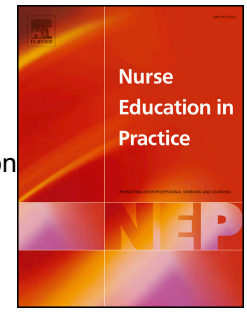

Design and development of a spiritual care competency framework for pre-registration nurses and midwives: A modified Delphi study

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DESIGN AND DEVELOPMENT OF A SPIRITUAL CARE COMPETENCY FRAMEWORK FOR PRE-REGISTRATION NURSES AND MIDWIVES: A MODIFIED DELPHI STUDY

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Conflict of interest statement

The authors have no conflict of interest to declare.

Abstract

This is the second of two papers reporting the development of a spiritual care competency framework for pre-registration nurses and midwives as part of a PhD study using an embedded sequential mixed methods eclectic research design. The first paper outlines how 116 competency items were generated from an in-depth review of international literature. It offers a theoretical model to underpin development of the Framework. Aim: This paper reports how the Framework was developed. Method/Results: Five focus groups were held with stakeholders in Malta (chaplains/spiritual leaders, undergraduate nursing/midwifery educators, qualified nurses/ midwives, parents/carers, patients/clients) to ensure that aspects of spirituality/spiritual care important to them, but not identified in the literature review, were included in the Framework. The resulting 55 competencies in seven domains formed the Delphi Questionnaire which was validated using a two round modified Delphi method involving experts from Malta. The final seven domain 54 item Framework demonstrated good to strong internal consistency, stability and a good fit with a six factor model. Conclusion: The Framework's greatest immediate contribution is in its ability to inform undergraduate nursing/midwifery spiritual care curriculum design and delivery. Further development of the Framework could assist in student selection ensuring that the 'art' of nursing/midwifery has parity with the 'science'.

Highlights

- The first pre-registration Spiritual Care Competency Framework was developed for nurses/midwives
- The Framework is informing design/delivery of spiritual care education programmes across Europe.

Keywords

Spirituality, Spiritual care competency, Modified Delphi, Spiritual care education

BACKGROUND

Spirituality is fundamental to the human condition (Puchalski et. al. 2009). Not necessarily linked to religious belief, this refers to a person's deep-seated sense of self, meaning, purpose and connection with self, others and the transcendent (RCN, 2011; WHO, 2006). Spirituality impacts on health, wellbeing and quality of life (Koenig et. al. 2012), is important to patients/clients internationally (Ross,

2006; Selman et. al. 2017) and is part of international healthcare guidance and policy (European Association for Palliative Care [EAPC] http://www.eapcnet.eu/ no date; World Health Organisation, 2006).

In recognition of the importance of spiritual, religious and cultural aspects of people's lives on their wellbeing, the European Commission (2010) recommends that the caring professions are educated in this respect. Nurses and midwives are obvious examples of the caring professions and spiritual care is written into international nursing and midwifery Codes of Ethics (ICM, 2014; ICN, 2012) and education guidelines (NMC, 2018). Practising nurses see spiritual care as part of their everyday practice, but international evidence shows that they feel unprepared for it requesting more education (Egan et. al. 2017; Schep-Akkerman and van Leeuwen 2009; RCN, 2011). Stand-alone educational programmes claim to improve students' understanding of spiritual care (van Leeuwen et. al. 2008; Cooper et. al. 2013; Attard et. al. 2014) but are limited by cross sectional single centre design involving small samples. The importance of students having role models for spiritual care in the clinical area has also been highlighted (Giske, 2012; Giske and Cone 2012).

Education on the topic of spirituality is variable both in quantity, content and delivery with some programmes having little or no identifiable component (Lewinson et. al. 2015). This may be because of competition for space in already packed curricula combined with uncertainty about what spirituality means (Swinton, 2006), what spiritual care looks like and therefore what would constitute suitable content and assessment. Research has only just begun to explore the factors contributing to spiritual care competency development, highlighting what might be important for education. The only prospective, longitudinal study of its kind, involving 2193 nursing/midwifery undergraduate students from 21 universities in eight European countries, identified that students' personal spirituality and perception of spirituality were significantly related to their self-rating of perceived spiritual care competency which increased over time (Ross et. al. 2018). Caring for patients, university teaching/discussion and life events were identified by students as important for their learning (Ross et. al. 2018).

The conflicting stance of some regulatory bodies with regard to the importance of spirituality within nursing and midwifery may be an additional reason for inconsistent inclusion of the topic in education programmes.. For example in the UK the Nursing and Midwifery Council (NMC) states that:

'Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical…and spiritual needs. They use information obtained during assessments…..to develop person-centred care plans ……that take account of their….preferences' (NMC, 2018, p13).

Yet the NMC is reluctant to include the spiritual within its Code of practice (NMC, 2015) opting for a tripartite biopsychosocial model of care (p5) rather than an holistic one (McSherry and Ross 2015; Smith, 2015).

Another reason for the inconsistent inclusion of spirituality within pre-registration nurse/midwifery education programmes could be because no competencies exist for spiritual care at point of registration. This doctoral study seeks to address this gap in knowledge by developing a spiritual care competency framework for pre-registration nurses and midwives.

The PhD study adopted an embedded sequential mixed methods eclectic research design using a Modified Delphi approach. First, 116 competency items were generated and arranged in 7 domains from an extensive review of the international literature in three discrete areas using Braun & Clarke's (2006) adapted six-phase content thematic analysis: spirituality and spiritual care, spiritual care in nursing/midwifery education and spiritual care curricular content and is described in detail in Attard et. al. (2019). The seven domains were:

1. A body of knowledge in spiritual care
2. Self-awareness in spiritual care
3. Interpersonal relationships and communication
4. Ethical and legal issues in spiritual care
5. Assessment and implementation of spiritual care
6. Quality assurance in spiritual care
7. Informatics in spiritual care

Next, a theoretical model was constructed to underpin the development of the spiritual care competency framework. How that Competency Framework was developed and validated is the focus of this paper.

STUDY AIM

To develop and validate a spiritual care competency framework for undergraduate nurses and midwives.

METHODS, ANALYSIS AND RESULTS

The spiritual care competency framework (hereon in referred to as the Framework) was developed using focus groups with key stakeholders to augment the 116 competencies already identified from the literature review (step 1). It was then validated using a Modified Delphi approach (step 2). Because the methods were sequential, each method and the analysis and results pertaining to it, are presented in turn.

Ethical approval

Ethical approvals were obtained from the Universities and from the hospital in Malta from which participants were recruited.

Step 1: Further development of the competency framework using focus groups

Rationale for focus groups

It was considered important to consult with stakeholders about their views on spirituality and spiritual care to ensure that aspects important to them, but not identified from the literature, were also included in the competency framework.The focus group method was chosen for this consultation for a number of reasons. The method originates from a non-positivist paradigm and the qualitative data are generated through an inductive approach with experts in the field (Babbie and Mouton, 2001). In-depth data are generated which incorporate the experience, values and needs of stakeholders by discussing the phenomenon from the participants' point of view (Polit and Beck, 2014). The main aim of the focus group is to encourage divergent thinking and to encourage the disclosure of personal perceptions. It also offers the opportunity to explore meanings, beliefs and cultural nuances that may influence the feelings, attitudes and behaviours of individuals through their lived experiences.Thus, the use of focus groups in this study was deemed appropriate in order to:

 Obtain information from different groups of participants on their views, experiences and attitudes in relation to the topic of spirituality and spiritual care.

 Clarify participants' experiences and perceptions of spirituality, spiritual needs and spiritual care in times of illness, loss and other life stressors.

 Support the information generated from the literature review.

Sampling and data collection

Purposeful snowball sampling was used to recruit participants (n=46) resident in Malta (selected for practical reasons as there is one university and one state hospital) to one of five focus groups of 6-10 participants each (Finch and Lewis, 2003). Focus groups consisted of: chaplains/spiritual leaders (n=10, representing: Catholic church, Church of Scotland, Church of England, Baptist church, Coptic Orthodox, Islam, Judaism, Jehovah Witnesses), undergraduate nursing/midwifery educators (n=11), qualified nurses (surgical, medical, mental health) and midwives (n=9), parents/carers who experienced loss/life limiting conditions (n=9), and patients/clients (medical, surgical, mental health, maternity, n=9). Participants were given one of six case studies (relevant to the group, see example in Box 1) and discussion was facilitated (by JA, DB) around two questions: 'what are clients' spiritual needs?' and 'what does the nurse/midwife need to know, think and do to meet those needs?'

Box 1: A case study example

Scenario 1
Eric Jenkins is a 34 year old male with a past medical history of depression. He has had some treatment for his depression and prescribed medicine which he is currently not taking. He presents to the Emergency Department with the complaint of wanting

to jump off a cliff and kill himself.
''What am I living for? I went from being an 'A' student to a loser. There is nothing more for me'' he whispers softly between tears. He tells his nurse that he has been drinking gin. He stopped a by passer who brought him to hospital before he acted on impulse.
Eric is an only son and has been the sole caregiver of his elderly mother and father for about 10 years. He tells his nurse that taking care of his parents has been 'his life'. His father died about 4 years ago. He continued taking care of his mother after his father died but was devastated 6 months ago when his mother died. He is now saying 'I have no purpose to my life." He looks very sad and continues to gaze downward. When he looks at you his eyes clearly show that he is asking for help. Eric believes in God, reads the Bible regularly, thinks that if you ''live a good life according to the Bible then things will go well for you''. He belongs to a non-denominational Christian church He used to go to church regularly, but not so much lately.

Questions:
What are the spiritual needs of Eric in this story?
What does the nurse need to know, be able to do, or think, in order to meet these needs?

Data analysis and results

Data were analysed as follows:

-Sessions were recorded and transcribed and detailed notes were taken.

