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Spirituality Education for End of Life Clinicians: A Quality Improvement Project

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Spirituality Education for End of Life Clinicians:

A Quality Improvement Project

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A DNP project proposal submitted in partial fulfillment of the requirements

for the degree of Doctor of Nursing Practice

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This is to certify that the DNP Project Final Report by

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has been approved by the DNP Project Team on

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for the Doctor of Nursing Practice degree

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Abstract

Significance and Background: The focus of this project was to strength the knowledge, comfort, and training of end of life(EOL) clinicians working with patients in the palliative care and hospice environments. While spirituality is considered one of the essential domains of hospice care, it is an area that is often brushed aside by staff and patients and their families. Spirituality is inadequately addressed due to knowledge deficits, time issues, and lack of self-efficacy. Addressing spiritual care is particularly important for patients with chronic and end stage illnesses. Patients and their families view spirituality as a way of coping with suffering.

Purpose: The purpose of this quality improvement project was to provide EOL clinicians with additional spirituality education. The additional education can enhance knowledge and competence and assist patients in achieving a better quality of life(QOL) through spiritual care.

Methods: The Plan, Do, Study, Act frame was used to develop a spirituality education program for EOL staff. The Spiritual Care and Competence Scale was given to participants before and after the education intervention to assess differences in clinicians' knowledge, competence, and comfort in providing spiritual care to her/his patients. The Sacred Heart University Institutional Review Board (IRB) granted approval for the project prior to implementation.

Outcome: At eight weeks, staff demonstrated more knowledge to identify and engage in spiritual care conversations with patients and families at first posttest. The survey responses show an increase their knowledge and competence when addressing a patient's spirituality and how the patients' spirituality fits in their overall plan of care.

Discussion: Through analysis of the pretests and the postests, the staff showed increased competence and understanding in supporting a patient's spirituality. For staff to become

efficient in providing spiritual care to their patients, ongoing spiritual care training is needed. This quality improvement supports staff education and awareness that reinforces EOL staff's ability to provide basic spiritual care.

Keywords: spirituality, spiritual care, pastoral care, palliative care, hospice, end-of-life care

Spirituality Education for End-of-Life Clinicians: A Quality Improvement

Problem Identification and Evidence Review

Description of the Practice Problem

Spirituality is recognized as one of the essentials components and disciplines of holistic care. It is a critical area that plays a special role in end-of-life (EOL) care. Burkhart et al., (2019) cite how spirituality engagement is linked to improved health outcomes, improved quality of life, decreased pain, better patient and family satisfaction, and better coping for the patient and family. However, even with spiritual care being part of the core palliative and hospice care, spiritual care remains the most neglected and the least developed and educated dimension in EOL care (Gijsberts et al., 2019).

Subjects such as religion, religious denominations, beliefs, patient's spirituality and the afterlife are uncomfortable subjects and barriers for clinicians to discuss with patients. Cultural and religious differences are other barriers that affect a clinician's ability to provide spiritual care. Despite regulations that mandate spiritual assessments and spiritual care, spiritual care remains neglected in clinical practice due to lack of staff education and preparation (Ali, er al., 2018). Zumstein-Shaha et al., (2020) report EOL clinicians desire further spiritual care training to provide better care to their patients and to overcome the existing barriers.

Lack of training and education, and discomfort are identified as primary obstacles to engaging a patient's spirituality and meeting their spiritual needs. Burkhart et al. (2019) also report confusion among EOL clinicians and uncertainty if an assessment for spiritual distress is within their scope of practice. These factors lead to a lack of confidence in understanding spirituality which also hinder a staff's ability to address and provide spiritual care.

The National Hospice and Palliative Care Organization (NHPCO) guidelines (National Hospice and Palliative Care Organization, 2022) for palliative and hospice care identify spiritual care as one of eight key domains necessary for delivering quality care for palliative and hospice patients (Zumstein-Shaha et al, 2020). Meeting spiritual care needs of patients has shown to improve patient's quality of life, coping, and well-being, as well as decrease anxiety due to death, loneliness, and depression. Not addressing a patient and family's spiritual care then presents as a missed opportunity to incorporate the patient's spirituality into her or his individual plan of care.

Description of Local Practice Problem

The project site is a statewide, non-profit palliative and hospice care agency that serves patients and families within Connecticut. The local problem arose from two areas. The first area was the staff's identified deficit in spirituality competency. Additional training in spiritual care would assist the agency clinicians in providing better service and care to their patients and families. The second aspect of this local problem is related to NHPCO's guidelines (National Hospice and Palliative Care Organization, 2022) and the emphasis of spiritual care as part of the overall holistic care for EOL patients. The targeted population was the agency's EOL clinicians which included nurses, social workers, chaplains, volunteers, art therapists, and other staff working in palliative and hospice care.

The purpose of this project was to provide an educational program for EOL clinicians and providers to enhance their comfort and competence of the spiritual needs of their patients. It was expected that this education for staff would help patients with their spiritual struggles and distress. Working with the palliative care and hospice director, this quality improvement project was aimed at all palliative and hospice staff including nurse case managers, social workers, music therapists, patient relations, and volunteers.

Clinical Question

With EOL clinicians (Problem), will providing an intervention of spiritual care education (Intervention-utilization of educational intervention) compared to current knowledge of spiritual care (Comparison)) improve clinician knowledge and competence to enhance the QOL for EOL patients (Outcome)? The hope is to ultimately enhance the quality of life for EOL patients, although this measurement of this end outcome is beyond the scope of this project.

External Evidence

Databases that were searched included CINAHL, NCBI, Medline, and PubMed. Searches were limited to those published between 2015 and 2022. The search was limited to English only articles. Nine studies met the inclusion criteria in this evidence review. Keywords included spiritual care, spirituality, pastoral care, chaplain, assessment, spiritual assessment, education, palliative care, hospice care, end of life, holistic care, faith, religion, beliefs, spiritual beliefs, and belief systems. Nine were deemed relevant to the clinical question. One article was a systematic review. One article was a controlled trial without randomization. Two articles were cohort studies, and five articles were qualitative studies. While research and evidence were sought from the past five years, one article and its evidence from 2015 pertained to this project and was include in evidence search. Appendix A provides an evidence synthesis table of the articles' information.

Most of the research cited similar conclusions. These conclusions show a theme of clinicians' desire to provide spiritual care and engage their patient's spirituality. Another shared conclusion is a lack of knowledge among nurses related to spiritual nursing care. Most of the articles also cited barriers clinicians encounter when providing spiritual care. The articles also provided evidence showing a correlation to providing spiritual care and increasing a patient's

quality of life. Articles were selected for review that focused on spirituality education for palliative care and hospice nurses as well as ones that focused on spiritual assessment of patients. The John Hopkins Nursing Evidence-Based Practice Quality Guide (JHNEBP) was used to rate the overall quality of the articles and was also used to determine the level of evidence of the articles (The Johns Hopkins Hospital (JHH)/Johns Hopkins University (JHU), n.d.). Permission was obtained from John Hopkins University to use the JHNEBP and referenced in Appendix D.

Evidence Appraisal Results

Within this section, the literature and research were reviewed to apply evidence-based practice recommendations on the education of spirituality. This section examines research that shows how spirituality improves quality of life for patients and why clinicians' knowledge of spirituality is critical to clinical practice. Nine articles were selected that showed a positive association between spirituality, patients' care and outcomes, and integration of spirituality in with nursing practice. Several articles reviewed different assessment tools to measure medical staff's knowledge of spirituality and presented their respective findings.

Burkhart et al., (2019) review the knowledge and approach of Veteran Affair nurses and providing spiritual care to their patients. Burkhart et al. (2019) use a qualitative descriptive method to describe spiritual care in nursing as well as addressing organizational facilitators and barriers in providing spiritual care. Different spiritual interventions are also described for nurses to use in addressing spiritual care with patients. This study also identified the lack of formal education in addressing spiritual needs and the lack of knowledge of spiritual resources.

Gijsberts et al., (2019) conducted a systematic review of 53 articles to explore the recent studies on spiritual care in palliative care in Europe. In the review evidence was identified that spiritual care at the end of life is important to patients and to their healthcare providers. Gijsberts

et al. (2019) also found that lack of spiritual support by healthcare providers is associated with poor quality of life, dissatisfaction with care, less hospice utilization, more aggressive treatment, and increased costs, particularly among ethnic minorities. In the systematic review, it was identified that caregivers need to develop their spiritual competency through education and self-reflection to address the cues and needs of patients.

Harrad et al., (2019) cited an overview of the measures used to assess spiritual care provision among nurses and healthcare staff. This study specifically identified 14 instruments available relating to nursing professionals spiritual care and assessment. The 14 measures were divided into 5 domains. Those domains of scales and assessments were beliefs and values and attitudes around spiritual care, frequency of provision or extent to which they provide spiritual care or willingness, respondents' level of knowledge around spirituality and spiritual care, ability to respond to spiritual pain, and lastly a mixture of various domains of beliefs, training, spiritual care practices, and perceived barriers to provision. Harrad et al., (2019) also reported that the source of the spiritual care education and type of education that is covered along with the individual participants also affect the efficacy of the spiritual care provided by clinicians. The necessity to conceptualize, define and operationalize spirituality for training, increased the ability to provide spiritual support.

Hu et al., (2019) conducted a nonrandomized study that compared a control group versus a study group. The intervention methods included lectures and instruction, case sharing, group discussion, and individual psychological counselling for the study group.

