Faith in Older People

NHS Education for Scotland

A scoping review to examine pre- and post-registration education in spiritual care for nurses and allied health professionals, excluding medicine and chaplaincy, in Scottish Higher Education Institutions (HEIs)

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A man was walking along a beach which was littered with starfish wriggling and gasping for water. He saw a boy throwing the starfish back into the sea. 'Why are you bothering,' said the man, 'when there are so many, and the next tide will bring more?' 'Well,' replied the boy, 'it makes a world of difference to the ones who do get thrown back.'

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and devotion in searching for the truth and their ability to articulate with clarity the critical points raised during the course of the scoping review.

A scoping review to examine pre- and post-registration education in spiritual care for nurses and allied health professionals, excluding medicine and chaplaincy, in Scottish Higher Education Institutions (HEIs)

March - September 2020

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First our thanks go to all those who agreed to be interviewed. They gave unstintingly of their expertise and time during a national crisis to inform this paper. Ten HEIs across Scotland were interviewed including two post graduate courses for nurses.

Introduction

In 2018 Faith in Older People (FiOP) and NHS Lothian Spiritual Care Team collaborated on a project to identify gaps in the care sector that pertained to spiritual care (SC). This was carried out by Aird and O'Neill (2018) in Hospital Based Complex Clinical Care Units (HBCCC) and a further paper Jaquet (2019) in Care Homes. Both papers made the following recommendations:

- Spiritual care educational resources should be identified and collated

- Education in spiritual care should be provided in undergraduate training of nurses and further embedded through continuing professional development.

As a result of this a proposal was made to NHS Education Spiritual Care Unit to carry out a scoping review on an identified group of Higher Education Institutions (HEIs), to ascertain the extent to which SC is a part of the curriculum in nursing and the current resources used in learning.

The background to the proposal was embedded in guidelines from the Scottish Government:

1. Scottish Government (2009) states that spiritual care (SC) is integral to healthcare, commending the work which had implemented previous policies drawn up by the Scottish Executive Health Department (SEHD 2002). The SEHD (2002) recognised that spiritual care teams are a vital link in providing specialist input in situations of long-term care, resourcing healthcare staff, and facilitating and delivering SC directly to patients, their visitors, and staff (Aird and O'Neill 2018). The integration of health and social care services extends this remit to include care/nursing homes to which the National Care Standards (2018) also apply, and which are based on a human rights approach.

2. Scotland's House of Care model (2014): 'Spiritual care is necessary for person-centred care and is therefore an integral part of healthcare.'

3. The Health boards have an obligation to deliver SC, considering a range of health-related policies such as the palliative care delivery plan (Scottish Government 2015).

4. The nature of increasingly dependent multi complex patients necessitates the acute need for Spiritual Care Education (SCE) of health staff (Aird and O'Neill, 2018).

Given that these two substantial pieces of research were based on current literature reviews and Scottish Government Guidelines it became apparent that a scoping review would enable a better understanding of the spiritual care education available to health care professionals in Scottish Higher Education Institutions.

Aim of scoping exercise

The overall aim was to make an inquiry into identified Health and Social Science Faculties in Scottish HEIs to determine the definition and teaching of SC that is available to nursing students. The exercise would encompass the inclusion of all faiths and none using the definition of the NHS Spiritual Care Teams of 'what gives meaning and purpose to someone's life' (Levison 2009), drawing on the definition of SC and its relationship to religious care as set out in the Scottish Executive Health Department 2002:

Spiritual care is usually given in a one-to-one relationship, is completely person centred and makes no assumptions about personal conviction or life orientation.

Religious care is given in the context of shared religious beliefs, values, liturgies, and lifestyle of a faith community.

Spiritual Care is not necessarily religious

Religious Care at its best should always be spiritual

Objectives of the scoping review:

- A literature review specific to HEI modules on SCE.
- Identify questions which will enable engagement with module leaders in an appreciative enquiry of SCE amongst a chosen sample of HEIs.
- Identify and analyse differences in approach and emphasis between HEIs.
- Create a framework for existing SCE resources identifying any gaps in current framework.
- Recommendations drawn from HEI interviews for inclusion of SCE in teaching programmes.

Methodology

The sample chosen for interview fulfilled the following criteria:

- An undergraduate or postgraduate programme for nursing.
- A prior agreement to be interviewed about SCE within the existing programme.

After searching the websites of each of the chosen samples, interviewees were selected based on their involvement with SCE within the nursing programme.

Each interview took an average of one hour over zoom with pre-set open- ended questions, in the form of appreciative enquiry, sent prior to the interview together with a list of educational resources and the reason for the scoping review. The interviews took place during the pandemic of Covid-19 and presented the research team with various challenges in communication with the HEIs. During this time, revalidation was required for all pre-registration nursing undergraduate programmes in Scotland. This was in once sense helpful

as all the modules were being revised giving permission to discuss SCE not previously articulated as a subject for nursing students. However it also caused some difficulty in setting up the interviews due to the immense pressure exerted on lecturers who were having to deliver lectures in an unprecedented way as well as support students on work placements that had not been previously envisaged. Consequently, this project has run over its projected time by three months, with the agreement of the project managers.

At the commencement of the interviews it was stated that all anonymity of participants and HEIs would be preserved in the writing up of the final paper. The questions were devised based on the main subject areas in learning: Subject matter; rationale for inclusion; methods of learning; assessment and resources. Because of the nature of open ended questioning the rich diversity of discussion clarified responses while standardising the interview process (Cormack, 1991).

Emerging themes were discussed within the research team during the four months of qualitative information gathering. Each interview was recorded in writing, transcribed, and classified into eleven main themes, building up a cohesive picture of SCE across the sample of HEIs. At the end of the process, the draft paper was discussed by the stakeholders, agreed, edited, and formatted before final publication.

Funding: Proposal accepted and funded by National Health Education for Scotland (NES) March 2020.

Ethical considerations

As this was in collaboration with NES the team was able to obtain permission from individual lecturers providing anonymity was preserved.

Literature Search Discussion

The literature search (*app i*) was initially based on previous knowledge gained from the research carried out in the Aird O'Neill (2018) and Jaquet (2019) papers. Both these papers concluded that health care workers offered and gave spiritual care to patients but were unable to articulate a definition or understand the skills of spiritual care, given that they had no formal education of the subject. Both before and after these papers were written there has been a plethora of literature available on the subject of SCE, particularly in the area of the need for this learning to be embedded in health care training (Booth, Kaylor 2018; Hu et al 2019). The Knowledge Network from the National Health Education for Scotland provided the literature and were extremely helpful in accessing information on papers not found on their platform.

Throughout the scoping review a snowball effect of additional literature enabled a more thorough view of SCE not just in Scotland, but also on the international platform. It was deemed important to reference the past (Cormack 1991) in order to give an overview of the SCE trajectory that has taken place in Scotland, affected by global influences and worldview trends. With this in mind, the literature search is in chronological order from 1994-2020. Bradshaw's seminal work (1994) provided a theoretical framework for SC in nursing, which although narrow in concept, gave nursing scholars a basis from which to open further discussion and debate.

It is surprising that with such a wealth of papers written on the subject of spiritual care there is little evidence of either knowledge or understanding within nursing care practice (Aird, O'Neill 2018; Connors et al 2017) or facilitated learning at undergraduate level (Cooper, Chang 2016). Given the wide range and variety of literature available, the search was selected on the basis of developing SCE within the curriculum; models of learning in SCE; resources available for teaching, assessment, practice and evaluation; and finally two papers were selected which described moral injury, the result of internal scarring from unresolved significant events in professional life.

Virtually all the literature described the practical dichotomy of nurses at the bedside of patients listening to deep questions about life that they felt unable to answer, not only for the patient but also for themselves. As a consequence all the models of learning have an

existential framework enabling the healthcare professional to look inwards before looking outwards (Frouzandeh et al 2015; Narayanasamy 1999; Strand et al 2016; Best et al 2020; Attard et al 2019).

The basis of developing SCE within the curriculum:

Bradshaw (1994) commenced the debate within nursing which articulated the historical spiritual philosophy of the care of people and the conflict that this presented to the modern anthropocentric philosophical position of contemporary nursing. This debate has continued a global scale, culminating in the dichotomy of current discussion that seeks to ensure person centred care remains with the person and not with the professional. The post enlightenment person centred philosophy has now been realised in nursing not only for the patient but also in seeking to address the needs of the carer.

However, it appears that the literature addressing these debates have come mainly from the northern hemisphere western worldview and rarely from either the southern hemisphere or east of Europe. Ross (1996); Bradshaw (1997) and Grosvenor (2000) continued to discuss the possibilities of how to teach SC and the form this would take in the curriculum at the time. The evidence for the need to teach nurses how to answer existential questions was clear as well as the positive effect that spiritual care had on health (Grosvenor 2000). Grosvenor (2000) was able to add 4 hours of teaching into the BSc three- year programme but found difficulty in accessing appropriate trainers. Pesut (2002) entered the debate, along with many others from the Americas, and evaluated the spiritual care content of their nursing baccalaureate. There was a clear need to develop the self-reflective content of the SCE and the baton was picked up by many others (Cerra Fitzpatrick 2008; Kennedy et al 2013).

Much more importantly it appeared that SCE was required to be embedded at a much higher level for it to become an integral part of the curriculum. Both Bradshaw (1994) and Kennedy et al (2013) recommended that spiritual care did not become another module but was instead threaded through the curriculum as a whole philosophy of caring. In 2008, the Scottish Government Health Department developed a spiritual care competency framework for all practitioners. This gave a clear directive to all educational institutions to embed SCE as part of their curriculum in health care professional learning.

During this time, international scholarly articles were being added to the library of SCE. Cooper et al (2013) observed that the Australian Nursing Council required nurses to provide SC, for which there was no formal content within their teaching curriculum. Baldacchino et al (2015) started to undertake research in Malta with student nurses using a newly formed model of SCE. Frouzandeh et al (2015) introduced SCE in Iran and then formally evaluated it with positive results. Hu et al (2019) recognised China's inadequate training as well as resources in SCE but saw the essential need for spiritual care in practice. In Taiwan Suh-Ing et al (2019) evaluated their SCE module and realised that there were significant gaps in the nurse's SCE. The European Association for Palliative Care re-evaluated its SCE (Best 2020) and again discovered that there were significant gaps in the education since the introduction of guidelines in 2013 and so revised their training. This established SCE as an international need but required a sharing of information across the whole globe. Certainly, many of these articles have cited one another, and in particular the late Professor Baldacchino as well as Ross, Attard and Bradshaw feature highly in various papers. Some scholars may see this as a negative use of 'inhouse' citations, rather than citing authors whose work is coal face as opposed to academic.

The World Health Organisation (2014) have a paucity of information on spiritual care within their documents, one of which (The Global Atlas of Palliative Care at the End of Life 2014) documents the need for the integration of psychological and SC however there is no expansion of this in the body of the document and no guidance as to the resources that might be available for learning. They cite the American and Tanzanian model of Lutheran Churches supporting the healthcare system, but do not appear to have a model for learning in SCE.

In the UK, the Nursing and Midwifery code of Professional Standards of Practice (2018) provide a specific basis for enabling academics to include SCE in their curriculums:

Prioritising People:

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed, and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

While subsequent paragraphs do not mention the words ‘spiritual care’ it is evident from research that this should be included as the golden thread running through ‘prioritising people’. The above NMC framework is the worldviews and values that people uphold throughout their lives, regardless of their circumstances, and therefore should be upheld by those who care for them. However, it is difficult to find spiritual care language present in the 2018 standards.

The Six Cs (2020), which is a set of values for all health and social care staff, **comprise courage, commitment, compassion, competence, communication, and care**. These were written for NHS England but did not specifically articulate spiritual care. The 2020 NMC competencies for registered nurses, expects them to ‘carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, **spiritual,** genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement.’ It seems to be not that the values of SC are missing but rather the SC language used to describe them, which if not articulated by teachers, will be challenging to be embedded in practice by learners.

The literature search raised the following questions and informed the questionnaire (*app iv*):

- What methods do HEIs employ to teach SCE?
- What resources do they use?
- How do nurses ‘carry out comprehensive and systematic SC nursing assessments’ on patients in their care?
- How are nurses assessed as competent to deliver SC in practice?

Summary of themes compiled from all interviews

1. Curricular Spiritual Care Education Component

The SCE component in each curriculum had a diverse range, but all held to the same understanding as defined by Mowat and Swinton (2018) that *the spiritual task is to offer friendship, comfort, and hope to each other in ways that are meaningful to the individuals concerned.* Although the literature cites various SCE models of learning none of them were used in any of the HEIs in Scotland. Two of the HEIs gave examples of other models of learning that they were using and felt had a significant component of SC within that model. An explanation of SC models used internationally is given in *app ii* as well as in Box 1.