-Validation of the accuracy of the transcripts as a true account of the discussions was obtained through feedback from 10 participants across the five focus groups. Maltese transcripts (from focus groups with nurses/midwives and clients/carers) were translated into English by a professional linguist. Both the English and Maltese versions were examined by a moderator who confirmed the accuracy of the translation.

-The transcripts and notes were read and re-read to ensure familiarisation with the data. They were coded and categories, sub-categories and themes were identified using Krueger and Casey's (2009) framework.

-Duplicate and similar categories to those already identified from the literature were removed resulting in a list of new themes and categories as shown in Table 1.

Table 1 here

Following removal of duplicates and merging of similar concepts the 170 competencies identified from the literature review and focus groups were collapsed to 55, and arranged in 7 emergent domains; this formed the Modified Delphi Questionnaire (Table 2) to be validated in the next stage.

Table 2 here

Step 2: Validation of competency items and domains using modified Delphi

Rationale for Modified Delphi

There is ongoing epistemological debate about the pros and cons of the Delphi method in terms of its rigour, concerns about artificial divergence in responses giving rise to false consensus (Hassan and Keeney, 2011), and identifying who the 'real experts' are (Landeta, et. al. 2011). Consequently, continual modifications are being made with multiple types of Delphi methods being available. Delphi was however, considered the most appropriate method for reaching consensus amongst the wide range of stakeholder groups in this study, where each group had its own clearly defined set of criteria to be considered as 'expert'.

Sampling and data collection.

The aim of this next stage was to ask experts to evaluate the competency statements and domains listed in the Modified Delphi Questionnaire (Table 2) using a two round modified Delphi process (Keeney, et al 2006) based upon Lockean inquiry (Mitroff and Turoff 1975) and Couper's (1984) Sequence Model. 'Experts' (n=271) in spiritual care were recruited from a hospital in Malta (using Polit and Beck's 2014 process) by purposeful and snowball sampling on the basis of their knowledge and experience of spiritual care guided by the theories: 'fundamental ways of knowing' (Carper, 1978), 'from novice to expert' (Benner, 1984) and the 'Spiritual Care Competency Scale' (SCCS) (van Leeuwen et. al. 2009). Figure 1 shows the 10 groups of experts from Malta included and explains the criteria for their selection. For each of the 55 items in the questionnaire, participants were asked 'To what extent do you think that newly qualified nurses and midwives should demonstrate these competencies (knowledge, skills and attitude)?'They rated each item on a 7-point Likert scale from 'not at all important = 1' to 'extremely important = 7'. Of 760 individuals invited to take part, 271 agreed to participate of which 241 completed the questionnaire in round 1 (R1) and 205 completed the questionnaire in round 2 (R2).

Figure 1 here

Analysis

Data analysis involved computing the mean, standard deviation, 95% confidence interval of the population mean and the percentage agreement for each competency item. Consensus for retaining an item was achieved if more than 75% of participants rated the item as 5, 6 or 7 (indicting moderate to strong agreement) on the 7 point Likert scale in both Delphi rounds.

Following Delphi Round 2 the competency Framework was tested for construct validity by Exploratory Factor Analysis (EFA) (Bryman and Cramer, 2001) involving 3 stages. In stage 1, factor extraction, highly interrelated variables in the correlation matrix were condensed into factors using Spearman's correlation co-efficients (Pett et. al. 2003). Cattell's (1966) Scree Test was used to determine the number of factors to be retained using a cut off point for factor extraction at eigen values greater than 1.00 (Russell, 2000). In stage 2, the factors were rotated, kappa (*k*) coefficients were calculated. In stage 3 the factor loadings were estimated by counting the low (-0.10 to +0.10) factor loadings on the set of factors from the factor pattern matrix. Those variables with loadings of at least 0.40 on at least one factor were retained. The items were also assessed for cross loading. Although there is no consensus about the strategy to use when items cross load, the item which cross loaded was assigned to the factor to which it appeared to be theoretically related (Pett et. al. 2003). Following factor analysis, the three items with the highest loading on each factor were identified as these shared more variance with the factor than items with lower loadings (Pett et. al. 2003). They were interpreted in relation to the results of the Modified Delphi and named accordingly. When more than three items loading on a factor were labelled as undefined, this was considered to be a new factor.

Results

Consensus

54 competency items achieved the pre-determined 75% level of consensus by the end of Round 2.The majority of items (n=27) scored above 90% and 25 items scored higher than 80% level of agreement. With the exception of Item 55 (which was subsequently removed), all items had a mean rating score significantly higher than 5 since the lower 95% confidence limit of the population mean rating score was above 5. This implies that the population mean rating score of these items was more than 1 scale point higher than the middling rating score 4.

Internal consistency

According to George and Mallery (2003) a Cronbach α coefficient of 0.8-0.9 is 'good' and above that is 'excellent'. The total competency domains and competency items obtained a Cronbach α of 0.97 indicating homogeneity of the framework across time.The individual 7 domains and the respective competency items had Cronbach α coefficients of 0.79 to 0.93 indicating good to strong internal consistency.

Stability

Spearman's test indicated very high correlations between R1 and R2 (0.9 to 1) for 23 items and high correlations (0.7 - 0.89) for 31 items. Only one item had a moderate correlation coefficient (0.5 - 0.69) (Item 35: rs = 0.554). The framework was therefore considered to be stable.

Exploratory factor analysis

Results from the exploratory factor analysis showed a good fit of a six factor model which included five of the seven domains: Domain 1 Body of knowledge in spiritual care; Domain 4 Ethical and legal issues in spiritual care; Domain 5 Quality assurance in spiritual care; Domain 6 Assessment and

implementation of spiritual care; Domain 7 Informatics in spiritual care. A new 6th factor emerged, called 'healthcare chaplaincy' which related to referral to chaplains and spiritual leaders, and may reflect the religious culture of Malta. Items in Domain 2 'self-awareness and the use of self' and Domain 3'communication and interpersonal skills' were not defined as these loaded on various other factors so were merged throughout. Only two items (8 and 24) cross loaded on another factor, while five competency items scored <0.4 on the rotated factor loading.

The final Spiritual Care Competency Framework has 54 competencies (item 55 removed) arranged in seven domains as illustrated in Table 2.

DISCUSSION

The Spiritual Care Competency Framework

This study is novel in that it has developed the first pre-registration spiritual care competency framework for nurses and midwives from an extensive review of the international literature and from focus groups with a wide range of stakeholders in one country (Malta). It demonstrated good to strong internal consistency, stability, a good fit with a six factor model and it met strict quality assurance criteria. On the whole, there was strong overlap in the themes and categories which emerged from the literature review and the focus group discussions, reinforcing the concept of spirituality as an established component within holistic care (Ross, 2006; Puchalski et. al. 2009). The fact that the themes obtained from the focus groups in Malta concurred with the international literature also suggests that the Framework may be of relevance across cultures.

Implications of the framework for teaching and learning

Module/study unit vs threaded through curricula

It is likely that spiritual care competency development is more suited to the threaded approach to curricula design rather than a specific module/study unit on spiritual care. There is some evidence that single modules/study units may raise students' spiritual awareness and enhance their confidence in engaging with spiritual care (van Leeuwen et. al. 2008; Cooper et. al. 2013; Attard et. al. 2014) but most studies were limited by cross sectional single centre design involving small samples.

More compelling evidence for using a 'threaded' curricula approach is provided by the findings from a longitudinal multinational study of nursing/midwifery students (Ross et. al. 2018). Students' overall perceived spiritual care competency score increased significantly ($p<0.01$) over the duration of their degree studies; significant increases were also noted in the six subscales of the Spiritual Care Competency Scale (SCCS, van Leeuwen et. al. 2009) which align strongly with the seven Framework domains. The 'threaded' approach seems to fit well with the theoretical model for the development of competencies in spiritual care proposed by Attard et. al. (2019). The model proposes the evolution of the student through novice to competent (Benner, 1984), whereby the student moves from the simplest cognitive (knowledge, comprehension and application) and affective behaviour (receiving,

responding and valuing) to the most complex cognitive and affective aspects of spiritual care (Bloom, 1956). Ross et. al.'s (2018) findings support the model. Overall perceived competency developed over time and competencies in the more complex aspects of spiritual care such as 'assessment and implementation' (Domain 6), 'referral', and 'professionalization and improving the quality of spiritual care' (Domain 5), showed greatest improvement reaching their peak at point of registration as measured by the SCCS (van Leeuwen et. al. 2009).

Informing the content and delivery of pre-registration nurse/midwifery education programmes

There has been a lack of guidance about the nature of spirituality and spiritual care content within nursing/midwifery curricula. The new Framework fills this gap by providing evidence that the following seven domains should be integrated within curricula:

1. A body of knowledge in spiritual care
2. Self-awareness in spiritual care
3. Interpersonal relationships and communication
4. Ethical and legal issues in spiritual care
5. Assessment and implementation of spiritual care
6. Quality assurance in spiritual care
7. Informatics in spiritual care.

Students' personal spirituality has been correlated with enhanced perceived spiritual care competency (Ross et. al. 2016; Ross et. al. 2018) which suggests that reflection on own beliefs and values may be important in achieving some competencies, particularly in Domain 2 ('self-awareness in spiritual care'). Students attributed their learning about spiritual care to 'caring for patients' and 'discussions in university and with other students' (Ross et. al. 2018). Therefore, scenarios, narratives and case studies which encourage 'reflection in and on practice' (Weeks et. al. 2017) may be useful learning strategies in the attainment of competencies in Domains 1 ('knowledge in spiritual care'), 4 ('ethical and legal issues') and 6 ('assessment and implementation of spiritual care'). A reflective education model may encourage students to consider and critically review their practice, emotional responses and thoughts with the purpose of learning from these experiences and integrating them consciously in practice (van Leeuwen and Cusveller, 2004). Additionally, whether or not students encounter role models who practice spiritual care may help or hinder their appreciation of its importance (Giske 2012; Giske and Cone 2012).