Hu et al., (2019) defined a patient's spirituality and spiritual health as one of the most important dimensions of their wellness and health. Research showed that the enhancement of nurses' spiritual health boosts their personal satisfaction with life and job satisfaction. It also reduces

burnout and assists them with providing spiritual care to patients in their clinical work. Hu et al., (2019) also reported that spiritual care education and training helps nurses to understand patients' senses of honor, values, and background. This understanding assisted staff with providing them with spiritual well-being as well as meaning and purpose amidst adversity.

Lukovsky et al., (2021) conducted a study with the purpose to assess hospice and palliative care nurses and holistic nurses' perceptions of spirituality and spiritual care, and the influence of additional spiritual care training on nurses' ability to provide spiritual care. The study design was a descriptive study that utilized a web survey based off of the Spirituality and Spiritual Care Rating Scale (SSCRS). Of the 241 participants, 91.63% of respondents felt nurses received insufficient instruction and training on matters concerning spiritual care. Eighty percent of the participants indicated that they addressed their patients' spirituality in their daily practice. Lukovsky et al. (2021) conclude from their study that additional spiritual care training empowered nurses to feel more proficient in providing spiritual care to their patients. The spiritual care training should utilize components of providing spiritual care to patients, strategies to identify patients' spiritual needs, and ways to address the identified needs.

Walker and Breitsameter (2017) conducted a qualitive research study with the purpose of exploring what role spirituality plays in daily practice, how spiritual care is provided within the holistic approach of hospice care, and how spirituality is understood by staff and the volunteers. The results of each interview varied based on the participants own background and experience with hospice, and death and dying. Despite varied responses, the participants acknowledged critical areas of spiritual care and a patient's spirituality. Participants' responses included acknowledging a patient's fear about dying, a patient's acceptance of her/his death, and

expression of patients' feelings. Walker and Breitsameter (2017) report the benefits of staff being mindful of spiritual needs and sensitivity to these needs.

Zumstein-Shaha et al., (2020) cite how nurses play a pivotal role in assessing and attending to spiritual needs through their care of diagnosis, treatment, and end of life care. Zumstein-Shaha et al., (2020) conducted a qualitative study to explore nurses' care of patients' spiritual needs. The survey consisted of two main questions. The first question asked nurses for patients' spirituality at the beginning of their cancer journey. The second question asked nurses to share their experiences with patients' spirituality and their own responses to spirituality.

Stories were divided into several themes which included observing patients' religious and spiritual rituals, patients' struggling with their disease, finding mean in the midst of the disease, acceptance of the disease, and staff's reflections on religion and spirituality. This study revealed the need for training on the importance of spiritual care as an essential element in quality of care. Nurses expressed an awareness of the importance of addressing spirituality, however found it difficult and even uncomfortable to talk to patients about spirituality or to encourage patients to share their spirituality. Nurses stated they felt a lack of spiritual competency, particularly in finding the right words, and were hesitant to assess patients out of a concern that they would not be able to respond to their needs.

O'Shea et al., (2011) conducted a study to evaluate the effect of a spiritual education session on pediatric nurses' perspectives toward providing spiritual care. O'Shea et al. (2011) cite that physicians, nurses, and caregivers in pediatric palliative and hospice care have recognized the importance to address spiritual needs for children, as well as for family members. It is also critical to recognize that providing spiritual care is distinctly separate from the health

care professionals' usual focus of identifying and resolving specific medical problems, but rather spiritual care is about accompanying the child and family on a journey of making meaning.

O'Shea et al. (2011) found in their literature review and study the lack of spirituality education that nurses receive. The independent variable within their study was the educational session with a focus on pediatric spiritual care. Findings from the study and posttest confirmed that the spiritual education presented to the nurses had a significant effect on posttest scores and increased their education on spirituality. The change in test scores indicated that the nurses had a more positive perspective toward providing spiritual care after the session.

Van Leeuwen et al., (2009) identified the need to educate nurses and nursing student in spiritual care and how a spirituality assessment recognizes strengths and weaknesses within a nurse's education and practice. As one of the domains within holistic and hospice care, it is critical for a nurse to have a foundation and understanding of spirituality and how it plays a role within a patient's plan of care. A spirituality assessment is needed to determine a caregiver's ability to provide spiritual care and its relevant frameworks.

Van Leeuwen et al. (2009) designed the Spiritual Care Competency Scale (SCCS) as a twenty-seven question assessment around six dimensions. This competency scale was chosen as the assessment tool for this project based on the six dimensions the survey is centered around. The six dimensions are 'assessment and implementation of spiritual care,' 'professionalism and improving spiritual care,' 'personal support and patient counseling,' 'referral to professionals,' 'attitude towards the patient's spirituality,' and 'communication.' Van Leeuwen et al. (2009) stated the 'assessment and implementation of spiritual care' dimension refers to a clinician's ability to determine a patient's spiritual needs and/or problems. It also involved the development of the patient's spiritual care plan. The 'professionalization and improving the quality of spiritual

care' dimension includes the activities of the clinician aimed at quality assurance and policy development in the area of spiritual care.

Van Leeuwen et al. (2009) report the 'personal support and patient counseling' dimension was seen as the heart of spiritual care, with items defined in terms of interventions. 'Referral to professionals' is the dimension relating to interdisciplinary care with other healthcare disciplines and in particular with the chaplain or spiritual care coordinator. Personal factors relevant to providing spiritual care were assigned to the 'attitude towards patient spirituality' dimension. While this dimension revealed a poor Cronbach's alpha, the inter-item correlation indicates a homogeneous scale. Lastly, the dimension of "contact and communication" between clinician and patient are essential aspects of spiritual care. The SCCS is suitable for measuring nursing competencies on a group level in terms of the education or training.

Evidence Appraisal Recommendations

Nine articles were reviewed that researched the subject of providing spirituality and spiritual care education to EOL clinicians. Appendix A analyzes the pertinent information from each of the research articles. Appendix B summarizes the level of evidence of the nine articles and Table B2 of Appendix B identifies the outcomes of the spiritual education as beneficial for staff or not beneficial. All except one article report the benefits of additional spirituality training for EOL staff. The article *Spiritual Care in Palliative Care: A Systematic Review of the Recent European Literature* (Gijsberts, et al., 2019) concluded that the evidence for spiritual care interventions, based on its evidence, was low. However, it also cited future studies are necessary to investigate the effects of spiritual care more fully, and to develop outcome measurements that appropriately capture the effects of the variety of spiritual care practices and its impact on

patients. The remaining eight articles did find spiritual education as beneficial recommended the training for nurses and clinicians. Therefore, this project was aimed at examining and improving the knowledge of end-of-life staff and to improve their assessment skills and ability to provide spiritual care to their patients.

Internal Evidence

All agency staff receive spirituality training as part of the new hire training. The agency has 104 palliative care and hospice clinicians. The training is done through a video module for employees to watch (S. Steinmetz, personal communication, February 14, 2023). The spirituality training explains how spirituality is part of the patient's overall plan of care. The training also clarifies the role of a team chaplain or spiritual care coordinator. The chaplain is tasked with assessing and assisting to meet a patient's spiritual and religious needs (S. Steinmetz, personal communication, February 14, 2023).

Project Planning

Project Goals

1. To evaluate EOL staff competency and understanding of spirituality prior to educational intervention.
2. Provide education to agency staff on spirituality education and assessing spiritual care and spiritual distress
3. Determine if training on spirituality improved staff competence of spirituality as measured by completion of the pretest, 1 week posttest, and then 8 week posttest of the Spiritual Care Competency Care Scale.

Framework

This project will be a quality improvement project. The British Medical Journal (BMJ) as cited by Backhouse and Ogunlayj (2020) defines quality improvement as a systematic continuous approach that aims to solve problems in healthcare, improve service provision, and ultimately provide better outcomes for patients. An additional definition of quality improvement is an improvement in patient outcomes, system performance, and professional development that results from a combined, multidisciplinary approach in how change is delivered. The primary intent of his quality improvement project will be to improve EOL clinicians' competency and understanding of spirituality.

The framework of this quality improvement project utilized the Institute for Healthcare Improvement (IHI) which consists of three driving questions and a Plan-Do-Study-Act cycle (Langley et al., 2009). The primary goal of his quality improvement project will be to improve EOL clinicians' competency and understanding of spirituality. The project utilized the four phase of the Plan-Do-Study-Act cycle (Reed and Card, 2016). The Plan phase consisted of identifying the problem and goals, creating the plan, evaluating the evidence, identifying intervention areas, and meeting with agency staff. The Do phase consisted of staff completing the pretest, providing the educational intervention, and staff to complete the posttest 1 week and 8 weeks after the intervention. The Study phase was composed of analyzing the staff pretests and posttests. The Act phase consisted of implementing the educational tool for new staff, disseminating findings to agency, and identifying further areas for growth with staff.

Context

The agency provides EOL care to patients with advanced illness, and their families. The program's hospice care emphasizes the management of EOL care which encompasses pain and

other physical symptoms, psychosocial dynamics, and spiritual care. Patients enrolled in the agency's hospice program are entitled to spiritual care service, however for various reasons these services are not always utilized. Participants within this project will be palliative and hospice team members which include the nurses, social workers, chaplain, volunteer coordinator, physical therapists, patient relations, and hospice team manager.

Key stakeholders

Key stakeholders within this project were the palliative care and hospice director, academic project advisor, Geraldine Budd; and Sacred Heart student Mark Valigorsky. The hospice director is also serving as the project clinical mentor. Agency staff involved were staff clinicians of the interdisciplinary care team, as previously defined.