Box 1. Spiritual Care Models of Learning

1. Attard et al Ross competency Framework (2019) details 54 competencies for spiritual care and the development of this into a framework for learning. Seven spiritual care domains were evaluated positively in Malta and subsequently trialled in 19 countries. It is able to transcend through all modules as a threaded approach rather than the stand alone module.

2. Barba B Tesh A Courts N (2002) describe the Edenization of community living which turns an institution into a home using the paradigm of joy, love, and hope. SCE is not overt, and neither is it named, but it is stamped across the whole philosophy. The foundation of Edenization has been used in some HEIs to teach students how to care, particularly for older people, who are called Elders, not because they are older, but because of the mature and experienced knowledge that they can bring to a community. Those who care for them are in their space at the Elder's invitation, not because the carer should be there.

3. Best et al Palliative Care Model (2020) addresses spiritual care in an end of life setting. It was a reworking of Gamondi et al's (2012) model of SCE which developed modules as standalone or incorporated into existing modules. This is multi-disciplinary learning led by the Chaplain. Facilitated self-reflection is blended with an understanding of spiritual care and the tools required for spiritual assessment. What is most interesting about this model is the spiritual care language used throughout, and therefore a rounded understanding that what is being discussed in the classroom will reach the bedside.

4. Frouzandeh (2015) training course: Trialled and evaluated in Iran using blended learning which taught nurses how to alleviate spiritual tension in patients. Prior to this model being launched there had been no concept of SCE within the curriculum. The evaluation showed a marked improvement in the confidence of nurses to offer and promote spiritual care amongst patients.

5. McTaggart et al's (2012) GLIDER Model was developed by a Chaplaincy team for delivery across several platforms of learning. It used blended learning with practice-based scenarios and was developed using the Spiritual Care Matters document for NHS Scotland. Learners explored spiritual care issues in secure environments, using summative assessment to gain the final certificate. Evaluation demonstrated improved patient care and staff wellbeing. This Model is now being rewritten to take into consideration more current methods of practice in SCE.

6. Narayanasamy' s ASSET Model (1999) was developed in response to the need for clearer direction in the delivery of SCE for nurses. It is a standalone module using blended learning applying knowledge and skills in the practical setting. The list of resources which accompany this model are all pre 1999, although Narayanasamy' s own work was republished in 2001.

7. Norwegian Partnership Model developed by Strand et al (2016) was a mixture of didactic teaching and reflective groups. It was particularly addressing questions of an existential nature raised by patients that nurses could not answer. After evaluation, this study concluded that the learning model had the potential to increase nurse's confidence in delivering spiritual care by being able to answer questions of life.

8. RCN Domains and competencies for Advanced Practitioner's (2018) list Spiritual Competencies from 7.9 – 7.14 in its document. While this is not a model in itself it does list six areas of SC which makes the presumption that an advanced nurse practitioner is able to assess spirituality for a patient in their care and then provide respectful and appropriate information to fulfil a patient's needs.

9. Williams (2015) described the Roper-Logan-Tierney (R-L-T) model of Nursing which is a practice centred theoretical model grounded in realism and accessibility. In 1929 Jean Piaget advanced developmental theory in psychology, underlying it with the philosophy of pragmatism. Roper, Logan, and Tierney used Piaget's theory to formulate a model of nursing now widely used (Bradshaw 1994). It was Roper (Edinburgh University) who first devised a model to answer the question 'What is nursing?' during the 1970s. Logan refined the model with Tierney and the results were published in 1980 as The Elements of Nursing. Over the years this has been further refined in line with current thinking to facilitate teaching and learning, patient assessment and care planning. Some HEIs feel that this addresses the spiritual content of a curriculum.

10. Spiritual Care Competencies for Chaplains (2020) details a Higher Education programme for healthcare chaplains across the UK. Four domains describe expectations of a registered healthcare chaplain focusing on spirituality and spiritual care, assuming that any religious needs will be met in the context of appropriate spiritual care. This has been included as it broadly follows

the spiritual conceptual framework expected of nurses in training and could be helpful when discussing SCE.

11. Sulmasy' s (2002) Biopsychosocial-Spiritual Model: This model is used in some HEIs as a way of approaching a complete understanding of a persons' wholeness. It was first initiated by George Engel in 1977 and later a similar model was adopted in 1996 by White, Williams and Greenberg. It was then developed by Sulmasy (2002) into a model of restoration of right relationships within the body. Interestingly his meaning, value and life statements correspond particularly with the pandemic in 2020: Dying raises questions of value, often subsumed under the term dignity; questions of meaning are often subsumed under the word hope. Questions of relationship are often expressed in the need for forgiveness. To take this further: to die believing that one's life and death have been of no value is the ultimate indignity; to die believing that there is no meaning to life, suffering, or death is abject hopelessness. To die alone and unforgiven is utter alienation. The author examines various ways of assessing spiritual needs, attitudes to stressful life events in order to find those that are best able to facilitate the patient's spiritual healing at the end of life.

12. Warrender and MacPherson's (2018) 'spiritual transition model' shows how mental distress may move through five stages before once again living a meaningful life. They discuss denial, social disengagement, and the subject of social death, when a person is viewed as less socially valuable, compared with biological death. The five key components of Spirituality: meaning; value; transcendence; connecting; becoming are modelled as the driver for nursing care, individually or corporately.

1.1 Six out of the ten HEIs felt that there was 'not enough' or 'no evidence' of SCE content within the programme and what there was tended to be 'ad hoc' or 'random'. Some commented on the gaps in student learning, such as

recognition of the theory of SC as a specific subject or the use of spiritual language in the classroom which would be recognisable in practice.

1.2 Most described the SCE component in other terms, such as

- Values Based Reflective Practice (VBRP)
- What Matters to You
- Understanding Mental Health and Well Being; compassion
- Palliative Care
- Inner spirit lectures
- Caring for self and others
- Communication in difficult circumstances
- Courageous Conversations
- Breaking bad news
- Personhood
- Making Sense
- Delivering Nursing Care
- VIPS (Values based professional practice)
- Facing Older People
- 10 Essential Shared Capabilities of Mental Health
- Edenising your Environment
- Problem based learning methodologies.

1.3 Others felt that SCE did not generally fit into the competency framework of present curriculum, ‘not as a deliberate omission but more by chance.’

1.4 For those who specifically mentioned SCE within their curriculum it took the form of the following:

- Spiritual Care Module with assessment
- Spiritual Care Assessment and Care Planning
- Applying Spiritual Care for Self-Care
- Understanding Spiritual Care

- Spiritual Care in Practice
- Death and Spiritual Well Being
- Discussion forums for self-reflection on spirituality
- Spiritual Care Matters
- Death and Dying
- The Spiritual and Relational components of caring.

One felt the subject of Gerontology laid down a foundation of basic nursing care which enabled the subject of spirituality to be addressed more easily. Some of these modules are standalone while others are repeated across three years of learning increasing in depth and understanding. In one HEI first year students are given a critical understanding of SCE enabling them to internally process the concept.

1.5 It appeared that most of the HEIs felt that SCE was a natural, but not articulated, component of palliative and mental health care. There is a perception that palliative or mental health care holds the monopoly for discussing SCE. All other life situations did not feature highly as needing SC input. However, it seems that even palliative and mental healthcare have thin evidence of the core values of SCE. Student nurses can face death on their first day on a ward having not had a single conversation about how, what, or why. One HEI explained that most students are quite young and have not had the life experience needed to deal with death and dying, and so are quite unable to answer or even listen to existential questions. This is the single most important reason for core values to be taught in first year rather than a tragedy that reminds educators to teach SC, said one interviewee.

1.6 One HEI felt that it was important for nurses to think about their own personhood and so encouraged them to work on a self-portrait of ten key personal characteristics. This would then enable them to think about the same aspects in others, who might be fearful of initiating a courageous conversation.

1.7 Various phrases or euphemisms were used to describe what SCE means: ‘feeding the soul’; ‘connecting with the soul’; ‘whittling down the language and terminology to mean spiritual care’, but none of this ‘soul language’ was present in the curriculum.

1.8 Where religion and faith are inextricably linked to the culture of the community there is a fear that this will cause conflict and tension if introduced in the classroom. In this environment the challenge for the lecturers is how to facilitate that discussion in a safe and secure environment while at the same time ensuring students can articulate the difference between spirituality and religion. This may possibly require the updating of the spiritual care definition as quoted at the commencement of this paper (HDL (2002)76). In subsequent discussions it was pointed out that to understand and give credence to someone's faith or underlying philosophy of life was a basic human right. Therefore, nurses need to learn the art of asking a patient whether they adhere to a religion or none in order to give greater holistic care. This has been described by Bremault Phillips and her colleagues (2014/16) who have devised a SC tool for initial patient assessment. Three HEIs touched on this subject, two feeling that nothing should be taboo in a discussion and one holding to the view that SCE discussions could cause conflict and tension particularly for individual students. However programme leads recognised that although a sensitive approach was required to prevent SCE become the subject rather than nursing, there was a need to teach nurses accommodation and recognition of individual faith preferences which would in all probability differ from their own. It is important to recognise that according to the European Union Statistics (2019) 64.1% of the population of the UK have a faith- based religion. While these statistics may be somewhat out of date, nonetheless it would appear that almost two thirds of the population are disenfranchised if student nurses are not able to access religious or SC learning at some point during their training. What matters to the patient should be the highest priority for a healthcare provider, whether this means providing pet therapy; calling an appropriate person with specialist knowledge to give care or reading a portion of the Bible or Qur'an if the patient cannot do this for themselves.

1.9 The length of time given to SCE or similar subject was wide ranging. Chaplains as invited lecturers are given only a short period of time to discuss the biggest questions of life that will face a nurse. Table 1 shows the wide range of time across the different HEIs to SCE which is most likely in a three- year course:

Table 1: Allotment of time given to SCE across Scottish HEIs

- Midwives are taught baby loss and the role of the chaplain – 1 hour.
- 1 or 2x2hr sessions in 1st and/or 2nd year – Death and Dying; inevitability of dying; grief; bereavement; mortality. In 2nd year it evolves into the meaning of life and a deeper understanding of dying and could possibly include a three-hour workshop.
- One HEI had a whole day devoted to SCE in first year using chaplain lecturers.
- 3rd year involved palliative care and bereavement care with a 2- hour session and occasionally Values Based Reflective Practice (VBRP).
- Induction training is now online, so the face to face component has gone which makes it difficult to discuss deep issues of death and dying at the beginning of training. Could be counterproductive if some nurses have already faced this in their own lives but not dealt with it appropriately.

1.10 Chaplains are often involved in the teaching of student nurses but feel 'utterly inadequate' because they have much more to say than in the allotted time. Yet they see a real appetite for the subject of SC because of its emotive component. If the classes are too large, discussion is challenging. Smaller HEIs have the advantage over the large classes of 100 or so where discussion or workshops have difficulty in creating safe spaces in which to hold reflective dialogue. Chaplains reveal that the learning of SC works best when they are involved in the design and delivery because they are specialists in their subjects. If the module leader has no previous involvement or knowledge of SCE then to design a course and deliver it is challenging. One HEI said that SCE should be foundational. 'It is something we engage in as a whole person vocation rather than connecting our memories and intellect for the process of medical care'. Another commented that over the past few years their involvement with student nurses had been greatly reduced and now only consisted of one lecture on SCE during the three/four- year course. In this HEI Palliative care had also had its SCE component cut from a suite of 8 modules to 3 modules. 'Such a

reduction in a subject means that the thinness of learning renders it almost unrecognisable.'

2. Rationale for inclusion of SCE within the curriculum

The rationale for including SCE in the curriculum proved just as diverse in all ten HEIs. The content of curriculums is determined by the programme lead in discussion with the team who have various expert knowledge.

2.1 Curriculum is led by requirements of the registering body for each person on the register to have certain learnt knowledge. In terms of nursing, the Nursing and Midwifery Council (NMC) require all new nurses to understand spiritual care assessment. Spiritual Care is part of the essential skills clusters of the NMC. In the UK Board of Healthcare Chaplaincy Competency Framework (2020) there is reference to the need for training nurses in SC. It quotes that 'spiritual care is now expected of nurses based on the NMC competencies for new registrants.' However, only three out of ten HEIs quoted the NMC expectation as a driver for learning. One mentioned it as a reference for a new course commencing in the autumn while another said that although nursing study was based around the person centred framework and the NMC standards it should be patient needs and nurse learning that drives the curriculum rather than a list of standards. 'Standards have to be maintained but should not be the means by which care is given or received as it is the care that is the foundational aspect and not a list of achieved standards.'

