to patients' spiritual needs and are more likely to proactively provide spiritual care to patients. Other studies indicate that training in spiritual care for healthcare professionals may have positive effects on the quality of care as reported by patients (van de Geer et al., 2017, S14; Vlasblom et al., 2011, S35). Tornøe et al. (2015, S27) point out that the nature of spirituality makes it more complex to teach in educational settings than more concrete dimensions of care, as there are no fixed answers; therefore, healthcare practitioners might benefit from receiving spiritual and existential education and practice at their workplace in addition to the end-of-life-care training they normally receive.

Based on the results of this review, the authors believe that to ensure the provision of spiritual care for patients in healthcare practices, there should be courses offered on a regular basis as part of high-quality educational strategies for healthcare personnel. As discussed by Hvidt et al. (2020), the nature of spirituality and aspects related to individual preferences and values make it at once fundamental to healthcare and at the same time difficult to provide. While it is not necessarily easily accomplished, the authors agree

and suggest that spiritual care competencies are something we as human beings and healthcare providers must develop throughout our lives.

4.3 | Limitations

A strength of the study was the involvement of a research librarian in the whole process (Pollock et al., 2021). The use of validated checklists and tools for critical appraisal was challenging because of the great diversity in types of studies and methodologies. The authors found that doing the appraisal according to the type of approach was necessary and strengthened the process of selecting studies.

The included studies are limited to English language and are predominately from settings in Western countries influenced implicitly by a Christian cultural heritage or explicitly through faith-based organisations. This means the findings may be of limited use in cultures dominated by other religions, though the commonalities across studies should be of interest and have transferable value since religiosity can be considered an ontological part of being human. It is also a limitation that non-English studies were not included.

Furthermore, there are several types of biases in the included studies. Most commonly is the small number of participants involved, thus making it difficult to transfer or apply the results to other settings. However, small numbers may also imply that there are effects, and these need to be verified in larger studies, preferably with experimental design and control groups. The difference in methods makes it difficult to undertake quantitative summaries across studies, and the great variation in educational strategies also makes this problematic.

Another type of bias is that the understanding of spirituality differs globally, and thus, we cannot be sure exactly what is measured in each study. The findings in this review imply that raising awareness of spirituality does have an impact on those participating in the education or courses, which, in and of itself, is an important consideration. Overall, there is need for more research to establish that this training will benefit all patients receiving healthcare services.

When reporting the results, it was challenging to include a full description of the teaching and/or learning strategies of each study. Therefore, details about the educational content (and full references) are provided in the Appendix S3.

5 | CONCLUSION

Several studies point to the idea that courses in spiritual care should be implemented in all education; moreover, integrating spirituality education into the curricula and using patient cases and simulation can be a very effective approach. Learning is a journey that begins with raising awareness about spirituality; thus, personal and group reflection is seemingly a preferred teaching method to stimulate the students toward developing skills in this area. It is also important that nurses and other healthcare professionals realise that they do not always need to have all the answers to deep questions from patients; often, it is enough to simply be there with them on their journey through suffering, to provide 'presence' that is non-judgemental, open, and accepting as they experience the hardships of life.

On the other hand, it is useful to expand our understanding and our language about what is included in spiritual care so that nurses can help their patients articulate what is deeply personal and important to them and their care. In addition, is it necessary to implement spiritual care into practice not only through awareness raising, but also hands-on training, making this part of regular care. The authors also suggest providing regular courses to help professionals acknowledge that spiritual issues may be challenging and to foster an atmosphere where staff collaborate and support both each other and their patients and families. If nurses succeed in establishing workplace environments in healthcare practices where resource allocation and skills in spiritual care is prioritised, then, spiritual care can truly become beneficial to our patients.

There is clearly a need for greater consensus about how to describe spirituality and spiritual care in healthcare settings, while allowing for cultural variances and differences in native languages. Nevertheless, the greatest challenge may be that there is a lack of words to describe what spiritual care can be in clinical practice, and that the international community of research in this field may be linguistically biased when non-native English research is translated and shared. The authors therefore recommend that there be further research to support words and concept developments to describe spirituality in those languages used in each country. When spiritual care is understood in one's native language, articulated with words close to what is comprehensive for clinical practitioners and care receivers, then nurses and healthcare professionals can find a common ground for doing standardised trials to demonstrate effects and compare findings internationally.

This review found a wide range of studies with insights into educational interventions or strategies for teaching nursing and allied healthcare students and staffs about spiritual care. However, there is still need for more high-quality evidence on spiritual care interventions and strategies to guide nursing practice and education.

6 | RELEVANCE TO CLINICAL PRACTICE

The findings in this scoping review are important for clinical practice in developing research-based strategies in spiritual care education and training. The findings support the inclusion of spiritual care both in monodisciplinary and multidisciplinary educational settings, although there is no 'right' way or best standard to guide spiritual care curricula. The main result of spiritual care is in building awareness of spiritual issues and by self-awareness where students learn about their own spirituality. It is recommended to include how to deal with spiritual distress and endure in meaningless and powerless situations. It is challenging to establish a long-term effect of spiritual care education, and the many studies that report on effective courses provided for healthcare professionals underscores the need to keep up the focus upon spiritual

care competence building in both pre-and post-graduate settings. To ensure the provision of spiritual care for patients in healthcare practices, continuing and multidisciplinary education is recommended.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTIONS

LRy and MBS performed the searches for potentially relevant articles. LRy, MBS and TG marked relevant articles in the screening programme Rayyan. All authors participated in the calibrating process, selection of studies, critical appraisal and drafting of the final manuscript. All authors agreed upon the final version to be published.

DATA AVAILABILITY STATEMENT

Information about excluded studies is available upon request.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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