Although the competency Framework provides an important guide to inform curriculum design, the 54 competencies require further refinement to identify what is essential to include within crowded undergraduate curricula. This work has begun through a three year (2016-2019) Erasmus+ funded project called 'Enhancing Nurses and Midwives Competency is Spiritual Care through Innovative Education and Compassionate Care' (EPICC Project). The project has engaged over 30 pre-registration nurse/midwifery educators and stakeholders from 21 European countries in reducing the number of competencies to nine and then to four using a consensus approach. Encouragingly the

competencies have been of relevance across countries, suggesting they are not culturally bound. Other outputs include a co-produced Gold Standard Educational Matrix to underpin the competencies, a Toolkit containing teaching and learning activities, a Website (www.epicc-project.eu) and a Network. Educators across the European countries involved, are testing out the competencies and teaching and learning activities within their universities. In some countries, where university curricula are currently being re-written, the competencies are shaping course design by being mapped against course content. They are also being used to assess students' spiritual care practice whilst on clinical placement.

Future developments

Further work is needed to inform student nurse/midwife selection by identifying the cognitive, functional and ethical attributes that are most likely to lead to spiritually competent practice. Although there is some evidence to support the theoretical model developed by Attard et. al. (2019) which highlights the development of spiritual care competency over time, further testing of that model is required, for example to identify the barriers and facilitators for development of spiritual care competency within the wider 'community of practice' (Weeks et. al. 2017).

Strengths and Limitations of the study

A major strength of the study is the use of extensive international evidence selected on the basis of strict quality assurance criteria to derive the initial list of competencies. Secondly, extensive stakeholder consultation informed development and refinement of the Framework (focus groups, Modified Delphi). This maximised its utility, ensuring the emergent Framework's relevance to nursing and midwifery education and practice. The study is further strengthened by the rigour of its triangulated research design.

The study is limited by the fact that the focus groups and Modified Delphi were conducted in Malta which is traditionally a Roman Catholic country. This was addressed to some extent by including stakeholders from other faith and non-faith backgrounds. It is possible that the new sixth factor ('healthcare chaplaincy') which emerged from the exploratory factor analysis (EFA) of the Framework is closely linked to the religious and spiritual beliefs of the participating sample and is a further limitation. However, a current project which is relating the competencies to nurse/midwifery pre-registration education across Europe (EPICC Project), suggests that the competencies may not be culturally bound, but rather universally relevant, at least across the 17 countries represented in that project.

CONCLUSION

A seven domain 54 item pre-registration spiritual care competency Framework which demonstrated good to strong internal consistency, stability and a good fit with a six factor model, was developed for nurses and midwives using a rigorous triangulated research design. This is a landmark achievement

as it is the first framework to be developed based upon a relevant and robust theoretical model (Benner, 1984; Carper, 1978), best available evidence (international literature and research), and ensuring its fitness for purpose through stakeholder engagement.

The competency Framework's greatest immediate contribution is in its ability to inform undergraduate nursing/midwifery curriculum design and delivery, a gap which has long been identified. Further work is needed to inform student selection and to identify the barriers and facilitators to spiritual care competency development, thereby enabling the production of an integrated model of spiritual care competency. This is important to ensure that the 'art' of nursing/midwifery is given the same attention as the 'science' and that patients/clients and their families experience the holistic and person centred care that international health care policy considers to be so important.

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Table 1: The themes and categories identified from the focus groups

Domain 1:	**Body of knowledge in spiritual care**	
Categories	**Themes**	**Domain**
Nurses'/midwives' need for Knowledge on spiritual/religious issues. Knowledge of spiritual/religious aspects of care. Nurses'/midwives' need for spiritual care education at pre- and post-registration. Knowledge of spiritual/religious issues relevant to clients' illness.	Elements in the educational preparation of nursing/midwifery students on spiritual/religious issues.	**BODY OF KNOWLEDGE IN SPIRITUAL CARE**
Domain 2:	**Self-awareness and use of self in spiritual care**	
Categories	**Themes**	**Domain**
Nurses/midwives personal spirituality Vocational calling of nurse/midwife Meaning of spirituality/ religiosity Knowledge of spiritual/ religious interventions and access to resources Knowledge and respect for diverse beliefs and decisions that affect care Maintain professional barriers	The role of nurses/midwives in providing spiritual care Nursing/midwifery as vocational professions Educational preparation of nurses/midwives in spiritual/ religious issues	**SELF-AWARENESS AND USE OF SELF IN SPIRITUAL CARE**

Domain 3: Communication and interpersonal relationship in spiritual care		
Categories	**Themes**	**Domain**
Effective nurse/midwife-client communication. Dealing with clients' emotional needs. Being with the client and their family. Communication and interpersonal skills. Therapeutic client-nurse/midwife-relationship. Responding to cultural diversity. Nurses/midwives as healers.	Client's need for effective communication and interpersonal skills. Being with the client and their family. Responding to cultural diversity. Maintaining a good client – nurse/midwife relationship while respecting boundaries.	**COMMUNICATION AND INTERPERSONAL RELATIONSHIP IN SPIRITUAL CARE.**
Domain 4: Ethical and legal issues in spiritual care		
Categories	**Themes**	**Domain**
Ethical and legal issues that protect clients and staff. Clients' need for information to reach decisions. Respect for clients' spiritual/religious beliefs and decisions in their care. Respect for Issues pertaining to confidentially, dignity, information, clients' wishes.	Ethical and legal responsibilities relating to spiritual care in relation to the client, the family and team. Clients' rights for confidentiality, privacy, informed choice and dignity.	**ETHICAL AND LEGAL ISSUES IN SPIRITUAL CARE.**
Domain 5: Quality assurance in spiritual care		
Categories	**Themes**	**Domain**
Creating a spiritual environment for clients and staff. Nurses'/midwives' as providers of	Nursing/midwifery as vocational professions. Nurses/midwives as providers	**QUALITY ASSURANCE IN SPIRITUAL CARE**

humane holistic care. Vocational calling of the nurse/midwife. Providing a multi-disciplinary approach to spiritual care. Maintaining professional boundaries. Professional and educational responsibilities of staff.	of holistic care adopting a multi-disciplinary approach. Nurses'/midwives' responsibility in creating a spiritual environment for clients and staff. Responsibility of nurses/midwives to participate in continuing professional education to improve practice. Maintaining professional boundaries as outlined in the code of ethics.	
Domain 6: Assessment and implementation of spiritual care		
Categories	**Themes**	**Domain**
Organisation of spiritual care. Assessment, implementation and evaluation of spiritual care. Spiritual assessment of clients and their families. Implementation of spiritual care and provision of interventions. Support for clients, their families and professionals. Implementing spiritual/religious interventions to clients and their families in hospital and community. Referral to spiritual leaders and other resources. Barriers to spiritual care.	Assessment of spiritual needs of clients and family. Organisation and Implementation of spiritual/religious interventions in hospital and community to assist clients find meaning and purpose. Referral to spiritual leaders and other members of the multi-disciplinary team.	**ASSESSMENT AND IMPLEMENTATION OF SPIRITUAL CARE**
Domain 7: Informatics in spiritual care		
Categories	**Themes**	**Domain**
Use of video conferencing as a resource for learning about spiritual care	Information technology a resource to assist spiritual care.	**INFORMATICS IN SPIRITUAL CARE**

Table 2: Modified Delphi Questionnaire

Generic core competencies in spiritual care **Domain 1: Knowledge in spiritual care**
1. Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* view of care, attentive to the body-mind-spirit in all healthcare settings.
2. Identify the influence of the world's major faiths/religions (*e.g. Christianity, Islam, Judaism, Hindu and Buddhism*) cultural beliefs and practices in the appropriate clinical context and along the lifespan continuum (*from conception to death*).
3. Demonstrate knowledge of the basic spiritual needs of individuals which include: • A meaningful philosophy of life (*values and moral sense*). • A sense of the transcendent (*outside of self, view of deity/higher power and something beyond the immediate life, having hope*). • Belief and faith in self, others and for some a belief in a deity/higher power. • A relatedness to nature and people (*friendship*). • Experiencing love and forgiveness (*a sense of life meaning*).
4. Recognise the importance of the spiritual dimension (*with or without religion*) that sustains physical and mental well-being.
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/her behaviour in dealing with spiritual needs.
7. Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA, RESPECT and HOPE tools*) and informal methods (e.g. *listening to clients' stories*).
8. Demonstrate knowledge and understanding of the grieving process (*denial, anger, bargaining, depression and acceptance*).
9. Demonstrate knowledge and understanding of spiritual/religious development of individuals and assist spiritual/religious growth.
10. Demonstrate knowledge of complex theories of spirituality, such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations.
11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (*e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?*)
12. Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care.
13. Demonstrate knowledge of resources, support systems/agencies that inform nurses/midwives to access spiritual care for clients, their families and staff in all healthcare settings (*e.g. place for worship, Church and support groups*).
14. Demonstrate knowledge on assisting clients in healthcare according to the clients' religious/spiritual, cultural beliefs, such as the use of complimentary/alternative therapies, diets, nutritional supplements and prayer.
Domain 2: Self-awareness and the use of self