2.2 The above requirement from the NMC is not explicit in either content or method of learning. This means that the SCE content ebbs and flows over a period of time dependant on lecturers available and their interpretation.

2.3 One HEI described the primary driver for SCE inclusion as attrition of students who felt they had not been prepared for the challenges of death and dying and the need to answer existential queries from patients.

2.4 Other module teams look at content of learning and then discuss who is best placed to deliver, drawing in guest lecturers or others with expert knowledge.

SCE content in the programme is then determined on asset- based strengths of the programme team.

2.5 In one HEI, the module leader was involved in decision making for the inclusion of SCE but because the clinical component of nursing was so great lectures with a lesser priority were required to be streamlined of which SC was one.

2.6 Students themselves can be drivers for inclusion of subject content depending on the lecturer's knowledge. One interviewee said that nurses do want more learning on how to hold critical conversations with patients, particularly about death and dying. Even though some HEIs offer additional modules for extracurricular study in SCE one at least does not encourage student nurses to take this up due to possible conflict of study time available.

2.7 The rationale for including VBRP is TURAS (the CPD digital platform for all nurses) and can be used as an alternative approach for personal reflection post registration. There appears to be a misunderstanding amongst nurses as to what spiritual care consists of – for instance in one class of VBRP nurses were tittering because they felt that it was not relevant to them. Perhaps because they do not have a grounding in spiritual understanding during their training and therefore no theory that allows them to be able to give context to SC in practice.

2.8 For postgraduate nurses, the RCN competencies for Advanced Practitioners (AP) includes spiritual competencies in one of its domains. However, most post graduate programmes have an expectation, rather than a pre-requisite of learning, that nurses will arrive with pre-existing SCE knowledge and so do not teach this subject in their already packed programmes. If they have had no SCE during training, then they are at a prior disadvantage as an AP.

2.9 Drivers for inclusion of spiritual care resources are recommendations from the Healthcare Chaplaincies or usefulness of resources in specific areas of clinical practice. Resource choice also rests with the lecturer and their particular passion in interpreting the various components of SCE. There was in general a cohesiveness of use of resources across the HEIs, such as VBRP; What Matters to You and the 10 steps for Mental Health. But there were many other

unknown resources, and the interviewees felt a register of such resources would be useful if available.

2.10 Other drivers for SCE resources included accessibility; a good fit with curricular activities and vision of the curriculum; gaps identified in the existing resource list. It was mentioned that there is a careful balance between having appropriate resources and being overwhelmed by a cluttered reading list.

2.11 During the scoping review a resource list was compiled and can be found in *app iii*.

3. Description of Module titles using/not using spiritual care language

The Module titles as described in 1.4 were many and varied, with covert SC language. Described variously as holistic care, person centred care, relationship centred care, there were components of each of these that had the SC concept at its heart as described at the beginning by Mowat and Swinton (2018). One person did not feel this was an issue as the majority of SCE is covert within each of the year groups, expounding the broad values and philosophy which allowed SC to be part of the curriculum without actually verbalising it. The question raised by many of the HEIs was the definition of SC language which was inconsistent across the country.

3.1 Some felt that there is now more of an acceptance of SC language relating to mindfulness with a greater cultural and social awareness of SC within people's lives and a readiness to discuss them. For instance, using resources that draw on emotional responses and a willingness to openly discuss SC within the context of individual lives ensures a greater depth and richness of learning.

3.2 Given that most of the HEIs struggled to find SCE within their curriculum the discussion focussed on the concepts and values that embodied SC. Many of the interviewees alluded to 'a thread' or 'golden thread' of spirituality which could be found throughout their programmes. However, when asked to define this 'thread' there did not appear to be any language to describe it although similar words were used such as compassion, listening, the art of allowing someone to answer their own questions, hearing the non-verbal communication and giving permission to articulate it. Many of the resources such as

Death Cafes and narrative stories enabled these conversations between students. However, very few of the HEIs were able to draw these threads together into one subject and actively call it SCE. Most agreed that the components of SCE were core values required for nursing but were unable to add this to a packed clinical curriculum. As a core value only two HEIs recognised that this should be a required field in first year to prevent attrition, by addressing clinical placement fears and anxiety either of facing death or existential conversations. If a core value, then some commented that it should be reflected in the competency framework to give more kudos to SCE as a subject within the curriculum and consequently rigorously assessed.

4. Spiritual Care Language

4.1 There was a fear expressed during some interviews of using the language of spirituality: 'Why have we not articulated it better? We are threading it through but without calling it SCE and perhaps we should.' 'Have we exchanged PCC language for the SC language which brings a richness and depth to caring that PCC cannot as it deals with the problems of living rather than the living itself.' 'People don't like to use this language because they are fearful of the consequences of using the wrong language – or the perceived wrong language – but who taught or is teaching that it is inappropriate?' 'PCC has hijacked the language without taking any of the SC because that component is too deep to deal with.'

4.2 There appears to be no common language of SC within academia. Without the example of lecturers use of language students are unable to articulate this in clinical areas. Finding that language is problematic because it arises from personal meaning in life, world view, culture, and nurture/nature. One post registration course did not articulate the word spiritual anywhere in all its learning outcomes, even though in this specialist subject difficult conversations would be commonplace.

4.3 Sessions on communication in difficult circumstances are not in common usage for undergraduates and only found in two of the eight HEIs. One HEI commented that undergraduate students are not mature enough to withstand

the rigors of such language and due to a packed curriculum, it was better to focus on more useful clinical issues. However, one of the two HEIs that dealt with difficult conversations, did so because of the attrition caused by not addressing it. They felt that first year students needed that critical understanding to build on in later years as they developed life experiences and deepening their communication and listening skills.

4.4 Final reflective comment from a lecturer: 'The language of spiritual care has been handed down to non-qualified nurses who don't know what they are articulating and won't know unless they are taught and supported.'

5. Transference of learning

The transference of SCE learning into practice was evidenced through the use of resources such as Digital stories; Compassionate Connections and Relationship Centred theories. There was little evidence of assessment of SCE, only two out of the ten showing summative assessment, the rest were either formative or none at all.

5.1 All of the interviewees mentioned the need to link theories to learning, the connection between reality and theory. But in practice, many recognised that the gaps in learning were at the commencement of training, for without theory there is no framework on which to base meaning.

5.2 One HEI that assessed SCE did so because students are strategic in their learning and clinical transfer is based on their need to know. Their summative essay focused on a long- term condition in which the student discussed psychological, social, spiritual, and physical aspects of care related to that case study. The second HEI that assessed did so on clinical placements through mentors sign off. The tutors gained formative understanding of student learning through reflective writing and class engagement. Another said that there used to be a written assignment but now the assessment is non-specific and so interwoven with other subjects that it is often missed altogether.

5.3 Personal narrative enables transference of learning. One example was a 22-year old student nurse on community training dealing with a 22 -year old with

a brain tumour. She had been pregnant, lost the baby and was requiring palliative care. The nurse was able to learn how to manage her emotions in a group setting safely, responding appropriately and professionally. The complexities of emotional management borders SCE requiring specialist and sensitive teaching but enables nurses to link theories of learning with reality.

5.4 One HEI commented that SC 'bleaches into many aspects of care and cannot be removed as a single subject,' or from personal worldviews. One example was given of a black evangelical student with strong, dogmatic views. But in the safe environment of the class these could be discussed with respect, understanding professionalism within personal views which did not just transcend spirituality but also culture and colour. These are not easy discussions but are rich in learning. The challenge is for the lecturer to facilitate that safe learning environment.

5.5 Difficult conversations are challenging to both teach and assimilate into clinical practice. However, one HEI taught nurses not to avoid existential questions but rather to foster an environment which would encourage those deep feelings to surface. In order to do this, nurses were taught self-awareness and self-reflection.

5.6 Half of the HEIs talked of assimilation in learning where nurses learnt from each other as well as in class. Probably the greater part of their learning was in practice where they watched staff members, their mentor and each other making sense of class learning.

5.7 Two HEIs commented that lecturers bring a rich experience to students because of their own depth of learning. This brings with it another concept of enabling students to understand the essence of a particular patient rather than seeing them through the eyes of their condition.

5.8 It appears that difficult conversations are generally spiritual in origin. Both questions and answers require empathy, compassion and sensitivity which is a particular skill, essential to nursing and challenging to assess.

5.9 One HEI felt that although they presently had no assessment for SCE, perhaps it would give greater credence to the subject if it were assessed. Possibly the use of the nursing meta paradigm would lend itself to SCE assessment

preventing student strategic learning as it would be integrated widely across the four- year programme.

6. Methods of learning

Methods of learning were wide and rich across all the modules.

6.1 Small group discussions and reflective tutorials were among the most common form of learning, giving opportunity for sensitive conversations in a safe environment. Death cafes were a recognised form of small group discussion. One HEI described small group learning as active learning communities to which every student must belong throughout their training in order to discuss clinical issues in a safe environment. This was also used to reflect on difficult situations they had come across in the wards.

6.2 Other methods included: Digital stories; blended learning with an individual focus; case based scenarios; online learning; formal lectures; quizzes; debates; group learning and presentations; simulation; patient narrative; individual study; video presentations with discussion.

6.3 The Scottish Practice Based Competency Framework for nurses requires mentor sign off to show learning. Although this is strategic learning on the part of the students, they are still able to learn through emulation, simulation, and a sharing of knowledge.

6.4 Students are all encouraged in independent learning and it appeared that much of SCE is on a personal basis through reading lists. One HEI encouraged the reading of specific novels with SC values which were then discussed in their tutorial groups while another used a book group to initiate discussion.

6.5 A range of resources are chosen to deliver learning that tap into different learning styles.

7. Patient assessment

Without exception none of the HEIs used any form of patient assessment for spiritual care, despite the inclusion of patient spiritual assessment in the NMC guidelines for new nurses.

8. Vision for SCE

There was evidence of vision for the inclusion of SCE in future curricular studies, both in terms of pre and post graduate study.

8.1 Five of the ten HEIs were rewriting modules that encompassed SCE at the time of interviewing. All commented on the fact that this conversation had given them cause for reflection on the subject, and a register of resources which they had not previously seen. One mentioned that the resource list was the most valuable part of this scoping review.

8.2 One HEI speculated that as SC is not explicit in their programme it should belong in practice as learnt behaviour rather than taught theory. Person centred care appears to be more about routine and practicalities of a patient in care, even although this is not the taught theory.

8.3 Those few HEIs that did have a specific SCE component to their programmes commented that they wished to strengthen their modules, using more specific resources and external assets such as healthcare chaplains to aid in delivery.

8.4 'I don't know what I don't know about SC,' was one comment in the context of lack of specialist knowledge. This particular HEI was going to action SCE to the programme team for discussion.

8.5 Some discussion resulted from a possibility of a spiritual care competency framework, but many were divided. Because SC is seen as a 'bleaching' theory or a 'golden thread' concept, it cannot be seen as a tick box exercise on the part of strategic learners. Neither is it a clinical exercise where knowledge is learnt and practised. Rather it is an ongoing foundation of learning which grows with experience. Some recognised that this starts from the first student day, others felt

that it was too deep a subject to mix with clinical modules. One commented that SCE should be interwoven throughout the programme built incrementally along with communication skills. However, certainly for some there was a long- term aim to introduce SC into the first year rather than leaving it as small 'silo sessions later on.'

9. Barriers to SCE

There was also evidence of barriers to SCE and a recognition of gaps in present learning.

9.1 One of the barriers to learning is the size of a group and the subject being discussed. Due to the sensitive nature of SC small group discussion is an asset but not always possible with large year groups. For instance, in one- year group there was 650 student nurses and midwives. In another, the lecture theatre would be packed to its maximum of 60 students (pre-Covid).

9.2 Diversity of the group and cultural backgrounds may inhibit certain discussion, depending on the specialist knowledge of the lecturer. Therefore, it is possible that the lecturer could inadvertently act as a barrier to discussion.

9.3 Geographical extent of campuses is a challenge if lecturers only work on certain campuses. This requires specialist knowledge across a whole programme team, or it means one lecturer travelling extensively. Online small groups may help this, but discussion of sensitive nature usually requires face to face learning.

9.4 Packed curriculums present a barrier to any further additions and SCE is generally seen as low priority compared to clinical learning.

9.5 Some lecturers do not feel the necessity of SCE or that it 'doesn't fit our module'. This may mean prior learning with lecturers before delivery can take place.

9.6 Post graduate modules have an unspoken pre-requisite of the need to hold difficult conversations, presuming that experienced nurses are skilled in the art of SC. Quite often, post graduate students have not yet had appropriate life experiences to be able to deal with SC. For example: a student District Nurse had a case where a patient wanted to die in the local hospice but because of Covid-19

had to be looked after at home. The patient was of ethnic minority and therefore required specialist resources to be put into the home in order to accommodate his faith. The nurse was required to offer empathy and compassion within a different culture than her own causing a great deal of stress and consequent debriefing.