Buy-in with the staff initially started with email messages from the hospice director to share the project, its intervention, and goals with the staff. Buy-in also took place over several meetings with this NP-DNP student meeting staff at their interdisciplinary care team meetings to broach the subject of spirituality. It also included observing how the chaplain/spiritual care coordinator and the team members worked together.

Plan

The plan for this project included gathering research and evidence on how spirituality plays a role with palliative care and hospice patients. The research and evidence reviewed also involved researching nurse and EOL staff's understanding of spirituality, spiritual distress, grief, and barriers to spirituality. Evidence identified teaching areas of spirituality to include defining religion and spirituality, spiritual distress, stages of grief, barriers for staff, and case studies to invite staff reflection. Other identified areas within the evidence included interventions for EOL

staff to provide spiritual care, and strategies to identify spiritual needs of patients, and ways to address the identified needs (Lukovsky et al., 2021).

In discussion with the palliative care and hospice director it was determined the best approach was to provide the educational intervention around the different geographic team's interdisciplinary care team (IDT) meetings. These meetings occur on Tuesday, Wednesday, and Thursday of each week. The educational intervention was provided in both in person as well as through online Microsoft Teams meetings for staff members who could not attend in person. The SCCS assessment was be provided at the beginning of each team meeting to gather a baseline initial assessment. A week later and eight weeks later the SCCS assessment was to measure staff learning.

Description of Practice Change

The practice change intervention for this project was an educational component on spirituality for the EOL staff. The educational intervention was conducted with PowerPoint presentation and covered the areas of distinguishing the differences between religion and spirituality, defining spirituality, defining spiritual distress, defining states of grief, interventions for staff, and the review of case studies to help staff identify spirituality aspects within the patient visits. The PowerPoint was given to the hospice director and chaplains to be used for future education, and to expand upon to provide further areas of training and education for the staff.

Evaluation

The project evaluation involved comparing the clinician pretest scores to their posttest scores using the SCCS. The pretest answers were compared to the posttest answers and while monitoring any changes in the answer responses.

Barriers to Implementation

Engagement of spirituality with patients may seem like an additional task for the EOL clinician to complete. Staff may express resistance with having to attend the educational meeting during already busy days with work, assessments, and documentation. Staff may also complain of lack of time. Another barrier is staff's lack of understanding and uncomfortableness to discuss spirituality and viewing it as a taboo subject. In order to overcome these barriers, the educational intervention could be shared as a recording for the staff to view at a more convenient time in their schedule. The team chaplains could also assist in acting as change champions and answering question for staff.

Timeline

December- January 2022

- Review project proposal draft and make revisions
- Build agency buy-in with hospice director and staff
- Submit to Sacred Heart University IRB for review

February 2023

- Review research evidence
- Continue to build educational intervention
- Submit to Sacred Heart University IRB for review
- Attend agency meetings to build buy-in and gather internal evidence

March 2023

- Finalize educational intervention
- Conduct project proposal with Agency director and project advisor
- Schedule educational intervention

April 2023

- Conduct project educational intervention and gather initial pretest questionnaires
- Gather final questionnaires and analyze information
- Review information with Project advisor

May-June 2023

- Present final completed project to the University community
- Submit final paper to Sacred Heart University College of Nursing

Some revision of the timeline was done as necessary. Completion was ultimately in late June 2023.

Resources and Budget

Budget for assessment of clinician' knowledge and level of competency in providing spiritual care and education intervention will have minimal to no cost. Significant time spent for the program centered around educational intervention with no cost. The use of the SCCS questionnaire was at no cost and permission was obtained from Rene van Leeuwen as noted in Appendix E. The SCCS comprises six spiritual-care-related nursing competencies and shows good homogeneity and a good test-retest reliability (van Leeuwen et al. 2009).

Dissemination Plan

The results of the project and a submission of the final DNP Project Paper will remain with the College of Nursing at Sacred Heart University and the University library. Additionally, the paper will be reviewed and edited by the DNP student author with the goal of revising and submitting to meet the author guidelines as required by the American Journal of Hospice and Palliative Care.

Ethical Review

Table 1 displays the DNP student author's responses based on Fosters' (2013) questions to differentiate quality improvement from research. Answers to questions 1-10 are marked yes.

Questions 11-14 are answered no to indicate this project meets criteria for a quality improvement project (Appendix G). It also indicates the project does not qualify as human subjects 'research. It was submitted to Sacred Heart University Institutional Review Board for review and found to be Exempt. Email from Sacred Heart University Institutional Review Board is found in Appendix F.

Table 1

Differentiating Quality Improvement and Research Activities Tool

Question		Yes	No
1.	Is the project designed to bring about immediate improvement in patient care?	X	
2.	Is the purpose of the project to bring new knowledge to daily practice?	X	
3.	Is the project designed to sustain the improvement?	X	
4.	Is the purpose to measure the effect of a process change on delivery of care?	X	
5.	Are findings specific to this hospital/setting?	X	
6.	Are all patients who participate in the project expected to benefit?	X	
7.	Is the intervention at least as safe as routine care?	X	
8.	Will all participants receive at least usual care?	X	
9.	Do you intend to gather just enough data to learn and complete the cycle?	X	
10.	Do you intend to limit the time for data collection in order to accelerate the rate of improvement?	X	
11.	Is the project intended to test a novel hypothesis or replicate one?		X
12.	Does the project involve withholding any usual care?		X
13.	Does the project involve testing interventions/practices that are not usual or standard of care?		X
14.	Will any of the 18 identifiers according to the HIPAA Privacy Rule be included?		X

Adapted from Foster, J. (2013). Differentiating quality improvement and research activities. Clinical Nurse Specialist, 27(1), 10–3. https://doi.org/10.1097/NUR.0b013e3182776db5

Project Implementation

Description of Actual Project Implementation

The project implementation started with planning the dates and settings of the educational sessions. After conversation with the hospice direction, it was determined that both in-person and on a Zoom or Microsoft Teams call would work best. The pretest-posttest and educational

presentation were planned to be held after the each hospice team's interdisciplinary team meeting(IDT). The hospice agency is composed of three teams with one team meeting on Tuesday, another on Wednesday, and the third on Thursday.

The hospice teams were informed of the spirituality project and emailed Microsoft Teams meetings invitations. Time and opportunity were given for team members to ask any questions in advance by email from the DNP student and hospice director. During the first day of implementation with the first team, the DNP student met with three staff members in office and fourteen team members attended the Microsoft teams call. A QR code for the pretest was embedded in the PowerPoint presentation. The pretest link was also sent in the Microsoft Team chat for members to take. The second educational session took place the following day with the second team after their IDT team meeting. Three staff members attended the second session in person, and 12 team members were on the Microsoft Teams call. The third educational session took place the following day on Thursday. There were no members in person, and seven staff members attended the Microsoft Teams call. The link for the pretests were sent in the group chat for participants to take.

Description of Deviations from Project Plan

There were two deviations from the project plan. The first deviation was a change from a paper pretest and posttest to an online version. This change was made for convenience for the staff members attending the presentation in person. Staff members could access the online pretest and posttest through the website link as well as a QR codes to take on their cell phones. The online survey platform used SurveyPlanet. SurveyPlanet also scores each question which made for accurate analysis of each question.

The second deviation was changing the answer scale on the SCCS. Van Leeuwen's SCCS utilized a 5-point Likert scale and a 6-point Likert scale was utilized for this project's pretest and posttest. The rationale for the change to a 6pt Likert scale was to add the answer "none." The answer "none" provides a response option where respondents might not be able to identify with any of the other answers. An additional answer option also causes the respondent to give more time and thought to which answer she or he may select.

Evaluations

Process Measures

Process outcomes are defined as quality indicators derived from a specific process which has an influence on outcome (Singh and Boyle, 2020). Process outcomes promote evidence-based best practices that have been proven to improve outcomes or the patient experience of care. During intervention phase of this project17 members were present the first meeting, 15 members were present the second meeting, and seven members were present the final meeting. Of the 39 members that attended the meetings, 28 members voluntarily took the pretest and one week posttest surveys. 17 members took the eight-week posttest survey. The education presentation (Appendix G) was provided in-person as well as on Microsoft Teams.

The pretest and posttest SCCS questionnaire were used as the primary instrument to measure staff's knowledge and competency of spirituality and providing spiritual care to patients. The staff that participated in the education and pretest and posttest were composed of nurses, social workers, chaplains, volunteer coordinator, art and music therapists, patient relations staff, and other staff working in palliative and hospice care. No demographic or descriptive information was obtained to protect the identity of the participants.

The comparative results of the pretest and posttest are as found in Tables 2 and 3.

Table 2

Questions 1-5 of SCCS

1.*I am open to a patient's spiritual/religious beliefs, even if they differ from my own.*

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	0	0	0
Disagree	3(10.7%)	0	0
Neither	10(35.7%)	2(7.1%)	4(23.5%)
Agree	9(32.1%)	13(46.4%)	9(52.9%)
Strongly Agree	5(17.9%)	11(39.3)	4(23.5%)
*Unanswered	1(3.6%)	2(7.1%)	

2. *I am aware of my personal limitations when dealing with a patient's spiritual/religious beliefs*.