15. Be aware of own spirituality and use of self (*e.g. own strengths, limitations, values, beliefs*) as a resource for spiritual care.
16. Recognise the possible impact of the nurse's/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care.
17. Acknowledge and respect the influence of clients' diverse cultural world views, beliefs and practices in the expression of their spirituality in healthcare.
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (*e.g. psychologists, chaplains, counsellors, spiritual leaders*) as deemed necessary.
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care.
Domain 3: Communication and interpersonal skills
20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/families in their spiritual needs and sufferings.
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/religious readings and prayer as a means of encouragement and hope.
22. Assess barriers to effective communication in providing spiritual care (*e.g. language, beliefs, culture, anxiety, fear and anger*) and adapt accordingly by active listening, empathy and/or referral to other members of the multi-disciplinary team.
23. Understand and apply the principles of a therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey.
24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/midwife-client relationship (abiding by the professional ethical/legal codes of conduct).
Domain 4: Ethical and legal issues
25. Appreciate the uniqueness of each person and their right to decline spiritual care.
26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/spiritual beliefs, values, practices and lifestyles (*e.g. diet, sexual orientation*).
27. Demonstrate sensitivity, support and respect for the client's autonomous and diverse healthcare decisions/choices influenced by religious/spiritual beliefs and practices (*e.g. blood transfusion, childbirth practices, chemotherapy, immunisation*).
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (*self-esteem and self-respect*) and integrity (*adherence to moral and ethical principles*).
29. Acknowledge and respect the clients' right for information and informed consent to empower the m and facilitate decision-making regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices.
30. Disclose clients' spiritual/religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team, while maintaining confidentiality to safeguard clients' welfare.
Domain 5: Quality assurance in spiritual care

31. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/midwife.
32. Implement professional caring behaviour demonstrating altruism (*a sense of giving*), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues.
33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on.
34. Recognise the need for continuing educational interest through supervision, self-reflection, role models, conferences and other learning resources in order to improve spiritual care.
35. Take initiative to participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilise the evidence to bring about practice improvement.
36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity, such as creative art (*e.g. painting*).
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual well-being of clients, their families and health carers and modify accordingly.
38. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all healthcare system.
Domain 6: Assessment and implementation of spiritual care
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) and informal (*listening to the clients' experiences*) assessment methods.
40. Identify signs of spiritual distress in clients and family (*e.g. pain, anxiety, guilt, loss, anger at God and despair*) and plan to address this distress while being aware of barriers to spiritual care, such as lack of time and education.
41. Plan spiritual care while identifying its intersections (*shared elements*) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns.
42. Utilise spiritual care models which integrate client-centred care and a problem–based approach while focusing on holistic care.
43. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically.
44. Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/religious needs maintaining patience, tact, perseverance and discipline.
45. Provide spiritual care interventions sensitively by promoting clients' positive self-concept (*e.g. positive coping techniques*) monitoring spiritual expression while respecting clients who do not conform to advice given on their health.
46. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time.

47. Facilitate family participation in the care of the irrelative to maintain spiritual habits and rituals and identify alternatives to instil hope.
48. Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team.
49. Recognise the importance of timely referral of clients/their families to chaplains and spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*).
50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow-up.
51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care.
Domain 7: Informatics in spiritual care
52. Acknowledge the use of information technology as a resource of learning about spiritual care.
53. Acknowledge the use of information technology as a means of a communication network with clients/their families and members of the multi-disciplinary team on spiritual issues and spiritual support.
54. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care. 55. Acknowledge the use of information technology, such as Facebook, Twitter, Desk monitor etc., as a medium for spiritual inspirations.

Manuscript Details

Manuscript number	NEP_2018_233_R2
Title	DESIGN AND DEVELOPMENT OF A SPIRITUAL CARE COMPETENCY FRAMEWORK FOR PRE-REGISTRATION NURSES AND MIDWIVES: A MODIFIED DELPHI STUDY
Article type	Research Paper

Abstract

This is the second of two papers reporting the development of a spiritual care competency framework for pre-registration nurses and midwives as part of a PhD study using an embedded sequential mixed methods eclectic research design. The first paper outlines how 116 competency items were generated from an in-depth review of international literature. It offers a theoretical model to underpin development of the Framework. Aim: This paper reports how the Framework was developed. Method/Results: Five focus groups were held with stakeholders in Malta (chaplains/spiritual leaders, undergraduate nursing/midwifery educators, qualified nurses/ midwives, parents/carers, patients/clients) to ensure that aspects of spirituality/spiritual care important to them, but not identified in the literature review, were included in the Framework. The resulting 55 competencies in seven domains formed the Delphi Questionnaire which was validated using a two round modified Delphi method involving experts from Malta. The final seven domain 54 item Framework demonstrated good to strong internal consistency, stability and a good fit with a six factor model. Conclusion: The Framework's greatest immediate contribution is in its ability to inform undergraduate nursing/midwifery spiritual care curriculum design and delivery. Further development of the Framework could assist in student selection ensuring that the 'art' of nursing/midwifery has parity with the 'science'.

Keywords	Spirituality; Spiritual care competency; Modified Delphi; Spiritual care education.
Taxonomy	Nursing Competence, Nursing Education, Nursing Research Methods
Manuscript category	Doctorate Studies
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Submission Files Included in this PDF

File Name [File Type]

Letter to Editor revised April 19.docx [Cover Letter]

Table of revisions 2.docx [Response to Reviewers (without Author Details)]

paper 2 revised July 2019.docx [Revised Manuscript with Changes Marked (without Author Details)]

title and authors revised April 19.docx [Title Page (with Author Details)]

Tables review April 2019.pdf [Manuscript (without Author Details)]

NEP Paper1Conflict of interest.docx [Conflict of Interest]

To view all the submission files, including those not included in the PDF, click on the manuscript title on your EVISE Homepage, then click 'Download zip file'.

Research Data Related to this Submission

There are no linked research data sets for this submission. The following reason is given:
Data will be made available on request

Dear Karen

Paper: DESIGN AND DEVELOPMENT OF A SPIRITUAL CARE COMPETENCY FRAMEWORK FOR PRE-REGISTRATION NURSES AND MIDWIVES: A MODIFIED DELPHI STUDY

Please find attached the above paper for the 'Doctorate Studies Research' section of the special edition on competency and pedagogy being edited by Keith Weeks and David Pontin.

All authors have contributed and have confirmed the final edition, which has been uploaded.

This work has not been published elsewhere.

The findings are novel. This is the first time a pre-registration Spiritual Care Competency Framework for nurses/midwives has been developed based upon sound evidence and a triangulated research design. The Framework is needed to inform design/delivery of spiritual care education programmes for nurses and midwives. Follow-on work will identify what competences are needed by nurses/midwives at entry and at point of registration by developing an Integrated Model of Spiritual Care Competence similar to that produced by Weeks et al (2017).

This paper is the second of 2 papers. The first has been submitted by Josephine Attard and is entitled '*DEVELOPING A SPIRITUAL CARE COMPETENCY FRAMEWORK FOR PRE-REGISTRATION NURSES AND MIDWIVES*

I appreciate that the 2 titles are very similar. Previously Paper 1's title was 'Competency item generation and development of a theoretical model to underpin formulation of a spiritual care competency framework for pre-reg Nurses and midwives'. If you think it is better to revert to that then please feel free to change it. Any other suggestions are welcome too.

I refer to paper 1 in my paper and have left a space for the reference to be inserted.

I have also attached a table with the changes made in relation to the 3 referees' comments.

I look forward to hearing from you.

Kind regards

Linda Ross (on behalf of the authors)

Table of revisions 2

Reviewer 1	Response/change
1. Abstract: The sentence: "It offers a theoretical model to underpin development of the Framework. This paper reports how that Framework was developed" Could be worded with more clarity regarding the aims, methodology and method and conclusion. The content is placed within the abstract however the reordering would make it more approachable to an interested reader/ researcher.	The suggested headings (aim, method, results, conclusion) have been added to the abstract (see red type)
2. The reference is missing in the abstract.	See editor's note – not needed for abstract
3. The inclusion of the highlights is noted and provides further areas essential interest.	No action needed
4. Paragraph on page 2. " it is written into their ethics.." Please stipulate further details- whose ethics?	'….is written into international nursing and midwifery Codes of Ethics…'
5. Background: "Yet, the NMC is reluctant to include the spiritual within the (INSERT NAME OF THE CODE) Code (NMC 2015) preferring to stick continue with a biopsychosocial model of care (p 5) (McSherry and Ross 2015, Smith 2015). LEVEL OF LANGUAGE	'….within its Code of practice (NMC 2015) opting for a tripartite biopsychosocial model of care (p5) rather than an holistic one….'
6. Before the "seven domains" there is an omitted reference	Added, but incomplete in reference list as this is the reference to paper 1 which sits alongside this one. Can you please supply the missing details?
7. Suggested wording; Next, a theoretical model was constructed to underpin the development of the spiritual care competency framework. How that Further exploration includes how the competency framework was developed and validated is the focus of this paper	I think the current wording is clear. The alternative wording suggested does not make sense to me.
Data analysis and results: Suggest write this as Step 1. Step 2.	Added (see red text)

Referencing. The notation for APA references is et. al. There are some minor differences in reference format throughout the paper- missing . and missing ,	Corrected as advised, but the NEiP paper I had by my side had it differently: et al., so I have gone with the reviewer's as the editor had approved all their comments except one.
Reviewers 2 and 3, no changes suggested	

DESIGN AND DEVELOPMENT OF A SPIRITUAL CARE COMPETENCY FRAMEWORK FOR PRE-REGISTRATION NURSES AND MIDWIVES: A MODIFIED DELPHI STUDY

Conflict of interest statement

The authors have no conflict of interest to declare.