9.7 Nurses respond to the deeper meanings of life in different ways, appropriate to their levels of insight. In a large class of first year General Nursing students where the average age is 20 one lecturer commented that they did not have the maturity to deal with the depth of SC conversations, instead sat at the back of the lecture hall on their phones. Another commented that even post registration students did not understand the art of VBRP and talked over the lecturer. On the other hand, it appeared that Mental Health student nurses with the same lecturer understood the deeper meaning of SC and how it underpinned the day to day care of patients. While there are issues of experiential maturity present in every profession, nurses are expected to be resilient in their role from day one on clinical placement. Respect for learning on the part of the student requires concentration in a lecture; on the part of the lecturer an understanding that deep and rich engagement can only occur with small group learning. Teaching methods must match the subject and so experiential learning fosters relationships between student and mentor providing a forum whereby knowledge becomes understanding and competence.

9.8 There is a fear in speaking about spiritual care. On questioning HEIs about this it appears to be multifactorial: students being out of their depth; being unable to answer questions that were too deep; a fear of being inappropriate or overzealous; a fear of proselytization; lack of confidence in their ability to fix things, which nurses classically find pleasure in doing and where clinical problems are relatively straightforward to fix; an inability to listen carefully because of not wanting to hear what cannot be answered. So, there is a need to learn resilience and what to do with powerlessness. In terms of proselytization, one commented that in fact it is the lecturers who are left in this warp of fear which is born of a lack of understanding SC.

9.9 One HEI commented that there seems to be a lack of value placed on SC not only at student/learning level but also at higher management level where little credence is placed on it as a subject. This higher management level might be described as those who would take responsibility for ensuring that SCE is a core subject in healthcare learning so that it would become part of everyday conversation. Rather than as one junior doctor said to his patient who asked to see a Chaplain, 'oh that kind of thing went out of the window years ago.' This is no reflection on the doctor, but on those at educational management level and heads of programmes who deem SCE as unimportant. Module teams need to be guided by programme leads, who also need to be informed themselves. As there is no Scottish directive or consistency of practice for SCE each HEI interprets the need for SCE as they see fit rather than adhering to standards of professional practice that might be seen in a competency framework.

9.10 As mentioned previously there is no language to describe SC in HEIs. Without a language there is little desire for discussion or teaching. One HEI described SC as 'not sexy enough.' Clinical care is all about research and robust evidence- based practice which appears to have overtaken the holistic unseen care of a person in hospital.

9.11 One HEI mentioned that there is a huge tension between essential care and the non-essential and this is possibly because in adult nursing advanced technical orientation has dislodged the caring focus of the nursing theory. Has nursing lost its theoretical model of compassion and become a medical scientific model instead? Self-reflection requires time and is often squeezed out by the clinical element.

9.12 Supporting students in SC on the wards is time consuming. Critical conversation demands a skillset that is often not present on the ward and therefore the specialist knowledge of a chaplain is of paramount importance. While there is a tendency to refer all such conversations to the chaplain, there could be an understanding that students sit in on such conversations, learning by seeing and listening rather than abdicating learning. This requires a culture change from senior management to recognise the skills of chaplaincy, using them as student teaching assets.

9.13 SC seems to have been placed under the premise of palliative or mental health care rather than being available for all patients regardless of their condition.

9.14 The reduction in the number of long stay patients in hospital means that it is more difficult to have meaningful conversations or build relationships with short stay patients.

9.15 Because of the diversity of learning across the Scottish HEIs there is significant inequity in SCE. Some HEIs use the educational assets that Healthcare Chaplaincies offer while others have reduced the SC educational component of the curriculum. This produces a post code lottery for the students in terms of the specialist knowledge that could be available to them through chaplaincy teams.

10. Covid-19 Pandemic

The influence of the Covid-19 Pandemic cannot be denied and just over half of the HEIs recognised that this has changed their outlook on SCE. The NHS struggles with this 'last taboo' in supporting life/death situations and Covid-19 has magnified this, requiring HEIs to take note of the various challenges that have been identified during 2020.

10.1 The consequences of Covid-19 will result in further challenging and critical conversations that nurses may need to address in their training. Those patients who contracted the disease and survived, or those who have lost loved ones will need to talk through these traumas. No one has yet been prepared for these conversations. One HEI commented that we need to have some form of assessment tool ready as well as a referral pathway that does not lead straight back to the already overburdened GP.

10.2 In areas where Covid-19 has had little impact on the population, there have been neither questions from students nor class discussion on the immediacy of mortality. But in other areas where the possibility of death was a greater reality there was stress and anxiety amongst students. This was twofold: from the issues of working amongst highly contagious patients to the pressure of dealing with difficult conversations. One such example is of post registration students being

asked to complete Anticipatory Care Plans without previous training. This involves asking patients or relatives if they want to have Do Not Resuscitate (DNR) stamped on their form. The students were understandably anxious because they had no tools with which to assess patient understanding of DNR and no language or knowledge to answer existential questions. To combat this the lecturer ran webinars using Chaplains who talked through compassion and resilience. These were oversubscribed. Whatever the cause of stress and anxiety, student nurses needed high levels of support during the pandemic. For example one student had an end of life conversation with a 52 year old with Diabetes having never had this level of conversation before but was able to take it to the active learning community and discuss it openly with tutors and colleagues. Whether online or in person this still requires considerable manpower.

10.3 Covid-19 will change the way learning will take place. Education rooms are restricted in the numbers that can be taught face to face. For the present time, most learning will be online including discussion seminars. 'Where some subjects in health and social care lend themselves to blended learning, spiritual care and particularly the communication components do not. The human formation aspect of spiritual care takes place through discussion and shared experience.' One commented that blended learning is a challenge because of the need for face to face discussions which allow human development. Online conversations are only half a conversation – the other half is energy, body language and the ability to use silence, impossible on zoom.

10.4 One of the biggest problems nurses had to face during Covid-19 was their own mortality. There appeared to be an inequity in terms of help available as some HEIs reported that there was no one there to talk students through their questions when they felt anxious and fearful for the future. Nurses generally deal with other people's deaths or extreme illness, but in this situation, they were facing the possibility that they could be the next victim. However, it seems that some Health Boards had processes in place to offer support and counselling to healthcare staff and students. This took the form of telephone support systems, zoom calls and a physical presence from chaplains and psychologists, all using a tiered approach of support. Rather than there being no support available it is the

awareness of its existence that appears to be the issue as well as the inequity of that support across the country. There was also a general feeling that the culture of engaging with chaplaincy should be normalised rather than presuming that any engagement must represent some dysfunction or weakness of character.

10.5 During the pandemic there was also the problem of grief – grieving for the life they once had, now changed beyond recognition, both in the workplace and at home. There was a recognition that nurses needed to deal with themselves first before responding to patient grief and paralysing fear. 'This was no longer about diseases, which is easy to deal with – it was about life,' said one interviewee.

10.6 Some of the quotes gathered from the Wall Street Journal of April 10 2020 show the extreme grief suffered by relatives who are now trying to make meaning of the situation: 'I'll be with you every step of the way' a daughter promised her father before he got into the ambulance. She wasn't. In another case, the nurses held the patient's hand as she died while her eight children watched on video link: 'We have been robbed of those together stories because we could not even grieve together.' One man articulated a deeper spiritual dimension by saying: 'I thought I might die – I didn't want to go. I've prayed more in these past few weeks than ever before.' These deep conversations from patients and relatives require specialist knowledge and skills by those who nurse them.

10.7 Interestingly a positive comment was that Covid- 19 enabled and increased listening skills because students had time to listen to patients. The constant interferences from large ward rounds and visiting disappeared and so deep and rich conversations could continue uninhibited.

10.8 Another positive comment was that those nurses who had nursed patients through Covid-19 had a better understanding of the emotional and spiritual needs of these patients.

11. Comment on Scottish Government involvement

For a variety of reasons, the Scottish Government was not able to sign-off a draft delivery plan for Spiritual Care in 2014. In spite of this, various aspects of this draft delivery plan were fully supported and funded by the Scottish Government as 'demonstrator projects' in Spiritual Care – notably 'Community Chaplaincy Listening®' (or CCL®), 'Values-Based Reflective Practice®' (or VBRP®) and the Scottish Patient Related Outcome Measure® (or PROM®). However, there is an impression that ground has been lost in the absence of a nationally agreed strategy for the delivery of Spiritual Care. At least one HEI expressed the opinion that these conversations were not being taken seriously enough at Government level to make significant changes in nurse education. A new strategy is in the process of being developed which should be published in March of 2021, and the importance of training and education for all staff in Spiritual Care will be informed by this report and embedded in the strategy. The National Clinical Director is fully supportive of this area of healthcare and the need for a national strategy and is committed to speaking at its launch.

Conclusion

In conclusion it appeared that during the interviews most of the HEIs were having a conversation about SCE that they had not previously considered but recognised the need to add this into the curriculum in some form or other. However, the underlying question from the interviewer regarding the definition of SCE in a particular HEI was never actually answered. Most articulated that it was not necessarily a module, or a competency but rather a 'golden thread' or an infusion that permeates body, mind and spirit across all disciplines and subjects. There was no cohesiveness or even similar universal strands of the subject across the HEIs to allow academic sharing. Given the diversity of learning across Scottish HEIs there appears to be a panoramic inequity in the learning experience of student nurses. This not only impacts them during their training but may cause further post registration challenges.

Nurses continue to fear the subject of spirituality thinking that it is too personal, or it might somehow persuade them to think in a different way or indeed have a conflict of interest with the patient's care. However most nurses engage in the most intimate of personal tasks with all people from the community, yet baulk at the thought of having a conversation with someone who needs to make sense of the situation they find themselves in, which may just mean listening.

Core values of spirituality encompass faith, hope, and love in various and individual forms. These form the foundation of caring for others and ourselves. However, it appears that while most of the HEIs had included workshops or seminars in the curriculum to discuss existential issues, most were directed towards palliative or mental health care. The narrative of linking spiritual care and palliative or mental health care, while necessary, should be broadened to meet the life affirming needs of all people. Few HEIs have addressed this broad spectrum of spirituality, and the euphemisms used to address SC such as caring conversations and compassionate care fall short of the richness and diversity which enable and empower patients and their carers to find meaning within their current situations in life.

Table 2 summarises current SCE delivery in eight HEIs across Scotland, recommending ways in which gaps might be filled underpinned by existing literature. The question remains whether the information from this scoping review is transferable across Scotland's HEIs.

Table 2: Outlining current delivery and recommendations from scoping review

Current Delivery of SCE	Recommendations	Literature
1. Diverse range of SCE component in HEIs present curriculum on a scale from no mention to specific SCE modules.	Possible formation of focus groups among student nurses to discuss their perceptions of SCE. National agreement on SCE theory. National agreement on Core Values of spirituality. Equity of taught time across HEIs. Lectures delivered by SC specialists such as Chaplains. National competency framework for SCE.	Grosvenor D 2000 Teaching Spiritual Care to Nurses *Health and Social Care Chaplaincy* 3 (2) Baldacchino D, 2015 Spiritual Care Education of Healthcare Professionals Religions 2015, 6, 594–613; doi:10.3390/rel6020594
2. Rationale for inclusion of SCE in curriculums	NMC statement for new nurses. Attrition of students due to inability in dealing with issues of death and dying, rather than building knowledge, confidence, and resilience as they better understand their own mortality. Students as drivers to personalise content of curriculum. TURAS content – platform for CPD. RCN competencies for Advanced Practitioners require SC but generally not addressed during post registration training.	Pesut B 2003 Developing Spirituality in the Curriculum: Worldviews, Intrapersonal Connectedness, Interpersonal Connectedness *Nursing Education Perspectives* Nov/Dec pp 290-294 Cooper, K Chang E Sheehan A Johnson A 2013 The Impact of spiritual care education upon preparing undergraduate nursing students to

		provide spiritual care *Nurse Education Today* 33 pp 1057- 1061 NMC Code of Professional Standards of Practice for Nurses and Midwives 2018 Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf accessed October 2020
3. Module titles not reflecting language of spirituality	National agreement on SCE language. Examine the fear surrounding use of SC language and HEI decision as to whether students are mature enough to learn and use it.	McKenzie R 2010 *An Ethnography of Scottish Healing Wells, Their Contemporary Use, and the Implications for Nursing Practice* PhD thesis Filed in Aberdeen University
4. Lack of framework for transference of learning	Equity of learning conversational caring both pre and post registration. Understanding the rich diversity of the community and providing what matters most to the individual.	Principles of Spiritual Care Services 2008 Scottish Government Health Dept. CEL 49 Attard J Baldacchino D Camilleri L 2014 Nurses' and midwives' acquisition of competency in spiritual care: A focus on education *Nurse Education Today* 34 pp1460-1466