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	0	0	0
Disagree	5	0	0
Neither	11(39.3)	2(7.1%)	0
Agree	10(35.7%)	16(57.1%)	14(82.4%)
Strongly Agree	2(7.1%)	11(39.3)	3(17.6%)

3. *I can listen actively to a patient's 'life story' in relation to his or her illness/handicap.*

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	0	0	0
Disagree	3(10.7%)	0	0
Neither	11(39.3)	1(3.6%)	1(5.9%)
Agree	9(32.1%)	14(50%)	12(70.6%)
Strongly Agree	5(17.9%)	13(46.4%)	4(23.5%)

4. *I have an accepting attitude in my dealings with a patient (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere and personal)/*

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	0	0	0
Disagree	1(3.6%)	0	0
Neither	14(50%)	2(7.1%)	0
Agree	8(28.6%)	16(57.1%)	13(76.5%)
Strongly Agree	5(17.9%)	10(35.7%)	4(23.5%)

5. *I can report orally and/or in writing on a patient's spiritual needs.*

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	0	0	0
Disagree	1(3.6%)	0	0
Neither	12(42.9%)	1(3.6%)	0
Agree	11(39.3)	15(53.6%)	13(76.5%)
Strongly Agree	4(14.3%)	12(42.9%)	4(23.5%)

Table 3

Questions 6-10 of SCCS

6. *I can tailor care to a patient's spiritual needs/problems through multidisciplinary consultation.*

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	0	0	0
Disagree	4(14.3%)	0	0
Neither	10(35.7%)	3(10.7%)	2(11.8%)
Agree	12(17.9%)	15(53.6%)	12(70.6%)
Strongly Agree	2(7.1%)	10(35.7%)	3(17.6%)

7. *I know when I should consult a spiritual advisor concerning a patient's spiritual care.*

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	0	0	0
Disagree	1(3.6%)	0	0
Neither	6(21.4%)	1(3.6%)	0
Agree	17(60.7%)	10(35.7%)	14(82.4%)
Strongly Agree	4(14.3%)	17(60.7)	3(17.6%)

8. *I can help a patient continue his or her daily spiritual practices (including providing opportunities for rituals, prayer, meditation, reading the Bible/Koran, listening to music).*

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	1(3.6%)	0	0
Disagree	8(28.6%)	0	0
Neither	11(39.3)	9(32.1%)	4(23.5%)
Agree	5(17.9%)	14(50%)	10(58.8%)
Strongly Agree	2(7.1%)	5(17.9%)	3(17.6%)
*Unanswered	1(3.6%)		

9. *I can attend to a patient's spirituality during the daily care (e.g. physical care*).

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	1(5.9%)
Strongly Disagree	1(3.6%)	0	0
Disagree	6(21.4%)	0	0
Neither	12(42.9)	3(10.7%)	1(5.9%)
Agree	7(25.0%)	18(64.3%)	12(70.6%)
Strongly Agree	2(7.1%)	5(17.9%)	3(17.6%)
*Unanswered		1(3.6%)	

10. *Within the department, I can contribute to quality assurance in the area of spiritual care.*

Answer	Pretest	1wkPosttest	8wk Posttest
None	0	0	0
Strongly Disagree	0	0	0
Disagree	0	0	0
Neither	9(32.1%)	1(3.6%)	0
Agree	17(60.7%)	18(64.3%)	9(52.9%)
Strongly Agree	2(7.1%)	9(32.1%)	8(47.1%)

The posttests' Agreed and Strongly Agree responses showed a positive increase when compared to the pretest answers. Regarding the first question three staff members found that after the presentation they were now open to a patient's beliefs, compared to not being receptive beforehand. The percent of staff who agreed/strongly agreed that they were open to a patient's spiritual beliefs increased from 50% to 85.7% on the one-week posttest, and then 76.4% on the eight week posttest. The second questioned asked about staff's awareness of their own personal limitations. 42.8% of staff indicated they were aware of their personal limitations beforehand, and after the educational presentation, the awareness increased to 96.4% on the one-week posttest, and then 100% on the eight-week posttest. The third question regarding staff's openness to a patient's spiritual and religious beliefs increased from 50% on the pretest to 96.4% on the one-week posttest, and 94.9% on the eight week posttest.

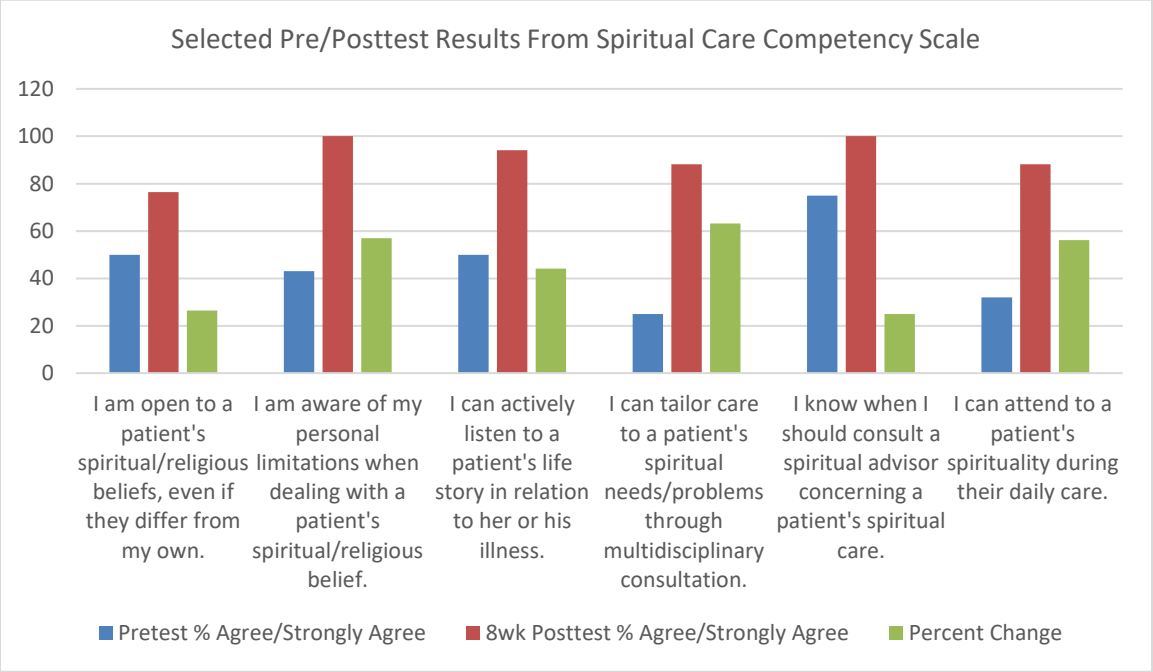
Staff indicated having an accepting attitude toward patient's feelings, which increased after the education presentation. There was also a strong indication in question five that staff can report on a patient's spiritual needs. Question six asked about tailoring a patient's plan of care with multidisciplinary care. The percent of staff who disagreed that they could tailor care to a patient's spiritual needs decreased from 14.3% to 0% on the one- and eight-week posttests. Question seven had high agreement responses pretest and increased agreement responses on the one week and eight-week posttests.

Question eight asked participants about assisting patients in their spiritual practices. Survey results show nine members who disagreed that they could not, indicated posttest that they could. Question nine inquired about staff tending to patient's spirituality during care. Pretest agree/strongly agree totaled 32.1% and agreed responses totaled 82.2% on the one-week posttest

and 76.4% on the eight-week posttest after the educational presentation. This increase in answers points toward confident and competent staff who can ~~are able to~~ provide the holistic care to their patients. Question 10 asked about contributing to the quality assurance toward spiritual care and had strong responses of agreement pretest and posttest.

Figures 1 and 2 show the percent change in selected questions from the EOL staff. These questions were selected based on the respondent's answers and change based on the educational intervention.

Figure 1



Key Lessons Learned

The results of the educational intervention showed an increase ability for EOL staff to attend to patients' spirituality during daily care and to tailoring care to patients' needs and care through multidisciplinary consultation. The hope is that education of staff leads to providing higher quality of care for patients and increased satisfaction of EOL care for patients and their families.

This project has enhanced my knowledge and assisted in my growth as a professional nurse educator and researcher. The project allowed me to research, collect, and analyze data to support the importance of EOL staff trained in spirituality. There are several key lessons learned. The first lesson is identifying a timeline and maintaining it as much as possible, while also having extra time built in should it be needed. Additional educational information would have been beneficial for staff. While handouts are either filed or thrown out, an information card to be held on staff's badge holder would provide key takeaway points that staff could literally hold onto. If the project is to be repeated, it would be beneficial for the project lead to identify areas to discuss. It would be beneficial for staff and patients to utilize the chaplains and spiritual care coordinators on the palliative and hospice teams. They are the subject matter experts in this subject and valuable resources for the staff.

Sustainability

This DNP project was recorded on ZOOM and shared with the hospice agency for future use. The agency will be free to revise the education PowerPoint as based off stakeholder feedback.

Dissemination:

The results of the project and a submission of the final DNP Project Paper will remain with the College of Nursing at Sacred Heart University and the University library. Additionally, the paper will be revised to meet publication guidelines of the American Journal of Hospice and Palliative Care, after which the paper will then be submitted.

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Appendix A

Evidence Synthesis Table

Search Question in PICO format: With EOL clinicians (Problem), will providing an intervention of spiritual care education (Intervention-utilization of educational intervention) compared to current knowledge of spiritual care (Comparison)) improve clinician knowledge and competence to enhance the QOL for EOL patients (Outcome)?