Abstract

This is the second of two papers reporting the development of a spiritual care competency framework for pre-registration nurses and midwives as part of a PhD study using an embedded sequential mixed methods eclectic research design. The first paper outlines how 116 competency items were generated from an in-depth review of international literature. It offers a theoretical model to underpin development of the Framework. Aim: This paper reports how the Framework was developed. Method/Results: Five focus groups were held with stakeholders in Malta (chaplains/spiritual leaders, undergraduate nursing/midwifery educators, qualified nurses/ midwives, parents/carers, patients/clients) to ensure that aspects of spirituality/spiritual care important to them, but not identified in the literature review, were included in the Framework. The resulting 55 competencies in seven domains formed the Delphi Questionnaire which was validated using a two round modified Delphi method involving experts from Malta. The final seven domain 54 item Framework demonstrated good to strong internal consistency, stability and a good fit with a six factor model. Conclusion: The Framework's greatest immediate contribution is in its ability to inform undergraduate nursing/midwifery spiritual care curriculum design and delivery. Further development of the Framework could assist in student selection ensuring that the 'art' of nursing/midwifery has parity with the 'science'.

Highlights

- The first pre-registration Spiritual Care Competency Framework was developed for nurses/midwives
- The Framework is informing design/delivery of spiritual care education programmes across Europe.

Keywords

Spirituality, Spiritual care competency, Modified Delphi, Spiritual care education

BACKGROUND

Spirituality is fundamental to the human condition (Puchalski et. al. 2009). Not necessarily linked to religious belief, this refers to a person's deep-seated sense of self, meaning, purpose and connection with self, others and the transcendent (RCN, 2011; WHO, 2006). Spirituality impacts on health, wellbeing and quality of life (Koenig et. al. 2012), is important to patients/clients internationally (Ross,

2006; Selman et. al. 2017) and is part of international healthcare guidance and policy (European Association for Palliative Care [EAPC] http://www.eapcnet.eu/ no date; World Health Organisation, 2006).

In recognition of the importance of spiritual, religious and cultural aspects of people's lives on their wellbeing, the European Commission (2010) recommends that the caring professions are educated in this respect. Nurses and midwives are obvious examples of the caring professions and spiritual care is written into international nursing and midwifery Codes of Ethics (ICM, 2014; ICN, 2012) and education guidelines (NMC, 2018). Practising nurses see spiritual care as part of their everyday practice, but international evidence shows that they feel unprepared for it requesting more education (Egan et. al. 2017; Schep-Akkerman and van Leeuwen 2009; RCN, 2011). Stand-alone educational programmes claim to improve students' understanding of spiritual care (van Leeuwen et. al. 2008; Cooper et. al. 2013; Attard et. al. 2014) but are limited by cross sectional single centre design involving small samples. The importance of students having role models for spiritual care in the clinical area has also been highlighted (Giske, 2012; Giske and Cone 2012).

Education on the topic of spirituality is variable both in quantity, content and delivery with some programmes having little or no identifiable component (Lewinson et. al. 2015). This may be because of competition for space in already packed curricula combined with uncertainty about what spirituality means (Swinton, 2006), what spiritual care looks like and therefore what would constitute suitable content and assessment. Research has only just begun to explore the factors contributing to spiritual care competency development, highlighting what might be important for education. The only prospective, longitudinal study of its kind, involving 2193 nursing/midwifery undergraduate students from 21 universities in eight European countries, identified that students' personal spirituality and perception of spirituality were significantly related to their self-rating of perceived spiritual care competency which increased over time (Ross et. al. 2018). Caring for patients, university teaching/discussion and life events were identified by students as important for their learning (Ross et. al. 2018).

The conflicting stance of some regulatory bodies with regard to the importance of spirituality within nursing and midwifery may be an additional reason for inconsistent inclusion of the topic in education programmes.. For example in the UK the Nursing and Midwifery Council (NMC) states that:

'Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical…and spiritual needs. They use information obtained during assessments…..to develop person-centred care plans ……that take account of their….preferences' (NMC, 2018, p13).

Yet the NMC is reluctant to include the spiritual within its Code of practice (NMC, 2015) opting for a tripartite biopsychosocial model of care (p5) rather than an holistic one (McSherry and Ross 2015; Smith, 2015).

Another reason for the inconsistent inclusion of spirituality within pre-registration nurse/midwifery education programmes could be because no competencies exist for spiritual care at point of registration. This doctoral study seeks to address this gap in knowledge by developing a spiritual care competency framework for pre-registration nurses and midwives.

The PhD study adopted an embedded sequential mixed methods eclectic research design using a Modified Delphi approach. First, 116 competency items were generated and arranged in 7 domains from an extensive review of the international literature in three discrete areas using Braun & Clarke's (2006) adapted six-phase content thematic analysis: spirituality and spiritual care, spiritual care in nursing/midwifery education and spiritual care curricular content and is described in detail in Attard et. al. (2019). The seven domains were:

1. A body of knowledge in spiritual care
2. Self-awareness in spiritual care
3. Interpersonal relationships and communication
4. Ethical and legal issues in spiritual care
5. Assessment and implementation of spiritual care
6. Quality assurance in spiritual care
7. Informatics in spiritual care

Next, a theoretical model was constructed to underpin the development of the spiritual care competency framework. How that Competency Framework was developed and validated is the focus of this paper.

STUDY AIM

To develop and validate a spiritual care competency framework for undergraduate nurses and midwives.

METHODS, ANALYSIS AND RESULTS

The spiritual care competency framework (hereon in referred to as the Framework) was developed using focus groups with key stakeholders to augment the 116 competencies already identified from the literature review (step 1). It was then validated using a Modified Delphi approach (step 2). Because the methods were sequential, each method and the analysis and results pertaining to it, are presented in turn.

Ethical approval

Ethical approvals were obtained from the Universities and from the hospital in Malta from which participants were recruited.

Step 1: Further development of the competency framework using focus groups

Rationale for focus groups

It was considered important to consult with stakeholders about their views on spirituality and spiritual care to ensure that aspects important to them, but not identified from the literature, were also included in the competency framework.The focus group method was chosen for this consultation for a number of reasons. The method originates from a non-positivist paradigm and the qualitative data are generated through an inductive approach with experts in the field (Babbie and Mouton, 2001). In-depth data are generated which incorporate the experience, values and needs of stakeholders by discussing the phenomenon from the participants' point of view (Polit and Beck, 2014). The main aim of the focus group is to encourage divergent thinking and to encourage the disclosure of personal perceptions. It also offers the opportunity to explore meanings, beliefs and cultural nuances that may influence the feelings, attitudes and behaviours of individuals through their lived experiences.Thus, the use of focus groups in this study was deemed appropriate in order to:

• Obtain information from different groups of participants on their views, experiences and attitudes in relation to the topic of spirituality and spiritual care.

• Clarify participants' experiences and perceptions of spirituality, spiritual needs and spiritual care in times of illness, loss and other life stressors.

• Support the information generated from the literature review.

Sampling and data collection

Purposeful snowball sampling was used to recruit participants (n=46) resident in Malta (selected for practical reasons as there is one university and one state hospital) to one of five focus groups of 6-10 participants each (Finch and Lewis, 2003). Focus groups consisted of: chaplains/spiritual leaders (n=10, representing: Catholic church, Church of Scotland, Church of England, Baptist church, Coptic Orthodox, Islam, Judaism, Jehovah Witnesses), undergraduate nursing/midwifery educators (n=11), qualified nurses (surgical, medical, mental health) and midwives (n=9), parents/carers who experienced loss/life limiting conditions (n=9), and patients/clients (medical, surgical, mental health, maternity, n=9). Participants were given one of six case studies (relevant to the group, see example in Box 1) and discussion was facilitated (by JA, DB) around two questions: 'what are clients' spiritual needs?' and 'what does the nurse/midwife need to know, think and do to meet those needs?'

Box 1: A case study example

Scenario 1
Eric Jenkins is a 34 year old male with a past medical history of depression. He has had some treatment for his depression and prescribed medicine which he is currently

not taking. He presents to the Emergency Department with the complaint of wanting to jump off a cliff and kill himself.
''What am I living for? I went from being an 'A' student to a loser. There is nothing more for me'' he whispers softly between tears. He tells his nurse that he has been drinking gin. He stopped a by passer who brought him to hospital before he acted on impulse.
Eric is an only son and has been the sole caregiver of his elderly mother and father for about 10 years. He tells his nurse that taking care of his parents has been 'his life'. His father died about 4 years ago. He continued taking care of his mother after his father died but was devastated 6 months ago when his mother died. He is now saying 'I have no purpose to my life." He looks very sad and continues to gaze downward. When he looks at you his eyes clearly show that he is asking for help. Eric believes in God, reads the Bible regularly, thinks that if you ''live a good life according to the Bible then things will go well for you''. He belongs to a non-denominational Christian church He used to go to church regularly, but not so much lately.

Questions:
What are the spiritual needs of Eric in this story?
What does the nurse need to know, be able to do, or think, in order to meet these needs?

Data analysis and results

Data were analysed as follows:

-Sessions were recorded and transcribed and detailed notes were taken.

-Validation of the accuracy of the transcripts as a true account of the discussions was obtained through feedback from 10 participants across the five focus groups. Maltese transcripts (from focus groups with nurses/midwives and clients/carers) were translated into English by a professional linguist. Both the English and Maltese versions were examined by a moderator who confirmed the accuracy of the translation.

-The transcripts and notes were read and re-read to ensure familiarisation with the data. They were coded and categories, sub-categories and themes were identified using Krueger and Casey's (2009) framework.

-Duplicate and similar categories to those already identified from the literature were removed resulting in a list of new themes and categories as shown in Table 1.

Table 1 here

Following removal of duplicates and merging of similar concepts the 170 competencies identified from the literature review and focus groups were collapsed to 55, and arranged in 7 emergent domains; this formed the Modified Delphi Questionnaire (Table 2) to be validated in the next stage.