5. Methods of learning	Although richly diverse, require equity of learning across HEIs. Recognition and awareness of Chaplaincy specialist knowledge as an asset for learning.	Baldacchino D, 2015 Spiritual Care Education of Healthcare Professionals Religions 2015, 6, 594–613; doi:10.3390/rel6020594 Connors J Good P Gollery T 2017 Using Innovative Teaching Strategies to Improve Nursing Student Competence and Confidence in Providing Spiritual Care Nurse Educator March/April 42 (2) pp62-64
6. SC patient assessment	Use of patient assessment tools for SC required to fulfill NMC requirements for new nurses	Frouzandeh N Fereshteh A Noorian C 2015 Introducing a spiritual care training course and determining its effectiveness on nursing students' self-efficacy in providing spiritual care for the patients *Journal of Education and Health Promotion* May 4 (34) Lewinson L McSherry W Kevern P 2015 Spirituality in pre-registration nurse education

		and practice: A review of the literature *Nurse Education Today* 35 pp 806-814 Brémault-Phillips S Olson J Brett-MacLean P Oneschuk D Sinclair S Magnus R Weis J Abbasi M Parmar J Puchalski C 2014/16 Integrating Spirituality as a Key Component of Patient Care *Integrating Religion and Spirituality into Clinical Practice* Special Issue Editors Hefti R Arndt B European Conference on Religion, Spirituality and Health
7. Future vision for SCE in HEIs	A desire for inclusion but a vagueness about how this should proceed i.e. threaded through the course or a dedicated module. Either needs discussion on content definition. Dissemination of resource list to enable further discussion.	Kennedy J, Stirling I, McKenzie I, Wallace D 2013 *Developing Innovation in Spiritual Care Education: research in Primary Health and Social Care* Chaplaincy Report National Health Education for Scotland (NES)
8. Barriers to SCE	The challenge of smaller groups for discussion, which gives optimum efficacy, within large cohorts of students. Address challenges with multi campuses.	Taylor, R 2017 Progressive respiratory disease: The importance of prognostic conversations and advance care planning *Breathe* 13 (4) pp 269-273

	A general understanding that SCE should be included in nursing curriculum in all HEIs. The definition of spiritual care which requires updating	
9. Influence of Covid-19	Consider future papers on existential conversations with patients. Changes in methods of learning will reduce person to person engagement and discussion which is required for the deep personal discussions of spirituality.	Murray E 2019 Moral injury and the ongoing debate about the psychological harms of working in healthcare *British Journal of Cardiac Nursing* 14 (12) pp1-3 Stovall M Hansen L Ryn M 2020 A Critical Review: Moral Injury in Nurses in the Aftermath of a Patient Safety Incident *Journal of Nursing Scholarship* 0:0 pp1-9
10. Necessity of Scottish Government involvement	To work with SG to increase awareness of SCE and to ensure it has a platform in all HEIs in the future.	Principles of Spiritual Care Services 2008 Scottish Government Health Dept. CEL 49

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Appendices

Appendix i

Literature Search

A brief literature search has been conducted using Google Chrome and the Scottish Knowledge network. The snowball effect of the search yielded additional material, an ongoing process throughout the review, informing as interviews took place.

The main words used for the search were:

Teaching Spiritual Care Education for Nurses + Scotland + Higher Educational Institution 1994-2020.

This is by no means an exhaustive list as there is a plethora of information written on spiritual care education for nurses, allied healthcare professionals and Chaplains. This will provide an overview of the general direction of spiritual care education in Scotland throughout various institutions over the last twenty- six years and the rationale that has underpinned both the need and the trajectory. There are international papers which have been included to show that this subject has global initiative and the need to share what resources we have identified.

This scoping review is specifically looking at pre- and post-registration education in spiritual care for nurses and allied health professionals, excluding medicine and chaplaincy.

Table 3: Chronological Literature Search 1994 - 2020

Literature	**Short Review**
Bradshaw A 1994 *Lighting the Lamp* Scutari Press	The book is divided into four parts providing a theoretical framework for continuing critical work into research; education; methods and organisation of spiritual care and quality assurance. The four parts cover a theological and philosophical analysis of spiritual care; a historical investigation into the spiritual aspect of nursing; contemporary nursing anthropologies and finally the implications of practical application to patient care. While the modern approach of person- centred care is not addressed, the foundations of what we now use is embedded in the philosophy of holistic understanding and caring for the whole person. Bradshaw has written the book from the classic Judeo-Christian viewpoint in an effort to provide evidence for the spiritual dimension of man. While this is laudable for those who believe in theocracy, it somehow diminishes the spirituality of all the other faiths and non-faiths of the world. However, she does acknowledge the anthropocentric philosophical position of contemporary nursing which forms the body of her work. She posits that Descartes, the Father of the Enlightenment, is responsible for the purely physical understanding in patient care, and therefore has caused a split between body, mind, and soul.
Ross L 1996 Teaching Spiritual Care to Nurses *Nurse Education Today* 16 (1) pp38-43	Spiritual care is part of the nurse's role, but it is not clear if or how the subject is taught or how effective such teaching is in helping nurses to give spiritual care. This paper is an exploration of ways in which spiritual care could be taught, reviewed by Grosvenor in 2000.

Life Worth Living: How Someone You Love Can Still Enjoy Life in a Nursing Home; The Eden Alternative in Action: 1996 Amazon Books.co.uk: Thomas, William H	The Edenization of a community turns an institution into a home using the paradigm of joy, love, and hope. SCE is not overt, and neither is it named, but it is stamped across the whole philosophy. The foundation of Edenization has been used in some HEIs to teach students how to care, particularly for older people, who are called Elders, not because they are older, but because of the mature and experienced knowledge that they can bring to a community. Those who care for them are in their space at the Elder's invitation, not because the carer should be there.
Bradshaw A 1997 Teaching Spiritual Care to Nurses: An alternative approach *International Journal of Palliative Nursing* Jan 3 (1) pp51-57	Reviewed by Grosvenor as above

Grosvenor D 2000 Teaching Spiritual Care to Nurses Health and Social Care Chaplaincy *3 (2)* DOI: 10.1558/hscc.v3i2.28	The complexity of human experience of illness involves body, mind and spirit and the accompanying gender culture split has forced researchers to examine what spirituality really means. Ross (1996) argued the need for spiritual care education and devised a conceptual framework to help nurses meet those needs. Grosvenor cites four other educationalist models of spiritual care. Bradshaw argued that spiritual care is the basis of nursing until the Enlightenment when it became a 'contract of care rather than compassionate service' reducing spiritual care to physical care causing a lack of soul, spirit, and heart in nursing. On Grosvenor's course 4 hours was given to spiritual care education in the curriculum during 3 years of BSc Nursing. Difficulty finding qualified teachers in this area meant less credibility for this course. The author's final question asks: Is there a case for teaching spiritual care separate from bodily care, who should teach it and what should be taught?
Pesut B 2002 The development of nursing students' spirituality and spiritual care-giving *Nurse Education Today* 22 pp128-135	While the baccalaureate curriculum in Canada differs from that in the UK the education content remains broadly the same. This study explored how students perceived their spirituality and spiritual health, and spiritual care nursing. A questionnaire with open ended questions was given to first and fourth year students using the spiritual well-being scale. The fourth year students demonstrated a greater understanding of patient-centred approaches to spiritual care and could clearly identify the difference between spirituality and religion. A limitation of this study is that it was conducted in a Christian University and there was a bias towards most students having some form of religious faith. To be more robust the questionnaire requires to be taken to a secular HEI.
Pesut B 2003 Developing Spirituality in the Curriculum:	Pesut argues that including spirituality under a psychosocial domain does not address the specific needs of spiritual care, which addresses the inner core of the meaning of life rather than the external features

Worldviews, Intrapersonal Connectedness, Interpersonal Connectedness *Nursing Education Perspectives* Nov/Dec pp 290-294	that have an effect on one's mental health. Excluding discussions of God excludes beliefs of a significant numbers of patients, therefore we should not be afraid to debate what we might not believe. Worldviews, reflective practice on values and beliefs provide rich classroom dialogue and enable the exploration of the meaning of life with patients if required. Three elements of spirituality are explored which the author purports should be addressed in the curriculum: Interpersonal connectedness; intrapersonal connectedness; worldviews. While she is very definite about the value placed on the need to include spiritual care in nurses curriculum, she is also a realist in understanding some of the risks in exposing students to deep heart reflection.
McKenzie R 2010 *An Ethnography of Scottish Healing Wells, Their Contemporary Use, and the Implications for Nursing Practice* PhD thesis Filed in Aberdeen University	Chapters 4: Section 1 and 2 relevant for this study. A core aim of this research was to impact nursing care with a spiritual dimension. McKenzie purports that during the last part of the 20th century nursing became overwhelmed 'by the rapid growth in its technical base'. His examination of Evidence Based Practice concludes that there is a conflict of interest between politics and patients in which qualitative research appears to have no place, given that all research is based on the gold standards of RCT. McKenzie feels the gap between theory and practice is ever widening in terms of the reality of academia and the practical elements that make up nursing care – something which has not been truly defined. In particular he discredits Narayanasamy, McSherry and others for poor scholarship which he feels has damaged academic credibility of spirituality in nursing. Interestingly he cites works which have discussed the essence of spiritual care language.

Principles of Spiritual Care Services 2008 Scottish Government Health Dept. CEL 49	Seven main areas for underpinning all spiritual care services provided or funded by the NHS in Scotland. Also includes learning and training competency framework for practitioners
Cerra A Fitzpatrick J 2008 Can In-Service Education help prepared Nurses for Spiritual Care *Journal of Clinical Nursing* Vol 25(4) pp204-209	This paper reiterates the need for spiritual care educational intervention in nursing studies. This paper was a doctoral study, and the ASSET model was used as the basis for spiritual care education. The programme comprised of a 2- hour lecture with case studies and participatory discussion. Only 41 nurses were used in this study and all from the same hospital. The majority of the nurses were Caucasian which may have caused a biased variable in the results. However, all 41 nurses were affected by the educational intervention that they received despite the brevity of it. Other findings showed that those nurses who were affiliated in some way to religious or spiritual groups or with a personal understanding were more open to exploring these issues with their patients. This affiliation cannot be assumed and therefore the educational component is necessary for nurses to explore their own world view in spiritual care.
Cooper, K Chang E Sheehan A Johnson A 2013 The Impact of spiritual care education upon preparing undergraduate nursing students to provide spiritual care *Nurse Education Today* 33 pp 1057-1061	This was the first Australian study in the form of a literature review to observe the nature of spiritual care education in undergraduate nursing students. This review found that globally student nurses had neither an understanding of the term spirituality/ spiritual care nor had sufficient education to deliver spiritual care with confidence. The literature found that nurses need to have spiritual self-awareness which impacts on how they understand and provide spiritual care. Some researchers feel that spiritual care should be threaded through the curriculum, others feel that it should be a separate component.

	Given that the Australian NMC equivalent (ANMC) requires nurses to be prepared to provide spiritual care it is necessary to prepare them adequately.
Kennedy J, Stirling I, McKenzie I, Wallace D 2013 *Developing Innovation in Spiritual Care Education: research in Primary Health and Social Care* Chaplaincy Report National Health Education for Scotland (NES)	Main recommendation is that Spiritual Care Education should be offered on all medical courses at HEIs and highlighted an Asset based Approach to Spiritual care education. Interviews were conducted with 31 health and social care practitioners; policy makers; voluntary workers and chaplains. Three recommendations: 1. Common frameworks should be introduced to Spiritual care with an asset- based approach. This had been previously highlighted in the Harry Burns Annual Report of 2009, the discovery of assets in the community which can build health and wellbeing. 2. Joint training which is locality based. 3. Action research across sectors. The principles of asset- based approach is outlined through discussion with other practitioners. 'Take the pain,' says Mark Evans Chaplain NHS Fife 'and translate it into words.' Commenting on this paper, Jane Cantrell, and Jane Harris (NES) both felt a discussion of Spiritual care should be included when planning workforce development around person centred practice.
Rosvik J 2013 Development, evaluation, and the effects of the VIPS practice model for the person-centred care of patients with dementia: An intervention study in	This paper has been used to describe the implementation of the VIPS framework, used in some universities to give a framework for spiritual care, although this is not articulated in spiritual language: The 'VIPS' framework developed by Dawn Brooker sums up the elements in person centred care for persons with dementia as Values, Individualised approach, the Perspective of the person living with dementia and Social environment.