Article abbreviated title	***First Author & Year***	***Evidence Type***	***Sample, Sample Size, Setting***	***Findings that help answer clinical question***	***Limitations***	***Evidence Rating†***	
						Level/ Quality	
1. Spiritual Care in Nursing Practice in Veteran Health Care.	Burkhart et al. 2019	Qualitative descriptive method	39 Registered Nurses that worked at a midwestern VA health system participated in a two-phase study to explore spiritual care in the VA setting.	With educational programs and resources in place, staff are more aware of ques of spiritual distress among patients. Also identifies opportunities for medical staff to improve spiritual care for its patients.	Participants who came forward may value spiritual care and may not represent the entire VA RN population. Participants from one health center may not represent the entire health network	Level III	B

Article abbreviated title	***First Author & Year***	***Evidence Type***	***Sample, Sample Size, Setting***	***Findings that help answer clinical question***	***Limitations***	***Evidence Rating†***	
						Level/ Quality	
2. Spiritual Care in Palliative Care: A Systematic Review of the Recent European Literature	Gijsberts et al. 2019	Systematic review to map the recent studies on spiritual care in palliative care in Europe.	53 studies were included in the review. 17 were quantitative studies of which the majority (*n* = 11) were survey studies, 27 qualitative studies with most of which were interview studies (*n* = 13), and 9 mixed-methods studies.	The findings gained through this study have shown the variety of spiritual care practices and the significance of developing spiritual competencies and visibility of spirituality and spiritual care in healthcare. Concludes stating Future studies are necessary to investigate the effects of spiritual care more fully.	Possible bias of the study is utilizing a broad definition of spiritual care in order to include as many studies on spiritual care as possible. Review of studies are mainly from Northern Europe and not from the other parts of the continent.	Level I	C
3. Spiritual care in nursing: an overview of the measures used to assess spiritual care provision and related factors amongst nurses.	Harrad et al. 2017	Literature Review to identify instruments available relating to nursing professionals spiritual care and assessment	Review of 14 articles related to spiritual care and assessment	This review analyzes studies and assessments used to evaluate nurses' understand-ing of spirituality and providing it to the patient. It also discusses barriers to providing spiritual care. Findings also point to training and	The variety of ways that spiritual care and assessment are conceptualized, operationalized and defined it becomes difficult to ascertain which factors are the most important when considering how to increase spiritual care delivery.	Level V	B

Article abbreviated title	***First Author & Year***	***Evidence Type***	***Sample, Sample Size, Setting***	***Findings that help answer clinical question***	***Limitations***	***Evidence Rating†***	
						Level/ Quality	
				spiritual education as an important consideration, for hospice staff to provide spiritual care.			
4. Effectiveness of spiritual care training to enhance spiritual health and spiritual care competency among oncology nurses	Hu et al. 2019	A nonrandom-ized controlled trial to establish a spiritual care training protocol and verify its effective-ness.	Sample setting consisted of two randomly assigned groups. The study group (45 people) and the control (wait-listed) group (47 people). The study group received one spiritual care group training session every six months. The control group participated in monthly nursing education sessions for twelve months.	The results displayed that the study group had higher total spiritual health and spiritual care competency scores as well as higher scores for their individual dimensions than the control group.	Most participants were senior nurses within the organization.	Level III	B

Article abbreviated title	***First Author & Year***	***Evidence Type***	***Sample, Sample Size, Setting***	***Findings that help answer clinical question***	***Limitations***	***Evidence Rating†***	
						Level/ Quality	
5. A Survey of Hospice and Palliative Care Nurses' and Holistic Nurses' Perceptions of Spirituality and Spiritual Care	Lukovsky et al. 2017	Experimen-tal, descriptive Study to assess hospice and palliative nurses' and holistic nurses' perceptions of spirituality and spiritual care.	A convenience sample was recruited from members of the HPNA and the AHNA	The study provides evidence that 50% of nurses had spirituality training in their studies and jobs. Participants also indicated that they had limited exposure to spirituality training. Nurses who feel well prepared in spiritual matters are more comfortable within the spiritual domain of care. The vast majority of respondents felt nurses received insufficient instruction and training on matters concerning spiritual care (n = 219 [91.63%]).	-Data constricted to a timeframe of 4 weeks. -researchers did not have access to data on the number of members who met eligibility for inclusion or to which organization they belonged.	Level II	A

Article abbreviated title	***First Author & Year***	***Evidence Type***	***Sample, Sample Size, Setting***	***Findings that help answer clinical question***	***Limitations***	***Evidence Rating†***	
						Level/ Quality	
6. The Provision of Spiritual Care in Hospices: A Study in Four Hospices in North Rhine-Westphalia	Walker, & Breitsameter 2017	Qualitative design To explore what type of role spirituality plays in daily practice, how spiritual care is provided considering the holistic approach of hospice care, and how spirituality is understood	The sample included full-time hospice staff which was comprised of 5 nurses, 2 directors of patient care, 3 members of the psychiatric service, one directors of the hospices, 2 chaplains, and 9 volunteers from 4 hospices in North Rhine-Westphalia.	Participant results varied for each answer. The researchers point to the need of having spiritual training so staff understand the meaning of spiritual care, spirituality, and how to respond to a patient's spiritual needs.	- The results are therefore influenced by a specific setting and organizational structure. A different setting, in which time-management cannot be handled as generously, and in which volunteers do not play a significant role, is likely to generate different results.	Level III	B
7. Nurses' response to spiritual needs of cancer patients.	Zumstein-Shaha et al. 2020	Qualitative Study to collect narratives of nurses' experiences in responding to spiritual care needs	62 nurses returned surveys (58 surveys from the USA, 4 surveys from Switzerland)	This study revealed the need for training on the importance of spiritual care as an essential element in quality of life care. Nurses who are specifically trained in spiritual and	-Participant exposure to the palliative care and hospice fields, presenting the possibility of work and educational bias.	Level III	B

Article abbreviated title	***First Author & Year***	***Evidence Type***	***Sample, Sample Size, Setting***	***Findings that help answer clinical question***	***Limitations***	***Evidence Rating†***	
						Level/ Quality	
				religious issues are reported to be more likely to incorporate spiritual assessment into their practice.			
8. The effect of an educational session on pediatric nurses' perspectives toward providing spiritual care	O'Shea et al. 2011	Case Study to evaluate the effective-ness of a spiritual educational session on pediatric nurses' perspectives concerning the provision of pediatric spiritual care	Convenience sample of 41 pediatric and neonatal nurses that worked in a large university-affiliated children's hospital	Findings confirmed that the spiritual education presented to the nurses had a significant effect on posttest scores. The change in test scores indicated that the nurses had a more positive perspective toward providing spiritual care after the session.	-The small convenience sample (N = 41) was homogenous and limits the generalizability of the findings to other populations. - The posttest measure was conducted immediately after the education session. Therefore, only the short-term effect of knowledge and attitudes of the one group was measured. Although findings were statistically significant, no longitudinal effects were investigated.	Level IV	A
9. The validity and reliability of an instrument to assess nursing competencies in spiritual care.	van Leeuwen et al. 2009	Cross sectional study/ longitudinal study on the develop-ment of a valid and reliable	Students from Bachelor-level nursing schools in the Netherlands	-The study conducted in demonstrated valid and reliable scales for measuring spiritual care competencies within a nursing student population.	-Sample population did not represent the total population of nursing students across all secular and religious groups in Dutch society. -Did not sample non-Christian participants.	Level IV	A

Article abbreviated title	***First Author & Year***	***Evidence Type***	***Sample, Sample Size, Setting***	***Findings that help answer clinical question***	***Limitations***	***Evidence Rating†***	
						Level/ Quality	
		instrument, the spiritual care competence scale, as an instrument to assess nurses' competencies in providing spiritual care.		-The finding of this study developed a spiritual care competency scale to measure a nurses knowledge and understanding of spiritual care.			

†Use John Hopkins Evidence Level and Quality Guide

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Appendix B

Level of Evidence Synthesis Table

Article Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Level I: Systematic review or meta-analysis		**X**							
Level II: Randomized controlled trial									
Level III: Controlled trial without randomization				**X**					
Level IV: Case-control or cohort study								**X**	**X**
Level V: Systematic review of qualitative or descriptive studies									
Level VI: Qualitative or descriptive study, CPG, Lit Review, QI or EBP project	**X**		**X**		**X**	**X**	**X**		
Level VII: Expert opinion									

†Use John Hopkins Evidence Level and Quality Guide

Table B2. Outcomes Synthesis Table

Article Number	1	2	3	4	5	6	7	8	9
Spiritual education found being beneficial	X	X	X	X	X	X	X	X	X
Not Beneficial									
Other findings									

Appendix C

Spiritual Care Competency Scale

(0= None 1=Strongly Disagree 2=Disagree 3-Neutral 4- Agree 5- Strongly Agree)

1.I am open to a patient's spiritual/religious beliefs, even if they differ from my own
0-1-2-3-4-5

2. I am aware of my personal limitations when dealing with a patient's spiritual/religious beliefs
0-1-2-3-4-5

3. I can listen actively to a patient's 'life story' in relation to his or her illness/handicap
0-1-2-3-4-5

4. I have an accepting attitude in my dealings with a patient (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere and personal)
0-1-2-3-4-5

5. I can report orally and/or in writing on a patient's spiritual needs
0-1-2-3-4-5

6. I can tailor care to a patient's spiritual needs/problems through multidisciplinary consultation
0-1-2-3-4-5

7. I know when I should consult a spiritual advisor concerning a patient's spiritual care
0-1-2-3-4-5

8. I can help a patient continue his or her daily spiritual practices (including providing opportunities for rituals, prayer, meditation, reading the Bible/Koran, listening to music)
0-1-2-3-4-5