Table 2 here

Step 2: Validation of competency items and domains using modified Delphi

Rationale for Modified Delphi

There is ongoing epistemological debate about the pros and cons of the Delphi method in terms of its rigour, concerns about artificial divergence in responses giving rise to false consensus (Hassan and Keeney, 2011), and identifying who the 'real experts' are (Landeta, et. al. 2011). Consequently, continual modifications are being made with multiple types of Delphi methods being available. Delphi was however, considered the most appropriate method for reaching consensus amongst the wide range of stakeholder groups in this study, where each group had its own clearly defined set of criteria to be considered as 'expert'.

Sampling and data collection.

The aim of this next stage was to ask experts to evaluate the competency statements and domains listed in the Modified Delphi Questionnaire (Table 2) using a two round modified Delphi process (Keeney, et al 2006) based upon Lockean inquiry (Mitroff and Turoff 1975) and Couper's (1984) Sequence Model. 'Experts' (n=271) in spiritual care were recruited from a hospital in Malta (using Polit and Beck's 2014 process) by purposeful and snowball sampling on the basis of their knowledge and experience of spiritual care guided by the theories: 'fundamental ways of knowing' (Carper, 1978), 'from novice to expert' (Benner, 1984) and the 'Spiritual Care Competency Scale' (SCCS) (van Leeuwen et. al. 2009). Figure 1 shows the 10 groups of experts from Malta included and explains the criteria for their selection. For each of the 55 items in the questionnaire, participants were asked 'To what extent do you think that newly qualified nurses and midwives should demonstrate these competencies (knowledge, skills and attitude)?'They rated each item on a 7-point Likert scale from 'not at all important = 1' to 'extremely important = 7'. Of 760 individuals invited to take part, 271 agreed to participate of which 241 completed the questionnaire in round 1 (R1) and 205 completed the questionnaire in round 2 (R2).

Figure 1 here

Analysis

Data analysis involved computing the mean, standard deviation, 95% confidence interval of the population mean and the percentage agreement for each competency item. Consensus for retaining an item was achieved if more than 75% of participants rated the item as 5, 6 or 7 (indicting moderate to strong agreement) on the 7 point Likert scale in both Delphi rounds.

Following Delphi Round 2 the competency Framework was tested for construct validity by Exploratory Factor Analysis (EFA) (Bryman and Cramer, 2001) involving 3 stages. In stage 1, factor extraction, highly interrelated variables in the correlation matrix were condensed into factors using Spearman's correlation co-efficients (Pett et. al. 2003). Cattell's (1966) Scree Test was used to determine the number of factors to be retained using a cut off point for factor extraction at eigen values greater than 1.00 (Russell, 2000). In stage 2, the factors were rotated, kappa (*k*) coefficients were calculated. In stage 3 the factor loadings were estimated by counting the low (-0.10 to +0.10) factor loadings on the set of factors from the factor pattern matrix. Those variables with loadings of at least 0.40 on at least one factor were retained. The items were also assessed for cross loading. Although there is no consensus about the strategy to use when items cross load, the item which cross loaded was assigned to the factor to which it appeared to be theoretically related (Pett et. al. 2003). Following factor analysis, the three items with the highest loading on each factor were identified as these shared more variance with the factor than items with lower loadings (Pett et. al. 2003). They were interpreted in relation to the results of the Modified Delphi and named accordingly. When more than three items loading on a factor were labelled as undefined, this was considered to be a new factor.

Results

Consensus

54 competency items achieved the pre-determined 75% level of consensus by the end of Round 2.The majority of items (n=27) scored above 90% and 25 items scored higher than 80% level of agreement. With the exception of Item 55 (which was subsequently removed), all items had a mean rating score significantly higher than 5 since the lower 95% confidence limit of the population mean rating score was above 5. This implies that the population mean rating score of these items was more than 1 scale point higher than the middling rating score 4.

Internal consistency

According to George and Mallery (2003) a Cronbach α coefficient of 0.8-0.9 is 'good' and above that is 'excellent'. The total competency domains and competency items obtained a Cronbach α of 0.97 indicating homogeneity of the framework across time.The individual 7 domains and the respective competency items had Cronbach α coefficients of 0.79 to 0.93 indicating good to strong internal consistency.

Stability

Spearman's test indicated very high correlations between R1 and R2 (0.9 to 1) for 23 items and high correlations (0.7 - 0.89) for 31 items. Only one item had a moderate correlation coefficient (0.5 - 0.69) (Item 35: rs = 0.554). The framework was therefore considered to be stable.

Exploratory factor analysis

Results from the exploratory factor analysis showed a good fit of a six factor model which included five of the seven domains: Domain 1 Body of knowledge in spiritual care; Domain 4 Ethical and legal

issues in spiritual care; Domain 5 Quality assurance in spiritual care; Domain 6 Assessment and implementation of spiritual care; Domain 7 Informatics in spiritual care. A new 6th factor emerged, called 'healthcare chaplaincy' which related to referral to chaplains and spiritual leaders, and may reflect the religious culture of Malta. Items in Domain 2 'self-awareness and the use of self' and Domain 3'communication and interpersonal skills' were not defined as these loaded on various other factors so were merged throughout. Only two items (8 and 24) cross loaded on another factor, while five competency items scored <0.4 on the rotated factor loading.

The final Spiritual Care Competency Framework has 54 competencies (item 55 removed) arranged in seven domains as illustrated in Table 2.

DISCUSSION

The Spiritual Care Competency Framework

This study is novel in that it has developed the first pre-registration spiritual care competency framework for nurses and midwives from an extensive review of the international literature and from focus groups with a wide range of stakeholders in one country (Malta). It demonstrated good to strong internal consistency, stability, a good fit with a six factor model and it met strict quality assurance criteria. On the whole, there was strong overlap in the themes and categories which emerged from the literature review and the focus group discussions, reinforcing the concept of spirituality as an established component within holistic care (Ross, 2006; Puchalski et. al. 2009). The fact that the themes obtained from the focus groups in Malta concurred with the international literature also suggests that the Framework may be of relevance across cultures.

Implications of the framework for teaching and learning

Module/study unit vs threaded through curricula

It is likely that spiritual care competency development is more suited to the threaded approach to curricula design rather than a specific module/study unit on spiritual care. There is some evidence that single modules/study units may raise students' spiritual awareness and enhance their confidence in engaging with spiritual care (van Leeuwen et. al. 2008; Cooper et. al. 2013; Attard et. al. 2014) but most studies were limited by cross sectional single centre design involving small samples.

More compelling evidence for using a 'threaded' curricula approach is provided by the findings from a longitudinal multinational study of nursing/midwifery students (Ross et. al. 2018). Students' overall perceived spiritual care competency score increased significantly ($p<0.01$) over the duration of their degree studies; significant increases were also noted in the six subscales of the Spiritual Care Competency Scale (SCCS, van Leeuwen et. al. 2009) which align strongly with the seven Framework domains. The 'threaded' approach seems to fit well with the theoretical model for the development of competencies in spiritual care proposed by Attard et. al. (2019). The model proposes the evolution of the student through novice to competent (Benner, 1984), whereby the student moves from the

simplest cognitive (knowledge, comprehension and application) and affective behaviour (receiving, responding and valuing) to the most complex cognitive and affective aspects of spiritual care (Bloom, 1956). Ross et. al.'s (2018) findings support the model. Overall perceived competency developed over time and competencies in the more complex aspects of spiritual care such as 'assessment and implementation' (Domain 6), 'referral', and 'professionalization and improving the quality of spiritual care' (Domain 5), showed greatest improvement reaching their peak at point of registration as measured by the SCCS (van Leeuwen et. al. 2009).

Informing the content and delivery of pre-registration nurse/midwifery education programmes

There has been a lack of guidance about the nature of spirituality and spiritual care content within nursing/midwifery curricula. The new Framework fills this gap by providing evidence that the following seven domains should be integrated within curricula:

1. A body of knowledge in spiritual care
2. Self-awareness in spiritual care
3. Interpersonal relationships and communication
4. Ethical and legal issues in spiritual care
5. Assessment and implementation of spiritual care
6. Quality assurance in spiritual care
7. Informatics in spiritual care.

Students' personal spirituality has been correlated with enhanced perceived spiritual care competency (Ross et. al. 2016; Ross et. al. 2018) which suggests that reflection on own beliefs and values may be important in achieving some competencies, particularly in Domain 2 ('self-awareness in spiritual care'). Students attributed their learning about spiritual care to 'caring for patients' and 'discussions in university and with other students' (Ross et. al. 2018). Therefore, scenarios, narratives and case studies which encourage 'reflection in and on practice' (Weeks et. al. 2017) may be useful learning strategies in the attainment of competencies in Domains 1 ('knowledge in spiritual care'), 4 ('ethical and legal issues') and 6 ('assessment and implementation of spiritual care'). A reflective education model may encourage students to consider and critically review their practice, emotional responses and thoughts with the purpose of learning from these experiences and integrating them consciously in practice (van Leeuwen and Cusveller, 2004). Additionally, whether or not students encounter role models who practice spiritual care may help or hinder their appreciation of its importance (Giske 2012; Giske and Cone 2012).

Although the competency Framework provides an important guide to inform curriculum design, the 54 competencies require further refinement to identify what is essential to include within crowded undergraduate curricula. This work has begun through a three year (2016-2019) Erasmus+ funded project called 'Enhancing Nurses and Midwives Competency is Spiritual Care through Innovative Education and Compassionate Care' (EPICC Project). The project has engaged over 30 pre-registration nurse/midwifery educators and stakeholders from 21 European countries in reducing the

number of competencies to nine and then to four using a consensus approach. Encouragingly the competencies have been of relevance across countries, suggesting they are not culturally bound. Other outputs include a co-produced Gold Standard Educational Matrix to underpin the competencies, a Toolkit containing teaching and learning activities, a Website (www.epicc-project.eu) and a Network. Educators across the European countries involved, are testing out the competencies and teaching and learning activities within their universities. In some countries, where university curricula are currently being re-written, the competencies are shaping course design by being mapped against course content. They are also being used to assess students' spiritual care practice whilst on clinical placement.