Norwegian nursing homes dissertation University of Oslo	
Timmins F Neill F 2013 Teaching nursing students about spiritual care – A review of the literature *Nurse Education in Practice* November 13 (6) pp 499-505	Increased secularization in Europe and resulting ambivalent attitude towards spirituality and religion is contrasted with increased professional and public interest in this topic. Additionally, there are concerns that patient's spiritual needs are not being met and nurses are often ill equipped to provide this care. Nurses while positively disposed towards spiritual care delivery, and often carrying out spiritual care in practice, do so with little preparation. While teaching spiritual care to nursing students is advocated there is little research on this topic. Three papers were identified that examined teaching approaches with nurses and nursing students. Due to methodological issues such as small sample sizes and limited testing generalizing from these studies is difficult. Approaches used were firmly rooted in a religiosity framework.
Attard J Baldacchino D Camilleri L 2014 Nurses' and midwives' acquisition of competency in spiritual care: A focus on education *Nurse Education Today* 34 pp1460-1466	Identifies the predictive effect of pre and post registration taught study units in spiritual care competencies for nurses and midwives. This was a quantitative study with participants from the spiritual care study unit in Malta University. The response rate was 89% and 74% respectively. A Likert spiritual care competency scale was mailed to all participants who were required to maintain anonymity. No significant differences were found between nurses and midwives apart from an increased awareness and knowledge following education in the nurses. This finding increases understanding on the transfer of knowledge to competency after learning. It appeared that for spiritual care to be routed into subsequent care, education and learning should be integrated in one of two ways: either at the beginning of UG training and then again through the academic programme or

	academically and clinically across the entire programme. Either way the pedagogical methods need to be robust for effective learning. The authors acknowledge the high percentage (95%) of Roman Catholic nurses may have biased the results of this study towards Maltese culture.
Taylor E Testerman N Hart D 2014 Teaching Spiritual Care to Nursing Students: An Integrated Model *Journal of Christian Nursing* April/June 31 (2) pp94-99	Graduating nurses are required to know how to support patient spiritual well-being, yet there is scant literature about how spiritual care is taught in undergraduate programs. Typically, spiritual content is sporadically included; the authors recommend integrating spiritual care throughout the nursing curriculum. This article describes how one Christian nursing school integrates spiritual care content, supports student spiritual well-being throughout the program, and evaluates spiritual care instruction at graduation.
WHO Global Atlas of Palliative Care at the End of Life 2014	Within the WHO definition of palliative care, the document states that this type of care integrates the psychological and spiritual aspects of care. However, in the paragraph that discusses psychological, social, cultural, and financial barriers, spiritual care is not even alluded to. Even recognizing that CHAT (a project in Tanzania) is based on the Lutheran Church healthcare system this still does not translate into any spiritual language, the sustainability of which is supported by a large network of fundraising Evangelical Lutheran Churches in Tanzania and America. There are no available resources to support spiritual care education.
Baldacchino D, 2015 Spiritual Care Education of Healthcare Professionals	Integration of theoretical SC education into clinical practice in Malta. This article advised the importance of a hospital chaplain even with SC trained nurses, because Chaplains would have specialised care in theological beliefs and conflicts. This research was carried out using inter-professionals, adopting online learning and interactive simulation models. A literature review revealed four main areas as essential for

Religions 2015, 6, 594–613; doi:10.3390/rel6020594	learning SC: importance of real-life situations; use of pedagogical methods such as reflective journals; awareness of and overcoming conditions inhibiting spiritual care learning; evaluation of students SC learning experience. In Malta voluntary work in a spiritual setting is acknowledged by the University. Interesting exercise where 15 students were invited to experience an hour of aloneness in a room without clock or phone to simulate the possible feelings of boredom and isolation experienced by older persons. They also used arts for expression of the complex needs of SC. Recommendations: 1. Examination in SC would identify the degree of acquisition of competence – need to develop a framework on competencies in SC. CPD in order to maintain those competencies. 2. Clinical practice: teachable moments on reflection and supervision for debriefing.3. Management: spiritual leadership to foster spirituality in the workplace. 4. Further research needed to identify the most appropriate and effective pedagogical approaches. 5. Personal spirituality fosters a healthy spiritual environment.
Frouzandeh N Fereshteh A Noorian C 2015 Introducing a spiritual care training course and determining its effectiveness on nursing students' self-efficacy in providing spiritual care for the patients *Journal of Education and Health Promotion* May 4 (34)	Introducing SC training in a nursing school in Iran. Interestingly China, Malta and Iran have all quoted Florence Nightingale. Lack of nurse understanding in SC has driven this research, recognising the importance of the nurse in this role of offering SC. Methods of teaching used were theoretical understanding and identifying SC needs, brainstorming, analysis of spiritual stress, small group work and sharing personal experience and reflection. Practical assessments of actual patients in oncology wards and evaluation of their performance with patients. Conclusion: SC training increased nurses understanding and confidence in giving SC.

Lewinson L McSherry W Kevern P 2015 Spirituality in pre-registration nurse education and practice: A review of the literature *Nurse Education Today* 35 pp 806-814	A systematic literature review which revealed studies involving pre-registration programmes in spirituality are few, those that did exist showed innovation in the teaching of spiritual care. 28 studies, mostly from North America with only four from UK, observed spiritual awareness amongst students; spiritual assessment of patients; spirituality through the medium of art and the context within pre-registration educational programmes. The conclusion affirmed the spiritual dimension of nursing as an established concept and the need for education to fulfil it. However more research is needed to justify its inclusion in nursing programmes.
Cooper K Chang E 2016 Undergraduate nurse students' perspective of spiritual care education in an Australian context Nurse Education Today 44 pp 74-78	The Australian equivalent of the NMC requires competency in providing spiritual care as a part of holistic care provision. Despite this there is poor educational preparation. This qualitative study looked at how competent student nurses felt in providing spiritual care after completing a module in the subject. This comprised of 3 h F2F lectures per week for 13 weeks. The study found that nurses felt better prepared to provide holistic and spiritual care after receiving SCE. The study was extremely small however and the module appeared lengthy given all clinical modules to be studied. The reason for this was that the college had a Christian orientation.
Mark Hazelwood, Scottish Partnership for Palliative Care Rebecca Patterson, Scottish Partnership for Palliative Care Scottish Hospices working to address the challenges facing	This report is a collaboration by the Scottish Partnership for Palliative Care and all Scottish Independent Voluntary Hospices. Most hospices have education departments and provide education and training on a range of topics including holistic assessment and symptom management; communication skills; anticipatory care planning; breaking bad news; loss, grief, and bereavement; family support and spirituality in healthcare.

health and social care in Scotland 2016 Available at: https://www.palliativecarescotland.org.uk/content/publications/SPC00001-Final-Summary-ONLINE.pdf accessed October 2020	
Connors J Good P Gollery T 2017 Using Innovative Teaching Strategies to Improve Nursing Student Competence and Confidence in Providing Spiritual Care Nurse Educator March/April 42 (2) pp62-64	Nurses felt there was inadequate preparation to deal with patients' spiritual needs. Discussed various teaching methods of simulation, reflective journaling, and lecturing. Nursing literature provides little information on how to teach spiritual care. This article looks at interrupted simulation teaching with reflection halfway through. This included spiritual assessments and small group work, active listening, and appropriate touch. Student perception of their ability to provide spiritual care improved significantly with this method of teaching.
Taylor, R 2017 Progressive respiratory disease: The importance of prognostic conversations and advance care planning *Breathe* 13 (4) pp 269-273	While this article is based on the palliative care of patients with COPD and their prognostic conversations, it formulates the opinion that the medical model needs to be realistic in order to meet emotional needs in a deep and meaningful way rather than meeting needs according to a curative model. It is here that the medical and nursing models diverge. This paper transcends all the normal taboos of death and the 'drive to survive', instead it is based on honest questions such as what does the future hold? These are the basis of spiritual care regardless of the trajectory of life placing. On

	discussing the subject of hope Taylor insightfully suggests that 'hope is a complex mix of anticipatory perspective that is about much more than survival.'
Booth L Kaylor S 2018 *Holistic Nursing Practice* July/August 32 (4) pp177-181 Teaching Spiritual Care Within Nursing Education: A Holistic Approach	Student nurses are unprepared to meet the spiritual needs of patients and are often uncomfortable addressing this. This article aims to describe the student perspective of spirituality in relation to the holistic care model. Findings from the study provide insight about preparing nursing students to deliver spiritual care in nursing practice.
Warrender D MacPherson S 2018 *Making Sense: Death, dying and mental health* Palliative Care within Mental Health: Ethical Practice Ch 23 pp324-337	A treatise/individual study paper about the meaning of death and how people deal with the inevitability of life and death. It discusses denial, social disengagement, and the subject of social death, when a person is viewed as less socially valuable, compared with biological death. It discusses the five key components of Spirituality: meaning; value; transcendence; connecting; becoming. All of which may be the driver for nursing care, individually or corporately. Warrender and MacPherson's 'spiritual transition model' shows how mental distress may move through 5 stages before once again living a meaningful life.
Hu Y Jiao M Li F 2019 Effectiveness of spiritual care training to enhance spiritual health and spiritual care competency among oncology nurses *BMC Palliative Care* 18 (104)	Although spiritual care is a basic element of holistic nursing, nurses' spiritual care knowledge and abilities are often unable to satisfy patients' spiritual care needs. Therefore, nurses are in urgent need of relevant training to enhance their abilities to provide patients with spiritual care. China places great emphasis on spiritual health, recognising that nurses are the chief providers of SC to patients. However, they recognise that inadequate training has led to unmet needs in patients. Currently at the time of

	writing there is little relevant interventional research. In this study nurses were recruited by voluntary participation and randomly assigned to an intervention group. Subsequently a SC training protocol was drafted, and the results showed that training intervention increased the nurses understanding and therefore confidence in delivering SC. The recommendation of this paper was that nurses urgently needed to receive education or training to improve their spiritual care knowledge and skills. Limitations of study – nurses were only recruited from a single hospital and had a minimum of seven years' experience.
Murray E 2019 Moral injury and the ongoing debate about the psychological harms of working in healthcare *British Journal of Cardiac Nursing* 14 (12) pp1-3	Describes moral injury as the witnessing of inadequately addressed human suffering or being exposed to morally injurious experiences bringing about feelings of shame and guilt, manifesting as social isolation and emotional numbing. Research suggests that the quality of social support at the time of event can reduce the impact. Processing such events need to take place in appropriate places, with the right people and time to reflect.
Suh-Ing H Li-Ling H Chen-Yi K Breckenridge-Sproat S Hui-Ling L Chen T Tzu-Hsin H Tsung-Lan C 2019 Factors associated with spiritual care competencies in Taiwan's clinical nurses: A descriptive	A study to determine the factors associated with nurses' spiritual care competencies. Descriptive correlational method with cluster sampling from 14 units of a medical centre and a hospital. Questionnaires yielded a 97.03% response (incentive of 250 NTW dollars given after completing the questionnaire). Several spiritual care-related scales were used for the study. The results of the study showed that most Taiwanese nurses felt they were moderately able to deliver spiritual care but needed a role model in the clinical setting as well as a moderate interest in spirituality. Having a higher educational level or having Christian/catholic beliefs and experiencing a major life event significantly negatively correlated with their spiritual care competence. The study concluded that these factors need

correlational study *Journal of Clinical Nursing* 00 pp1-15	to be addressed to enhance their spiritual care competency as well as enhance recreation for meditation; encourage practice of spirituality; provide good role models; good bedside teaching; objective structured clinical examinations and continued self-reflection.
Best M Leget C Goodhead A Paal P 2020 *BMC Palliative Care* 19 (9) An EAPC (European Association for Palliative Care) white paper on multi-disciplinary education for spiritual care in palliative care	The aim of this white paper is to guide educators of palliative care healthcare professionals in spiritual care education. Four core elements of spiritual care competencies which had been previously outlined by Gamondi et al (2013) were explored, critically revised, and updated into the present spiritual care education in palliative care. Further notes are in the Education Models *app ii*.
NMC Code of Professional Standards of Practice for Nurses and Midwives 2018 Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf accessed October 2020	Specific parts of the Code which allude to Spiritual Care: Prioritising People: You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed, and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged. 1 Treat people as individuals and uphold their dignity To achieve this, you must: 1.1 treat people with kindness, respect, and compassion 1.3 avoid making assumptions and recognise diversity and individual choice

	1.5 respect and uphold people's human rights 2.2 recognise and respect the contribution that people can make to their own health and wellbeing 2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing, and care 2.6 recognise when people are anxious or in distress and respond compassionately and politely 3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life 3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information, and support when they need it.
Stovall M Hansen L Ryn M 2020 A Critical Review: Moral Injury in Nurses in the Aftermath of a Patient Safety Incident *Journal of Nursing Scholarship* 0:0 pp1-9	Defines moral injury as 'one that violates deeply held moral values and beliefs, and can put an individual at risk for burnout, post-traumatic stress disorder, or a betrayal of what is right by someone in a position of authority.' The results of a mixed methods study showed that there were core moral injury symptoms: guilt; shame; spiritual existential crisis and loss of trust. Secondary symptoms of moral injury included depression, anger, self-harm, anxiety, and social problems. The authors examine the phenomenon of nursing perfectionism which often causes moral distress given that dealing with human nature will never yield a perfect breeding ground. Memories of bad experiences cause moral residue. Exposure to a life altering event at work can lead to long-term emotional, psychological, and spiritual harm. Moral injury described as 'a deep soul wound that pierces a person's identity, sense of morality, and relationship to society.' As this was merely a literature review the authors were only able to

	describe the symptoms and their causative factors. Further research has been urgently demanded to take this further.
UK Board of Healthcare Chaplains Competency Framework 2020	This is a nationally agreed standard of practices and competences for all UK healthcare Chaplains. The structure follows NMC pillars, using the four word domains: Professional Practice; Organisational Practice; SC Practice and Reflective Practice. It follows the philosophy of EPICC's definition of spirituality and spiritual care, which places care and values on the bias of palliative care although the framework goes far beyond. It states that 'competence in spiritual care is now expected of nurses' defining this and recognising that there should be some partnership of SC with patients. The framework uses SC language that is familiar and based on personal values such as celebration, hope, dignity, respect, privacy, empathy, compassion.