9. I can attend to a patient's spirituality during the daily care (e.g. physical care)

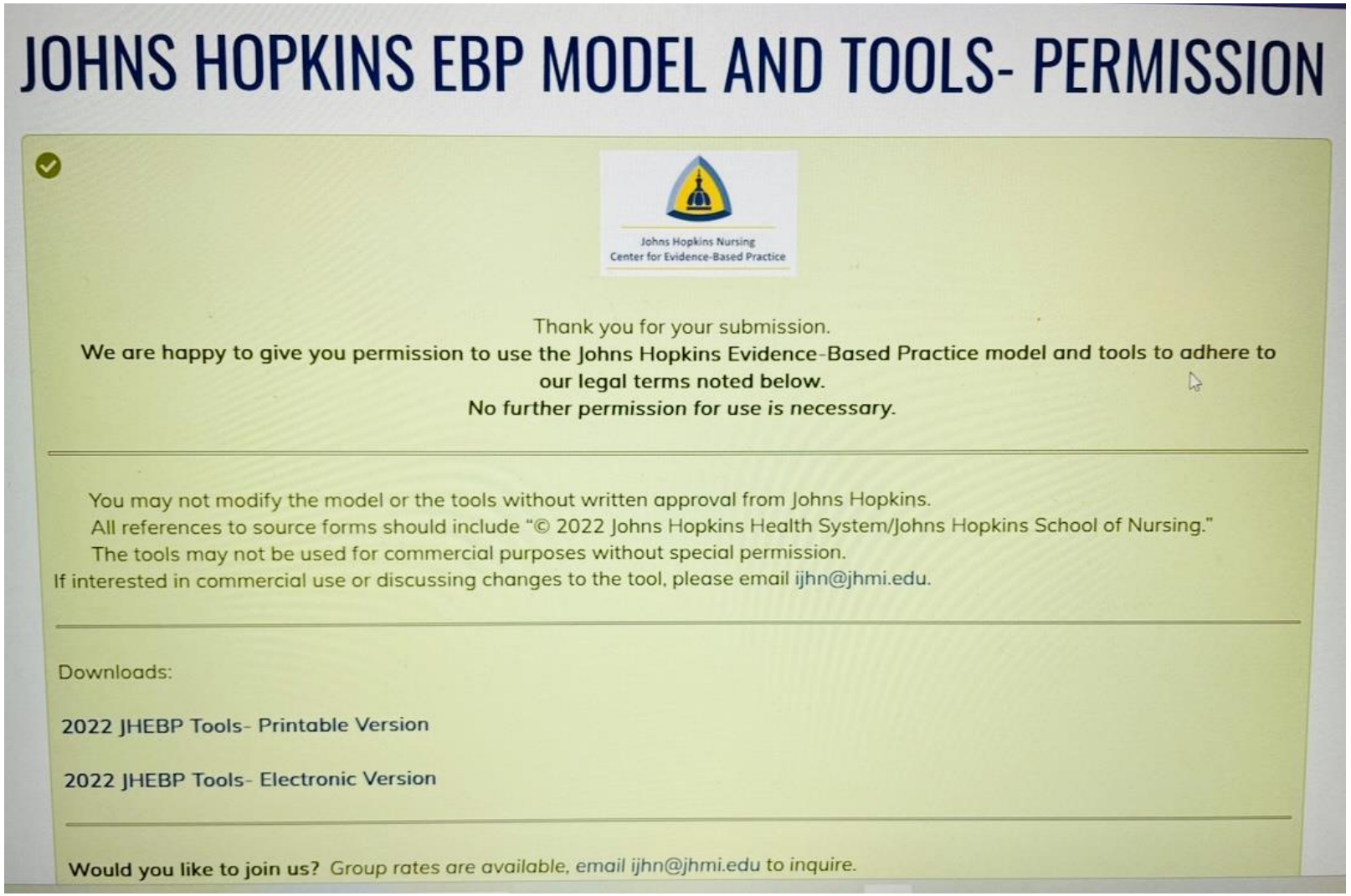
0-1-2-3-4-5

10. Within the department, I can contribute to quality assurance in the area of spiritual care.
0-1-2-3-4-5

Source:

van Leeuwen, R., Tiesinga, L. J., Middel, B., Post, D., & Jochemsen, H. (2009). The validity and reliability of an instrument to assess nursing competencies in spiritual care. Journal of Clinical Nursing, 18(20), 2857- 2869. https://doi.org/10.1111/j.13652702.2008.02594.x

Appendix D


JOHNS HOPKINS EBP MODEL AND TOOLS- PERMISSION
Johns Hopkins Nursing
Center for Evidence-Based Practice
Thank you for your submission.
We are happy to give you permission to use the Johns Hopkins Evidence-Based Practice model and tools to adhere to our legal terms noted below.
No further permission for use is necessary.
You may not modify the model or the tools without written approval from Johns Hopkins.
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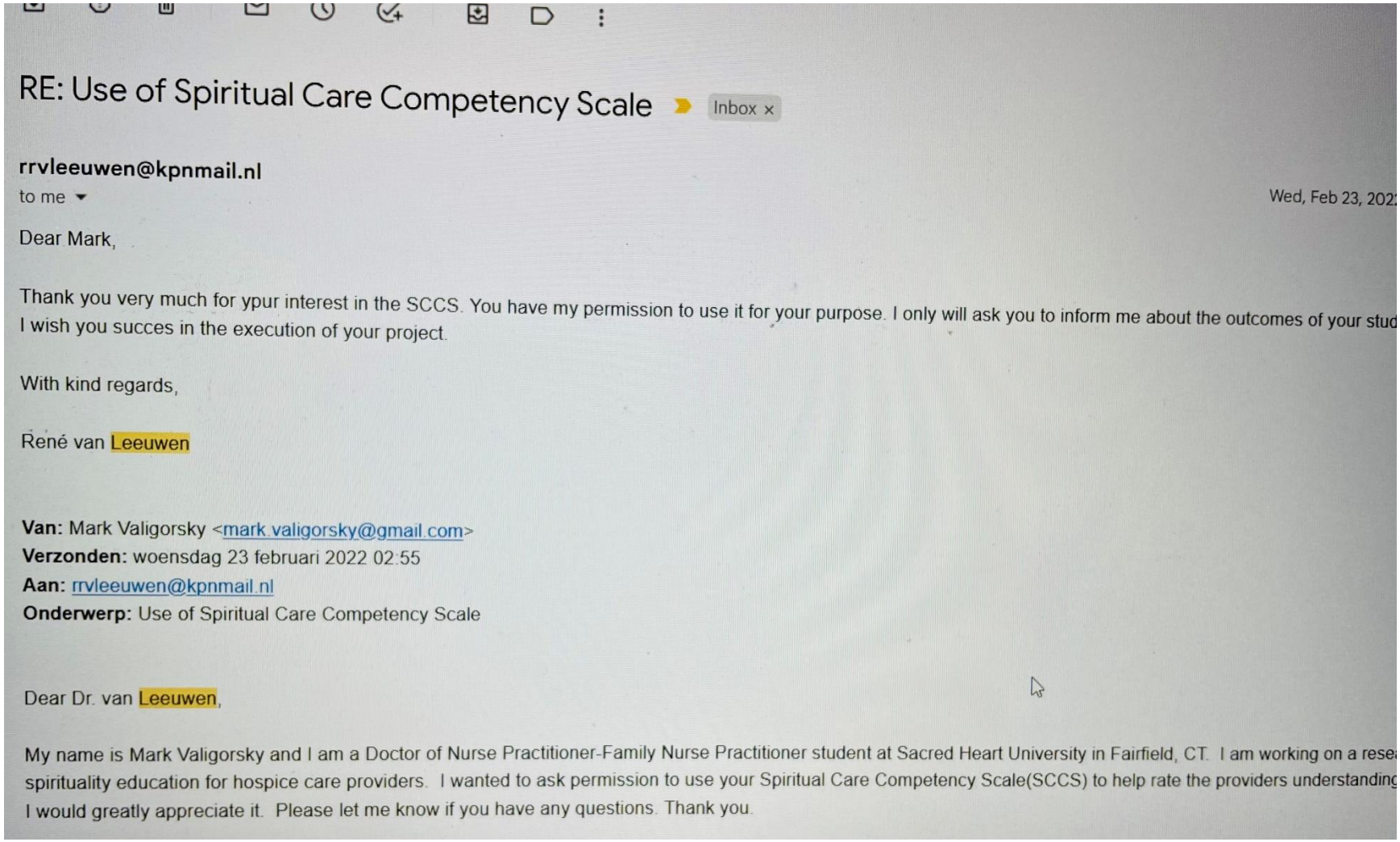
Downloads:
2022 JHEBP Tools- Printable Version
2022 JHEBP Tools- Electronic Version
Would you like to join us? Group rates are available, email ijhn@jhmi.edu to inquire.

Appendix E



RE: Use of Spiritual Care Competency Scale Inbox ×

rrvleeuwen@kpnmail.nl
to me Wed, Feb 23, 202

Dear Mark,

Thank you very much for ypur interest in the SCCS. You have my permission to use it for your purpose. I only will ask you to inform me about the outcomes of your stud
I wish you succes in the execution of your project.