Future developments

Further work is needed to inform student nurse/midwife selection by identifying the cognitive, functional and ethical attributes that are most likely to lead to spiritually competent practice. Although there is some evidence to support the theoretical model developed by Attard et. al. (2019) which highlights the development of spiritual care competency over time, further testing of that model is required, for example to identify the barriers and facilitators for development of spiritual care competency within the wider 'community of practice' (Weeks et. al. 2017).

Strengths and Limitations of the study

A major strength of the study is the use of extensive international evidence selected on the basis of strict quality assurance criteria to derive the initial list of competencies. Secondly, extensive stakeholder consultation informed development and refinement of the Framework (focus groups, Modified Delphi). This maximised its utility, ensuring the emergent Framework's relevance to nursing and midwifery education and practice. The study is further strengthened by the rigour of its triangulated research design.

The study is limited by the fact that the focus groups and Modified Delphi were conducted in Malta which is traditionally a Roman Catholic country. This was addressed to some extent by including stakeholders from other faith and non-faith backgrounds. It is possible that the new sixth factor ('healthcare chaplaincy') which emerged from the exploratory factor analysis (EFA) of the Framework is closely linked to the religious and spiritual beliefs of the participating sample and is a further limitation. However, a current project which is relating the competencies to nurse/midwifery pre-registration education across Europe (EPICC Project), suggests that the competencies may not be culturally bound, but rather universally relevant, at least across the 17 countries represented in that project.

CONCLUSION

A seven domain 54 item pre-registration spiritual care competency Framework which demonstrated good to strong internal consistency, stability and a good fit with a six factor model, was developed for

nurses and midwives using a rigorous triangulated research design. This is a landmark achievement as it is the first framework to be developed based upon a relevant and robust theoretical model (Benner, 1984; Carper, 1978), best available evidence (international literature and research), and ensuring its fitness for purpose through stakeholder engagement.

The competency Framework's greatest immediate contribution is in its ability to inform undergraduate nursing/midwifery curriculum design and delivery, a gap which has long been identified. Further work is needed to inform student selection and to identify the barriers and facilitators to spiritual care competency development, thereby enabling the production of an integrated model of spiritual care competency. This is important to ensure that the 'art' of nursing/midwifery is given the same attention as the 'science' and that patients/clients and their families experience the holistic and person centred care that international health care policy considers to be so important.

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DESIGN AND DEVELOPMENT OF A SPIRITUAL CARE COMPETENCY FRAMEWORK FOR PRE-REGISTRATION NURSES AND MIDWIVES: A MODIFIED DELPHI STUDY

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Table 1: The themes and categories identified from the focus groups

Domain 1: Body of knowledge in spiritual care		
Categories	**Themes**	**Domain**
Nurses'/midwives' need for Knowledge on spiritual/religious issues. Knowledge of spiritual/religious aspects of care. Nurses'/midwives' need for spiritual care education at pre- and post-registration. Knowledge of spiritual/religious issues relevant to clients' illness.	Elements in the educational preparation of nursing/midwifery students on spiritual/religious issues.	**BODY OF KNOWLEDGE IN SPIRITUAL CARE**
Domain 2: Self-awareness and use of self in spiritual care		
Categories	**Themes**	**Domain**
Nurses/midwives personal spirituality Vocational calling of nurse/midwife Meaning of spirituality/ religiosity Knowledge of spiritual/ religious interventions and access to resources Knowledge and respect for diverse beliefs and decisions that affect care Maintain professional barriers	The role of nurses/midwives in providing spiritual care Nursing/midwifery as vocational professions Educational preparation of nurses/midwives in spiritual/ religious issues	**SELF-AWARENESS AND USE OF SELF IN SPIRITUAL CARE**
Domain 3: Communication and interpersonal relationship in spiritual care		
Categories	**Themes**	**Domain**

Effective nurse/midwife-client communication. Dealing with clients' emotional needs. Being with the client and their family. Communication and interpersonal skills. Therapeutic client-nurse/midwife-relationship. Responding to cultural diversity. Nurses/midwives as healers.	Client's need for effective communication and interpersonal skills. Being with the client and their family. Responding to cultural diversity. Maintaining a good client – nurse/midwife relationship while respecting boundaries.	**COMMUNICATION AND INTERPERSONAL RELATIONSHIP IN SPIRITUAL CARE.**
Domain 4: Ethical and legal issues in spiritual care		
Categories	**Themes**	**Domain**
Ethical and legal issues that protect clients and staff. Clients' need for information to reach decisions. Respect for clients' spiritual/religious beliefs and decisions in their care. Respect for Issues pertaining to confidentially, dignity, information, clients' wishes.	Ethical and legal responsibilities relating to spiritual care in relation to the client, the family and team. Clients' rights for confidentiality, privacy, informed choice and dignity.	**ETHICAL AND LEGAL ISSUES IN SPIRITUAL CARE.**
Domain 5: Quality assurance in spiritual care		
Categories	**Themes**	**Domain**

Creating a spiritual environment for clients and staff. Nurses'/midwives' as providers of humane holistic care. Vocational calling of the nurse/midwife. Providing a multi-disciplinary approach to spiritual care. Maintaining professional boundaries. Professional and educational responsibilities of staff.	Nursing/midwifery as vocational professions. Nurses/midwives as providers of holistic care adopting a multi-disciplinary approach. Nurses'/midwives' responsibility in creating a spiritual environment for clients and staff. Responsibility of nurses/midwives to participate in continuing professional education to improve practice. Maintaining professional boundaries as outlined in the code of ethics.	**QUALITY ASSURANCE IN SPIRITUAL CARE**
Domain 6: Assessment and implementation of spiritual care		
Categories	**Themes**	**Domain**
Organisation of spiritual care. Assessment, implementation and evaluation of spiritual care. Spiritual assessment of clients and their families. Implementation of spiritual care and provision of interventions. Support for clients, their families and professionals. Implementing spiritual/religious interventions to clients and their families in hospital and community. Referral to spiritual leaders and other resources. Barriers to spiritual care.	Assessment of spiritual needs of clients and family. Organisation and Implementation of spiritual/religious interventions in hospital and community to assist clients find meaning and purpose. Referral to spiritual leaders and other members of the multi-disciplinary team.	**ASSESSMENT AND IMPLEMENTATION OF SPIRITUAL CARE**
Domain 7: Informatics in spiritual care		
Categories	**Themes**	**Domain**

Use of video conferencing as a resource for learning about spiritual care	Information technology a resource to assist spiritual care.	**INFORMATICS IN SPIRITUAL CARE**

Table 2: Modified Delphi Questionnaire

Generic core competencies in spiritual care Domain 1: Knowledge in spiritual care
1. Recognise the role of nurses/midwives in demonstrating an understanding of the concept of spirituality through an individualised *(personalised)* view of care, attentive to the body-mind-spirit in all healthcare settings.
2. Identify the influence of the world's major faiths/religions (*e.g. Christianity, Islam, Judaism, Hindu and Buddhism*) cultural beliefs and practices in the appropriate clinical context and along the lifespan continuum (*from conception to death*).
3. Demonstrate knowledge of the basic spiritual needs of individuals which include: • A meaningful philosophy of life (*values and moral sense*). • A sense of the transcendent (*outside of self, view of deity/higher power and something beyond the immediate life, having hope*). • Belief and faith in self, others and for some a belief in a deity/higher power. • A relatedness to nature and people (*friendship*). • Experiencing love and forgiveness (*a sense of life meaning*).
4. Recognise the importance of the spiritual dimension (*with or without religion*) that sustains physical and mental well-being.
5. Identify the distinctions and relationship between spirituality and religiosity and acknowledge cultural differences in meeting spiritual and religious needs related to health.
6. Demonstrate knowledge and understanding of the client's condition in order to understand his/her behaviour in dealing with spiritual needs.
7. Demonstrate knowledge of spiritual assessment through established tools (*e.g. FICA, RESPECT and HOPE tools*) and informal methods (e.g. *listening to clients' stories*).
8. Demonstrate knowledge and understanding of the grieving process (*denial, anger, bargaining, depression and acceptance*).
9. Demonstrate knowledge and understanding of spiritual/religious development of individuals and assist spiritual/religious growth.
10. Demonstrate knowledge of complex theories of spirituality, such as helping skills, caring and healing theories in assisting clients to get the strength to accept and cope with life's crisis situations.

11. Value knowledge and experience as important elements in dealing with the clients' and their families existential questions (*e.g. What have I done to deserve all this? Why me? What is the meaning and purpose of this?*)
12. Acknowledge the role of chaplains, spiritual leaders as part of the multi-disciplinary team in providing spiritual care.
13. Demonstrate knowledge of resources, support systems/agencies that inform nurses/midwives to access spiritual care for clients, their families and staff in all healthcare settings (*e.g. place for worship, Church and support groups*).
14. Demonstrate knowledge on assisting clients in healthcare according to the clients' religious/spiritual, cultural beliefs, such as the use of complimentary/alternative therapies, diets, nutritional supplements and prayer.

Domain 2: Self-awareness and the use of self

15. Be aware of own spirituality and use of self (*e.g. own strengths, limitations, values, beliefs*) as a resource for spiritual care.
16. Recognise the possible impact of the nurse's/midwife's own spirituality during interactions with clients and colleagues and avoid imposing this in providing spiritual care.
17. Acknowledge and respect the influence of clients' diverse cultural world views, beliefs and practices in the expression of their spirituality in healthcare.
18. Acknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team (*e.g. psychologists, chaplains, counsellors, spiritual leaders*) as deemed necessary.
19. Address personal inner feelings and stressful situations through consultation and participation in reflective/support groups to reflect *in* and *on* actions as a means of self-awareness on the quality of spiritual care.