Appendix ii

Models of SCE Learning:

This literature search describes thirteen models of SCE learning that are used in curriculums internationally. This is not an exhaustive list by any means. The challenge to all curriculum developments is that observed by Attard et al (2019), to add another module to an already packed curriculum means that SCE is likely to drop off the end of the list. Clinical learning will always trump existential learning as it is considered the necessary part of a nurse's duty to the patient. However, as the evaluation in all these models of learning has proved, nurses still must answer existential questions and need the confidence, knowledge, and skills to be able to answer professionally and with competency.

All these models of learning from 1999-2020 are still in use in one form or another, perhaps having been modified by the various international HEIs to suit their own curriculum. The spiritual language used in each model ensures that nurses can articulate this in the clinical space, unafraid to do so having been able to discuss this first in the classroom setting.

1. Attard et al Ross competency Framework (2019) details 54 competencies for spiritual care and the development of this into a framework for learning. Seven spiritual care domains were evaluated positively in Malta and subsequently trialled in 19 countries. It is able to transcend through all modules as a threaded approach rather than the stand-alone module.

2. Barba B Tesh A Courts N (2002) describe the Edenization of community living which turns an institution into a home using the paradigm of joy, love, and hope. SCE is not overt, and neither is it named, but it is stamped across the whole philosophy. The foundation of Edenization has been used in some HEIs to teach students how to care, particularly for older people, who are called Elders, not because they are older, but because of the mature and experienced knowledge that they can bring to a community. Those who care for them are in their space at the Elder's invitation, not because the carer should be there.

3. Best et al Palliative Care Model (2020) addresses spiritual care in an end of life setting. It was a reworking of Gamondi et al's (2012) model of SCE which developed modules as standalone or incorporated into existing modules. This is multi-disciplinary learning led by the Chaplain. Facilitated self-reflection is blended with an understanding of spiritual care and the tools required for spiritual assessment. What is most interesting about this model is the spiritual care language used throughout, and therefore a rounded understanding that what is being discussed in the classroom will reach the bedside.

4. Frouzandeh (2015) training course: Trialled and evaluated in Iran using blended learning which taught nurses how to alleviate spiritual tension in patients. Prior to this model being launched there had been no concept of SCE within the curriculum. The evaluation showed a marked improvement in the confidence of nurses to offer and promote spiritual care amongst patients.

5. McTaggart et al (2012) GLIDER Model was developed by a Chaplaincy team for delivery across several platforms of learning. It used blended learning with practice-based scenarios and was developed using the Spiritual Care Matters document for NHS Scotland. Learners explored spiritual care issues in secure environments, using summative assessment to gain the final certificate. Evaluation demonstrated improved patient care and staff wellbeing. This Model is now being rewritten to take into consideration more current methods of practice in SCE.
6. Narayanasamy' s ASSET Model (1999) was developed in response to the need for clearer direction in the delivery of SCE for nurses. It is a standalone module using blended learning applying knowledge and skills in the practical setting. The list of resources which accompany this model are all pre 1999, although Narayanasamy' s own work was republished in 2001.

7. Norwegian Partnership Model developed by Strand et al (2016) was a mixture of didactic teaching and reflective groups. It was particularly addressing questions of an existential nature raised by patients that nurses could not answer. After evaluation,

this study concluded that the learning model had the potential to increase nurses' confidence in delivering spiritual care by being able to answer questions of life.

8. RCN Domains and competencies for Advanced Practitioner's (2018) list Spiritual Competencies from 7.9 – 7.14 in its document. While this is not a model in itself it does list six areas of SC which makes the presumption that an advanced nurse practitioner is able to assess spirituality for a patient in their care and then provide respectful and appropriate information to fulfil a patient's needs.

9. Williams (2015) described the Roper-Logan-Tierney (R-L-T) model of Nursing which is a practice centred theoretical model grounded in realism and accessibility. In 1929 Jean Piaget advanced developmental theory in psychology, underlying it with the philosophy of pragmatism. Roper, Logan, and Tierney used Piaget's theory to formulate a model of nursing now widely used (Bradshaw 1994). It was Roper (Edinburgh University) who first devised a model to answer the question 'What is nursing?' during the 1970s. Logan refined the model with Tierney and the results were published in 1980 as The Elements of Nursing. Over the years this has been further refined in line with current thinking to facilitate teaching and learning, patient assessment and care planning. Some HEIs feel that this addresses the spiritual content of a curriculum.

10. Spiritual Care Competencies for Chaplains (2020) details a Higher Education programme for healthcare chaplains across the UK. Four domains describe expectations of a registered healthcare chaplain focusing on spirituality and spiritual care, assuming that any religious needs will be met in the context of appropriate spiritual care. This has been included as it broadly follows the spiritual conceptual framework expected of nurses in training and could be helpful when discussing SCE.

11. Sulmasy' s (2002) Biopsychosocial-Spiritual Model: This model is used in some HEIs as a way of approaching a complete understanding of a persons' wholeness. It was first initiated by George Engel in 1977 and later a similar model was adopted in 1996 by White, Williams and Greenberg. It was then developed by Sulmasy (2002) into a model

of restoration of right relationships within the body. Interestingly his meaning, value and life statements correspond particularly with the pandemic in 2020: Dying raises questions of value, often subsumed under the term dignity; questions of meaning are often subsumed under the word hope. Questions of relationship are often expressed in the need for forgiveness. To take this further: to die believing that one's life and death have been of no value is the ultimate indignity; to die believing that there is no meaning to life, suffering, or death is abject hopelessness. To die alone and unforgiven is utter alienation. The author examines various ways of assessing spiritual needs, attitudes to stressful life events in order to find those that are best able to facilitate the patient's spiritual healing at the end of life.

12. Warrender and MacPherson's (2018) 'spiritual transition model' shows how mental distress may move through five stages before once again living a meaningful life. They discuss denial, social disengagement, and the subject of social death, when a person is viewed as less socially valuable, compared with biological death. The five key components of Spirituality: meaning; value; transcendence; connecting; becoming are modelled as the driver for nursing care, individually or corporately.

Appendix iii

Resources for SCE Learning

The resources that are in this register are wide ranging from across Scotland. Some are national and all are globally accessible as of April 2020. To the authors knowledge there is no such register of SCE resources available in Scotland apart from this tentative gathering of information.

Table 4: Resources in Spiritual Care Education for Health and Social Care workers in Scotland available October 2020

Spiritual Care Education Resource	**Information**
Acceptance and Commitment Therapy	A previous GP who made a career change to psychotherapy and life coach devised behaviour change strategy increasing psychological flexibility. This intervention uses acceptance and mindfulness and has become increasingly used in mainstream education as Acceptance and Commitment Therapy (ACT). Further information at: https://contextualconsulting.co.uk/workshop/russ-harris-webinar-series-tune-up-tuesdays-practical-playful-webinars-to-lift-your-act
Conversation Ready	This is a framework for improving End-of-life care and is a white paper enabling healthcare organisations and clinicians to provide respectful end of life care that is concordant with patient stated goals, values, and preferences. The framework is relevant whether you are a leader in a large hospital, a social worker in the community, a doctor in a clinic, or a palliative care nurse in a skilled nursing facility. Further information at: http://www.ihi.org/resources/Pages/IHIWhitePapers/ConversationReadyEndofLifeCare.aspx

CRUSE Bereavement Care Scotland	An on-line training course **Bereavement and Loss for NHS Scotland**, commissioned by the Scottish Government Health Directorates, has been undertaken by more than 10,000 NHS Scotland staff and can be made available to other organisations and groups. **Grief Awareness Training**, helping professionals to raise their knowledge and awareness of bereavement issues, is regularly delivered to a wide variety of audiences, including solicitors, care homes, health, and social care staff. Further information at: http://www.crusescotland.org.uk/mqta.html
Death Café	Inspired by a Swiss sociologist Bernard Crettaz, Jon Underwood founded the Death Café, a social franchise and irregular event, now held worldwide, to open a frank discussion of death over tea and cake. The first café was in London in 2011 from which he and his mother produced a guide to running Death Café. There have been more than 4800 in 51 countries. It is now being used as a teaching model to enable students to discuss the question of death in a secure and safe environment. The students choose their topic for discussion from a 'menu' of starters, mains, and dessert. Tragically Jon died of a brain hemorrhage at the age of 44. For further details at: https://deathcafe.com/deathcafe/11487/
Death Doulas	People who are certified to offer calm and tranquility in the process of death and dying. For further details can be found: https://doulagivers.com/?gclid=CjwKCAjw1K75BRAEEiwAd41h1EZU-Oy3VUZA2Rh5i1pzCjcC7p4cXjVrDpRe2R1d6KTy7HX5xstz0xoCPQUQAvD_BwE

Digital Stories	Engaging students in constructivist learning of which one example can be found: http://nursingeducation.lww.com/blog.entry.html/2019/04/03/utilizing_digitalst-OShD.html
Dundee University	Spiritual Care Programme for UG Nursing Curriculum which has based the module on current literature for Spiritual wellbeing and Spiritual Care. The driver for this inclusion is the NMC statement which expects newly qualified nurses to be able to make an …..assessment of…..spiritual needs.
Faith in Older People (FiOP) Spiritual Care Matters: online learning	This educational resource is based on and supported by Spiritual Care Matters (NES, 2012). As an eLearning course it has been piloted and well received in Care Homes and is now available to all health and social care workers across Scotland. Further information at: https://www.faithinolderpeople.org.uk/resources/?resourcetopic=spirituality Spiritual Care Matters is an online learning course designed to promote, recognise, respect, and support the spiritual well-being of older people. The course is an introduction to spiritual care, exploring how spiritual care is defined, what it means in practice and why it matters. The course uses Open Badges to recognise learning for ongoing staff development. The course is made up of 5 x 30 minute 'lessons' received in a daily email. Each 'lesson' consists of a short Audio Podcast (this is a mini broadcast), a practical task and some questions to help reflect on learning.