With kind regards,

René van Leeuwen

Van: Mark Valigorsky <mark.valigorsky@gmail.com>
Verzonden: woensdag 23 februari 2022 02:55
Aan: rrvleeuwen@kpnmail.nl
Onderwerp: Use of Spiritual Care Competency Scale

Dear Dr. van Leeuwen,

My name is Mark Valigorsky and I am a Doctor of Nurse Practitioner-Family Nurse Practitioner student at Sacred Heart University in Fairfield, CT. I am working on a rese
spirituality education for hospice care providers. I wanted to ask permission to use your Spiritual Care Competency Scale(SCCS) to help rate the providers understanding
I would greatly appreciate it. Please let me know if you have any questions. Thank you.

Appendix F

PT **Prof. Christopher B. Taber** 2/10/23

To: Mark Cc: Feride, Madeline >

IRB#230210A - Exempt Status Request

Dear Applicant,
Thank you for your submission to the IRB requesting exempt review. Based on the application submitted, the IRB is pleased to approve your submission and we wish you great success in your research.

Sincerely,
Christopher Taber
Chair, IRB

Christopher B. Taber, PhD, CSCS*D, USAW3, EP-C, PES
Director, Exercise and Sport Science M.S. Program
Associate Professor
College of Health Professions
Sacred Heart University
(203) 396-6342

Appendix G

DR. SUSAN L. DAVIS, R.N., & RICHARD J. HENLEY COLLEGE OF NURSING
Sacred Heart University

Mark Valigorsky
DNP-FNP Program

Spirituality Education for the Interdisciplinary Care Team in End of Life Care

DR. SUSAN L. DAVIS, R.N., & RICHARD J. HENLEY COLLEGE OF NURSING
Sacred Heart University

INTRODUCTION AND PURPOSE

Clinician-Spirituality Self Evaluation
https://s.surveyplanet.com/v5w10502

Purpose: To provide EOL clinicians with additional spirituality education

DR. SUSAN L. DAVIS, R.N., & RICHARD J. HENLEY COLLEGE OF NURSING
Sacred Heart University

OBJECTIVES

Define compassion, spirituality, spiritual health, and spiritual distress

Articulate indicators and signs of spiritual distress in End of Life(EOL) patients

Barriers for Hospice health care providers

Review how Spiritual Care is expressed in the clinical setting and implications for practice.

DR. SUSAN L. DAVIS, R.N., & RICHARD J. HENLEY COLLEGE OF NURSING
Sacred Heart University

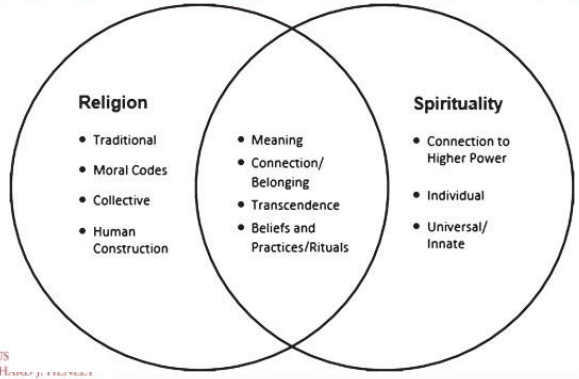
COMPASSION

Author Viktor Frankl writes *compassion* means "to suffer with." Compassionate care calls others to walk with people in the midst of their pain, to be partners with patients rather than experts dictating information to them.

One of the challenges clinicians face is to help patients find meaning and acceptance in the midst of suffering and chronic illness.

Ethicists have reminded us that religion and spirituality form the basis of meaning and purpose for many people(Puchalski, 2001).

Religion	Spirituality
Set of beliefs and practices associated with a recognized religion or denomination (Zumstein-Shaha, Ferrell, and Economou 2020).	Spiritual health often includes six aspects: an individual's relationship with her/himself, with others, and with the environment; his or her beliefs; the ability to overcome adversity; and the meaning of life(Hu, Jaio, and Li 2019).
Condemned Vs Saved	
Traditions/Sacraments that need to be provided to the patient	A sense of connectedness, purpose, meaning and 'transcendence of self



SPIRITUALITY(CON'T)

Spirituality related to finding meaning. Who we are, what we believe, what we value (Zumstein-Shaha, Ferrell, and Economou 2020) .

Related to seeking inner well-being, inner-peace.

A patient's spirituality and religion help her/him cope better with stress, chronic disease, cancer, relationships, and life.

Spiritual care is recognized as an essential component of holistic nursing care that should be provided to all patients. Providing Spiritual Care and meeting Spiritual Care needs are linked to improved health outcomes, improved quality of life, increased patient satisfaction, and better coping for patients and families (Gijsberts et al. 2019) .

SPIRITUAL DISTRESS

Spiritual Distress is defined as "the impaired ability to experience and integrate meaning and purpose in life through connectedness with self, other, art, music, literature, nature, and/or power greater than oneself"(Klimasiński, Baum, Praczyk , Ziemkiewicz , Springer, Cofta, & Wieczorowska-Tobis, K., 2022).

Separation and disconnection are the primary experiences of a spiritual struggle.

To feel separated from one's relationship with God, separated from one's beliefs or practices related to those beliefs resulted in feelings of upset, despair, hopelessness, and loneliness(Fitch and Bartlett, 2019).

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GRIEF AND BEREAVEMENT

Avis, Stroebe, andSchut define five stages of Grief:

- Denial and Isolation
- Anger
- Bargaining
- Depression
- Acceptance

Other stages: shock, numbness, isolation, new patterns, isolation

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SIGNS OF SPIRITUAL DISTRESS

Spiritual Pain
- Why is this happening to me?
- What doesall of this mean?

Spiritual Alienation
- Feeling abandoned by God or others.
- Where is God when I needHim/Her most?
- I can do it myself!

Spiritual Anxiety
- I think God is punishing me. Why else would I have this disease/illness/cancer?
- Afraid of dying.

Spiritual Despair/Hopelessness
- What hope do I have? God doesn't care.
- I stopped praying. God is not listening.

Spiritual Guilt
- Feeling guilty or ashamed of something they have done.
- I haven't exactly led a "good life.".
- I should have lived my life better.

Spiritual Anger
- I want nothing to do with God. He has nothing to offer.
- If God is good and loving, why is he allowing this to happen?

Spiritual Loss
- I don't think God loves me .
- I don't feel God's love anymore.

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BARRIERS ENCOUNTERED BY CLINICIANS

Healthcare providers uncomfortable and not confident asking about Spiritual Care

Healthcare providers unclear knowledge of accessing resources

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STRATEGIES FOR REFERRING TO SPIRITUAL CARE

Spiritual Care/Chaplain assisting Healthcare provider with admission assessment

Healthcare provider/Patient identifies Spiritual Issues such as guilt, shame, anger, regret, fear, isolation, loneliness, grief, post traumatic stress syndrome(PTSD).

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CASE STUDY DISCUSSION

- *What was the nurse's clue that Ron may be experiencing spiritual distress?*
- *How might Ron's behavior display itself?*
- *What spiritual distress issues would you identify?*

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SPIRITUALITY CASE STUDY #1

Ron is a67 year-old male diagnosed with stage four colon cancerDuring the admission visit, the nurse is reviewing the plan of care. Ron comments, "I just don't know what to do anymore."

Realizing Ron is probably feeling overwhelmed, the nurse pauses and assures Ron that he has time to reflect with him about his choices. The nurse and Ron agree on a social work and spiritual care services referral for moderate spiritual distress related to conflict between beliefs and treatment options.

The social worker follows up with Ron.During their meeting Ron reflects on his quality of life and no longer having the quality of life that he lived before the diagnosis. He misses running, hiking, fishing, and being able to get outdoors.

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SPIRITUALITY CASE STUDY #2

Jennifer is a47 year-old female diagnosed with breast cancer. She has gone through surgery, chemotherapy, and the cancer has returned and found spread to multiple organs.

Since her diagnosis, she seems more emotionally withdrawn than usual. (more quiet, not engaging in conversation, little eye contact, depressed). Thinking the patient is having a grief reaction, the nurse has referred the patient to a social worker for counseling. The social worker follows-up with the patient and agrees with the nurse's assessment that the patient is experiencing grief and loss. The social worker refers Jennifer to the chaplain services to provide additional support.

During the chaplain's assessment, Jennifer shares the fact that her older sister was also diagnose with breast cancer, and she had died 3 years ago.

Jennifer recalls encouraging her sister to "fight the disease" and to overcome her symptoms. No that Jennifer is experiencing the cancer personally, she realizes her approach with her sister ma not have been helpful, and she feels guilty.

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CASE STUDY DISCUSSION

- What were the indicators that Jennifer may be experiencing spiritual distress?
- What spiritual distress is Julie experiencing?
- Were there any surprises for you?
- Have you seen "Jennifer" in your clinical practice? What does this patient look like?

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TAKE HOME POINTS

Define Spirituality and Religion

Identify signs of Spiritual Distress that warrant a Spiritual Care Follow Up

Questions?

Posttest

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BENEFITS OF SPIRITUAL CARE

Decreased anxiety, depression and discomfort → Increased Coping

Increased health outcomes → Increased healthcare decision - making

Decreased isolation → increased ability to enjoy life

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SPIRITUAL CARE INTERVENTIONS FOR CLINICIANS

- **Compassionate presence**
- **Reflective listening/query about important life events**
- **Support patient sources of spiritual strength**
- **Open ended questions**
- **Inquiry about spiritual beliefs, values and practices**
- **Life review, listening to the patient's story**
- **Targeted spiritual intervention**
- **Continued presence and follow up***

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Appendix H

Executive Summary

Palliative and hospice care continues to be one of the most under-utilized medical services for patients with chronic diseases. It provides holistic end of life (EOL) care to patients and their families in a critical and stressful time. Spiritual care for EOL patients is one of the essential domains of care. Subjects such as religion, religious denominations, beliefs, patient's spirituality and spiritual beliefs tend to be uncomfortable subjects for EOL staff to engage their patients in. EOL staff have little to no training on spirituality and providing spiritual care to their patients. An educational tool is needed to train and cultivate EOL staff on spirituality. Ongoing research on spirituality education continues to show an increase in knowledge and engagement of spirituality with EOL patients. Speaking with the hospice director at the local hospice agency, she identified spirituality as a needed area for support for the staff and its patients. The local hospice agency is committed to providing holistic and inclusive care to its patients. This instruction is provided in its orientation.