Domain 3: Communication and interpersonal skills

20. Understand and communicate the principles of the ministry of 'PRESENCE' by being with the clients/families in their spiritual needs and sufferings.
21. Understand and communicate the principles of the 'ministry of WORDS' by the use of the spoken language, appropriate humour, spiritual/religious readings and prayer as a means of encouragement and hope.
22. Assess barriers to effective communication in providing spiritual care (*e.g. language, beliefs, culture, anxiety, fear and anger*) and adapt accordingly by active listening, empathy and/or referral to other members of the multi-disciplinary team.
23. Understand and apply the principles of a therapeutic trustful nurse/midwife-client relationship by responding appropriately providing realistic hope in order to accompany them on their journey.
24. Assess the impact of self on the effectiveness of communication in spiritual care while maintaining boundaries between the nurse/midwife-client relationship (abiding by the professional ethical/legal codes of conduct).

Domain 4: Ethical and legal issues

25. Appreciate the uniqueness of each person and their right to decline spiritual care.

26. Demonstrate sensitivity and respect for diversity in clients' and their families' religious/spiritual beliefs, values, practices and lifestyles (*e.g. diet, sexual orientation*).

27. Demonstrate sensitivity, support and respect for the client's autonomous and diverse healthcare decisions/choices influenced by religious/spiritual beliefs and practices (*e.g. blood transfusion, childbirth practices, chemotherapy, immunisation*).
28. Facilitate ways of safeguarding clients' privacy, safety and security guided by the ethical code of conduct to maintain clients' dignity (*self-esteem and self-respect*) and integrity (*adherence to moral and ethical principles*).
29. Acknowledge and respect the clients' right for information and informed consent to empower the m and facilitate decision-making regarding their illness, care and treatment in line with their values, spiritual/religious beliefs and practices.
30. Disclose clients' spiritual/religious information verbally or by documenting in an empathetic, sensitive manner to the multi-disciplinary team, while maintaining confidentiality to safeguard clients' welfare.

Domain 5: Quality assurance in spiritual care

31. Identify the contribution of spirituality towards self-professional growth based on the vocational calling as a nurse/midwife.
32. Implement professional caring behaviour demonstrating altruism (*a sense of giving*), wisdom, discipline, joy, responsibility, patience, understanding, caring, courage, reassurance and trust towards the clients, their families and colleagues.
33. Provide supervision in the provision of emotional support of professionals, students and members of the team engaged in spiritual care in order to have the capacity to witness and endure distress while sustaining courage and hope to move on.
34. Recognise the need for continuing educational interest through supervision, self- reflection, role models, conferences and other learning resources in order to improve spiritual care.

35. Take initiative to participate in research, projects, innovations and teaching activities on spirituality and spiritual care designed to utilise the evidence to bring about practice improvement.

36. Create and foster a spiritual work environment through a supportive, caring, calm environment, nurtured by a spiritual healthy workforce, support system and purposeful activity, such as creative art (*e.g. painting*).
37. Acknowledge the importance of evaluating the environment to determine the extent of spiritual well-being of clients, their families and health carers and modify accordingly.
38. Evaluate spiritual care resources to maintain consistency in holistic care while identifying the legal, political and economic implications of incorporating spiritual care in all healthcare system.

Domain 6: Assessment and implementation of spiritual care

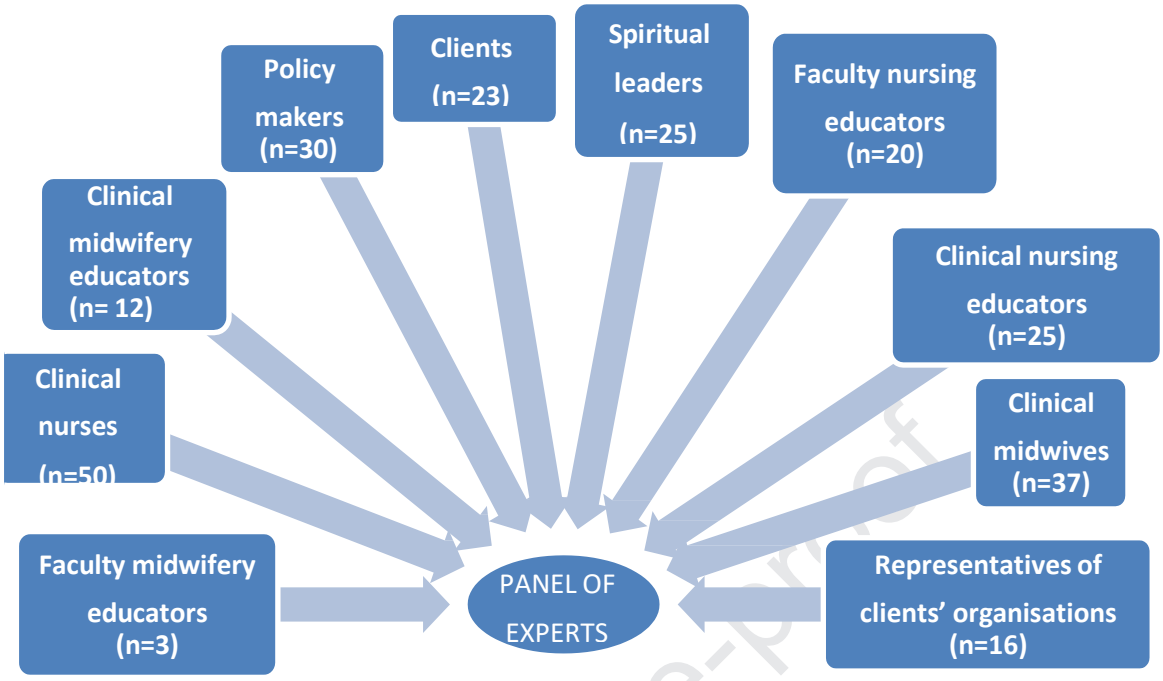
39. Demonstrate ability to facilitate clients' expression of their thoughts and feelings about spirituality to elicit a spiritual history, by the use of formal (*using an established tool*) and informal (*listening to the clients' experiences*) assessment methods.

40. Identify signs of spiritual distress in clients and family (*e.g. pain, anxiety, guilt, loss, anger at God and despair*) and plan to address this distress while being aware of barriers to spiritual care, such as lack of time and education.
41. Plan spiritual care while identifying its intersections (*shared elements*) with ethical, legal, psychological, cultural, spiritual, religious issues and health concerns.
42. Utilise spiritual care models which integrate client-centred care and a problem–based approach while focusing on holistic care.
43. Plan spiritual care in the best interest of the client by including the client and the multi-disciplinary team in order to meet the clients' spiritual needs holistically.
44. Understands the 'ministry of ACTION' in conveying spiritual care i.e. helping clients find meaning in their suffering while addressing compassionately their spiritual/religious needs maintaining patience, tact, perseverance and discipline.
45. Provide spiritual care interventions sensitively by promoting clients' positive self- concept (*e.g. positive coping techniques*) monitoring spiritual expression while respecting clients who do not conform to advice given on their health.
46. Respond to clients' spiritual needs promptly demonstrating unhurried actions and good quality time.
47. Facilitate family participation in the care of the irrelative to maintain spiritual habits and rituals and identify alternatives to instil hope.
48. Recognise and acknowledge the role of chaplains and spiritual leaders as experts and collaborators in spiritual care to clients, their families and other members of the multi-disciplinary team.
49. Recognise the importance of timely referral of clients/their families to chaplains and spiritual leaders and members of the multi-disciplinary team (*e.g. counsellor, psychologist*).
50. Provide spiritual care feedback to clients and the relevant members of the team ensuring follow-up.
51. Monitor and evaluate effectiveness of spiritual care interventions in order to recognise unmet spiritual needs, identify problems encountered during spiritual interventions, and provide possible solutions to enhance delivery of spiritual care.

Domain 7: Informatics in spiritual care

52. Acknowledge the use of information technology as a resource of learning about spiritual care.
53. Acknowledge the use of information technology as a means of a communication network with clients/their families and members of the multi-disciplinary team on spiritual issues and spiritual support.
54. Acknowledge the use of information technology as a means of documenting spiritual care delivered and to maintain consistency with holistic care.
55. Acknowledge the use of information technology, such as Face book, Twitter, Desk Monitor etc. as a medium for spiritual inspirations

Figure 1 The modified Delphi groups of 'experts'



1. Qualified nurses/midwives directly involved with the care of clients in a medical/surgical/mental health/palliative or maternity care settings in hospital and public healthcare sector and who have demonstrated the required level of competency in spiritual care through the Spiritual Care Competency Scale (SCCS) set selective criteria (van Leeuwen *et al.*, 2008).
2. Nursing or midwifery educators involved in the teaching of pre-registration nursing/midwifery students at the Faculty and clinical practice.
3. Chaplains and spiritual leaders of different religious denominations assisting clients in hospital and the public healthcare setting and persons considered by colleagues as an authority in the area of spirituality in nursing/midwifery, such as the hospital psychologist, counsellors, bereavement midwife and persons involved in pastoral care.
4. Policy makers in nursing/midwifery, such as managers, directors, representatives of nursing and midwifery unions and client organisations.
5. Representatives of patients' organisations, such as breast cancer, organ transplant, asthma and support groups for those suffering from diabetes.
6. Clients who have received care in a medical/surgical/mental health/palliative or maternity department in a public and/or private healthcare setting. Participants must have a good command of the English language.

Participants had to have a good command of the English language, be willing to participate and had sufficient time to participate in the study.

No conflict of Interest