Healthcare Chaplaincy NHS Boards in Scotland	NHS Boards in Scotland have spiritual care training programmes, developed in response to requests for training from various disciplines and units and provided by the chaplaincy teams. Some provide this in conjunction with HEI's, please contact the relevant health board chaplaincy team for your area. The training can comprise of the following: a) Medicine of the Elderly – 'Spirituality at the End of Life' Continuing Professional Practice Development – The Final Act of Care – 'Spiritual and Religious Care – Multi-Cultural and Religious Diversity Issues' b) Foundation In Critical Care – 'Spirituality in the ICU Setting' c) Palliative Care – 'Spirituality in Palliative Care' d) Weekly staff induction – face to face introduction to the Spiritual care team for all new NHS staff e) Paediatric nursing staff – mandatory updates: Spiritual Care in situations of loss and bereavement f) Paediatric health care support workers – mandatory update: Spiritual Care in situations of loss and bereavement g) The Spiritual care team can act as professional supervisors for a range of student placements: medical students; nursing students. The Spiritual care team can facilitate group staff support and debrief sessions at the invitation of medical and nursing staff in particularly complex or traumatic cases. The team can offer

	one to one support for staff e.g. after complex and challenging cases, following personal bereavement or the death of a close colleague. All these are subject to availability in the different health boards in Scotland.
Huunuu Cards	A series of cards that create big conversations in three easy steps: Talk; Plan; Share. Further information at: https://www.huunuu.com/ Used by some HEIs as a resource for discussion groups.
Janki foundation based in the UK	Free mobile App offers meditations as 'antidote' for stressed healthcare professionals and carers. Called Happidote. Module 7: Spirituality in healthcare Exploring spirituality and healing / Spiritual care in practice. Further information at: https://www.jankifoundation.org/
McSherry Dr W Making Sense of Spirituality in End of Life Care 2015 Available at: http://tvscn.nhs.uk/wp-content/uploads/2016/02/Master-Class-27-01-2015.pdf accessed October 2020	A report for Staffordshire University with power point presentation. It points to the importance of 'educational preparedness' and the need for a comprehensive and holistic assessment which includes spirituality. It includes a helpful spiritual taxonomy and a spiritual assessment acronym. It concludes with a recognition that while many health professionals already possess the skills to undertake spiritual care, the knowledge needs to be refined and purposeful.
McTaggart I Munro G Rogerson E Martingdale L 2012 Learning about Spiritual Care: It Matters! *Journal of Healthcare Chaplaincy* 15 (1)	A small e-learning unit (GLIDER™) aimed at all healthcare workers who have contact with patients and their families was developed in partnership with the University of Dundee and NHS Tayside, supported by NHS Greater Glasgow and Clyde, funded by NHS Education Scotland. Common themes of change were noted in participants including becoming more

(GLIDER: provided by the Council of Deans of Health, was delivered over 6-8 weeks in the first year of pre-reg course with Four key elements: 1. Spiritual Care Matters Document 2. Reality practice based scenarios 3. Online discussion boards based on a film. 4. Interactive element linking theory and practice	focussed in their thinking, more aware of the needs of their colleagues and considerate as to the place of faith appropriate to the individual. The GLIDER™ has now been refined and used as part of the undergraduate nursing programme at the University of Dundee whilst currently being considered for inclusion in both the medical and dental school undergraduate programmes as part of the university's commitment to interprofessional learning.
National Health Education for Scotland (NES) Host for: Values Based Reflective Practice Community Chaplaincy Listening Service	<u>Values Based Reflective Practice (VBRP)</u> Spiritual Care is person centred care which seeks to help people (re)discover hope, resilience, and inner strength in times of illness, injury, transition, and loss. Spiritual Care is provided by all who work in health and social care as well as by patients, carers, and friends. The role of specialist spiritual care providers - healthcare chaplains - includes helping to resource, enable and affirm colleagues of different disciplines in their

Religion and Belief Matter: An information resource for all Healthcare Staff A Multi-Faith Resource for Healthcare Staff Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff 2012 Compassionate Connections Programme	delivery of spiritual care. Significantly this involves supporting them in reflecting on their own spirituality and that of patients and their carers. In the field of Spiritual Care, NES has the following roles: • Continuing professional development of healthcare chaplains • Developing educational resources to enhance the delivery of spiritual care by the health and social care workforce in Scotland • Helping to promote an evidence base for spiritual care which informs best practice Values Based Reflective Practice, otherwise known as VBRP®, is a model which has been developed by NHS Scotland to help staff deliver the care they came into the service to provide. It does this by promoting regular inter-disciplinary group reflection through using community space. This community space aims to provide: • Information and a source of support to those trained in facilitating VBRP® sessions • Advice for those wishing to find out more about VBRP® and signposts to local information

	• Information for managers considering utilising the principles of VBRP® within their organisation. VBRP® can be used by anyone working in health and social care and is applicable across all disciplines and professional groups. VBRP® uses the principles of reflective practice to enable practitioners to understand and recognise their personal and professional value and by doing so supports them in delivering safe, effective, and person-centred care. Available at: http://www.knowledge.scot.nhs.uk/vbrp.aspx accessed October 2020 The Community Chaplaincy Listening Service The Community Chaplaincy Listening service, through active listening, seeks to build resilience and enhance wellbeing; allowing individuals to tell their story in the presence of those who have particu1lar spiritual expertise. Healthcare Chaplains help individuals to explore questions and seek meaning in their story as they try to deal with life and its transitions. The Listeners do not have the answers but take seriously the questions people are asking and can often help the individual 'hear' what they are saying themselves. This enables people to discover their own way forward which offers the potential for transformation and change - thereby supporting positive self-management and promoting wellbeing.

	Contact for further details: Alan Gibbon CCL Scotland Programme Administrator Email: alangibbon@nhs.net Email: CCL@nes.scot.nhs.uk Religion and Belief Matter: An information resource for all Healthcare Staff A 33- page document written in 2008 for the purpose of raising awareness and provide links between religion, spirituality, and health. The vulnerability of people when they are ill should be protected by those who care for them, who in turn require understanding and knowledge in all areas of physical, mental, and spiritual aspects. This resource covers: What are religious needs and what is the link between religion and health? Why respond to them and who responds and what is the evidence base for responding? What Health boards can do and what is the relevant legislation? Available at: http://www.elament.org.uk/self-help-resources/religion-belief-matter-an-information-resource-for-health-care-staff-nes/ accessed October 2020 A Multi-Faith Resource for Healthcare Staff Produced for NHS Scotland, this resource describes and discusses the main faith and belief groups in Scotland. It shows the religious and cultural diversity of six million people and was

	developed to underpin the guidelines for the spiritual care policy of patients within the NHS. It covers all the following areas: Introduction • Attitudes to healthcare staff and illness • Religious practices • Diet • Fasting • Washing and toilet • Ideas of modesty and dress • Death customs • Birth customs • Family planning • Blood transfusions, transplants, and organ donation. Available at: https://lx.iriss.org.uk/content/multi-faith-resource-healthcare-staff accessed October 2020 Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff Seminal work on Spiritual Care resources in Scotland (2012) which answers the question why spiritual care is necessary and important. Can be used in tandem with the multi-faith resource manual as it underpins the definition of spiritual care and the robust research that accompanies the rationale for education and delivery in the NHS. Gives a message to educators and methods of learning such as narrative and reflection. In order to maximise the utilisation of Spiritual Care Matters, eight projects across Scotland were awarded £3,000 each to develop spiritual care education of pre and post registration healthcare professionals. The reported activity was highlighted at a conference in May 2010, published Dec 2012. Four received national awards and the interim report recommended better integration with health and social care priorities. (Spiritual Care Matters: A health

	professional workshop: final Report SE region 2010). Available at: https://www.faithinolderpeople.org.uk/resource/spiritual-care-matters/ accessed October 2020 Compassionate Connections Programme An educational resource that combines stories and learning guides providing a rich panorama of people living real lives. Visual aids, learning sessions and lesson plans are all available for both health and social care students and post registration CPD. Resources are free for those who become part of the community of the knowledge network. Available at: http://www.knowledge.scot.nhs.uk/compassion.aspx accessed October 2020
Nolan, M Professor Sheffield University Relationship Centred Theories	Prof Nolan has been working on the value of relationships between people which are the fundamental basis of care. Although this is born out of gerontology he feels that it is transferable across the ages. He has developed a framework of learning and his vimeo is available at: https://www.kingsfund.org.uk/audio-video/mike-nolan-how-relationship-centred-care-can-improve-patient-outcomes accessed October 2020
Patient Voices	Using reflective digital storytelling to unearth first person stories that use compelling and motivational insight driving organisational change, growth, and success. Available at: https://www.patientvoices.org.uk/ accessed October 2020

RCN (2011) Spirituality and nursing care: a pocket guide. RCN, London.	Written by Professor Linda Ross this is a helpful pocket booklet that illustrates the need for on the go knowledge of SC. Available at: http://www.elament.org.uk/media/1205/spirituality_in_nursing_care-_rcn_pocket_guide.pdf accessed October 2020
Reed's Spiritual Perspective Scale 1987	Spiritual Perspective Scale (SPS; Reed 1987): a 10-item self-report scale of the saliency of spiritual beliefs and behaviours in many different aspects of the participant's life; 6-point Likert scale format; the scale was developed primarily for assessing the elderly, in a nursing context, but gave an ability to meet patient spiritual needs. Academic citation found at: Reed P 1987 Spirituality and well-being in terminally ill hospitalised adults *Research in Nursing and Health* 10 (5)
SAGE and THYME Developed by Manchester University NHS Foundation Trust 2018	SAGE & THYME is a mnemonic that acts as an aid memoire for a structured conversation with a person in distress or with concerns. 'SAGE' gets the user into the conversation and 'THYME' gets them out. This is a structured spiritual care resource enabling the healthcare worker to assess the situation quickly and with empathy. It is based on the evidence behind effective communication skills: Setting – Ask – Gather – Empathy – Talk – Help - You – Me – End. The SAGE & THYME foundation level workshop is taught to 30 participants in 3 hours using three trained SAGE & THYME facilitators, using group work, a presentation and conversation rehearsals. Available at: http://www.sageandthymetraining.org.uk/sage-thyme-model-and-benefits-1 accessed October 2020

Spiritual Well Being Scale Paloutzian R and Ellison Bufford R 2002 *Journal of psychology and theology* 19(1) pp56-70	A scale used in psychology to determine the spiritual wellbeing of a person which has translated well into the nursing situation. Spiritual Well-Being Scale (SWB; Ellison 1983): developed as a general indicator of the subjective state of well-being, the SWB provides an overall measure of the perceived spiritual quality of life in two senses: religious and existential. It consists of 20 items on a 7-point Likert scale, with two subscales. Article available for full download at: https://www.researchgate.net/publication/232527349_The_Spiritual_Well-Being_Scale Accessed October 2020
Nurse Spiritual Care Therapeutics Scale Taylor E Mamier I 2015 *Western Journal of Nursing Research* Vol 37 (5) pp 679-694	An instrument to assess spiritual care by nurses. This paper assesses the use of such spiritual care instruments and others.
Talking About Spirituality in Health Care Practice White G (2006) Published by Jessica Kingsley	Jessica Kingsley publishes a range of books on spiritual care
Ten Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland) 2011 National Health Education for Scotland	Available at: http://www.knowledge.scot.nhs.uk/making-a-difference/resources/ten-essential-shared-capabilities.aspx accessed October 2020 Para 2.3 Religion, belief, and spiritual care short discussion and then an activity following which relates to mental health and sexual orientation. The resource gives good guidance on mental health and wellbeing.

What Matters to You?	A resource from NES and Scottish Government that has been individualised to each area in Scotland. It asks the questions of individuals in order to assess and understand the person centred care that matters to that person. Available at: https://www.whatmatterstoyou.scot/ Accessed October 2020

Appendix iv

Interviews for Scoping Review April – June 2020

Spiritual Care Education for healthcare professionals in HEIs, Scotland

Each interview will be conducted maintaining anonymity for both interviewee and the name of the HEI in question when writing up the scoping paper and disseminating the information.

Areas of inquiry interview guidelines:

1. An understanding of what is presently being offered in the curriculum which specifically alludes to spiritual care as defined by Mowat and Swinton (2018):
   'Spiritual care acknowledges the presence and importance of such things as joy, hope, meaning and purpose as well as the reality of disease, suffering, disappointment and death. This means that spiritual care is much broader than any one faith or religion and is of relevance to everyone. The Spiritual task is to offer friendship, comfort and hope to each other in ways that are meaningful to the individuals concerned.'
2. Can you tell us about the spiritual care education component in your curriculum?
3. Are you able to tell us how you put together the spiritual care education component in your curriculum?
4. Can you share with us the methods of learning you employ to deliver spiritual care education?
5. How does your curriculum assess spiritual care education during undergraduate training?
6. Where does spiritual care learning fit into the present competency framework for undergraduate training?

7. Do you use any of the spiritual care patient assessments that are presently available, such as:

    a. Narayanasamy,1999, 2001 ASSET Model (Actioning spirituality and spiritual care education and training in nursing) Acronym ACCESS

    b. Puchalski and Romer 2000 Acronym FICA

    c. Ananda Rajah and Hight 2001 Acronym HOPE

8. Are there any other educational resources that you use which have a spiritual care approach?

9. What is the driver for choice of spiritual care educational resources?

10. Have you heard of any of the educational resources that are attached in Table I?

References for interview guidelines

Mowat H Swinton J The Purple Bicycle Project 2018 Available at:
https://www.abdn.ac.uk/sdhp/documents/TPBP_Booklet_1.pdf

Accessed March 26 2020

McSherry Dr W Making Sense of Spirituality in End of Life Care 2015 Available at:

http://tvscn.nhs.uk/wp-content/uploads/2016/02/Master-Class-27-01-2015.pdf

accessed March 26 2020

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