A pretest and posttest were used to assess clinicians' knowledge on spirituality. The pretest was taken before the educational intervention to assess clinicians' knowledge, competence, and comfort on providing spiritual care to her/his patients. The same assessment was used for the posttest. This pretest assessment was to serve as a baseline to compare the clinician knowledge after the educational intervention. The survey that was used to assess EOL clinicians was the Spiritual Care Competency Scale (SCCS). The SCCS was created by Rene van Leeuwen and was designed to measure clinicians' knowledge in providing spiritual care in patients. The pretest and posttest SCCS questionnaire consist of 10 questions about spirituality that evaluate the participant's understanding. The SCCS questionnaire measures six core

domains of spiritual care-related nursing competencies. Clinicians were initially given the SCCS to assess themselves and their current knowledge on spirituality. The local hospice agency is composed of different hospice teams. All of the teams participated in the pretest, educational intervention, and one-week and eight-week posttests to create a good sampling.

The pretest assessment served as a baseline to compare the clinician knowledge after the educational intervention. One-week posttest results compared to the pretest showed an increase in knowledge and competence among the EOL clinicians. The eight-week posttest results showed sustained results among clinicians' responses on the SCCS survey. Examining the one-week and eight-week posttest results, clinicians responded that they could attend to a patient's spiritual needs and contribute to the organization's goal of providing spiritual care.

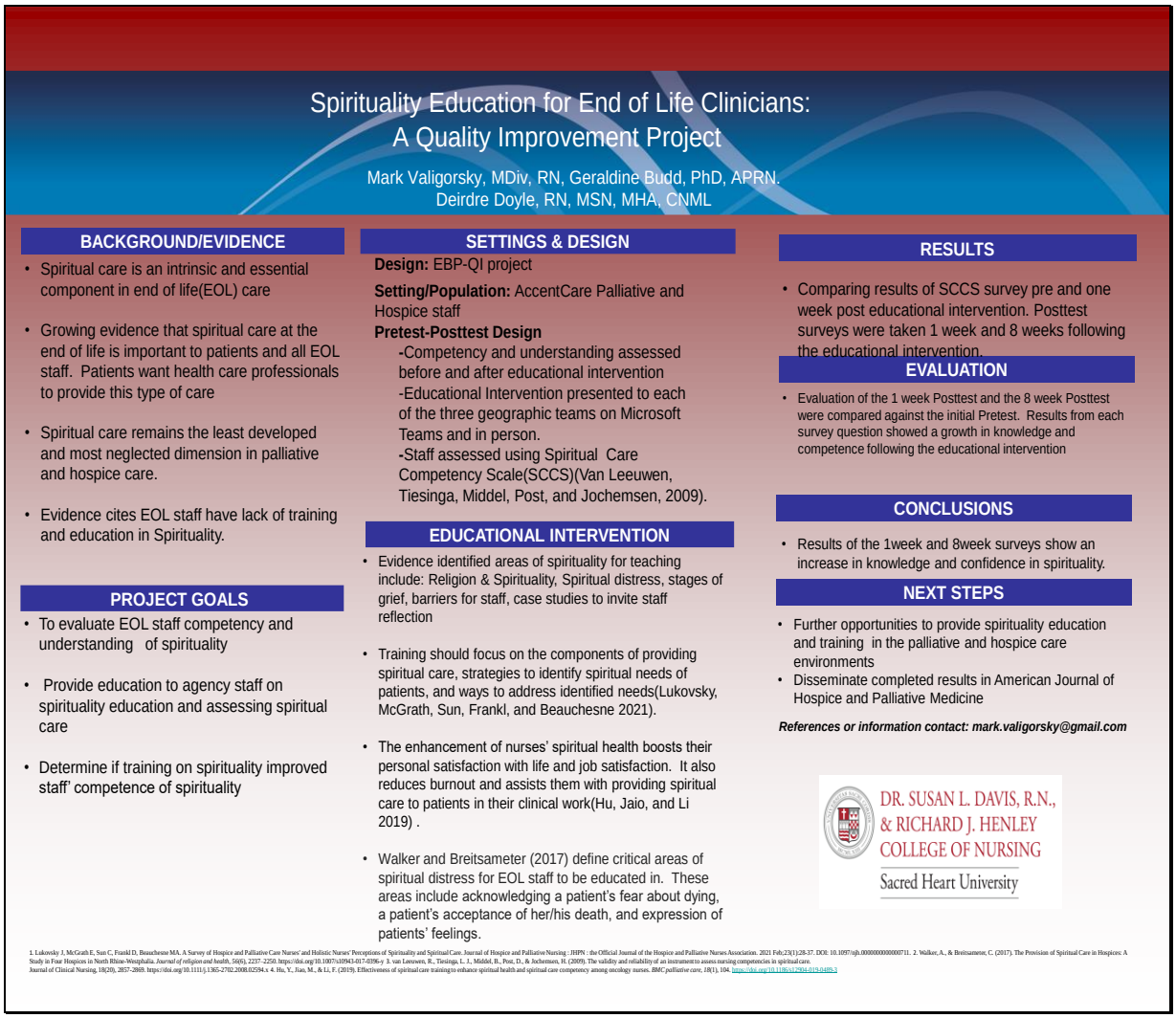
The educational intervention was given to the hospice director and to the teams' chaplains to continue to be sustained as a tool for teaching staff about spirituality. The initial presentation was also recorded to provide the education to future staff. One barrier to implementation was limited amount of time to provide the educational intervention. EOL clinicians are often on the go, like any healthcare worker. Time is the most precious resource. The educational intervention had to be concise and to the point with its delivery and content. Early discussion with staff about the project was widely accepted as clinicians expressed hesitation in engaging patients with their spiritual beliefs.

In summary, this project was designed to provide the education necessary to support spiritual health care delivery by clinicians in the EOL setting. EOL organizations must seek to provide further education to improve approaches related to spirituality. The return on investment could be viewed in three ways. One way is more knowledgeable staff who are confident in engaging patients and families on their spirituality. The second measure is greater engagement

of a patient's spirituality. The third measure on return on investment is greater patient and family satisfaction with the EOL services. This training serves to provide better quality of care for EOL patients in their most needed time of life.

Appendix I

Poster Presentation



Spirituality Education for End of Life Clinicians: A Quality Improvement Project

Mark Valigorsky, MDiv, RN, Geraldine Budd, PhD, APRN.
Deirdre Doyle, RN, MSN, MHA, CNML

BACKGROUND/EVIDENCE

- Spiritual care is an intrinsic and essential component in end of life(EOL) care
- Growing evidence that spiritual care at the end of life is important to patients and all EOL staff. Patients want health care professionals to provide this type of care
- Spiritual care remains the least developed and most neglected dimension in palliative and hospice care.
- Evidence cites EOL staff have lack of training and education in Spirituality.

PROJECT GOALS

- To evaluate EOL staff competency and understanding of spirituality
- Provide education to agency staff on spirituality education and assessing spiritual care
- Determine if training on spirituality improved staff' competence of spirituality

SETTINGS & DESIGN

Design: EBP-QI project

Setting/Population: AccentCare Palliative and Hospice staff

Pretest-Posttest Design

-Competency and understanding assessed before and after educational intervention
-Educational Intervention presented to each of the three geographic teams on Microsoft Teams and in person.
-Staff assessed using Spiritual Care Competency Scale(SCCS)(Van Leeuwen, Tiesinga, Middel, Post, and Jochemsen, 2009).

EDUCATIONAL INTERVENTION

- Evidence identified areas of spirituality for teaching include: Religion & Spirituality, Spiritual distress, stages of grief, barriers for staff, case studies to invite staff reflection
- Training should focus on the components of providing spiritual care, strategies to identify spiritual needs of patients, and ways to address identified needs(Lukovsky, McGrath, Sun, Frankl, and Beauchesne 2021).
- The enhancement of nurses' spiritual health boosts their personal satisfaction with life and job satisfaction. It also reduces burnout and assists them with providing spiritual care to patients in their clinical work(Hu, Jaio, and Li 2019) .
- Walker and Breitsameter (2017) define critical areas of spiritual distress for EOL staff to be educated in. These areas include acknowledging a patient's fear about dying, a patient's acceptance of her/his death, and expression of patients' feelings.

RESULTS

- Comparing results of SCCS survey pre and one week post educational intervention. Posttest surveys were taken 1 week and 8 weeks following the educational intervention.

EVALUATION

- Evaluation of the 1 week Posttest and the 8 week Posttest were compared against the initial Pretest. Results from each survey question showed a growth in knowledge and competence following the educational intervention

CONCLUSIONS

- Results of the 1week and 8week surveys show an increase in knowledge and confidence in spirituality.

NEXT STEPS

- Further opportunities to provide spirituality education and training in the palliative and hospice care environments
- Disseminate completed results in American Journal of Hospice and Palliative Medicine

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